FLORIDA HIE SERVICES

The Florida Society For Post-Acute And Long-Term Care Medicine

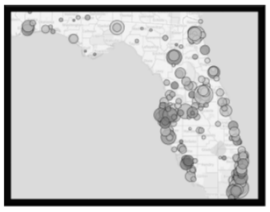
9/18/2018

Florida HIE Services

- The Agency for Health Care Administration established the Florida Health Information Exchange Services in 2011
- The Agency oversees the operations of the Florida HIE Services with input from several stakeholder advisory groups
- The Agency has contracted with Audacious Inquiry (Ai) to provide the technology and to run the day-to-day operations of the Florida HIE Services

Encounter Notification Service

- ENS routes notice of patient hospital encounters to subscribing organizations, including ambulatory practices, hospitals, ACOs, and health plans.
- **Hospital data sources**
  - 215 connected hospitals
  - 95% of acute care hospital beds
  - Real-time data feeds
  - Inpatient and Emergency Department
  - Admissions, Discharges, and Transfers
  - See the complete list at florida-hie.net




EMERGENCY

Encounter Notification Service

- **ENS connects hospitals, primary care providers, payers, and others responsible for coordinating patient care by providing real-time notice of patient health care encounters.**
  - Over 8M patient lives covered in Florida
  - Over 800k notifications delivered every month
  - Over 70 subscribing organizations are receiving data
    - 5 health systems (inclusive of over 50 hospitals)
    - 22 Accountable Care Organizations (ACOs)
    - 30 provider groups
    - 14 health plans

Encounter Notification Service

- **Improved Post-Discharge Follow-Up Care**
  - One participating ACO had over 73,000 Transitional Care Management (TCM) eligible discharges during a study period.
  - The ACO was able to leverage ENS to get 69% (50,322) of those patients in for a follow-up visit within the TCM-required 1-2 week timeframe.
- **Reduced Avoidable Readmissions**
  - Another participating ACO saw a 40% reduction in re-admissions per quarter during their first year of participation in ENS.

Encounter Notification Service

- **Better Data**
  - One ACO had a direct ADT feed (non-ENS) from the only hospital system in their service area, but realized via claims that they were missing significant ER utilization.
  - This ACO subscribed to ENS and found they were missing 35% of total patient ER utilization without ENS subscription.
- **Reduced Cost**
  - One ACO with a small panel (~10K patients) attributed a total annual savings of $284,000 to their ENS subscription via avoided readmissions.
  - Another ACO saw their average 90-day total spend post discharge decrease by $1,882 per instance when using ENS to capture TCM.

ENS for LTPAC

- **Long-Term and Post-Acute Care providers can connect to the ENS network as both senders and recipients of data.**
  - By sending data, LTPAC providers are connecting with hospitals, ACOs, and physician practices statewide to share encounter data with the goal of improving patient care.
  - By receiving data, LTPAC providers can know about their patients acute care encounters in real-time and take steps to improve the transition to post-acute care (or home).

ENS for LTPAC

- **Preferred SNF Networks**
  - As the prevalence and sophistication of Preferred SNF Networks grow, health systems are actively asking their LTPAC partners to connect to ENS for more effective communication and care coordination
  - ACOs and hospitals want their referral partners connected and sharing data through ENS


HealthAffairs TOPICS JOURNAL

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 36, NO. 9: MARKET CONCENTRATION

Reducing Hospital Readmissions Through Preferred Networks Of Skilled Nursing Facilities

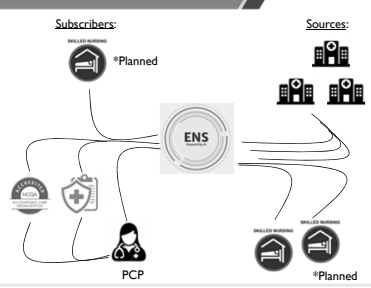
John P. McHugh[1], Andrew Foster[2], Vincent Mor[3], Renée R. Shield[4], Amal N. Trivedi[5], Terrie Wetle[6], Jacqueline S. Zinn[7], and Denise A. Tyler[8]See fewer authors

ENS for LTPAC

- **Reducing avoidable readmissions**
  - LTPAC providers are now financially responsible for readmissions from hospitals that refer patients to their facilities (see CMS Skilled Nursing Facility Readmission Measure).
  - ENS can be an effective tool for mitigating avoidable readmissions by notifying LTPAC providers of hospital encounters on their recently discharged patients.
- **Shared insights**
  - As the ENS network continues to grow, more value is generated as social workers and discharge planners at hospitals have a window into recent SNF utilization and the capacity for patients to return to the SNF in lieu of an admission or prolonged Length of Stay

ENS for LTPAC

- **Leverage the Network**
  - While SNFs implement policies, programs, and develop capabilities - such as ENS - to reduce readmissions, LTPAC connectivity to ENS allows for care management resources from PCPs, ACOs, and Health Plans already using ENS to be brought to bear for the same goal of reducing re-hospitalizations.



Funding for ENS Connectivity

- **The Agency for Health Care Administration (AHCA) has funding available to connect Medicaid providers – like SNFs and other LTPAC providers – to ENS as both data sources and recipients of data.**
  - Funding covers up to $5k per connection to become a data source
  - Funding covers the cost of receiving data on up to 250k patients for 12 months
  - Send questions about funding details to AHCA at flhii@ahca.myflorida.com

Connecting to ENS

- **Getting connected**
  - Sign the standard ENS Agreement
  - Coordinate technical kick-off with Ai and your organization's IT vendor
  - Confirm your data feed includes the requisite patient demographic and clinical information (i.e. discharge diagnosis)
  - Provide a list of patients on whom you would like to receive alerts OR direct ENS to use your data feed to "auto-subscribe" you to your recently discharged patients
  - Choose your subscription configuration preferences and alert delivery method
  - GO LIVE!

Encounter Notification Service

- **Receiving Notifications**
  - Real time or batch delivery
  - CSV or HL7 formatting options
  - Delivered via Direct Messaging or SFTP
  - Proactive Management of Patient Transitions (PROMPT) user interface
- **PROMPT demo - link**

Contact Us

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