# Connecting Care: Real-World Solutions for Rural Health from HealtheConnections

North County Leadership Summit 2026

Karen Gonyea, Associate Vice President
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# Learning Objectives

- Identify how HIE supports care coordination, reduces administrative burden, and improves operational efficiency for rural health professionals.
- Describe how HealtheConnections data can be accessed through her integration, portal-based tools, and other methods to support timely, whole-person care.
- Explain how unique and newly developed tools from HealtheConnections can support rural public health efforts.
- Evaluate real-world use cases demonstrating streamlined workflows, reduced care gaps, and improved clinical and population health outcomes.

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# Health Information Exchange in New York State

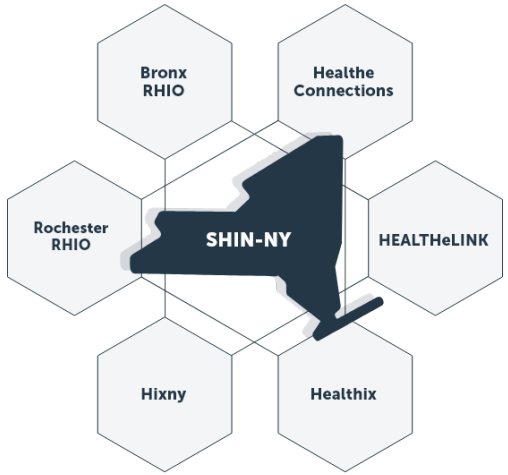
# The Network Behind the Record

- Health Information Exchange (HIE) is a central repository of health data that lets patient information flow securely among health, public health, and care providers.
- The SHIN-NY is New York's state-funded, secure network for sharing records, overseen by the New York eHealth Collaborative (NYeC).
- Six NYSDOH-certified Qualified Entities (QEs) are the backbone of the SHIN-NY — including HealtheConnections.
- *Rochester RHIO announced partnership with HealtheConnections(August 2026)*

SHIN·NY
STATEWIDE HEALTH INFORMATION NETWORK FOR NEW YORK

NEW YORK STATE Department of Health

NYeC
NEW YORK eHEALTH COLLABORATIVE




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

# HealtheConnections – Who We Are

## TRUSTED PARTNER OF CHOICE SINCE 2010

**1.5K** Organizations

**4.6K** Health Care Offices

**600** Data Contributors

**14K** Providers

**16M** Patients

### SERVICES

Patient Lookup • Results • Secure Messaging • Imaging • Reports & Dashboards • Analytics

### SELECTED BY THE SHIN-NY TO DELIVER

Statewide Encounter Alerts • Primary Document Repository

***One connection. Statewide reach. Consistent standards.***

# Every Gap in the Record Has a Name

## *Meet Denise*

# Denise

- 58 years old
- Rural county, lives 45+ minutes from the nearest hospital
- Seasonal work; insurance and employer changed twice in three years
- HX: Type 2 diabetes, uncontrolled; hypertension diagnosed last spring
- Breast cancer survivor
- No consistent primary care provider
- Several Health-Related Social Needs identified: transportation, food insecurity, financial strain

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# A Fragmented Healthcare System – 1 Patient, 5 Settings, 5 Records

No one setting has seen her whole history—including Denise. Every handoff restarts the story from scratch.

### Urgent care
Seasonal-job town

Not aware of labs completed last month at another urgent care

›

### Regional ED
Hypoglycemic episode

The ED repeats an A1C drawn 11 days earlier

›

### Admission
3 days inpatient

HRSN screening not completed, not aware of previous needs

›

### Discharge Home
Follow-up 45 min away

Discharge summary sent to a PCP she no longer sees

### Care manager / CBO
Never notified of admission or discharge

Not set up to for Statewide Encounter Alerts

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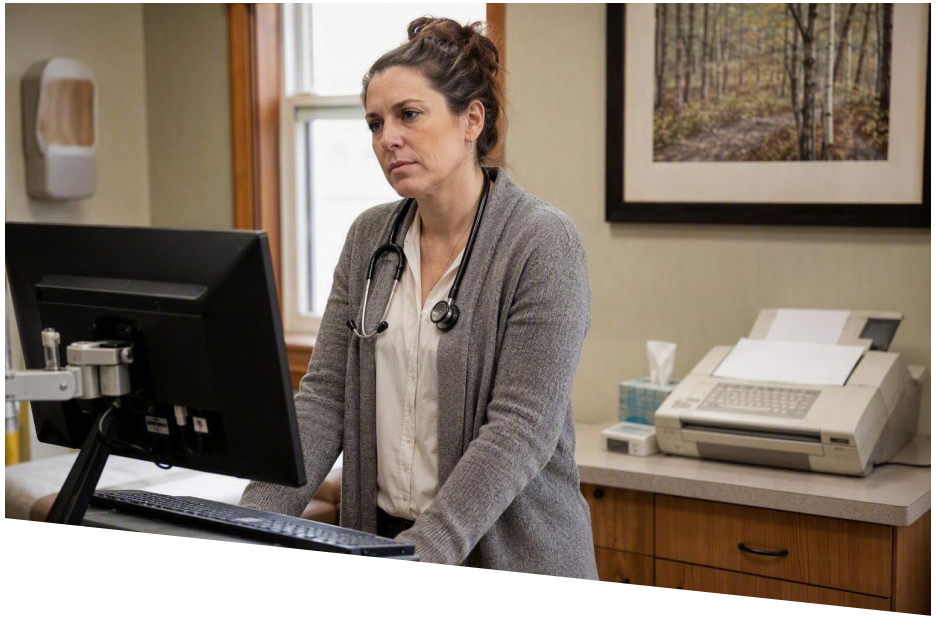
**This is where an HIE changes the story.**

Five settings, one shared record – comprehensive history and statewide alerts, all in real time.

# *Giving Providers the Full Patient Picture*



# Isolated by Default, Not by Choice

- Referrals and records still move by fax, phone, and patient memory
- Discharge summaries often arrive after the follow-up visit has already happened
- Imaging gets repeated because prior studies can't be retrieved in time
- Lean-staffed sites lose clinical hours to chart chasing

**DENISE:** *The ED repeated an A1C drawn 11 days earlier. Her discharge summary went to a PCP she no longer sees. Both of these, in one year.*

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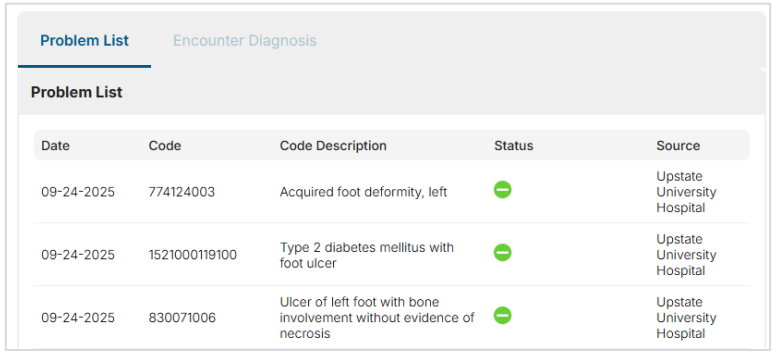
# HealtheConnections' HIE Portal

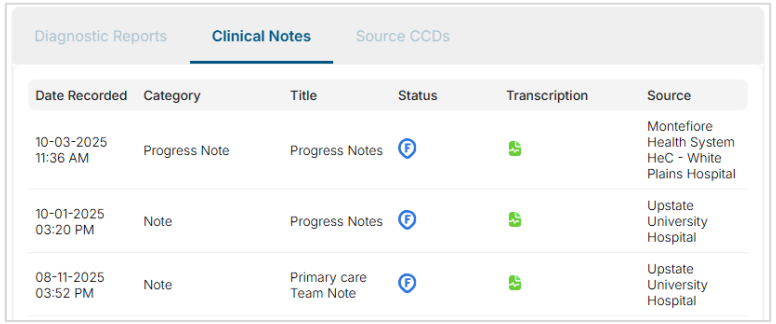
## One login — everything Denise's clinicians couldn't find, already in one place



Problem List | Encounter Diagnosis

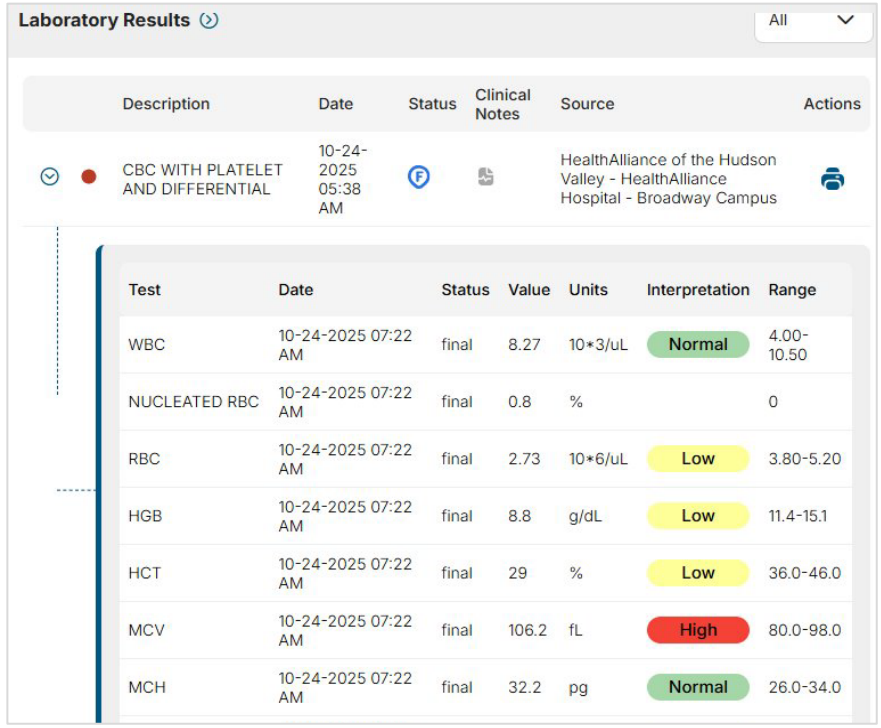
**Problem List**

| Date | Code | Code Description | Status | Source |
|---|---|---|---|---|
| 09-24-2025 | 774124003 | Acquired foot deformity, left | | Upstate University Hospital |
| 09-24-2025 | 1521000119100 | Type 2 diabetes mellitus with foot ulcer | | Upstate University Hospital |
| 09-24-2025 | 830071006 | Ulcer of left foot with bone involvement without evidence of necrosis | | Upstate University Hospital |



Diagnostic Reports | Clinical Notes | Source CCDs

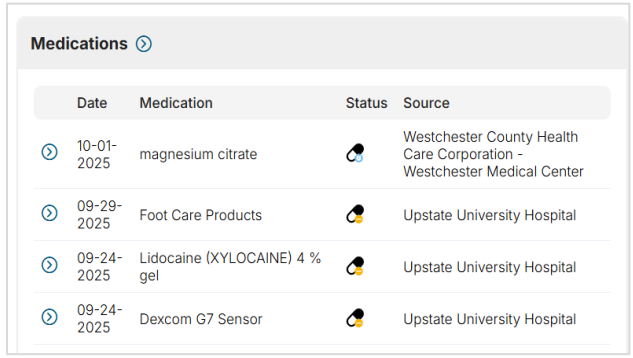
| Date Recorded | Category | Title | Status | Transcription | Source |
|---|---|---|---|---|---|
| 10-03-2025 11:36 AM | Progress Note | Progress Notes | | | Montefiore Health System HeC - White Plains Hospital |
| 10-01-2025 03:20 PM | Note | Progress Notes | | | Upstate University Hospital |
| 08-11-2025 03:52 PM | Note | Primary care Team Note | | | Upstate University Hospital |



**Laboratory Results** All

| Description | Date | Status | Clinical Notes | Source | Actions |
|---|---|---|---|---|---|
| CBC WITH PLATELET AND DIFFERENTIAL | 10-24-2025 05:38 AM | | | HealthAlliance of the Hudson Valley - HealthAlliance Hospital - Broadway Campus | |

| Test | Date | Status | Value | Units | Interpretation | Range |
|---|---|---|---|---|---|---|
| WBC | 10-24-2025 07:22 AM | final | 8.27 | 10*3/uL | Normal | 4.00-10.50 |
| NUCLEATED RBC | 10-24-2025 07:22 AM | final | 0.8 | % | | 0 |
| RBC | 10-24-2025 07:22 AM | final | 2.73 | 10*6/uL | Low | 3.80-5.20 |
| HGB | 10-24-2025 07:22 AM | final | 8.8 | g/dL | Low | 11.4-15.1 |
| HCT | 10-24-2025 07:22 AM | final | 29 | % | Low | 36.0-46.0 |
| MCV | 10-24-2025 07:22 AM | final | 106.2 | fL | High | 80.0-98.0 |
| MCH | 10-24-2025 07:22 AM | final | 32.2 | pg | Normal | 26.0-34.0 |



**Medications**

| Date | Medication | Status | Source |
|---|---|---|---|
| 10-01-2025 | magnesium citrate | | Westchester County Health Care Corporation - Westchester Medical Center |
| 09-29-2025 | Foot Care Products | | Upstate University Hospital |
| 09-24-2025 | Lidocaine (XYLOCAINE) 4 % gel | | Upstate University Hospital |
| 09-24-2025 | Dexcom G7 Sensor | | Upstate University Hospital |

**1,700+ users accessing 4,600+ patients every day.**
**Built and owned by HealtheConnections.**

# Denise’s A1C From 11 Days Ago Is Already There

**Patient Care Coordination Note**

Formatting of this note is different from the original.
This patient has enrolled in the SUNY Upstate Outpatient Pharmacy Medication Adherence Program (MAP). They have elected to receive their medications in pill pouches (dispense type).

Before changing their pharmacy, or if you have any questions, please contact the MAP Team at 315-464-8875, or via Epic chat at Â¢€œPharmacy MAP.Â¢€□

| Problem | Noted Date | Diagnosed Date |
|---|---|---|
| Ulcer of left foot with bone involvement without evidence of necrosis | 09/24/2025 | |
| Type 2 diabetes mellitus with foot ulcer | 09/24/2025 | |
| Acquired foot deformity, left | 09/24/2025 | |
| Diabetic Charcot foot | 09/24/2025 | |
| Graves' disease | 08/13/2025 | |
| Graves disease | 07/29/2025 | |
| Overview (07/29/2025):Formatting of this note might be different from the original. On methimazole | | |
| Subacute osteomyelitis of left foot | 07/29/2025 | |
| Acute osteomyelitis of left foot | 07/22/2025 | |
| Diabetic ulcer of left midfoot associated with type 2 diabetes mellitus, with bone involvement without evidence of necrosis | 07/22/2025 | |
| At high risk for skin breakdown | 07/22/2025 | |
| Combined forms of age-related cataract of right eye | 03/18/2025 | |
| Impacted cerumen of left ear | 11/01/2024 | |
| Tinnitus of left ear | 11/01/2024 | |
| Sensorineural hearing loss (SNHL) of both ears | 11/01/2024 | |

**Medications**

| Date | Medication | Status | Source |
|---|---|---|---|
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| 09-24-2025 | Lidocaine (XYLOCAINE) 4 % gel | | Upstate University Hospital |
| 09-24-2025 | Dexcom G7 Sensor | | Upstate University Hospital |
| 09-17-2025 | Vitamin D3 1.25 MG (50000 UT) | | Cornerstone Family Healthcare - Kaplan Family Pavilion |
| 09-15-2025 | Ofloxacin 0.3 % Ophthalmic Solution (OCUFLOX) | | Upstate University Hospital |
| 09-15-2025 | prednisoLONE Acetate 1 % Ophthalmic Suspension | | Upstate University Hospital |

**Immunizations**

| Administered Date | Vaccine | Status | Source |
|---|---|---|---|
| 04-16-2024 | Pneumococcal Conjugate PCV20 | ✗ | Upstate University Hospital |
| 04-16-2024 | Influenza Quad IM Pres Free (0.5 mL dose) | ✗ | Upstate University Hospital |
| 04-25-2023 | Hep B, adult | ✓ | Westchester County Health Care Corporation - Westchester Medical Center |
| 11-22-2022 | influenza virus vaccine, live | ✓ | Westchester County Health Care Corporation - Westchester Medical Center |
| 10-26-2022 | hepatitis B adult vaccine | ✓ | Westchester County Health Care Corporation - Westchester Medical Center |
| 10-26-2022 | hepatitis A adult vaccine | ✓ | Westchester County Health Care Corporation - Westchester |

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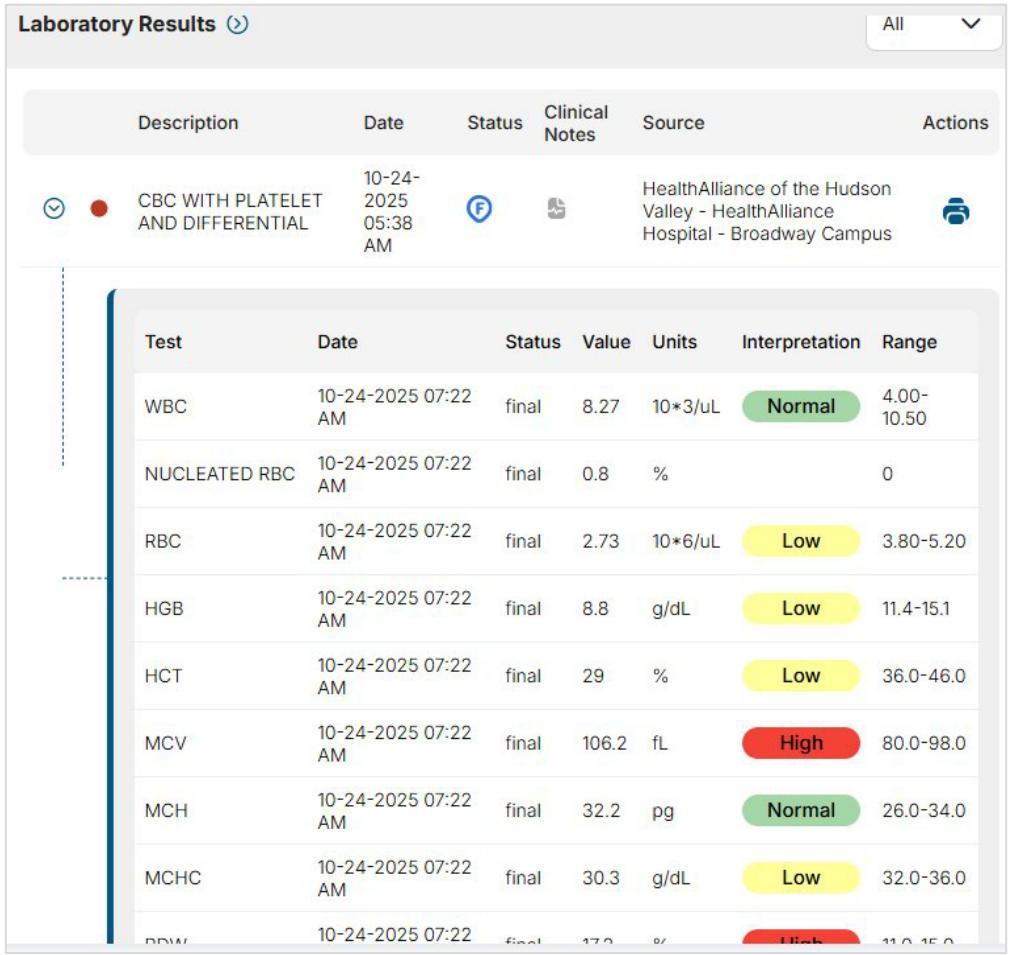
## Patient Lookup

- ✓ Full history at a glance—allergies, medications, immunizations and more
- ✓ Hospital progress notes, op notes, and discharge summaries for detailed insights
- ✓ Recent labs, imaging reports, and progress notes from inpatient and outpatient settings
- ✓ All available in one view!

# Her Labs Reach the PCP She Actually Sees



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| MCH | 10-24-2025 07:22 AM | final | 32.2 | pg | Normal | 26.0-34.0 |
| MCHC | 10-24-2025 07:22 AM | final | 30.3 | g/dL | Low | 32.0-36.0 |
| RDW | 10-24-2025 07:22 | final | 17.2 | % | High | 11.0-15.0 |

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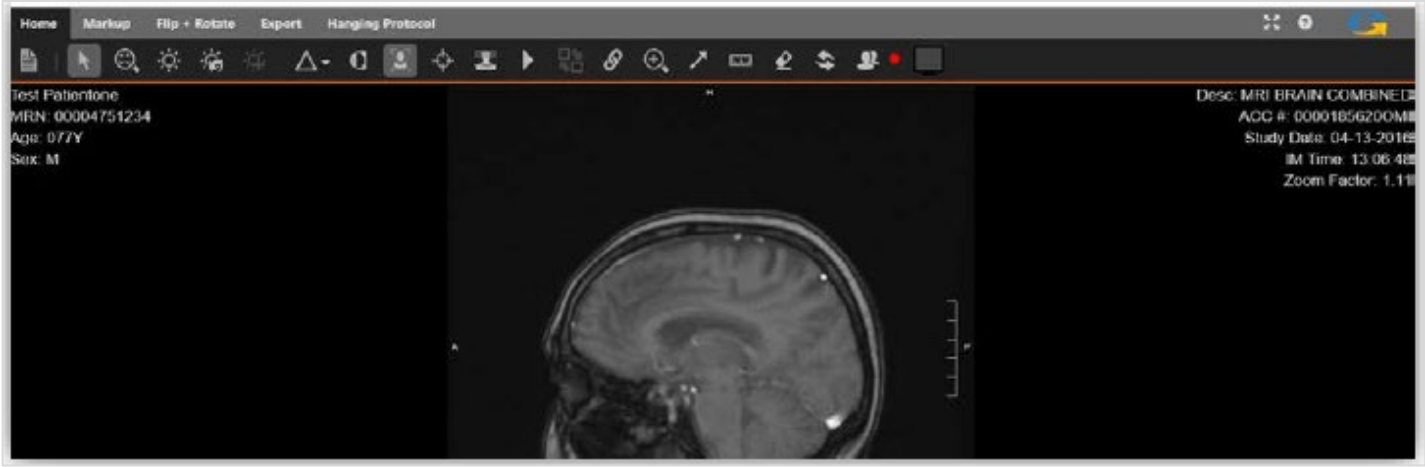
## Results

- ✓ Available to view in Patient Lookup by provider
- ✓ Automated lab, radiology and transcription delivery directly into the provider EMR
- ✓ Fits existing workflows—fast and efficient
- ✓ Keeps primary and specialty teams working from the same numbers

# Her Prior Scan Is Reviewed Locally, Not Repeated




Diagnostic Reports | Clinical Notes | Source CCDs

**Diagnostic Imaging**

| Date Recorded | Category | Title | Status | Transcription | Source | Actions |
|---|---|---|---|---|---|---|
| 06-09-2026 09:44 AM | Diagnostic imaging study | BI MAMMOGRAM SCREENING TOMOSYNTHESIS BILATERAL | | | Optum Medical Care PC | |

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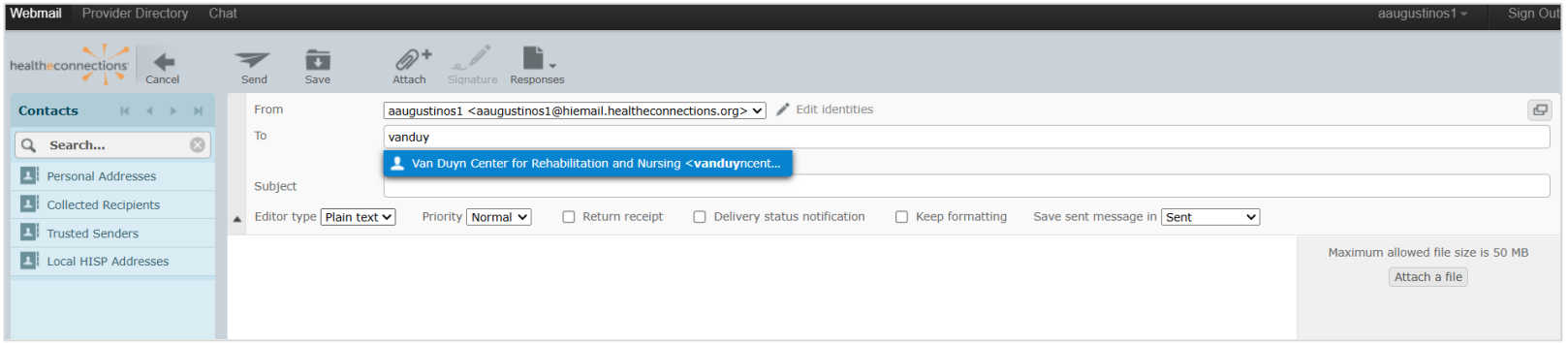
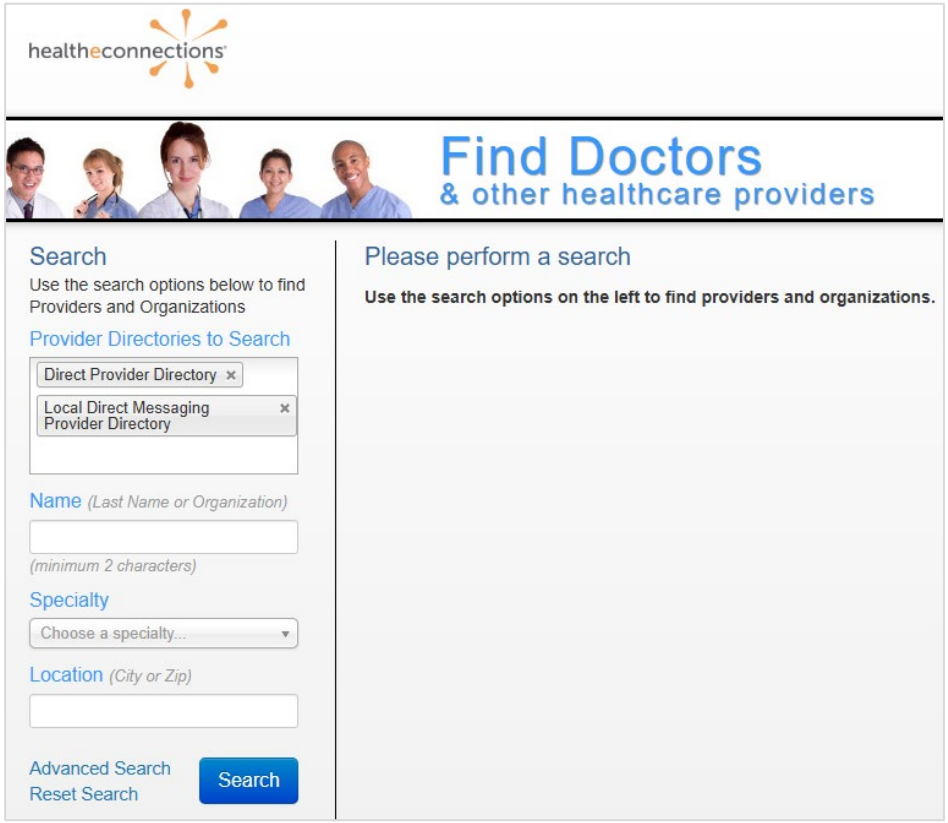
## Image Exchange

- ✓ Easy access to diagnostic quality images
- ✓ No special equipment or software required
- ✓ Removes the burden on patients and staff to chase down discs

# Her Care Manager Confirms the Same Afternoon

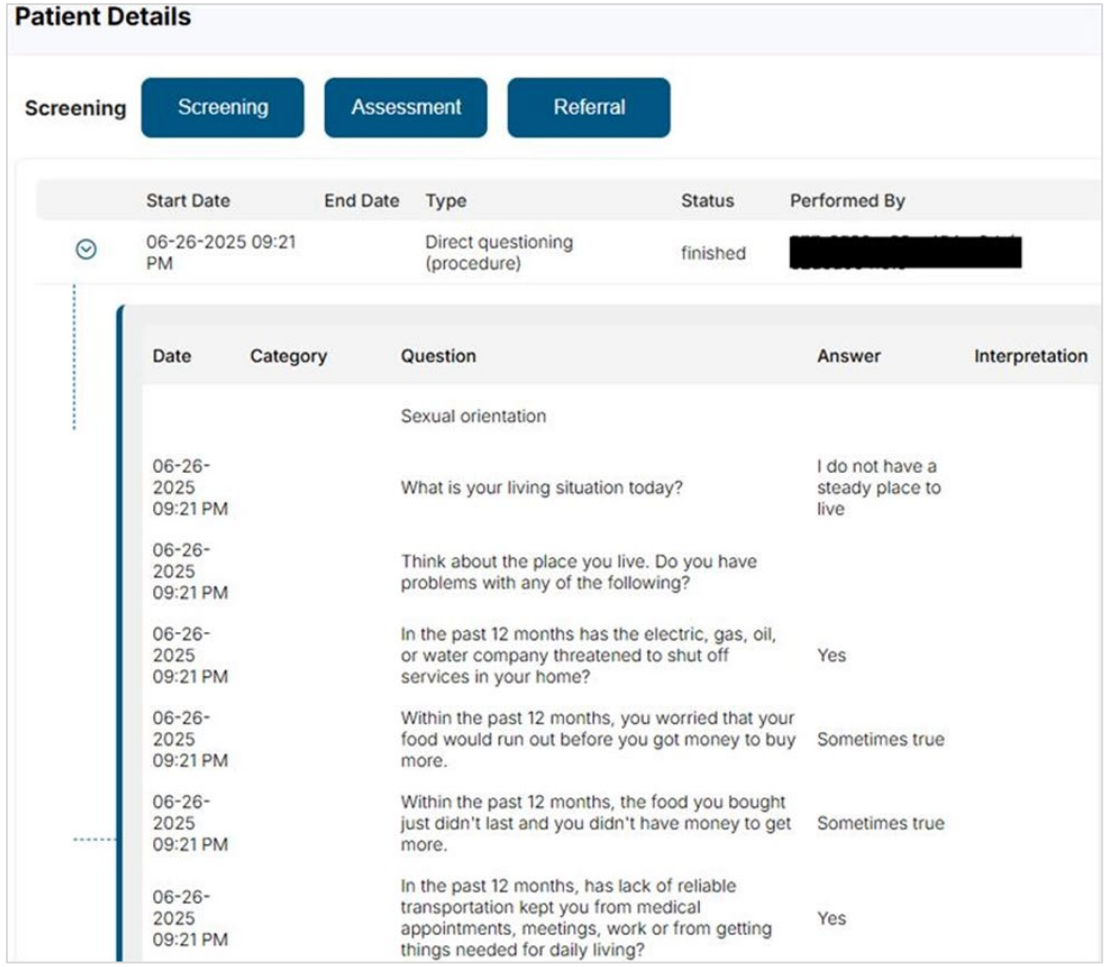



## Secure Messaging

- ✓ Securely share PHI, results and documents between care teams
- ✓ National Provider Directory for fast, direct provider-to-provider contact
- ✓ Fully HIPAA compliant collaboration across settings

# Her Provider Sees the Whole Person



**Patient Details**

Screening | Screening | Assessment | Referral

| Start Date | End Date | Type | Status | Performed By |
|---|---|---|---|---|
| 06-26-2025 09:21 PM | | Direct questioning (procedure) | finished | [redacted] |

| Date | Category | Question | Answer | Interpretation |
|---|---|---|---|---|
| | | Sexual orientation | | |
| 06-26-2025 09:21 PM | | What is your living situation today? | I do not have a steady place to live | |
| 06-26-2025 09:21 PM | | Think about the place you live. Do you have problems with any of the following? | | |
| 06-26-2025 09:21 PM | | In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? | Yes | |
| 06-26-2025 09:21 PM | | Within the past 12 months, you worried that your food would run out before you got money to buy more. | Sometimes true | |
| 06-26-2025 09:21 PM | | Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. | Sometimes true | |
| 06-26-2025 09:21 PM | | In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? | Yes | |

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## Health-Related Social Needs (HRSN) Data

- ✓ 1115 Medicaid Waiver screenings, assessments, and referrals available in Patient Lookup
- ✓ Diagnostic z-codes for social needs
- ✓ Gain further insights into patient needs and risk factors
- ✓ Ensure appropriate care management and community-based services are in place

# Denise’s Record Follows Her

- ✓ 1 complete record replaces 5 partial ones
- ✓ Faster, better-informed decisions at the point of care
- ✓ Fewer duplicate tests, fewer avoidable gaps, less administrative chase
- ✓ Staff time returned to patients instead of paperwork

## What Our Partners Are Saying

*“Use of SHIN-NY services, such as patient lookup, is associated with a 50% reduction in hospital readmission”*

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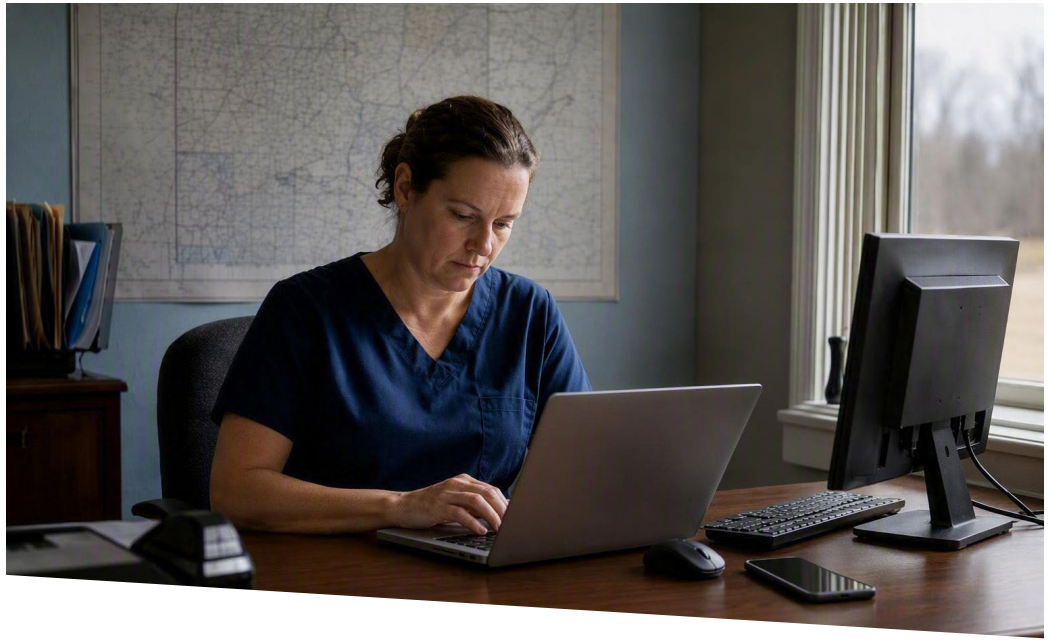
# *Turning HIE Data into Population-Level Insight*

# Small Departments, County-Sized Problems

- Relying on data that’s 2-3 years old
- A chronic disease burden everyone knows is high, but no one can quantify
- Limited staff covering surveillance, reporting, and outreach countywide
- Investigations that stall waiting on records from multiple facilities



**DENISE:** *Her diabetes, her new hypertension diagnosis, and her unmet social needs were not tracked by the county. Multiply her by a few thousand and that is the gap.*

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# Two Level of Insight, One Data Source

**Individual**

- Disease investigation and follow-up
- Death determinations
- Clinical care in LHD-operated clinics
- Case-level history across facilities

**Population**

- Prevalence across the service area
- Trends over time
- CHA/CHIP development
- Program targeting and grant reporting

**One resident, or 2,000 you've never seen.**

**Individual** — "What happened to Denise?" | **Population** — "What's happening in this county?"

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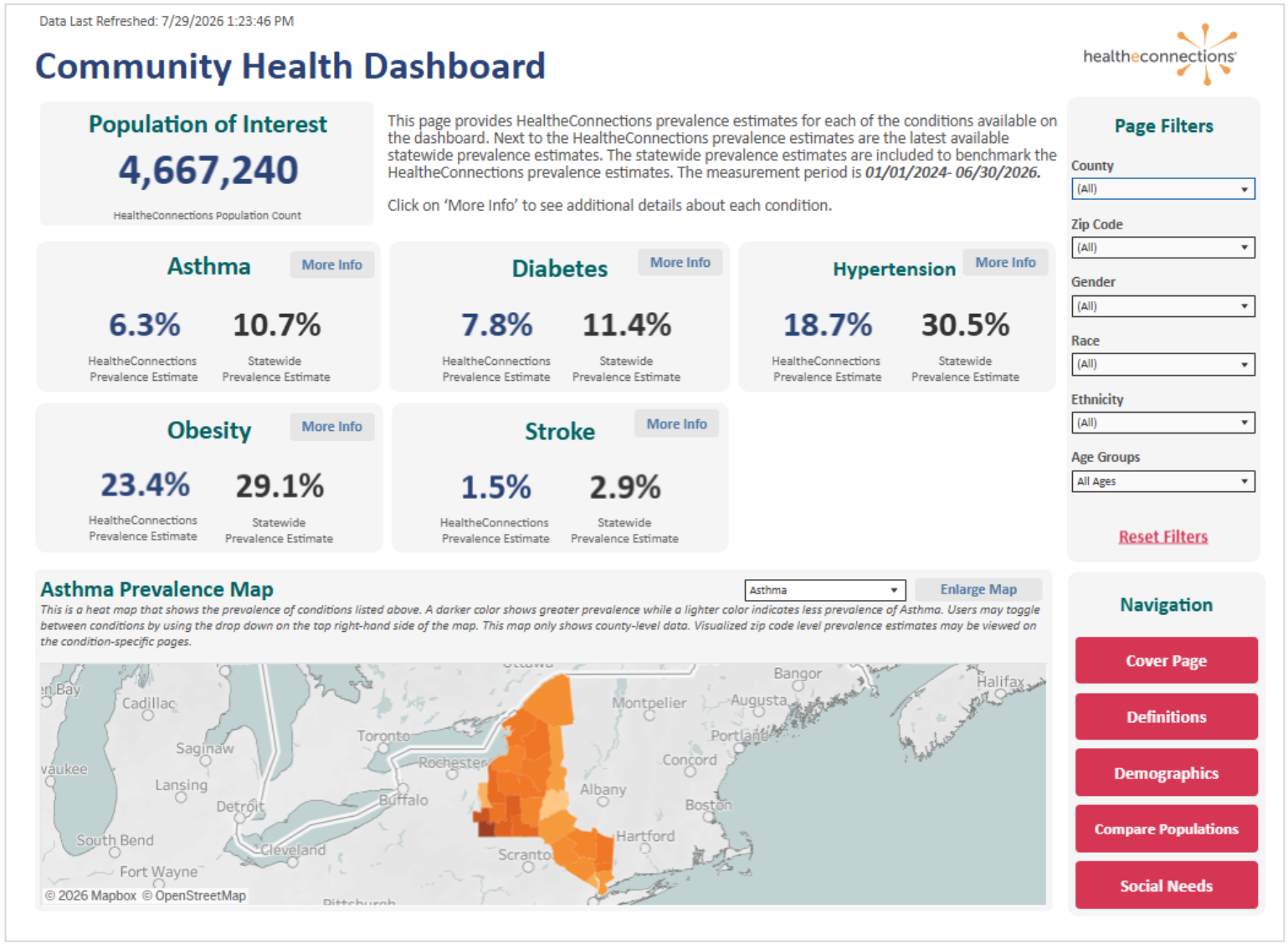
# Community Health Dashboard

- ✓ View timely prevalence estimates across their service area
- ✓ Stratify data by county, ZIP code, age, gender, race, and ethnicity
- ✓ Explore community-level health trends and patterns
- ✓ Download data extracts for additional analysis



# Community Health Dashboard, continued

## Demographics

This page provides age, gender, race, and ethnicity counts and percentages for each of the counties that HealtheConnections serves. Users may download a copy of the data available on this page. *Note, the census population estimates are static and therefore not impacted by the page filters. In addition, the age group page filter does not impact the age group display in the table below.*

### Total Population of Interest

**4,667,240**

HealtheConnections Population Count

### Age Groups

| | | |
|---|---|---|
| 0-1 | 149,818 | 18.7% |
| 2-17 | 872,493 | 12.1% |
| 18-29 | 691,640 | 3.2% |
| 30-39 | 562,419 | 14.8% |
| 40-49 | 527,060 | 11.3% |
| 50-59 | 509,358 | 10.9% |
| 60-69 | 578,750 | 12.4% |
| 70-79 | 444,302 | 9.5% |
| 80-89 | 228,612 | 4.9% |
| 90+ | 102,788 | 2.20% |

### Gender

| | | |
|---|---|---|
| Female | 2,245,207 | 48.1% |
| Male | 2,030,328 | 43.5% |
| Unknown | 391,705 | 8.4% |

### Ethnicity

| | | |
|---|---|---|
| Hispanic Or Latino | 449,849 | 9.6% |
| Not Hispanic Or Latino | 2,796,257 | 59.9% |
| Unknown | 1,421,134 | 30.4% |

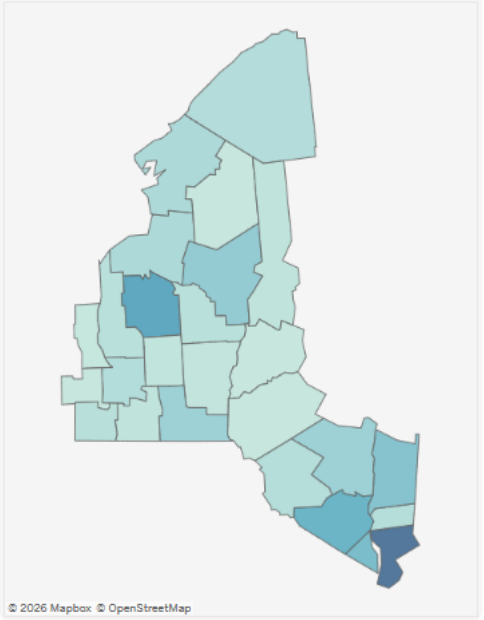
### Race

| | | |
|---|---|---|
| American Indian Or Alaska Native | 19,699 | 0.4% |
| Asian | 100,029 | 2.1% |
| Black Or African American | 373,857 | 8.0% |
| Native Hawaiian Or Other Pacific Islander | 7,916 | 0.2% |
| Other Race | 287,175 | 6.2% |
| Unknown | 1,217,577 | 26.1% |
| White | 2,660,987 | 57.0% |

### HealtheConnections Population Map

County

*This map shows population density for the HealtheConnections catchment area. The counts in each area are derived from the HealtheConnections population. The darker the color, the more populated the area. You can see population density by county or zip code by toggling the filter in the top right corner of the map. To see a larger version of this map, click the 'enlarge map' button on the top right corner.*




### Page Filters

County Name: (All)

Zip Codes: (All)

Gender: (All)

Race: (All)

Ethnicity: (All)

Age Groups: All Ages

Reset Filters

### Navigation

Back to Dashboard

View Data Table

## Diabetes Details

This page displays information about Diabetes. Please note that the page filters apply to all visualizations except for the Social Vulnerability Index Map, which is not impacted by any filters other than *County Name*.

### Population of Interest

**2,271**

HealtheConnections Population Count

### Diabetes Prevalence Estimate

**11.5%**

HealtheConnections Prevalence Estimate

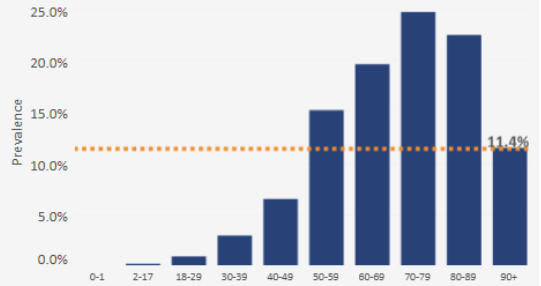
### NYS Diabetes Prevalence Estimate

**11.4%**

Statewide Prevalence Estimate

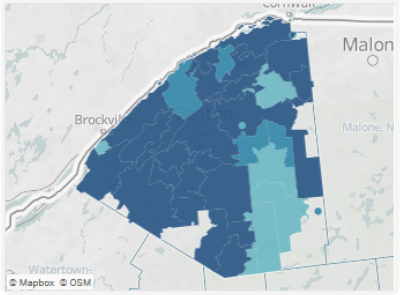
### Diabetes Prevalence Estimate by Age

Age



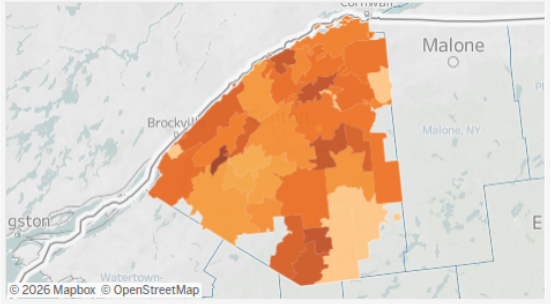

### Social Vulnerability Index (SVI) Map

*This map shows social vulnerability by zip code. A darker color on the map indicates greater social vulnerability. More information can be found on the Definitions page.*




### Diabetes Prevalence Map

*This is a heat map that shows the prevalence of diabetes. A darker color shows greater prevalence while a lighter color indicates less prevalence of diabetes.*




### Page Filters

County Name: St Lawrence

Zip Code: (All)

Gender: (All)

Race: (All)

Ethnicity: (All)

Age Groups: 90 and older

Reset Filters

### Map Legends

SVI Scale: 0 – 1

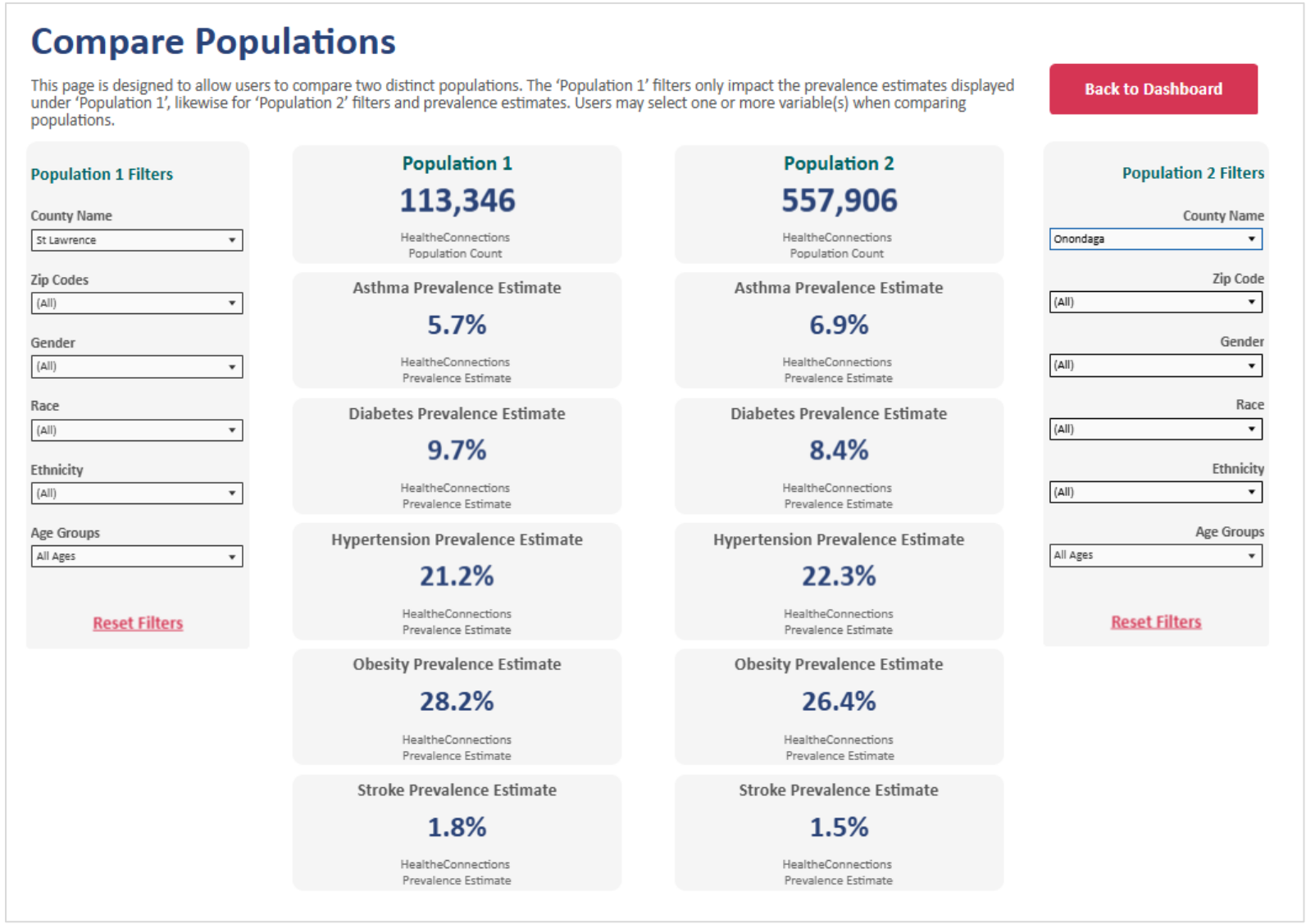
Diabetes Prevalence: 0.0% – 25.0%

### Navigation

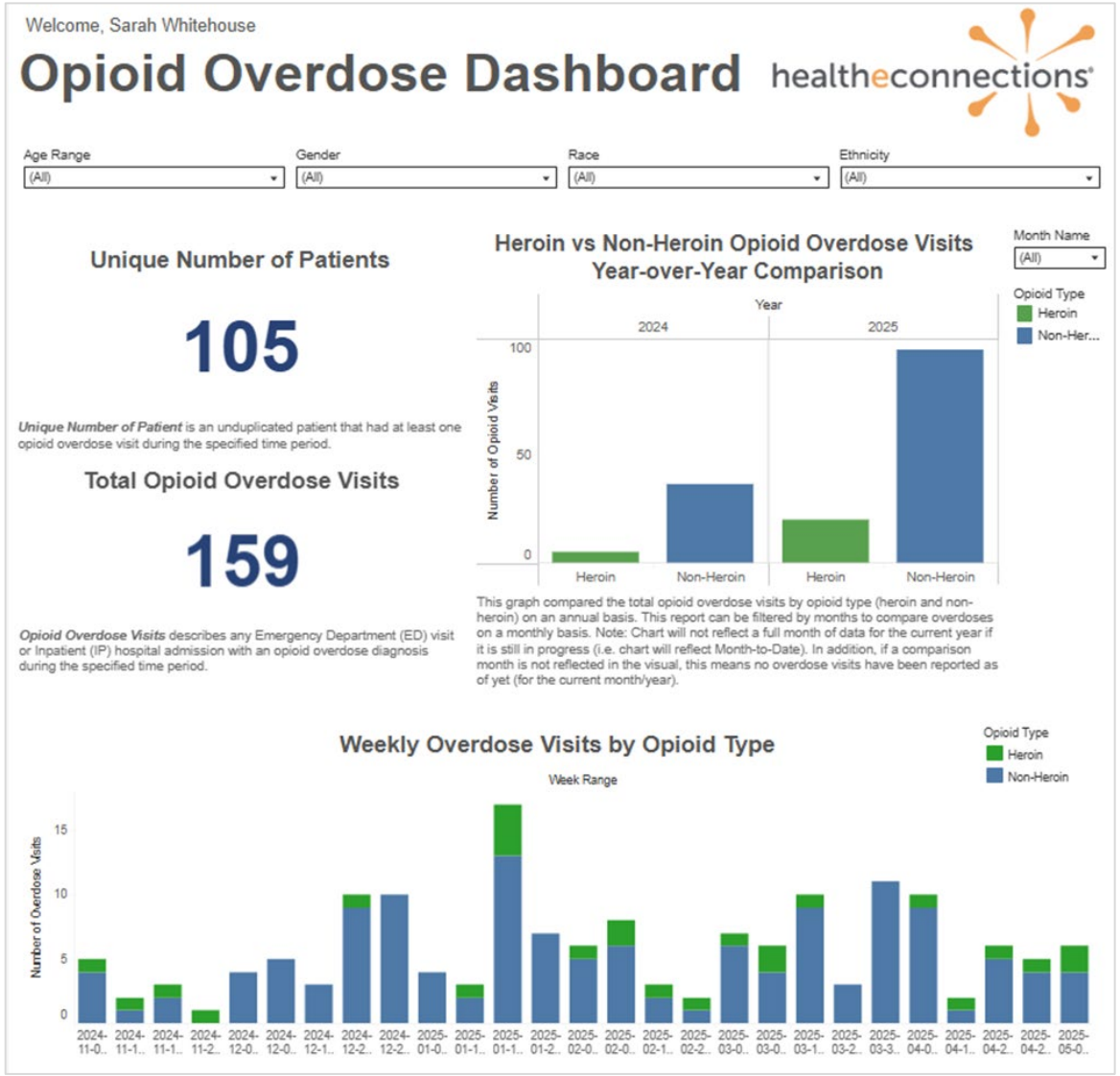
Back to Dashboard

View Data Table

# Community Health Dashboard, continued




**DENISE:** *Compare by ZIP and age and her profile — rural, 58, uncontrolled diabetes and hypertension — stops being an anecdote and becomes a segment you can size and target.*



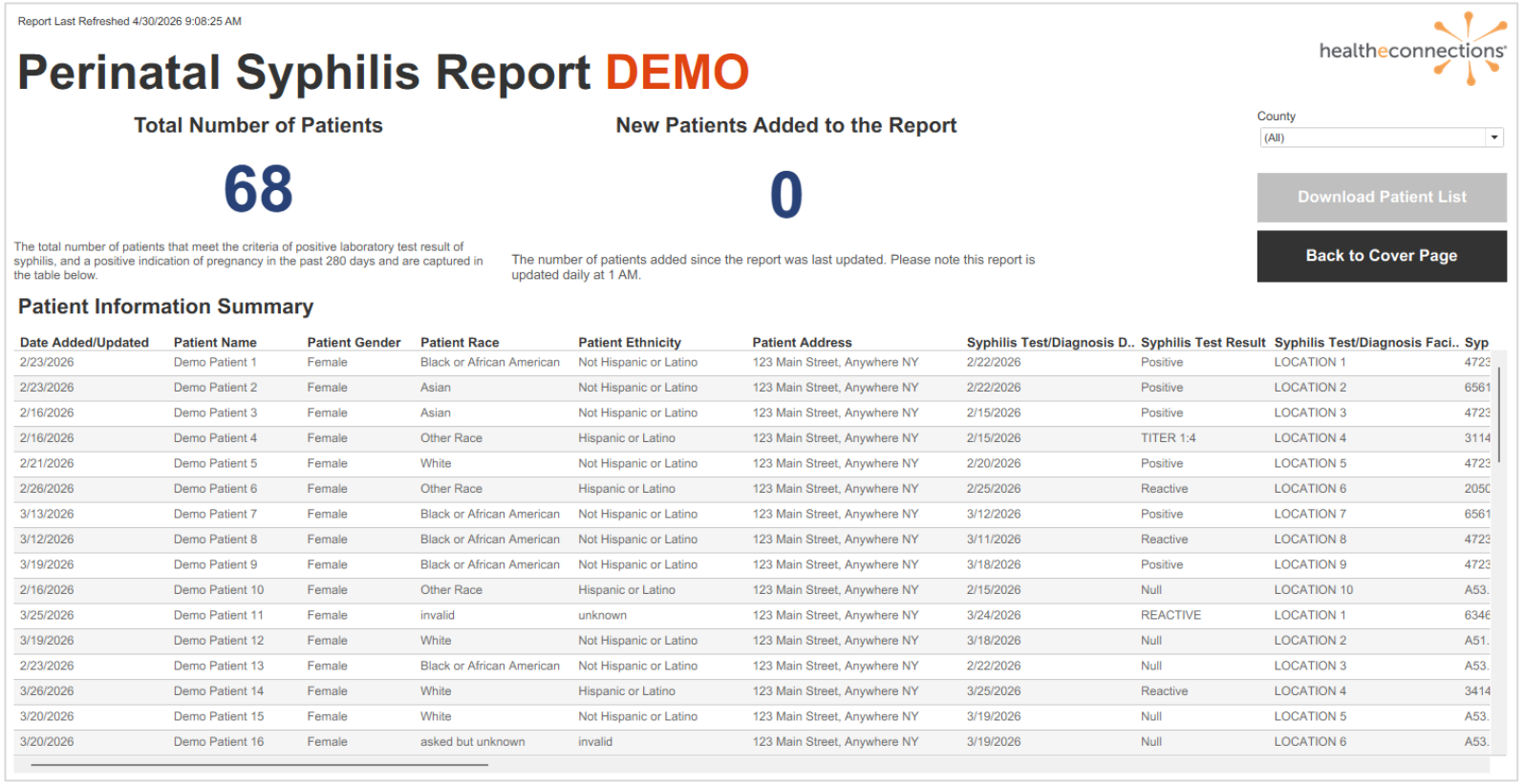

**DENISE:** *Her diabetes diagnosis was a chronic condition. An opioid overdose hospital visit is an acute event. The same visibility, a different crisis.*

# Opioid Overdose Hospital Visit Report

- ✓ Track trends over time
- ✓ Analyze data by demographics and geography
- ✓ Identify potential hotspots and monitor local patterns

# Perinatal Syphilis Report

- ✓ Specific use-case requested by Orange County, since expanded to ~10 LHDs
- ✓ Quickly and easily identify new cases
- ✓ Supports care coordination and follow-up



Report Last Refreshed 4/30/2026 9:08:25 AM

## Perinatal Syphilis Report DEMO

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**Total Number of Patients**

**68**

The total number of patients that meet the criteria of positive laboratory test result of syphilis, and a positive indication of pregnancy in the past 280 days and are captured in the table below.

**New Patients Added to the Report**

**0**

The number of patients added since the report was last updated. Please note this report is updated daily at 1 AM.

County: (All)

Download Patient List

Back to Cover Page

**Patient Information Summary**

| Date Added/Updated | Patient Name | Patient Gender | Patient Race | Patient Ethnicity | Patient Address | Syphilis Test/Diagnosis D.. | Syphilis Test Result | Syphilis Test/Diagnosis Faci.. | Syp |
|---|---|---|---|---|---|---|---|---|---|
| 2/23/2026 | Demo Patient 1 | Female | Black or African American | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 2/22/2026 | Positive | LOCATION 1 | 4723 |
| 2/23/2026 | Demo Patient 2 | Female | Asian | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 2/22/2026 | Positive | LOCATION 2 | 6561 |
| 2/16/2026 | Demo Patient 3 | Female | Asian | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 2/15/2026 | Positive | LOCATION 3 | 4723 |
| 2/16/2026 | Demo Patient 4 | Female | Other Race | Hispanic or Latino | 123 Main Street, Anywhere NY | 2/15/2026 | TITER 1:4 | LOCATION 4 | 3114 |
| 2/21/2026 | Demo Patient 5 | Female | White | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 2/20/2026 | Positive | LOCATION 5 | 4723 |
| 2/26/2026 | Demo Patient 6 | Female | Other Race | Hispanic or Latino | 123 Main Street, Anywhere NY | 2/25/2026 | Reactive | LOCATION 6 | 2050 |
| 3/13/2026 | Demo Patient 7 | Female | Black or African American | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 3/12/2026 | Positive | LOCATION 7 | 6561 |
| 3/12/2026 | Demo Patient 8 | Female | Black or African American | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 3/11/2026 | Reactive | LOCATION 8 | 4723 |
| 3/19/2026 | Demo Patient 9 | Female | Black or African American | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 3/18/2026 | Positive | LOCATION 9 | 4723 |
| 2/16/2026 | Demo Patient 10 | Female | Other Race | Hispanic or Latino | 123 Main Street, Anywhere NY | 2/15/2026 | Null | LOCATION 10 | A53. |
| 3/25/2026 | Demo Patient 11 | Female | invalid | unknown | 123 Main Street, Anywhere NY | 3/24/2026 | REACTIVE | LOCATION 1 | 6346 |
| 3/19/2026 | Demo Patient 12 | Female | White | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 3/18/2026 | Null | LOCATION 2 | A51. |
| 2/23/2026 | Demo Patient 13 | Female | Black or African American | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 2/22/2026 | Null | LOCATION 3 | A53. |
| 3/26/2026 | Demo Patient 14 | Female | White | Hispanic or Latino | 123 Main Street, Anywhere NY | 3/25/2026 | Reactive | LOCATION 4 | 3414 |
| 3/20/2026 | Demo Patient 15 | Female | White | Not Hispanic or Latino | 123 Main Street, Anywhere NY | 3/19/2026 | Null | LOCATION 5 | A53. |
| 3/20/2026 | Demo Patient 16 | Female | asked but unknown | invalid | 123 Main Street, Anywhere NY | 3/19/2026 | Null | LOCATION 6 | A53. |

**DENISE:** *Orange County asked what their version of this looked like. Every county has a different Denise.*

**DENISE:** *Denise's daughter just had her first baby. This pilot alerts her county health department so that they can conduct outreach and provide timely services to our new mom.*

# Reaching New Mothers Within Days, Piloting Public Health Alerts

**Statewide Reach** → Real time birth-related hospital alerts for county residents

**Named, Not Estimated** → Actual new mothers to reach, not a monthly count

**Twice Weekly** → Outreach before a post-partum visit, not after

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# The Pharmacy is Part of the Care Team

**Partnership** → Pilot with the Community Pharmacy Enhanced Service Network (CPESN)

**Trigger** → Pharmacies are in real-time when a patient is newly diagnosed with diabetes

**Action** → Pharmacists delivery diabetes education at the point of care

**DENISE:** *She had no consistent PCP — but she had a pharmacy. A new diabetes diagnosis caught at the counter, where she shows up.*

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# From Guesswork to Timely Data

- Planning on current, county-specific numbers — this quarter, not a three-year-old survey
- A burden you can finally put a number on — and put in the grant application
- Answers in minutes, without adding a single staff hour
- Investigations that move the same day, not after days of records requests

## What Our Partners Are Saying

*Public health professionals describe the Community Health Dashboard as a "huge asset" with "especially useful" geographic and demographic insights for planning and decision-making.*

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# *Leveraging HIE Data for those Closest to Patients*

# Closest to Residents, Furthest from the Data that Matters

- Hospitalizations learned weeks late
- Duplicated outreach across organizations
- Impact hard to prove to funders
- Every grant its own form, its own silo

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# Statewide Encounter Alerts, powered by HealtheConnections

**HealtheConnections was awarded a contract to launch a new statewide alerting service, featuring:**

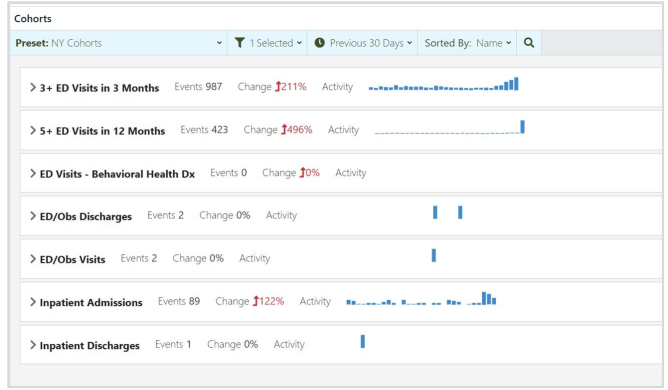
- ✓ **Consistent, Statewide Coverage**
  Complete real-time alerts from ***all*** hospitals across NYS, regardless of QE region. Alerts sent for ***Inpatient and Emergency Department admissions, discharges, and transfers.***

- ✓ **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.

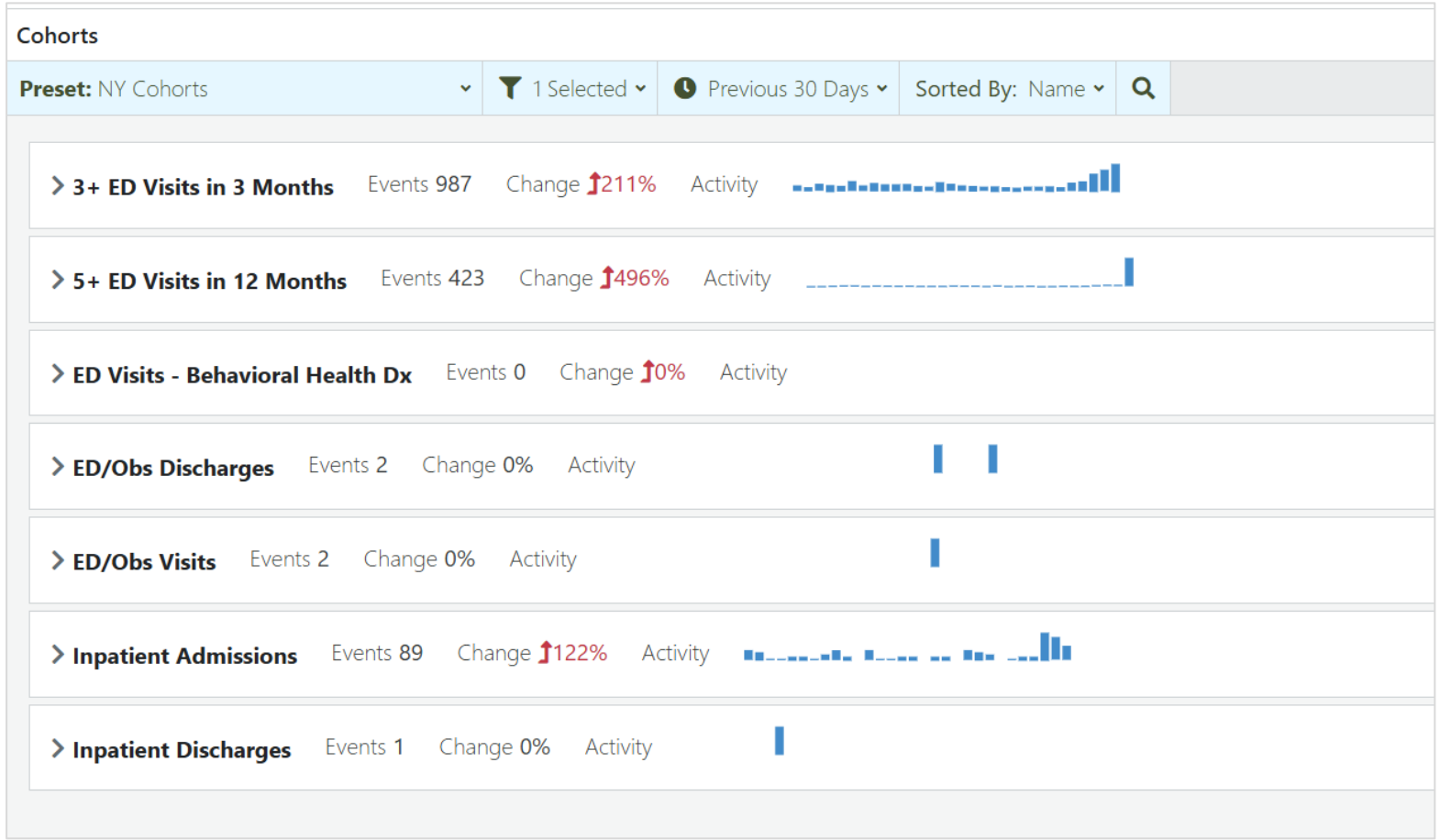
**Since launch in late 2025, 2.4K users across 285+ organizations have adopted the service, supporting 12M+ empaneled patients.**

SHIN·NY
STATEWIDE ENCOUNTER ALERTS
powered by healtheconnections



Healtheconnections.org/alerts

# Finding Denise Before Her Next Admission

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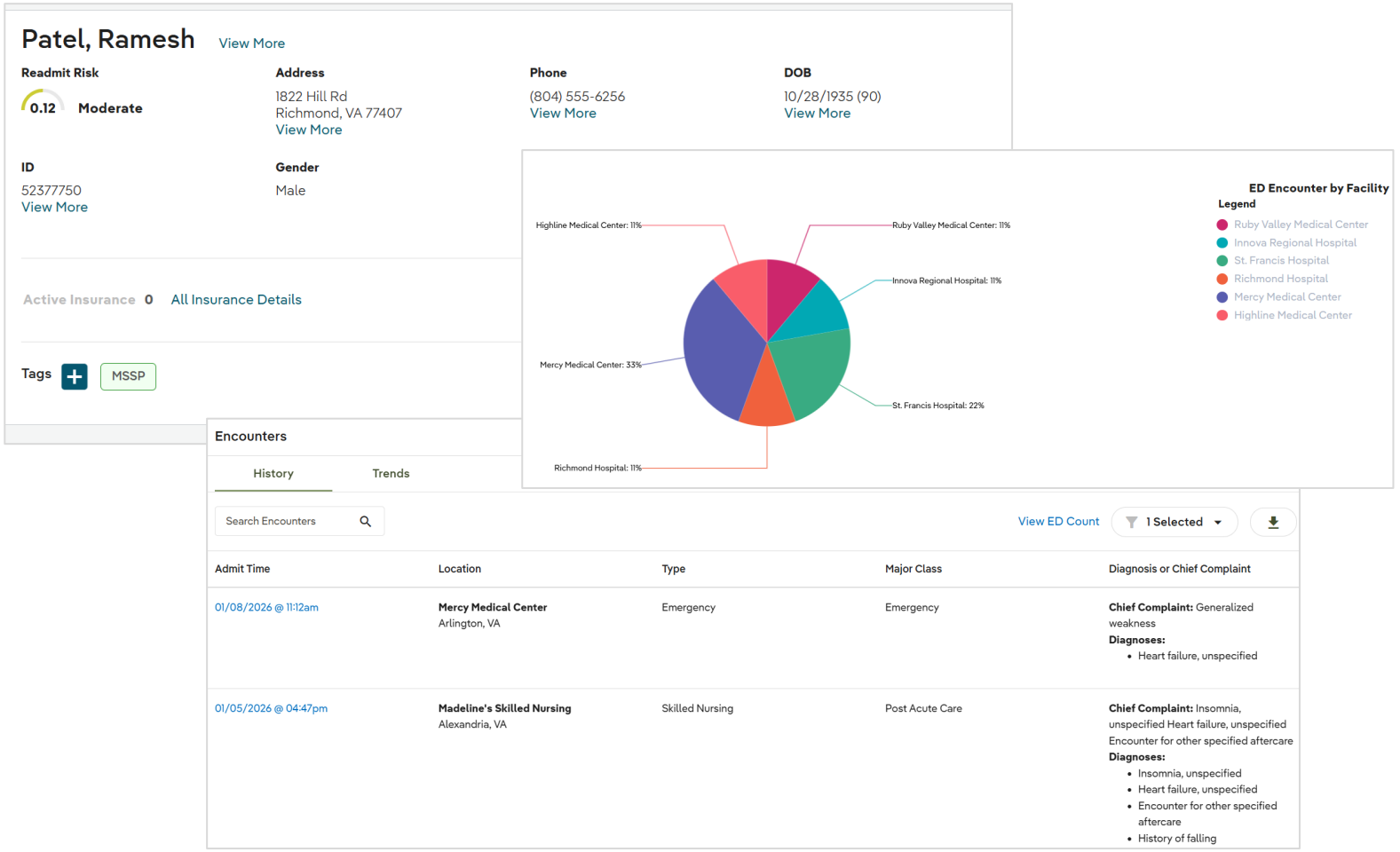
## Populations of Interest Stratification

- ✓ Denise surfaces in a cohort of uncontrolled diabetes patients with 2+ ED visits
- ✓ Build cohorts on your own criteria: diagnosis, utilization, geography, program
- ✓ Custom filters and downloads for outreach lists, reporting, and analytics

# Reaching Denise on the First Try

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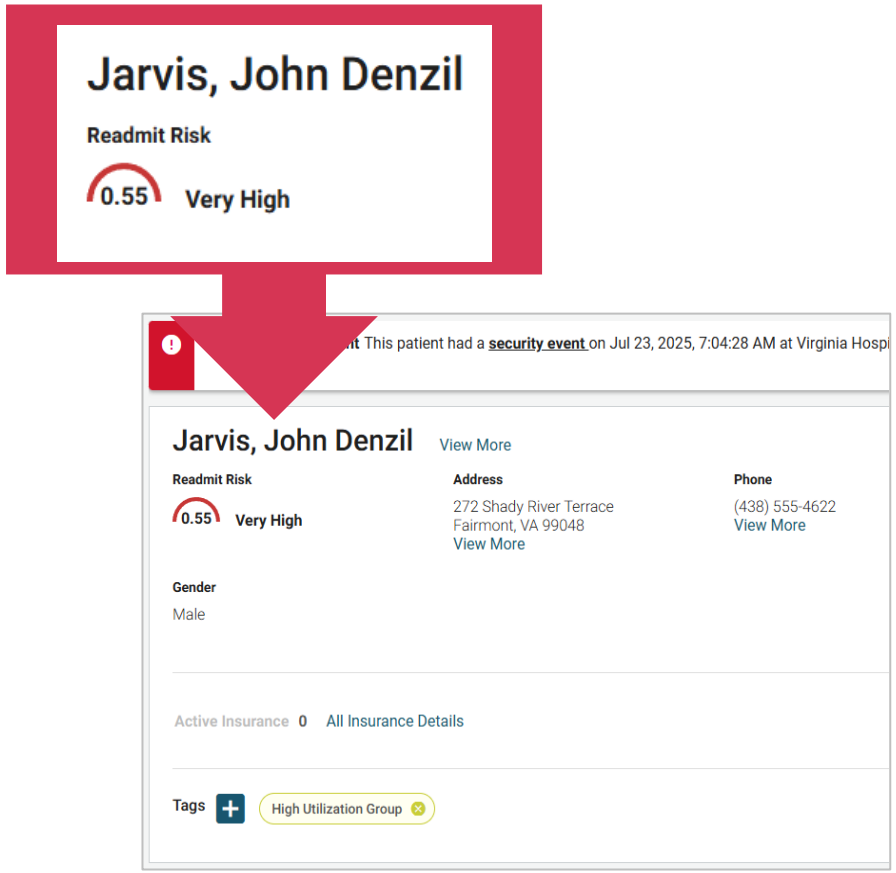
## The Right Contact Info, at the Right Time

- ✓ Her current phone and address, refreshed from every hospital statewide
- ✓ Custom tags group her by program, diagnosis, or care team
- ✓ Encounter history and trends: two urgent care visits, one ED trip, one admission in 14 months

# Knowing Denise Is Likely to Return




## Powered by Data

- ✓ Trained on 18.3M+ encounters, historical plus real-time

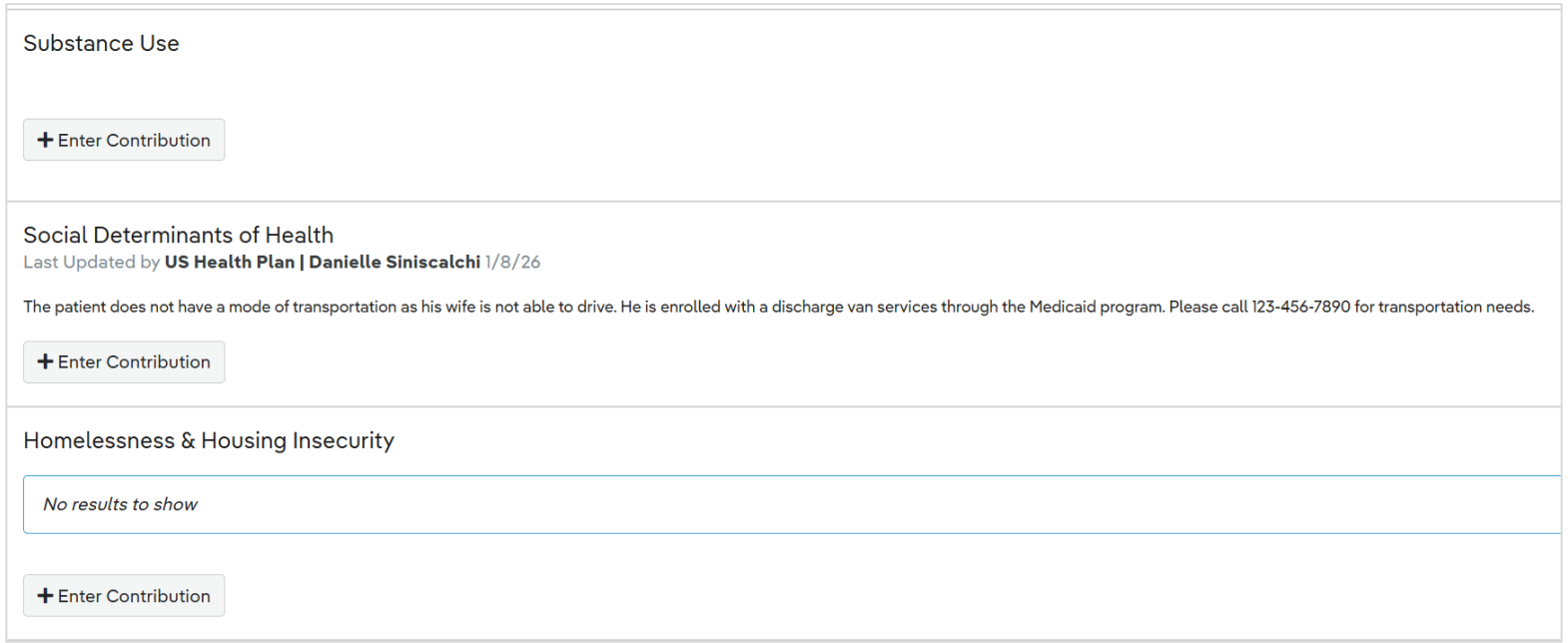
## Rich Inputs

- ✓ Demographics, diagnosis codes, visit history, hospital quality scores
- ✓ SDOH factors - Denise's transportation, food, and financial strain all count

## Dynamic Risk Score

- ✓ Continuously updated; outperforms the standard LACE model
- ✓ Care managers work the top of the list, not the whole panel

# One Care Team Around Denise




## Collaborate Across Care Settings

- ✓ Her CBO care manager, PCP, and hospital see the same care team and insights
- ✓ Transportation and food needs travel with her– no one re-screens from scratch
- ✓ Accessible to all organizations with portal access

# The Alert Reaches Her Team in Minutes

- Direct feeds and integrations with leading EHRs
- Notices sent via Secure Message, email, or text
- sFTP file access and portal access
- Denise's admission notifies her care manager the same day, not weeks later
- **Combine delivery options to fit your needs!**

nextgen healthcare
Epic
MEDENT
MEDITECH
Allscripts
MatrixCare by ResMed
PointClickCare
eClinicalWorks
ORACLE Cerner
And more!
CureMD

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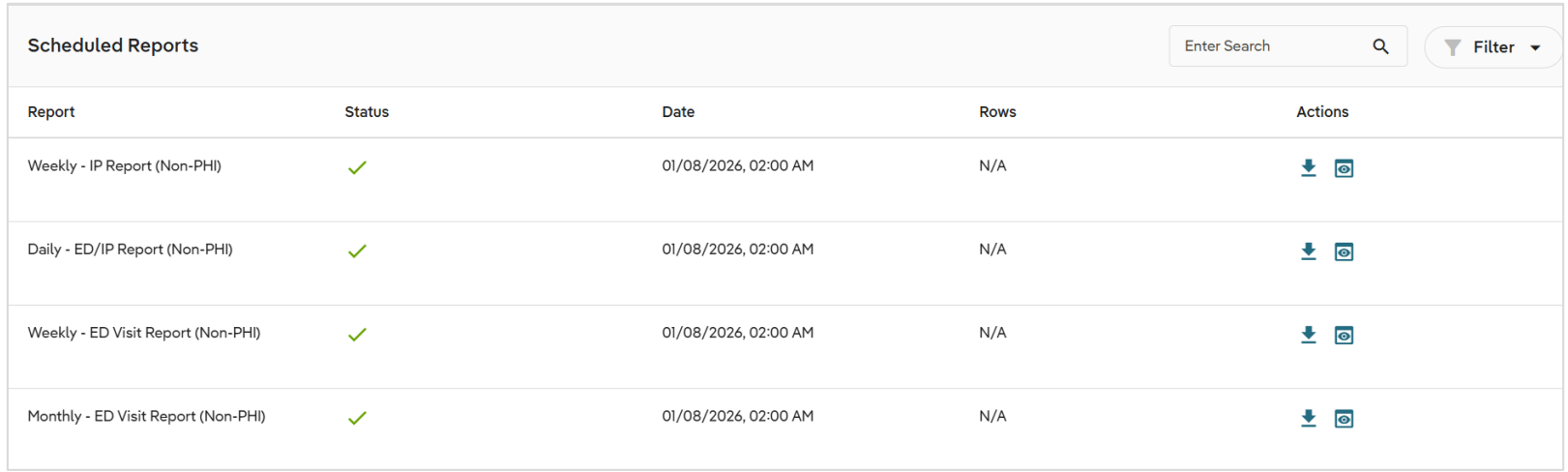
# Proving the Follow-Up Happened




| | A | B | C | D | E | F | G | H | I | J | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 insufficier |
| 4 | Grimmett | Benjamin | 5685242 | (206)335-1244 | Jenifer 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 | Jenifer 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

- ✓ Schedule PDF or CSV reports – hourly, daily, weekly, or monthly
- ✓ Choose fields, filters, and frequency to fit your workflow and QI requirements
- ✓ Include risk scores, diagnosis codes, descriptions, and more
- ✓ Track how many patients, like Denise, were reached

# Data That Reaches the Front Line

- ✓ Alerts trigger action in minutes, not weeks
- ✓ Patient Lookup answers the question on the spot
- ✓ Dashboards and reports prove program impact
- ✓ Complete care team, secure messaging, and more

## What Our Partners Are Saying

*"We received a real-time alert that a client was in the emergency room. As a result, our team was able to reach out and provide a medically tailored food box within two days to support recovery."*

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# One Patient, One Source, Real Rural Impact

| Who | What They Needed | What We Provided | Why It Matters in a Rural Setting |
|---|---|---|---|
| Her Care Team | Full record at the point of care | Patient Lookup, Results, Images | Faster chart completion, streamlined ROI, fewer duplicate records |
| Her County | How many residents look like Denise | Dashboards, Prevalence, Trends | Regulatory and quality reporting for CAHs, RHCs, and FQHCs |
| Her Community | Admission, discharge and transfer notices | Statewide Encounter Alerts | Value-based care, coding accuracy, stronger data governance |

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# We’re Here to Help!

# Let’s Find Your Starting Point

**New to HealtheConnections?**
Email us at support@healtheconnections.org and we’ll walk you through connecting your organization. Explore healtheconnections.org for a full look at our HIE services.

**Already connected with us?**
Sign Up to become an Authorized User and start using the portal right away.
Visit the Resource Center for trainings, user guides, and on-demand demos.

**Interested in Statewide Encounter Alerts?**
Contact us to bring real-time, statewide admission, discharge and transfer alerts to your team—no matter which QE you work with.

**Not sure where to start?**
Tell us what you’re trying to solve, and we’ll show you which piece of the HIE gets you there.

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# Questions?

# Thank You for Attending!


healtheconnections.org

support@healtheconnections.org

315-671-2241 x5