MVC Case Study: McLaren Port Huron Hospital

Custom Analytics: Patient Follow-Up 2020-2021

Background

Initial Outreach

In January 2020, McLaren Port Huron Hospital leadership reached out to MVC for support regarding their rates and adherence to follow-up visits in the CHF patient population.

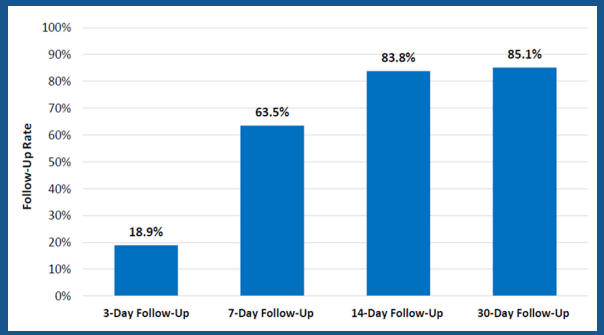
Inception Meeting

The MVC team held an inception meeting with hospital members to develop a roadmap of support. Following this contact, McLaren Port Huron provided a list of patients that had been referred for follow-up after hospitalization for CHF. This information was then used to match with MVC claims data sources to identify adherence to follow-up.

Custom Analytics

MVC completed a patient match (c.70%) which revealed that adherence to follow-up visits at McLaren Port Huron was high, especially at 14 and 30 days post-discharge.

Post-Match Findings Related to Follow-Up and Utilization (CHF)



Utilization Factor	Percent
30-Day Readmission Rate	14.9%
30-Day Home Health Utilization Rate	36.5%

Continued Collaboration

Follow-Up Contact

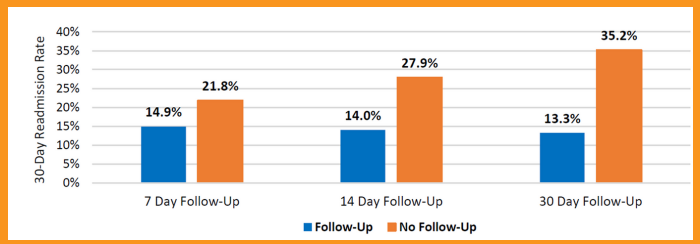
After pausing activity due to COVID-19 and the reallocation of resources, McLaren Port Huron re-engaged with MVC following the dissemination of the Chronic Disease Management Reports for CHF and COPD in November 2020.

MVC then met with McLaren Port Huron Hospital leadership to review follow-up rates related to high readmissions for COPD (compared to MVC all). After detailed discussion, McLaren Port Huron requested additional custom analytics related to readmissions in their COPD population.

Custom Analytics

This analysis showed that although 30-day readmission rates for COPD at McLaren Port Huron were high overall (19.6%), patients that had a follow-up had reduced readmission rates. Patients that had a follow-up visit within 30-days post discharge had a 30-day readmission rate of 13.3% compared to 35.2% in those without a 30-day follow-up visit. A zip-code level analysis also revealed that specific areas were subject to higher readmission rates.

30-Day Readmission Rate by Follow-Up Status (COPD)



Best Practice Sharing

- To supplement these data, the MVC team also provided best practice approaches used by other collaborative members, including information on specific risk readmissions tools (BOOST, LACE, RRAT, AHRQ Readmission Tookit).

Next Steps

Final Request

In January 2021, McLaren Port Huron requested that MVC replicate the same analysis for CHF. In addition, interest in the development of a Chronic Kidney Disease cohort for the MVC registry was shared.

Custom Analytics

Similar to COPD, CHF readmission rates were lower in those patients that had a follow-up compared to no follow-up at McLaren Port Huron. Again, a zip-code level analysis revealed that certain areas were subject to higher readmission rates.

MVC Member Feedback

"Being a medium size community hospital, we don't have access to high level data analytics to assist us in really understanding our readmission performance. It was just a matter of reaching out and asking for help - we loved being able to have an initial conference call to go over our struggles and then determine what kind of information we needed.

We held an Improvement Event that included physicians, senior leadership, nursing and other ancillary services. We identified seven additional reduction tactics. We also brought the best practices MVC provided to us to our Readmissions Reduction meeting. At first, I didn't think MVC would meet our timeline, but they not only met it but exceeded all expectations."

Michigan Value Collaborative

McLaren PORT HURON

Blue Cross Blue Shield of Michigan