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) was working 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. Sample Pages from MPP 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	My Triggers cause: *Check all that apply
___ Tobacco/secondhand smoke ___ Vaping ___ Chemical fumes ___ Dust ___ Pet dander ___ Strong odors/inhaled scents ___ Pollution ___ Hot weather ___ Cold weather ___ Illness Others: _____	___ 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: _____

Pay attention to your body and learn/know your own "normal" or baseline. Recognizing early symptoms of a flare-up means you can help decrease its severity and potentially avoid an admission to the hospital.

Things that help keep my COPD controlled: *Check all that apply	When I have a flare, these are the steps I follow: *Check all that apply
___ rescue and maintenance inhalers ___ breathing exercises ___ Oxygen ___ Cpap/bipap ___ flu/pneumo vaccines as recommended ___ frequent handwashing ___ symptom diary ___ pulmonary rehab ___ cover mouth or nose when outside ___ use of incentive spirometer/flow meter ___ to monitor baseline lung function ___ pulse oximeter to monitor oxygen levels Others: _____	___ call primary care physician ___ call pulmonologist ___ call for rescue rx -antibiotic/steroids ___ use nebulizer ___ use rescue inhaler ___ apply oxygen **Take your action plan to you physician for review and discussion of flare up steps to follow. Others: _____

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COPD SELF-CHECK TOOL

American Lung Association.

My COPD Action Plan

It is recommended that patients and physicians/healthcare providers complete this action plan together. This plan should be discussed at each physician visit and updated as needed.

The green, yellow and red zones show symptoms of COPD. The list of symptoms is not comprehensive, and you may experience other symptoms. In the "Actions" column, your healthcare provider will recommend actions for you to take based on your symptoms by checking the appropriate boxes. Your healthcare provider may write down other actions in addition to those listed here.

Green Zone: I am doing well today	Actions
• Usual activity and exercise level • Usual amounts of cough and phlegm/mucus • Sleep well at night • Appetite is good	☐ Take daily medicines ☐ Use oxygen as prescribed ☐ Continue regular exercise/diet plan ☐ At all times avoid cigarette smoke, inhaled irritants* ☐ _____

Yellow Zone: I am having a bad day or a COPD flare	Actions
• More breathless than usual • I have less energy for my daily activities • Increased or thicker phlegm/mucus • Using quick relief inhaler/nebulizer more often • Swelling of ankles more than usual • More coughing than usual • I feel like I have a "chest cold" • Poor sleep and my symptoms woke me up • My appetite is not good • My medicine is not helping	☐ Continue daily medication ☐ Use quick relief inhaler every _____ hours ☐ Start an oral corticosteroid (specify name, dose, and duration) _____ ☐ Start an antibiotic (specify name, dose, and duration) _____ ☐ Use oxygen as prescribed ☐ Get plenty of rest ☐ Use pursed lip breathing ☐ At all times avoid cigarette smoke, inhaled irritants* ☐ Call provider immediately if symptoms don't improve* ☐ _____

Red Zone: I need urgent medical care	Actions
• Severe shortness of breath even at rest • Not able to do any activity because of breathing • Not able to sleep because of breathing • Fever or shaking chills • Feeling confused or very drowsy • Chest pains • Coughing up blood	☐ Call 911 or seek medical care immediately* ☐ While getting help, immediately do the following: ☐ _____

*The American Lung Association recommends that the providers select this action for all patients.

1-800-LUNG-USA | Lung.org/copd

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.

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.