Community Collaboration to Support ED Utilization & Care Transitions Programs

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Overview

Collective Platform Use in Oregon—Where are we now?

Since late 2014, the Oregon EDIE Utility Initiative has connected hospital data statewide to health plan, CCO, primary care, behavioral health, and post acute settings to reduce emergency department utilization rates and improve transitions of care. This work has utilized the Collective Platform, developed by Collective Medical, to share real-time admission and discharge data and key clinical notes about complex patients with all connected facilities.

EDIE Utility Accomplishments to Date:

Collective Platform Network Facilities:

- All 60 hospitals in Oregon are contributing data to the Collective Platform and receiving EDie notifications for high risk patients when they admit to the ED setting.
- 240+ Primary Care practices 50 Behavioral Health organizations
- Numerous Government programs onboarded—Area Agencies on Aging (AAA/APD), Developmental Disabilities, Tribal Health, Oregon State Hospital
- Post-Acute Care—Over 100 facilities currently onboarded in Oregon

2018 Oregon ED Utilization Rates (compared to 2017 rates)

- Overall ED utilization decreased by 1.4 %
- ED Visits by high utilizers decreased 5%
- Visits by high utilizers with co-morbid mental health and substance use disorder decreased by 2.7%
- Potentially avoidable ED visits decreased by 11.2%
- ED visits decreased 31% by high utilizers in the 90 days following initial care guideline

Community Collaboration Defined

Community Collaboration—What are we talking about?

As the EDIE Utility Initiative evolved, users of the Collective Platform determined that through coordinated efforts, people from different organizations could work together to more effectively manage complex and high-risk patients. This work involved both ***coordination*** and ***collaboration*** to achieve desired results:

Coordination: The ability to use different parts of the system together smoothly and efficiently.

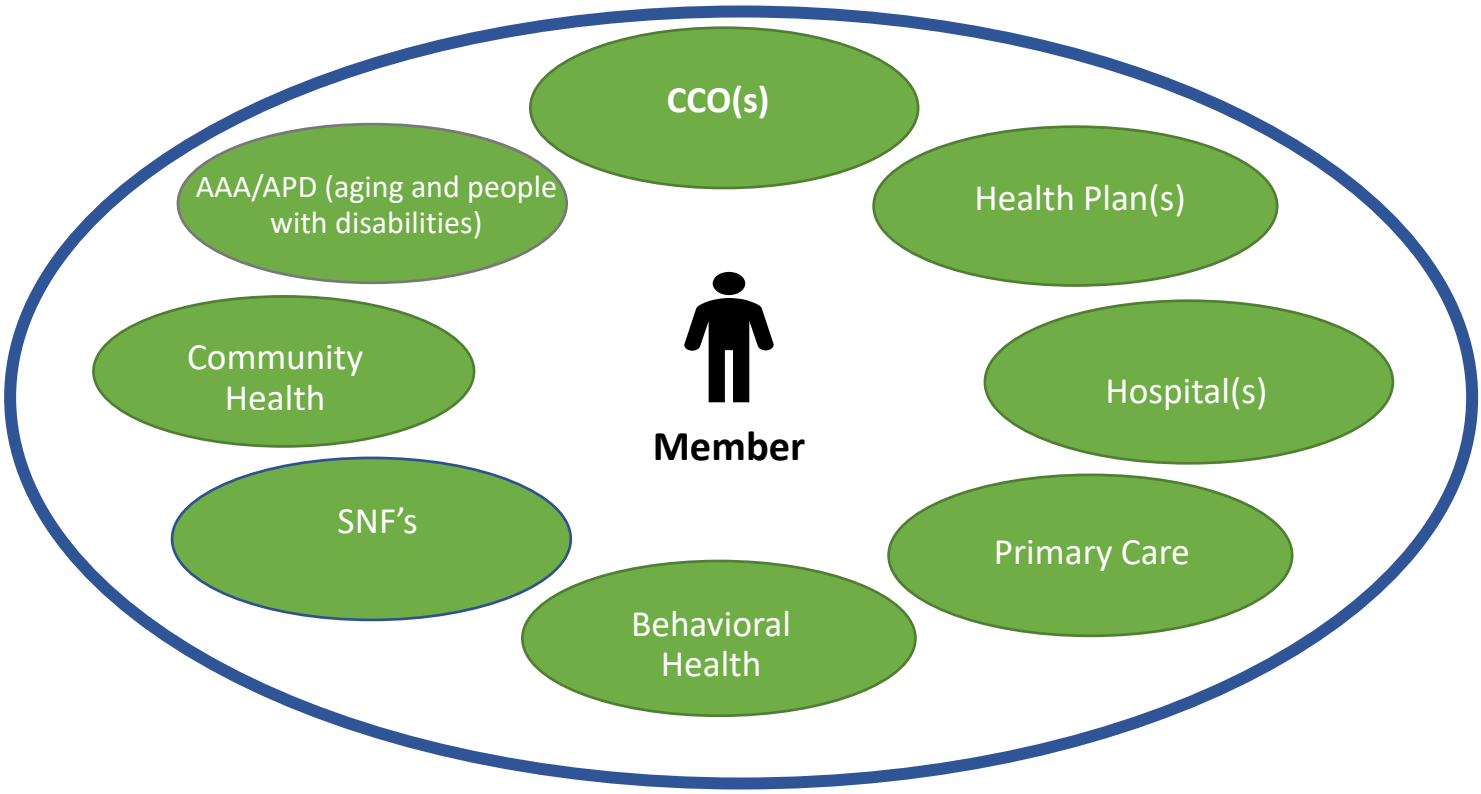
Collaboration: Process of two or more people or organizations working together to complete a task or achieve a goal.

Benefits of Cross Organizational Care Coordination

- Shared identification of members most needing support
- Address physical, behavioral and social needs together
- Ensures access to services and care needed
- Reduces duplication
- Leverages resources to better serve the population
- Provides support for clinicians and others dealing with a complex patient challenging population

Organizations Involved in Community Collaboration

Effectively managing complex and high-risk patients requires work across all community systems to build a model of care for patients. The diagram below briefly illustrates the types of organizations involved in community collaborations.



Opportunities for Community Collaboration

- Organizations want to work together—despite sometimes competitive interests
- Develop a shared understanding of organizational environments and workflows
- Leverage resources by identifying shared workflows, roles and responsibilities
- Develop repeatable processes across organizations
- Build relationships which makes the work easier overall

Challenges for Community Collaboration

- Organizations may have varying resources
- Takes time to build trust among organizations
- Lots of competing priorities can hamper sustained focus
- Some organizations are attached to their own workflows and struggle with adopting shared workflows

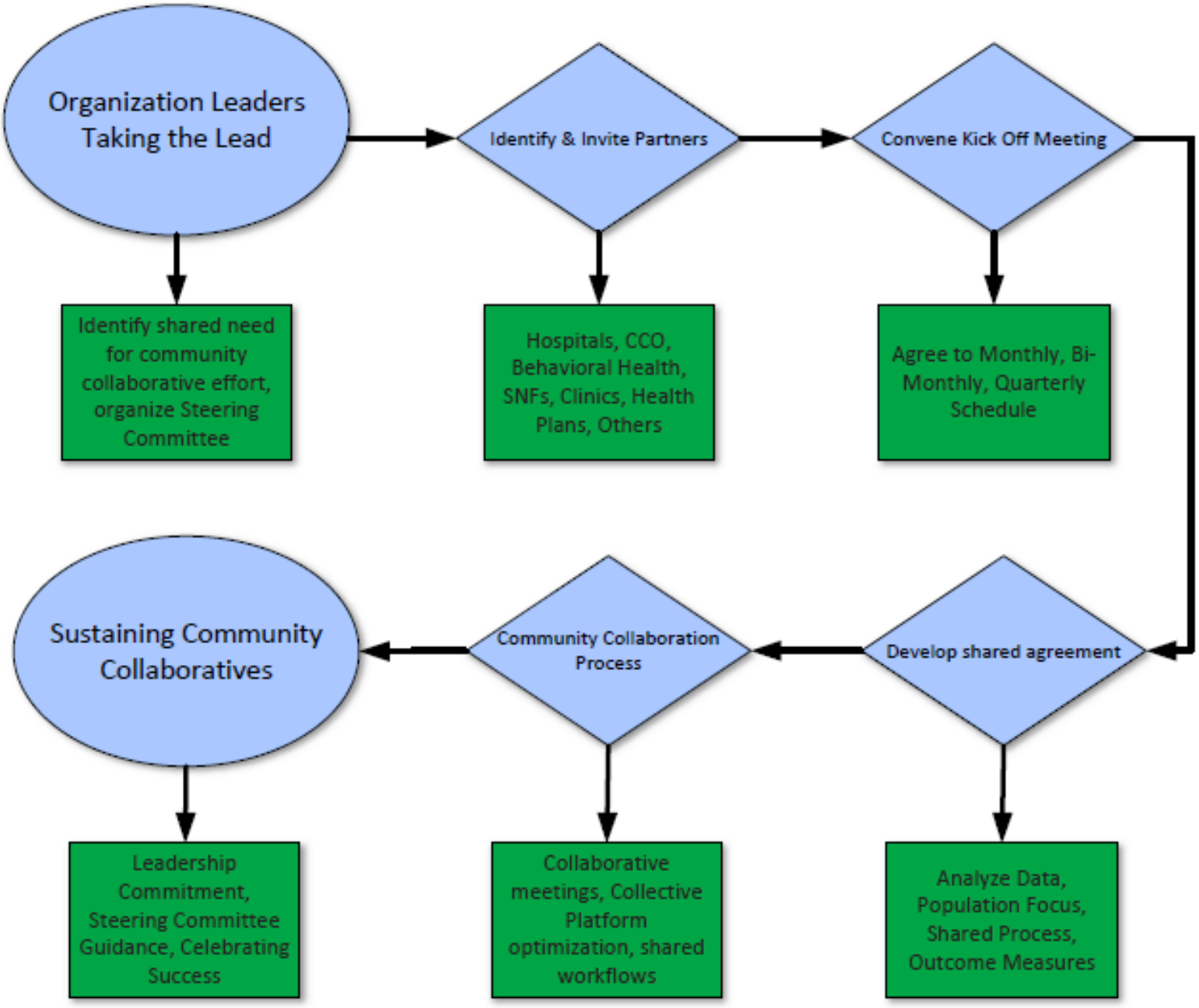
Community Collaboration Roadmap

Each community is unique and will approach the work of reducing ED utilization and improving transition of care in different ways. The following high-level steps may assist communities in organizing the work.

Note: A number of examples of tools/processes to use at each Roadmap step are provided in the Appendix.

- **Step 1:** Community leaders identify a need for the effort and agree to sustained leadership commitment. Convene a small Steering Committee to help guide the effort.
- **Step 2:** Solicit interest from key health care partners, including CCOs, commercial health plans (e.g. Med Advantage), primary care and behavioral health clinics, and others.
- **Step 3:** Convene those who are interested and get started—others may come along as momentum builds. Communities may also decide to add this work to existing community forums or efforts.
- **Step 4:** Develop shared agreement--Share data and agree together on population of focus, shared process for working together (e.g., monthly meetings) and desired outcome measures (e.g., reduced ED utilization or improved transition of care between acute care and post acute care settings).
- **Step 5:** Launch and convene regular Community Collaboration efforts (e.g., monthly, bi-monthly collaborative meetings).
- **Step 6:** Commit to sustained (e.g., one year) Community Collaboration efforts.

The diagram below outlines a potential **Roadmap for Community Collaboration.**



Community Collaboration Key Reminders

- Sustaining community collaboration over time takes ongoing collective leadership commitment and structure (e.g., engaged and committed Steering Committee)
- Collaborative meeting agendas should be action oriented
- Keep the cadence of meetings (monthly, quarterly) to sustain engagement and build relationships
- Revisit the value on a regular basis, share learnings and celebrate successes

A note about support from HIT Commons:

The HIT Commons has provided support to several community collaboratives in their early stages. HIT Commons will continue to provide assistance with developing and launching community collaboratives in cooperation with local community partners. HIT Commons staff can assist with agenda setting and facilitation in the collaborative early stages but believes that success of the effort hinges on local community partners leading the effort over the long term. See page 23 For More Information on how to connect with HIT Commons for this work.

Appendix

Example: Lane County Community Collaborative Charter and Participants

The Lane County Community Collaborative started in early 2019. The Charter guiding this work and the participants involved are provided below. While not every organization attends each meeting, the Collaborative continues to meet on a regular basis to sustain its effort on reducing ED utilization and improving transitions of care.

Background

The Emergency Department Information Exchange (EDIE) was adopted by all hospitals in Oregon in 2014/15. This has enabled hospital Emergency Departments in Oregon to receive real time notifications about ED/IP utilization. PreManage extends these same real time notifications to health plans and providers. PreManage has been broadly adopted by CCO's, commercial health plans, primary care and behavioral health, as well as other key providers.

In several communities in Oregon, cross organizational community collaboratives have been formed to identify opportunities to leverage the community adoption of the Collective Medical tools to facilitate improved cross organizational care coordination and communication for high needs, high utilizing patients. The outcomes of these efforts have resulted in reduced duplication, streamlined workflows, improved communication and reduced ED utilization.

Several organizations in Lane County have adopted Collective Medical tools, and there is an opportunity to work across systems (hospitals, health plans and clinics) to improve care coordination by clarifying roles and responsibilities and developing streamlined workflows.

Objectives

- Identify roles, responsibilities and processes for cross organizational care coordination to reduce unnecessary ED utilization and improve transitions of care
- Optimize the use of Collective Medical platform (EDIE/PreManage) tools to support identified processes and to improve communication

Roles and Responsibilities

The primary role of the Steering Committee is to ensure the successful identification and adoption of processes that facilitate cross organizational care coordination, leveraging the use of the Collective Medical tools to improve care for high needs high utilizing patients.

Steering Committee responsibilities:

- Approve scope and measures of success
- Determine population of focus and priority areas of focus
- Assure organizational resources for workgroup to be successful
- Address/resolve any identified barriers
- Ensure agreed upon processes are implemented
- Monitor performance to established success criteria

A workgroup will be initiated in early March comprised of Steering Committee members and 1-2 staff members with first-hand knowledge of the current processes. Meeting frequency will be determined by the Steering Committee.

Workgroup responsibilities:

- Identify current processes before, during, and after an ED visit
- Identify roles, responsibilities and processes for increasing coordination and communication
- Share best practices and develop shared agreement on use of Collective Medical tools (cohorts, reports, development of care guidelines etc.)

Scope/Timeline

In Scope:

- Medicaid Population with ___ED visits in _____ months
- Development of workflows for cross organizational care coordination
- Optimization of the use of Collective Medical tools by participating organizations and development of shared agreements on community use of tools

Out of Scope:

- IP transitions of Care
- Other

Timeline:

March Conduct current state mapping and identify opportunities for collaboration and improvement

Apr-June Identify roles, responsibilities and processes for increasing coordination and communication

July-Sept Implement new workflows and evaluate progress

Success Criteria:

• To be developed with participants

Participants: See table on next page.

Stakeholder Group	Participating Organization(s)
Sponsor/Convener:	Trillium Community Health Plan HIT Commons
Health Plan	Trillium Community Health Plan Pacific Source CCO
Hospitals	Peace Health
Primary Care	Community Health Centers of Lane County Eugene Pediatrics Oregon Integrated Health Oregon Medical Group PeaceHealth Medical Group Springfield Family Physicians
Behavioral Health	Options Counseling and Family Services Center for Family Development Trillium Behavioral Health
Oral Health	Advantage Dental
Aging and Disability	Lane County Aging and Disability Services
EMS	Eugene/Springfield Fire

Example: Using Data to Determine Population of Focus

As part of developing a shared agreement for community collaboration, participating organizations should work with their data and analytics teams to identify potential populations of focus. Some potential areas to explore include:

- Chronic Conditions
- MH Diagnoses (e.g. CCO Disparity Cohort)
- SUD
- Number of ED visits—consider ability to impact (e.g. rising risk)
- Engagement with Primary Care
- Engagement with Behavioral Health

Other considerations in evaluating data on complex or high risk populations:

- Look at those not going to the ED—what is working
- ED visits related to pain
- Homelessness
- Avoidable ED visits—is there a pattern?

Note: A work of caution against endless data analysis—there is no single solution to reducing ED utilization!

Example: Convene regular Community Collaboration meetings

A small, community collaborative Steering Committee should commit to regular phone calls to outline and plan meeting agendas and organize logistics such as meeting location, calendar invites and materials preparation.

Topics to cover at collaborative meetings include those listed below and a sample agenda follows.

- **Sharing data on complex and high risk populations**
  - Present each organization's recommendations on key populations of focus
  - Agree to a community collaborative cohort for the Collective Platform
  - Agree to commit staff and resources to ongoing work on the population of focus

- **Optimize each organization's use of Collective tools**
  - Perform an Organizational Assessment on the use of the Collective Platform (see page 14)
  - Request technical assistance from Collective Medical Support Team (support@collectivemedical.com)
  - Address and resolve technical issues and barriers
  - Promote the use of the Collective Community (e.g., the Help section) on the platform for access to resources and help with questions. https://community.collectivemedical.com/t/18aks5/collective-medical-getting-started

- **Align community use of Collective Platform**
  - Share best practices and develop shared agreement on use of tools (cohorts, reports)
  - Develop shared agreement on information sharing processes (care team, care history, care guidelines). See Information Sharing Resource Guide at http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/01/Sharing-Information-on-the-Collective-Platform-Resource-Guide-Final-December-2019.pdf

- **Map current state to understand each organization's existing workflows**
  - Establish roles and responsibilities for Collaborative partners to address patient needs Before, during, after ED visits. See example table below and page 20 for blank template to use in creating your community's own process)
  - Consider developing a special care coordination program for high utilizers

- **Identify together best opportunities for developing shared workflows**
  - Break down the work into manageable chunks, but avoid "silo" thinking
  - Document and test shared agreements, roles and responsibilities and continue to refine and expand through ongoing meetings

Example: Community Collaborative Meeting Agenda		
TOPIC	**TIME**	**LEAD**
Welcome, Introductions	08:30 – 08:45	Annette
Emergency Department Perspectives • Dr. Charlotte Ransom, ED Medical Director PeaceHealth • Tina Morris, Director of Care Management PeaceHealth	08:45 – 09:15	Liz
Putting it into Action • Small group exercise	09:15 – 09:50	Liz
Break	09:50 – 10:05	
Use of Collective Medical Platform • Cohorts and flags/tags • What's going well/Barriers and issues • Next Steps worksheet	10:05 – 10:35	Liz
Lessons Learned – "Working with the SPMI Population • Susan Alger, Director Care Management PacificSource	10:35 – 10:50	Annette
Current Improvement Efforts • Updates • Collaborative next steps	10:50 – 11:20	Liz
Wrap – up • Review action items	11:20 – 11:30	Annette

Collective Platform Organizational Assessment

As the Community Collaboratives begins its work together, it is helpful to get key clinics onboarded effectively with the Collective Platform. The organizational assessment tool below can be helpful to review a clinic's current state with the platform and identify key action steps/improvements to make to more effectively engage with the tool to support the Community Collaborative efforts.

Collective Platform Clinic Checklist

Clinic Name: **Date:**

Clinic Contact for Follow-Up:

Sponsoring Payer/CCO Contacts: **CM Contact** (if available):

1. **Collective Contacts:** Do you know how to contact CM for support? Do your clinic users know how to access Collective technical support—either from the clinic or CM?
   - ☐ Yes
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com
     - If no, review CM Help section on Q#9 below

2. **Collective Eligibility File:** Has your clinic successfully uploaded a Collective eligibility file? Have you set a regular schedule for updating and uploading your file? Or, does your clinic use the OCHIN Collective feed?
   - ☐ Yes Date of most recent upload:
   - ☐ Yes Schedule for regular updates:
   - ☐ Yes Member assignments included (Y/N & approx. #):
   - ☐ Notes:

   - ☐ OCHIN Feed (check if clinic uses this feed or not):
     - Are patients loaded at clinic site-specific level in Collective portal? Y/N?
     - If no, make note to connect to CM support for follow up

3. **Collective Accounts:** Do you know how to establish, maintain and terminate Collective Accounts for your clinic?
   - ☐ Yes Clinic Account Manager Name:
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com
   - ☐ # Users/Roles:

4. **Collective Clinic Usage:** Do you know how to use the "Manage Facility" > "Manage Users" pages to view Summary statistics for your clinic's Collective usage?
   - ☐ Yes
   - ☐ No
     - If no, do brief demo and connect to CM for follow up: support@collectivemedicaltech.com

5. **Collective Groups:** Are any Collective groups properly configured for your clinic (e.g., payer type, other)? Do you know how to add groups to your eligibility file and request a test file be processed by CM?
   - ☐ Yes Groups loaded*:
   - ☐ No
     - If no, connect to CO webinar resources, CM for follow up: support@collectivemedicaltech.com

   * Note: OCHIN clinics can't load their own groups but can view shared TPO groups loaded by CM

6. **Collective Cohorts:** Has your requested set of cohorts loaded into Collective? Do you know how to request changes, additions, etc.?
   - ☐ Yes Cohorts loaded:
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com

7. **Collective Notifications:** Do you understand how the email/fax notifications work and how to request modifications to these requests?
   - ☐ Yes Notifications loaded:
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com

8. **Collective Scheduled Reports:** Have you requested any Scheduled Reports for your clinic? Do you know how to request report additions/modifications?
   - ☐ Yes Reports loaded:
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com

9. **Collective Help Section:** Do you know how to access the Help Section, called "Collective Medical Customer Community"?
   - ☐ Yes
   - ☐ No
     - If no, connect to CM for follow up: support@collectivemedicaltech.com

10. **Other items to review:**
    - ☐ Verify that the following are visible in the clinic portal:
      - For CCO-sponsored Clinics: ED Disparity Measure (cohort & flag)
      - Other standard cohorts: 5+ ED visits, IP visits, etc.
    - ☐ Verify that new Care Team box is enabled
      - Yes
      - No
        - If no, connect to CM for follow up: support@collectivemedicaltech.com
    - ☐ Verify that Oregon Insights template is enabled
      - Yes
      - No
        - If no, connect to CM for follow up: support@collectivemedicaltech.com

11. **Additional questions/needs for clinic:**

Example: Establishing Roles & Responsibilities for Cross-Organizational Care Coordination

The detail framework below was developed by the Portland Community Collaborative led by The Portland Clinic and Providence Health Plan. The group agreed upon common tasks and roles to help better organize and coordinate efforts around high utilizers. A blank version of this framework template is also provided below to help communities determine their own roles and responsibilities.

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

Before an ED Visit

Tasks	Responsible Party	Notes
Monitor ED Utilization	All	Cohorts to monitor: • PHP and Regence will monitor TPC mutual patients to avoid duplicate calls • Compass will monitor TPC & PHP mutual high utilizer 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 schedule with a PCP. The ED guide will document this in EDIE • If the ED guide cannot schedule an appointment, the health plan will work on getting the patient established with a PCP • TPC will reach out to high utilizer patients who have not seen their PCP in over one year
Generate Care Recommendation	1. TPC 2. Compass 3. Providence ED	• Primary care should be responsible for generating the care guideline for high utilizer patients. • If primary care and a specialty are both involved, they will work together to create the care plan that primary care generates • ED Care Manager will create a care guideline if a PCP/specialist is not involved. They will ensure that the provider reviews all active care guidelines on a patient. Content should include: • If same day/next day appointments are available • On call contact info/hours

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.

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

Schedule ED follow up appointment	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.

Role and Responsibilities 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