Medicaid Transformation Learning Symposium

Advancing Adoption of the Collective Platform

October 9, 2019

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Jenna Moody, Health Plan Success Manager

collectivemedical®

Our mission

Eliminate friction from care delivery

through real-time collaborative care

Agenda

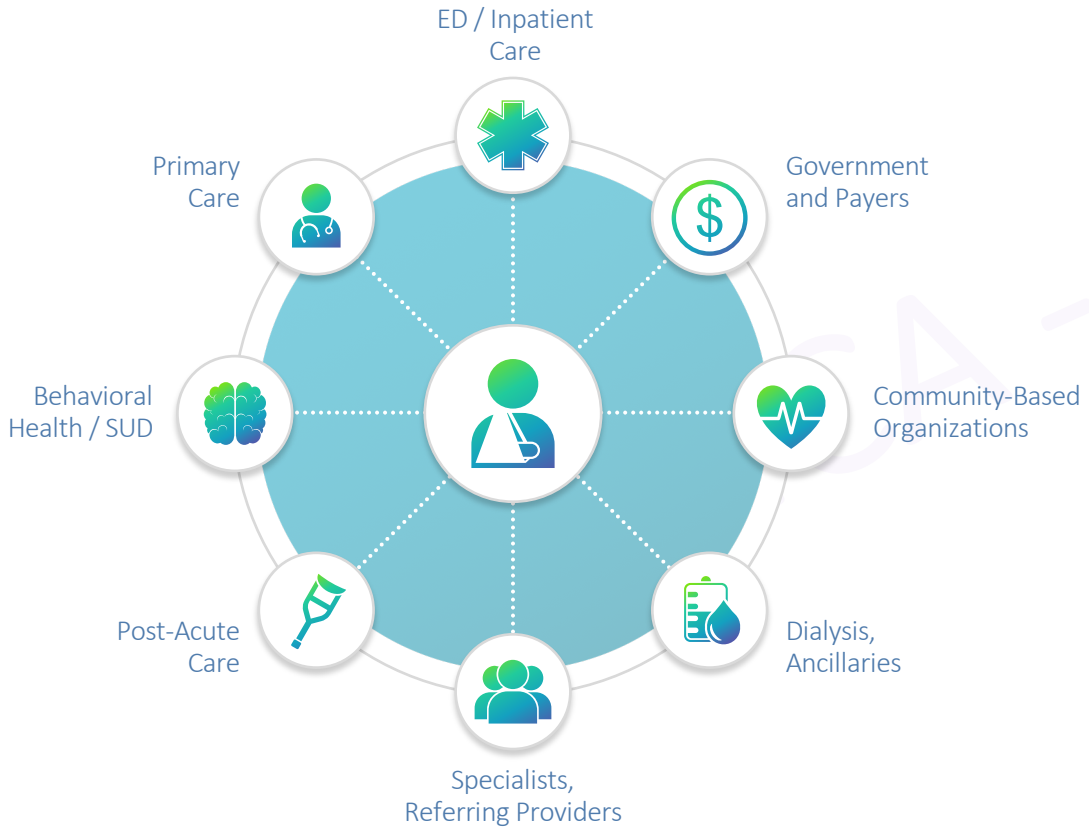
Collective Medical and Network Updates

Successes with Washington MCOs

Use of Collective Platform

Collective Engages Diverse Providers on a Common Patient

Collective is a patient identification and tracking solution that gets the right information to the right person at the point of care. Our mission is to eliminate friction from care delivery through real-time collaborative care



A NETWORK

Collective is a network of hospitals, emergency departments, primary care, specialists, behavioral health, post-acute care, and health plans across the United States, sharing important patient information at the time of care

A PLATFORM

Collective is a platform that intelligently connects each member of a patient's care team for seamless collaboration at the right time and through the best medium

A COMMUNITY

Collective is a community of providers in the care of patients—especially those with complex medical needs—in your communities and across the country.

Washington, Statewide outcomes

Providers in Washington faced a threat in 2011 that would have limited Medicaid reimbursement to three non-emergency visits per year. Physicians rallied to find an alternate solution and implemented the ER is for Emergencies program, for which Collective Medical was and remains the technical backbone. All hospitals and nearly all payers and ambulatory providers in the state are on the network.

After joining the Collective network and implementing our platform, care teams in Washington state saw:

…all within the program's first year of use.

Elevator Speech: Collective Helps Washington achieve improved patient outcomes at a lower cost

Reduce avoidable hospital admissions and readmissions

Reduce overdoses and opioid prescriptions coming from the ED

Reduce number of ED encounters from frequent utilizers

Improve efficiency in post-discharge follow-up

Increase savings both at an organizational level and statewide

Improve satisfaction from both patients and providers

The Collective Platform

COLLECTIVE EDie

Emergency Department Providers

Identifies high-risk patients who walk in "the front door" of a health system: delivers key insights to providers at the point of care

COLLECTIVE ACO

ACO Care Managers, ACO Network Providers

Communicates in real-time when and where members are having clinical encounters and stratifies encounters into cohorts of interest – each with a respective set of alerts and workflow orchestrations; captures and shares care plans/guidelines and care history information on high-risk members who traverse the Collective Network

COLLECTIVE PLAN

Risk-bearing Entity Care Managers and Case Managers

Improves transitions of care by electronically routing discharge information from acute facilities; improves data transmission from post-acute settings to/from the ED

COLLECTIVE AMBULATORY

Clinic Physicians, Case Managers

Alerts providers when complex patients of interest (i.e. those defined in analytics) have encounters across the Collective Network; captures and shares care plans/guidelines and care history information on complex members who traverse the network

COLLECTIVE POST-ACUTE

SNFists

Improves transitions of care by electronically routing discharge information from acute facilities; improves data transmission from post-acute settings to/from the ED

Collective's unique capability is to identify, connect, and facilitate collaboration across providers sharing in complex patients' care. A dynamic patient-specific care plan is paramount to the impact of the Collective platform.

Engaging Providers on a Common Population

Collective is a patient identification and tracking solution that gets the right information to the right person at the point of care. Our mission is to eliminate friction from care delivery through real-time collaborative care

STRATEGICALLY ALIGNED

Collective is a network of hospitals, emergency departments, primary care, specialists, behavioral health, post-acute care, and health plans across the United States, sharing important patient information

TECHNICAL READINESS

Collective is a platform that intelligently connects each member of a patient's care team for seamless collaboration at the right time and through the best medium

OPERATIONAL FIT

Collective is a community of providers, nurses, social workers and case managers in the care of patients—especially those with complex medical needs—in your communities and across the country.

“What does HIPAA say specifically about Treatment, Payment, Healthcare Operations (TPO), and public health?”

Use and Disclosure for Treatment

“A covered entity may disclose protected health information for treatment activities of a health care provider”

– 45 CFR 164.506(c)(2)

Use and Disclosure for Payment

“…to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits”

– 45 CFR 164.501

Use and Disclosure for Health Care Operations

“…population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination”

– 45 CFR 164.506(c)(4); 45 CFR 164.501

Use and Disclosure for Public Health

“A covered entity may use or disclose protected health information for the public health activities and purposes in this paragraph [such as collecting or receiving] information for the purpose of preventing or controlling disease, injury or disability…"

– 45 CFR 164.512(b)

Other useful links and information

Recent articles about Collective Medical and Collective EDie:

- Addressing the health care system flaws that feed the opioid crisis
- Emergency Department Information Exchange Can Help Coordinate Care for Highest Utilizers
- How an IPA in Washington Collaborates with the Local EMS
- De-risking care transitions by distilling signal from noise
- Empowering case managers to drive better patient outcomes

THANK YOU
Need more information?

Feel free to email:
rachel.leiber@collectivemedical.com

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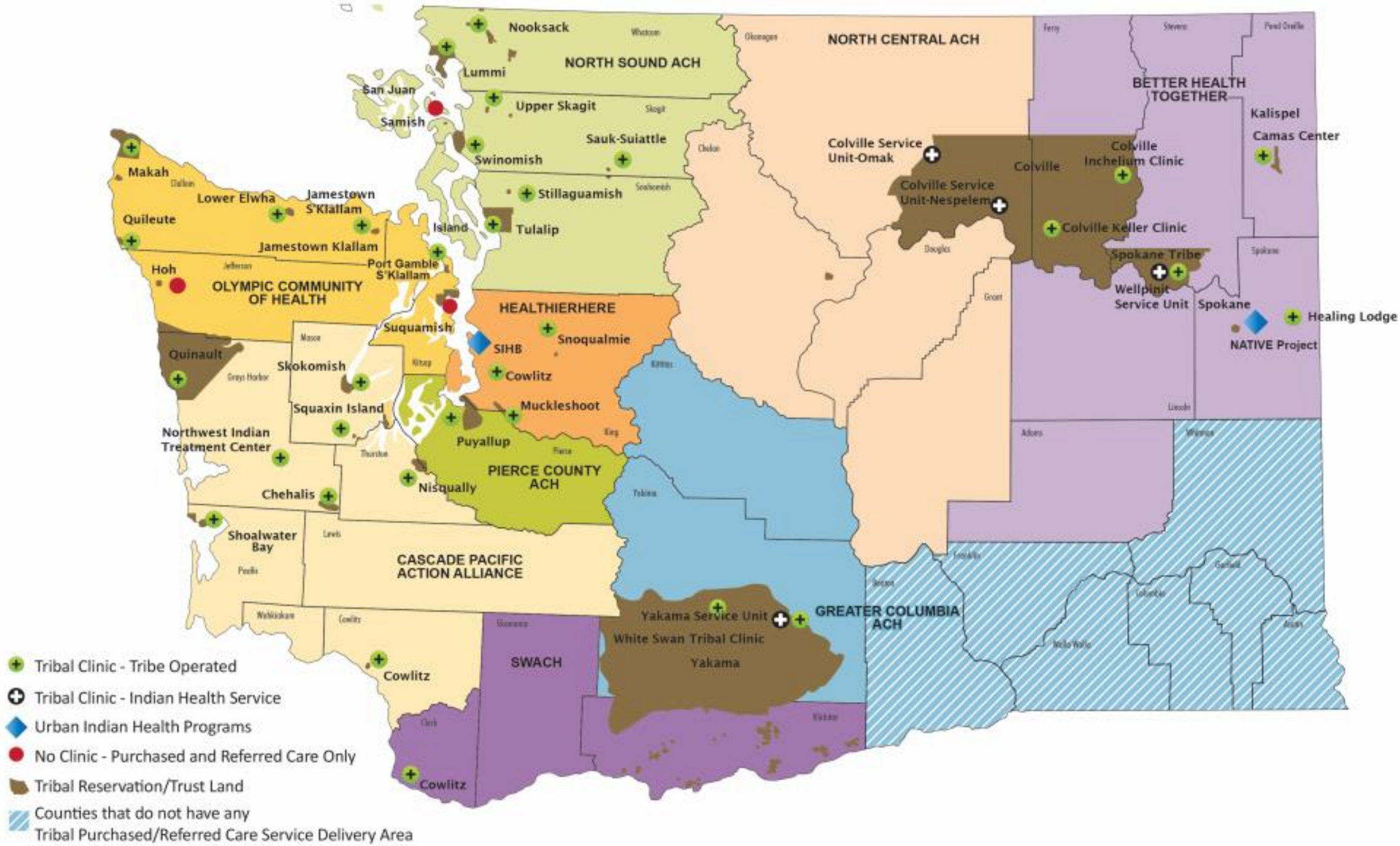
North Central Accountable Community of Health

Assisting partners with Collective Medical implementation

Efforts To Date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Suquamish
Port Gamble S'Klallam
Jamestown Klallam
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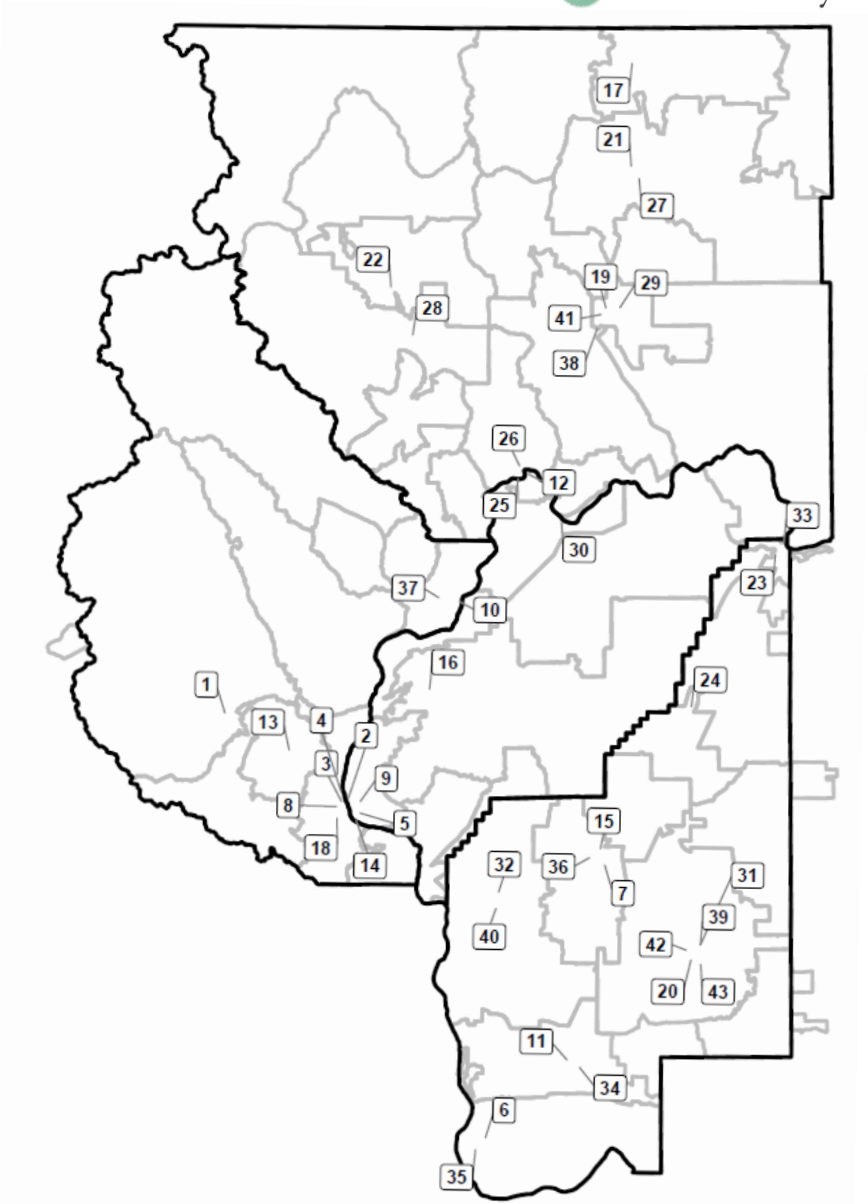
Snoqualmie
SIHB
Cowlitz
Muckleshoot
Puyallup
PIERCE COUNTY ACH
Nisqually
Quinault
Skokomish
Squaxin Island
Northwest Indian Treatment Center
Chehalis
Shoalwater Bay
CASCADE PACIFIC ACTION ALLIANCE
Cowlitz
SWACH
Cowlitz
NORTH CENTRAL ACH
Colville Service Unit-Omak
Colville Service Unit-Nespelem
Colville
Colville Inchelium Clinic
Colville Keller Clinic
BETTER HEALTH TOGETHER
Kalispel
Camas Center
Spokane Tribe
Wellpinit Service Unit
Spokane
Healing Lodge
NATIVE Project
Yakama Service Unit
White Swan Tribal Clinic
Yakama
GREATER COLUMBIA ACH
Tribal Clinic - Tribe Operated
Tribal Clinic - Indian Health Service
Urban Indian Health Programs
No Clinic - Purchased and Referred Care Only
Tribal Reservation/Trust Land
Counties that do not have any Tribal Purchased/Referred Care Service Delivery Area

Outpatient Partners

North Central Accountable Community of Health

Whole Person Care Collaborative

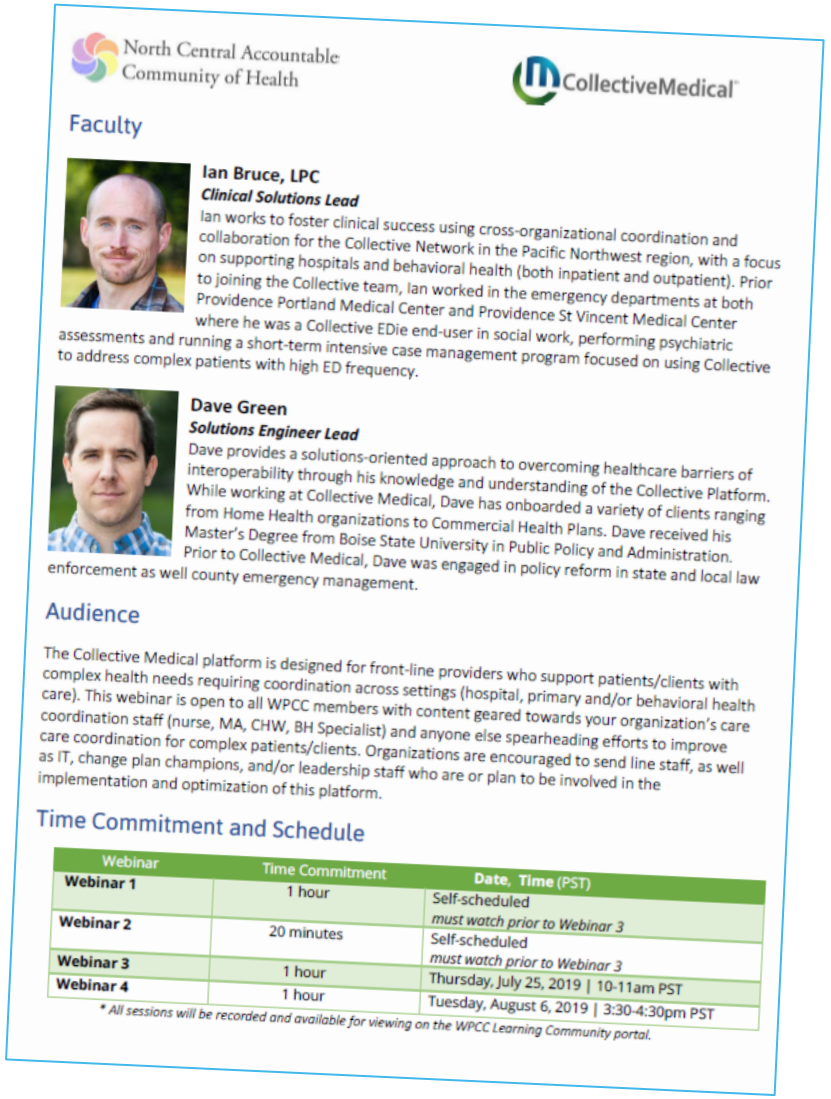
- 17 healthcare organizations (41 clinics/sites)
  - 4 FQHCs
  - 5 BH orgs (10 sites)
  - 5 orgs managing both primary care clinic(s) and critical access hospital
- Varying levels of integration



Training and TA for clinics

North Central Accountable Community of Health

- 2 self-scheduled (pre-recorded) webinars
- 2 live webinars with CM staff
  - Focus on notifications/cohorts (what do you wish you knew?)
  - Focus on care guidelines/histories (what do you wish others knew?)
- Individualized TA from practice facilitators (in the early stages)



North Central Accountable Community of Health

CollectiveMedical

Faculty

Ian Bruce, LPC
Clinical Solutions Lead
Ian works to foster clinical success using cross-organizational coordination and collaboration for the Collective Network in the Pacific Northwest region, with a focus on supporting hospitals and behavioral health (both inpatient and outpatient). Prior to joining the Collective team, Ian worked in the emergency departments at both Providence Portland Medical Center and Providence St Vincent Medical Center where he was a Collective EDie end-user in social work, performing psychiatric assessments and running a short-term intensive case management program focused on using Collective to address complex patients with high ED frequency.

Dave Green
Solutions Engineer Lead
Dave provides a solutions-oriented approach to overcoming healthcare barriers of interoperability through his knowledge and understanding of the Collective Platform. While working at Collective Medical, Dave has onboarded a variety of clients ranging from Home Health organizations to Commercial Health Plans. Dave received his Master's Degree from Boise State University in Public Policy and Administration. Prior to Collective Medical, Dave was engaged in policy reform in state and local law enforcement as well county emergency management.

Audience

The Collective Medical platform is designed for front-line providers who support patients/clients with complex health needs requiring coordination across settings (hospital, primary and/or behavioral health care). This webinar is open to all WPCC members with content geared towards your organization's care coordination staff (nurse, MA, CHW, BH Specialist) and anyone else spearheading efforts to improve care coordination for complex patients/clients. Organizations are encouraged to send line staff, as well as IT, change plan champions, and/or leadership staff who are or plan to be involved in the implementation and optimization of this platform.

Time Commitment and Schedule

Webinar	Time Commitment	Date, Time (PST)
Webinar 1	1 hour	Self-scheduled *must watch prior to Webinar 3*
Webinar 2	20 minutes	Self-scheduled *must watch prior to Webinar 3*
Webinar 3	1 hour	Thursday, July 25, 2019 | 10-11am PST
Webinar 4	1 hour	Tuesday, August 6, 2019 | 3:30-4:30pm PST

** All sessions will be recorded and available for viewing on the WPCC Learning Community portal.*

*Talk to **Mariah Brown** or **Wendy Brzezny** if you want to learn more about this approach!*

Hospital/ED Partners

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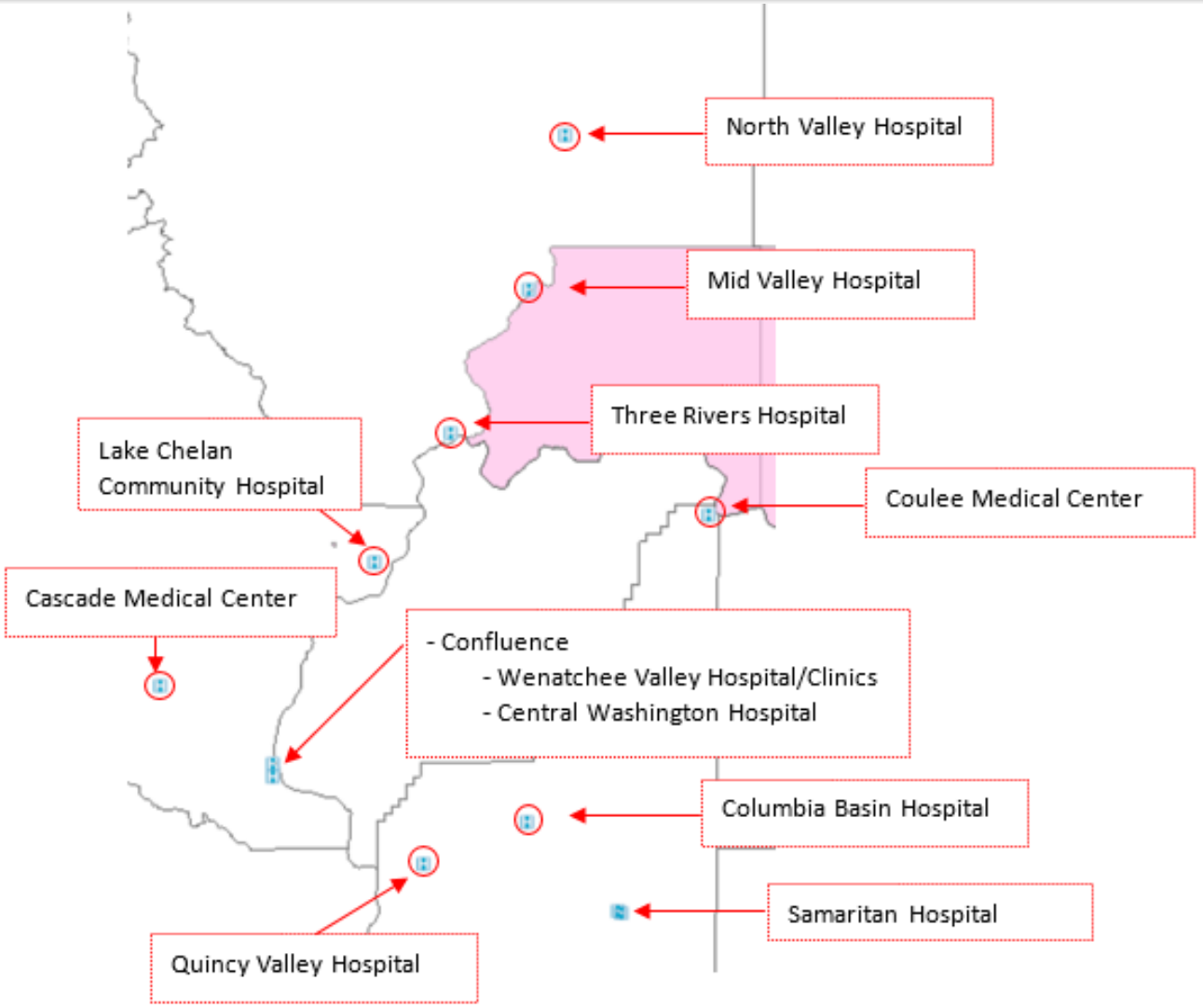

Source: Health Services and Resources (HRSA) Map Tool
Critical Access Hospitals circled in red

Training and TA for EDs

North Central Accountable Community of Health

- EDie for Beginners webinar
- Clinical Training for ED staff (1.5 hour webinar with CM staff)
- Training targeting managers/leaders (EDie Super User Training: Overview for Leadership)
- Optional in-person meetings with CM staff onsite (technical focus on reports)

Talk to John Schapman if you want to learn more about these approaches!

Lessons Learned & Next Steps

North Central Accountable Community of Health

- Not every organization had capacity to take on Collective Medical implementation at this time
  - Chose to meet them where they were at (no requirements)
  - Partners appreciated structure and flexibility
- Allowed organizations to self-select into TA/training
  - Recorded trainings for benefit of frontline staff and future use
- Encouraged partners to start small
  - Experiencing small wins helps with buy-in!
- Plan on offering continued training/TA throughout the MTP with goal of making tool stick (regardless of staff turnover, EHR changes)
  - Combination of individualized and regional support
- Look forward to statewide efforts with workgroup!

Parting Thoughts

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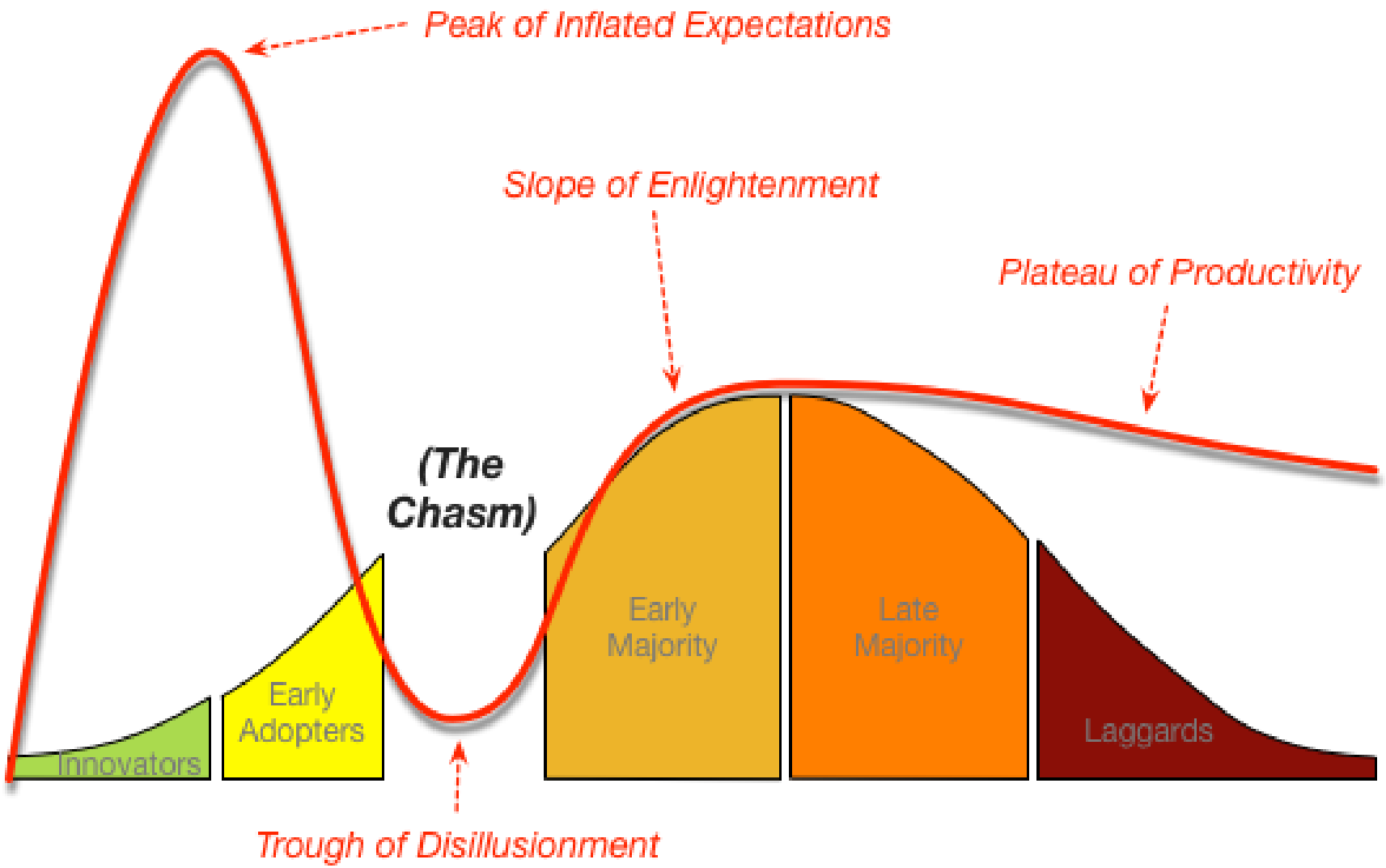
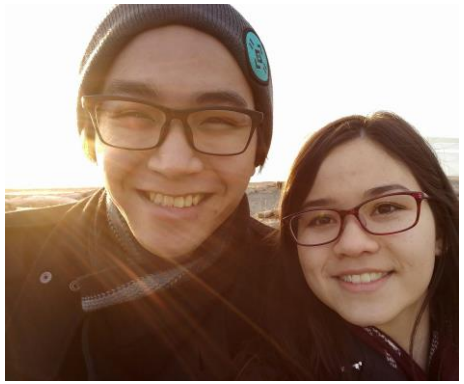


Source: http://weblog.tetradian.com/2016/08/09/tech-adoption-tech-evolution-lifecycle-mgmt/

HealthierHere


Healthier Washington Learning Symposium October 9, 2019

Collective Ambulatory: Optimization and Standardization

A Call to Action

- Michael McKee, Director of Clinical Practice Transformation, HealthierHere
- Abby Berube, Assistant Director – Safety and Quality, Washington State Hospital Association

Current State

Problem: While adoption of Collective Ambulatory is growing, its use is not optimized.

Fractured Health System	• Unclear team roles and responsibilities • Diverse organizations receiving referrals
Inefficient Communication	• Variation in use/interpretation of data fields • Redundant documentation in disparate places • Time wasted looking for right info at the right time
Underutilized Technology	• Troubleshooting in a vacuum • No shared learning to inform system enhancements

Future State

Goal: Reliably and effectively coordinate care for patients across settings using the Collective Ambulatory platform.

Statewide Consistency (norms)

- Clear content creators vs content consumers
- Standardized data input, retrieval, and sharing of information
- Process to continuously improve, update or maintain data
- Training and QA support

Streamlined Feedback to Collective Medical

- Challenges shared across settings indicate priority of fixes
- Workarounds discussed in context of care delivery
- Access to critical info across the continuum

Patient Safety

- Shared or co-created care recommendations
- Increased visibility of an individual's care team
- Real-time notifications of ED visits and the reason

Metrics

- Reported platform usage and population health
- Who are super users vs who needs coaching support
- Navigation within CM platform, which areas are utilized

The Ask

Will WA ACHs work together to develop standardized protocols and processes for the use of Collective Ambulatory?

Where has this worked before?

- Oregon successfully deployed statewide steering committee with multiple partners to create common vision.
- Oregon Community Collaboratives comprised of health care network partners (e.g. hospitals, CHCs/Primary Care Providers, and Behavioral Health Agencies) collectively establish roles, responsibilities, shared agreements and expectations.

Are we starting from scratch?

- No. Oregon shared its toolkit, metric dashboard and protocols.

Who will support the implementation?

- HealthierHere partnered with Comagine Health to provide training, technical assistance, and practice coaching.

Other considerations:

- Agencies need to consider allocating staff time to access Collective Ambulatory.
- Process and workflow change is a continuous and ongoing endeavor
- Populations of focus may vary by network and geography (e.g. rural vs. metropolitan)
- Need to develop shared metrics of success (follow-up time, access, actions)

Next Steps

1. Review draft “Collective Ambulatory Standards Workgroup” Charter document
   - What metrics are needed for our work?

2. Identify lead(s) from your ACH to participate in the Workgroup

3. Review Oregon’s tools including “EDIE/PreManage Information Sharing Resource Guide for Oregon Users” guide
   - How can we advance a similar model for Washington?

4. Identify priorities
   - What are the top issues you encounter? For example, use cases, timeliness of data, viewer/edit access, feedback loops, notifications, integration with PDMP, ADT alerts, etc.

NAVOS MENTAL HEALTH SOLUTIONS

Populations Served

- Infants to older adults
- Moderate to Severe Mental Health Illnesses & Substance Use disorders.

Location & Type of Services

- Serving South King County
- Outpatient/Community Services
- Inpatient Involuntary Hospital
- Intensive community based support
- Residential & housing support
- Crisis & afterhours triage services

Mission:

Navos is committed to transforming the quality of life of people vulnerable to mental illness and substance use disorders by providing a broad continuum of care.

We believe that diversity, inclusion and equity are vital to living our values and achieving our mission.

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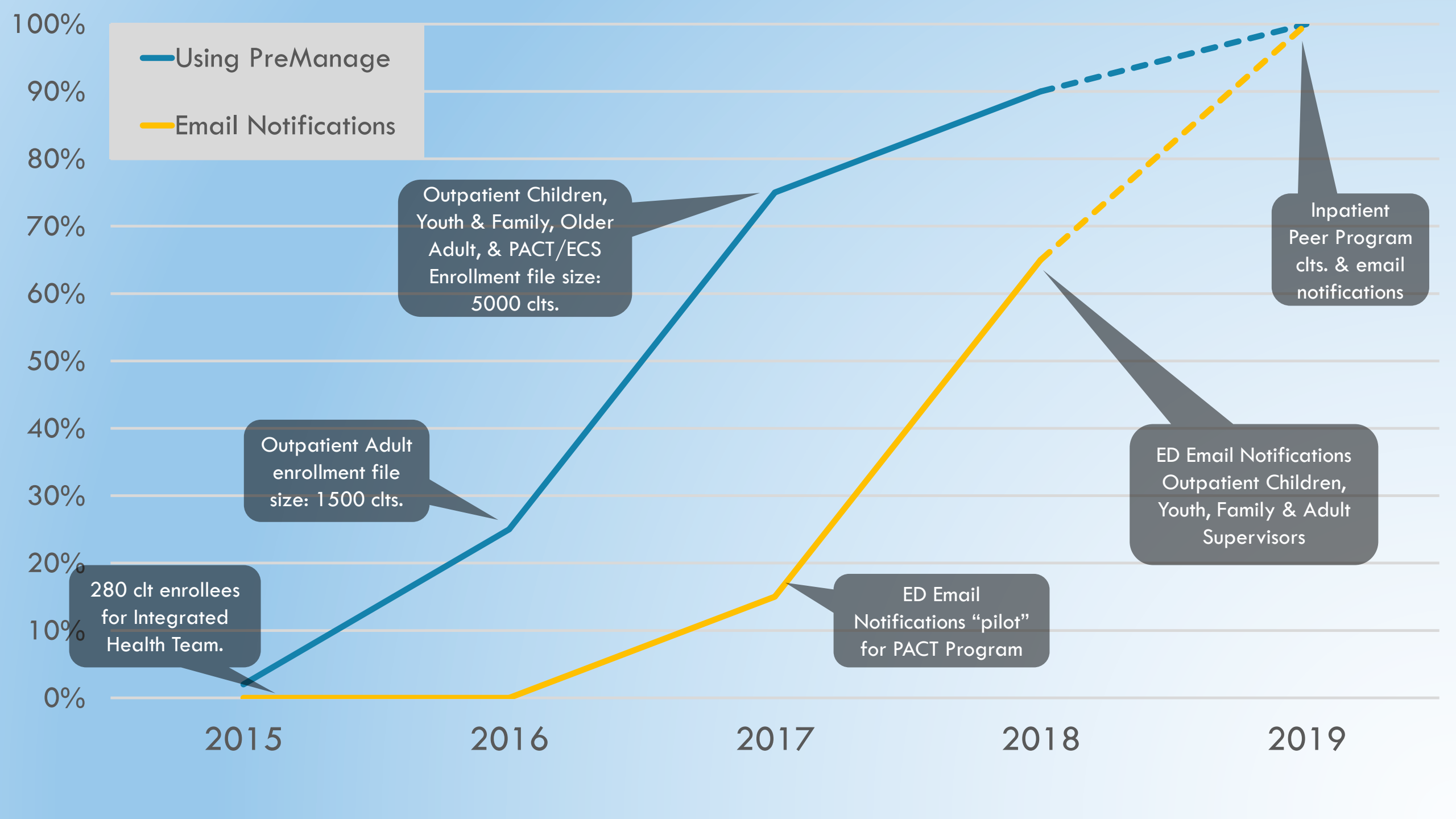
100%
90%
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Using PreManage
Email Notifications
2015
2016
2017
2018
2019
280 clt enrollees for Integrated Health Team.
Outpatient Adult enrollment file size: 1500 clts.
Outpatient Children, Youth & Family, Older Adult, & PACT/ECS Enrollment file size: 5000 clts.
ED Email Notifications "pilot" for PACT Program
ED Email Notifications Outpatient Children, Youth, Family & Adult Supervisors
Inpatient Peer Program clts. & email notifications

QUICK TIPS!

Partnership & Leadership

- Find a clinical champion!
- Partner with integrated care.
- Convince your Senior Leaders that this is a priority.
- Let programs define their own workflows, reports, cohorts.

Accountability

- Find a product owner/account manager to manage the portal.
- Personally demo the software
- Measure success – track progress: user accounts, top entry points, communication methods, etc.
- Follow up with Users and ask about their experiences!

Plant Seeds for Clinical Demand

- Start small and pilot!
- Create prototypes of reports & cohorts to showcase.
- Give access to anyone – you can limit PHI!

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SUCCESSES

Integrated care with KC Public Health clinic

- Bi-weekly staffing
- Case reviews of high-and super-utilizers
- Care Recommendations – input into the patient's Collective chart

Amount and types of information

- Have been able to locate unengaged/missing clients

Opportunities

- CoMagine coaching
- Discovering population data analysis & findings
- Providing a tool that makes gathering information easier
- Opportunities for staff to be clinical champions

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CHALLENGES

Ambiguity of chief complaints

- Medical vs Behavioral
- Substance use/abuse vs psychiatric
- Complex needs of clients: medical, mental health, shelter, food, etc.

Access to information

- Behavioral health hospitals & clinics not on platform
- Care guideline utilization
- Missing and/or vague chief complaints & diagnoses
- Lack of published best practices for reducing ED visits & education

Changes

- Providers & Caseloads
- Community Mental Health Clinic
- Lack of resources

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DATA ANALYSIS: QUESTION 1

Who are our high utilizers?

5 or more ED visits in a year

or

On pace for 5+ ED visits

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DATA FINDINGS: HIGH UTILIZERS

- 18% of active clients are high utilizers
- 65% of visits are made by high utilizers

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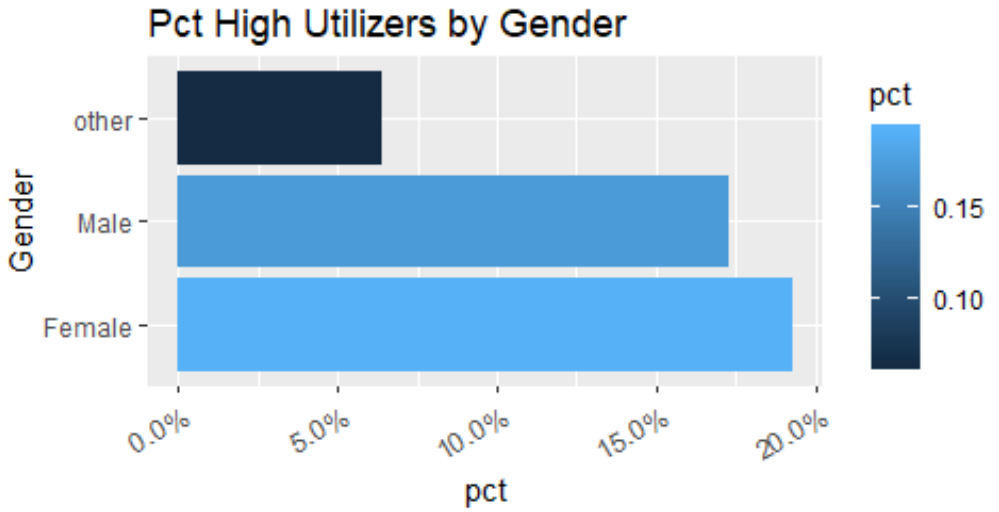
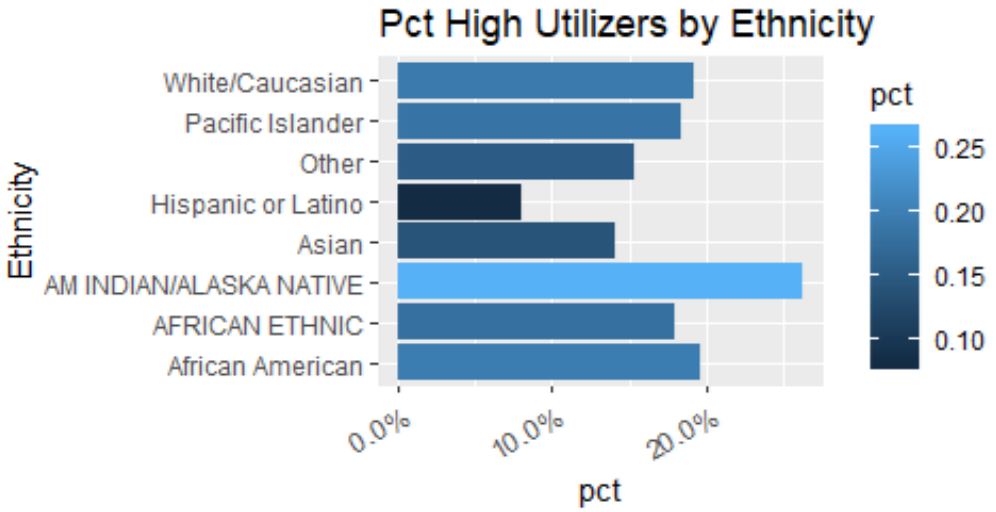
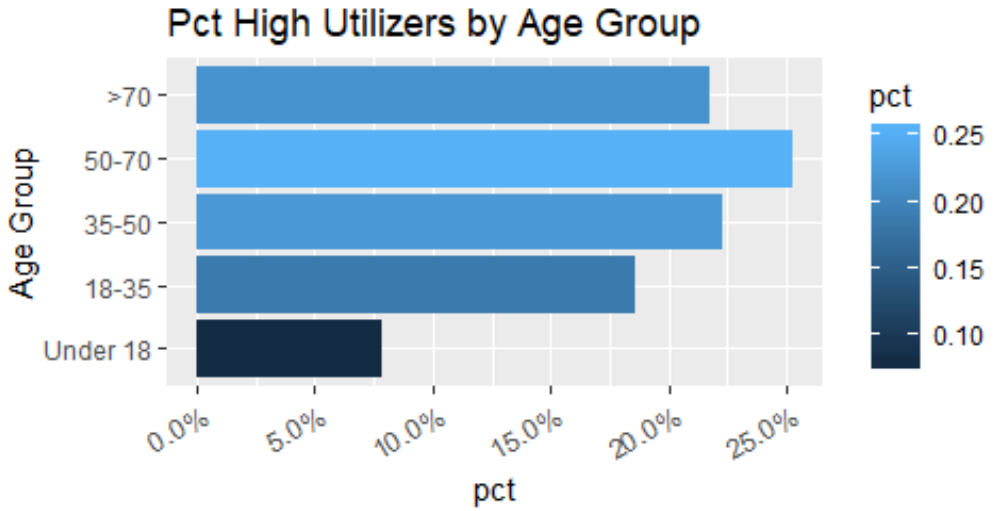
DATA FINDINGS: HIGH UTILIZERS







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DATA ANALYSIS: QUESTION 2

Did email implementation lead to faster response times by clinicians?

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DATA FINDINGS: EMAIL IMPLEMENTATION

First Time ED Visits:

- 2X more likely to be seen within 30 days after the email implementation

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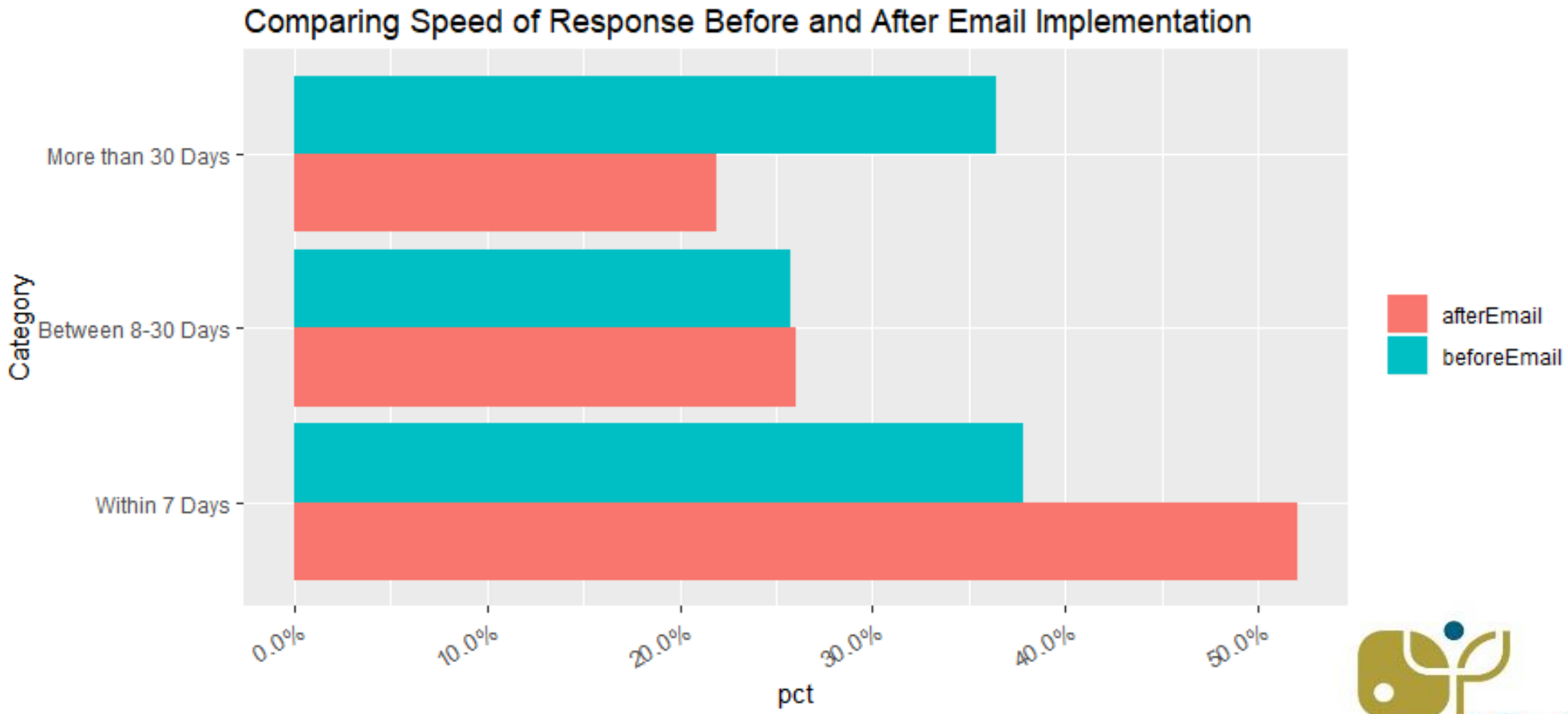
DATA FINDINGS: EMAIL IMPLEMENTATION



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GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

HCA Learning Symposium
Advancing Statewide Use of Collective Medical Modules

October 9, 2019

Collective Ambulatory tools are an essential of element of GCACH's Care Coordination Strategy

2017

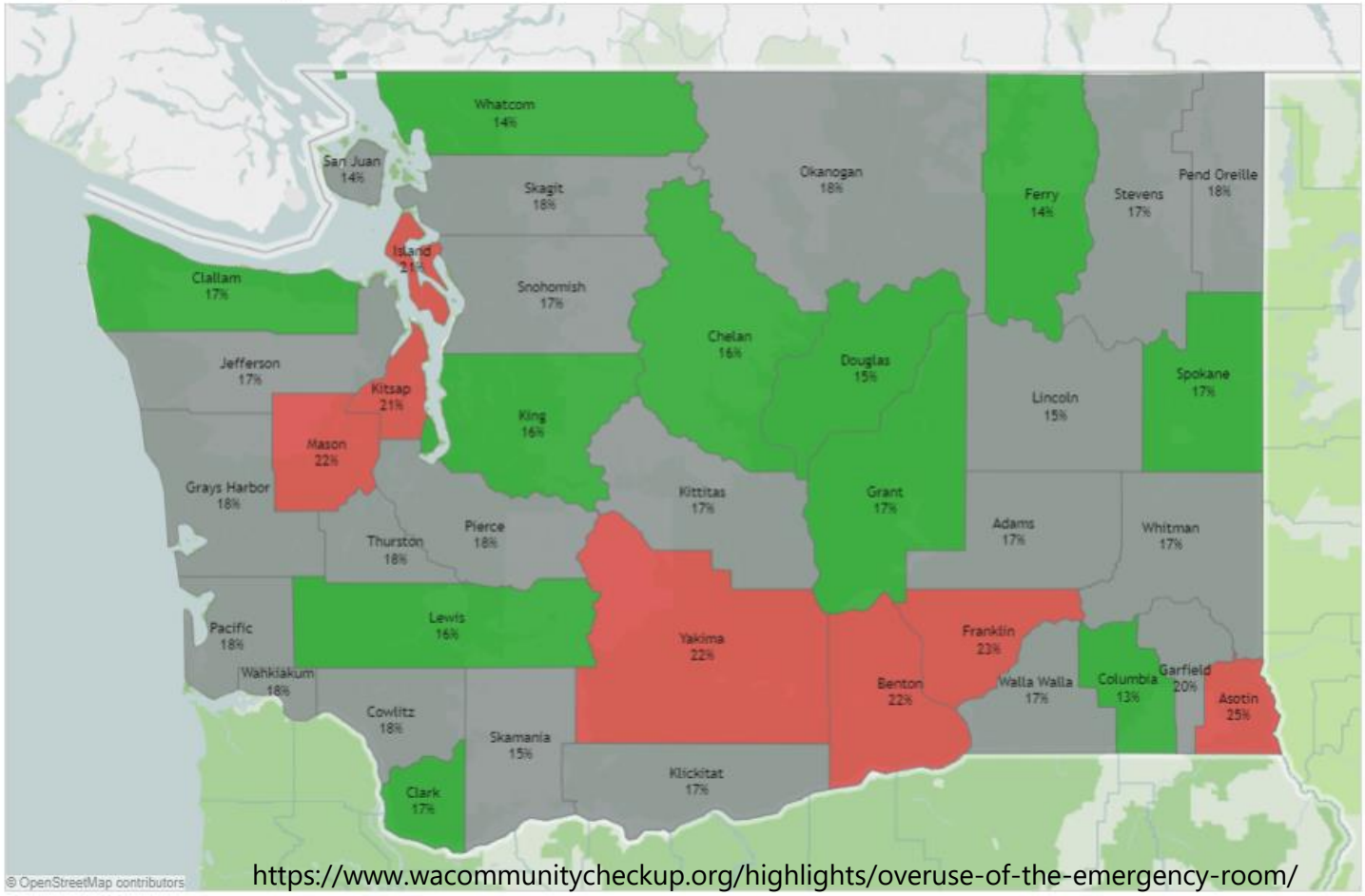
Highlight : Overuse of the Emergency Room

Insurance Type
- All
- Commercial
- Medicaid

Legend
- Better
- Average
- Worse

State Average: 18%

County Results - Potentially avoidable ER visits



https://www.wacommunitycheckup.org/highlights/overuse-of-the-emergency-room/

ED Visits Per Thousand (VPT) rate:

Benton and Franklin Counties = 765 VPT
Washington State Rate = 582 VPT.

12,700 additional ED visits than statewide average

At $1,500 per ED visit, approximate savings of more than $19 million

*Medicaid Transformation Project Pay-for-Performance baseline 2017 from HCA

Care Coordination requires reliable flows of information from EDs and Hospitals to track patients for follow up.

MILESTONE 6

Milestone	Milestone Category	Reporting Quarter	Reporting Method
6A.1	Care Coordination Across the Medical Neighborhood	Q1-4	X, #, N

Milestone 6 Reporting: Care Coordination

6A.1 Care Coordination Across the Medical Neighborhood [Quarterly] [X, #, N]

1. Please attest that your practice is using at least one of the following tools: EDIE, PreManage and/or Direct Secure Messaging.

Attest Yes: The organization is using at least one HIT tool listed above	**Attest No**: The organization is not using any HIT tool listed above
Select if appropriate	Select if appropriate

MCO Sponsorship to Collective Medical

GCACH	•GCACH will provide list of Cohorts to the MCOs; Clinics within the same organization that cross over cohorts will be identified. (The Commerical Medical Platform is sponsered by Organization and not by individual clinics)
GCACH	*GCACH will send list to MCOs of the provider organizations that are in need of CM sponsorship
MCO	*Once MCOs receives list of organizations from GCACH, the MCOs will talk amongst each other and will decide which organizations they will be sponsoring.
MCO	*Once sites have been divided amongst the MCOs, they will notify GCACH Practice Transformation Navigators.
GCACH	•GCACH Practice Transformation Navigators so that they can send out an email to the organizations informing them that they will be sponsored by an MCO, which will be CC'd on the mail so that the MCO can send Discovery and connect with the appropriate organization contact.
Organization	*Once the organization has filled out the discovery form, they will send it back via email to their sponsoring MCO.
MCO	*Once discovery form is back to the MCO, they will pass that along to Collective Medical and that will indicate to Collective Medical that they will be sponsoring that organization.
Commerical Medical	*After Collective Medical has received Discovery form, they will contact organization to contract and provide Patient File form that Collective Medical will upload into their system. Commerical Medical and/or the Organization will contact the Practice Navigator to assist with faciliating the completion of the file form.
GCACH	•The GCACH Practice Navigator will assist the Organization in developing policies, procedures and processes to ensure the use of the Collective Medical Platform supports milestone completion.
GCACH	•The GCACH Practice Navigator will follow up with the organization no less than monthly to ensure the utilization of the Commerical Medical Platform.

GREATER COLUMBIA
ACCOUNTABLE COMMUNITY OF HEALTH

THANK YOU

MCO Support for CMT Expansion

Presented by: Jorge Rivera
Molina Healthcare of WA.

MOLINA® HEALTHCARE

MCOs and Collective Medical Technologies

- Medicaid Managed Care Organizations have been sponsoring providers to implement CMT applications since 2011.
- Most initial applications were focused in connecting Emergency Rooms with Case Managers from Providers and MCOs.
- Behavioral Health providers are being added since the first roll out of Integrated Managed Care, IMC, in SW WA in 2016.
- All 5 Medicaid MCOs operating in WA have agreements with CMT
- Providers connected through CMT applications include:
  - Hospitals
  - Community Clinics
  - Pediatrics
  - Behavioral Health Providers
  - Care Coordination Organizations (CCO)

Implementation – Things to keep in mind

- Most providers work with more than one MCO
  - There is a need to keep consolidate and aggregate information
  - There is no difference at this point in which MCO provides sponsorship
- MCOs have additional requests for installation of CMT platform
  - Beyond ACH project driven work
- Some key stakeholders in the process are still not part of the system
  - EMS, Law Enforcement, some pilots are moving forward but payment mechanisms are not in place
- MCOs are now meeting regularly, soon also with CMT, to make sure we align ACH based expansion efforts

Implementing with ACHs – Specific Roles

ACH:

- Identify providers in need of CMT sponsorship.
- Communication to provider about roles
- Coordination with MCOs to process sponsorship
- Any additional support for provider.

MCO

- Make decision whether to move forward with sponsorship
- Breakout assignment of providers for sponsorship
- Submit Discovery document to CMT
- MCO may engage with provider outside of this process to ensure best practices with tool if it is part of partnership

CMT:

- Receive Discovery Process requests in order received
- Follow up with providers data file needs, etc .
- Communicate with provider on status and additional needs

Provider:

- *Identification of any existing engagement with CMT*
- *Identification of a lead for the organization wide, not site by site*
- *Complete Discovery document and submit back to sponsoring MCO*
- *Engage with CMT when they reach out to request follow up to secure data*
- *Submission of data to CMT*

Questions?

Thanks.

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MCO	•*Once sites have been divided amongst the MCOs, they will notify GCACH Practice Transformation Navigators.
GCACH	•GCACH Practice Transformation Navigators so that they can send out an email to the organizations informing them that they will be sponsored by an MCO, which will be CC'd on the mail so that the MCO can send Discovery and connect with the appropriate organization contact.
Organization	•*Once the organization has filled out the discovery form, they will send it back via email to their sponsoring MCO.
MCO	• *Once discovery form is back to the MCO, they will pass that along to Collective Medical and that will indicate to Collective Medical that they will be sponsoring that organization.
Commerical Medical	• *After Collective Medical has received Discovery form, they will contact organization to contract and provide Patient File form that Collective Medical will upload into their system. Commerical Medical and/or the Organization will contact the Practice Navigator to assist with faciliating the completion of the file form.
GCACH	•The GCACH Practice Navigator will assist the Organization in developing policies, procedures and processes to ensure the use of the Collective Medical Platform supports milestone completion.
GCACH	•The GCACH Practice Navigator will follow up with the organization no less than monthly to ensure the utilization of the Commerical Medical Platform.