

# **A Community Asset Health Information Exchange with Providers and Health Plans**

October 5, 2017 Avalon #16 2:20PM – 3:10PM

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# Agenda

## Overview

- Providers and Health Plan Community Introduction
- HealthShare Exchange

## Health Information Exchange Community Asset for Care Coordination

- Encounter Notification Service
  - ENShare
  - Smart Notifications
- Care Team Identification
- High Utilizer Identification

## Learning Objective Take Away

# Providers and Health Plan Community Introduction

Providers are becoming more At Risk with New Shared Savings Contracts with the Health Plans

- Including the Post Acute Care of Long Term Care

Quality Measurement Continues to Evolve With the Federal Government: MIPS, MACRA, CPC+

- [HSX White Paper](https://www.healthshareexchange.org/sites/default/files/pdf/07.07.17_hsxservices_valueforproviders_final.pdf)  
[https://www.healthshareexchange.org/sites/default/files/pdf/07.07.17\\_hsxservices\\_valueforproviders\\_final.pdf](https://www.healthshareexchange.org/sites/default/files/pdf/07.07.17_hsxservices_valueforproviders_final.pdf)

Delegation of Care Coordination Activities From the Health Plans to Providers and ACO's

Care Coordination Activities Are Only Successful When You Know About What is Happening in the Community As a Whole

# HealthShare Exchange

# Who is HealthShare Exchange?

HSX is a non-profit 501(c)(3) health information exchange (HIE) organization serving the greater Philadelphia Region. The corporation was formed in May 2012 and the Board and Governance was formed in January 2013.

The **HSX Mission** is to provide secure access to health information that enables preventive and cost effective care; improves the quality of care; and facilitates the transitions of care.

The **HSX Vision** is to build a trusted community of healthcare stakeholders collaborating to deliver better healthcare to patients.

# HSX Membership – a unique mix compared to other HIEs

## Health Systems

- 40 Hospitals
- 93%+ Emergency Department (ED) visits in the region

## Behavioral Health Organizations

- Eagleville Hospital
- Elwyn
- Northwestern Human Services

## Specialty Hospitals

- Physicians Care Surgical Hospital

## Accountable Care Organizations

- Delaware Valley ACO
- Philadelphia-Camden Integrated Kidney Care

## Other Risk-Bearing Entities

- Tandigm

## Health Plans

- AmeriHealth
- AmeriHealth Caritas
- **AmeriHealth New Jersey**
- AmeriHealth Pennsylvania
- Health Partners Plans
- Independence Blue Cross

## Clinically Integrated Networks

- Doylestown Healthcare Partnership

## Independent Ambulatory Practices

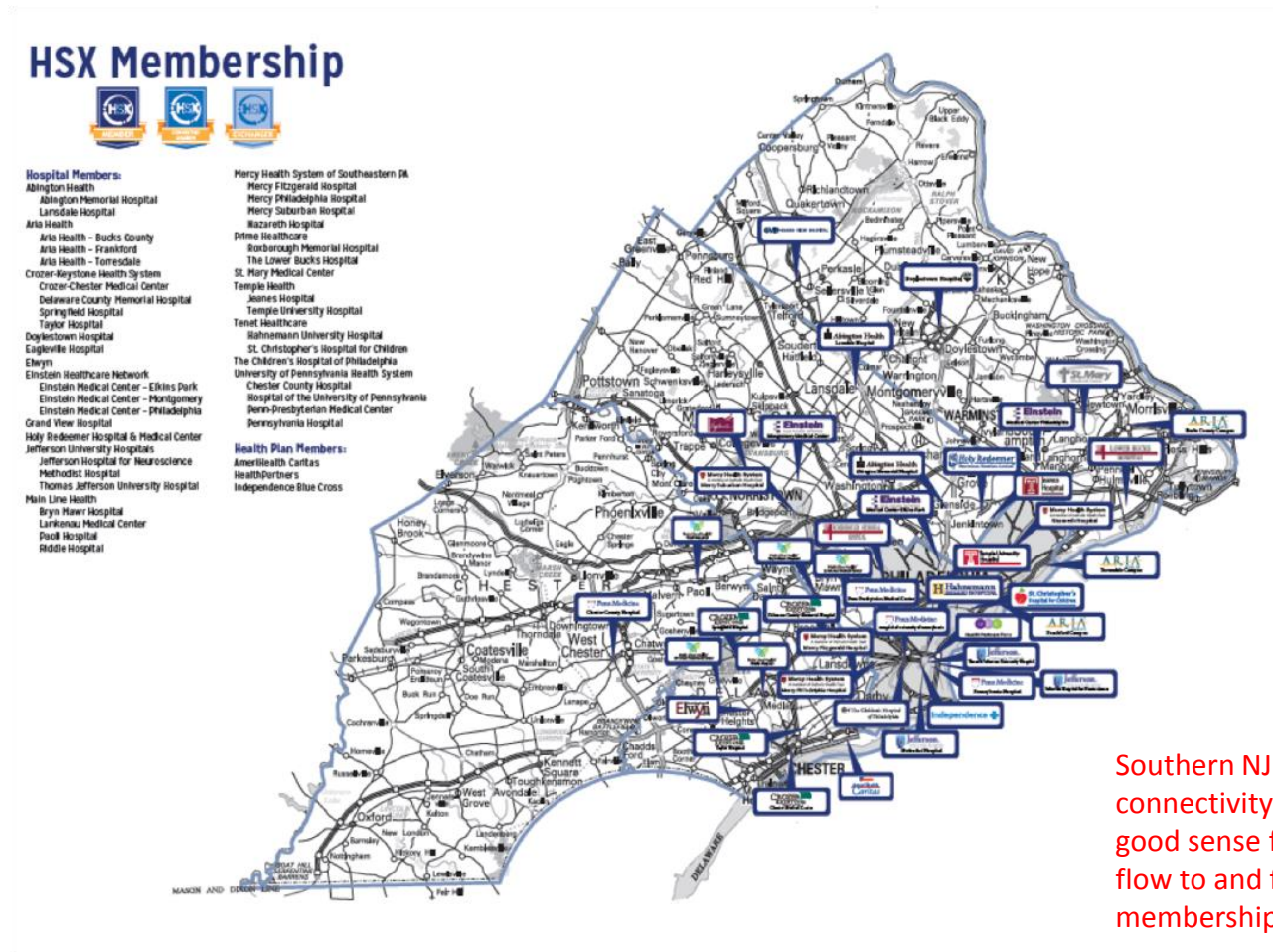
**(includes Federally Qualified Health Centers)**

- 79 Organizations

## Long-term Care Organizations

- Abramson Center for Jewish Life
- Genesis Healthcare

# HSX Membership



Southern NJ  
connectivity makes  
good sense for patient  
flow to and from HSX  
membership

# Care Coordination



# Coordinating The Care Coordination

## Encounter Notification Service Description

- Organizations can Subscribe to Panels of Patients and Receive Timely Notifications When Their Patients are Hospitalized or Present to an Emergency Department and then are subsequently discharged.
- Recently Added the Ability to Subscribe to Long Term Care Admissions and Discharges

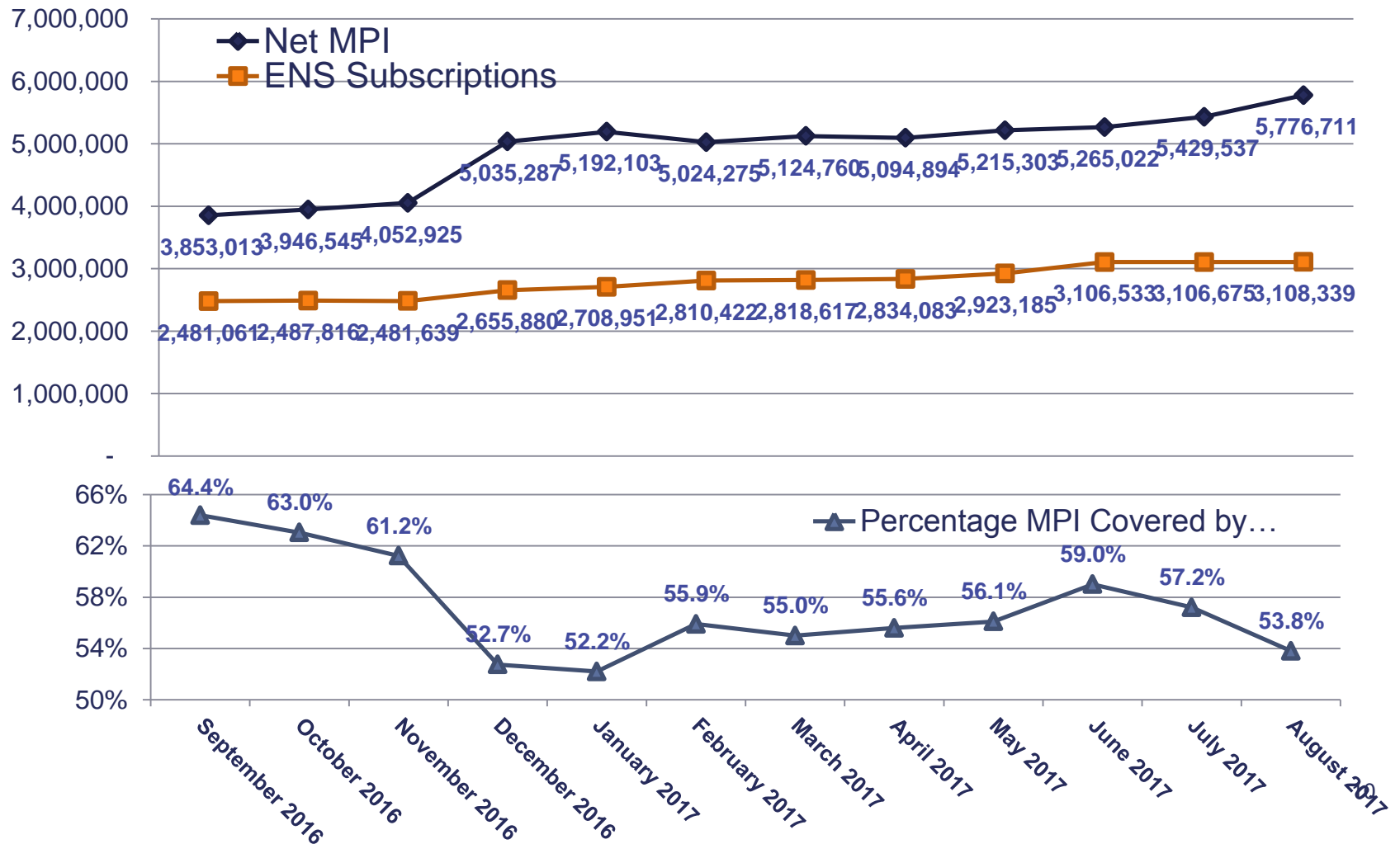
## Encounter Notification New Features

- ENShare Light Weight Care Management
- Smart Notification
- Care Team Identification

## Population Health Reporting

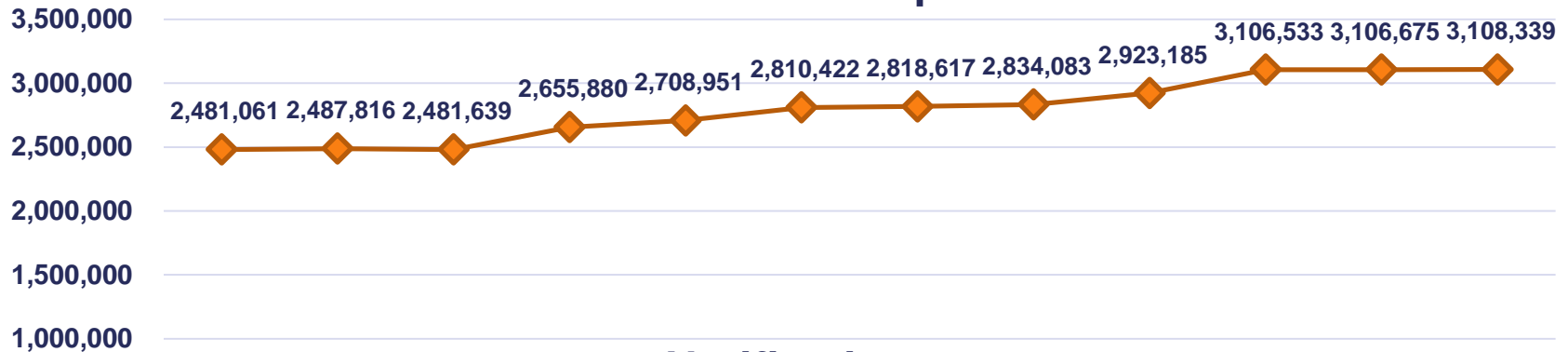
- Identification High Utilizers

# ENS Subscriptions as % of Net MPI

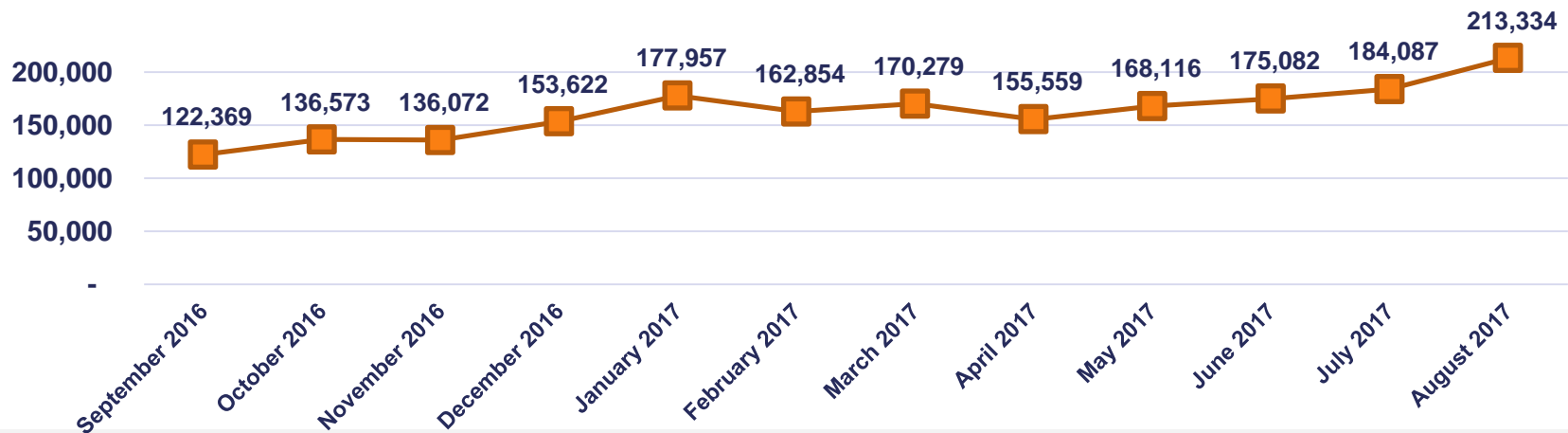


# ENS Patient Subscriptions and Notifications

## Patient Subscriptions

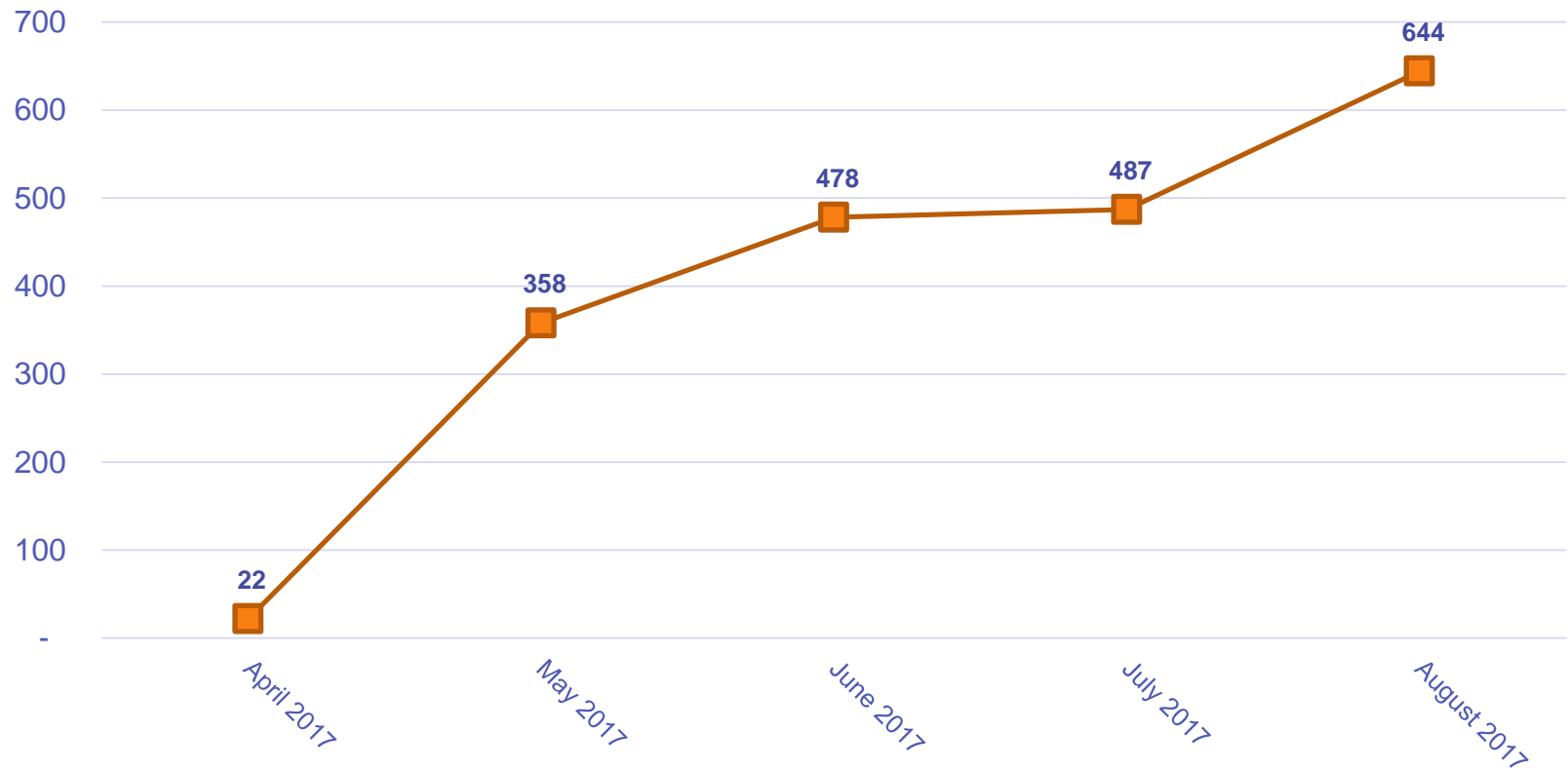


## Notifications



# Encounter Notification Service

## Total LTC Notifications Sent to Subscribers



# ENShare Capabilities

The screenshot displays the ENShare PROMPT web application. The browser window shows the URL <https://promptdemo.ainq.com/#/notifications>. The application header includes the ENS and PROMPT logos, a user profile for Jennifer Natale, and a search bar. Below the header, there is a filter section with a search bar labeled "Filter by Name or MRN" and a dropdown menu showing "Any Participants (3)". The main content area is divided into two columns. The left column lists notifications for four patients: Hector Patton, Brady Ewing, Julie Mathis, and Dean Stein. Each notification includes the patient's name, MRN, hospital, date, time, and event type. The right column provides detailed information for Hector Patton, including his contact number, DOB, address, city/state, race, ethnicity, PCP, NPI, and ACO. It also lists the most recent event, including the event date, type, location, practice location, hospital service, patient diagnosis, discharge disposition, discharge to location, patient complaint, and admit source. At the bottom, there is a status log and an event history table.

**ENS** Encounter Notification Service® | **PROMPT** Proactive Management of Patient Transitions

Filter by Name or MRN  Any Participants (3) Add Filters

**HECTOR PATTON (468971786)**

194-869-1518

DOB: 8/9/67  
Address: 16 Green Milton Parkway  
City/State: Houston, RI  
Race: White  
Ethnicity: Unknown

PCP: Elaine Mc Millan  
NPI: 6038657209  
ACO: Pioneer ACO

**Most Recent Event**

Event Date: 7/26/16 2:18 AM  
Event Type: IP Transfer  
Event Location: Toronto General Hospital  
Practice Location: Chevy Chase  
Hospital Service: Surgery  
Patient Diagnosis: ZUZ5 LOW B/P  
Discharge Disposition: Discharged/transferred to home under care of a Home IV provider  
Discharge to Location: Hospital  
Patient Complaint: QIP965 HEAD INJ  
Admit Source: Physical Referral

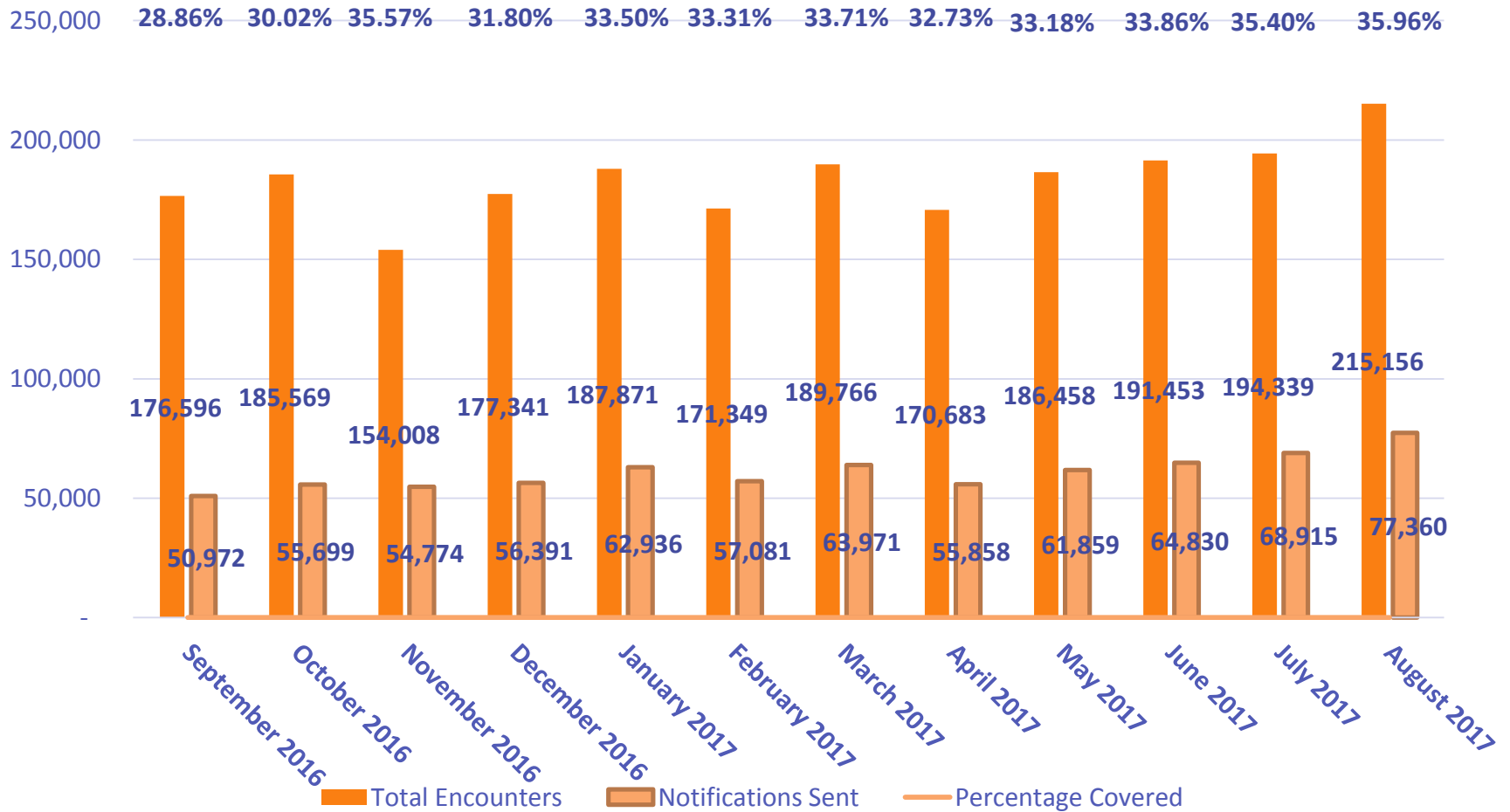
**Status Log**

**Event History**

+	6/25/16 11:59 AM	Diagnosis: XIQ1LT LEG PAIN/FOOTBALL Complaint: FIN13655HEAD INJ	Toronto General Hospital	IP Admit

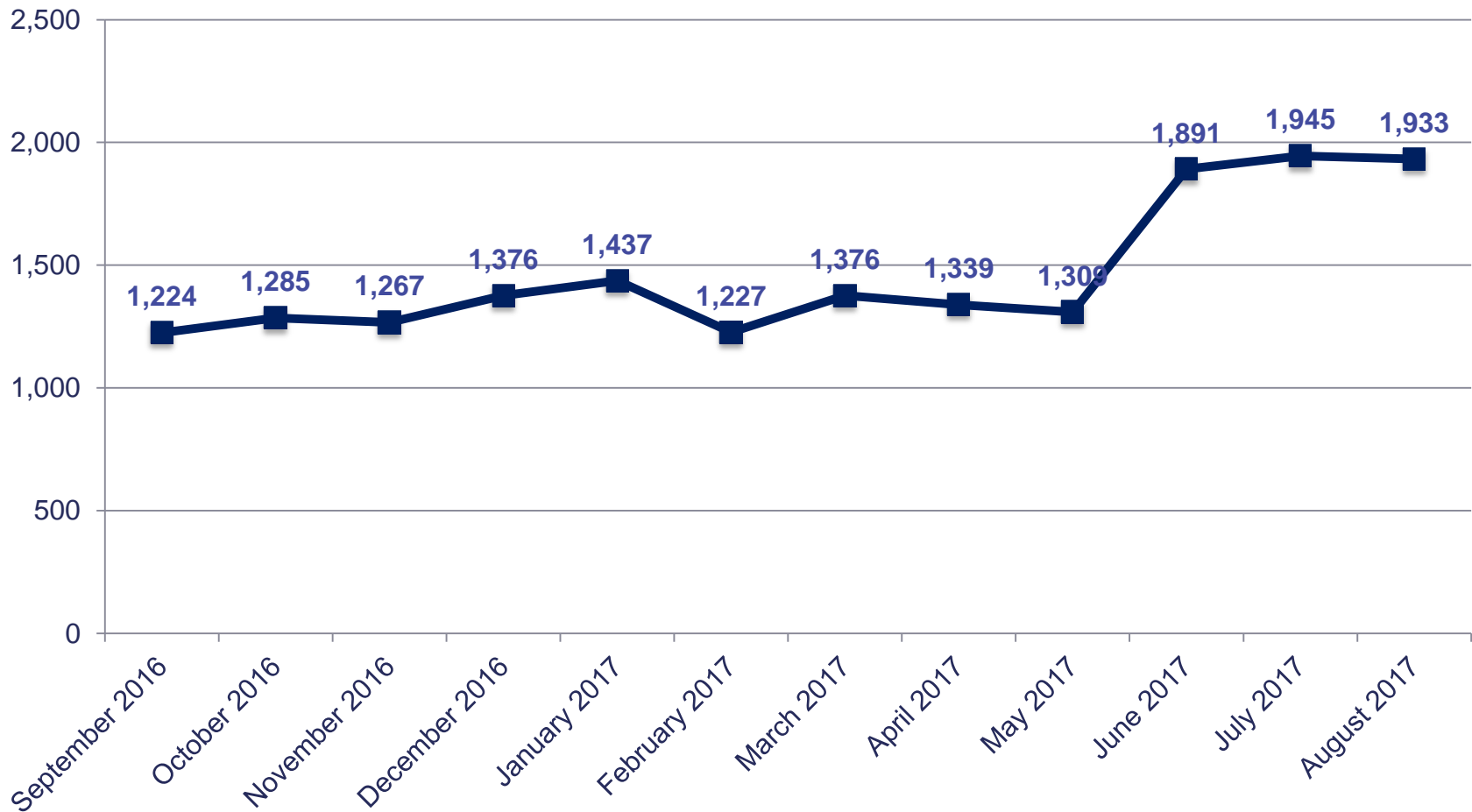
# Emergency Department Admits and Discharges

# ENS Coverage of Emergency Admit Encounters



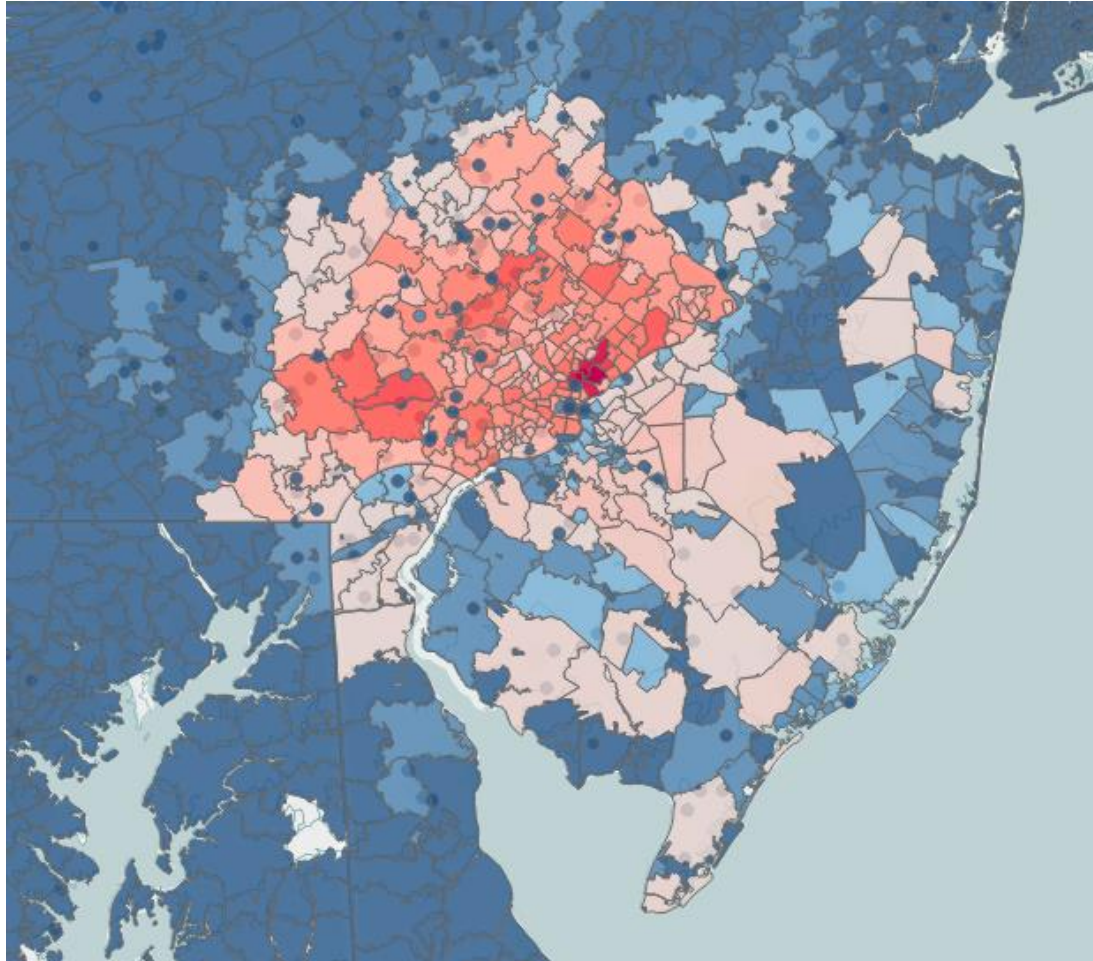
# Clinical Activity History

## Total Documents Delivered





# Population Health



# North Philadelphia High Utilizers

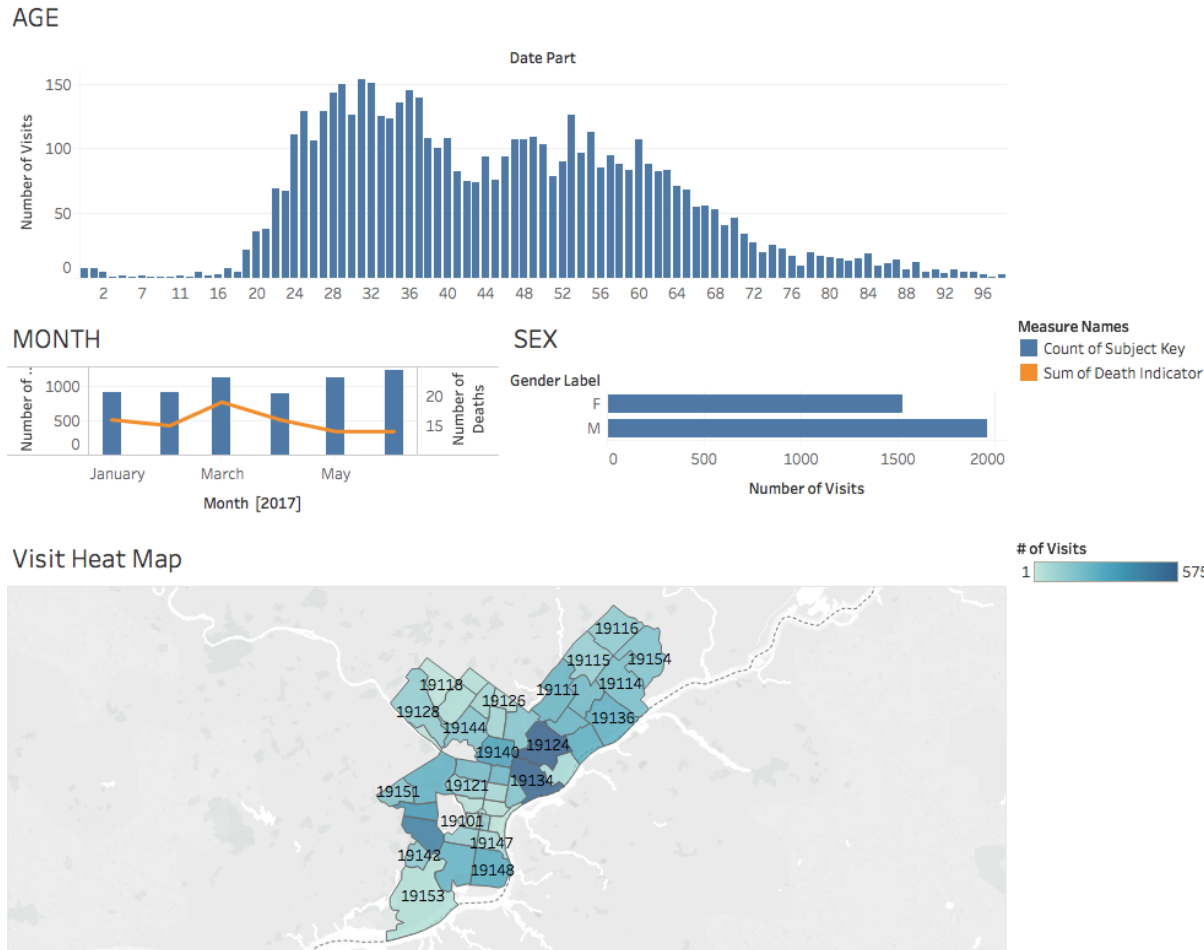
Zip Codes	Greater than 10 ED Visits	Greater than 20 ED Visits
19120	22	6
19121	24	7
19122	4	1
19123	1	0
19124	111	23
19125	7	1
19126	5	1
19130	8	0
19131	23	2
19132	62	11
19133	30	5
19134	37	4
19138	7	1
19140	105	20
19141	17	7
19144	40	12
<b>Total</b>	<b>503</b>	<b>101</b>

Individual Identified High Utilizers and Targeted Care Coordination Would Reduce the Emergency Department Visits

Community Could Come together To Combine With Social Services and Social Determinant Data Sources To Affect Health Outcomes

# Opioid Usage Dashboard

# Locating in Real Time The Prevalence of an Individual With a Specific Condition to Improve Health Outcomes



# Learning Objectives Take Away

# Track 5 in Room Avalon #19 at 3:25PM

HSX Next Presentation on Where We are Headed:

New Roles for Health Information Exchange: Evolution  
from Data Aggregator to Data Provider

# Sharing is Caring

#JustHSXit!



@HealthShareExch



HealthShare  
Exchange of  
Southeastern  
Pennsylvania



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Pennsylvania



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Exchange



+HsxsepaOrg1



HealthShare  
Exchange



# Thank You!

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