Project Utilize:

Successfully Using Multi-Stakeholder Collaboration and Innovative Technology to Address the Quadruple AIM

Indiana Health Information Exchange

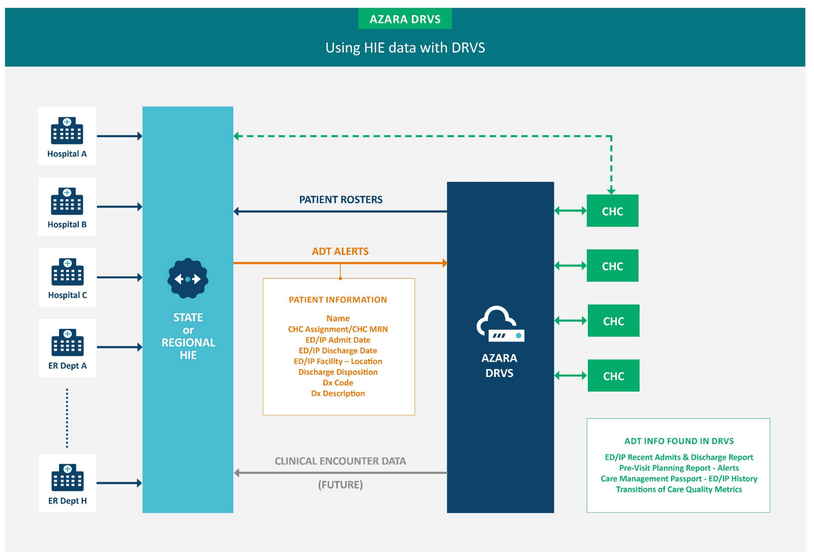
BACKGROUND:

Project Utilize demonstrates the impact of an extraordinary collaboration among four organizations—the Indiana Primary Healthcare Association, the Indiana Health Information Exchange, Indiana's Family and Social Services Administration, and Azara Healthcare. The collaboration resulted in the implementation of Alerts of Admissions, Discharges and Transfers from Emergency Departments and Inpatient settings to 20 Community Health Centers, serving over 450,000 patients.

WHAT IS QUADRUPLE AIM?

1. **Reducing Costs:** Reduction in ED visits and Hospital Admissions/Readmissions
2. **Population Health:** Focus on patient population – high ED utilization, co-morbities
3. **Healthcare Team Well Being:** Improved Coordination within the Care Team and a more proactive approach to meeting the patient's needs ahead of follow up visits reported
4. **Patient Satisfaction:** High satisfaction with follow-up calls reported by patients.

HOW IT WORKS:



The Goal: Through novel collaboration, solve a need for Indiana's safety net and its patients by using health information exchange to support the Quadruple Aim.

The Solution: ADT Alerts & CareManager Access

ADT Alerts

- Daily notifications of care
- Manage populations
- Timely outreach
- One source

CareManager

- Customized open access
- See full care continuum/historical longitudinal record
- Includes allergies, meds, past medical history, details on ADT alert visits to support clinical decision making
- Data from 92% of the IN population

"ADT Alerts clearly were an improvement from the prior non-automated methods of determining when ADTs happened. Once the IHIE/Azara ADT Alerts were in place, RNs leading the transitional care contact, and PCPs involved in overseeing that care, immediately appreciated the improvement in timeliness of follow up, scheduling, and pre-visit data assimilation, which improves care and patient experience. Ultimately, it makes healthcare personnel more satisfied with the services they provide."

Dr. Steven Waltz, MD
Primary Care – Valley Professionals Health Center

"The Indiana Quality Improvement Network at the IPHCA and Indiana's Community Health Centers have received exceptional benefits from the strong partnership with IHIE. Because of the close collaboration, health centers in Indiana that utilize our population health technology now have access to daily ADT alerts from inpatient stays and emergency department visits as well as access to IHIEs longitudinal care records for their patients. This has been a game changer for care coordination and their ability to manage care transitions to improve patient care and outcomes."

Angela M. Boyer, M.H.A.
Chief Strategy Officer, IQIN HCCN Director, IPHCA

OUTCOMES/RESULTS/OPEN DOOR HEALTH SERVICES:

Measurable Results

- Follow up appointments scheduled within 7 days – 44% (Dec, 2020) to 72% (March, 2022)
- Follow up call made within 48 hours of discharge – 5% (Dec, 2020) to 50% (March, 2022)
- Rate of readmission within 30 days – 30% (Nov, 2020) to 21% (March, 2022)
- Appointment No Show rates – 36% (Nov, 2020) to 13% (March, 2022)

Anecdotal Results

- Patients reports high satisfaction with follow up calls
- Providers report improved coordination within the Care Team and a more proactive approach to meeting the patient's needs ahead of follow up visits.

COLLABORATING PARTNERS:

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