

Success Story: Rhode Island Quality Institute Transitions of Care

[Rhode Island Quality Institute](#) (RIQI) is a non-profit organization with the mission to significantly improve the quality, safety, and value of health care in Rhode Island. RIQI operates [CurrentCare](#), the state’s Health Information Exchange (HIE). An HIE allows health care professionals to securely share a patient’s vital medical information electronically. This success story highlights how RIQI developed useful tools for providers that provide timely, accurate, and actionable information to manage patient’s transitions of care.

The Challenge: Historically, provider practices in Rhode Island received patient’s care transition information in a variety of ways including telephone, fax, or in person when the patient arrived for their appointment with their medical record. Practices had access to plenty of patient information from many different sources, but usually the information was not timely; therefore, its value was limited. To improve the timely delivery of data, RIQI reached out to practices interested in improving data flow around transitions of care to pilot a dashboard.

The Strategy: To eliminate the care transition data flow challenges between hospitals and other providers, RIQI created a simple dashboard that informed a practice if any of its patients were discharged or admitted to the hospital or emergency room. The dashboard is sourced by data stored in the HIE and uses Active Analytics for the presentation layer. The dashboard is updated when an admission, discharge, or transfer (ADT) event is created in the hospital’s electronic health record (EHR) or registration system; it is then subsequently transmitted to the HIE. The dashboard data is updated every 45 minutes and provides practices with up-to-date pertinent patient information (see Image 1). The dashboard significantly reduces the time needed to transition patient information from hospitals to ambulatory systems.

Image 1: Admission Alert

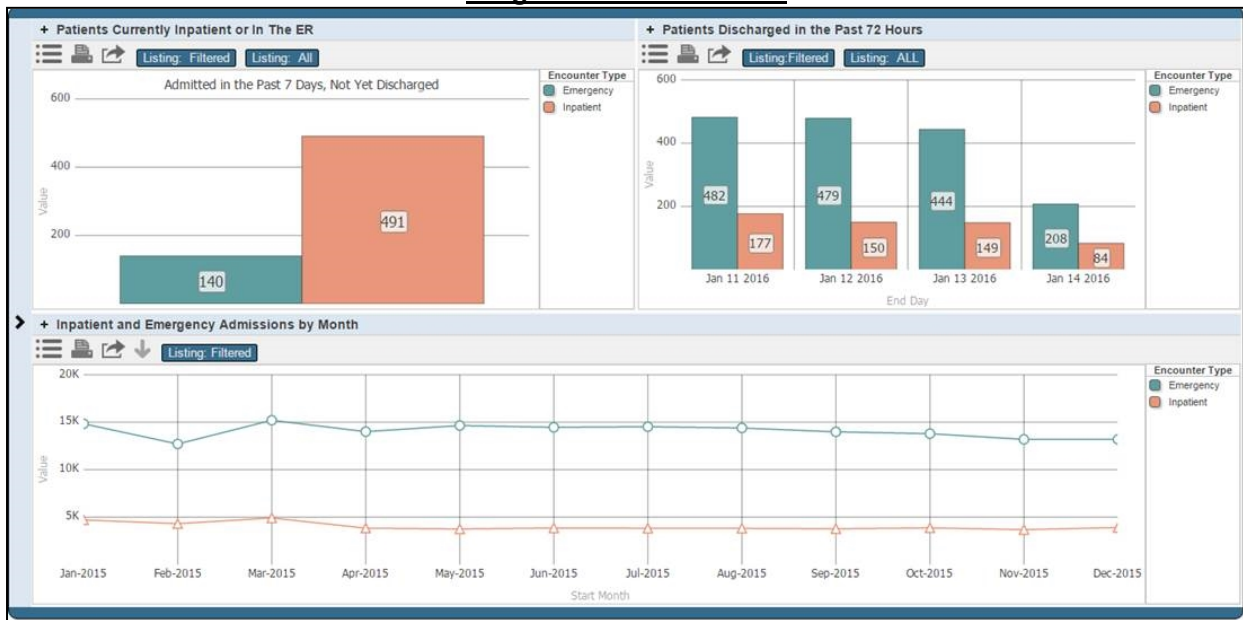


The dashboard is the visual component of the system, but either care management alerts or [hospital alerts](#) drive the content. Care management alerts include basic demographics, primary care physician (PCP) if indicated, the reason for the visit, and where the visit took place (along with whether it was an ADT). Care management alerts allow practices to enroll all of their patients (panels), so they can receive alerts on patients even if they are not enrolled in CurrentCare. The dashboard is customizable, and each practice can change their views/alerts as desired.

For practices that do not choose to enroll in care management alerts, the dashboard also provides valuable hospital alerts that prevent practices from searching in multiple places for patient data. Hospital alerts are valuable resources for PCPs and their care teams because when an individual enrolls in CurrentCare, they name a PCP on the enrollment form. When the PCP adopts the alert service, the system automatically sends hospital alerts on all patients who have enrolled and identified that physician as their PCP. If a practice notices that a patient was discharged from a hospital, a practice can reach out and treat the patient accordingly.

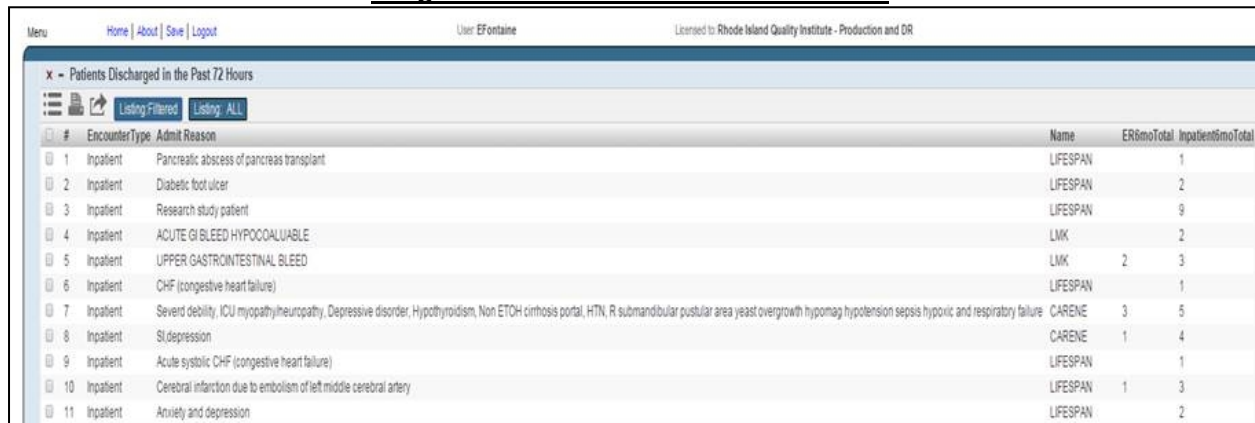
Dashboard data can be viewed at an aggregate level (see Image 2) as well as at an individual patient level. This aggregate view helps practices identify patient trends, such as the peak time of the day for patient emergency department (ED) use. If there are significant numbers of ED visits during regular office hours, the practice can educate patients about calling the office instead of visiting the ED. Another example is that most ED admissions after 10:00 p.m. on a Friday night are related to alcohol and/or substance abuse issues. PCPs could use that data to develop an intervention to target that patient population.

Image 2: Dashboard Data



Drilling down into the data on the dashboard (see Image 3) reveals a list of patients who are currently in the hospital or ED, and it shows how many times in the last 6 months that each patient was admitted to a hospital or ED. This data can instantly identify high hospital utilizers.

Image 3: Dashboard Data Drilldown View



#	Encounter Type	Admit Reason	Name	ER6moTotal	Inpatient6moTotal
1	Inpatient	Pancreatic abscess of pancreas transplant	LIFESPAN		1
2	Inpatient	Diabetic foot ulcer	LIFESPAN		2
3	Inpatient	Research study patient	LIFESPAN		9
4	Inpatient	ACUTE GI BLEED HYPOCOAGULABLE	LMK		2
5	Inpatient	UPPER GASTROINTESTINAL BLEED	LMK	2	3
6	Inpatient	CHF (congestive heart failure)	LIFESPAN		1
7	Inpatient	Severe debility, ICU myopathy/leuropathy, Depressive disorder, Hypothyroidism, Non ETOH cirrhosis portal, HTN, R submandibular pustular area yeast overgrowth hypomag hypotension sepsis hypoxic and respiratory failure	CARENE	3	5
8	Inpatient	SI depression	CARENE	1	4
9	Inpatient	Acute systolic CHF (congestive heart failure)	LIFESPAN		1
10	Inpatient	Cerebral infarction due to embolism of left middle cerebral artery	LIFESPAN	1	3
11	Inpatient	Anxiety and depression	LIFESPAN		2

Lessons Learned: Providers and hospitals need to be more receptive to new data. During the implementation of the dashboard, RIQI met with hospitals regularly and provided them with alert reports; they called it the “alerts-you-would-have-gotten report.” Most hospitals estimated lower alerts than they actually received and were surprised by the higher number revealed by the report. It is important to show facilities and practices their data because they often under or overestimate the actual numbers. By showing current data and data trends, the dashboard provides practitioners with information they can act upon to improve patient care at a practice and the hospital level.

During the pilots, care managers realized they needed to adjust their workflow. Adjustments needed to be made to manage individual patient needs as well as changes at the aggregate level, such as understanding how many patients receive follow-up care after a discharge.

Next Steps: Rhode Island is a small state, and there is plenty of patient mobility between health care systems with patients often going to different hospitals and practices. With the dashboard, practices can easily determine if any of their patients were admitted or discharged from area hospitals, helping to coordinate better patient care. Currently, the dashboard is being piloted by three practices with the goal of expanding to at least an additional 30 practices by the end of 2016. RIQI plans to explore the use of dashboards and care management reports with their long-term and post-acute care practices who currently only receive hospital alerts.