strategy template: healthcare_127_Encounter Alerting Service (EAS)

Priority Strategy title: Expand use of the MN Encounter Alerting Service

Strategy Catalogue unique identifier(s): 127
Original submitting organization(s)/agency(ies): Long Term Care Imperative
Drafting organization/agency: Department of Human Services
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1) This priority strategy addresses the following aspect of the Commission’s charge (select only the one that represents the best fit):

☐ Transform the health and human services system.
☐ Increase administrative efficiencies and improve program simplification within health and human services public programs.
☒ Identify evidence-based strategies for addressing the significant cost drivers of State spending on health and human services.
☐ Reduce waste in administrative and service spending in health and human service
☐ Advance health equity across geographies, racial and ethnic groups

2) Please describe the populations impacted by this strategy:

The strategy applies to persons covered by Medical Assistance or MinnesotaCare who receive treatment in an Emergency Room, Hospital, or Long Term Care (LTC) facility.

3) Problem statement

a) What is the primary problem the strategy is expected to mitigate or resolve relative to the focus area?

Fragmented care is expensive; the sooner a provider who is accountable for coordinating a person’s care can be informed of a health event, the more effectively they can support recovery, transitions between care settings, and avoid re-hospitalization. This strategy continues efforts to implement more timely communication from an emergency room, hospital or LTC facility to a person’s care team.

b) What is the secondary problem(s) the strategy is expected to mitigate or resolve relative to the focus area and/or other focus areas?

There is an administrative cost to provider systems in communicating key information to all necessary, permitted, responsible parties. Establishing a standards based, consistent approach for exchanging critical information for Minnesotans helps reduce administrative cost and complexity.
4) Priority Strategy description

a) What is the strategy?

Expand participation in the Minnesota Encounter Alert System (MN EAS) so that more Medical Assistance and dually eligible enrollees benefit. Additional information about the MN EAS system can be found here: www.mneas.org.

Currently providers voluntarily participate, and there are 77 sources enable delivery of over 20,000 alerts per month. DHS contributes attributed patient panels for Integrated Health Partnerships (IHPs), and providers who perform care coordination can upload additional consenting panels. On average, one quarter (25%) of the notices generated can be matched and delivered to a subscribing participants care coordination panel. Expanding to add remaining sources and additional care coordination panels would allow more of the alerts to be delivered. Having a critical mass of the providers contributing to and benefiting from the alerting service in an area accelerates the value gained and in turn encourages participation. Two ways to accelerate participation include: introducing additional use cases for county or Medicaid payer participation; and enhancing alerts to include discharge summary info so that the alerts have even greater value to receiving providers.

b) What steps are required to implement the strategy?

A Center for Medicare and Medicaid Services (CMS) proposed interoperability rule may in the future require hospitals to share alerts as a condition of participation in Medicare and Medicaid, and Medicaid payers may be required to participate in trusted information exchange networks. DHS will continue onboarding providers in anticipation of this rule. Providers are electing to add dually-eligible panels and may opt in the future to add Medicare panels that are part of a value-based payment arrangement. This helps accelerate participation because providers can use consistent workflows and the alerts for Medicaid and Medicare consumers can be matched at a higher rate to the appropriate care team. DHS has added participation in the MN EAS or a similar health information service as part of the quality framework for IHP contracts.

To enhance the alerts so that additional information such as discharge summary notes can be pushed to the appropriate care teams, DHS would need to work with Audacious Inquiry, and the Minnesota Department of Health (MDH) to connect the MN EAS to the National e-health exchange. When an alert is received, the MN EAS could then leverage existing e-health exchange network to obtain discharge summary info and include it when pushing the alert to the receiving organization. DHS needs to update HITECH documentation and obtain approval from CMS annually. Ongoing collaboration with MDH and the E-Health Advisory community will be required to ensure alignment with the direction and recommendations of the Health Information Exchange (HIE) task force. This strategy could complement and help lay groundwork for other transformational HIE activity proposed by MDH.

i. Who will need to take them?

MN DHS, Audacious Inquiry, provider participants of MN EAS

ii. When will they need to be taken?

Outreach and onboarding of providers continues to occur.

Enhancing alerts could be done anytime following an update to CMS, but is ideally initiated prior to July 2021 in order to maximize federal HITECH matching funds.

iii. How long will implementation take?
Basic onboarding of new providers typically takes three weeks, but may take longer for more extensive workflow or system integration. Introducing and obtaining approval for additional use cases from MN EAS participants takes approximately 6 months. Remaining work to enhance alerts is estimated to take approximately 6-12 months.

iv. What will be the associated systems impacts?

Currently there are no impacts to DHS systems as this strategy addresses infrastructure between providers and is supported by an external vendor. See responses to other questions regarding broader system impacts.

v. What will be the associated resource requirements?

Implementation does require staff and IT resources of provider systems. For provider organizations receiving information, this includes time of staff for onboarding/training and workflow discussions. For organizations sending information, required resources also include information technology resources to establish connection information from electronic health records (E.H.R.). For systems desiring deeper integration into existing infrastructure and workflow tools, resources required may be higher. Implementation could be supported by the existing DHS FTEs and the Audacious Inquiry contract, which are currently funded through the federal Health Information Technology for Economic and Clinical Health (HITECH) Act (90%) and state Medicaid dollars (10%). No MN-IT resources are required.

vi. What will be the implementation challenges? Does the strategy create an administrative burden or additional costs for the State or for any external stakeholder(s)?

Provider systems must prioritize health IT initiatives and resources. The CMS proposed rules around interoperability of patient information are expected to include requirements related to health IT that may impact the capacity and priority of this work. There will be some beneficiaries for whom no previous care coordination relationship was established which may increase caseloads and visibility into active needs. The focus of this strategy is for Medicaid and Medicaid/Medicare dually eligible populations, but this service could be leveraged as part of a broader statewide strategy for other populations and use cases. Work to determine how best to align this strategy will be required. Many provider systems operate in multiple states or in border communities and solutions need to be interoperable and flexible so they can be implemented in alignment with an overarching strategy. See above for costs to external stakeholders. DHS will have ongoing system support costs to sustain the service, eligible to be matched by federal dollars based on available CMS guidance.

c) How will the strategy mitigate or resolve the primary problem it is addressing?

Greater provider participation allows the service to deliver a higher rate of alerts to the appropriate care provider. (Example – currently alerts might be received by the service, but if the patient’s care coordinator is not subscribed, the alert cannot be delivered. Likewise, a care coordinator may be subscribed, but if the patient is seen at one of the ERs/hospitals that is not yet participating, they will not receive the alert.)

d) What are possible unintended consequences this strategy could have?

i. Possible interest in use of the service for populations beyond Medicaid.

ii. Deeper community discussion about data sharing hurdles including need to review patient consent notices.

iii. Greater identification of care coordination needs.

5) Expected results and supporting evidence
a) What are the expected results, and when will their impact be experienced?

See programmatic/population impacts below.

Overall health care costs for Medicaid enrollees who receive coordination following an ER or hospitalization are lower than those who do not.

Additionally - providers participating in value-based arrangements can reduce hospital readmission penalties or increase opportunities for shared savings.

i. What is the anticipated fiscal impact to the State in the next biennium? (select one)
   ☑ Cost savings

ii. If new costs or cost savings are anticipated, what is the scope? (select one): TBD
   ☐ Small: $1 to $999,999
   ☐ Medium: $1 million to $9,999,999
   ☐ Large: Greater than $10 million

iii. Will any state investment be required?

   Yes, Medicaid state share investment is currently being used to support this service and will continue to be needed to maintain it. State investment is maximized by leveraging HITeCH (available through September 2021), because enhancements to and expansion of the service are part of the overall HITeCH budget. Remaining implementation will need to be supported through Medicaid Management Information Systems federal match.

iv. What will be the programmatic and population impacts?

   For a consumer, health care is more cohesive and support needed during a care setting transition can be arranged sooner. This impact can be experienced immediately as evidenced by family and patient stories shared by participants who describe a sense of relief or re-assurance that their care team was on the same page and knew about an event so they could help with follow-up.

   For health care providers in hospital or ER setting, the service reduces administrative burden (phoning/faxing) and allows for critical health event information to be communicated seamlessly to a patient’s primary provider. The service ensures that the provider can receive the information securely even if they are not on the same E.H.R. system or part of the same health system.

   For primary care providers or other care coordination staff, less time is spent searching and seeking updated clinical information and there are improved health outcome because the critical information was pushed to them right away when there was still time to intervene.

   For providers who have traditionally not been able to participate in e-health exchange – this service provides a low cost, high value way to receive necessary notifications.

v. What are the key results of the equity review evaluation?
The strategy promotes cohesive and supportive health care for the consumer, while promoting a reduction in cost, administrative burden, and time for individuals covered by Medical Assistance or Medicare receiving treatment in an emergency room, hospital or long term care facility. Populations that benefit most from this strategy are those who experience high use of the emergency room as their main source of care – homeless, persons with mental illness, etc. Additionally, provider systems who disproportionately serve these populations were previously unable to take advantage of e-health opportunities due to cost.

Equity considerations:

- How will this strategy allow for the communication of key events if an individual doesn’t have a primary provider?
- How is cultural competency being considered?
- Does the strategy have unintended consequences?
- Does the strategy make provisions for accountability?

Please note that after the equity review, changes in a particular strategy may not be needed. However, procedures associated with that strategy may need to be created or enhanced to ensure equitable outcomes can be achieved.

b) What evidence supports the strategy’s effectiveness, if any?

Medicare beneficiaries who had transitional case management following a discharge had a significantly lower overall mean cost ($3,358 vs. $3,033).

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6583218/ MN has relatively low rates of using that service (https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Provider-Utilization-and-Payment-Data-Phy/fs4p-t5eq/data) and a functioning ADT system would aid/enable this.

Studies indicate that if the necessary follow-up is not provided after an ER or hospitalization, recovering patients are more susceptible to complications and illness, resulting in worse health outcomes and costly readmissions (Kirsch, Kothari, Ausloos, Gundrum & Kallies, 2015). Also, people who are not seen by their primary provider within 30 days of an ER or hospital admission have a 10x greater risk of readmission. (Moran, Davis, Moran, Newman, & Mauldin, 2012).

Recent trade industry voices.

CMS has proposed requiring the sharing of hospital alerts: CMS Interoperability Roadmap