Welcome
Richard J. Donoghue
Senior Vice President for Strategy, Planning and Business Development NYU Langone Medical Center
SHIN-NY Overview & Update

Patrick J. Roohan
Director,
Office of Quality and Patient Safety (OQPS)
New York State Department of Health
Overview of Healthix

Thomas F. Check
President and CEO
Healthix, Inc.
About Healthix

Healthix facilitates the coordination of care and secure exchange of patient information among disparate providers to improve clinical outcomes, promote efficiency and reduce healthcare costs.
Healthix holds health records of 10,000,000 people
Participants

148 Participants  548 Facilities

- Hospitals and Health Systems
- Long Term Care
- Physician Practices
- Behavioral Health Organizations
- Community Based Organizations
- Health Plans
Interoperability… A Growing Trend

Healthix has seen +172% growth in the number of participating organizations over the past 24 months
Data in Healthix

- Allergies
- Consent
- Diagnosis/Problem List
- Demographics
- Encounters
- Insurance
- Lab Results
- Medications
- Plans of Care
- Radiology Reports
- Summary Documents
  - Discharge Summaries
Healthix Services

Healthix currently provides a range of services, which support and enhance patient care and coordination:

- Clinical Event Notifications
- Consent Management
- EHR Integration and Single Sign On
- Patient Record Look-Up
- Secure Messaging – Direct
- Reporting and Analytics
- Consulting Services
• New York State has an “opt-in” consent model
• Patients grant or deny consent to allow their providers to access community-wide health information and receive Clinical Event Notifications through Healthix
• Healthix has received over 1 million affirmative consents from patients across the greater New York area
9 RHIOs or Qualified Entities Make Up the SHIN-NY

RHIOs in New York State are adopting common standards to exchange data in the State Health Information Network – New York

STHL and THINC are merging as HealthlinkNY

Interboro and eHNLI are in merger discussions
Overview of Event Notifications
Brooklyn Health Home Introduction

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Maimonides Medical Center
The Brooklyn Health Home and Healthix:
Using Critical Event Notifications to Drive Care Coordination

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Brooklyn Health Home (BHH)

Goal is to:
- identify/address the full range of behavioral, medical and social problems affecting patients with multiple chronic conditions, serious mental illness (SMI) and/or HIV
- foster collaboration and timely exchange of patient information among involved providers
- drive measurable improvements in patient engagement and outcomes

Provides individuals with:
- a Care Manager, Care Navigator, and Primary Care Provider, supplemented by Psychiatrist and Therapist if needed. The Team is linked electronically to stakeholder members of the extended care team (including specialty providers, residential providers, and home care)

Care Managers/Care Navigators use Healthix to track patient health info:
- this includes monitoring to enable timely communication, sharing information through care transitions, coordinating post hospitalization, and assisting patients with appointments and linkages to specialty services.

BHH serves 8,000+ members who live and/or receive care in Brooklyn
Alerts Received
(ED visits, Inpatient and Psychiatric Admissions)

February – September 2014

Number of Alerts:
- February 2014: 118
- March 2014: 235
- April 2014: 242
- May 2014: 351
- June 2014: 280
- July 2014: 422
- August 2014: 478
- September 2014: 437
Response Time to Alerts Improving

Documented Care Manager Encounter Following an Alert

February – September 2014
Response to Alerts Increasingly Timely
(Occurred *During* Admission/Prior to Discharge)

Documented Care Manager Encounter Following an Alert
(Time from Admission)

% of alerts with an encounter during stay

- Within 1 Day into Admission
- Within 2 Days into Admission
- Within 3 Days into Admission
- Within 4-7 Days into Admission
- Within 8-30 Days into Admission

Feb-14  Mar-14  Apr-14  May-14  Jun-14  Jul-14  Sep-14
Post-Discharge Follow Up Improving

Documented Care Manager Encounter Following a Discharge Alert
Hospital Alert Response Protocol

Hospital Alerts trigger a standardized set of care management activities, designed to minimize the likelihood of a preventable ED visit or hospital readmission:

• **Notify** the member’s PCP and/or psychiatrist
• **Contact** hospital staff
• **Follow up** with the member (visit in the hospital if still in the ED or admitted) to learn the circumstances surrounding the ED visit/hospitalization
• **Case conference** with providers to understand the root causes of the ED visit/hospitalization and to develop a discharge plan
• **Follow up** with the member following discharge to implement the discharge plan, ensure attendance at follow up appointments, etc.
• **Update** the care plan, as appropriate
Connectivity Today

Brooklyn Health Home currently receives alerts from:

• Brookdale University Hospital and Medical Center
• Kingsbrook Jewish Medical Center
• Lutheran Medical Center
• Maimonides Medical Center
• The Brooklyn Hospital Center
• Wyckoff Heights Medical Center
Case Study: A Care Manager’s Response

EVENT

• A member visits the ED and is admitted to the hospital -- ALERT IS SENT
• Member has multiple medical as well as psychiatric conditions

RESPONSE:

• Care manager visits the member in the hospital and discusses reason for visit to ED
• Determined that individual has instability at home and disconnection from psychiatric care
• Care manager suggests reconnection to behavioral health care appointments and respite care
• Individual agrees and asks for help identifying a female therapist
• A week later Care Manager is present at hospital discharge
• Care manager prior to discharge has:
  – discussed specific respite/crisis program with member
  – reviewed discharge plan with hospital social worker
  – worked to identify most appropriate therapy team
  – developed individualized care plan for when providers are out on leave
• Member agrees to see new psychiatrist and therapist
• Member has an individualized care plan and behavioral team
Case Study: A Care Manager’s Response

EVENT

- Member presented to the ED and was later admitted to inpatient psychiatry – ALERT IS SENT
  (Member recently consented to BHH, but had not kept intake appointments with care manager)

RESPONSE:

- Same day - Care manager contacts hospital for inpatient social worker information
- Next day - Care manager visits the hospital and conducts a complete intake with member
  (outpatient providers, hospitalization history, contact info for PCP, psychiatrist, therapist, medical
  and psychiatric history, and elicited member’s experience at outpatient mental health clinic)
- Care manager learns that member desires to enter assisted senior living
- Care manager observed examination by a geriatric physician, and spoke to the nurse regarding
  discharge plan and recommendation of home health aide upon discharge.
- During this lengthy hospital stay - Care manager was in contact with hospital staff, assisted in
  obtaining outpatient medical records, and participated in discharge planning.
- Following discharge - Care manager made home visit, reviewed and assessed member’s status
  regarding follow up appointments, medication adherence, home health aide, transportation
  needs, housing options, and family supports.
- Care manager advocated efforts to determine whether home health aide hours could be
  increased.
Oscar - Introduction

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Healthix, Inc.
Mario Schlosser, Co-Chief Executive Officer, Oscar

Mary Ellen Connington, RN
Senior VP for Quality & Medical Management, Oscar
A new kind of health insurance company

Mario Schlosser, co-CEO, co-founder
Mary Ellen Connington, RN SVP Quality & Medical Management
Upon enrollment

Oscar members given option to consent to Healthix

When Oscar members open an e-account with the Plan they are pushed information about the RHIO and given the option to consent.
Get smarter, faster care

We can better coordinate your care by sharing medical information and notifications with your doctors. But we need your permission first.

Consent Form
Oscar Insurance Corporation
In this Consent Form, you can choose whether to allow Oscar Insurance Corporation ("Oscar") to obtain access to your medical records through a computer network operated by Healthix Inc. ("Healthix"), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to Oscar.

Yes please
I give consent for Oscar Insurance to access all of my electronic health information through RHIO to carry out the quality improvement or care management activities described in this Consent Form.

No thanks
I deny consent for Oscar Health Insurance to access my electronic health information through RHIO for any purpose.

Save
The Use Case

Case Management

- As part of Oscar’s Transitional Care initiative, Oscar’s Nurse Practitioner follows members with Clinical Event Notifications (CEN) for case management purposes.
- Oscar has integrated HEALTHIX into everyday care routines.
Care Transitions

Opportunity
Members have big care events (ER visits and emergent hospital admissions) and health plans often learn about it weeks to months later...sometimes after a very poor experience and after losing the opportunity to contribute to the discharge plan.

Health plan finds out...
Care Transitions

Oscar NP coordinates care & services

Cost

Quality

Member Experience
Care Transitions

- Healthix notified us of 66 ER or hospital admissions in the past 6 weeks
- We were able to engage 80% of members...and help with a wide range of issues
Member admitted for surgery to remove an abdominal mass.

Healthix notification & Tina met him and his family at the bedside, as he grappled with a possible cancer diagnosis.

Diagnosed with biliary duct cancer.

Tina (Oscar NP) supported discharge planning & ongoing case management through his cancer evaluation and treatment.
Mind the gap!

- Member rushing to work, foot stuck in subway gap, → traumatic ankle fracture.

- ER Admit, Healthix CEN & Tina reached out to him.

- Stabilized and discharged for urgent ankle surgery within 2-3 days, but with an Out Of Network (OON) surgeon (!).

- Tina found in-network surgeon quickly.
  - Saved cost of OON provider.
  - Very happy with his care.
College Daze

- A young enrollee in college, with childhood kidney disease & transplant.

- Healthix notification – admitted to hospital for worsening of his kidney function.

- Tina called & met him and his family at the bedside. Helped him:
  - find in-network specialists &
  - worked with the discharge planner to ensure follow-up with his physicians.

- Since then:
  - no recurrent hospitalizations and
  - home visiting RN to educate him on proper techniques for self catheter care while away at college.
Thanks!
Thank You for Attending