How HIEs Use Data to Improve Population Health

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Healthcare organizations are increasingly focused on managing patient populations to improve outcomes while reducing costs. Here are short profiles of how some health information exchanges (HIEs) are using data to support population health efforts.

Managing Populations

Healthix, an HIE in New York, is helping the NY AIDS Institute monitor and manage the HIV-positive (HIV+) population. As part of this process, Healthix identifies HIV+ individuals and the care they are receiving. Antiretroviral treatment and on-going medical care are critical for this population. Using the data available, the New York State Department of Health (NYSDOH) focuses on public health surveillance efforts providing linkages to care and needed therapies. This work has involved establishing Continuity of Care Document (CCD) transfer from Healthix to NYSDOH and automating associated processes. Healthix must also upload and match selected CCD data into the HIV registry. The process has also been expanded to include housing data and meaningful use data elements.

The Indiana Health Information Exchange (IHIE) provides clinical value reports to help its partners better manage patient populations and support quality metrics. For example, IHIE worked with a large payer, Anthem Blue Cross and Blue Shield, on a pilot to supplement the clinical information (e.g., lab results) of 200,000 commercial members. IHIE was able to find data on 90 percent of the members, which allowed Anthem to supplement its claims database with the additional clinical information. Claims information only shows that a patient has had a test—not the specific results. Having the clinical data available as well allows for more proactive interventions.

HealthInfoNet, an HIE in Maine, has focused on standardizing data, for example, mapping laboratory results to LOINC codes, to create comparative data sets for the Maine Centers for Disease Control (CDC) allowing the CDC to manage population health at the community level, in this case statewide. An analytic tool allows the Maine CDC to drill down to the town level and see performance around hemoglobin A1c management and its trending in a population in near-real time.

Bridging Gaps

HealthInfoNet has taken the lead on bridging the gap between healthcare services and social services. Maine residents often face barriers to getting care in rural areas—for example, getting access to transportation. The Data Across Sectors for Health (DASH) project is focused on creating a care management system that integrates medical and social data to help providers better understand the needs of their patients. HealthInfoNet is facilitating the integration of EHR data from critical access hospitals and federally qualified health centers with social data from community agencies.

Improving Outcomes

HealthInfoNet offers a suite of analytic services that use data from across the care continuum. Modules assess hospital performance, volume and market share, population risk, 30-day readmission risk, and variation management. Each of these modules help healthcare provider organizations to better manage patient populations to improve quality while reducing costs. For example, analytics make it easier to understand resource variation and identify areas that are not meeting targets. HealthInfoNet has also used HIE data to develop predictive models—for example, to identify patients with congestive heart failure—and published its research results here.

Data is pervasive in healthcare today. An important use of that data is for population health management.

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