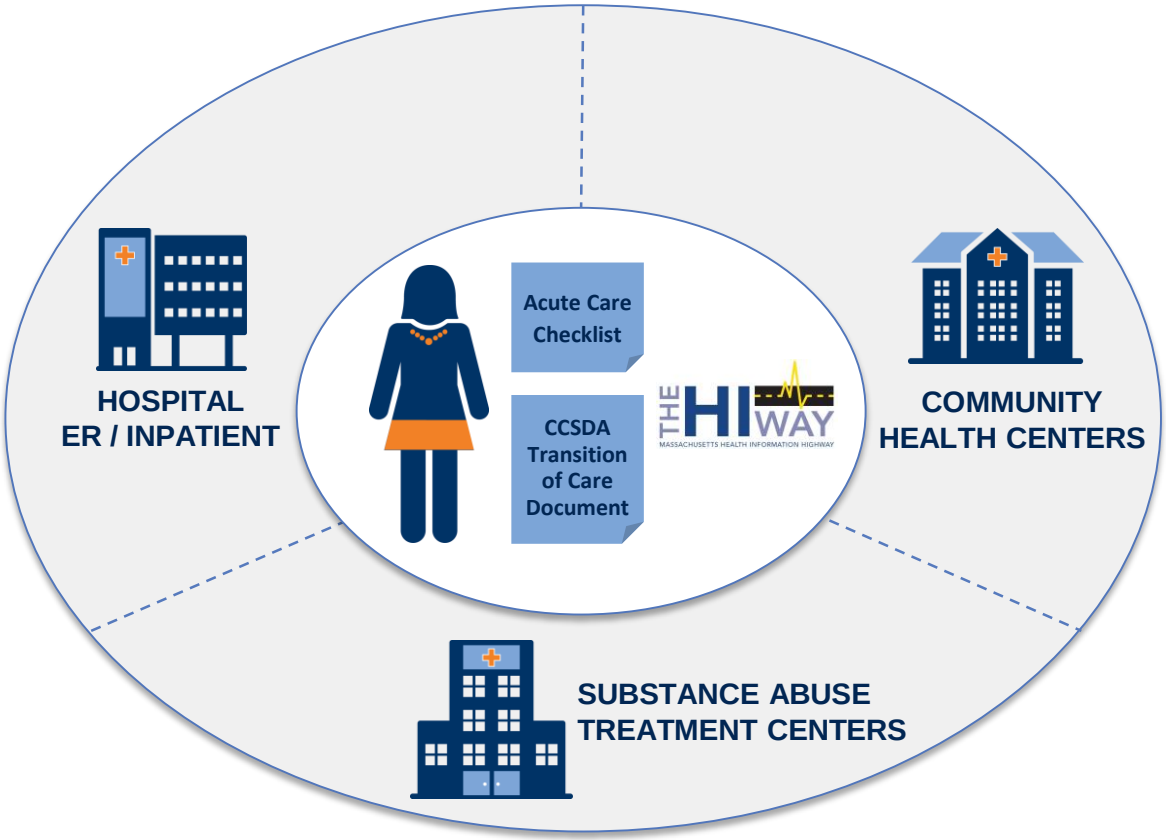
CARE COORDINATION USE CASE

TRANSITION AND COORDINATION OF CARE FOR CO-OCCURING ACUTE MEDICAL AND BEHAVIORAL HEALTH CONDITIONS



GOALS	Prompt, Accurate Assessment and Coordination	Sharing of pertinent information between providers via Mass Hlway	Attain better patient outcomes	Reduce readmissions

Icons provided by **MeHI** at mehi.masstech.org/Icons

CARE COORDINATION USE CASE

TRANSITION AND COORDINATION OF CARE FOR CO-OCCURING ACUTE MEDICAL AND BEHAVIORAL HEALTH CONDITIONS

ORGANIZATION

Regional Health Care Organization.

GOAL

Prompt, accurate assessment and coordination of care for patient with co-occurring medical and behavioral health condition. Sharing of pertinent information on treatment and medication status, discharge summaries and care plans in order to attain better patient outcomes and reduce costly readmissions.

TRADING PARTNERS AND SYSTEMS

- Hospital ER / Inpatient;
- Substance Abuse Treatment Centers;
- Community Health Centers.

DATA TO EXCHANGE

Standardized Clinical Documentation and data sets in Acute Care Checklist and CCD/Transition of Care Forms.

STORY

A homeless woman presents to a neighborhood Community Health Center (CHC) with acute cardiac symptoms as well as evidence of substance use disorder (SUD). She is assessed by a clinician at the CHC and transferred to an acute care hospital emergency room (ER) for treatment. The CHC clinician completes the new standardized Acute Care Checklist form and sends her to the acute care hospital ER via the Mass HIway.

Upon arrival in the ER, the patient's information from the CHC is already in the hands of the ER clinician. The patient is assessed and determined to be medically stable, but in need of treatment for SUD.

The patient requests treatment for her SUD and is discharged to a Substance Abuse Treatment Center. The ER clinician prepares the Standardized Transition of Care Document and sends it to the SUD via the Mass HIway.

Icons provided by **MeHI** at mehi.masstech.org/Icons