MVC CASE STUDY

Member Initiative: McLaren Physician Partners Tackles Care Management of COPD

ABOUT MCLAREN PHYSICIAN PARTNERS

Vision

To create a partnership with MPP physicians and the McLaren Health Care System to improve their population's health, enhance the patient experience, and create value.

Reach

MPP was originally established as a partnership between McLaren Health Care and its medical staff. MPP has since grown to encompass over 2,200 providers and over 250,000 managed lives in counties across Michigan (see Figure 1).

Figure 1. McLaren Physician Partners Service Area Map

BACKGROUND

INITIAL ISSUE

McLaren Physician Partners (MPP) worked to identify areas for improvement within their COPD patient population. Some common patient struggles consisted of higher utilization in the emergency department and inpatient settings and higher readmission rates, specifically among their Medicare patients (38%).

CASE REVIEWS

Five nurse managers were tasked with performing case reviews in order to identify areas for improvement. Five to 10 patients were pulled from each nurse manager's caseload that had three or more encounters in the past six months. Upon review, 83% of those patients had a concurrent cancer diagnosis, while all patients had other significant comorbidities (e.g., diabetes, congestive heart failure, etc.). Additionally, the reason for readmission was most often related to either respiratory insufficiency or a cancer treatment side effect. Care managers then engaged the patients and completed a questionnaire with them. Approximately 68% of these patients were identified as having a misunderstanding of their medication, 26% had environmental barriers, 14% were not compliant with medication, and fewer than 15% reported an inability to afford medication/devices.

PRELIMINARY CONCLUSIONS

Readmissions related to disease progression and inappropriate medication use were the major contributing factors to higher utilization in the inpatient setting and emergency department. Additionally, all admissions and readmissions were related to some form of respiratory insufficiency or cancer treatment side effects.

TARGETING INTERVENTIONS

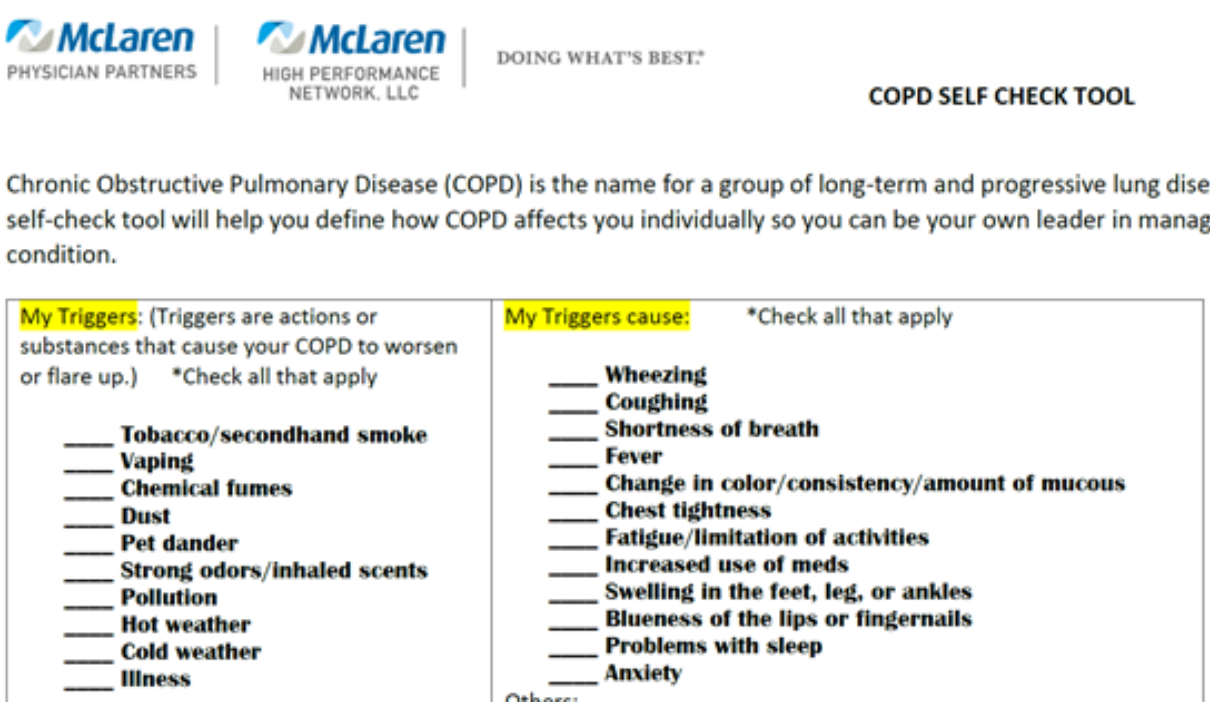
INTERVENTION

Due to the time this initiative was implemented, COVID-19 impacted the type of intervention that could be put into place. McLaren Physician Partners opted to adopt a telephonic intervention in order to address education needs and remove barriers. Specific needs were addressed around triggers that lead to exacerbation, managing medications and compliance, and developing a plan of action at first symptom.

Additionally, the intervention sought to minimize and remove barriers where possible (e.g., cost of medications, transportation issues for visits). Lastly, considerations were made regarding whether patients were a candidate for palliative care or not.

INTERVENTIONS, CONT. ON PAGE 2.

Figure 2. McLaren Physician Partners COPD Self Check Tool



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COPD SELF CHECK TOOL

Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of long-term and progressive lung diseases. This self-check tool will help you define how COPD affects you individually so you can be your own leader in managing your condition.

My Triggers: (Triggers are actions or substances that cause your COPD to worsen or flare up.) *Check all that apply

- ____ Tobacco/secondhand smoke
- ____ Vaping
- ____ Chemical fumes
- ____ Dust
- ____ Pet dander
- ____ Strong odors/inhaled scents
- ____ Pollution
- ____ Hot weather
- ____ Cold weather
- ____ Illness

My Triggers cause: *Check all that apply

- ____ Wheezing
- ____ Coughing
- ____ Shortness of breath
- ____ Fever
- ____ Change in color/consistency/amount of mucous
- ____ Chest tightness
- ____ Fatigue/limitation of activities
- ____ Increased use of meds
- ____ Swelling in the feet, leg, or ankles
- ____ Blueness of the lips or fingernails
- ____ Problems with sleep
- ____ Anxiety

Others:

INTERVENTIONS, CONT.

TOOLKIT DEVELOPMENT

Nurse navigators looked into possible ways to engage patients differently in order to hopefully prevent readmission or exacerbation that caused an admission. They were aware that what they were doing wasn't working, and needed some sort of upgrade.

A toolkit was developed that was sent to the patient prior to the phone call. A one- to two-hour phone call was then scheduled in order to adequately help the patient understand this toolkit. The kit required active participation and helped the patient develop specific goals and actions to take when they see signs of a potential exacerbation.

FINDINGS

After the implementation of this pilot program, all navigators came together to discuss their findings. Many issues were noted, including the fact that patients did not know the difference between their inhalers (rescue vs. long-acting). Additionally, patients often didn't know that some of their symptoms may have been preventable if they had been able to identify certain triggers.

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Michigan Value Collaborative
On the findings from the toolkit pilot

Of this group of patients who received this telephonic intervention, the readmission rate for those who were recently discharged and engaged decreased by more than 20%. Overall, McLaren Physician Partners saw a decrease in their hospitalizations due to the implementation of this program.

MOVING FORWARD

After deeming the pilot program successful, McLaren Physician Partners launched this toolkit for all their physicians to use in their COPD patient population (see Figure 2). Telecare coordination has been added as an additional tool in order to set the patient up for better success. This coordination is managed through a mobile app on a smartphone, tablet, or computer with audio or visual capabilities. Patients have the ability to directly message the care manager. If a patient does not have a smart device, a device is mailed to their home with a data plan for service.