SUCCESS STORY

A new vision for comprehensive care coordination

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 CMS BPCI and MSSP initiatives, which require care coordination to extend beyond the four walls of the hospital. Integrated care management solutions from Allscripts and a redesigned care management process helped break down siloes between departments and close gaps for better patient care.

CLIENT OVERVIEW

Holyoke Medical Center

HOLYOKE, MASSACHUSETTS, U.S.A.

Client 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 Centers for Medicare & Medicaid (CMS) value-based programs, including
  - Medicare Shared Savings Program (MSSP)
  - Model 2 Bundled Payments for Care Improvement (BPCI) Program

Allscripts Solutions

- Allscripts Care Director™
- Allscripts Care Management™
- CarePort (An Allscripts Company)
- CarePort Connect
- CarePort Guide
- CarePort Insight

"With Allscripts solutions, 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."

—- Michael Ipekdjian, RN, BSN, PHRN
Director of Transitional Care Management

FEWER READMISSIONS

Reduced readmission rate from .9 to .8 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)

Allscripts®

Breaking down siloes in care management

"One of the challenges we had was that our outpatient and inpatient case management efforts were disconnected. Departments couldn't see what the others were doing, so we risk loss of continuity of care," said Ipekdjian. "To accomplish quality care across the continuum, you can't have these siloes."

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, too.

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 of care

"We designed a uniform, patient-centered discharge process for all episodes of care," Ipekdjian said. "Then we implemented technology to integrate our care management systems, so we can share information to help patients across our entire continuum."

Holyoke Medical Center used a phased approach to implement the new model for care coordination. Phase one began in January of 2016, with the build of Allscripts Care Management for the inpatient side. This solution helps team members manage referrals, denials, documentation and discharge planning.

Phase two introduced Allscripts Care Director to the outpatient side, also in 2016. Ambulatory case managers can document their care plans, and track patients, worklists and intervention angles throughout the system.

> "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."
>
> —Michael Ipekdjian, RN, BSN, PHRN, Director of Transitional Care Management

Phase three 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

"Allscripts solutions enabled us to implement a single platform to encompass discharge planning, utilization management and evidence-based care plans," Ipekdjian said.

Press Ganey evaluations found that Holyoke Medical achieved several improvements in ratings related to care coordination, in just the first six months. For example, patient satisfaction with the discharge process increased 88.5% to 92.3%. "Holyoke's Care Transition score, which is a challenging measure for hospitals, increased from 54.4% to 60.4%...that's a giant leap for six months," he said.

"We operationalized a significant amount of technology in six months, and now we're looking at ways to use national risk stratification and predictive analytics," Ipekdjian said. "We're closing the gaps in care transitions…it's an exciting time for us."

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