Health Information Exchange for Dialysis Providers

March 29, 2018
Why HIE?

• According to the USRDS, ESRD patients account for
  • 1% of the total Medicare population
  • 7% of total annual Medicare FFS spending ($34B annually)

• How CMS pays for ESRD services is changing
  • Implemented the ESRD Prospective Payment System (PPS) in 2011
  • Launched the Comprehensive ESRD Care (CEC/ESCO) model in 2015
  • Ongoing changes to the PPS and the ESRD Quality Incentive Program (QIP), including adding hospitalization ratio to the QIP in 2020

• HIE services are emerging as a critical tool for success in a system of value-based care.
Florida HIE Services

• The Florida HIE currently offers three services –
  • Direct Messaging Service
    • Secure, HIPAA-compliant email service
    • DirectTrust accredited
  • State Gateway
    • Clinical document query
    • Federated exchange with no central data repository
  • Encounter Notification Service
    • Real-time hospital encounter notifications
    • Inpatient and emergency department
    • Admissions and discharges
The Encounter Notification Service (ENS) provides an alert any time one of your patients receives care at a participating hospital.

- 215 participating hospitals in Florida
- 95% of acute care hospital beds
- Real-time hospital encounter data
- Inpatient and emergency encounters
- Admission and discharge notifications
- Working to add SNF & LTPAC data sources
• **Hospital admissions**
  
  • ENS notifies dialysis provider of a patient’s hospital admission in real-time
  • Saves time spent calling local hospitals (and the local police department) when a patient misses an appointment and cannot be reached
  • Allows the dialysis provider to send clinic information, patient history, exam findings, dialysis prescription, medications, allergies, and diet orders to the admitting hospital
  • Allows nephrologists and renal dieticians the opportunity to consult when complex patients are admitted to the hospital
  • Stay informed about inpatient dialysis treatment, test results, medications, etc.
  • Gives the dialysis provider time to arrange for equipment and/or medications needed to ensure a smooth transition from the hospital setting
ENS Use Cases

• **Hospital discharges**
  - ENS notifies dialysis provider of a patient’s hospital discharge in real-time
  - Allows timely post-discharge follow-up appointments
  - Facilitates medication reconciliation as soon as possible post-discharge
  - Gives the dialysis provider time to request and review the patient’s discharge summary and new dialysis orders prior to the next dialysis appointment
  - Gives the dialysis provider the opportunity to provide patient education and support immediately after discharge in order to prevent avoidable readmissions
  - Allows the dialysis provider to answer patient questions about their hospital encounter and discharge instructions
  - Coordinate with the SNF or LPTAC (if the patient is not being discharged to home)
User Experience

• Get Better Data
  • ACO #1 had a direct admit/discharge feed (non-ENS) from the only hospital system in their service area
  • Realized via claims that they were missing significant ER utilization
  • Subscribed to patient population via ENS
  • Realized they were missing 35% of total patient ER utilization prior to ENS
User Experience

• **Improve transitions of care**
  • ACO #2 had over 73,000 TCM eligible discharges during a study period.
  • This ACO used ENS to get almost 80% of these patients in for a follow-up visit within two weeks of hospital discharge.

• **Reduce avoidable readmissions**
  • ACO #1 used ENS to reduce readmissions in a targeted service area by 40%.
  • This same ACO, managing a population of 10k patients, attributed a total annual savings of $284,000 to their ability to use ENS data to reduce avoidable readmissions.

• **Lower post-discharge spending**
  • ACO #2 used ENS to reduce 90-day post-discharge spending by 14%.
How ENS Works

• **ENS Overview**
  • Subscribers submit a list of patients to ENS, including first and last name, DOB, gender, address, and other demographic info
  • Hospitals send inpatient and emergency ADTs to ENS
  • ENS matches incoming ADTs to subscriber patient lists based on patient demographics, using a conservative, highly sophisticated matching algorithm
  • Matched ADTs are routed to the appropriate subscriber; unmatched ADTs are discarded
  • Subscriber preferences determine how, when, and where alerts are delivered.
How ENS Works

• **Alert delivery options** –
  • Real-time or batch delivery
  • Raw HL7 ADTs or CSV file format
  • Delivered by Direct, SFTP, or PROMPT
  • Participants can update their subscription configuration at any time

• **Some of the useful information contained in the alerts** –

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<thead>
<tr>
<th>Name</th>
<th>MRN</th>
<th>Date/time</th>
<th>Attending Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Insurance Company</td>
<td>Facility</td>
<td>Diagnosis Description</td>
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<td>Insurance ID</td>
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<td>Event</td>
<td>Episode ID</td>
<td>Discharge Disposition</td>
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<tr>
<td>Phone number(s)</td>
<td>Patient Class</td>
<td>Patient Complaint</td>
<td>Death Indicator</td>
</tr>
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</table>
How ENS Works

• PROMPT user interface (with test data)
• Dialysis clinics can also *contribute* encounter data to ENS –
  • Dialysis encounter data would be routed to health plans and providers that are subscribed to those patients, just like hospital encounter data is routed.
  • Engages the payer and provider as part of the care team, allowing them to assist in efforts to reach out to patients who have missed appointments.
  • The Florida HIE can work with most structured data to turn the information into encounter alerts that can be routed to entities subscribed to your patients.
  • There is no cost to contribute encounter data to ENS. Providers which contribute data receive a substantial discount on their subscription to the service.
Proposed Onboarding Timeline

• **Week One:**
  - Execute Participation Agreement as Data Subscriber

• **Week Two:**
  - Finalize subscription configuration preferences
  - Set up preferred delivery mechanism

• **Week Three:**
  - Provide list of patients on whom to receive alerts
  - Establish connectivity to contribute encounter data (optional)

• **Week Four:**
  - Go live
Additional Resources

• Florida HIE website – www.florida-hie.net
  • Additional information on ENS and other Florida HIE services
  • Contract and onboarding documentation for ENS

• AHCA’s HIE website – www.fhin.net
  • Florida HIE metrics
  • Medicaid Meaningful Use resources
  • AHCA’s recently published study on HIE in Florida
Contact Us

Phone: 850-322-1431

Email: aparsons@ainq.com

Website: florida-hie.net