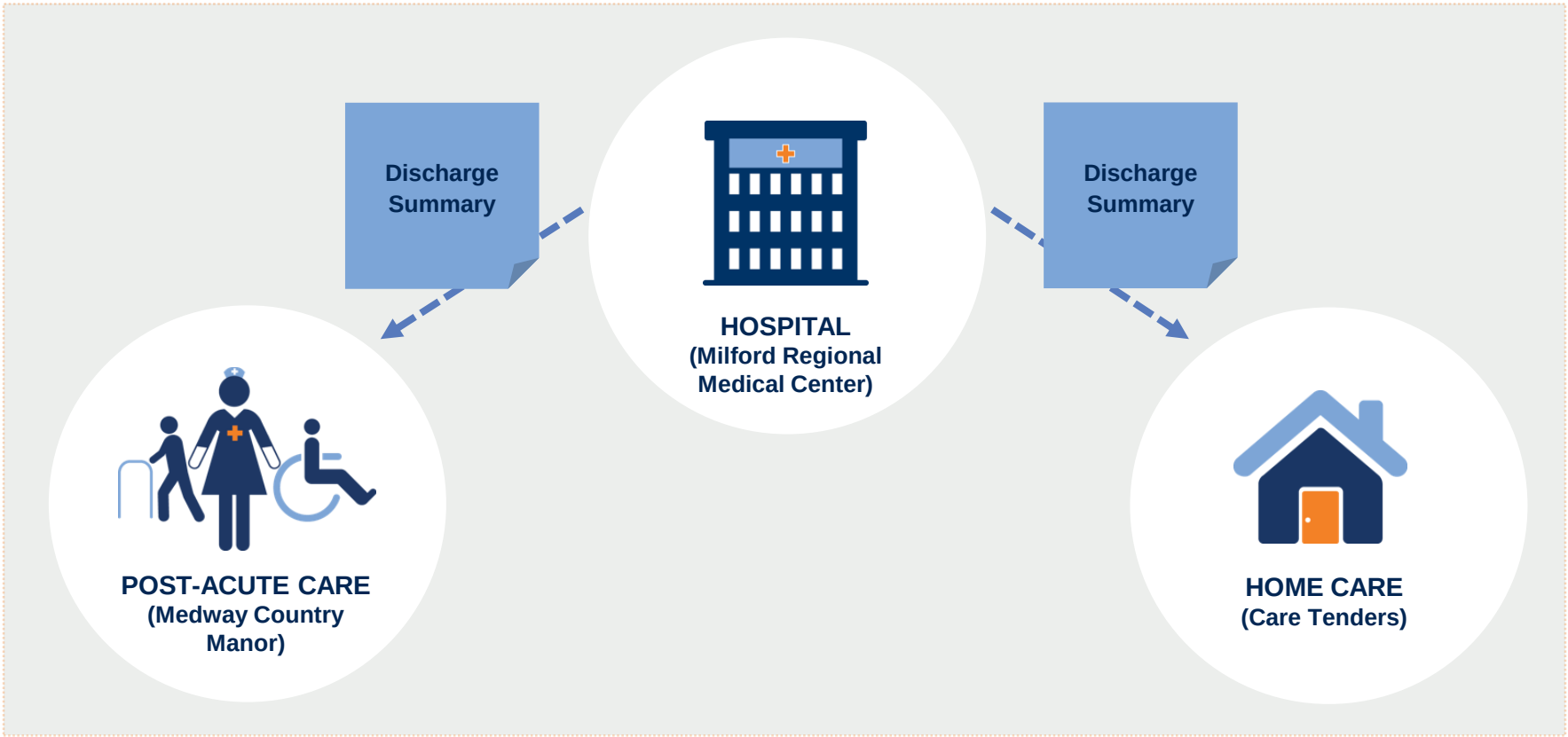
DISCHARGE SUMMARIES USE CASE

DISCHARGE SUMMARIES FROM HOSPITAL TO POST-ACUTE CARE OR HOME CARE



GOAL	Improve care coordination, reduce hospital readmissions, and support the Meaningful Use HIE objective.

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DISCHARGE SUMMARIES
FROM HOSPITAL TO POST-ACUTE CARE OR HOME CARE

ORGANIZATION

Milford Regional Medical Center, Care Tenders and Medway Country Manor.

GOAL

Improve care coordination and reduce hospital readmissions, and support the Meaningful Use HIE objective.

TRADING PARTNERS AND SYSTEMS

- **Milford Regional Medical Center** - acute care hospital (primary sender), using Meditech inpatient EHR and the Mass HIway;
- **Care Tenders** - home care and post-acute care facility (receiver), using Mass HIway webmail;
- **Medway Country Manor** - skilled nursing facility (receiver), using Mass HIway webmail.

DATA TO EXCHANGE

Discharge summary

STORY

Milford Regional Medical Center (MRMC) has traditionally struggled with the timely delivery of discharge summaries to some of their key post-acute and home care Trading Partners. MRMC is now using the Mass HIway to distribute discharge summaries electronically to post-acute care facilities and home care agencies in the Milford community. The project has brought together an organized, thoughtful project team with multi-stakeholder groups of leaders in the community. The efforts of this team led to MRMC being the first organization to achieve its final milestone under the Mass HIway Implementation Grant Program.

Workflow
Upon patient discharge, MRMC's Meditech system automatically generates a discharge summary which is addressed to either Care Tenders or Medway Country Manor and sent securely via the Mass HIway to a secure webmail account at the receiving facilities (Care Tenders or Medway Country Manor). The discharge summary is retrieved after the authorized staff at the receiving facility logs into their Mass HIway webmail account. The staff then delivers it to the appropriate care team who use the information contained in the discharge summary to provide appropriate care to the patient. This provides clinical staff with timely access to information about inpatient care, medications, and care plan along with other key information before the patient arrives at the SNF or the home care nurse visits the patient in their home.