EDCC Program Enrollment
Collective Platform Discovery Form

The Emergency Department Care Coordination (EDCC) Program in Virginia is to provide a single, statewide technology solution that facilitates real-time communication and collaboration among physicians, other health care providers, and clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of improving the quality of patient care services.

To begin, please help us better understand your organization by taking a few minutes to complete the form below. After submission, a ConnectVirginia representative will review your information and contact you regarding next steps. The discovery process is to determine existing organizational structure, partnerships, and workflows for the purpose of integrating the EDCC Program technology, the Collective Platform, most effectively at your organization. We welcome clarifying questions.
Please email your completed Discovery Form to support@connectvirginia.org.

Your Information

Name: _____ Title: _____

Email: _____ Phone: _____

How did you learn about the EDCC Program, ConnectVirginia, Collective Medical, EDie, or the Collective Platform (formerly named PreManage)?: _____

Organization Information

Organization Name: _____ Organization NPI: _____

DBA / Preferred Name: _____ NPI Taxonomy Description: _____

Drug Enforcement Agency (DEA) Number(s): _____ State Corporation Commission (SCC) ID(s): _____

Address 1: _____ Address 2: _____

City: _____ State: _____

ZIP Code: _____

Phone: _____ Email (optional): _____

Website (optional): _____

Does your organization have multiple locations?: ☐ **YES** / ☐ **NO**

If yes, how many? _____

Please provide names and locations: _____

If you are a large organization, please provide a list of locations in a separate document or spreadsheet.

Is your organization affiliated with any other organizations?: ☐ **YES** / ☐ **NO**

If yes, provide details: _____

Please list any partnerships your organization participates in—we might find places where communication and collaboration can occur. _____

Contact Information

Primary Contact:

Name: | Title:
Email: | Phone:
Office Hours (optional):

Designated Signatory for the EXCHANGE Trust Agreement (if different from name above):

Name: | Title:
Email: | Phone:
Office Hours (optional):

Clinical Contact:

Name: | Title:
Email: | Phone:
Office Hours (optional):

IT Contact:

Name: | Title:
Email: | Phone:
Office Hours (optional):

Accounts Payable (A/P) Contact:

Name: | Title:
Email: | Phone:
Mailing Address (if different from above):
Office Hours (optional):

Personnel & Patient Services Information

Estimated volume of patients:

Estimated number of personnel at your organization:

Are all personnel directly employed by your organization?: ☐ **YES /** ☐ **NO**

If no, please explain:

What types of providers do you have on staff? (e.g., MD, DO, PA, NP, RN, LCSW, MA, etc.):

Does your organization have staff who participate in case management?

Does your organization have dedicated staff for utilization review?

Please provide a brief description of patient services provided by your organization:

Please classify your organization according to your own definitions (e.g., PCP, FQHC, SNF, behavioral health, SUD, etc.):

Are any of your providers or patient services protected under 42 CFR Part 2 (e.g., substance abuse treatment, etc.):

How long does your organization define a patient as 'active'?:

Is there any additional information regarding your personnel or patient services that would be beneficial to note?:

Line of Business & Program Information

What lines of business do your organization currently provide services for? (e.g., commercial, Medicaid, Medicare, self-pay, etc.):
Note: Those who accept Medicare/Medicaid may receive priority to onboard in Virginia.

Does your organization accept financial risk for any or all of your patient population?: (financial risk includes an entity that takes upside only (gain sharing), upside/downside (risk sharing), as well as fully capitated risk for any population.)

Does your organization participate in any incentive or innovation programs? (e.g., CPC+, ED reduction grant, chronic condition management, etc.): ☐ **YES /** ☐ **NO**

If yes, please describe the program(s), staffing resources, and any reporting measures:

Does your organization have a network of SNF partners?: ☐ **YES /** ☐ **NO/** ☐ **NO, but may in the future**

If yes, how many SNF partners?: Please list names of the facilities.

Please list any initiatives your organization participates in, especially if around the Emergency Department or high-risk patients—we might find ways to help you.

Technical Information

Does your organization currently use an EMR / EHR?: ☐ **YES /** ☐ **NO**

If yes, which one?:

Does your organization have IT resources available?: ☐ **YES /** ☐ **NO**

Are they provided by an outside party?: ☐ **YES /** ☐ **NO**

The Collective Platform (formerly called 'PreManage') requires a 'Patient File' to be provided to Collective Medical on a regular interval (.e.g, daily, weekly, or monthly). This file would include basic patient demographic and provider information. Would your organization be able to meet this requirement?: ☐ **YES /** ☐ **NO**

Additional Information

Is there any other information you feel would be beneficial to provide at this time?:

Do Not Write Below This Line

For CVHIE Use Only	Date EXCHANGE Trust Agreement Signed	Date EXCHANGE Trust Agreement Executed	EDCCP Participant Node Authorized By
	Hospital Affiliation		Primary Specialty/Regional Planning Area