Healthix

Innovative Uses of HIE: Providing Value to the Community

SHIEC Annual Conference

August 28, 2017

Agenda

- **Healthix Overview**
- **Supporting Care of Patients with Complex Conditions**

Public Health:
AIDS Institute

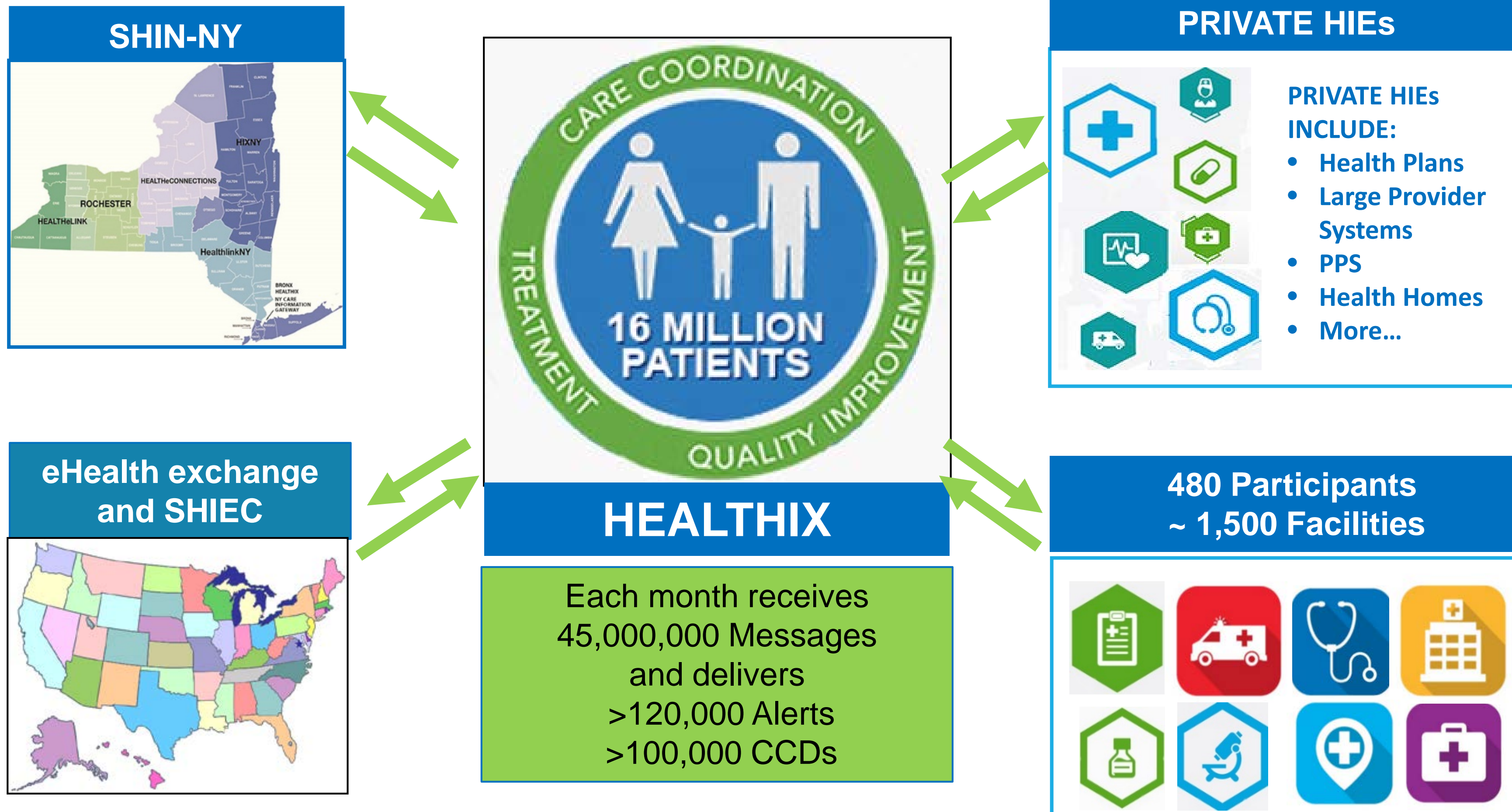
Frequent
ED Visitors

Homeless and
Unstably Housed Patients

Integrating
Behavioral
Health

Medicaid Health Homes
and DSRIP

Healthix Overview



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Public Health: AIDS Institute

The AIDS Institute of NYS DOH focuses on services to Persons HIV+/AIDS

- Maintains a registry of HIV+ persons in NYS
- Identifies HIV+ persons fallen out of care, encourages them to maintain treatment

Under a program funded by HRSA, Healthix:

- Identifies patients in Healthix with Diagnoses of HIV+
  - Plan to add lab results and medications as other indicators of HIV+
  - Creates a registry of these patients in Healthix
  - Whenever one of these patients has an encounter, Healthix sends a C-CDA (Over 400,000 per mo.)
- AIDS Institute determines:
  - Is this patient in the AIDS Registry already, or need to be added
  - Is this patient receiving the care that's needed
    - Allows focusing resources on patients who have fallen out of care

Homeless and Unstably Housed Patients

Algorithms identify homelessness or unstable housing based on address:

- Shelter, church, hospital, public place, text string (“homeless,” “none”)
- Will check State registry to see whether enrolled in health home (already eligible)

NYC Dept of Homeless Services (DHS) to become a Healthix Participant

- DHS will ask clients in homeless shelters for consent to access data in Healthix
- DHS case managers will query Healthix to see client’s medical conditions and encourage them to receive follow up care
- Healthix will send alerts to DHS if client presents in ED, is hospitalized, or is incarcerated or released from jail
  - Alerts case manager of the need for intervention
- ED physician will see that patient is known to DHS

Medicaid Health Homes and DSRIP

Managing a population of patients with high needs and complex conditions

- Alert care manager to ED or Inpatient admission, incarceration or release from jail
- Communicate care plan from care manager to community provider
- Calculate prospective risk of event (ED or IP admission, AMI, stroke, death) or initial diagnosis of a chronic disease, within next 6 or 12 months
  - Can alert care manager if risk increases – while there's still time to intervene

Frequent ED Visitors

Alert case managers in ED if patient needs special intervention:

- When patient presents in ED, search whether patient had 3 ED visits in past month
- Produce monthly report of patients discharged from the ED who then visited the same or another ED within 30, 60 or 90 days after

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Integrating Behavioral Health

Healthix accepts data from 42 CFR Part 2 facilities (alcohol, drug treatment and mental health services regulated by SAMHSA)

- Patient consent for provider or care manager to see data includes SAMHSA data
  - Non-SAMHSA provider gets fuller understanding of patient needs
- Behavioral health provider can see patient’s full medical condition and treatment

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Questions?

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