

## Connected Communities Implementation Grant Overview

### **Cape Cod Healthcare (CCHC)** **Award Amount \$434,000**

Trading Partners: Cape Cod Hospital, Falmouth Hospital, JML Care Center, BAYADA, Kindred at Home, Duffy Community Health Center, Harbour Health, Outer Cape Community Health Center, Community Health Center of Cape Cod

#### Project Highlights:

- CCHC and its collaborating organizations agreed upon standardized data elements to include in exchanges using C-CDA (Transition of Care Documents, Discharge Instructions, Discharge Summaries, and Medication Lists).
- An average of 81% of inpatient discharges from Cape Cod's two hospitals - Falmouth Hospital and Cape Cod Hospital - to three post-acute care organizations were accompanied by electronic C-CDA documents providing real time data to providers to improve care coordination and quality of follow-up care to patients.
- With the establishment of information exchange protocols and process connections, best practices were established so other provider organizations will have a template to work from when electronic exchange of information is possible for their operations. CCHC is well-positioned to expand this use case to many more post-acute organizations across Cape Cod.

### **Brockton Neighborhood Health Center (BNHC)** **Award Amount \$434,000** [Read Case Study](#)

Trading Partners: BNHC, Brockton Hospital, Brockton Area Multi-Services, Inc. (BAMSI), Highpoint Treatment Center, Good Samaritan Hospital

#### Project Highlights:

- The Clinical staff at both BNHC and Signature Healthcare Brockton Hospital created new workflows for patients needing Section 12A evaluation (emergency restraint and hospitalization of persons posing risk of serious harm by reason of mental illness) and using communication trees, they were able to better coordinate and ensure continuity of care for some of the most vulnerable patients referred to and discharged from the hospital.
- Due to the urgent nature of these referrals, the newly established workflow protocols retained the initial step of placing a phone call to the Emergency Department (ED). Accordingly, when a patient presents at BNHC in need of a Section 12A evaluation, BNHC Mental Health staff will make a phone call directly to the Emergency Department (ED) staff at Brockton Hospital to alert them that a patient is on the way. In addition, the new workflow requires BNHC staff to send a Continuity of Care (CCD) and Referral document through their NextGen EHR to the Emergency Department at the Hospital ahead of the patient's arrival to the ED. Hospital staff monitor the webmail inbox for the CCD and referral. When the CCD and referral arrive, the Hospital staff are able to identify the Primary Care Provider (PCP) from BNHC with whom they can communicate.

## CONNECTED COMMUNITIES

- Clinical staff at BNHC and Brockton Hospital created Communication Trees to ensure timely and efficient contact with the appropriate person at the provider organization to receive follow-up information for the patient's care and treatment.
- Upon discharge, staff at Brockton Hospital use communication trees, to contact the appropriate follow-up provider to inform them of the patient's status before the patient leaves the hospital.

### **Behavioral Health Network (BHN)**

**Award Amount: \$434,000**

Trading Partners: BHN, Baystate Medical Center, Noble Hospital, Wing Hospital

#### Project Highlights:

- Baystate Medical Center, Noble Hospital and Wing Hospital's inpatient units will receive patients' crisis evaluations and treatment history electronically from BHN Crisis Team via Direct message with attached C-CDA document delivered to the Pioneer Valley Information Exchange (PVIX). Upon receipt, PVIX will notify the admitting physician at the appropriate site that a new patient referral requires review and an admission decision.
- When an individual presents at an area Emergency Department and is determined to be in need of a mental health evaluation, an assessment request will be sent to the BHN Crisis Clinician embedded in the Emergency Department. A new record will be created in BHN's EHR. If the patient requires an inpatient level of support and is being referred to any of the collaborating organizations, the BHN Clinician will send a Direct message to the inpatient facilities Referral Direct Inbox that includes an electronic version of the assessment document and a C-CDA.
- This process will reduce the time that an individual waits in the ED for an appropriate placement, and ensures that the receiving inpatient program receives as much information about the individual as possible from the beginning, allowing the facility to design an effective plan of treatment sooner, and eventually a more effective discharge plan.

### **Reliant Medical Group**

**Award Amount: \$434,000**

Trading Partners: Reliant Medical Group, AdCare Hospital, VNA Care Network, MetroWest Medical Center, Milford Regional Medical Center, St. Vincent Hospital, UMass Memorial Medical Center, Holy Trinity Nursing and Rehabilitation Center, Jewish Healthcare Center, Life Care Center of Auburn

#### Project Highlights:

- When a patient is admitted to Adcare Hospital, staff obtain patient consent so that clinical documents can be sent from Reliant Medical Group back to Adcare, so that providers there have a more complete picture of the patient's medical history.
  - As a federal alcohol and drug treatment facility, Adcare Hospital falls under 42 CFR Part 2, so for this use case only information released from AdCare hospital is included in the ADT message to Reliant Medical Group (via Reliant's SAFEHealth).
  - An ADT message is released from AdCare only after the patient, at the time of admission, signs the appropriate release of information to Reliant Medical Group consent. This triggers Reliant's EHR to generate a CCD patient summary document which is sent via the Mass HIway directly back to AdCare Hospital
  - Unlike all other ADTs coming into SAFEHealth and Reliant's EHR, the ADT from AdCare Hospital is discarded instead of creating a Hospital encounter. This ensures that it is impossible to re-release information conveyed in that ADT, as stipulated in 42 CFR Part 2.

### **Berkshire Medical Center**

**Award Amount \$434,000**

Trading Partners: Berkshire Medical Center, Family Practice Associates, East Mountain Medical Associates, Community Health Programs, Berkshire Orthopedics, Berkshire Healthcare Systems, Berkshire Cardiology

#### Project Highlights:

- Clinicians are able to launch into patient context into dbMotion with single sign-in without having to log into another system(s) which allows trading partners to have real-time access to the data as it resides in the view within dbMotion making workflow more efficient.
- Clinicians no longer have to call for copies of notes, which then would have to be faxed over to the practice and then scanned into the EHR. These clinicians also have access to community data from within their EHR without having to log onto additional systems to track down critical notes and patient data.
- An unexpected success was the request by trading partner providers to stop the current faxing of discharge summaries to their offices. With this information now available to them electronically via dbMotion, they did not feel the need for the paper report to be faxed at all.

### **Lowell General PHO**

**Award Amount: \$434,000**

Trading Partners: Lowell General PHO, Lowell General Hospital (LGH), D'Youville Senior Care, D'Youville Center for Advanced Therapy, Genesis Palm Center, Genesis Westford House, Genesis Willow Manor, Genesis Nursing Care Center

#### Project Highlights:

- After implementing an electronic referral system in collaboration with community SNFs, LGH was able to reduce the average amount of time it takes for the Hospital to receive a response from a SNF regarding bed placement for a patient from 4 hours to less than one hour.
- 100% of inpatient discharge referrals from LGH to a community trading partner SNF were sent electronically.
- 100% of inpatient discharges from LGH to a community trading partner SNF (after a referral had been accepted) were sent an automated Transition of Care document electronically.

### **Upham's Corner Health Center (UCHC)**

**Award Amount: \$22,123 (Planning Grant)**

Trading Partners: UCHC and Boston Children's Hospital (BCH)

#### Project Highlights:

- Referrals were sent from Primary Care Providers or Nurse Practitioners at Upham's Corner Health Center to a Specialist at Boston Children's Hospital. Care summaries were automatically generated and sent to UCHC over the Mass HIway from the specialty department at BCH after the patient had been seen by the Specialist.
- UCHC was able to exceed their target percentage of care summaries received over the Mass HIway from BCH after a referral had been made. Over half of all referrals made by UCHC were followed by the receipt of a summary of care document from BCH.

### **Whittier IPA**

**Award Amount: \$434,000**

Trading Partners : Whittier IPA, Amesbury Psychological Associates, Anna Jaques Hospital, Country Center for Health and Rehab, Great Lakes Caring Home Health, Home Health VNA and Maplewood Center

#### Project Highlights:

- Wellport IPA staff collaborated with community trading partners and provided training and ongoing communication to convey the importance of using HIE to access clinical information for their shared patients to better coordinate care.
- Post-acute care trading partners used HIE to improve their medication reconciliation process by ensuring that staff had access to the most recent medication lists for their patients.