COLLABORATIVE VENTURES NETWORK

ADT Notifications and Improving Patient Outcomes

Admission, Discharge, Transfer (ADT) notifications are widely regarded as a key strategy to improving patient care coordination through Health Information Exchange (HIE). ADT notifications are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. Notifications are then sent to update physicians, care management teams, and health systems on a patient's status, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions. Beyond the real-time alerting application, ADT information serves as the foundation for "hot-spotting," or identification of individuals who are disproportionately high users of hospital services. This allows providers to steer those patients toward clinical and non-clinical interventions, reducing unnecessary overutilization by preventing avoidable emergency department visits and hospital readmissions. When a patient is admitted to a hospital, transferred, or discharged, an ADT notification is created by the hospital's electronic health record (EHR) system. The hospital EHR system sends the ADT notification through a trusted data-sharing organization which operates the ADT Notification service. Health Current is our Arizona HIE.

ADT messages are the vehicle for communicating updates about a patient's care transitions. The messages provide each patient's personal or demographic information (such as the patient's name, insurance, next of kin, and attending physician) and when that information has been updated. They also indicate when an ADT status (e.g., admitted, discharged) has changed.

- The alerts are triggered by an admission, discharge, or transfer event in a hospital information system that sends a message to the health information exchange system.
- The HIE system processes the message and transforms it into an alert sent to the primary care practice or community-based care manager (i.e. our Centers).
- This communication notifies the physician, care manager or care management team to initiate an intervention, improving the post-discharge transition, and supports management of patients with chronic conditions.

Why is this information so important? First, it enables providers to know who, out of their patient rosters, has been in hospital care over the past day, week, and even month, and ensure they receive the proper post-discharge care. By using these ADT feeds, care management teams can reach out to these patients via phone to monitor post-discharge behaviors and make sure to schedule follow-up office visits as needed.

For those Centers who use Azara DRVS, we are currently working on an ADT data migration project. The goal of this project is to migrate ADT data directly from Health Current (HIE) into DRVS. This will create one universe where all patient data will be located, instead of having to access this in various disparate systems (i.e. logging into the Health Current HIE portal). The vision is to have a robust data warehouse consisting of a seamless combination of clinical, claims, practice Management, and ADT information to facilitate care transformation, drive quality improvement, aid in cost reduction, and simplify mandated reporting.