

Lowell General PHO MeHI Connected Communities Project

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Lowell General Hospital

- Independent, not-for-profit community hospital serving Greater Lowell area and surrounding communities
- 2 primary campuses located in Lowell, MA
- Member of Circle Health, along with Circle Home, Lowell Community Health Center, and physician community
- EMR: Cerner



Lowell General Physician Hospital Organization

- 365 member physicians (96 PCPs)
- Many small or solo-physician practices
- Limited number of employed physician practices
- Multiple EMRs in community:
 - eClinicalWorks
 - Cerner
- Data warehousing and population health application
vendor: athenaHealth

eClinicalWorks



Preferred Skilled Nursing Facility Network

- PHO formalized relationships with 6 SNFs in 2015:

Genesis Healthcare	D'Youville Life & Wellness Community
• Palm Center • Westford House • Willow Manor • Heritage Nursing Care Center	• D'Youville Senior Care • D'Youville Center for Advanced Therapy

- Contracts align goals and expectations for high quality, high value post-acute care
- Quarterly Performance Improvement Meetings
- **EMR:** Point Click Care

MeHI Project Overview

Goal: Reduce avoidable readmissions, reduce costs, and improve patient experience by implementing real-time data feeds, optimizing existing technology and workflows, and implementing a centralized care management system to unify clinical information, improve care transitions, and improve cross-setting care management between the hospital, SNFs, and outpatient providers.

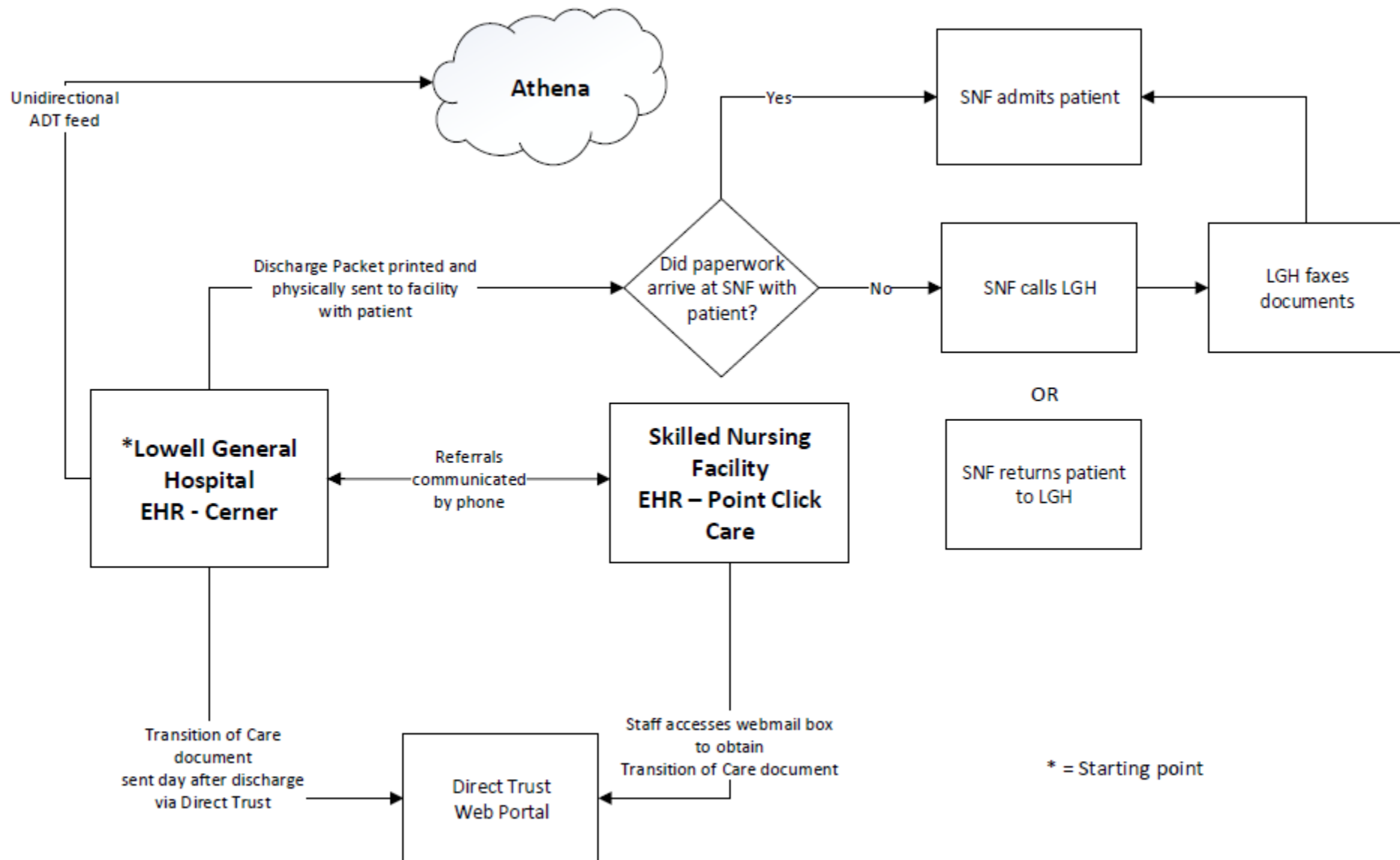
Collaborating Organizations:

6 Preferred SNFs
(Genesis & D'Youville)

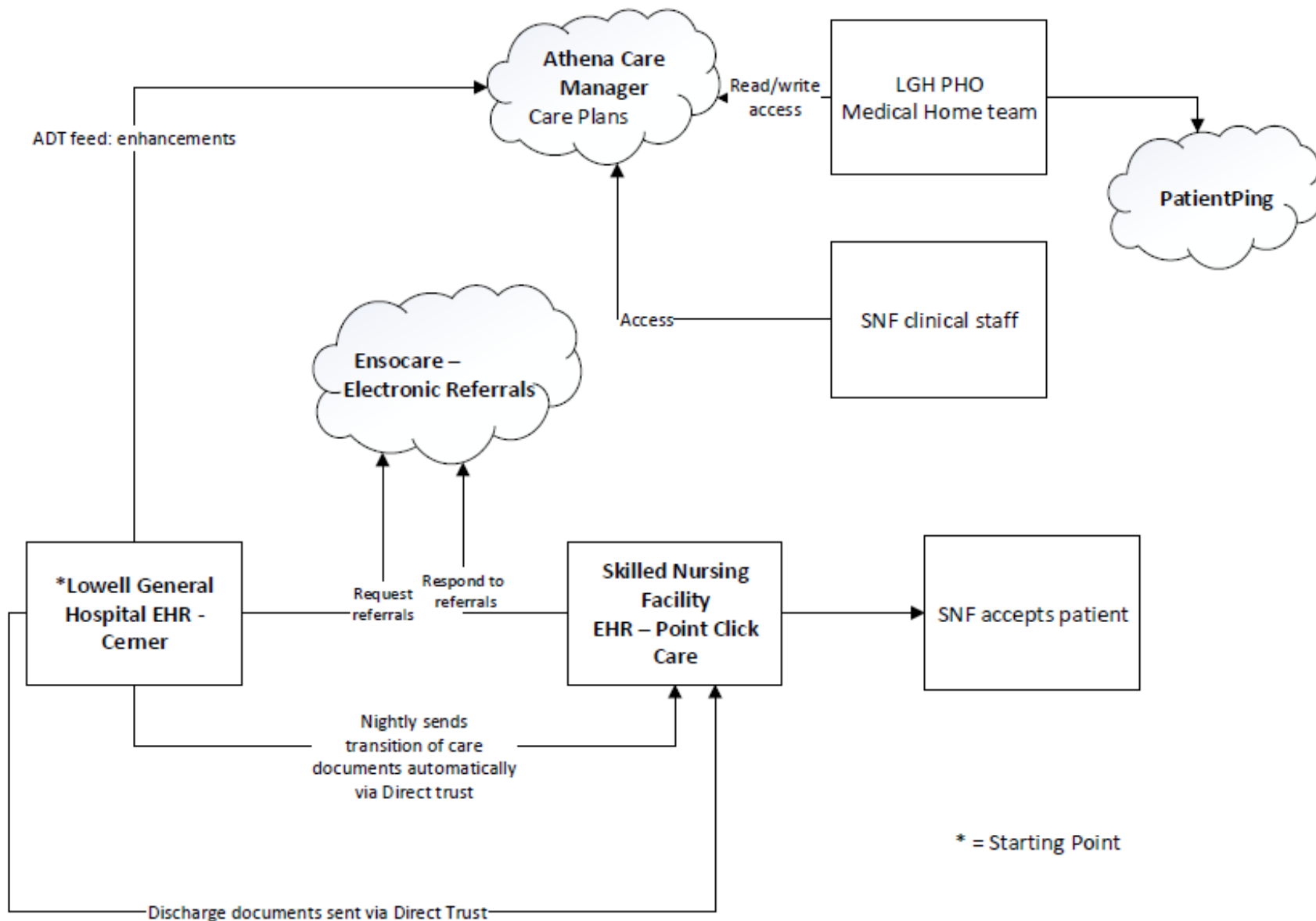
Lowell General Hospital
Lowell General PHO

Vendors
athenahealth
Cerner
Point Click Care

IT Current State



IT Future State



Use Case Overview

1	Ensocare	Implement Ensocare to support electronic, bi-directional communication between LGH and SNFs regarding SNF referrals
2	Transitions of Care Documents	Send TOCs electronically and automatically from LGH to SNFs via Direct
3	ADT Notifications	Care managers are notified in real time of discharges from LGH to Collaborating SNFs
4	athena Care manager	Use athena Care Manager to maintain centralized registry of SNF patients and store cross-setting, comprehensive patient care plans
5	Patient Ping	Implement Patient Ping, a web-based application that provides healthcare organizations with real-time utilization information for their patients to support care coordination

Use Case 1: Ensocare

Goal: Transition Hospital/SNF referral process to electronic platform to enable the exchange of more complete and accurate patient data, helping to increase efficiency of referral process.

Trading partners and systems:

- Lowell General Hospital
- Collaborating SNFs
- Ensocare

Metric: Average time required for hospital to receive a response from facility regarding bed placement

Baseline = 4 hours Target = 1 hour

Use Case 2: Transitions of Care Documents

Goal: LGH will send transition of care documents (CCDs) automatically and electronically from Cerner to SNFs' EMR via Direct

Trading partners and systems:

- Lowell General Hospital
 - Cerner
- Collaborating SNFs
 - Point Click Care

Metric: Reduce 30-day all cause inpatient readmission rate from Collaborating SNF

Use Case 3: ADT Notifications

Goal: Implement ADT feed from LGH to athena to notify care managers in real time of discharges from LGH to collaborating SNFs

Trading partners and systems:

- Lowell General Hospital
- Collaborating SNFs
- Cerner
- athena

Metrics:

- 1) 30-day all cause inpatient readmission rate from Collaborating SNF
- 2) Average length of stay at Collaborating SNF

Notifications		SETTINGS	⏮
Total (7)			×
Inpatient Re-Admission	1		
Inpatient Discharge	2		
Inpatient Admission	2		
ED Visit	2		
05-11-2016			×
SMITH [REDACTED] [REDACTED]-19		11:52 AM	×
Inpatient Discharge		Still patient or expected to return for outpatient services	
		05-11-2016 11:52 AM	
SMITH [REDACTED] [REDACTED]-19		11:52 AM	×
Inpatient Discharge		Still patient or expected to return for outpatient services	
		05-11-2016 12:00 AM	

Use Case 4: athena Care Plans

Goal: Use athena Care Manager to maintain registry of SNF patients and care plans for SNF population

Trading partners and systems:

- PHO Clinical Programs staff (SNF NP, RN Managers, SWs, CHWs, Registry Coordinator)
- Collaborating SNFs
- athena- web-based Population Health platform

Metrics:

- 1) 30-day all cause inpatient readmission rate from Collaborating SNF
- 2) Average length of stay at Collaborating SNF
- 3) Percentage of patients with a cross-setting, comprehensive care plan in athena

Chronic Obstructive Pulmonary Disease - COPD

Active8-23-2016

Add note ...

0 Assessments1 Goal+ GOAL+ ASSESSMENT

Practice breathing exercises and forceful coughing

Active8-23-2016

Succeeded 0Unachieved 0Paused 0Removed 0

Diabetes

Active6-13-2015

Add note ...

1 Assessment9 Goals+ GOAL+ ASSESSMENT

Insulin management

Active10-10-2016

Monitoring Blood Sugar

Active7-25-2016

Dailt Foot Care

Active7-25-2016

Diabetic Healthy Living

Active7-25-2016

Use Case 5: Patient Ping

Goal: Implement ADT feed from LGH to Patient Ping; Implement Patient Ping tool in order to receive real-time notifications of admissions and discharges for LGH-associated patients

Trading partners and systems:

- PHO Clinical Programs staff (SNF NP, RN Managers, SWs, CHWs, Registry Coordinator)
- Collaborating SNFs
- LGH/Cerner
- Patient Ping

Metrics:

- 1) 30-day all cause inpatient readmission rate from Collaborating SNF
- 2) Average length of stay at Collaborating SNF

Best Practices To Date

1. Partner collaboration – Involve all stakeholders upfront and understand where priorities are aligned
2. Our project involves many distinct components with an overarching goal, so central project team is critical
3. Communication is key
4. Innovation requires flexibility

Thank You!