Getting Started with the Collective Platform: An Implementation Guide for Oregon Clinics

IN PARTNERSHIP WITH

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Overview

What is the Collective Platform?

The Collective platform, developed by Collective Medical (Collective) provides powerful, real-time information about Emergency Department (ED) and Inpatient (IP) utilization activity. Users with access to the Collective platform can view the information on demand for patients in their care.

In addition, the platform provides a place where users can contribute critical information about high risk patients to assist ED providers in patient care and treatment.

For more information about the Collective platform and how the network is built, please view the "Getting Started" section on the Collective Community help section at: https://community.collectivemedical.com/t/18aks5/collective-medical-getting-started

Questions to Consider as You Begin

This resource guide is designed for primary care and behavioral health clinics. Clinics seeking to onboard with the Collective platform will first submit a Discovery Form to the Collective support team to assist with the onboarding steps. Please see more information about Clinic Onboarding at:

https://community.collectivemedical.com/t/18aks5/collective-medical-getting-started

Before a primary care or behavioral health clinic becomes live on the Collective platform, it is helpful to conduct a short, organizational assessment of your clinic's current care coordination or care management practices. Some key questions to consider include the following:

- How does your clinic identify & track ED and IP utilization now?
- How are high-risk patients managed now?
- What is your level of clinic staff/care management resources?
    - Medical assistant/office assistant
    - Triage/care coordinators
    - Nurse coordinators
    - Case/Care Managers, Behavioral Health Care Managers
    - Community Health Workers/Health Resilience Specialists
- How do you coordinate care with hospitals and/or your payers?
- What specific high-risk populations are you currently focused on/interested in?
- What other patient care/quality improvement projects is your clinic engaged in?

Answers to the above questions will assist your clinic in designing new or modified workflows which can be supported by the Collective platform.

Choosing Collective Platform Workflows

This section provides sample workflows that make use of the Collective platform data, key features and functionality. Your clinic size, staffing level and experience with the Collective platform will help you determine the workflow that is best suited to your environment.

There are three different workflows provided:

- Small or Early Stage Implementation Clinics
- Medium or Mid Stage Implementation Clinics
- Large or Advanced Stage Implementation Clinics

Clinic Workflows: A few introductory notes

- Don't spend extra time perfecting your implementation before you start. The Collective platform is a flexible tool—you will learn, refine and expand your use as you go.
- Designate an eager staff person or a small set of users willing to dive in and experience the tool and share its features with other staff. These early adopters will help inform the best, ongoing workflow for your clinic.
- Consider implementing a **Daily, Weekly, Quarterly** cadence to guide your team's use of the platform.

Small or Early Stage Clinics

The target clinics for the Small or Early Stage workflow include clinics with these characteristics:

- Small clinics with little or no case management resources
- Clinics wishing to tiptoe into Collective Ambulatory to learn more
- Clinics who have already onboarded but who are 'stuck'

Collective Platform Features Used

The main features used in this workflow are:

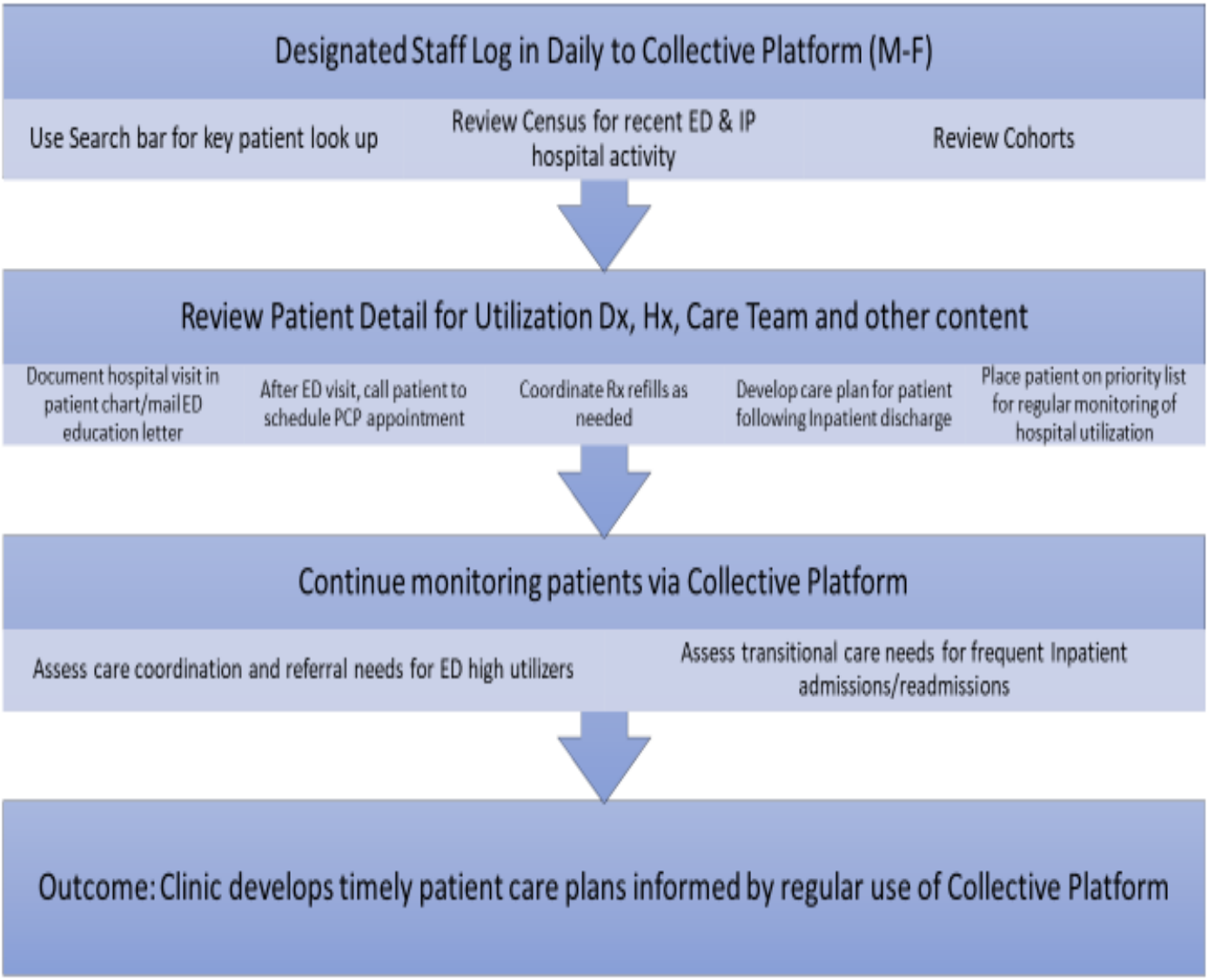
- Search box
- Census
- Cohorts

Examples of key Cohorts used at this stage/workflow include:

- 5 or more ED visits in past 12 months (ED focus)
- ED Disparity cohort (Oregon Medicaid mental illness population)
- Any IP discharge event (IP transitions of care work)

The following page outlines a summary workflow for Small or Early Stage Clinics.

Small or Early Stage Clinic: Sample Daily Workflow



Medium or Mid Stage Clinics

The target clinics for the Medium or Mid Stage workflow include clinics with these characteristics:

- Mid-size clinic with a nurse and/or other care management resource who do some care coordination but not necessarily full time.
- Clinics with some Collective platform experience who want to wade into additional features.
- Clinics who want to spread Collective platform use from 1-2 staff members to multiple staff.
- Clinics ready to establish a Daily, Weekly, Quarterly cadence for this work.

Collective Platform Features Used

The main features used in this workflow are:

- Cohort Review (becoming more targeted)
- Encounters with Notifications report pull (for weekly review)
- Insights: Care Guidelines, Safety & Security Events (to increase collaboration)
- Manual Facility Groups (also known as 'watch groups')

Note: Users can consult the Collective Community Help section for additional detail on these features at:

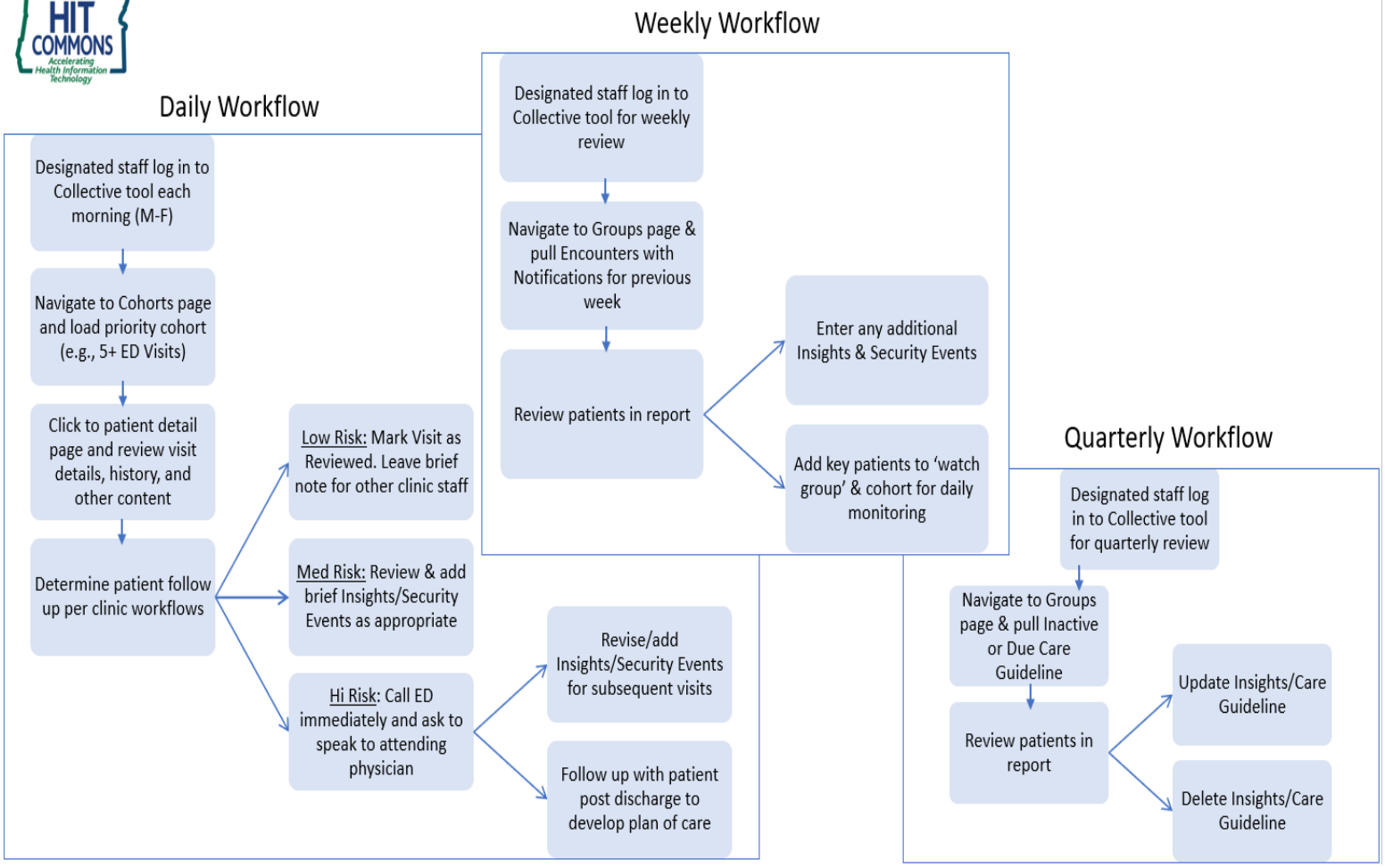
https://community.collectivemedical.com/

Some examples of key Cohorts used at this stage/workflow include:

- 5+ ED visits & IP Admits cohorts
- Other priorities: ED Disparity cohort
- Disease-specific cohorts for tracking chronic conditions (e.g., Asthma, Diabetes)
- 'Watch group' cohorts for tracking priority patients (e.g., patients on anti-coagulants)

The following page outlines a summary workflow for Medium or Mid Stage clinics.

Mid Stage Clinic: Sample Daily, Weekly, Quarterly Workflow



Large or Advanced Stage Clinic

The target clinics for the Large or Advanced Stage workflow include clinics with these characteristics:

- Large, multi-clinic organization with 20 or more physicians & dedicated case management staff, including triage coordinators, care coordinators and/or care managers.
- Experienced clinics who want to dive into additional Collective Ambulatory features.
- Clinics wishing to extend Collective platform use to Triage coordinators (the 'hub') and case/care managers (the 'spokes').
- Clinics able to establish & maintain a Daily, Weekly, Quarterly cadence for this work—and support separate but coordinated workflows by staff type (e.g., triage vs. care manager).
- Clinics may also introduce and convene a High-Risk Huddle workflow at this stage.

Collective Platform Features Used

The main features used in this workflow are:

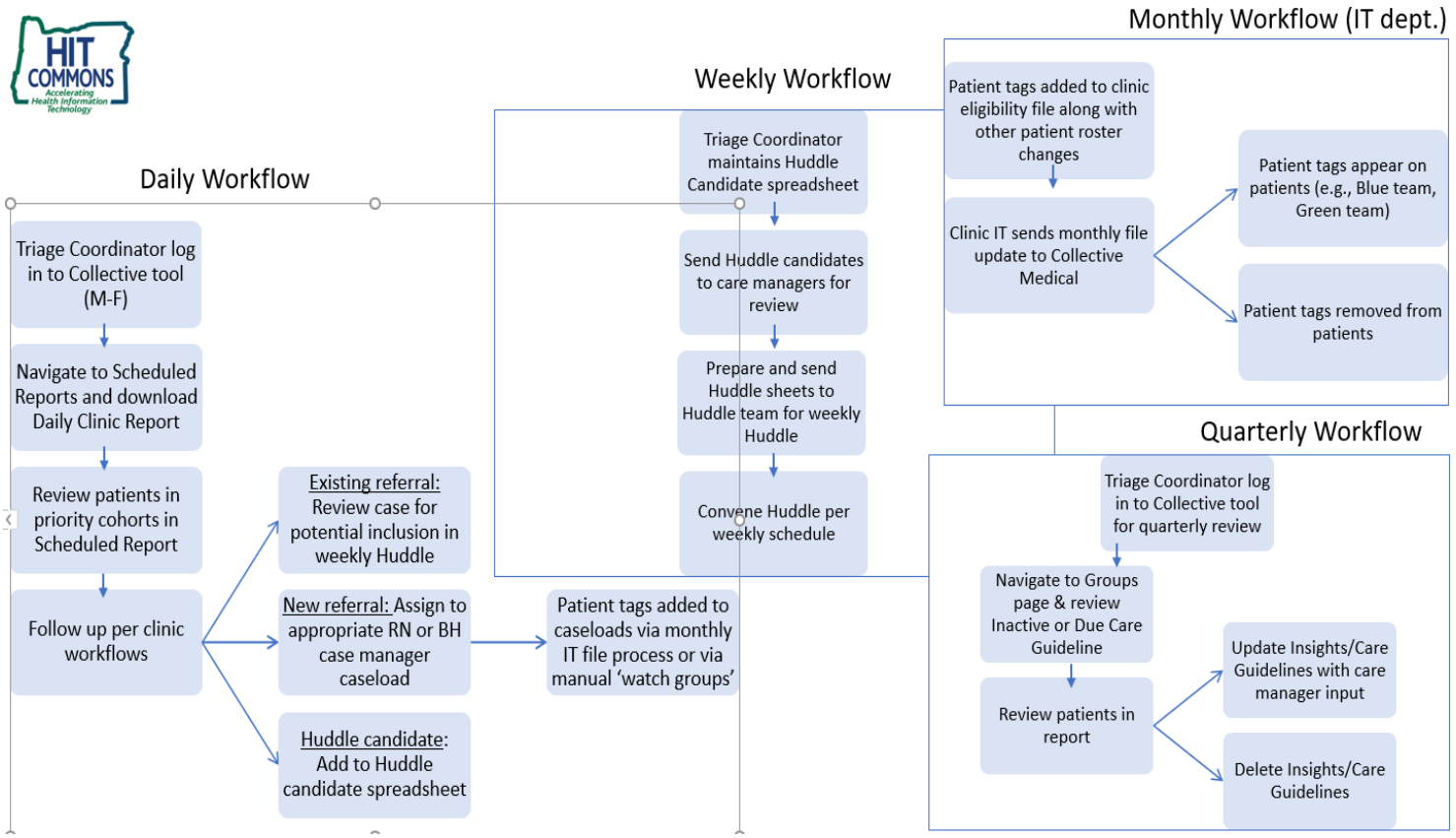
- Eligibility file additions (e.g., risk scores, care mangers teams, payer info) & ongoing updates
- Patient tags or flags
- Targeted cohorts (involving multiple criteria)
- Scheduled Reports
- Email Notifications
- Insights/Care Guidelines, Safety & Security Events

Some examples of key Cohorts used at this stage/workflow include:

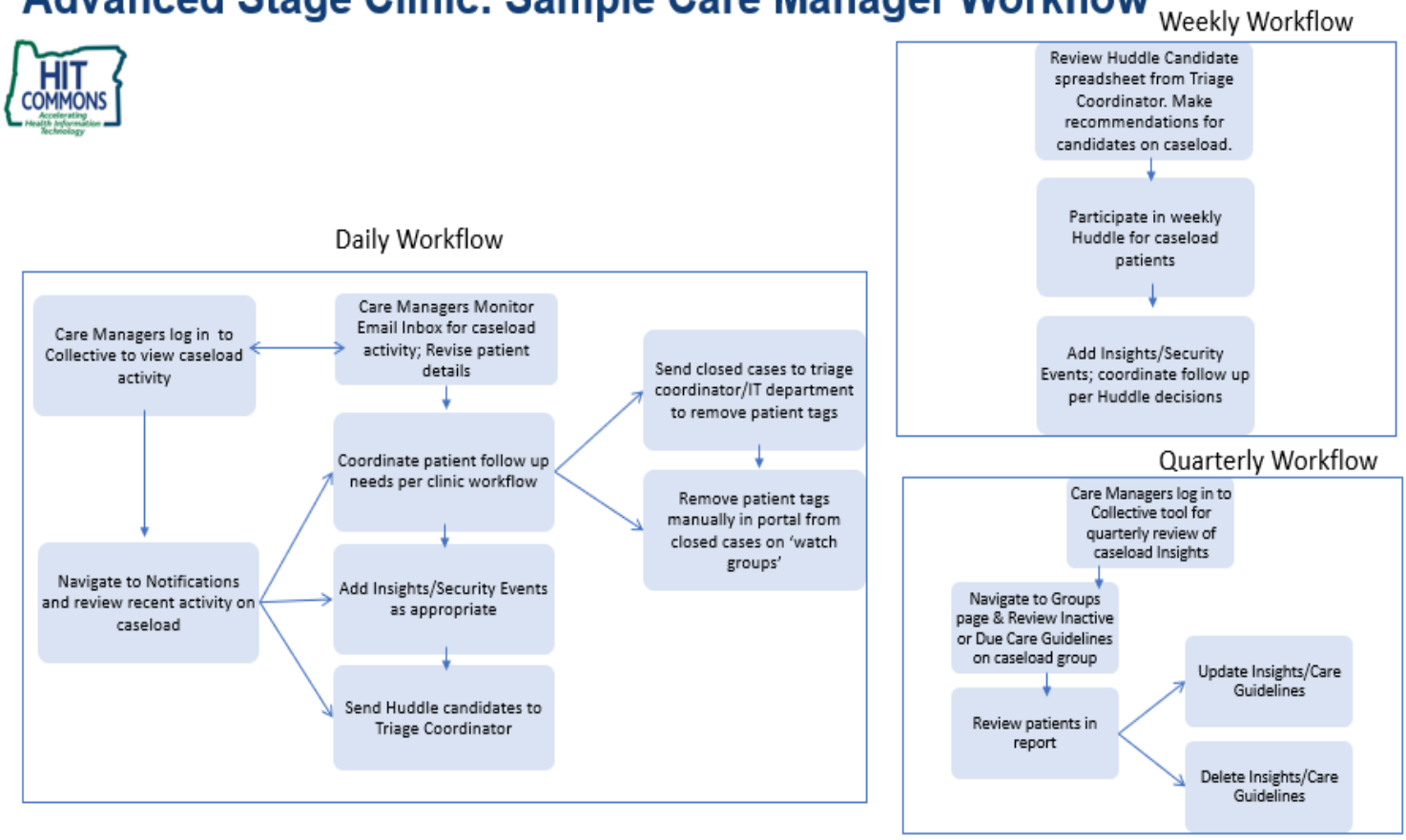
- Disease-specific for identifying high risk patients (e.g., chronic disease cohort)
- Payer-specific for joint projects & regulatory needs (e.g., Medicaid, Duals)
- Caseload-specific for care management teams (e.g., team green cohorts, team blue cohorts)

The following page outlines a summary workflow for Large or Advanced Stage clinics, including one workflow for a Triage Coordinator and one workflow for a Care Manager.

Advanced Stage Clinic: Sample Triage Coordinator Workflow



Advanced Stage Clinic: Sample Care Manager Workflow



Designing an ED Strategy

Once a clinic has onboarded with the Collective platform and implemented/refined its core workflows, it can turn to more targeted ED reduction efforts. This work will involve coordinating across organizations and will take dedicated leadership, commitment, patience and follow through.

Below are suggested steps for designing and carrying out an ED reduction strategy, followed by a case example from The Portland Clinic which lead a small, community collaborative in Portland and achieved significant ED reduction.

Key Steps to Designing an ED Strategy

Organizing the Work

1. **Select a Partner(s) to Collaborative with**
   - Leverage existing program work or regional pilots underway
   - Reach out to partners where you are seeing the highest proportion of ED utilization
   - Pull some data to see where high risk patients overlap across your organizations (e.g., PCP patients being seen by MH or Specialty providers)
   - It might take some leadership to get going!

2. **Select a Cohort to Focus on—A few examples:**
   - 5+ ED visits in 12 months (Oregon statewide high utilizer cohort)
   - 5+ ED visits in 6 months
   - 3+ ED visits in 90 days
   - ED Disparity Cohort (patients experiencing mental illness)
     - For organizations caring for CCO populations
   - Avoidable ED visits
   - Other mental health or clinical areas of concern (e.g., diabetes, asthma) based on your organization's population needs

3. **Build the Cohort—Some of the criteria options:**
   - Event Type: ED, Inpatient or Post-Acute visits
   - Utilization: Counts of visits (e.g., 5 or more)
   - Diagnosis: ICD-10 codes or Chief Complaint phrases
   - Demographics/Location: Age range; Hospital-specific
   - Groups: Key patient group (e.g., Dual eligible, enrolled in care management)*

   *Note: groups must be loaded as patient 'tags' in your eligibility file to use in cohorts
   - ✓ All partners should agree on common criteria to help with coordinated workflows and to measure success
   - ✓ To load the cohort in the platform, submit cohort requests to: support@collectivemedical.com

4. **Establish roles and responsibilities among partners***
   - Before ED Visit

- During ED Visit
- After ED Visit

*Note: See case study from The Portland Clinic which established a tool to establish roles and responsibilities. The Appendix provides a sample template for organizations to use and adapt for their own efforts.

5. **Agree on interventions by all partners (e.g., phone calls, enrolling in care management)**

6. **Define baseline period and intervention period for data reporting**

Doing the Work

7. Review Cohort Daily

- Some teams review cohorts twice daily (morning and then after lunch)
- Use 'Review Visit' feature to coordinate when multiple people work the same cohort
- *Note: sometime this feature is not enabled in your platforms. If not, email request to: support@collectivemedical.com

8. Coordinate patient follow up per established workflows

9. Manage risk—Enter Insights (Care Guidelines, Patient History) & Security Events

- This brief content helps to guide care in the ED for current/future visits
- Note: Refer to "Information Sharing Resource Guide" available at http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/01/Sharing-Information-on-the-Collective-Platform-Resource-Guide-Final-December-2019.pdf for tips on entering content in the Collective platform. See also: The Appendix for a one-page Care Guidelines Tip Sheet.

Sustaining the Work

10. Track internal utilization on selected cohort*

- Use Scheduled Reports to download and share with teams managing the work
- Use Encounters w/ Notifications to pull quick data sets directly from the Collective Platform on a selected data range
- *Note: Scheduled Reports work best for receiving data on a set schedule (e.g., weekly) and for large data runs (e.g., last 7 days). Encounters w/ Notifications can pull cohort data on demand from within the platform and work best for limited data runs (e.g., last 24 hours).

11. Maintain communication with ED providers*

- Do Monthly or Quarterly pulls of Patient with Active Insights or Patient with Due or Inactive Guidelines directly in Collective to review and update or delete patient guidelines
- Review and update per internal process
- *Note: Some clinics have a data analyst perform this regular review and coordinate needed updates from clinicians and care coordinators. Others ask assigned care coordinators or care managers to maintain care guidelines for their patient caseloads on an ongoing basis.

12. Regular check ins with partners to review/refine workflows

- Establish regular—weekly, monthly, quarterly—meetings with your external partners to discuss and refine cohorts, interventions and other workflow items to continue to improve the process.

13. Give it some time—this work takes time to build traction and momentum!

Case Study: The Portland Clinic

In 2017, The Portland Clinic convened a yearlong effort to reduce ED utilization among high utilizers through coordinating workflows across the clinic, Providence Health Plan, key hospitals and Compass Oncology specialty clinic. The work resulted in a 13% reduction in ED visits among the high utilizing population and the work continues today. See high level summary of the project below.

Portland Community Collaborative Strategies for High ED Utilizers

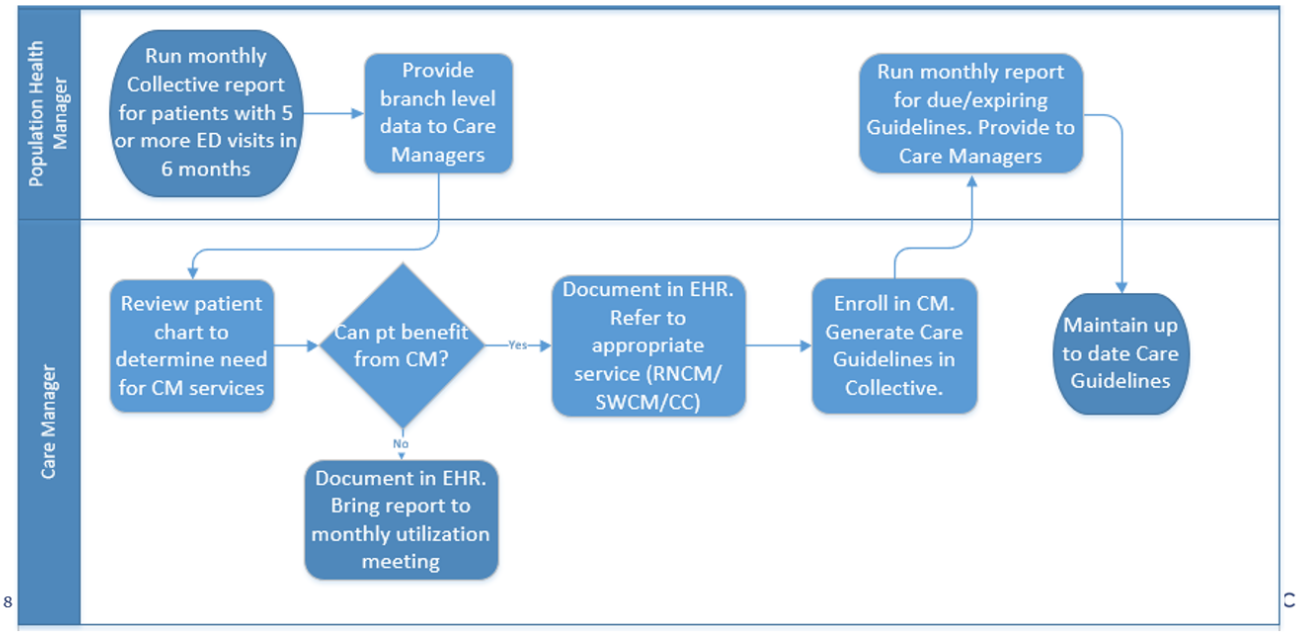
Internal Strategies

- **High Utilizer workflow** – using Collective reports, Care Management & Care Guidelines
- **Tracking Outcomes**

Community Strategies

- **Community Collaborative** – coordinating workflows, sharing cohorts & establishing roles
  - The Portland Clinic
  - Providence Health Plan
  - Regence
  - Providence St. Vincent Emergency Dept.
  - Compass Oncology
- **Tracking Outcomes**

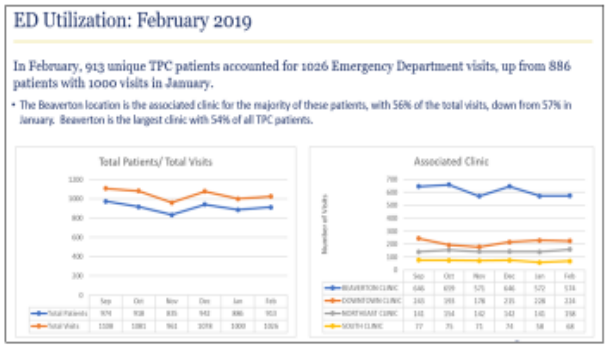
TPC high ED utilizer workflow

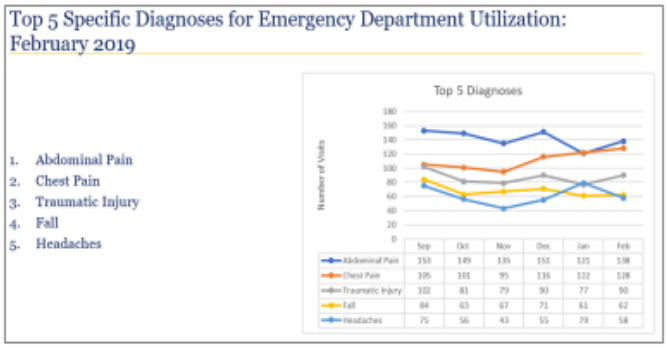


Tracking internal outcomes

Use Collective scheduled reports to look for trends and recommend workflow changes

- ED Utilization rates – overall, by branch, by provider, by ED, by health plan
- Reasons for ED use
- Avoidable ED utilization





The Portland Clinic

Community collaboration – shared cohorts

PHP cohorts

Member Cohorts — December 3 – January 1

Count	Change	Description	Activity
30	N/A	SPMI in the ED	
30	↑ 3%	Obstetric ED Visits	
28	↑ 75%	Sepsis Encounter in the ICU	
23	↑ 15%	NWPC Patients: 3 ED Visits in 3 Months	
20	↓ -44%	Pediatric Asthma ED Visits	
12	↓ -14%	TPC Patients: 3 ED Visits in 3 Months	
11	↑ 175%	IP Influenza Encounters	

TPC cohorts

Member Cohorts — Mon 9:43am – Now

Count	Change	Description	Activity
23	↑ 53%	Beaverton- IP Discharge	
1	0%	Behavioral Health Encounter Type	
4	↑ 100%	Compass Patients ED Encounters	
36	↑ 38%	Downtown - 0-15 Day Readmission	

The Portland Clinic

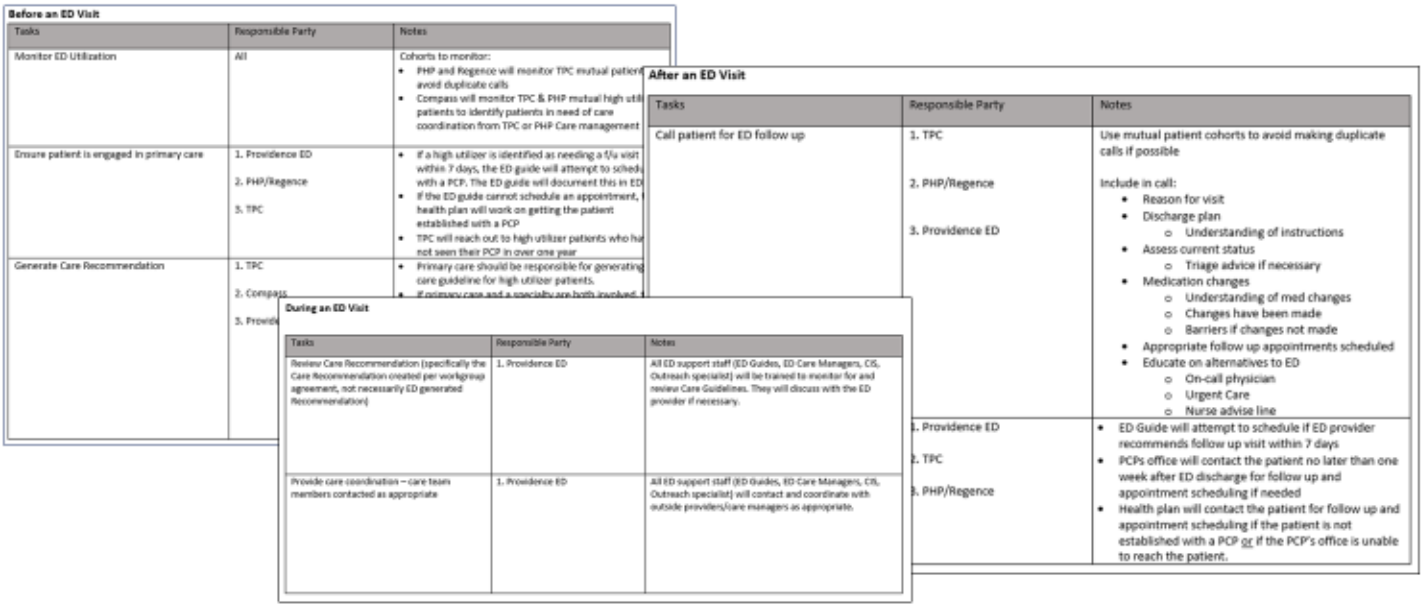
Community collaboration – coordinating workflows

Community Collaborative

- **Length:** August 2017 – March 2018
- **Participants:** primary care, health plan, hospital, behavioral health, specialty care, community outreach
- **Goal:** Decrease high ED utilization through aligning workflows, using the Collective platform as a centralized source of information and method of communication
- **Work:**
  - Understanding one another's processes, capabilities, and barriers
  - Outline roles and responsibilities of each type of organization in the lives of high ED utilizers
  - Modify workflows to decrease duplication of services, particularly in post hospital outreach calls and care management
- **Lasting effects:**
  - Shared Cohorts
  - Regular ongoing meetings with participants
  - Personal relationships and improved communication
  - Care Management team coordination

The Portland Clinic

Community collaboration – establishing roles



Before an ED Visit

Tasks	Responsible Party	Notes
Monitor ED Utilization	All	Cohorts to monitor: • PHP and Regence will monitor TPC mutual patient avoid duplicate calls • Compass will monitor TPC & PHP mutual high uti patients to identify patients in need of care coordination from TPC or PHP Care management
Ensure patient is engaged in primary care	1. Providence ED 2. PHP/Regence 3. TPC	• If a high utilizer is identified as needing a f/u visit within 7 days, the ED guide will attempt to sched with a PCP. The ED guide will document this in ED • If the ED guide cannot schedule an appointment, health plan will work on getting the patient established with a PCP • TPC will reach out to high utilizer patients who ha not seen their PCP in over one year
Generate Care Recommendation	1. TPC 2. Compass 3. Provid	• Primary care should be responsible for generating care guideline for high utilizer patients. • If primary care and a specialty are both involved,

After an ED Visit

Tasks	Responsible Party	Notes
Call patient for ED follow up	1. TPC 2. PHP/Regence 3. Providence ED	Use mutual patient cohorts to avoid making duplicate calls if possible Include in call: • Reason for visit • Discharge plan o Understanding of instructions • Assess current status o Triage advice if necessary • Medication changes o Understanding of med changes o Changes have been made o Barriers if changes not made • Appropriate follow up appointments scheduled • Educate on alternatives to ED o On-call physician o Urgent Care o Nurse advise line
	1. Providence ED 2. TPC 3. PHP/Regence	• ED Guide will attempt to schedule if ED provider recommends follow up visit within 7 days • PCPs office will contact the patient no later than one week after ED discharge for follow up and appointment scheduling if needed • Health plan will contact the patient for follow up and appointment scheduling if the patient is not established with a PCP or if the PCP's office is unable to reach the patient.

During an ED Visit

Tasks	Responsible Party	Notes
Review Care Recommendation (specifically the Care Recommendation created per workgroup agreement, not necessarily ED generated Recommendation)	1. Providence ED	All ED support staff (ED Guides, ED Care Managers, CIS, Outreach specialist) will be trained to monitor for and review Care Guidelines. They will discuss with the ED provider if necessary.
Provide care coordination – care team members contacted as appropriate	1. Providence ED	All ED support staff (ED Guides, ED Care Managers, CIS, Outreach specialist) will contact and coordinate with outside providers/care managers as appropriate.

The Portland Clinic

Community collaboration – establishing roles

Before an ED visit

1. Monitor ED utilization
2. Ensure patient is engaged in primary care
3. Generate care recommendations
4. Provide ongoing care management
5. Contact other care team members for care coordination

During an ED visit

1. Review care recommendations
2. Provide care coordination – contact care team members as needed

After an ED visit

1. Call patient for ED follow up assessment
2. Schedule ED follow up appointment
3. Perform cross-organizational care conference

The Portland Clinic

Community collaboration – tracking outcomes

Collaboration between PHP and TPC to manage ED utilization

- **Baseline period:** Aug 2016-July 2017
- **Measurement period:** Aug 2017-July 2018
- **Metric:** Members with 3 or more ED visits in 3 months
- **Intervention:**
  - TPC telephonic ED follow up
  - PHP/TPC collaboration and alignment on ED utilization interventions
  - No intervention by PHP
- **Outcomes:**
  - 13% decrease in ED utilization from baseline to measurement period
  - Improvement in PCP/PHP coordination
  - Decreased duplication of services, increased efficiency, decreased patient confusion/time

The Portland Clinic

Supporting Inpatient Transitions of Care

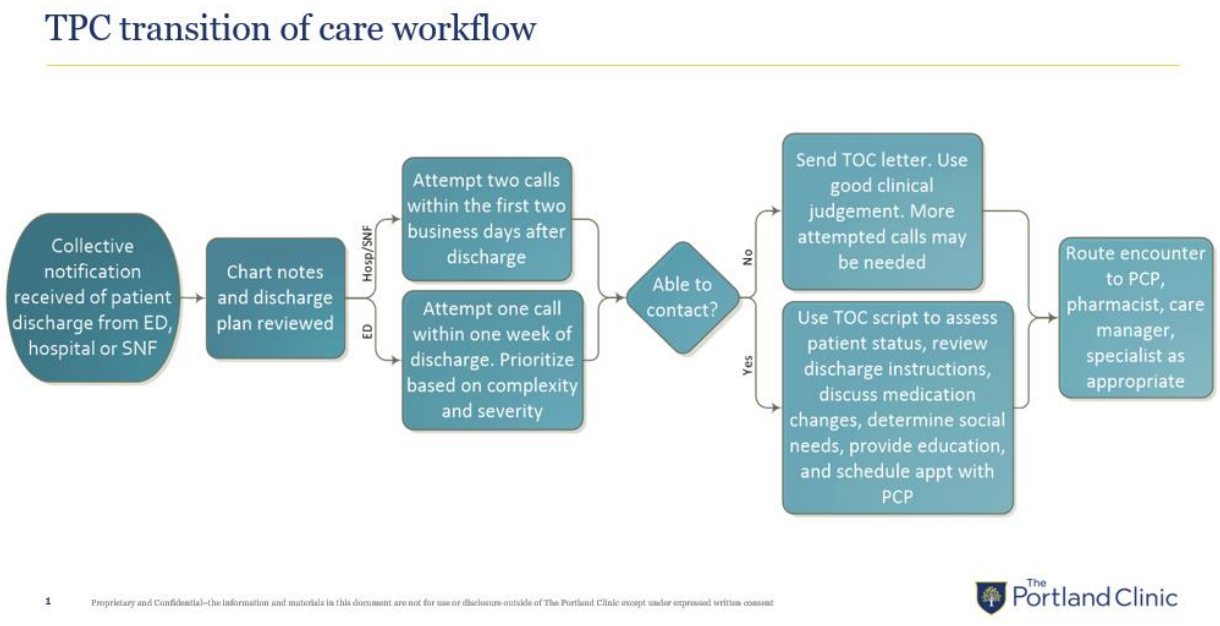
In addition to supporting ED reduction efforts, the Collective Platform provides real-time data on Inpatient Admits and Discharges. Clinics and others can use the Inpatient data to support timely transitions of care efforts.

To organize the work, clinics and others can use the steps outlined in ***Section 2 Key Steps to Designing an ED Strategy*** to organize the work and adjust the cohorts, interventions and other as needed to fit Inpatient transition of care needs. Clinics will find that the same features—cohorts, scheduled reports, care guidelines, roles & responsibilities—also apply for the Inpatient transitions of care workflow.

Below are three examples to help illustrate this work:

- The Portland Clinic's Transition of Care Workflow
- Providence Medical's Group's overview of its transition of care work on the Collective Platform
- Marquis Care (Skilled Nursing Facility-SNF) experience with the Collective Platform

The Portland Clinic's Transition of Care Workflow

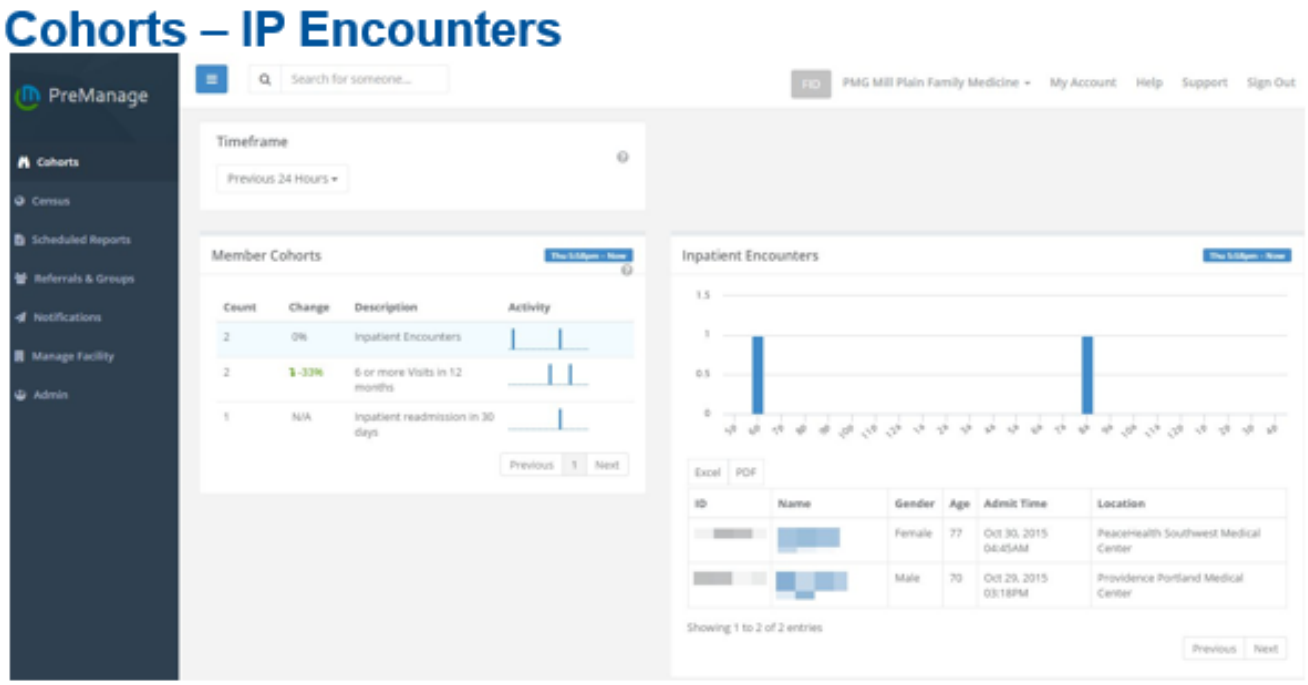


Providence Medical Group Care Management Staff

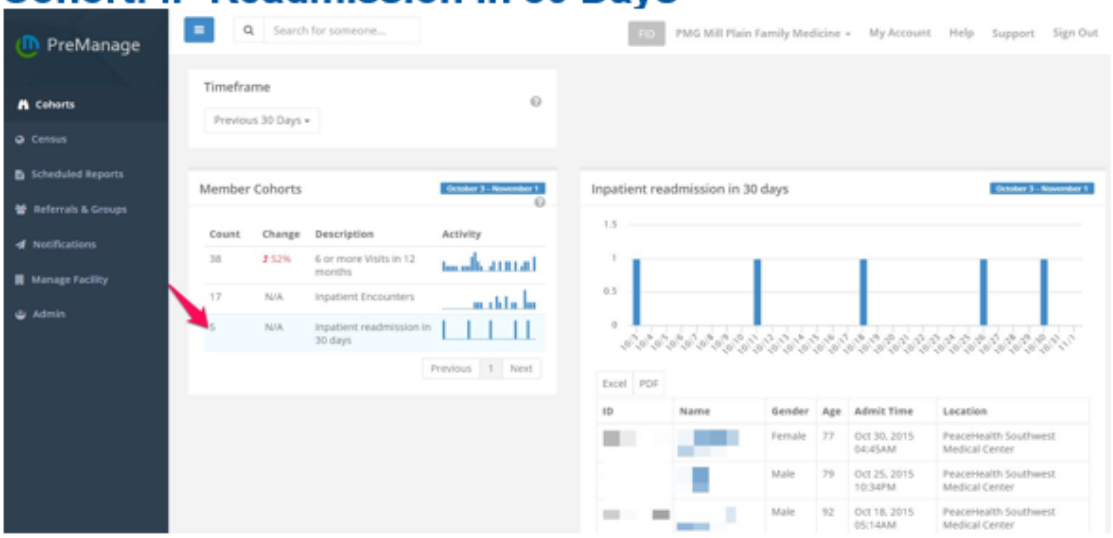
- 40 Embedded Case Managers (RN's or LCSW's) in primary care clinics throughout Oregon
- 11 Proactive Outreach Team members (RN's, LCSW's, CHW's) meeting complex patients in the community
- 20 Medical Assistants in a centralized location focusing on outreach post discharge from the hospital

Providence Medical Group Key Cohorts

- Inpatient Encounters
- Inpatient Readmission in 30 days

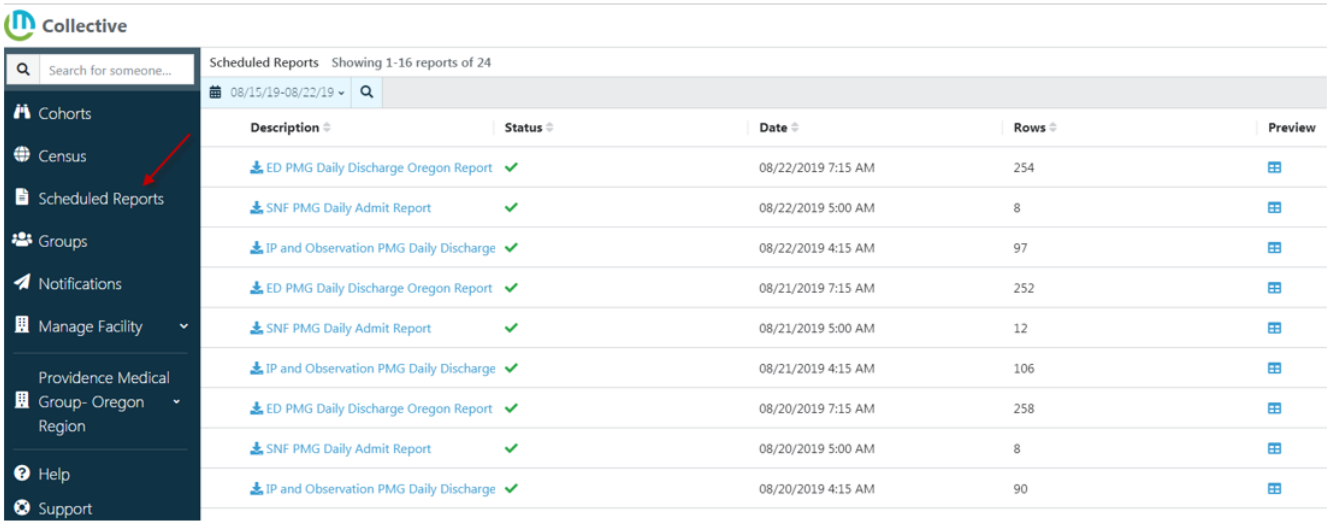


Cohort: IP Readmission in 30 Days



Providence Medical Group Daily Scheduled Reports

- Created by the Collective Medical based on given criteria—see Report Builder Form in Appendix
- Published daily
- Downloaded as Excel Spreadsheet
- Centralized location in Collective Platform for all PMG users to access



Providence Medical Group—Key Takeaways in Transitions of Care Efforts on the Collective Platform

Success in Transitions of Care

- Patient satisfaction
- Early interventions
- Increased revenue for the organization (TCM codes)

Challenges with Transitions of Care

- Multiple calls to reach patient and clinic
- Access to appointments in the clinic
- Accuracy of hospital Admission, Discharge, Transfer (ADT) data

Additional Considerations for Skilled Nursing Facility (SNF) Data

- Timely notification of the discharge
- Decreased the number of phone calls to the SNF
- Accuracy of data continues to be a challenge

Care Guidelines Process

- Criteria – 5 or more ED visits in the last 6 months
- Succinct
- Patient specific
- Relevant objective information
- 5-6 sentences long
- Recent (written in the last 90 days)

Marquis + Consonus- Skilled Nursing Facility Experience on the Collective Platform

In spring 2019, skilled nursing facilities (SNF) began reporting data into the Collective Platform and onboarding their staff to the Collective web portal to begin viewing patient data as they transitioned from acute care settings. Marquis Care was an early adopter of the Collective Platform and an overview of their work is provided below.

SNF Use Case Development-Why Collective Platform?

CMS accountability under Value Based Purchasing

- Rehospitalization (RH) Rates- SNF 2% "incentive Payment"
- Includes full 30 days from Acute transfer. Comparative rate.
- Most Stays are < 22 days, leaving 8 days in which we had no access to data

Safe Transitions /Information exchange

- Acute to SNF
- SNF to Home

CMS Quality Measures: 5 star and SNFQRP

- 5 Star: RH and ED rates for 30 days from Acute Discharge
- SNFQRP: RH rates measured for 30 days AFTER SNF Discharge.

SNF Collective Platform Notifications Utilized by Marquis

1. Admission of SNF residents – who have had more than the most recent qualifying Hospital stay in last 6 months
2. Post SNF Discharge for 90-day period
3. Any patient with a return to ED and/or New inpatient stay

New Admits Information Utilized by Marquis

All hospital, ER, clinics and SNF stays (if using PreManage) will be listed, including relevant DX. This will give the facility a sense of RH and ED risk during the SNF stay

- Care Guideline tabs are at the bottom of the individual patient screen, facility team can refer to these tabs for any information that other providers have uploaded.
- Security Alerts have been set for new admits – including history of violent behavior, sexual assault, suicide ideation.

Post SNF Discharge

- If any SNF patients in that 90 day return to ER or Hospital.
- Allows team to look at reason of new hospital /ED visit;

- Discuss as a team possible discharge/planning impact that the SNF could have done to mitigate.
    - What was the status when they left the SNF, i.e. planned, AMA, hospital and did not return?
    - Where did they go upon discharge, home alone, ALF?
- Home with_____
    - Did we coordinate a scheduled appointment with PCP?
- Prior to SNF discharge to be within that first week?
    - Was HH set up upon discharge? When was the SOC?
    - Did they have /receive their post discharge medications from retail pharmacy?
    - Based on reason for RH/ED (seen in PreManage)- could we have prevented this return?

Appendix

Early Stage Clinic Resource—Patient Letter Example

{Insert Clinic's Logo}

Dear {AUTOFILL PATIENT NAME},

Your primary care physician, Dr. {AUTOFILL PROVIDER LAST NAME}, has been notified about your recent Emergency Department visit at HOSPITAL NAME.

We recently called you to see how you are doing but were unable to reach you. At your earliest convenience, please call us at 555-555-5555 to schedule an appointment with your physician and/or speak to one of our dedicated nurses about any needs you may have after your hospital care.

If you have selected a new primary care physician for your care, please contact us at the above number so we can update our records.

Thank you.

{CLINIC CONTACT FOR PATIENT QUESTIONS}

{ADDRESS}

Mid Stage Clinic Resource—Care Guidelines Tip Sheet

Creating a Care Guideline

Intended to deliver brief, critical information to ED providers at the point of care relevant to patient's treatment in the ED. Information should be in succinct, bullet point format with no more than 5-6 bullet points. There are different subsections that allow you to organize the type of information you'd like to include:

1. **Care Recommendation:** (A recommendation for how a condition should be treated or has been successfully treated in the past)

Recommended Content	Example
Goals for patient care	PCP recommends hospice, but family is hesitant
Specific treatment protocols/recommendations	Low dose haloperidol effective for acute agitation
Outpatient care patient is currently receiving so ED can redirect patient back to appropriate care	Pt requires paracentesis weekly for cirrhosis, f/u with Dr. Jones every Wednesday
Baseline presentation	At baseline patient lists to the left, has shuffling gait, poor short- term memory

2. **Care Coordination:** (An explanation of the coordinated efforts in regard to this patient's care)

Recommended Content	Example
Engagement in primary care	Patient has not seen PCP in over 1 yr despite repeated outreach. Please attempt to schedule if patient presents to ED
Availability of Care Team member to intercept ED visit	ACT team available to attend ED visit, please call phone# in Care Team Box as soon as patient presents to ED

3. **Pain Management:** (A recommendation for how the patient's pain should be managed, including pain contracts, etc.)

Recommended Content	Example
Presence of a pain contract	Note who the prescriber is and a brief description- Patient has a pain contract with PCP, Dr Jones, receives 10mg Norco bid for chronic back pain. Patient has agreed not to receive pain medications from any other source unless a new acute issue, or will be in violation of pain contract

4. **Helpful ED-Based Interventions to Try:** (A list of helpful interventions that have been successful in prior ED visits)

Recommended Content	Example
Tips/strategies for engaging with the patient	Patient calmer when mother present, music helps alleviate anxiety
Successful interventions to redirect ED over-utilization	Set clear limits, patient will be inappropriate or aggressive, will use manipulation maneuver to get what she wants. Limit comfort measures

Creating a Care Guideline

Care Recommendation:

Care Coordination:

Pain Management:

Helpful ED-Based Interventions to Try:

Advanced Stage Clinic Resource – Scheduled Report Request Form

Collective Medical – Report Request Form

CollectiveMedical

Client Details

Account Name: [your organization's name]

Date Requested: [mm/dd/yyyy]

User Requesting: [requester's first and last name]

Report Details

Title: [report title]

Description: [brief description of report]

Frequency:
- ☐ Daily
- ☐ Weekly
  [day of week]
- ☐ Monthly
  [day of month]

Period:
- ☐ 1 Day
- ☐ 3 Days
- ☐ 7 Days
- ☐ Last 30 Days
- ☐ Last Month
- ☐ Last Year

Report Type (Choose one type of report and complete the related details)

☐ Census Report

Census Visit Types:
- ☐ Emergency
- ☐ Inpatient
- ☐ Observation

Census Visit Events:
- ☐ Admit Date
- ☐ Discharge Date

☐ Cohort Report

Cohort Name(s):
[name of the cohort (or cohorts) to include]

Report Columns

Patient Demographic Info

- ☐ First Name
- ☐ Last Name
- ☐ Formatted Name (Last, First)
- ☐ Member Record Number (MRN)
- ☐ Patient ID
  [additional patient ID value]
- ☐ Gender
- ☐ Date of Birth
- ☐ Patient Address
  - ☐ Full Address

  OR
  - ☐ Street
  - ☐ City
  - ☐ Zip Code
  - ☐ State
- ☐ Patient Phone
- ☐ Patient URL
  (Collective Medical direct patient link)

Encounter/Visit Info

- ☐ Admit Date (choose one)
  - ☐ mm/dd/yyyy hh:mm:ss
  - ☐ mm/dd/yyyy
  - ☐ dd/mm/yyyy hh:mm:ss
  - ☐ yyyy-mm-dd hh:mm:ss
- ☐ Discharge Date (choose one)
  - ☐ mm/dd/yyyy hh:mm:ss
  - ☐ mm/dd/yyyy
  - ☐ dd/mm/yyyy hh:mm:ss
  - ☐ yyyy-mm-dd hh:mm:ss
- ☐ Visit Major Class (ex: ED or Inpatient)
- ☐ Visit Type (ex: General Medicine)
- ☐ Visit Facility/Location
- ☐ Chief Complaint
- ☐ Diagnosis
  - ☐ Dx Description & Codes
  - ☐ Dx Codes Only
- ☐ Discharge Disposition
- ☐ Attending Physician
- ☐ Admitted Inpatient (Yes/No)

Supplemental Info

- ☐ ED Visit Count
  (choose all that apply)
  - ☐ 1 Month
  - ☐ 3 Month
  - ☐ 6 Months
  - ☐ 12 Months
- ☐ Inpatient Visit Count
  (choose all that apply)
  - ☐ 1 Month
  - ☐ 3 Month
  - ☐ 6 Months
  - ☐ 12 Months
- ☐ Care Recommendations Created
- ☐ Care Recommendations Updated
- ☐ Groups
  - ☐ All Groups
  - ☐ Specific Group(s)
    [group name(s)]
- ☐ Encounter Cohorts
  (Cohort(s) triggered from encounter)

[Additional Notes (optional)]

Please contact the Collective Medical Support Team at support@collectivemedical.com or 801-285-0770 with any questions.

Roles and Responsibilites Template

High ED Utilizers – Roles and Responsibilities of the Cross-Organizational Care Team

Before an ED Visit

Tasks	Responsible Party	Notes
Monitor ED Utilization		
Ensure patient is engaged in primary care		
Generate Care Guideline		
Provide ongoing Care Management		
Contact other care team members to coordinate care as needed		

During an ED Visit

Tasks	Responsible Party	Notes
Review Care Guideline (specifically the Care Guideline created per workgroup agreement, not necessarily ED generated Guideline)		
Provide care coordination – care team members contacted as appropriate		

After an ED Visit

Tasks	Responsible Party	Notes
Call patient for ED follow up		
Schedule ED follow up appointment		
Perform cross-organizational care conference		

For More Information

For more information on the HIT Commons EDie Utility, click here

For assistance with the Collective platform, contact Collective Medical Support:

support@collectivemedical.com