From Risk to Reward: Navigating the High-Risk Journey with Hixny

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Hixny®

Achieving Success With Value Based Payment Models

Bridging the Gap Between Complex Care & Financial Performance

5%

of complex, multi-morbid patients drive over 50% of total healthcare expenditures in New York State

The ultimate test of financial viability and sustainability of healthcare resources is managing the critical 5%.

- **The Financial Risk:** Under downside-risk contracts, unstructured data and blind spots lead directly to missed shared savings and severe financial penalties.
- **The Clinical Blindspot:** Traditional EHRs stop at the practice wall. Providers remain blind to out-of-network 911 calls, rural ED visits, and behavioral health crises until it is too late.
- **The Hixny Difference:** Success requires transforming fragmented regional data into real-time, actionable insights directly at the point of care.

Patient Profile

MEET JAMES “JIM” O’ROURKE

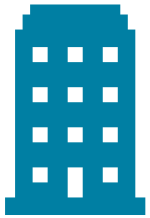
Patient Overview

78-year-old Male

Established patient of **Adirondack Valley Health Center**.

Insured by **CareBridge** (Medicaid Managed Care plan).

Frequent shortness of breath episodes leading to high panic, which **often trigger emergency 911 calls**.



Living Situation

Lives alone in a remote cabin near Inlet, NY (Adirondack Park).

Estranged family; local volunteer checks in weekly by phone.

No reliable vehicle; local volunteer drivers cannot navigate heavy winter snowstorms.

Nearest grocery and pharmacy are 35 miles away.

Relies on shelf-stable pantry boxes delivered monthly; fresh food is scarce.

Wood-stove heated home with poor indoor air quality that triggers his COPD flare-ups.

Chronic Conditions

Stage 3 Chronic Kidney Disease

Congestive Heart Failure (CHF)

Chronic Obstructive Pulmonary Disease (COPD) on home oxygen

Major Depressive Disorder

Heightened medical anxiety, worsened by severe seasonal isolation

Polypharmacy

ACE inhibitor (Lisinopril)

SGLT2 Inhibitor (Dapagliflozin)

Complement-Directed Therapy (Eculizumab)

Combination Therapy / Long-Acting Muscarinic Antagonists (Tiotropium) and Long-Acting Beta-2 Agonists (Salmeterol) w/ Inhaled Corticosteroids

As-Needed Rescue Inhaler (Albuterol)

Selective Serotonin Reuptake Inhibitor (Sertraline)

UNLOCKING VBP VALUE: DRIVING PRACTICE REVENUE WITH HIXNY DATA

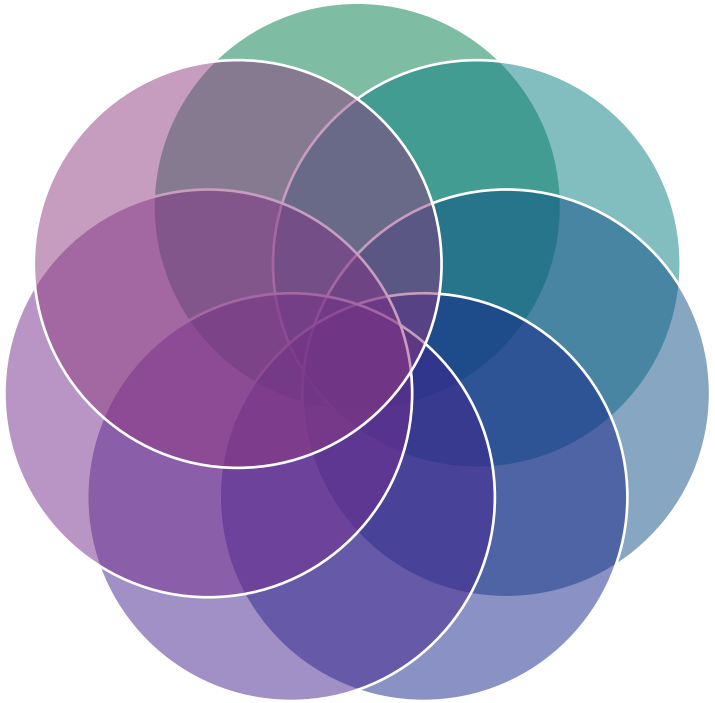
Total Potential Earnings

$ 20,338

Transitional Care Management Visit = $ 288

Readmission Avoided = $ 15,000

COPD Post Discharge F/U 14 Days = $ 250



HTN Control = $ 150

Intubation Avoided = $ 1,500

Stage 3 CDK eCFR & uACR Screen = $ 150

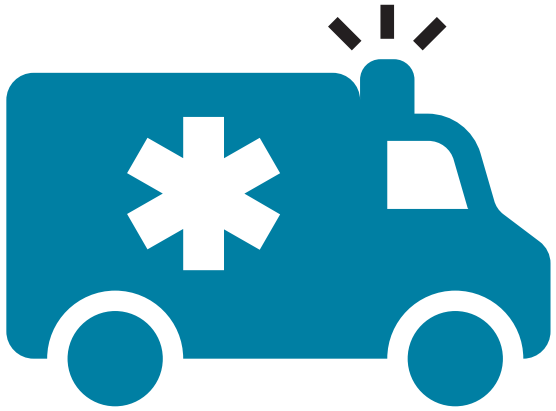
ED Visit Avoided = $ 3,000

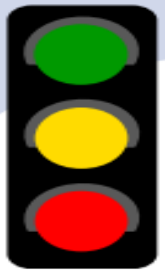
Triggering Event

COPD EXACERBATION SIGNS AND SYMPTOMS

Jim woke in the night **struggling to breathe** and was having **chest** pain with an **irregular heartbeat**. He noticed a **blue tinge** to his **nails**.

He was able to call 9-1-1.





Zone Tool
COPD

Every Day:

- ✓ Take your medicine as ordered.
- ✓ Check for any swelling in feet, ankles or legs.
- ✓ Eat low-salt/low-sodium foods.
- ✓ Balance activity and rest periods.
- ✓ Avoid smoking and secondhand smoke.

All Clear Zone ... *This is the safety zone if you have:*

- No shortness of breath
- No weight gain more than two pounds (weight may change one or two pounds some days)
- No swelling of your feet, ankles, legs or stomach
- No chest pain

Warning Zone ... *Call your doctor if you have:*

- Phlegm that increases in amount or changes in color or becomes thicker than usual
- Increased cough or wheezing
- Swelling of ankles or feet
- Shortness of breath with activity
- Weight loss or gain of three pounds in one day
- Fever of 100.5 F oral or 99.5 F under the arm
- Increased number of pillows needed to sleep or need to sleep in chair
- Anything else unusual that you assess or the resident mentions
- Symptoms that may indicate an adjustment in medication or oxygen therapy is needed

Medical Alert Zone ... *Go to the Emergency Room or call 911 if you have:*

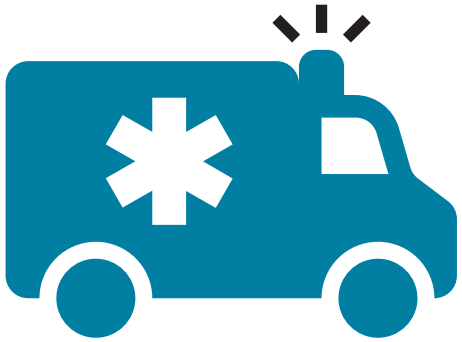
- Unrelieved shortness of breath
- Unrelieved chest pain
- Increased or irregular heart beat
- Change in color of your skin, nail beds or lips to gray or blue

This material from the NC Program on Health Literacy was adapted by GMCF for Alliant Quality and updated by the TMF Quality Innovation Network Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-QINQIO-C3-16-35

Quality Improvement Organizations

TMF Quality Innovation Network

EMERGENCY

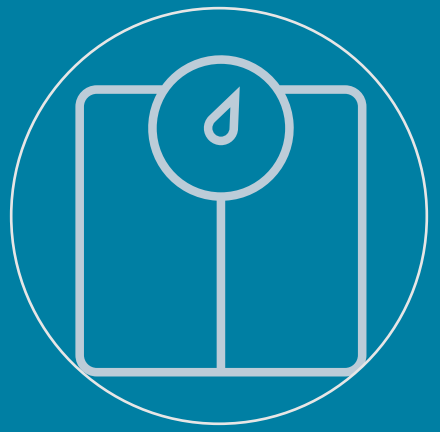


EMS treated Jim enroute to **High Peaks Medical Centers**'s emergency department, where he was admitted with a chief complaint of shortness of breath.

After assessment in the ED, Arthur was admitted to **High Peaks Medical Center**'s step down/pulmonary inpatient unit with a diagnosis of Acute exacerbation of COPD triggered by an underlying respiratory infection (unspecified pneumonia)

*Jim remained in the hospital for **10 days** and was then discharged home.*

DISCHARGE PLAN FOR JIM FROM HIGH PEAKS MEDICAL CENTER



Monitoring

- Weigh daily in the morning
- Contact your PCP if you gain > 2 pounds a day or >5 pounds in a week
- Report increased shortness of breath, dizziness, waking up at night to breathe, or swelling in legs/ankles.

Medication

- Antibiotics: complete remaining course.
- Diuretics: Take as prescribed, typically in the morning, to remove excess fluid.
- Heart Failure Medications: Continue adjusted therapy for ACE inhibitors, ARBs..

Lifestyle

- Limit sodium intake to 1,500–2,000 milligrams per day to prevent fluid retention.
- Limit fluid intake to 6-9 cups (1.5-2 liters) per day if recommended by your physician.
- CKD Monitoring; limit potassium, phosphorus and dietary protein.

Follow Up

- Home care and physical therapy ordered.
- Ensure a follow-up visit primary care provider (PCP) within 1–2 weeks of discharge.
- PCP to coordinate follow up with Pulmonology and Cardiology as needed.
- Labs: serum creatinine, blood urea nitrogen (BUN) & electrolyte panel.

Seek immediate care if you experience: severe shortness of breath, chest pain, fever > 100.4, swelling that does not improve with rest and/or new confusion or reduced alertness.

Transitional Care Management

Patient Panel Sync's Automatically with EHR

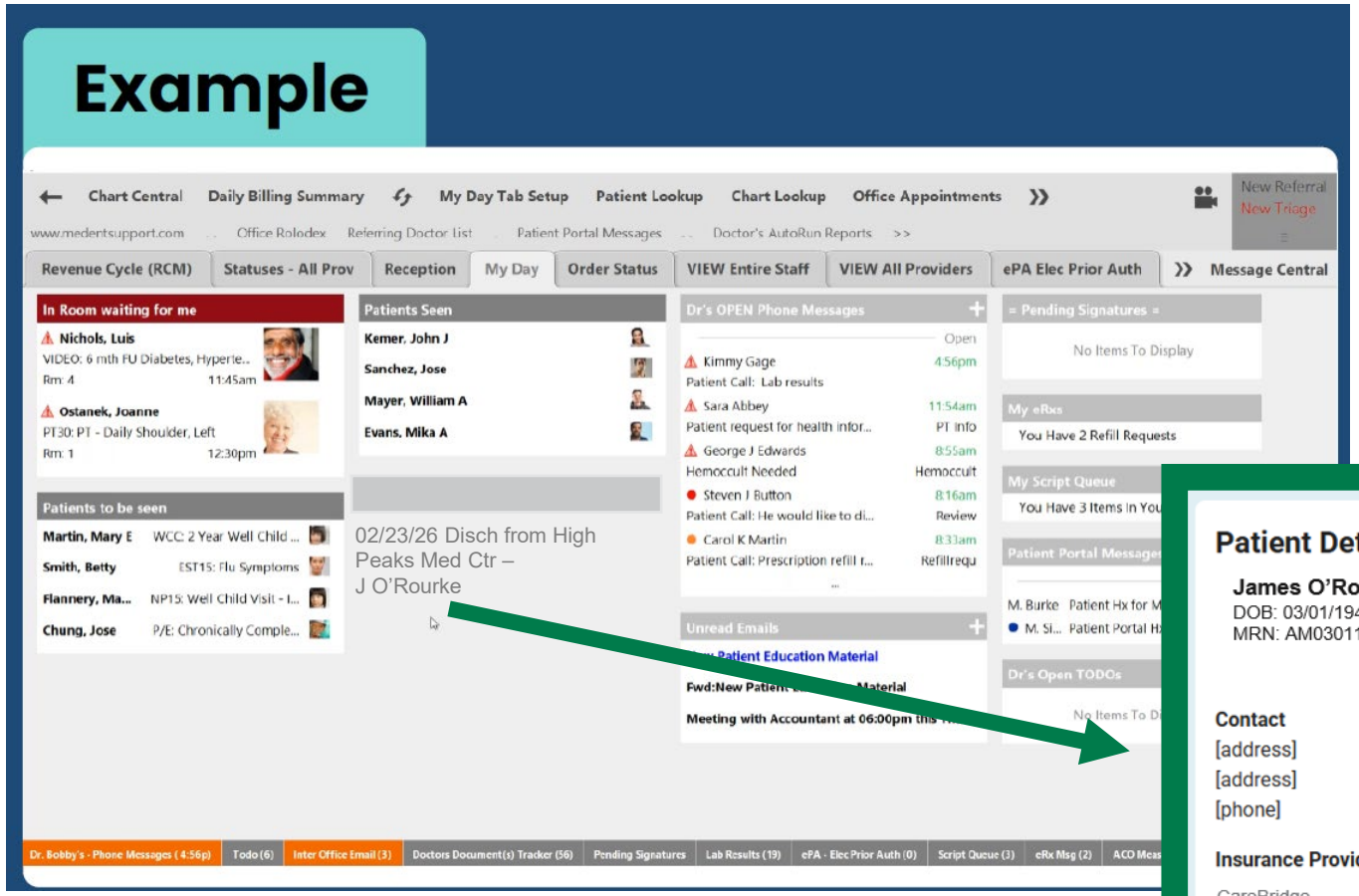
File Date	Assigning Authority Code	Facility MRN	First Name	Middle Name	Last Name	Patient Gender	Patient Address Line 1	Patient Address Line 2	Patient City	Patient State	Zip Code	Patient Home Phone Number	Patient DOB
20251204	AKDVLYHC	M0438956	John		Smith	M	65 Chill St		Old Forge	NY	13420	(518) 478-1111	19741229
20251204	AKDVLYHC	M0002345	Amy	Marie	Jones	F	12 Arrowhead Blvd		Big Moose	NY	13331	(518) 356-2245	19640101
20251204	AKDVLYHC	M1213338	James		O'Rourke	F	82 Lost Pond Way		Inlet	NY	13360	(518) 410-1112	19340722
20251204	AKDVLYHC	M8978971	Robert	John	Williams	M	78 Williams Dr		Thendara	NY	13472	(518) 632-9999	19970421
20251204	AKDVLYHC	M3339875	David	W	Jacobson	M	1400 Mountain View	Apt 2300	Glens Falls	NY	12801	(518) 383-4242	19801231

Roster-based alerts ensure your practice received alerts only for active patients – ensuring each alert is **meaningful** and **actionable**. With Medent's auto roster functionality, there is no reporting burden – **saving time** that is better spent managing care patients' care!

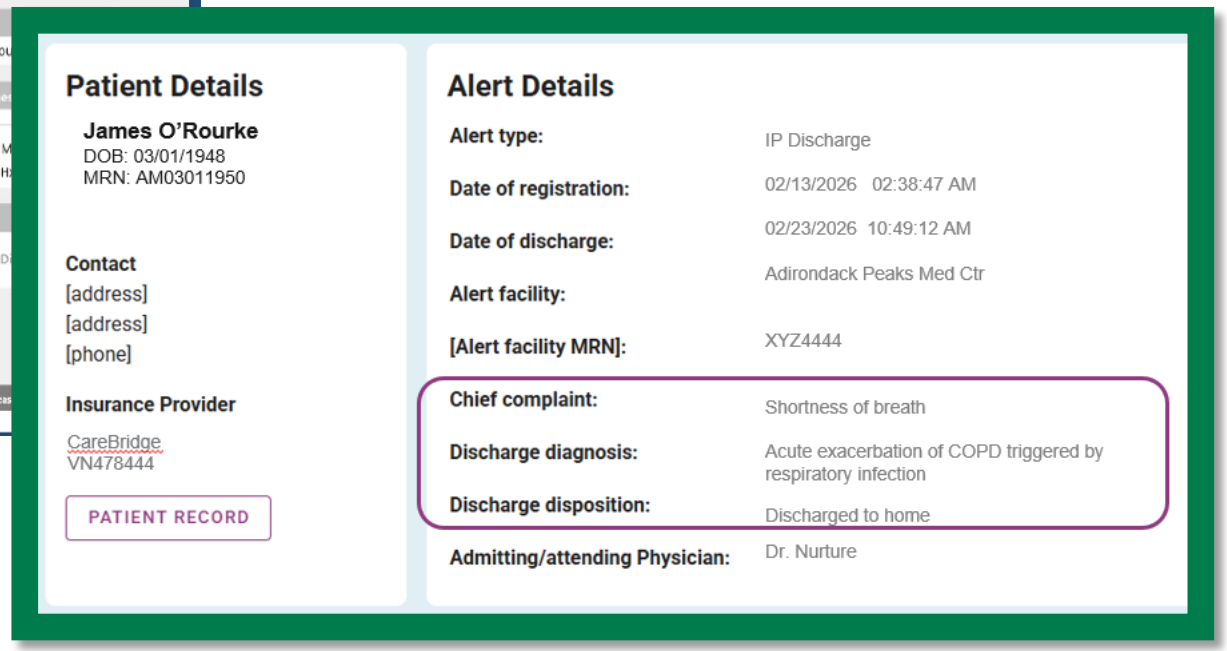
Facility MRN	First Name	Middle Name	Last Name	Patient Gender	Patient Address Line 1	Patient Address Line 2	Patient City	Patient State	Zip Code	Patient Home Phone Number	Patient DOB
M0438956	John		Smith	M	65 Chill St		Old Forge	NY	13420	(518) 478-1111	19741229
M0002345	Amy	Marie	Jones	F	12 Arrowhead Blvd		Big Moose	NY	13331	(518) 356-2245	19640101
M1213338	James		O'Rourke	F	82 Lost Pond Way		Inlet	NY	13360	(518) 410-1112	19340722
M8978971	Robert	John	Williams	M	78 Williams Dr		Thendara	NY	13472	(518) 632-9999	19970421
M3339875	David	W	Jacobson	M	1400 Mountain View	Apt 2300	Glens Falls	NY	12801	(518) 383-4242	19801231

medent

Receive ADTs Within Your EHR Workflow



Value = TCM timeclock starts the minute your patient walks out the hospital doors.



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

10% rate increase for 2026!

CPT Code 99496

Loc 99 Medicare reimbursement: $288.02

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

HOW JIM QUALIFIES FOR TCM

Jim fits the profile of a high-risk patient needing structured support to avoid re-hospitalization.

High-Risk Factors

- Age >70, multiple comorbid-ities, depressive disorder and medical anxiety, and living alone. Complicated by HRSNs.

Polypharmacy

- Discharged with new medication regimens (new antibiotic, changes to ARBs) and add'l monitoring for CKD impact.

Moderate/High Complexity

- Condition requires complex medical decision-making to manage medication titration, daily weights, and sodium intake.

Need for Education

- Needs extensive education on recognizing signs of COPD exacerba-tion.

Value = $ 288.02 for TCM visit plus $ 250 COPD P4P incentive

TCM SERVICES IMPLEMENTED FOR JIM (30-DAY PERIOD)

Upon discharge, the primary care team at Adirondack Valley Health Center initiates the following:

Contact Within 2 Business Days

A care coordinator calls Jim to review discharge instructions, ensure he has filled his new prescriptions, and schedules TCM appointment. Confirms he has transportation to the TCM visit at Adirondack Valley Health Center.

Face-to-Face Visit (Within 7–14 Days)

A TCM visit is scheduled within 7 days (99496) to conduct medication reconciliation, check vital signs, and assess his weight/fluid status, and ensure CKD monitoring.

Coordination of Care

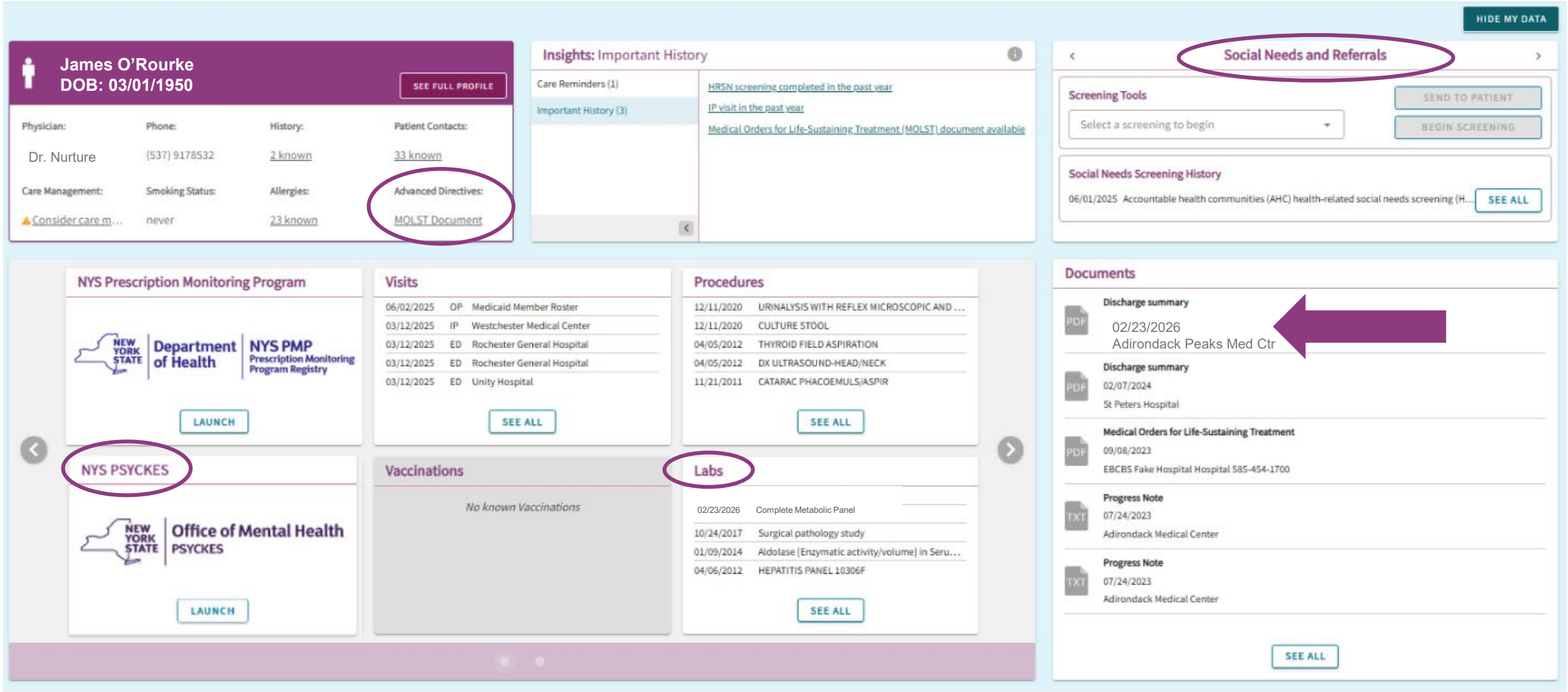
The primary care team coordinates with his home health agency for nursing visits and sets up oxygen therapy.

Non-Face-to-Face Services

Ongoing monitoring of his weight log, calls to the pharmacy for medication issues, and review of his self-care regimen.

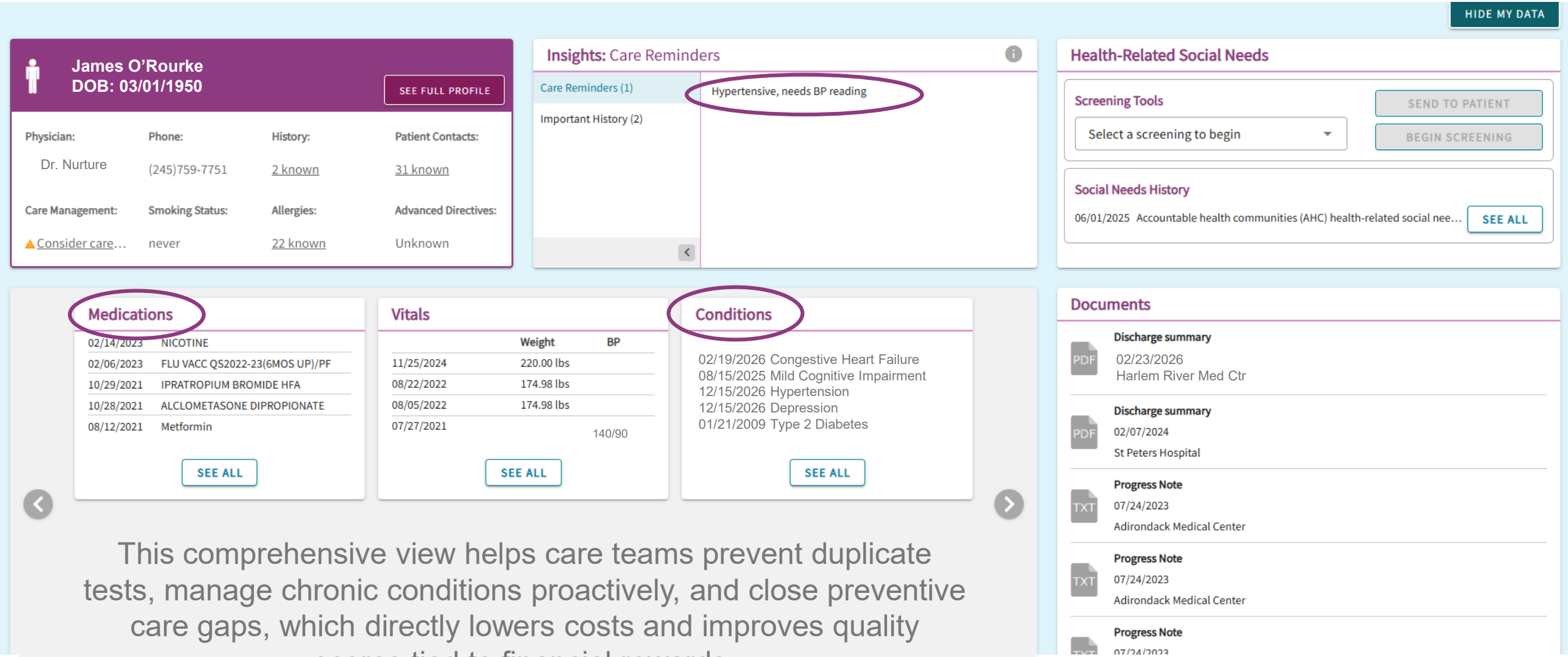
Patient Record Snapshot

HIXNY'S SNAPSHOT FOR COMMUNITY HEALTH RECORDS (W/ PATIENT CONSENT)



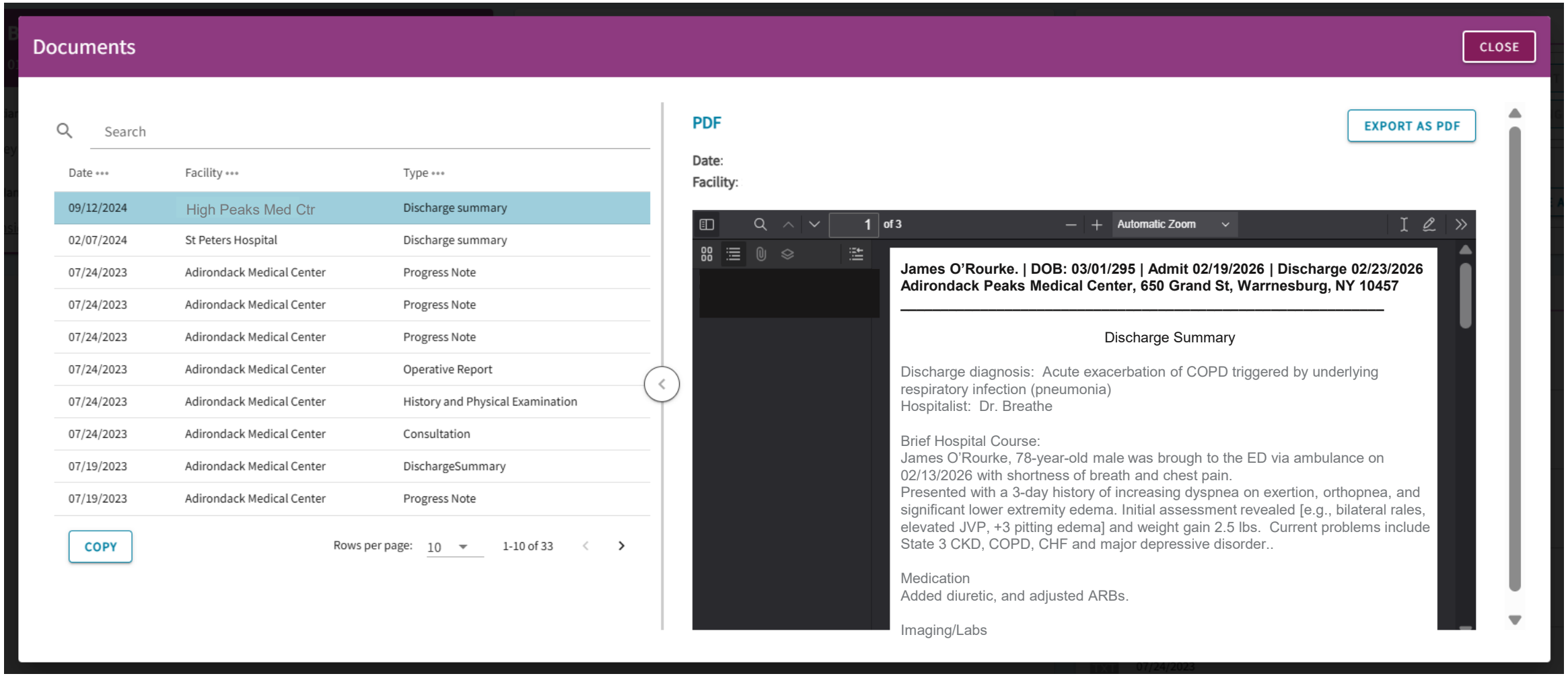
Viewing a patient's entire community health record supports value-based payment by connecting fragmented data across providers.

HIXNY'S SNAPSHOT FOR COMMUNITY HEALTH RECORDS (W/ PATIENT CONSENT)

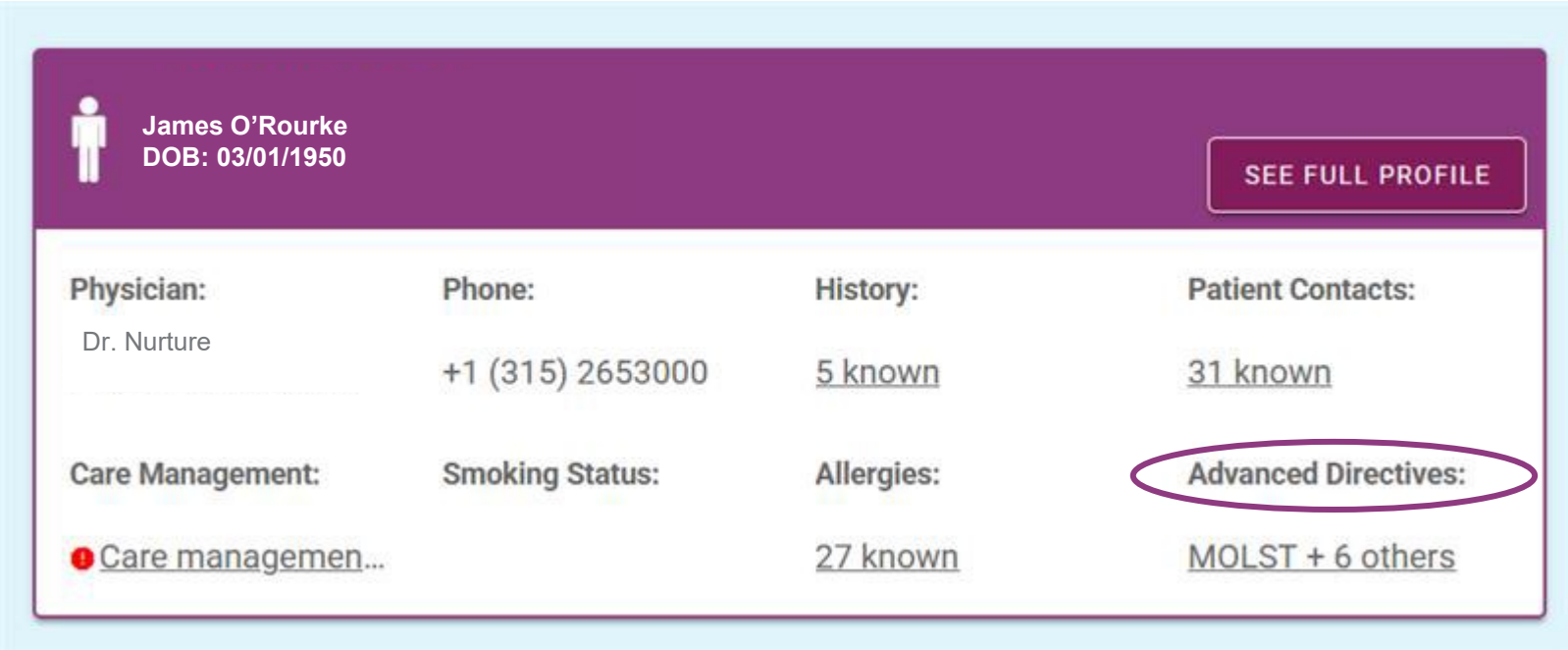


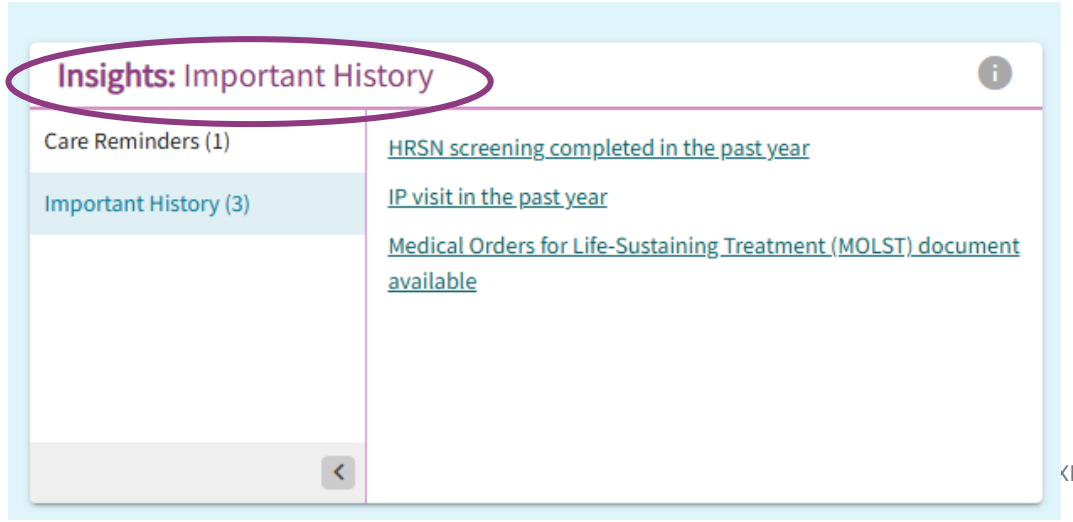
This comprehensive view helps care teams prevent duplicate tests, manage chronic conditions proactively, and close preventive care gaps, which directly lowers costs and improves quality scores tied to financial rewards.

PATIENT RECORD SNAPSHOT – DISCHARGE SUMMARY



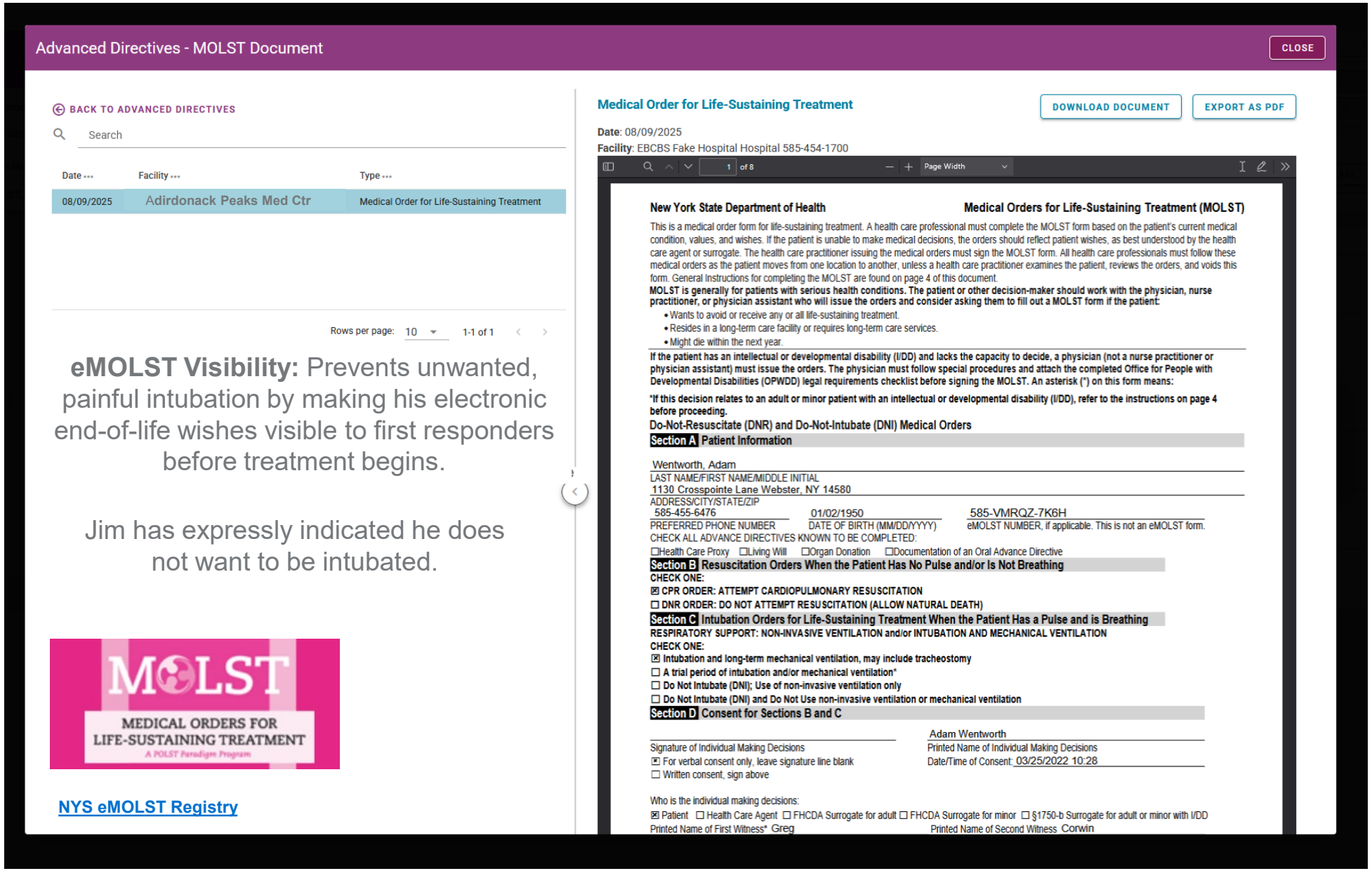
PATIENT RECORD SNAPSHOT – ADVANCED DIRECTIVES / IMPORTANT HISTORY



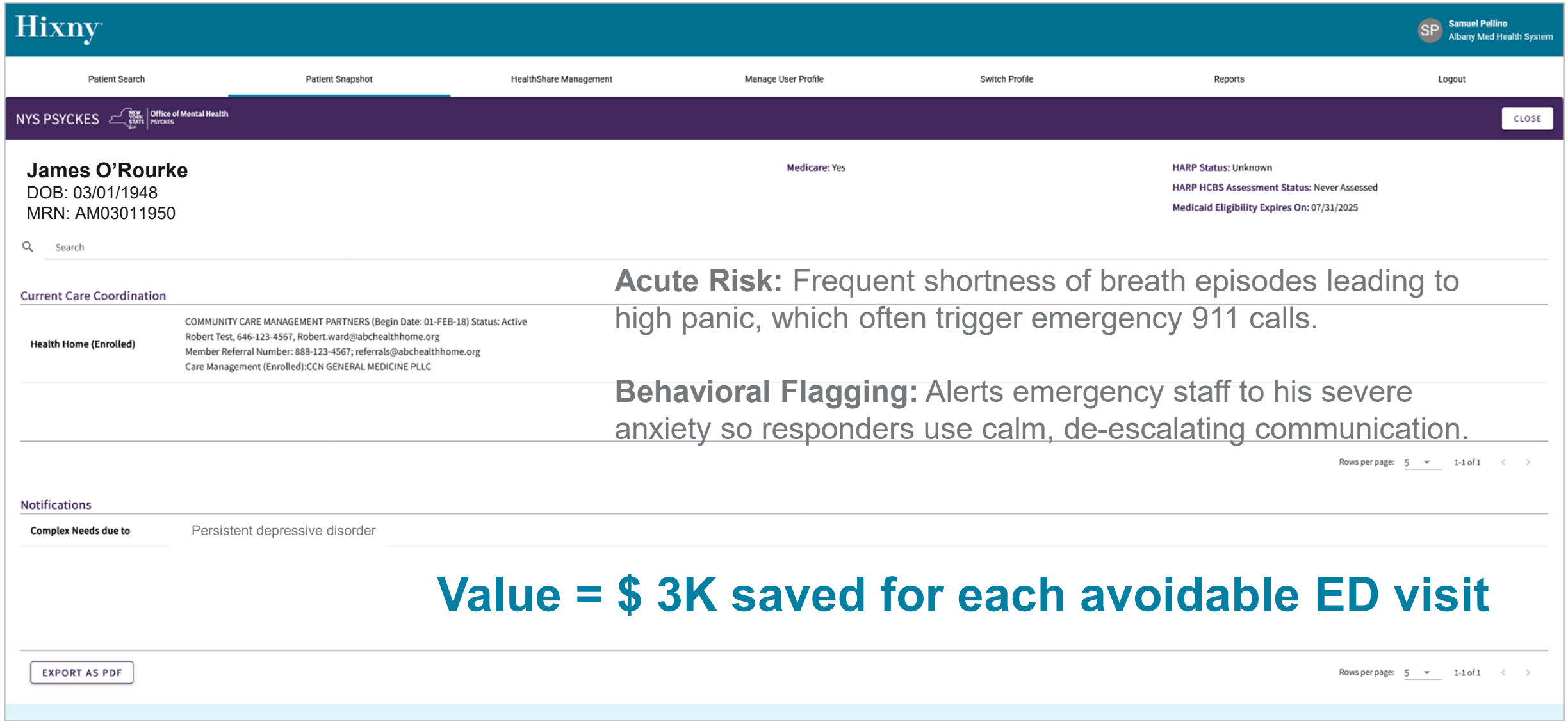


PATIENT RECORD SNAPSHOT – MOLST FORM

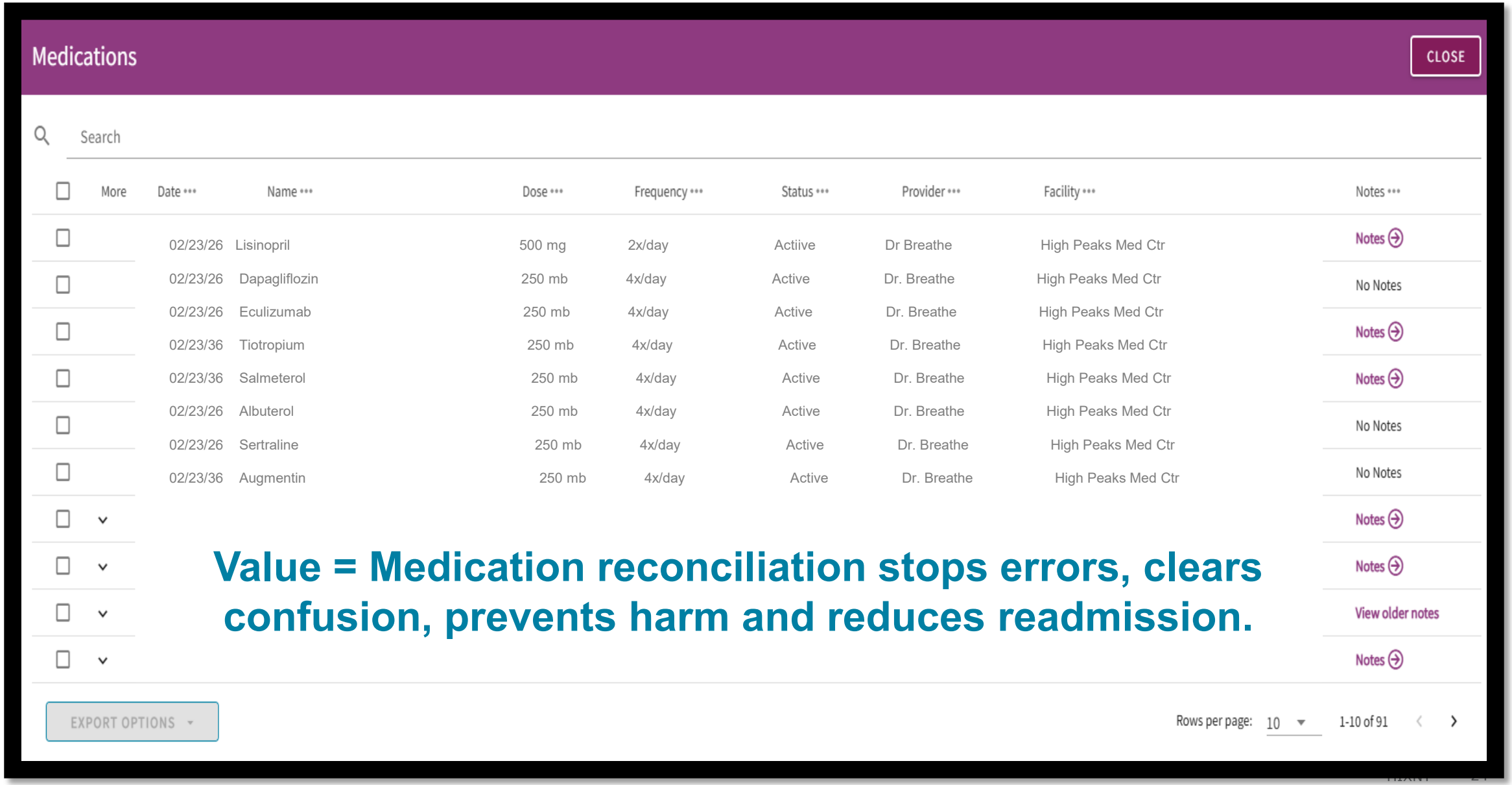
Value = Intubation in ED $ 1,500 per procedure



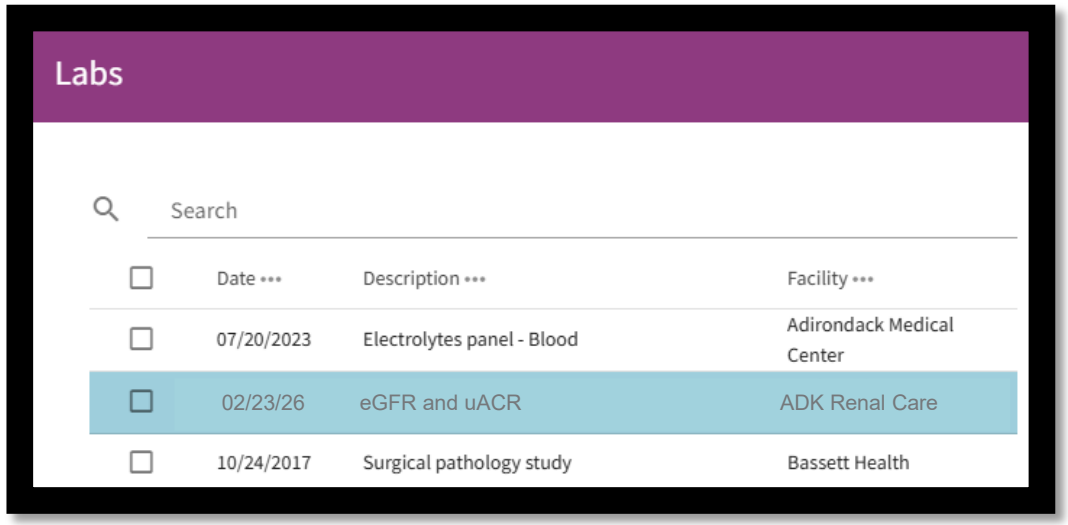
PATIENT RECORD SNAPSHOT – NYS PSYCKES



PATIENT RECORD SNAPSHOT – MEDICATION LIST

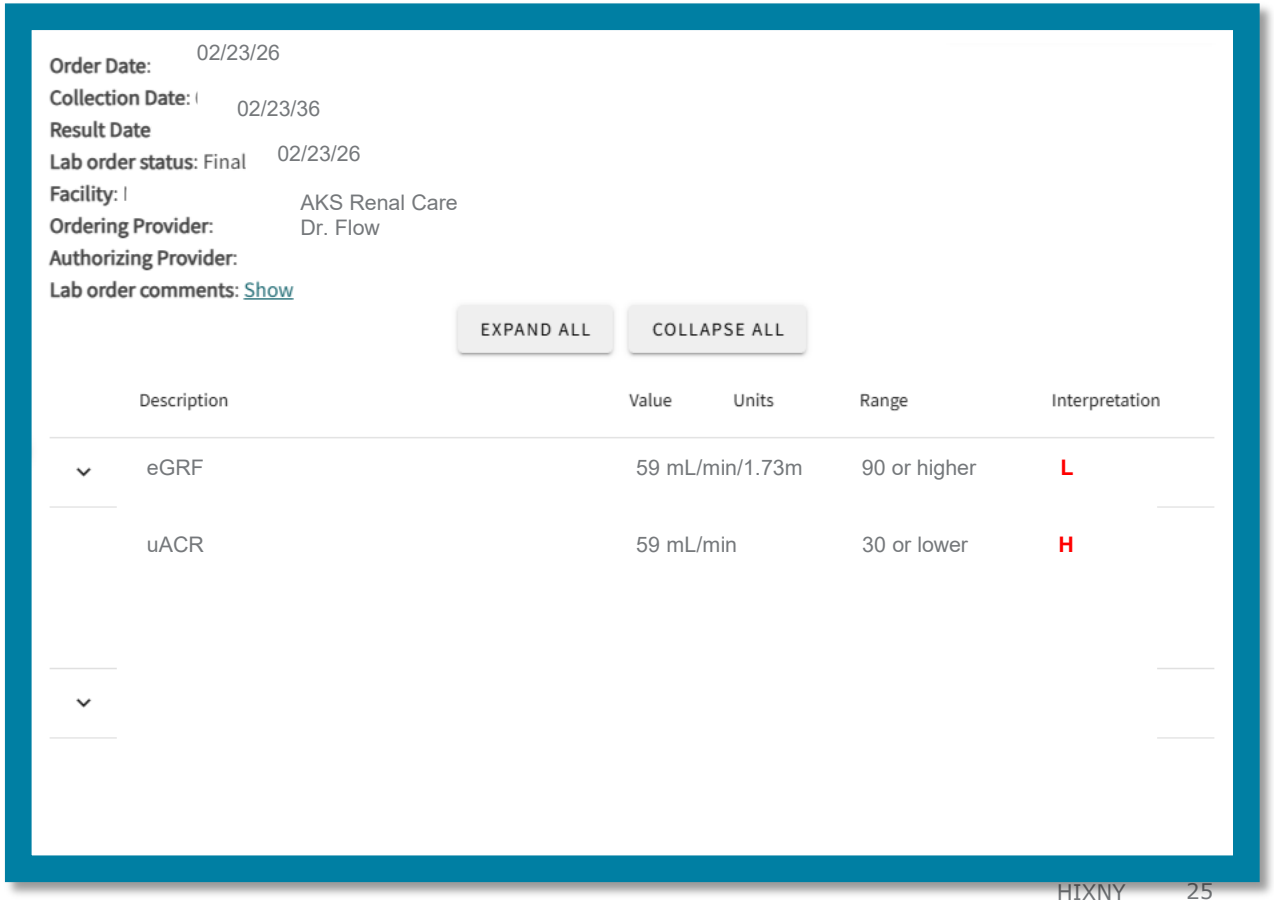


PATIENT RECORD SNAPSHOT – LAB RESULTS

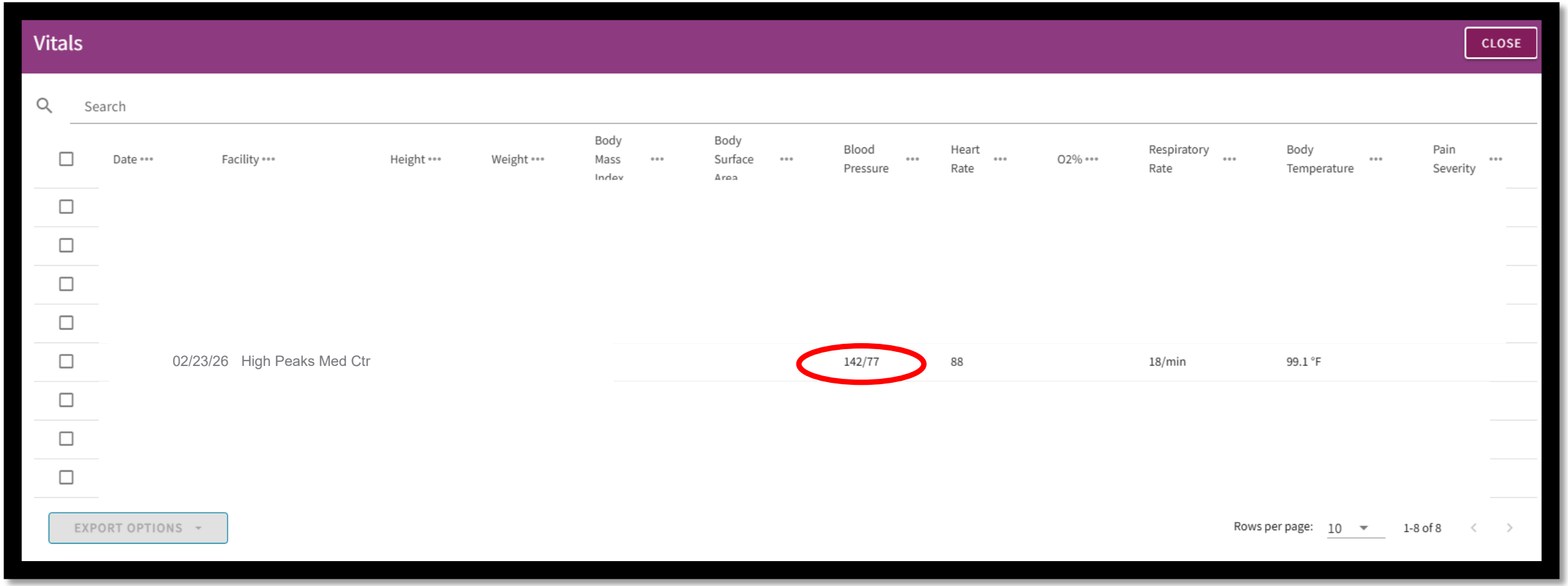


Optimize P4P metrics by analyzing community health records to identify care gaps closed by specialists or other providers.

Value = $ 150 Stage 3 CKD screening P4P incentive



PATIENT RECORD SNAPSHOT – VITAL SIGNS



Potential Value = $ 150 see before 12/31/26 w/ BP under 140/90 to qualify for CHF P4P incentive.

INTERPLAY BETWEEN CARE TRANSITIONS AND SOCIAL NEEDS

Housing Insecurity

Transportation

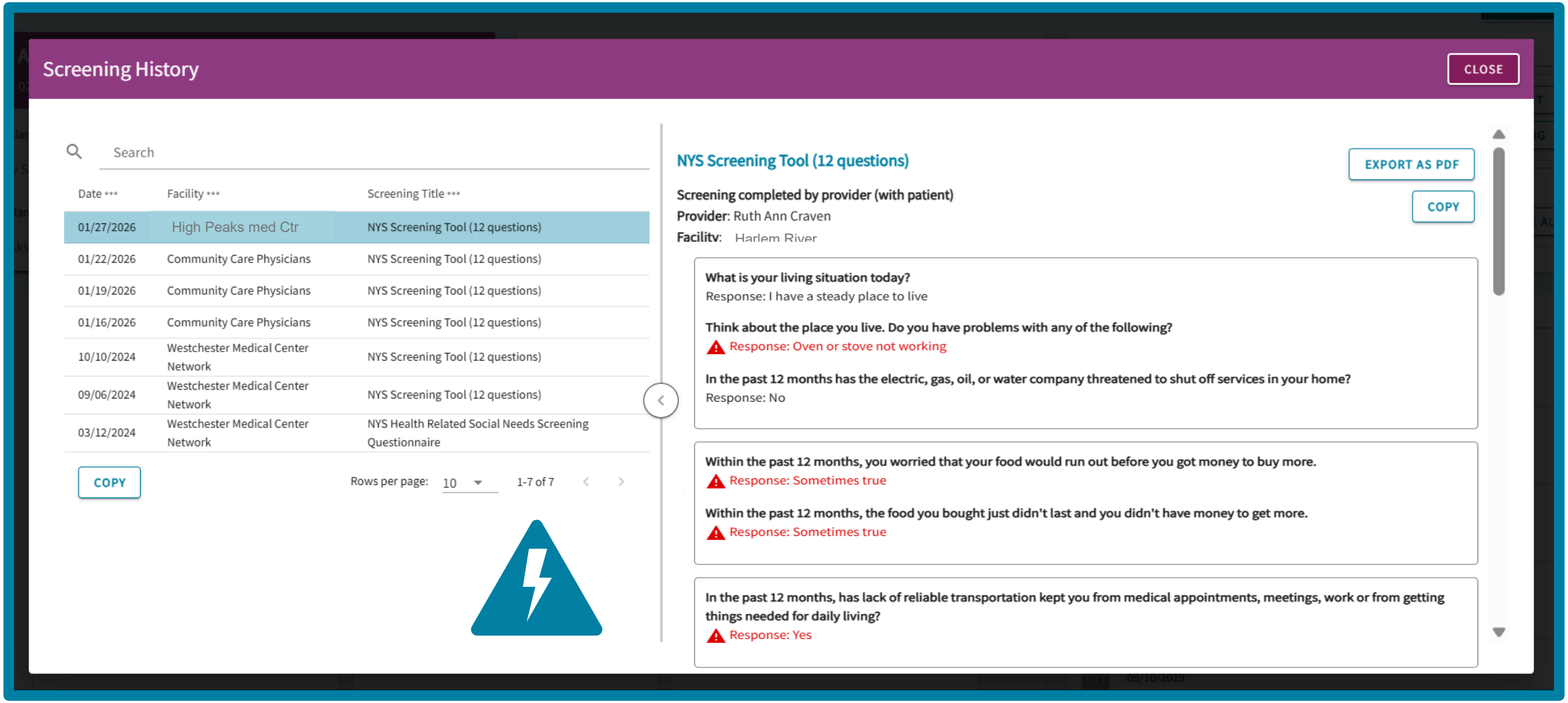
Low Health Literacy

Food Insecurity and Nutrition Deficits

Mental Health and Social Isolation

80% of health outcomes are driven by social, environmental, and economic factors.

SOCIAL NEEDS SCREENING HISTORY



SOCIAL NEEDS SCREENING HISTORY – REFERRALS TO COMMUNITY BASED ORGS

Social Needs History

CLOSE

Search

Date	Facility	Type
02/02/2026	Saratoga Hospital	Referral
02/02/2026	Saratoga Hospital	Referral
02/23 2026	ADK Valley HC	Referral
01/22/2026	Saratoga Hospital	NYS Screening Tool (12 questions)
01/07/2026	Saratoga Hospital	NYS Screening Tool (12 questions)

COPY

Rows per page: 10 1-5 of 5

Referral

Date: 02/02/2026

Facility: Harlem River

EXPORT AS PDF

COPY

Referring Provider	Service Type	Service Subtype	Referred to	Referral Status
ADK Valley HC	Nutrition	Home delivered meals	Meals on Wheels	Referred

Items per page: 10 1-1 of 1

Value = SDOH Coordination: Alerts care manager and community paramedics when home oxygen deliveries or food supports drop.

SCREENING TOOL – LIVING SITUATION

Screening Tool

NYS Screening Tool (12 questions)

Section 1 of 4: Living Situation

What is your living situation today?

- ○ I have a steady place to live
- ◉ I have a place to live today, but I am worried about losing it in the future
- ○ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Think about the place you live. Do you have problems with any of the following?

- ☐ Pests such as bugs, ants, or mice
- ☑ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ○ Yes
- ◉ No
- ○ Already shut off

BACK NEXT

Wood-stove heated home with poor indoor air quality that triggers his COPD flare-ups.

SCREENING TOOL - FOOD

Screening Tool

NYS Screening Tool (12 questions)

Section 2 of 4: Food

Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ○ Often true
- ○ Sometimes true
- ◉ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ○ Often true
- ○ Sometimes true
- ◉ Never true

BACK NEXT

Jim requires low sodium meals.

SCREENING TOOL – TRANSPORTATION, EMPLOYMENT, EDUCATION

Screening Tool

NYS Screening Tool (12 questions)

Section 3 of 4: Transportation, Employment, Education

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
- ( ) No

Do you want help finding or keeping work or a job?

- ( ) Yes, help finding work
- ( ) Yes, help keeping work
- (●) I do not need or want help

Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

- ( ) Yes
- (●) No

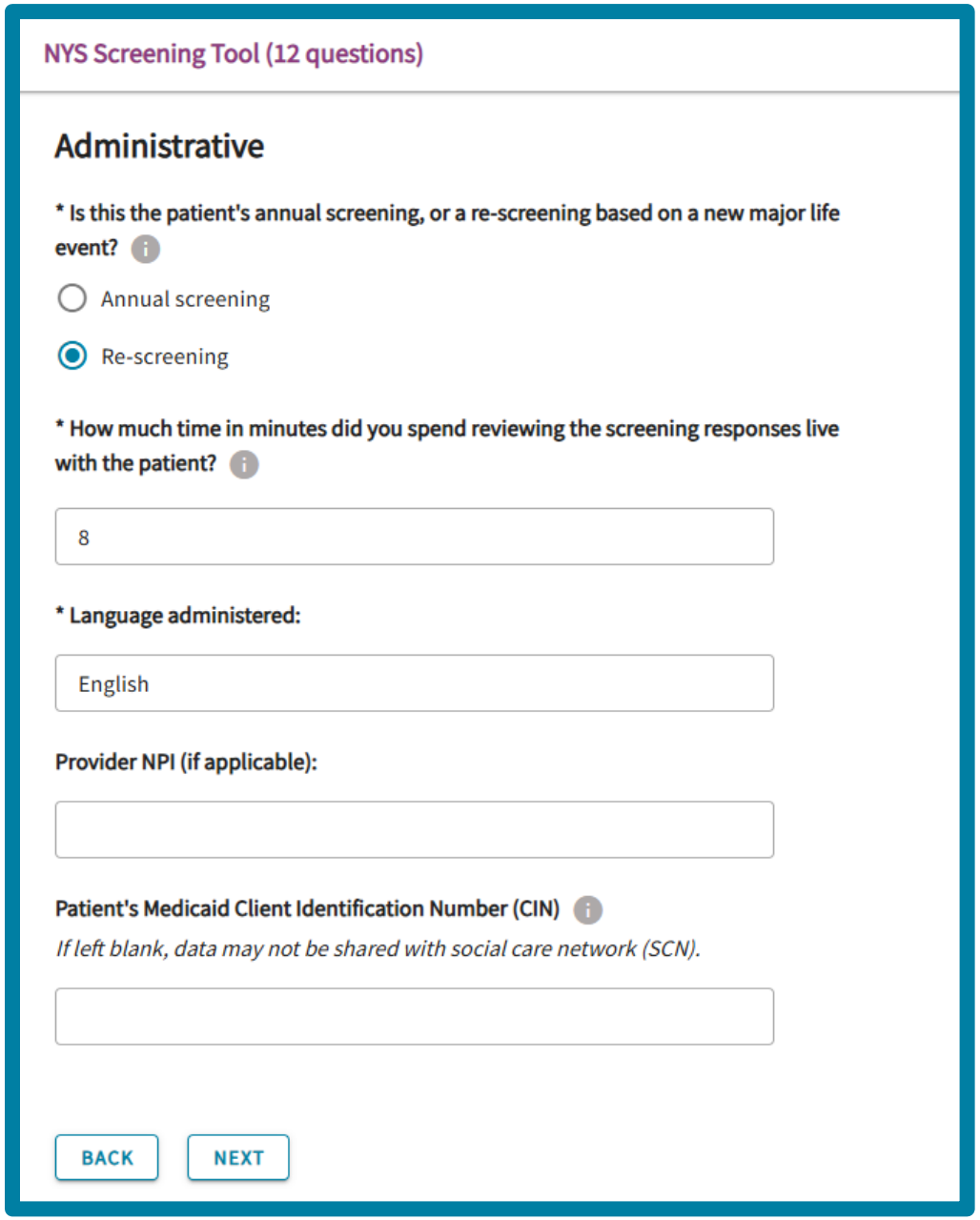
BACK NEXT

Jim has no reliable transportation and the nearest grocery stores is 35 miles away.

SCREENING TOOL – REIMBURSEMENT POTENTIAL

- For Medicaid or Medicaid managed care patients, screenings are eligible for **reimbursement** from Social Care Networks (SCNs) under the *NYHER 1115* waiver.
- Reimbursement is **$ 17.50** per qualifying screening.
- Annual screenings, and rescreening based on significant life events qualify.
- Contact your SCN for details.

Value = $ 17.50 for HRSN Screen



Longitudinal Care Management

Proactive management reduces total cost of care by targeting key high-cost drivers.

Medication Reconciliation

Action: Reconcile medications at every transition of care.

Impact: Prevents adverse drug events and dangerous interactions.

Savings: Avoids expensive emergency department visits and acute hospital admissions.

Readmission Avoidance

Action: Provide rapid post-discharge follow-up within 7 days.

Impact: Stabilizes patients at home and catches early warning signs.

Savings: Eliminates costly 30-day hospital readmission penalties.

Specialty Consults Co-Management

Action: Keep specialty visits strictly as focused, short-term consults.

Impact: Primary care retains ongoing management of the patient's overall health.

Savings: Prevents redundant testing and high-cost procedural referrals.

Value = $ 15K saved for each readmission avoided.

Lower Utilization + Better Chronic Control = More Shared Savings for Sharing

HOW CARE MANAGEMENT DRIVES SAVING IN VBP MODELS

Self-Management Support

- Teach patients daily coping skills.
- Prevent chronic disease flare-ups.

Answering Questions

- Clarify care plans and meds.
- Build trust and early contact.

Care Coordination

- Connect patients to specialists and necessary diagnostics.
- Close critical communication gaps.

Design Best Practices

- Direct patients to their PCMH.
- Prevent costly self-referrals to the ED or to specialists.

Value = $3K saved for each avoidable ED visit and $ 15K for each avoidable readmission – protecting shared savings.

Quality Improvement

HOW QUALITY TEAMS EARN P4P INCENTIVES – TARGETED CARE PATHWAYS

Cohort 1 - COPD

Goal: Reduce acute exacerbations and improve maintenance therapy.

Key Metrics:

- Appropriate prescribing of long-acting bronchodilator therapy.
- Post-discharge follow-up within 14 days of an acute flare-up.

Incentive Trigger: Documented care plan and reduced 30-day readmissions.

Cohort 2 – Stage 3 CKD

Goal: Slow disease progression and manage risk factors.

Key Metrics:

- Annual eGFR and urine albumin-to-creatinine ratio (uACR) testing.
- Blood pressure control under 130/80 mmHg.

Incentive Trigger: Reaching 80% panel screening compliance and BP control benchmarks.

Cohort 3 - CHF

Goal: Prevent fluid overload and avoid hospitalizations.

Key Metrics:

- Daily weight monitoring compliance and diuretic optimization.
- ACE/ARB/ARNI or beta-blocker therapy titration.

Incentive Trigger: Meeting medication optimization targets and transitional care completion.

Cohort 4 – Frequent ED Utilization

Goal: Redirect care to primary and ambulatory settings.

Key Metrics:

- Outpatient follow-up within 7 days of an emergency department visit.
- Care coordination and root-cause outreach for patients with 3+ visits.

Incentive Trigger: Reduce overall ED utilization rates by a targeted percentage (e.g., 10% YoY).

VALUE = P4P INCENTIVES TO BE EARNED

Cohort	Metric Type	Estimated P4P Payout Range	Revenue Model Basis
COPD	Care Gap Closure	**$ 100 - $ 250** per flare-up episode	14-day post-discharge follow-up bonus
Stage 3 CKD	Processing & Screening	**$ 50 - $ 150** per compliant patient/year	Annual eGFR + uACR screening bonus
CHF	Clinical Optimization	**$ 150 to $ 350** per managed patient/year	Meeting BP and beta-blocker titration goals
Frequent ED Users	Utilization / Shared Savings	**$ 3K** per avoided ED visit	Percent of shared savings from total cost reduction

UNLOCKING VBP VALUE: DRIVING PRACTICE REVENUE WITH HIXNY DATA

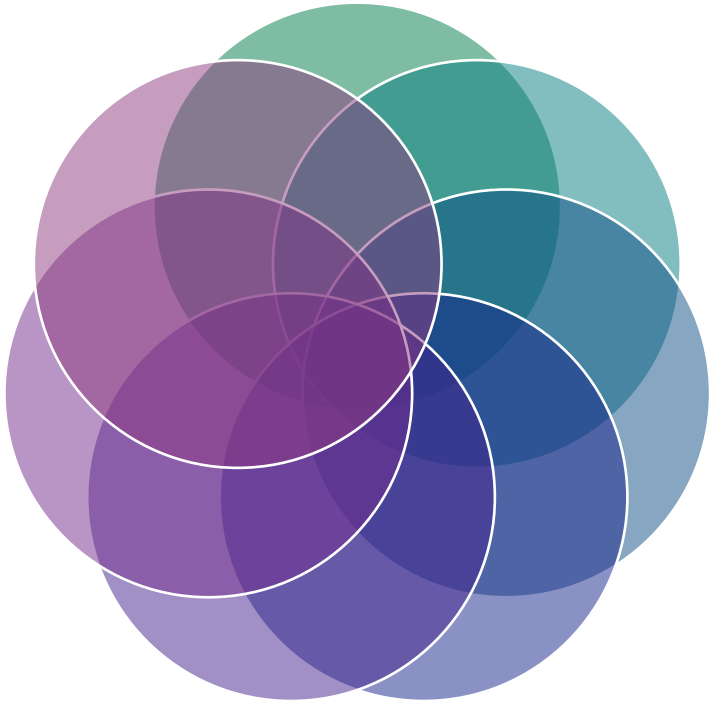
Total Potential Earnings

$ 20,338

Transitional Care Management Visit = $ 288

Readmission Avoided = $ 15,000

COPD Post Discharge F/U 14 Days = $ 250



HTN Control = $ 150

Intubation Avoided = $ 1,500

Stage 3 CDK eCFR & uACR Screen = $ 150

ED Visit Avoided = $ 3,000

Recap

Hixny Can Help!

Statewide Encounter Notifications

POWERED BY HIXNY

Hixny has been awarded a contract by the Statewide Health Information Network for New York (SHIN-NY) to make patient encounter alerts available to healthcare providers and health insurers statewide, effective immediately. The alerts system is the next iteration of an existing service that has delivered more than 7 million effective alerts annually to Hixny's existing health information exchange (HIE) users over several years.

WHAT ALERTS ARE INCLUDED?
Inpatient and ED admissions and discharges at every hospital in New York State.

HOW DO THESE ALERTS HELP ME PROVIDE BETTER PATIENT CARE?
The alerts, available in near-real time, allow for early identification of:

- Discharged patients with multiple chronic conditions that may benefit from care management, or for whom follow-up reimbursement is dependent on adherence to transitional care management (TCM) billing timelines
- Frequent users of emergency departments who may benefit from education about alternative locations for care, or a reminder about their PCP's protocol for sick or urgent visits

WHY SHOULD I SUBSCRIBE TO THESE ALERTS?

- Higher quality, more accurate encounter notifications thanks to statewide data checks
- Near real-time notifications, since Hixny receives encounter data through the hospitals' SHIN-NY connection, rather than local QEs
- Delivery to 25+ EHRs like Athena, eCW, EPIC, Cerner, MEDENT, Meditech, NextGen, and more
- Daily ADT message data feeds available for health plan and NYS health home care management and population health use
- Choice to receive alert type (IP and/or ED) for all—or a subset of—a facility, plan, or provider's patient panel
- Built to national leading security standards

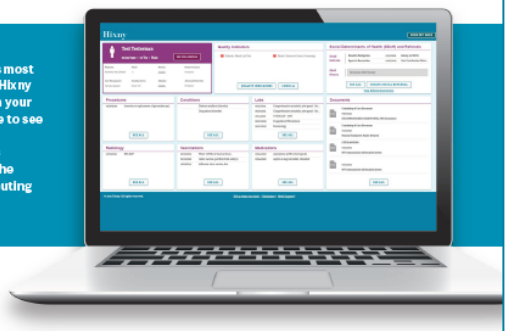
DOES MY ORGANIZATION HAVE TO PARTICIPATE WITH HIXNY TO SUBSCRIBE FOR ALERTS?
No. Providers can choose to receive notifications from Hixny even if they have designated another HIE as their primary connection to state data.

DO WE NEED TO COLLECT ANOTHER CONSENT FROM MEMBERS OR PATIENTS?
No. Patients are not required to provide any additional consent for providers to receive the alerts.

SHIN·NY
STATEWIDE ENCOUNTER ALERTS

POWERED BY Hixny

Welcome to Hixny's Patient Record Snapshot



THIS SUMMARY makes it easy to see your patient's most recent and relevant information available through Hixny in your EHR/EMR software. View the summary with your own organization's information included—or toggle to see external data only.

From here, you can click through to view details and historical data. You can also download any of the information as a PDF with both patient and contributing organization identified.

Helpful Tips

- To **find the patient's full history** in that category, click 'See All' on any tile
- To **save information to your EHR**, use 'See All' to export as PDF
- **View information as it loads without waiting.** Monitor progress in the lower right-hand corner of the screen with a button that gives you the option to:
  - *View Available Data Sources*
  - *View Pending Data Sources*
  - *View Unavailable Data Sources*

PATIENT OVERVIEW
See basic information, view allergy details or review care management needs. View all demographic information—including address, emergency contacts, insurance information and more—with a click.

QUALITY INDICATORS
Identify actions to discuss with the patient during their appointment—especially preventive screenings and follow-ups to previously diagnosed conditions. Red and yellow indicate gaps in care and areas of risk.

Check the patient's COVID-19 status with a click—including both testing status and results.

SOCIAL DETERMINANTS OF HEATH (SDOH) AND REFERRALS
View documented social needs history and, when applicable, take immediate action and make a referral for services provided by a community-based organization.

*Referrals are possible through Hixny's partnership with Healthy Alliance. If you access **UniteUs** to make patient referrals, please continue to use that platform directly.*

DOCUMENTS
See clinical summaries and notes from members of the patient's care team outside your facility. Review or download each document with a click.

LABS
View lab results.

CONDITIONS
See the patient's previous diagnoses.

IMMUNIZATIONS
Review the patient's immunization history—including COVID-19.

RADIOLOGY
See the radiology performed, as well as reports and—when available—images.

MEDICATIONS
See medications the patient may be taking or may have been prescribed.

Hixny

Key Considerations

- **Hixny's Statewide Alerts Solution**
  - Receive **real time** notification when your patients are admitted to or discharged from inpatient care or the ED at any hospital across NYS.
  - Roster-based alerts ensure each notification is **meaningful and actional**.
  - There is **never a charge** for providers in NYS to receive alerts for their patients; opt out clause if funding expires.
  - Patient consent is **not** required for alert notifications.

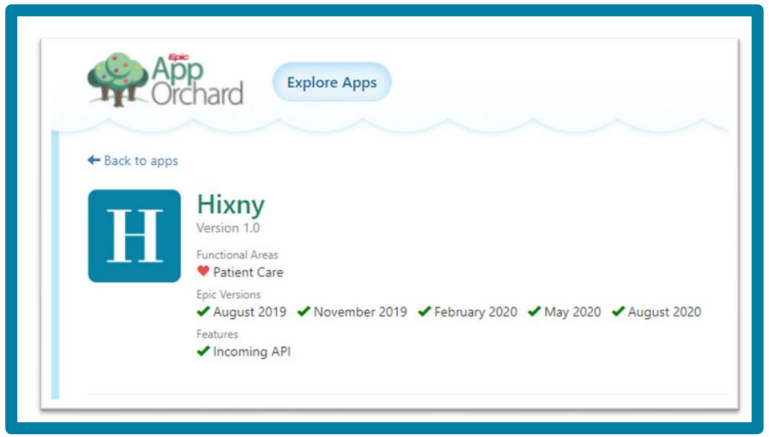
- **Hixny's Patient Record Snapshot**
  - Access patients' community health records (with consent) including medical history, advance directives, behavioral health history, social needs and social referral history.
  - Potential for reimbursement for HRSN screening of Medicaid/Medicaid managed care patients from SCNs through the NYHER 1115 waiver.
  - There is **no fee** to participate with Hixny's health information network.

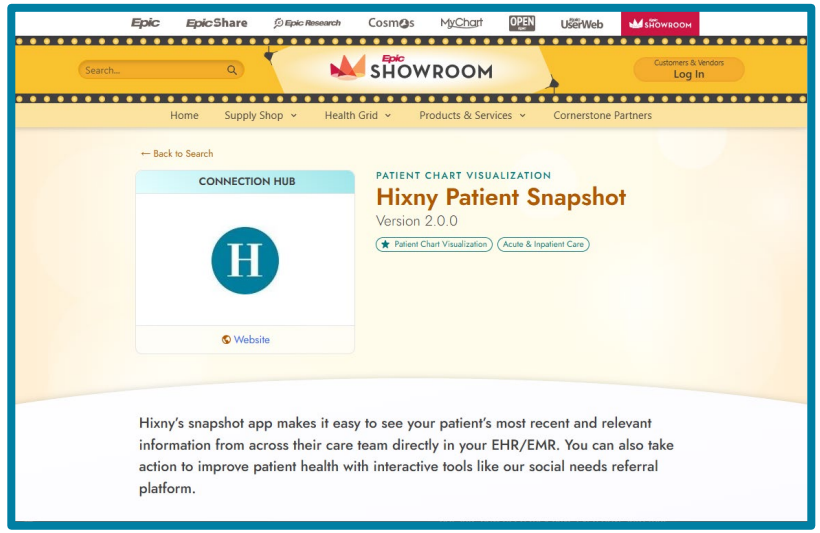
CUSTOMIZE YOUR TCM WORKFLOW WITH HIXNY'S STATEWIDE ALERT SOLUTION

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

- Direct Alerts to EHR
- HL7 Alerts to EHR
- Flat File of ADT HL7
- *Daily Digest* Report
- Feed of ADT HL7
- Alert Management Tool

Patient Snapshot





Making It Happen

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Learn more

hixny.solutions/4st28kU

Thank You

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