St. Vincent’s Health Partners deploys analytics-informed care management workflow with McKesson Care Manager™
Since its inception, St. Vincent’s Health Partners (SVHP), a physician-hospital organization based in Bridgeport, Connecticut, has focused on optimizing the quality of its patient care in order to improve outcomes, expand access to care, and meet the growing demands of value-based reimbursement models.

“As we move to value-based reimbursement, we need population health tools that allow us to follow a patient through each transition in care and to remain engaged with the patient in the home, in the hospital, and in post-acute care settings,” says Dr. Michael Hunt, CMIO/CMO of St. Vincent’s Health Partners.

SVHP is navigating its population health journey by partnering with McKesson, utilizing McKesson Population Manager™ to help drive improvements in care delivery and compliance with evidence-based clinical guidelines. Using population health analytics, SVHP has been successful in closing gaps in care for both acute and chronic patients, resulting in a 25% reduction in unnecessary utilization of the emergency department and inpatient services.

The organization recently turned its focus to proactive care management, deploying McKesson Care Manager™, a provider-oriented care management workflow and documentation solution, to provide holistic, evidence-based care across the continuum for targeted populations. SVHP is depending on this solution to help improve clinical outcomes, coordinate the patient care experience, engage providers in the care management process, and manage the costs of care for its high-risk patient populations.
Challenges

St. Vincent’s faces a stark reality. More than 84 percent of U.S. healthcare dollars are spent on patients with chronic conditions, with just five percent of the population accounting for almost half of all healthcare spending. In order to reduce costs and improve outcomes, patients with chronic conditions must be handled with particular care and transparency. Under value-based payment models, healthcare organizations are reimbursed based on quality, and must deliver care at a contained cost.

SVHP sought a solution to help it manage its complex, medium- and high-risk patient populations — and affect patient behavior to improve these patients’ quality of life. “We’re using the analytics provided by McKesson’s solutions to see where our patients fall on the health continuum,” says Colleen Swedberg, MSN, RN, CNL, Director for Care Coordination and Integration. “Then we have appropriate interventions that address the needs of each category.”

As a large organization that includes one hospital, four acute nursing facilities, four home health agencies and 54 practice sites, St. Vincent’s wanted to create a comprehensive view of quality, cost, and care for its patients across many care settings. Each of SVHP’s facilities already had their own unique ways of handling care coordination and case management — but none of these processes were conversant with one another.

In addition, in order to participate in CMS’s Bundled Payments for Care Improvement (BPCI) Initiative shared savings program, SVHP needed the ability to follow a patient for 90 days post-discharge as the patient passed through transitions of care. To ensure that patients were getting the care they needed — and avoiding unnecessary medical episodes, such as readmission and trips to the emergency department — SVHP also needed an integrated, evidence-based approach to care coordination.

“We are about to move toward bundled payments at the hospital,” says Hunt. “During this process, we have to be aware of where each patient has received care and what kind of care was provided, so we can monitor our success throughout the course of the episode to realize shared savings.”

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— Dr. Thomas Raskauskas, President/CEO
St. Vincent's Health Partners

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Answers

St. Vincent’s deployed McKesson Care Manager™, a provider-oriented care management workflow and documentation solution, to aggregate patient data and proactively engage those patients who could benefit most from targeted care management programs.

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Based on the organization’s desired outcomes, McKesson Care Manager uses clinical analytics data to identify potential patients for SVHP’s care management programs. A workflow rules engine allows SVHP to determine which combined criteria will trigger a patient’s selection. “By automatically applying patients to a queue, McKesson Care Manager identifies the patients we want to focus on to be successful. SVHP applies the right level of patient engagement based upon the number and severity of disease, medication utilization, and access to specialty, primary, and urgent/emergent services,” says Hunt.

SVHP was the first organization in the country to be accredited under URAC’s Clinical Integration and Accountable Care Accreditation programs, which sets high standards for quality, cost-effective, patient-centered care delivery. “McKesson Care Manager can document the process we used to select patients, let us track the patient engagement activities we used to improve each individual’s health, and demonstrate the effect of these interventions on patient care,” says Hunt.

Population health analytics provides SVHP with the analytical lens to identify and stratify patient populations, and apply the appropriate level of care management. “With this focus, we’re able to better manage the riskiest and most vulnerable patients within the population,” says Hunt.
Results

St. Vincent’s providers, physicians and care managers are now sharing the data they need to proactively manage their patients’ health across multiple care settings. “For us, McKesson Care Manager is the solution that really glues the network together. We’re still allowing all of these disparate clinical systems at the providers’ offices and at the hospital to function in their unique environment, but now we can have an overarching care plan and track a patient across the continuum,” says Hunt.

As its experience with care management broadens, SVHP is redefining the care model and the roles of members of its care teams. The organization’s primary care physician offices are required to become patient-centered medical homes within two years of joining the PHO. The hospital has accredited, certified nurse managers on staff, and the group’s skilled nursing facilities must pass case management courses as part of their state licensure. SVHP is working to clarify the responsibilities of each role, so that all staff members recognize how they can personally facilitate better care.

Guided by McKesson Care Manager, SVHP’s physicians, care managers and other caregivers now have a more complete understanding of the patient’s personal health challenges — and the resulting confidence to address missing information. “We have a much better chance of closing gaps in care when we’re sitting face to face with a patient. Our providers can see what needs to be done, and that transparency makes for not only a better experience for the patient, but for the provider as well,” says Swedberg.

Using population health analytics to better manage its patients’ gaps in care, St. Vincent’s has already been able to reduce unnecessary utilization of the emergency department and inpatient services by 25 percent. As SVHP continues to drive higher quality care across its network, the organization is confident that it will realize further cost reductions as a result of those efficiencies.

“With McKesson, we know we’re partnering with a professional company that is allowing us to quickly realize and understand our operational strategy. They’ve been very supportive of our model, which has to be very adaptable and progressive in order to be successful,” says Hunt.

At a Glance

Organization
St. Vincent’s Health Partners
Bridgeport, Connecticut
- St. Vincent’s Medical Center
- 275 primary care and specialist physicians
- 54 practice sites
- 4 skilled nursing facilities
- 4 home health agencies

Solution spotlight
- McKesson Care Manager™
- McKesson Population Manager™

Critical issues
- Assuming financial risk for population
- Managing critical care patients
- Reducing cost of care

Results
- 25% reduction in unnecessary utilization of the emergency department and inpatient services
- Ability to track and manage patients across the care continuum
- Evidence-based, blended clinical assessments and integrated care plans
- Care management workflow populated with existing clinical, lab and utilization data
- Hybrid-model care management system with network- and clinic-based roles
- Ability to share a holistic view of patients’ health status with physicians and providers
How does McKesson Care Manager work?

McKesson Care Manager helps organizations treat patients with multiple conditions holistically, producing an integrated, evidence-based care plan that gives all caregivers a big-picture view of the patient’s health status, prioritized goals and recommended interventions.

Once a patient is identified for inclusion in a care management program, the care manager accesses an evidence-based, blended assessment tailored to the patient’s conditions. Through integration with McKesson Population Manager™, the assessment is pre-populated with relevant clinical, lab and medication data — saving the care manager time and ensuring a smooth question-and-answer process for the patient. The assessment also addresses social determinants, such as support systems or psychological issues, and uncovers barriers to care access, such as a lack of transportation.

McKesson Care Manager uses InterQual® Coordinated Care Content to inform both the assessment and integrated care plan. As a physician-based organization that continuously reports on how its physicians are meeting quality metrics, SVHP appreciates the solution’s reliance on evidence-based clinical content, reviewed by hundreds of physicians to ensure clinical validity.

McKesson Care Manager is designed to support embedded (clinic-based), enterprise (network-based) or hybrid model care management programs, such as the one at St. Vincent’s. SVHP uses centralized care coordinators to perform initial outreach to each identified patient, completing the clinical assessment over the phone. The patient then partners with a clinic-based care manager or nurse case manager to establish a prioritized list of goals, review educational components and work to achieve successive healthcare goals.

Because the solution is integrated with SVHP’s clinical data, McKesson Care Manager automatically updates care plans as new clinical and lab information indicates changes in patient health. For example, ADT feeds into McKesson Population Manager and McKesson Care Manager auto-generate a work item for the care manager to contact patients shortly after discharge. The solution can also leverage information available in McKesson Risk Manager™ to automatically incorporate the patient’s risk scores, categories and utilization data, populating concurrent, prospective and predictive risk categories and the likelihood of hospitalization.