

THE SHIN-NY ANSWERS THE CALL FOR SOCIAL DETERMINANTS OF HEALTH (SDH) LEVERAGING EXISTING INFRASTRUCTURE IN SDH INNOVATION

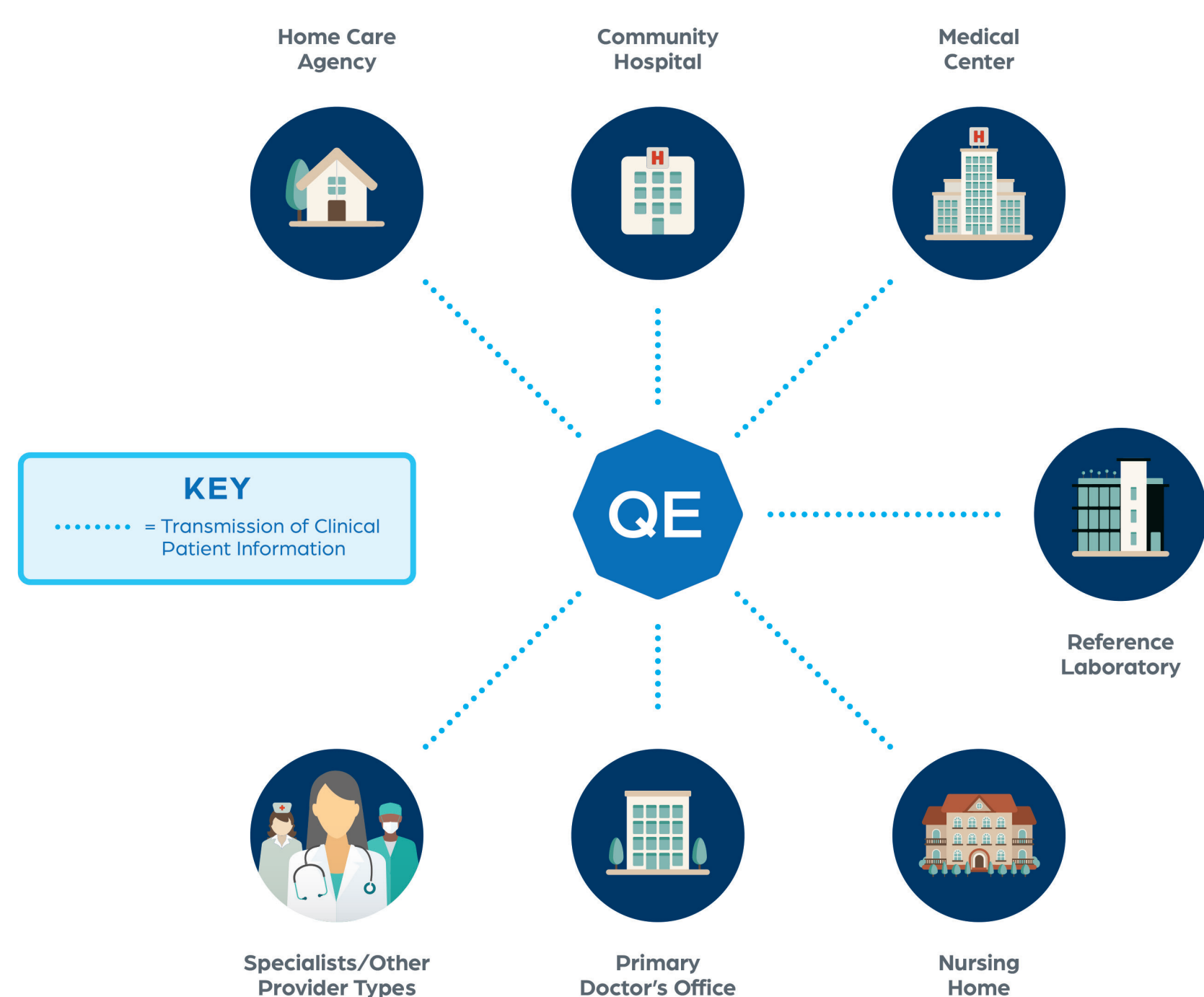
WHAT IS THE SHIN-NY?

New York State created the SHIN-NY to allow the secure, electronic exchange of patient data and connect healthcare professionals across the ecosystem to improve outcomes. The SHIN-NY is comprised of eight Qualified Entities (QEs), also known as regional health information organizations (RHIOs), and a statewide connector that provides secure sharing of important clinical data from participating providers' electronic health records (EHRs).



// The New York eHealth Collaborative (NYeC) and the Statewide Health Information Network for New York (SHIN-NY)'s shared mission to improve healthcare by collaboratively leading, connecting, and integrating health information exchange across the state makes the organization an ideal partner to promote usage of and exchange of nonclinical data elements like Social Determinants of Health (SDH) by leveraging the existing SHIN-NY infrastructure.

HOW DOES IT CONNECT PROVIDERS TODAY?



HOW DOES IT WORK?

By making it possible to immediately share data with patient's consent, the SHIN-NY helps streamline care and supports better patient experiences and outcomes while improving safety and lowering healthcare costs. The network is a strong tool to ensure the right information at the right time is available for care teams to provide the best care for their patients.



SHIN-NY 2020 ROADMAP

Last year, NYeC, in collaboration with key stakeholders from across NYS, developed the SHIN-NY 2020 Roadmap. This high-level framework presents ambitious goals and identifies a variety of tools and strategies for their achievement including:

- Value-Based Care (VBC) support to assist providers with additional functionality and data such as SDH
- Innovation and Interoperability to explore new opportunities such as open APIs and FHIR to improve health information exchange
- Creation of Community-Based Organization (CBO) and VBC workgroups to determine statewide technology, data, and standardization needs
- Connecting the SHIN-NY to statewide data sources such as the All Payer Database (APD) to streamline access to providers across the state and support quality measurement

HOW CAN IT CONNECT FOR SOCIAL DETERMINANTS OF HEALTH?

The SHIN-NY has been operational and exchanging data since 2010. Virtually all New York State hospitals and over 80,000 healthcare professionals are part of the network. The current and anticipated success of the enterprise demonstrate that the effort dedicated to building a solid foundation. With the New York State Department of Health (NYS DOH)'s continued support of the enterprise, the SHIN-NY, as it reaches a critical mass of clinical data, can continue to be leveraged for community-based organizations and be expanded to exchange nonclinical data sources including Social Determinants of Health (SDH).

THE SHIN-NY AND SDH IN ACTION

Rochester RHIO and Lifespan

A project team was assembled to include Lifespan, Rochester RHIO, and NYU/NYAM to implement the Community Care Connections Program. This program aimed to address issues facing older adults in the Rochester area by integrating Lifespan's community-based aging services with the healthcare delivery system. Rochester RHIO was integral to this project by providing health data management. Findings showed that the adults targeted in the study had fewer hospital admissions and ED visits, and saved on costs to the system.

Healthix and NYC Jail Alerts

In partnership with NYC Correctional Health Services (CHS), Healthix can alert an inmate's community healthcare provider or care manager anywhere in the SHIN-NY when he or she is incarcerated and released. This information is valuable to the provider or care manager, so they can plan appropriate outreach to the patient. In addition, CHS has access to an inmate's medical history through Healthix.

Bronx and Housing

Bronx RHIO has been working with all participant sites to identify homeless patients in their data via a variety of methodologies, including having providers directly identify patients by an indicator and linking addresses to shelters. Used by Delivery System Reform Incentive Payment (DSRIP) Program Performing Provider Systems (PPS) sites, these data are used to both identify ED high-utilizing patients and assist homeless patients in finding support.