Holyoke Medical Center

A new vision for comprehensive care coordination

About Holyoke Medical Center

Location: Holyoke, Massachusetts

Solutions in use: CarePort Care Management, CarePort Connect, CarePort Guide, CarePort Insight

Profile:

- Community hospital, subsidiary of Valley Health System
- 198 licensed beds, 10 bassinets
- 44,000 emergency room visits in FY 2016
- 6,383 inpatient discharges in FY 2016
- Participates in CMS value-based programs, including MSSP
- Model 2 BPCI Program

Holyoke Medical Center is the largest provider of healthcare services to one of the poorest communities in Massachusetts. It transitions patients between outpatient, inpatient, post-acute, and home settings tens of thousands of times each year. The organization participates in several value-based programs, such as the Centers for Medicaid & Medicare Services (CMS) Bundled Payments for Care Improvement (BPCI) and the Medicare Shared Savings Program (MSSP) initiatives, which require care coordination to extend beyond the four walls of the hospital. Integrated care management solutions from CarePort and a redesigned care management process helped break down silos between departments and close gaps for better patient care.

> "The inpatient and outpatient sides can access each other's information with the click of a button...It helps our case managers more effectively monitor patients moving through the continuum."
>
> *Director of Transitional Care Management*
> *Holyoke Medical Center*

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CarePort® Case study
Holyoke Medical Center

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Breaking down silos in care management

One of the challenges that Holyoke Medical Center faced was a disconnect between outpatient and inpatient case management efforts. Continuity of care was at risk because departments couldn't see what the others were doing. To accomplish quality of care across the continuum, Holyoke Medical Center knew that they couldn't have these silos. Disconnected systems contribute to gaps in communication, which can lead to gaps in care. Beyond potential risk for the patient, it can cause organizations to lose out on shared savings and bundled payments.

Holyoke Medical Center set out to redesign its care management program. Goals included providing superior transitional care management services, improving clinical outcomes, sustaining reduced readmission rates, and improving utilization of appropriate services.

The redesigned team includes an inpatient Case Management department, outpatient Community Navigation department, and a Patient Call Center to engage patients post-discharge. All teams report into the same leadership, but they needed a more unified technology solution to more effectively coordinate care.

Technology enables seamless transitions

Holyoke Medical Center designed a uniform, patient-centered discharge process for all episodes of care. They then implemented technology to integrate their care management systems to share information and help patients across the entire continuum.

Holyoke Medical Center used a phased approach to implement the new model for care coordination. Phase one began in January

Fewer readmissions

Reduced readmission rate by 11% in six months

Better transitions of care

Improved care transition score from 54.4% to 60.4% in six months
(Press Ganey)

Higher satisfaction

Increased patient satisfaction from 88.5% to 92.3% in six months
(Press Ganey)

Improved discharge planning

Ranked in the top ten within peer group for discharge planning
(Press Ganey)

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of 2016, with the build of CarePort Care Management for the inpatient side. This solution helps team members manage referrals, denials, documentation, and discharge planning.

Phase two introduced CarePort solutions to help Holyoke Medical Center assist patients and families in selecting post-acute care, proactively manage post-acute patients, and analyze trends. The outpatient EHR and care coordination system are integrated and have a live connection to the Massachusetts health information exchange.

Closing the gaps for better patient care

These solutions helped Holyoke Medical Center implement a single platform to encompass discharge planning, utilization management, and evidence-based care plans. Press Ganey evaluations found that Holyoke Medical Center achieved several improvements in ratings related to care coordination within the first six months. For example, patient satisfaction with the discharge process increased from 88.5% to 92.3%. Holyoke's Care Transition score also increased from 54.4% to 60.4%.

Holyoke Medical Center operationalized a significant amount of technology in six months and is subsequently identifying ways to leverage national risk stratification and predictive analytics. Holyoke Medical Center is closing the gaps in care transitions, and it's an exciting time for the provider.

> "We manage 27 different programs for defined patient populations, and while we tailor the care to their specific needs, we now have a unified case management approach."
>
> *Director of Transitional Care Management*
> *Holyoke Medical Center*

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CarePort is the leading care coordination network with thousands of providers connected across the U.S. The end-to-end platform bridges acute and post-acute EHR data, providing visibility into the entire patient journey for providers, physicians, payers, and ACOs. With CarePort, healthcare professionals can efficiently and effectively coordinate patient care to better track and manage patients as they move through the continuum. CarePort helps providers meet and comply with the patient event notification Condition of Participation, as part of the CMS Interoperability and Patient Access final rule, and the IMPACT Act. Read more about CarePort on careporthealth.com, Twitter and LinkedIn.

Learn more! Contact a CarePort® representative for more information.

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