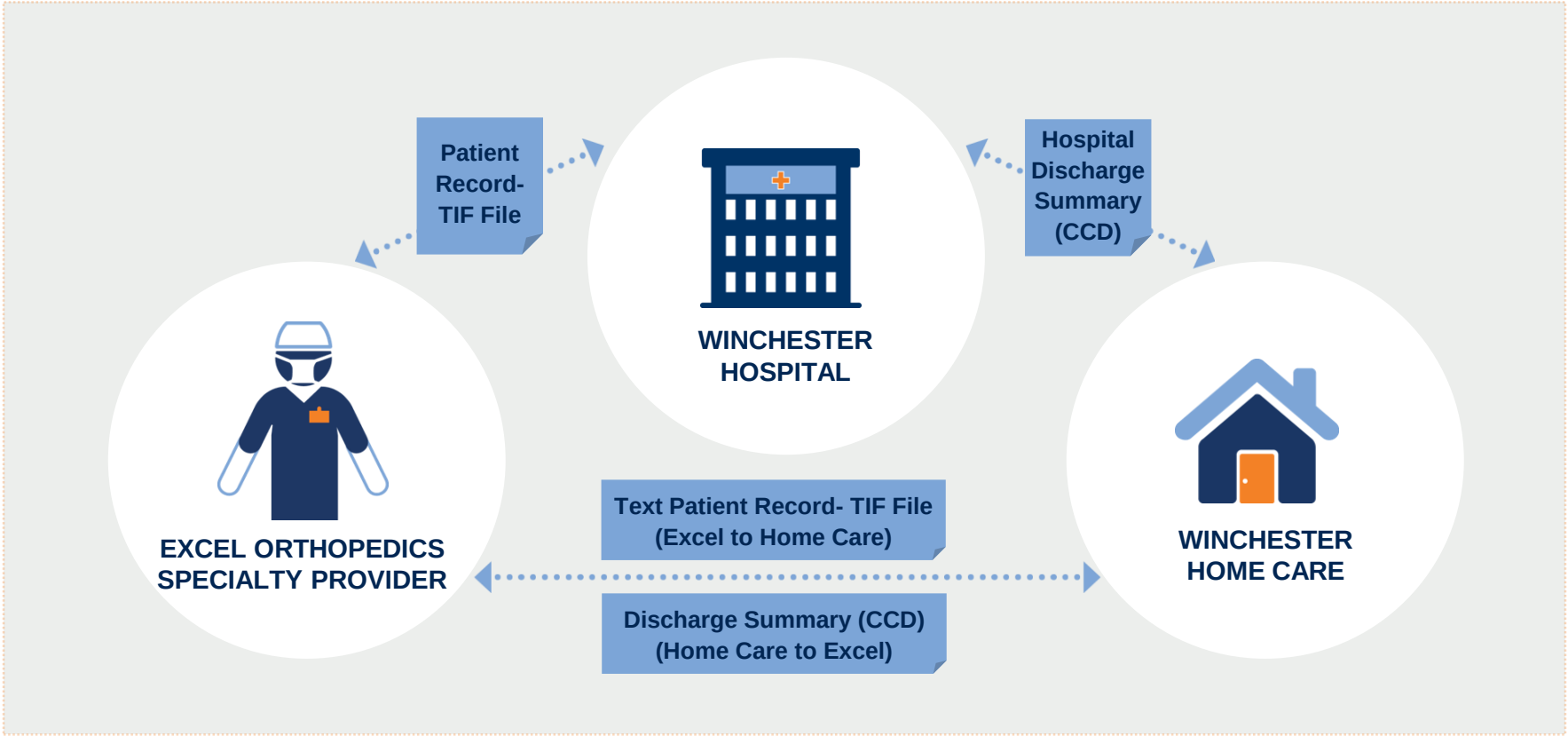
CARE COORDINATION USE CASE

NOTIFICATION OF PLANNED SURGERY FROM ORTHOPEDIC PRACTICE TO HOME CARE, PATIENT EDUCATION, AND PRE-ADMISSION TESTING



GOAL	Reduce the number of patients who utilize high cost post-acute services (Skilled Nursing Facility), improve care coordination, reduce hospital readmissions and reduce healthcare costs, and support the Meaningful Use HIE objective.

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NOTIFICATION OF PLANNED SURGERY FROM ORTHOPEDIC PRACTICE TO HOME CARE, PATIENT EDUCATION, AND PRE-ADMISSION TESTING

ORGANIZATION

Excel Orthopedics, Winchester Hospital Pre-Admission And Home Care Departments.

GOAL

Reduce the number of patients who utilize high cost post-acute services (Skilled Nursing Facility), improve care coordination, reduce hospital readmissions and reduce healthcare costs, and support the Meaningful Use HIE objective,

TRADING PARTNERS AND SYSTEMS

- **Excel Orthopedics- sender & receiver**, using eLINC to connect to the HIway;
- **Winchester Hospital Pre-Admission Testing- receiver**, using Mass HIway webmail to exchange patient information over the HIway;
- **Winchester Hospital Home Care- sender and receiver**, using Allscripts to generate a CCD and using Mass HIway webmail to exchange patient information over the HIway.

DATA TO EXCHANGE

- Patient record from Excel to Pre-Admission Testing and Home Care;
- CCD from Winchester Hospital to Home Care;
- CCD from Home Care to Excel Orthopedics.

STORY

The specialist at Excel Orthopedics identifies the need for a patient to have surgery, schedules the surgery with Winchester hospital and sends information via Mass HIway to Winchester Home Care for the purpose of enrolling the patient in a Joint Class, which provides education about post-surgery care. Patient choice may be obtained at the surgeon's office for post-acute home health services. The specialist (or designee) sends the patient demographic information to Winchester Hospital Home Care by logging into the eLINC secure messaging solution and accessing the Mass HIway Provider Directory to send the Direct message to Winchester Hospital Home Care. Home Care will contact the patient to remind them of the next scheduled class in an effort to increase patient participation on this class, which includes educating patients on options for home care directly from their inpatient stay, and thus will contribute to our efforts around decreasing SNF/rehab post inpatient stay.

A Winchester Hospital Home Care intake team member receives the notification through the Winchester Hospital e-mail account that there is a secure message waiting in the Mass HIway webmail account. The intake team member logs into the Mass HIway account to view the content of the message, and the patient will be contacted to be registered for the Winchester Hospital Joint Class.

The patient attends the class, has a pre-operative appointment with Pre-Admission Testing, has the scheduled surgery and is admitted to Winchester Hospital for post-surgical care. Prior to discharge, the case manager at the hospital offers the patient home care choice. For those patients who select Winchester Hospital Home Care, the case manager sends the CCD as an attachment via the Mass Hiway to Winchester Hospital Home Care. A Home Care Clinician visits the patient within one day of discharge to conduct a comprehensive assessment, provide services and create the home health plan of care. Upon discharge from home health services, the home care CCD is automatically generated from Home Care's Allscripts product. The discharging clinician will copy and paste the discharge clinical note into their secure HIway webmail account and send to Excel via the HIway.