

DATA PLUS: Healthix Analytics



Overview

Healthix Analytics provides predictive risk scores, dashboards and reports to support population health management and readmission management. Healthix Analytics assists in improving outcomes through early identification of serious health conditions and lowers costs by preventing avoidable ED visits and hospitalizations. An individual's risk score is calculated using clinical information, medical encounters and social determinants of health data.

Population Risk Management

The goal of Healthix Analytics is to enable providers and care managers to quickly identify individuals at high or increased risk for a range of conditions and events. Early intervention can prevent unnecessary admissions or ED visits; improve clinical outcomes; and reduce overall costs. Risk scores are updated each evening to reflect the clinical events of the day.

30-Day Readmission Management

Analytics for readmission management assesses information for those patients currently in, or recently discharged from, a hospital stay or ED visit. Healthix Analytics predicts the likelihood of a patient being readmitted or returning to an ED within 30 days.

Population Risk Models: Future 12-Month Risk

- Asthma exacerbation
- Chronic kidney disease
- Congestive heart failure
- COPD
- Diabetes (type 2)
- ED visit
- Heart attack/AMI
- Hypertension
- Inpatient admission
- Mortality
- Opioid abuse
- Predicted cost
- Stroke
- Suicide attempt

30-Day Readmission Risk

- ED visits
- Hospitalization

Quick Start

With "Quick Start" you immediately receive reports targeting certain patients, chronic conditions, and more. These reports will be delivered securely via email or an SFTP connection, weekly, monthly, or quarterly. **Call 1-877-695-4749**

Mailing Address:

1-877-695-4749 info@healthix.org

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Real-time. Data Driven. Analytics.

Social Determinants of Health Data

Healthix Analytics incorporates zip code or countybased social determinants of health data into all risk algorithms. An individual's residence can impact risk for unwanted events and conditions.

Community risk scores are determined by:

- Education level
- English proficiency
- Household income
- Income equality
- Insurance coverage
- Percentage of population living within half mile of a park
- Racial demographics
- Respiratory hazard
- Unemployment rate
- Urban concentration
- US citizenship



Individual Patient Risk				
SUMMARY				
DEMOGRAPHICS	Patient Future 12 Month Risks Asure Inpatient Encounter Risk	Emergency Visit Encounter Risk	HEDIS Compliance HCC RAF	
ALLERDES	Patient Future 12 Month Risks			
MEDICATIONS DAMPROCEDURES	Future Cost	Modifiable Risks and Care Gaps	Model Features	J \$35900
ADV DIRECTIVES	Inpatient Admission	Modifiable Risks and Care Gaps	Model Features	~~
eMOL51	Emergency Department Visit	Modifiable Risks and Care Gaps	Model Features	~ 100
ENCOUNTERS	Acute Myocardial Infarction	Modifiable Risks and Care Gaps	Model Features	~ A 8
DESERVATIONS				
LAB RESULTS	Asthma	Modifiable Risks and Care Gaps	Model Features	~
MCRO/PATH	Cerebrovascular Accident	Modifiable Risks and Care Gaps	Model Features	🖬
CARDIO/GI OBJETUATS	Congestive Heart Failure	Modifiable Risks and Care Gaps	Model Features	🖬
RAD RESULTS	Chronic Obstructive Pulmonary Disease	Modifiable Risks and Care Gaps	Model Features	~ 🖬
AESP RESIATS	Diabetes	Modifiable Risks and Care Gaps	Model Features	/
DOCLMENTS	Rypertension	Modifiable Risks and Care Gaps	Model Features	/ 1920
PANER DATA	Hypertension	, In		
MAGES	Mortality	Modifiable Risks and Care Johps	Model Features	/ II
STOP	Suicide	Modifiable Risks and Care Gaps	Model Features	0
	Oploid Use	Modifiable Risks and Care Gaps	Model Features	0



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