Healthix

Healthix Analytics provides predictive risk scores, dashboards and quick reports to support population health efforts, high-risk patient outreach and readmission management. Healthix Analytics assists in improving outcomes through early identification of serious health conditions and lowers costs by preventing avoidable ED and inpatient admissions.

Population Health and Patient Risk Management

Healthix Analytics enables providers and care managers to quickly identify individuals at high or increased risk for a range of conditions and events. Early intervention can prevent avoidable admissions or ED visits; improve clinical outcomes; and reduce overall costs. Risk scores are updated each evening to reflect the clinical events of the day. These risk scores and readmission data can be reviewed on an aggregate level to determine risk of the entire population, drilling down by zip code or other demographics.

30-Day Readmission Management

Analytics for readmission management assesses information for those patients currently in, or recently discharged from a hospital stay or ED visit. Healthix Analytics predicts the likelihood of a patient being readmitted or returning to an ED within 30 days.

Quick Start

With "Quick Start" you immediately receive reports targeting specific patients, chronic conditions, and more. These reports will be delivered securely via email or an SFTP connection, weekly, monthly, or quarterly.

Call 1-877-695-4749 to get started

HEALTHIX ANALYTICS

Population Risk Models: Future 12-Month Risk

- Asthma exacerbation
- Chronic kidney disease
- Congestive heart failure
- COPD
- Diabetes (type 2)
- ED visit
- Heart attack/AMI
- Hypertension
- Inpatient admission
- Mortality
- Opioid abuse
- Predicted cost based on national averages
- Stroke

30-Day Readmission Risk

- ED visits
- Hospitalization

DATA DISCOVERY: ANALYTICS

Providing insight to help manage population health, research, high risk patients, outreach resources and more.

Social Determinants of Health Data

Healthix Analytics incorporates zip code or county-based social determinants of health into all risk algorithms. An individual's residence can impact risk for unwanted events and conditions.

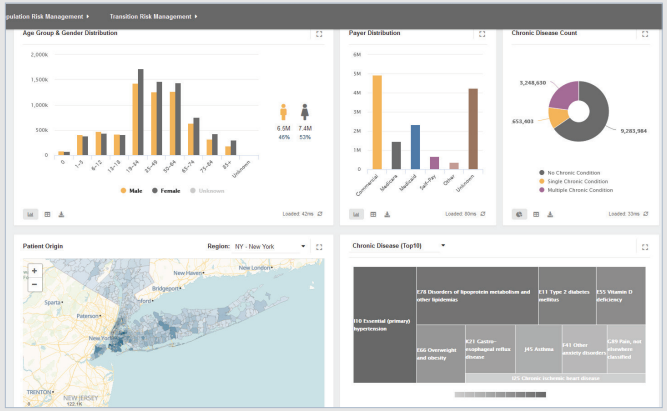
Community risk scores are determined by:

- Education level
- English proficiency
- Household income
- Income equality
- Insurance coverage
- Percentage of population living within half mile of a park
- Racial demographics
- Respiratory hazard
- Unemployment rate
- Urban concentration
- US citizenship

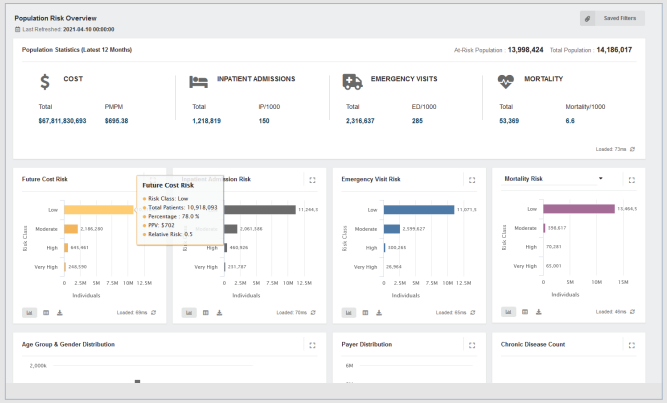
Benefits

- Provides risk models optimized by data from the entire HIE.
- For individual patients with consent, you can view the most significant features driving risk, which enable care intervention and resource allocation.
- Healthix Analytics gives you the information to target, customize and manage care for patients at risk. It can identify patient risk , even before a diagnosis is made, to aid in prevention and wellness initiatives.
- Analytics dashboards provide key metrics for organizational performance improvement.
- Population Health and aggregate data are available without requiring Healthix consent, drilling down to specific patient requires consent is granted.

HEALTHIX ANALYTICS



Population Health: Demographic View



Population Health: High Risk Patients

Contact Us

For more information on Healthix Analytics
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