ESRD Network 14

Supporting Quality Care
What is an HIE

- **HIE Type**
  - National
  - State
  - Region
  - Community

- **HIE Goal**
  - Share health information
  - Better patient outcomes
  - Lower costs
How do HIEs support Patient Care

- Community Data Manager
- Connecting health care systems
- Comprehensive patient records
- Real-time access
How do HIEs operate in Texas?

• Greater Houston HEALTHCONNECT (GHH)
• Healthcare Access San Antonio (HASA)
• Integrated Care Collaboration (ICC)
• PHIX (formerly known as Paso del Norte HIE)
• Rio Grande Valley HIE (RGV HIE)
HEALTH INFORMATION EXCHANGE IN SUPPORT OF THE TRIPLE AIM:

- Better Health care
- Better Health
- Affordable Care
**Question:** What is Health Information Exchange?  
-Is HIE a noun or a verb?

**Answer:** It’s both. HASA is a politically and financially neutral Health Information Exchange organization that specializes in the secure, electronic, real-time exchange of data between healthcare providers, for the purpose of improving patient care through data interoperability. We are local, non-profit, governed by our members and accountable to you.

- All HIEs are not created equal  
- All HIEs are not the same  
- There are other ways to accomplish data exchange
HIO Coverage Area – to date

HASA one of 5 State-funded initiatives
Non-profit, with broad community participation
External Data Partners

Future statewide/national connectivity via:
Texas Association of Health Information Organizations (TAHIO),
Strategic Health Information Exchange Coalition (SHIEC),
& HIE Texas Partnerships

Texas Health Resources

Paso Del Norte HIE

RGV HIE

Integrated Care Collaborative (ICC)

Greater Houston Health Connect
HASA Stats

Recent Successes:
- Qualified Registry for CMS
- SSO and Native Query Capabilities
- High Utilizer “CTP”
- 5 Payers using ALERTS
- Hospital Admission Dashboards
- MACRA Reporting
- SDoH Survey
- Whole-person Care Coordination
  - (CCM tools available)
Data Contributors

CONTRIBUTING MEMBERS
Methodist Health System
Nix Healthcare
CHRISTUS Santa Rosa
CHRISTUS Children’s Hospital
University Hospital
University Medical Associates
UT Medicine
Methodist Healthcare Ministries
Uvalde Memorial Hospital
Center for Health Care Services
Southwest General Hospital
Clarity Child Guidance
LabCorp
Lance Love MD, PA
Texas Liver Institute
Mid-Texas Family Practice
South Alamo Medical Group
Hill Country Urology
A thru Z Pediatrics

North Texas:
Texas Health Resources
Envision Imaging Centers
HeartPlace
Huguley Hospital
Southwest Diagnostic Imaging Center

Corpus Christi:
CHRISTUS Spohn
Cardiology Associates

West Texas:
Hendricks Health

Please check www.hasatx.org for an updated list.
## COMMITTED AND IN PROGRESS

<table>
<thead>
<tr>
<th>Organization</th>
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## COMMUNITY ADVOCATES

- Community First Health Plans
- Humana
- Superior Health Plan
- Oscar Health
- SA Military Health System
- SAPD & Sheriff’s Office
- Bexar County Medical Society
- Nueces County Medical Society
- YMCA of San Antonio
HASA Data Flow 2017

Client Providers

Virtual Health Record

EMR Feeds
CCD, ADT, Lab, Rad & Path

Composite CCDA, Clinical Reports

Lab & Rad Feeds

Client Rx, RAD, LAB

HASA Facts

Gaps in Care

HASA Care Coordination

Patient Clinical Abstract

Gaps in Care

Gaps in Care

HASP Facts

Patient data request

GoAccount

Surveillance, reportable conditions, prevalence reports, immunizations

Public Health

State Agencies

HiiToxas

CommonWell

State & National Exchange

Patient view, store or print

Client Patients

Patient data request

Patient Updates

Patient Messaging

Individual patient view
HASA 5 Core Services

- HASA ALERT
  - Closed Loop Referral system
  - Community Referrals
  - Case Management for Gaps in Care
  - MACRA quality reporting

- HASA CARE COORDINATION

- HASA FACTS
  - Describe healthcare utilization, syndromic surveillance, quality studies, MACRA measurements and disease specific cohorts

- HASA GO
  - Engage patients, population health management, prevention and wellness, health coaching

- Virtual Health Record
  - Aggregate patient information for community view

Near real-time report of admit/discharge from all data senders for specified patient population; interface not required.
Virtual Health Record

Patient Lookup

Problems/Meds/Allergies/insurance

ADT/Lab/Rad/Transcription

Encounters

Lab

Radiology

Transcribed Reports

Search

Clear All

Copyright 2017 Perfect Search Corporation. All rights reserved. Version: 7.1.2
Reporting Dashboard
HASAFacts Analytic Tools

• MIPS/Quality Metrics Reporting
• Readmission Report
• Alert Report
• LACE Report
• Care Team Lookup
• Soc. Determinants of Health
• Geospatial location
• Ad Hoc Reporting by request
# Example Alert Report

## Encounter Visits between 2016-10-03 and 2016-10-17

Prior visits within 30 days of dates selected

**Download CSV / printer**

### Baptist Medical Center

<table>
<thead>
<tr>
<th>Program</th>
<th>MemberID</th>
<th>MRN</th>
<th>FirstName</th>
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### Mission Trail Baptist Hospital

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### North Central Baptist Hospital

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<th>DischargeTime</th>
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### Methodist Hospital

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### Methodist Specialty and Transplant Hospital

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# Quality Metrics Example Report

## MIPS Measures

*for dates of service 2016-01-01 to 2016-05-16*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Denominator</th>
<th>Total Patients</th>
<th>Count with Result</th>
<th>Performance Met</th>
<th>Performance Not Met</th>
<th>Percent of Patients at Goal</th>
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<td>BMI Screening</td>
<td>Patients aged 18 and older</td>
<td>611</td>
<td>0</td>
<td>0</td>
<td>611</td>
<td>0</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>Women age 50 through 74</td>
<td>137</td>
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<td>0</td>
<td>137</td>
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<td>Clinical Depression Screening</td>
<td>Patients aged 18 and older</td>
<td>881</td>
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<td>881</td>
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<td>Colorectal Cancer Screening</td>
<td>Patients aged 18 and older</td>
<td>248</td>
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<td>0</td>
<td>248</td>
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<tr>
<td>Controlling High Blood Pressure</td>
<td>Patients aged 18 and older</td>
<td>610</td>
<td>0</td>
<td>0</td>
<td>610</td>
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<tr>
<td>Diabetes BP control &lt;140-90</td>
<td>Patients age 18 to 75 with Type 1 or Type 2 diabetes</td>
<td>10</td>
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<td>0</td>
<td>10</td>
<td>0</td>
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<tr>
<td>Diabetes foot exam</td>
<td>Patients age 18 to 75 with Type 1 or Type 2 diabetes</td>
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<td>0</td>
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<td>10</td>
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<tr>
<td>Diabetes: Medical Attention for Nephropathy</td>
<td>Patients aged 18 and older</td>
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<td>High Blood pressure screening and follow up</td>
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<td>611</td>
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LACE (Length of Stay, Acuity, Comorbidity, Emergency Visit) - Predictive Analytics

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Patient Name</th>
<th>DOB</th>
<th>Financial Class</th>
<th>Length of stay of most recent visit</th>
<th>Acuity of admission</th>
<th>Comorbidities</th>
<th>ED visits in past 6 months</th>
<th>Total Score</th>
<th>Risk Level</th>
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<tr>
<td>719615</td>
<td>DI_LDAOLEAAA</td>
<td>D_056552-10</td>
<td>NO PAYMENT</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>15</td>
<td>High</td>
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<tr>
<td>719633</td>
<td>DI_EEETRNEM</td>
<td>D_1-19-9</td>
<td>NO PAYMENT</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>11</td>
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<tr>
<td>412487</td>
<td>DI_AT PEDT</td>
<td>D_2-201880</td>
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<td>3</td>
<td>3</td>
<td>4</td>
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<tr>
<td>595428</td>
<td>DI_ZAIOVSO</td>
<td>D_9-0498-</td>
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<td>3</td>
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<td>9658</td>
<td>DI_LEDNOPLEOPL</td>
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<td>80491</td>
<td>DI_ZADLLOLD</td>
<td>D_600-10</td>
<td>NO PAYMENT</td>
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<td>DI_UPUNHTNU</td>
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<tr>
<td>721081</td>
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<td>166056</td>
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<td>667082</td>
<td>DI_AMRN EDT</td>
<td>DI_833-110-</td>
<td>MEDICARE</td>
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<td>3</td>
<td>0</td>
<td>6</td>
<td>Moderate</td>
</tr>
<tr>
<td>70855</td>
<td>DI_NTON T E</td>
<td>D_906-118</td>
<td>MEDICARE</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
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<td>Moderate</td>
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<td>287288</td>
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<td>NO PAYMENT</td>
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<td>741152</td>
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<td>5</td>
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</table>
SOCIAL Determinants for readmissions

Given that HASA aggregates patient information from across the community, the validation process was extended to assess the potential impact on readmissions rate as determined by the LACE score for patients living in highly vulnerable (based on income and education level) vs. moderate and low vulnerable zip codes of the community.

- Discharged patients for four successive dates (March 1, April 1, May 1 and June 1) from all participating San Antonio hospitals (35 in total) (N=3200) were categorized by zip codes and submitted to the LACE algorithm and scored on re-admissions likelihood. The zip codes were then stratified according to a high, moderate and low vulnerability category.
- Chart III below offers preliminary indications that correlational trends between readmissions and LACE score are consistent and more pronounced on the highly vulnerable zip code region. This finding can aid discharge planners and care teams in focusing with high intensity on the high risk LACE scoring cohort residing in highly vulnerable regions of the community.
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient SSN</th>
<th>Date of Birth</th>
<th>Date Reported</th>
<th>Reporting Facility</th>
<th>Provider Name</th>
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<tr>
<td>DL_E ET EN</td>
<td>431760201</td>
<td>DL_09-4-1</td>
<td>2019-03-07</td>
<td>Texas Health Physicians Group (THPG)</td>
<td>TIMOTHY RYAN SWOFFORD - Primary - EPROV_357177</td>
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<tr>
<td>DL_RPMPEARA</td>
<td>4845685763</td>
<td>DL_7-9041</td>
<td>2019-02-18</td>
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<td>MARK STANLEY MAYFIELD - Primary - EPROV_133941</td>
</tr>
<tr>
<td>DL_SSR R R</td>
<td>4845685763</td>
<td>DL_8407880</td>
<td>2018-12-25</td>
<td>Texas Health Harris Methodist Southlake</td>
<td>MARK STANLEY MAYFIELD - Primary - EPROV_133941</td>
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<td>4845685763</td>
<td>DL_418---4</td>
<td>2018-12-25</td>
<td>Texas Health Harris Methodist Southlake</td>
<td>SARA ELIZABETH SUTURE - Admitting - EPROV_357224</td>
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<td>DL_YRSANACA</td>
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<td>2018-12-25</td>
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<td>BINH DUC NGUYEN - Primary - EPROV_107344</td>
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</table>
Thank you.

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