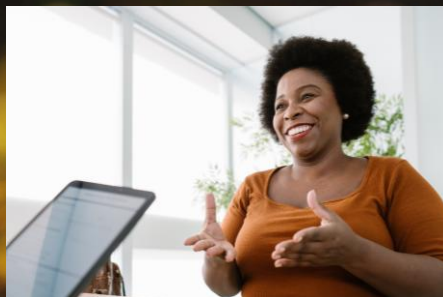




Healthix

EXCHANGING INFORMATION
TO TRANSFORM PATIENT CARE



Healthix SEAS Webinar

Overview / Agenda

- Introductions
- SHIN-NY Overview
- Review Healthix Alerts
- HealtheConnections Overview of SEAS
- Hixny Overview of SEAS
- Q&A
- Appendix

Speaker Introductions

Nan Brunette
Customer Success Associate
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516-265-6463



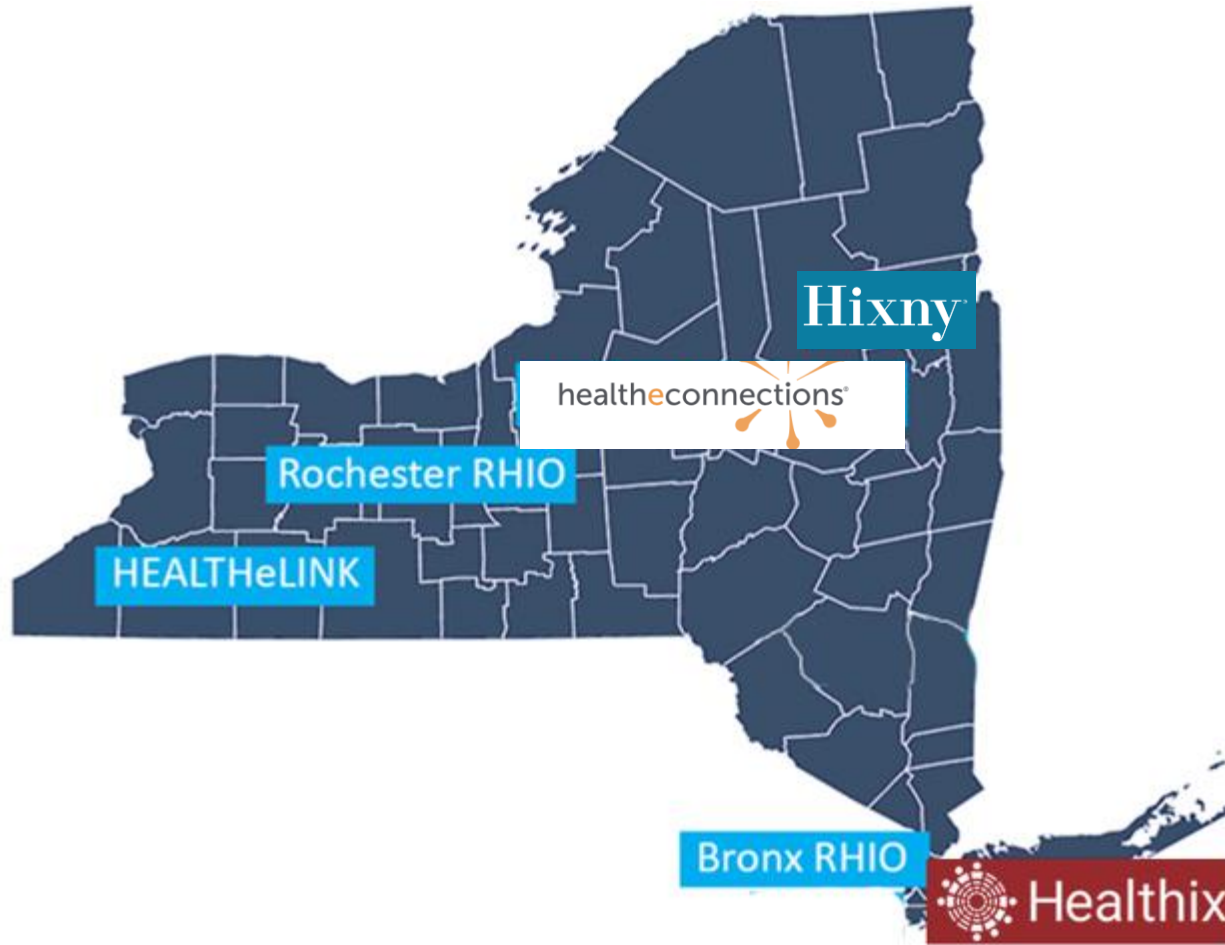
Alex Augustinos
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Business Development Manager
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SHIN-NY



The SHIN-NY connects six public Health Information Exchanges (HIEs), forming a regional health information network that stores and shares patient health information.

Each HIE aggregates data submitted from their Participants to create a comprehensive medical record for each patient.

- The New York eHealth Collaborative (NYeC) wants to increase efficiency, improve service, and offer participants a choice for a statewide alert solution.
- Statewide Services, such as Statewide Encounter Alerts, are one way they are attempting to do that.

STATEWIDE HEALTH INFORMATION NETWORK OF NEW YORK (SHIN-NY)

Healthix Overview

Standard Alerts for Established Healthix Customers

HEALTHIX ALERTS

What Healthix Customers Have Today

Alerts currently help organizations stay informed about key patient or client encounters across New York State. These alerts support timely awareness of emergency department visits, inpatient admissions and discharges, skilled nursing and rehabilitation events, mortality notifications and more.

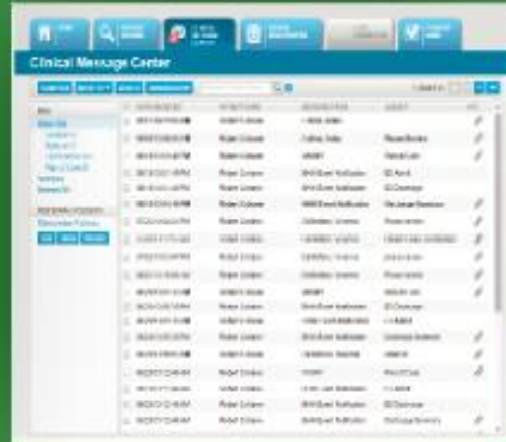
- Provides real-time, 24/7 information to help care teams identify important patient or client encounters.
- Supports timely follow-up after emergency department, inpatient, skilled nursing, rehabilitation, or mortality events.
- Helps organizations coordinate care when individuals receive services outside of their immediate care network.
- Creates a strong foundation for proactive outreach, care management, and transitions of care.
- Supports value-based care, HEDIS and quality reporting



HEALTHIX ALERTS WORKFLOW INTO CMC PORTAL



ALERT ARRIVES
CLICK THRU TO
PATIENT PORTAL
LOGIN



ARRIVE AT CLINICAL
MESSAGE CENTER



VIEW CLINICAL
EVENT DETAILS



CLICK ON PATIENT NAME
TO SEE AGGREGATE
PATIENT RECORD

Healthix EHR Vendor Partners

Healthix implements sites using two models of integration:

(1) Hub Model – where Healthix connects to the EHR's Hub to exchange data with multiple practices.

(2) Conventional Integration (Non-Hub) – supports customized connections.

Hub Model EHR

Accumedic
Amazing Charts
Antworks
athenahealth
Azalea
Celerity
Core CX360
Criteria
CureMD
DigiDMS
eClinicalWorks
EHI
Foothold Awards
Greenway-Intergy
Greenway-PrimeSuite
Health Fusion
HHA eXchange

HHA eXchange
HST Pathways
MatrixCare
MDLand
Medgen
Medi-EHR
Office Ally
Office Practicum
PointClickCare
Practice Fusion
PrecisionCare
Relevant Healthcare
Reliable Health
RXiHealth
SigmaCare
Surgical Information Systems – SIS Complete
TenEleven 1011
Welligent

Conventional Non-Hub Model

ADL Data Systems	Mckesson
AdvancedMd	MD-Reports
Allscripts – Professional	MDSpecialist
All Trac	Medi-Tab
Anasazi (Cerner)	Meditech
CareCompass (Cerner)	Medent
CareLogic	MHARS
Cerner	Netsmart
CyberMed	Nextgen
Eclipse	OmniMD
Elation	Optimus
Epic	Siemens Sorian
eVero	Thornberry NDoc
GE Centricity	
gGastro	
Homecare Homebase	
IMA Systems	
InSync	

<https://healthix.org/what-we-do/hubmodels/>

Moving Toward Statewide Encounter Alerts Service (SEAS)

Building on the Existing Alert Foundation

Statewide Encounter Alerts advances the value and efficiency to customers who already receive Alerts from Healthix. It supports a Statewide standardized approach to encounter notifications across regions and care settings in the following ways:

- Expands encounter visibility across New York State to help reduce gaps when care occurs outside a customer's immediate region or network.
- Supports a more efficient alerting experience through a statewide approach to eligible encounter notifications.
- Strengthens timely follow-up, care coordination, care management, and transitions of care.

Thank you for Participating!

Need more information? We'd love to hear from you...

Nan Brunette
Customer Success Associate
nbrunette@healthix.org
516-265-6463





Statewide Encounter Alerts

What They Are, Why They Matter,
and How to Get Started



Statewide Encounter Alerts, powered by HealtheConnections



A Trusted,
Proven Solution

HealtheConnections' enhanced alerting service delivers better tooling to support providers on a statewide scale.

✓ **Consistent, Statewide Coverage**

Complete real-time alerts from *all* hospitals across NYS, regardless of QE region. Alerts sent for *Inpatient and Emergency Department admissions, discharges, and transfers.*

✓ **Advanced Tools**

Built-in patient segmentation, integrated reporting, and readmission risk scores, supported by PointClickCare's industry-leading technology.

✓ **Targeted for Active Care Relationships**

Patient lists are the foundation of these alerts. The benefit is less noise, better targeting, and improved security and privacy for patients.

Timely Alerts, Delivered Your Way

Alerts and data flow directly into existing provider workflows

- Direct feeds and integrations with leading EHRs
- Notices sent via Secure Message, email, or text
- Portal Access
- sFTP file access
- Any combination/delivery options for varied disciplines



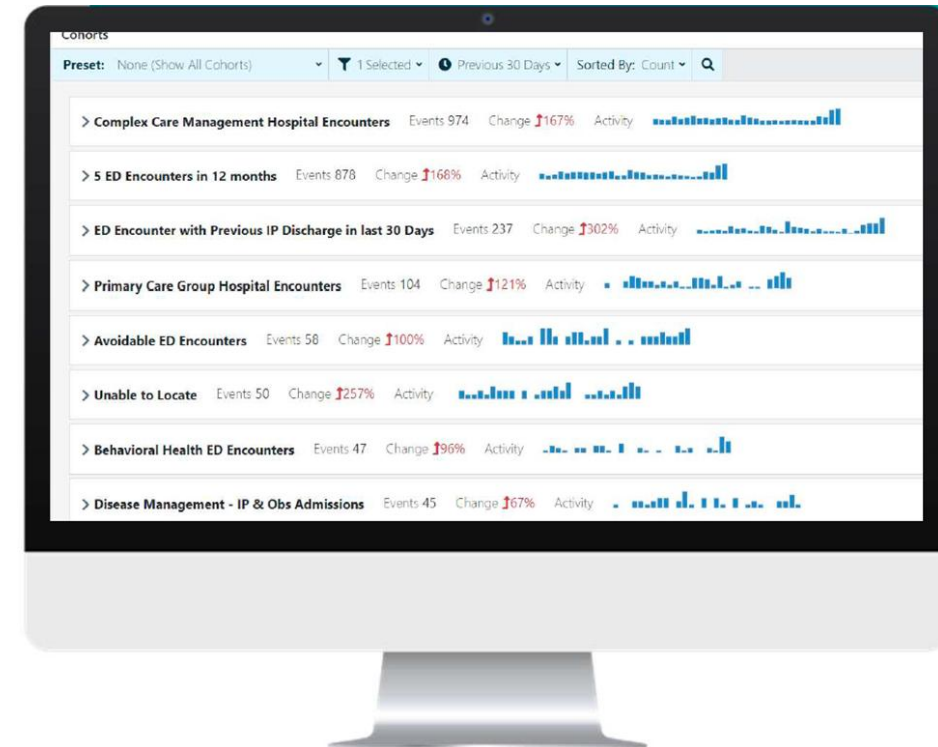
And more!



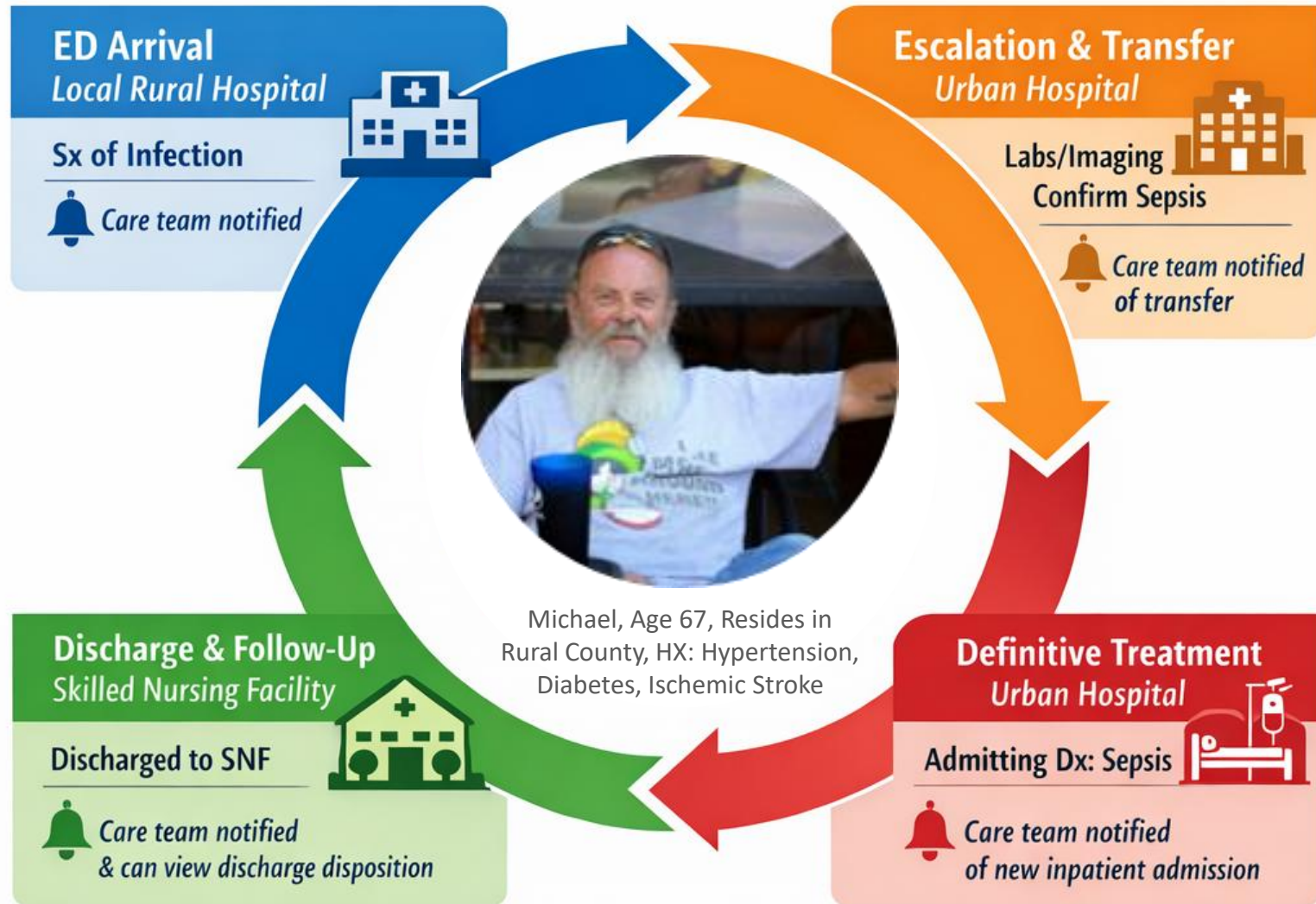
The Data You Need, The Way You Need It

Automated Reporting Made Simple

- ✓ Schedule PDF or CSV reports for download or automatic delivery
- ✓ Choose fields, filters, and frequency to fit workflows
- ✓ Supports either real time notification or aggregated summaries
- ✓ Fully configurable to your organization



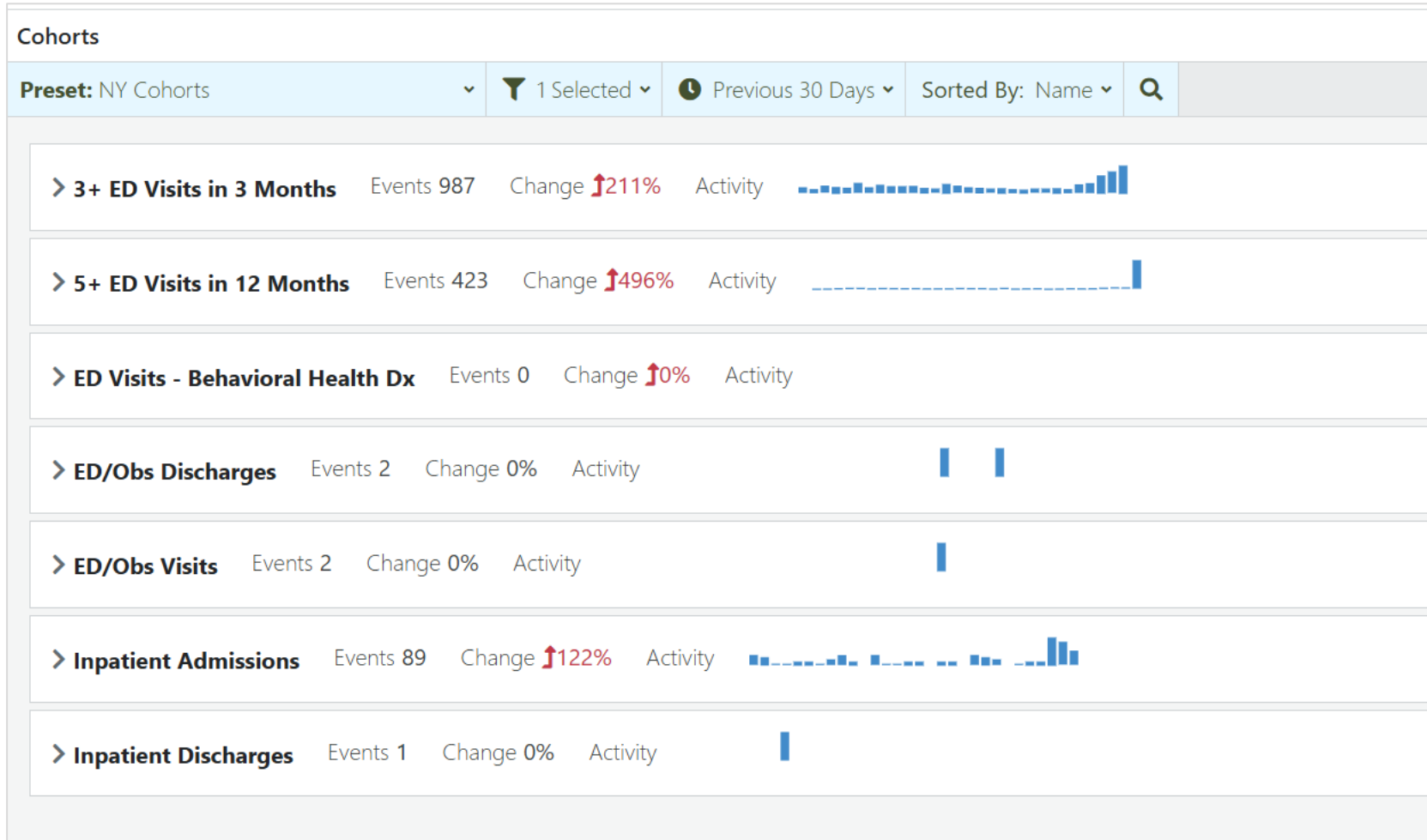
A Solution for Organizational Challenges



Statewide Encounter Alerts give the full picture—when every minute counts.

- ✓ Timely notification for meaningful interventions
- ✓ Seamless coordination across rural and urban care settings
- ✓ Keeps all providers informed, including community and credentialed teams
- ✓ Close gaps during care transitions
- ✓ Complete, timely data for quality reporting
- ✓ Streamline workflows for faster, more efficient care

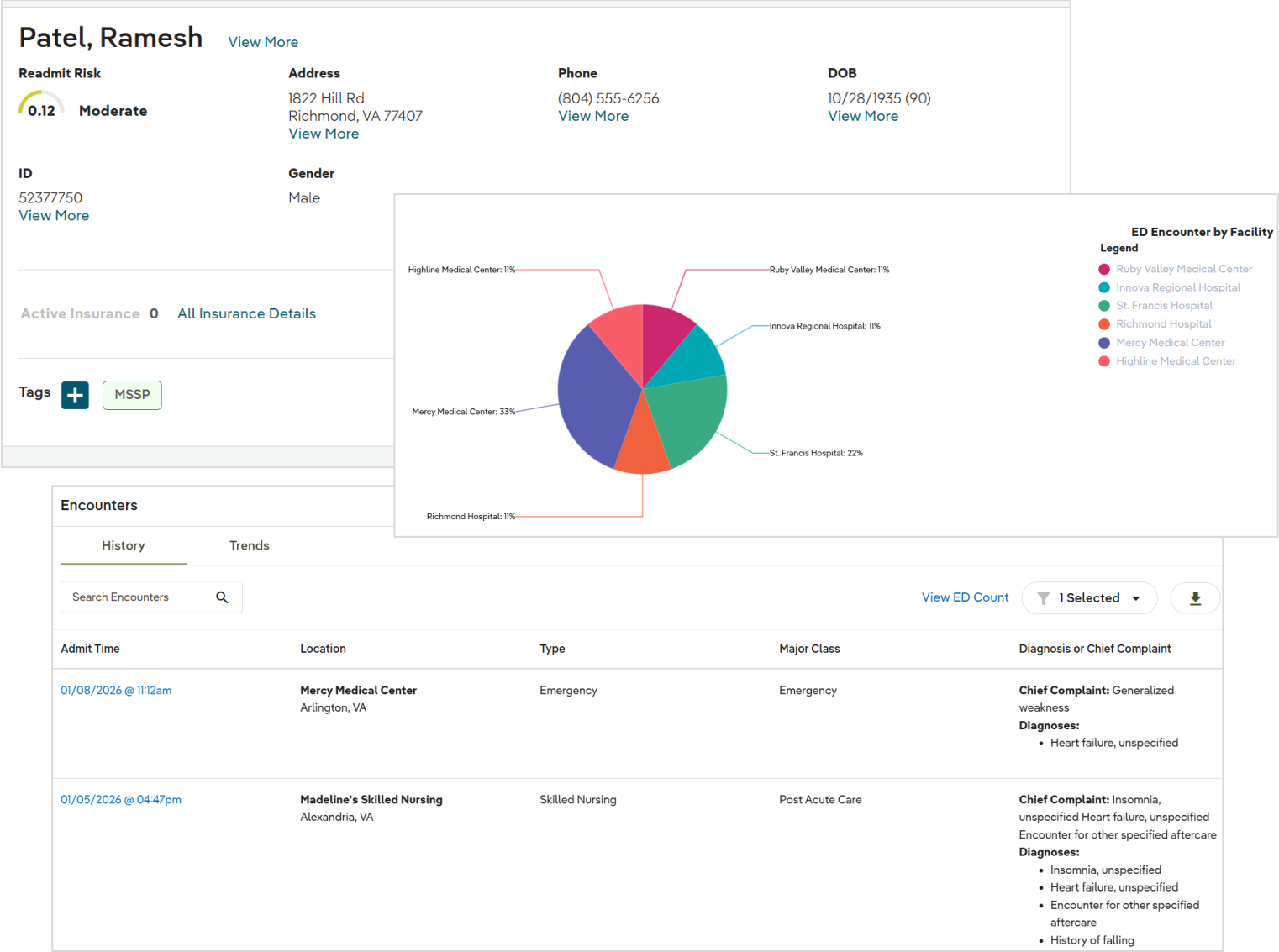
Service Overview – Cohorts



Populations of Interest Stratification

- ✓ Surface high utilization patients
- ✓ Identify trends
- ✓ Prioritize high risk groups for timely intervention
- ✓ Create cohorts based on custom criteria to meet your needs
- ✓ Custom filters and download options for easy reporting and analytics

Service Overview – Patient Overview



The Right Contact Info, at the Right Time

- ✓ Automatically surfaces the most up-to-date patient contact details sourced from all hospitals across the state
- ✓ Reduces wasted time chasing outdated numbers or addresses
- ✓ Custom tags to group and identify patients by program, diagnosis, group, etc.
- ✓ View patient level encounter history and trends

Service Overview – Readmission Risk Scoring



Jarvis, John Denzil
Readmit Risk
 0.55 **Very High**

This patient had a **security event** on Jul 23, 2025, 7:04:28 AM at Virginia Hosp

Jarvis, John Denzil [View More](#)
Readmit Risk 0.55 **Very High**
Address 272 Shady River Terrace
Fairmont, VA 99048 [View More](#)
Phone (438) 555-4622 [View More](#)
Gender Male
Active Insurance 0 [All Insurance Details](#)
Tags High Utilization Group

Powered by Data

- ✓ Trained on 18.3M+ encounters
- ✓ Combines historical + real-time updates

Rich Inputs

- ✓ Demographics, diagnosis codes
- ✓ 2-month visit history
- ✓ Hospital quality scores
- ✓ SDOH factors

Dynamic Risk Score

- ✓ Real-time, continuously updated
- ✓ Outperforms standard LACE model

Service Overview – Care Team and Care Insights



Substance Use + Enter Contribution
Social Determinants of Health Last Updated by US Health Plan Danielle Siniscalchi 1/8/26 The patient does not have a mode of transportation as his wife is not able to drive. He is enrolled with a discharge van services through the Medicaid program. Please call 123-456-7890 for transportation needs. + Enter Contribution
Homelessness & Housing Insecurity No results to show + Enter Contribution

Collaborate Across Care Settings

- ✓ View and share critical information for better informed care decisions
- ✓ Ensure patient needs are met and seamless continuity of care
- ✓ Accessible to all organizations with access

Service Overview – Scheduled Reports



Scheduled Reports

Enter Search

Filter

Report	Status	Date	Rows	Actions												
Weekly - IP Report (Non-PHI)	✓	01/08/2026, 02:00 AM	N/A	 												
Daily - ED/IP Report (Non-PHI)	✓	01/08/2026, 02:00 AM	N/A	 												
Weekly - ED Visit Report (Non-PHI)	✓	01/08/2026, 02:00 AM	N/A	 												
Monthly - ED Visit Report (Non-PHI)																
	1	Last Name	First Name	MRN	Patient Phone	Case Manager	LOB	Visit Location	Visit Phone	Admit Time	Major Class	Service	Discharge Time	Dx Codes	Dx Descriptions	
	2	Cade	Deborah	5685449	(206)336-1360		AAB	Highline Medical Center	(360) 532-8330	9/17/2015 7:30	Emergency	Emergency	9/17/2015 8:30		Chest Pain;RHR;42789 - Other specified	
	3	Diaz	Nicole	5685633	(206)337-1470		MA	Overlake Hospital	(425) 688-5699	9/17/2015 8:58	In-Patient	Ultrasound			Lower limb ischemia;Arterial insufficiency	
	4	Grimmett	Benjamin	5685242	(206)335-1244	Jenifier Smith	ABR	St. Joseph Medical Center	(425) 261-2001	9/17/2015 0:54	Emergency	Emergency	9/17/2015 1:54		78791 - Diarrhea;abdominal pain;78907	
	5	Howard	William	5685403	(206)336-1356	Jenifier Smith	DUAL	Auburn Regional Medical Center	(253) 833-7711	9/17/2015 1:38	In-Patient	MedicalSurgical		V235;V195;65963	Supervision of high-risk pregnancy with	
	6	Howard	William	5685403	(206)336-1359		AAB	Tacoma General Hospital	(206) 598-3302	9/17/2015 6:02	Emergency	Emergency	9/17/2015 7:02			

Customized to Meet Your Needs

- ✓ Hourly, daily, weekly, or monthly reporting
- ✓ Available for easy download or custom delivery
- ✓ Incorporate risk scores, diagnosis codes, diagnosis description and more
- ✓ Choose fields, filters and criteria to support reporting, analytics and quality improvement activities

Getting Started

Review our Resources

- Statewide Encounter Alerts: healthconnections.org/alerts
- Resource Center: healthconnections.org/resources

Request Access

- Contact HealtheConnections Support at support@healthconnections.org

Submit a Patient List

- Review the PL File Guidelines and Specification Outline
- Name the file: *PLA- SHINNY-(Facility Name)-(Date)*
- Submit the list via:
 - Secure Message users: patientsubscriptions@hiemail.healthconnections.org
 - Encrypted email: support@healthconnections.org

Not a HealtheConnections participant yet? No problem!

[Contact us](#) to learn how we can support your organization with Statewide Encounter Alerts
—no matter what QE you work with.





Thank you!

 315-671-2241 x5

 support@healthconnections.org

 healthconnections.org



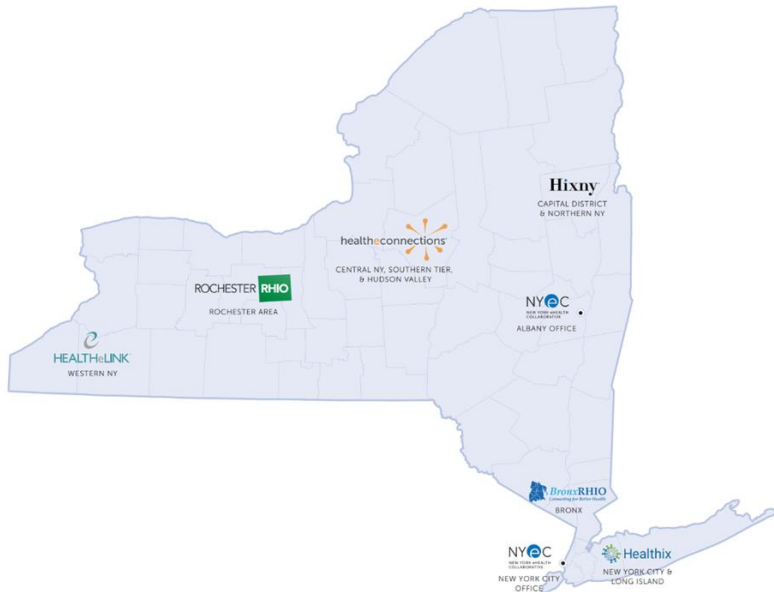
Hixny's Statewide Alerts Solution

Hixny®

Shift in SHIN-NY Structure

Prior to September 2025

Every NYS HIN received SHIN-NY funding to provide the *same set of core services* to SHIN-NY participants **in its geographic area.**



Since September 2025

A limited number of NYS HINs receive SHIN-NY funding to provide *select services* to all SHIN-NY participants, **regardless of geographic area.**



***Patient encounter alerts* is one of those services and Hixny is one of the HINs selected to provide alerts.**

What's In It For Providers?



Early identification of patients discharged from the hospital to meet the Transitional Care Management (TCM) billing timelines.



Reduction in hospital readmission penalties.



Meet key program requirements centered on reducing avoidable hospital use (such as the AHEAD and TEAM models).



Improved performance on value-based contracts through shared savings (reducing avoidable hospital use lowers overall cost of care) and improved performance on quality measures.



Providers receive all alerts through Hixny at **no cost**.

DRIVING DOWN AVOIDABLE HOSPITAL UTILIZATION



Inpatient Alerts

- Transitions of Care **(TRC)**
- Acute Hospital Utilization **(AHU)**
- Plan All-Cause Readmissions **(PCR)**
- Hospitalization Following Discharge from a Skilled Nursing Facility **(HFS)**
- Hospitalization for Potentially Preventable Complications **(HPC)**
- Follow-Up After Hospitalization for Mental Illness **(FUH)**
- Follow-Up After High-Intensity Care for Substance Use Disorder **(FUI)**
- Pharmacotherapy Management of COPD Exacerbation **(PCE)**
- Prenatal and Postpartum Care **(PPC)**
- Postpartum Depression Screening and Follow-up **(PDS-E)**



ED Alerts

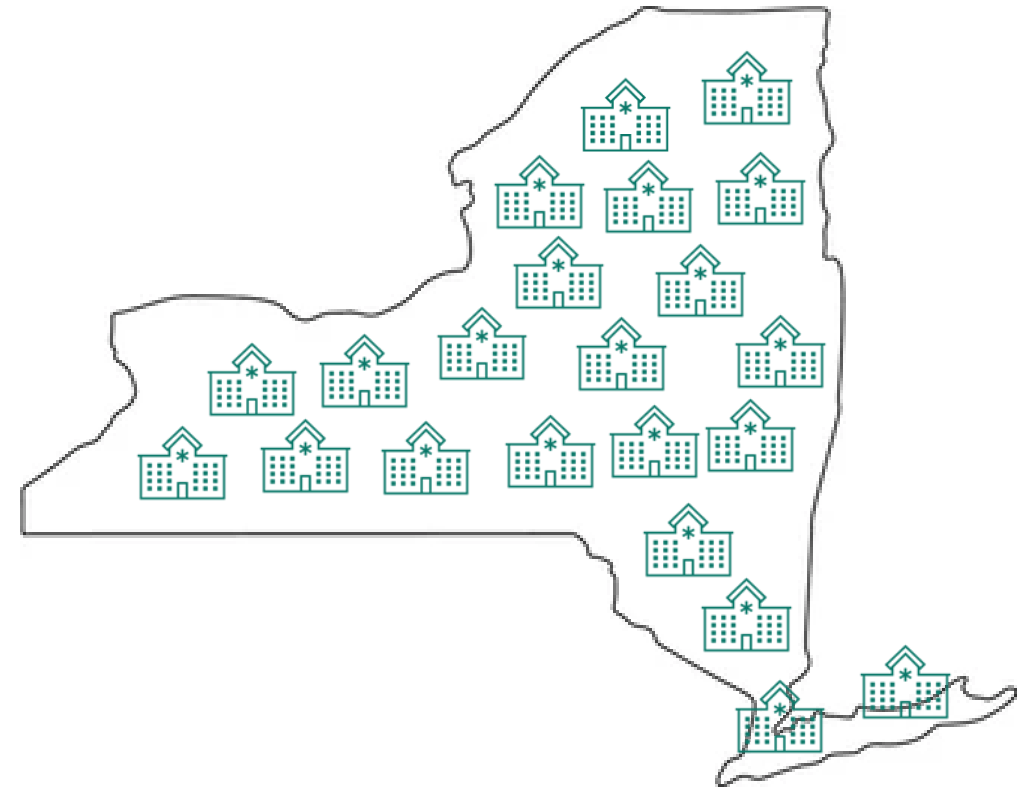
- Emergency Department Utilization **(EDU)**
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions **(FMC)**
- Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes **(EDH)**
- Follow-Up After Emergency Department Visit for Mental Illness **(FUM)**
- Follow-Up After Emergency Department Visit for Substance Use **(FUA)**

Statewide Hospital Alerts

- Alerts available from every hospital in NYS for healthcare providers and healthcare insurers statewide.
- On average, **seven people** are discharged from inpatient care across New York State **every minute**.

Do you know which of these seven are your patients?

¥ Statewide Planning and Research Cooperative Systems (SPARCS) data – inpatient discharges in New York State during calendar year 2021 = 3,997,431.



Transitions of Care (TOC)

“

.....
The process of transferring a patient's care from one setting or level of care to another, such as from hospital to home or hospital to skilled nursing facility.

These transitions are particularly **vulnerable** points in the healthcare continuum due to high-risk communication breakdowns, medication errors, and fragmented information transfer.

60% of medication errors and 80% of serious medical errors occur during these hand-offs, often leading to **avoidable hospital readmissions**.

.....
~ **Agency for Healthcare Research and Quality [AHRQ]**”

TRANSITIONAL CARE MANAGEMENT (TCM)



**Team-based
approach**



**Supports patient
transition to
community setting**



**Care team accepts
patients at
discharge
(eliminates service
gap)**



**Ensures assigned
responsibility for
patient care,
facilitates services
across providers
for 30-days**



**Moderate or high
complexity medical
decision making
for patients with
medical and/or
psychosocial
problems.**

Care Coordination



CUSTOMIZE YOUR TCM WORKFLOW WITH HIXNY'S STATEWIDE ALERT SOLUTION

Providers choose a customized solution with one or multiple options – whatever integrates most **efficiently** into your workflow.

eClinicalWorks
Improving Healthcare Together



MEDITECH

medent

Netsmart

**athena
health**

**FOOTHOLD
TECHNOLOGY**

veradigm®

Direct Alerts to EHR

HL7 Alerts to EHR

Flat File of ADT HL7

Daily Digest Report

Feed of ADT HL7

Alert Management
Tool

REAL-TIME ALERTS, NOT DELAYED REPORTS



Sends alert notifications **directly to providers' workflow in real time.**

No more logging into multiple systems to obtain information about patients' hospital use.



Allows provider to manage the roster of patients they would like to receive alerts on, as well as the types of alerts they would like to receive.

Ensures the notifications received are relevant, **reducing "alert fatigue"** for staff and clinicians.



Hixny ensures data completeness and quality of the alerts – so each alert received is **meaningful and actionable.**

Receive the critical data elements to determine appropriate follow up for the patient.

| Real Time | Efficient | Meaningful | Actionable |

HIXNY'S ALERT MANAGEMENT TOOL

Alerts

Manage Roster

View Patients

Manage User Profile

Switch Profile

Logout

Upload patient roster

Enter roster name

Upload roster file

Drag and drop file here

or

Browse Files

Click on [roster template](#) and the required .csv format.

UPLOAD

Active patient rosters

VIEW ALL ACTIVE PATIENTS

Upload date	Uploaded by	Roster name	Patient total
08/01/2025	Jeffrey Perreault	Test Roster	5

Deleted Rosters

HIXNY'S ALERT MANAGEMENT TOOL

Alerts

Manage Roster

View Patients

Manage User Profile

Switch Profile

Logout

Filters

RESET ALL

<

Alert Type

Alert Facility

Sex

Age Range

Chief Complaint

Discharge Diagnosis

Discharge Disposition

Payer

Alert Status:

Active Alerts

Archived Alerts

Display As:

Cards

Table

10 Alerts

Search

Sort by:

All

Group alerts by patient

DOWNLOAD ALERTS CSV

MRN	First Name	Last Name	Date of birth	Sex	Alert Date	Facility	Alert Type	Chief complaint	Discharge diagnosis	Discharge disposition	Options
987654	Marcus	Olsen	05/13/2001	Female	08/12/2025	Glens Falls Hospital	ED admission		Orthopedic surgery		...
987654	Marcus	Olsen	05/13/2001	Female	08/01/2025	Albany Medical Center	ED discharge	Stomach pain	Stomach ulcer	Discharged to home	...
987654	Marcus	Olsen	05/13/2001	Female	08/01/2025	Albany Medical Center	ED admission	Stomach pain			...
987654	Marcus	Olsen	05/13/2001	Female	07/15/2025	Glens Falls Hospital	IP discharge		Orthopedic surgery	Discharged to home	...
987654	Marcus	Olsen	05/13/2001	Female	07/10/2025	Glens Falls Hospital	IP admission		Orthopedic surgery		...
654321	Catherine	Barney	01/16/1988	Female	07/09/2025	Saratoga Hospital	ED discharge	Dizziness	Low glucose	Discharged to home	...
654321	Catherine	Barney	01/16/1988	Female	04/09/2025	Saratoga Hospital	ED discharge	Dizziness	High glucose	Discharged to home	...
456789	Patient 2	Patient 2	08/25/1976	Female	08/20/2025	St. Peter's Hospital	ED admission	Cut on finger	Laceration		...
123456	Jeremy	Donahue	08/10/1955	Male	08/29/2025	Saratoga Hospital	ED discharge	Dental pain	something else	Discharged to home	...
123456	Jeremy	Donahue	08/10/1955	Male	08/27/2025	Saratoga Hospital	ED discharge	Dental pain	Abcessed molar	Discharged to home	...

HIXNY'S ALERT MANAGEMENT TOOL

Alerts

Manage Roster

View Patients

Manage User Profile

Switch Profile

Logout

Filters

RESET ALL

<

Alert Type

Alert Facility

Sex

Age Range

Chief Complaint

Discharge Diagnosis

Discharge Disposition

Payer

Alert Status:

Active Alerts

Archived Alerts

Display As:

Cards

Table

DOWNLOAD ALERTS CSV

10 Alerts

Search

Sort by:

All

Group alerts by patient

Marcus Olsen

MRN987654

Date of birth05/13/2001

SexFemale

PayerMVP

Alert Type

Date

Discharge Disposition

Chief complaint

ED admission

08/12/2025

ARCHIVE

VIEW ALERT DETAILS

PATIENT RECORD

Marcus Olsen

MRN987654

Date of birth05/13/2001

SexFemale

PayerMVP

Alert Type

Date

Discharge Disposition

Chief complaint

ED discharge

08/01/2025

Discharged to home

Stomach pain

ARCHIVE

VIEW ALERT DETAILS

PATIENT RECORD

Marcus Olsen

ARCHIVE

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Tell us what you think

Redisclosure / Disclaimer

Need Support?

HIXNY'S ALERT MANAGEMENT TOOL

Alerts

Manage Roster

View Patients

View Alert Details

CLOSE

Patient Details

Marcus Olsen

05/13/2001

Female

MRN: 987654

Contact

[address]

[address]

[phone]

Insurance Provider

[provider name]

[provider ID number]

PATIENT RECORD

Alert Details

Alert type:

ED discharge

Date of registration:

08/01/2025

8:23:19 PM

Date of discharge:

[d08/01/2025

11:27:00PM

Alert facility:

Albany Medical Center

[Alert facility MRN]:

987654

Chief complaint:

Stomach pain

Discharge diagnosis:

Stomach ulcer

Discharge disposition:

Discharged to home

Admitting/attending Physician:

Dr. Something

< PREVIOUS ALERT

NEXT ALERT >

SexFemale

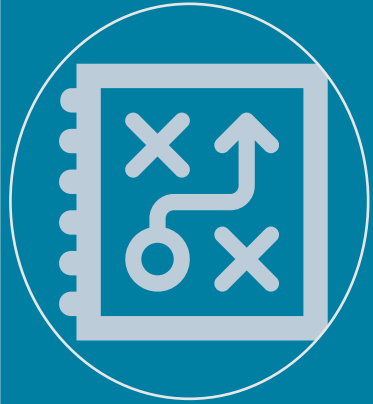
Discharge Disposition

PayerMVP

Chief complaintStomach pain

PATIENT RECORD

MAKING IT HAPPEN



**Hixny
Schedules
Strategy
Session with
Provider**



**Confirms SCPA
& Signs Hixny's
SEAS SOW**



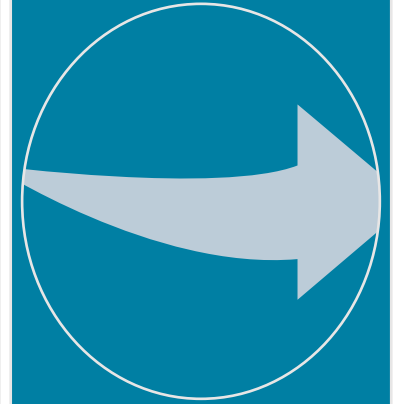
**Complete Pre
Implementation
Mtg**



**Submit Initial
Patient Roster /
or EHR Vendor
Provides
Automated
Patient Roster**



**Case is Opened
with Hixny's
Implementation
Team**



Go Live!
(standard
implementa-
tion go live in
3-4 weeks)

Real Time | Efficient | Meaningful | Actionable

Next Steps



**Sign
Contracts**



Email me

RuthAnn Craven

Business Development Manager
rcraven@hixny.org



Learn more



hixny.solutions/4st28kU

Thank You

Hixny®

QUESTIONS?



462 Seventh Avenue
8th Floor
New York, NY 10018

877.695.4749
www.healthix.org

Healthix Overview

Appendix

The SHIN-NY: In A Nutshell

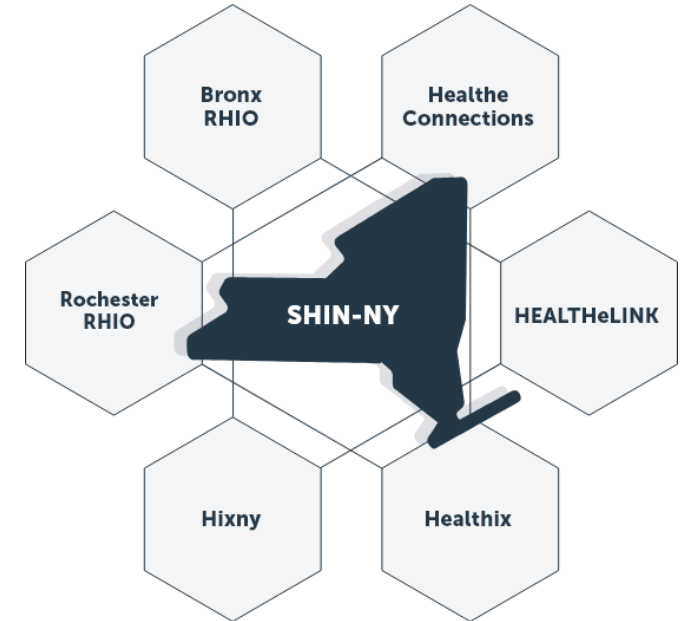
- A state-funded, secure network for sharing electronic clinical records
- Health Information Exchange (HIE) organizations certified by NYS DOH as Qualified Entities (QEs) are the backbone of the SHIN-NY, providing the services that make secure, vital access to a patient's health information possible statewide
- Patient health information is accessed and exchanged securely between healthcare providers & organizations with appropriate consent
- Efficient access to clinical records helps providers better manage patient care

While QEs have primarily been established within geographical regions, participants may connect with the QE that best aligns with their needs.



SHIN-NY Efficiency

- The SHIN-NY is made of 6 QEs, this includes HealtheConnections.
- Today, all 6 QEs provide very similar services.
- The New York eHealth Collaborative (NYeC) wants to increase efficiency, improve service, and offer participants choice.
- **Statewide Services, such as Statewide Encounter Alerts, are one way they are attempting to do that.**





About HealtheConnections

TRUSTED PARTNER OF CHOICE SINCE 2010



1,600 Organizations



4,600 Health and Care Offices



14,000 Licensed Physicians



16M Patients

HealtheConnections' services include Patient Lookup, Results, Imaging, Reports & Dashboards, Health-Related Social Needs (HRSN), Secure Messaging, and **Statewide Encounter Alerting**.



Health Information Exchange in NYS

Why NYeC Launched Statewide Encounter Alerts

Problem: Fragmented Coverage & Inefficiency

- Multiple QEs provided overlapping alerting services
- Inconsistent formats, delivery methods, and alert quality
- Alerts missed when patients crossed regions or care settings
- Incomplete event visibility for providers

Solution: Reliable, Comprehensive Alerts

- Unified data source and routing for full coverage- the Encounter Gateway
- Every eligible encounter triggers an alert

Benefits: Supporting Care and Innovation

- Timely data for care coordination and transitions
- Helps meet HEDIS and quality reporting goals
- Standardized data enables next-generation features

What Does this Mean Today?

If You're a Current HealtheConnections Participant

- You can access Statewide Encounter Alerts, powered by HealtheConnections.
- Leverage this service to enhance your workflows and support more comprehensive patient care.
- Consent and provider-based alerting methods are no longer supported.

If You Participate with Another QE

- Your QE still delivers alerts, and the Encounter Gateway Service (EGS) remains available. Consult your current QE about their long-term alerting plans.
- You have the potential to receive alerts via Statewide Encounter Alerts, powered by HealtheConnections. Evaluate how this service could add value to your workflows.
- To work with HealtheConnections, your organization must elect it as an Additional or Value-Added HIN on the Statewide Common Participation Agreement (SCPA).



Statewide Encounter Alerts Demonstration

Moderate

CPT Code 99495

Loc 99 Medicare reimbursement: \$212.18

Within 2 business days of discharge

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver
- At least moderate level of medical decision making during the service period.

Within 14 calendar days

- Face-to-face visit

High

CPT Code 99496

Loc 99 Medicare reimbursement: \$288.02

10% rate increase
for 2026!

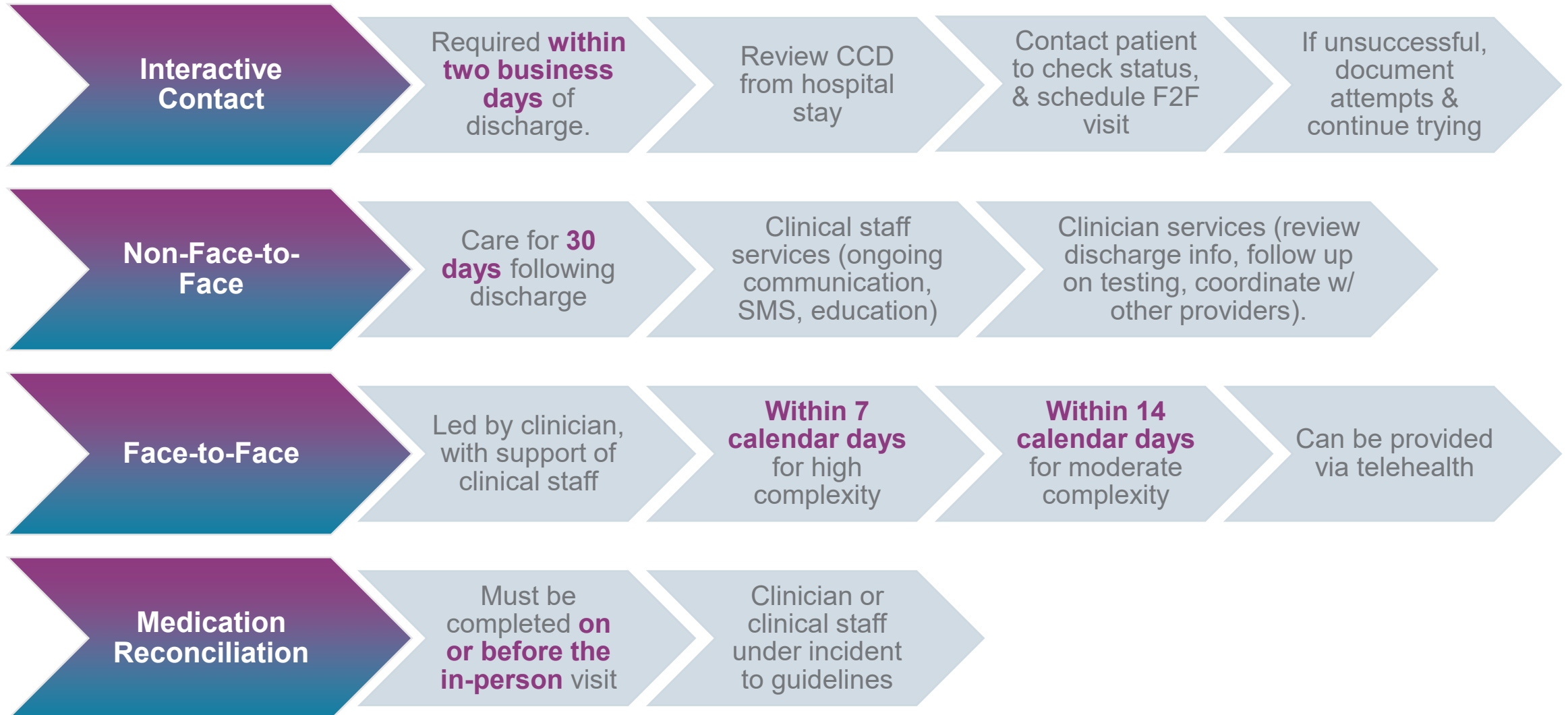
Within 2 business days of discharge

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver.
- High level of medical decision making during the service period.

Within 7 calendar days

- Face-to-face visit

THE 30-DAY BRIDGE: CORE COMPONENTS OF TRANSITIONAL CARE MANAGEMENT



What Do Clients Provide?

- A roster of patients including basic demographic information.
- Excel template provided for initial patient roster submission.
- Setup with sFTP for automated updates to patient roster.
- **COMING SOON!** Automated rosters directly from EHRs.

Facility MRN

First Name

Middle Name

Last Name

Patient Gender

Patient Address Line 1

Patient Address Line 2

Patient City

Patient State

Zip Code

Patient Home Phone Number

Patient DOB

Insurance ID

Consent Status

Inpatient Encounter, Sacred Heart Hospital

Admission Time: 10-21-2024, 12:11 PM

Discharge Time: 10-23-2024, 09:34 AM

Enter search term or open menu

▼

Visit Details

Chief Complaint

Left side chest pain

Admitting Provider

Adam Delphin, MD (234) 567-8901

Attending Provider

Marianne Fields, MD (234) 555-1213

Discharge Disposition

Patient discharged to home. More information here regarding the patient's discharge disposition.

Documented Diagnosis

Pleural effusion on left

Unspecified pleural effusion

Pneumothorax on left

Other spontaneous pneumothorax



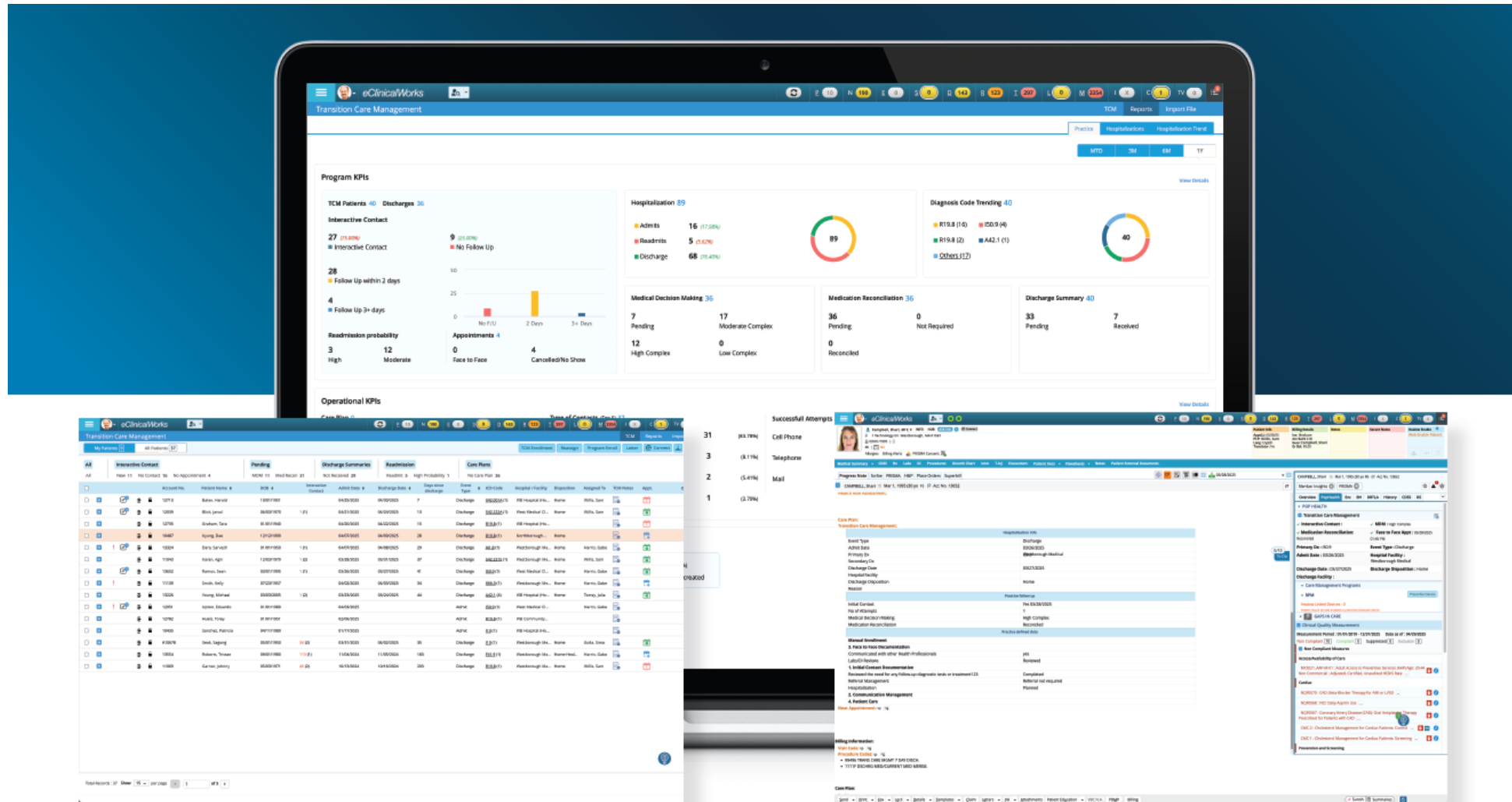
Alerts received via Direct Messaging and saved in the patient’s chart.

Reports are available to see the list of patients in the hospital.

MRN	First Name	Last Name	Date of Birth	Sex	Alert Date	Hospital	Alert Type	Chief Complaint	Discharge Diagnosis	Discharge Disposition
CM12345	Jane	Smitherton	7/22/1949	F	2/16/2026	BronxCare	ED Admit	Nausea, vomiting		
08348111M	Jack	Hill	8/25/1945	M	2/16/2026	Albany Medical Center	IP Discharge	Altered mental state	Acute ischemic stroke	discharge to SNF
987654CL	Danner	Claus	12/28/1979	F	2/16/2026	St Barnabas	ED Discharge	Acute knee pain	Closed transverse patella fracture	discharge home
NL896689	Bambi	Doe	12/1/1991	F	2/15/2026	NYC H+H North Central Bronx	IP Discharge	Vaginal bleeding	Postpartum hemorrhage	discharge home
HoH588	Fawn	Doe	8/22/2018	F	2/15/2026	Adirondack Medical Center	IP Discharge	Altered mental state	Post-traumatic stress disorder	transfer to psych hospital
COMP68969	Arthur	Joneston	4/22/1997	M	2/15/2026	St Barnabas	ED Discharge	Chest pain	Acute myocardial infarction	discharge home
DD1079	Jill	Hill	1/21/2000	F	2/15/2026	Montefiore Medical Center	IP Admit	Rupture of membranes		
O45454599	Roberto	Roberts	2/17/2009	M	2/15/2026	Westchester Medical Center	IP Discharge	Right upper quadrant pain	Cholelithiasis	discharged home

HIXNY 53

Transitional Care Notifications (TCN) dashboard *(version 12.0.3)*



STATEWIDE ALERTS IN EPIC IN BASKET NOTIFICATIONS

In Basket folders for each alert type. Click on a folder to see all alerts of that type.

The screenshot shows the Epic In Basket interface. The top navigation bar includes Home, In Basket (with a 99+ badge), Patient List, Referral Search, Schedules, Tasks, Specimens, Catalog, and A. Eddie. The main content area is titled "My In Basket" and "My Messages > ED Notifications". On the left, a sidebar lists folders: My Messages, ED Notifications (3), Inpatient Notifications (15), Outpatient Notifications (36), Pt Status Notifications (4), Referral Notifications (5), Result Notifications (6), and Secondary Review. The main table displays a list of notifications with columns: Status, Patient, Event Type, Arrival Date, Discharge Date, Department, and Providers. The table contains three rows of data.

Status	Patient	Event Type	Arrival Date	Discharge Date	Department	Providers
New	Grand Centra, Vicky	ED Dismiss	03/15/2024		United Regional Health Care System	
New	Infusion, Isla	ED Dismiss	03/12/2024		United Regional Health Care System	
New	Infusion, Isla	ED Dismiss	03/09/2024		United Regional Health Care System	

This screenshot is similar to the one above, showing the Epic In Basket interface. The left sidebar is visible, and the main table displays the same data. A red rectangular box highlights the data rows of the table, specifically the columns Status, Patient, Event Type, Arrival Date, Discharge Date, and Department.

Status	Patient	Event Type	Arrival Date	Discharge Date	Department	Providers
New	Grand Centra, Vicky	ED Dismiss	03/15/2024		United Regional Health Care System	
New	Infusion, Isla	ED Dismiss	03/12/2024		United Regional Health Care System	
New	Infusion, Isla	ED Dismiss	03/09/2024		United Regional Health Care System	

STATEWIDE ALERTS IN EPIC IN BASKET NOTIFICATIONS (CON'T)

Any messages that have not been read will appear in bold. Once you click on a message to read it, the text will appear normal with a status of read.

To adjust what type of notifications you receive in your In Basket, navigate to the **Menu > Settings > Event Notifications**.

New Msg

Refresh

Done

Print Selected

Open Patient

Event Monitor Settings

Search

Sort

Properties

☐	Status	Patient	Event Type	Arrival Date ▼	Discharge Date	Department	Providers
☐	New	Grand Centra, Vicki	ED Dismiss		03/15/2024	United Regional Health Care System	
☒	Read	Infusion, Isla	ED Dismiss		03/12/2024	United Regional Health Care System	
☐	New	Infusion, Isla	ED Dismiss		03/09/2024	United Regional Health Care System	

Message

Patient Info

Meds/Problems

Vitals/Labs

My Last Notes

Help

Set as Default

II

Isla Infusion

Do you have a question about this report?

Ask a Question

Infusion, Isla

MRN: 206091

ED

Providers: Treatment team

3/13/2024 - 3/12/2024

Status: Discharged

Clinical Impressions

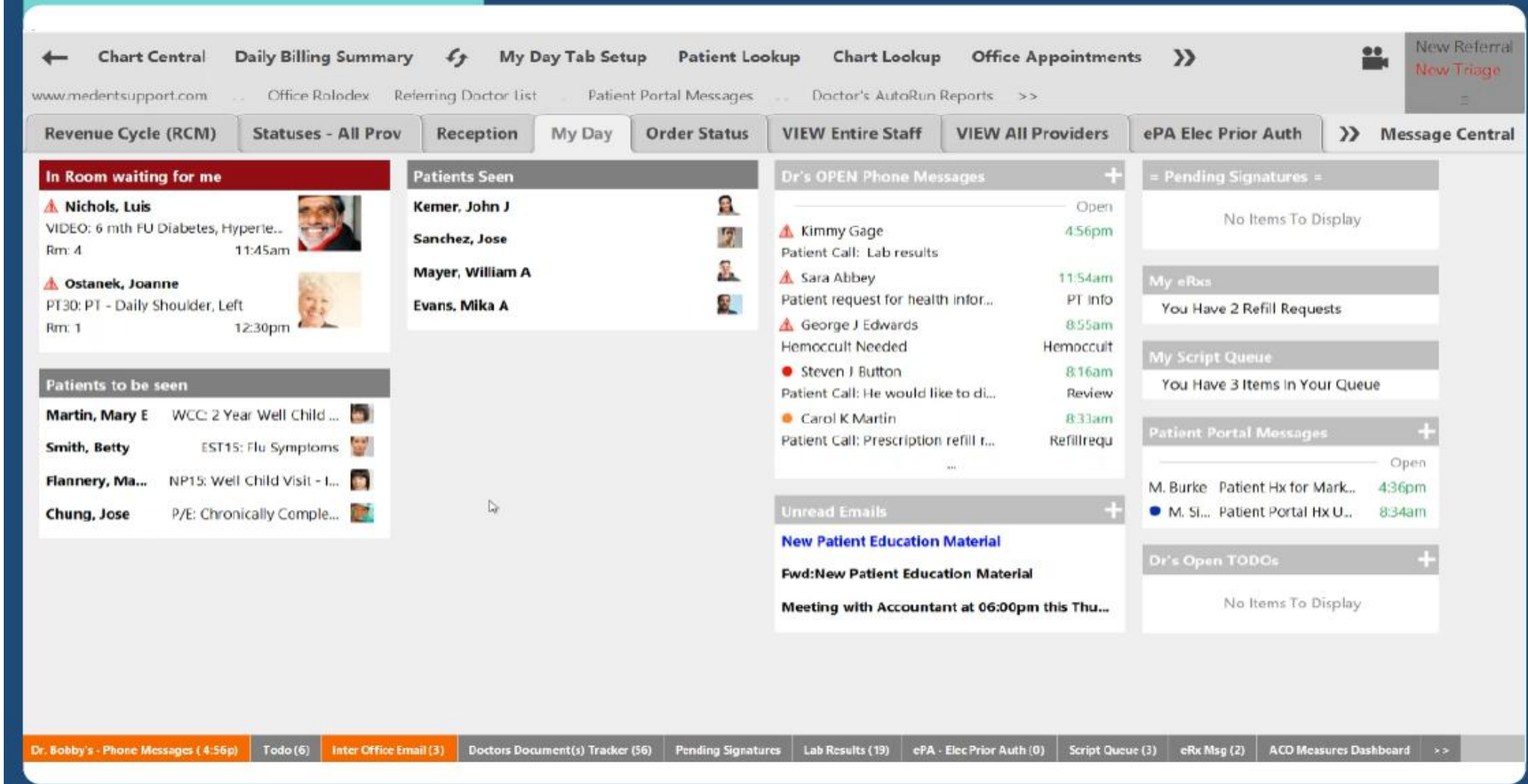
None

Disposition

LWBS

Example

Message Central



The screenshot displays the Medent Message Central interface. At the top, there is a navigation bar with links: Chart Central, Daily Billing Summary, My Day Tab Setup, Patient Lookup, Chart Lookup, Office Appointments, and a double arrow icon. Below this is a secondary navigation bar with links: www.medentsupport.com, Office Rolodex, Referring Doctor List, Patient Portal Messages, Doctor's AutoRun Reports, and a double arrow icon. The main content area is divided into several sections:

- Revenue Cycle (RCM)**: Includes links for Statuses - All Prov, Reception, My Day, Order Status, VIEW Entire Staff, VIEW All Providers, ePA Elec Prior Auth, and Message Central.
- In Room waiting for me**: Lists patients currently in the room, including Nichols, Luis (VIDEO: 6 mth FU Diabetes, Hyperle... Rm: 4, 11:45am) and Ostanek, Joanne (PT30: PT - Daily Shoulder, Left Rm: 1, 12:30pm).
- Patients to be seen**: Lists patients scheduled for future visits, including Martin, Mary E (WCC: 2 Year Well Child ...), Smith, Betty (EST15: Flu Symptoms), Flannery, Ma... (NP15: Well Child Visit - I...), and Chung, Jose (P/E: Chronically Comple...).
- Patients Seen**: Lists patients who have been seen, including Kemer, John J, Sanchez, Jose, Mayer, William A, and Evans, Mika A.
- Dr's OPEN Phone Messages**: Lists open phone messages from patients, including Kimmy Gage (Patient Call: Lab results, 4:56pm), Sara Abbey (Patient request for health infor..., 11:54am), George J Edwards (Hemoccult Needed, 8:55am), Steven J Button (Patient Call: He would like to di..., 8:16am), and Carol K Martin (Patient Call: Prescription refill r..., 8:33am).
- Unread Emails**: Lists unread emails, including New Patient Education Material and Fwd:New Patient Education Material.
- Pending Signatures**: Shows a message "No Items To Display".
- My eRxs**: Shows a message "You Have 2 Refill Requests".
- My Script Queue**: Shows a message "You Have 3 Items in Your Queue".
- Patient Portal Messages**: Lists patient portal messages, including M. Burke (Patient Hx for Mark..., 4:36pm) and M. Si... (Patient Portal Hx U..., 8:34am).
- Dr's Open TODOs**: Shows a message "No Items To Display".

At the bottom, there is a status bar with various counts: Dr. Bobby's - Phone Messages (4:56p), Todo (6), Inter Office Email (3), Doctors Document(s) Tracker (56), Pending Signatures, Lab Results (19), ePA - Elec Prior Auth (0), Script Queue (3), eRx Msg (2), ACO Measures Dashboard, and a double arrow icon.

STATEWIDE ALERTS IN MEDITECH EXPANSE

☒ Emergency Department Discharge for [REDACTED] alerts@hixny.net

Message

<meta http-equiv="Content-Type" content="text/html; charset=iso-8859-1"><div style="width:1200px"><pre style="white-space:-moz-pre-wrap;white-space:pre-wrap;word

Patient Demographics

[REDACTED]

Attachment	View	Status
Document3.hl7		Pending
Document1.txt		Pending

Click on the paperclip icon to process.
Converts the HL7 message fields into readable text that will open in a workload message.
Search a user to whom we would send this workload message content.
That adds the data to the patient chart and allows the user to forward the message on to other users.

File Name C:\WPLUserStorage\.temp\eeafca4583944ebeb1f38a58a897774\489

* User [REDACTED]

* Patient [REDACTED]

From Clinical Summary		From Patient Record	
Name	[REDACTED]	Name	[REDACTED]
DOB	[REDACTED]	DOB	[REDACTED]
Sex	[REDACTED]	Sex	[REDACTED]

[REDACTED] was discharged from MIB on 03/19/26 at 11:14pm

Reason for visit:
Diagnosis: Sprain of unspecified ligament of left ankle, initial encounter