Uploaded to VFC Website

November 2012

This Document has been provided to you courtesy of Veterans-For-Change!

Feel free to pass to any veteran who might be able to use this information!

For thousands more files like this and hundreds of links to useful information, and hundreds of "Frequently Asked Questions, please go to:

Veterans-For-Change

Veterans-For-Change is a 501(c)(3) Non-Profit Corporation
Tax ID #27-3820181

If Veteran's don't help Veteran's, who will?

We appreciate all donations to continue to provide information and services to Veterans and their families.

https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=WGT2M5UTB9A78

Note: VFC is not liable for source information in this document, it is merely provided as a courtesy to our members.

COPD Disease Management Program: 2008 – 2009

	All Members with COPD	*Members with moderate risk COPD*	*Members with High Risk COPD*
Definition	All Community Health Group members with COPD.	Members with diagnosis of COPD identified through hospital claims data, ambulatory claims data, and pharmacy data of members receiving anticholinergics, inhalers etc., with hospital inpatient admission or ER tx within the last 6 months.	Members with a primary diagnosis of COPD and secondary diagnosis of diabetes or other co-morbidities; members with hospital admission, or ED tx within last 3 months.
Member Interventions	• Targeted member mailings twice per year. Promotion of key self-care messages; promotion of My Health Zone, health education resource guides and overall health education benefits. • Enter interventions in CHG NET.	• Targeted member letter • Initial telephone call-assessment of needs; completion of call tracking assessment tool. • Quarterly mailing of COPD health education materials. • Mail information on smoking cessation programs as applicable. • Establish a database of all patients with COPD; enter all interventions in CHG NET. • Monitor-disease progression, compliance with medications, exacerbation history, co-morbidities. • Continue quarterly telephone re-assessments. • Coordinate efforts with other case management initiatives as needed.	• Same interventions as for all COPD pts. • Evaluate individual need for home evaluation by RN or RT. • Analyze results of telephonic surveys and modify program as needed to meet needs identified by high-risk members. • CM review of hospitalizations, ED encounters and pharmacy utilization reports to determine opportunities to prevent adverse events and address system issues identified. • Automatic health education referral for all hospital admissions and ED visits. • Consider referral to specialty health ed. • Monitor compliance with PCP and pulmonology f/u. • Conduct monthly telephone calls (at minimum). • Consider pulmonary rehabilitation. • If patient with Stage III COPD and/or on oxygen, closely monitor utilization of services.

COPD Management Program

	All Members with COPD	Members with moderate risk COPD	Members with High Risk COPD
Practitioner Interventions	• Annual distribution of COPD management program overview with the clinical practice guideline (Global Initiative for Chronic Obstructive Lung Disease-GOLD, 2006); annual distribution of identified members. • Biannual mailing of COPD initiative material promoting self-care and management. • Annual review and approval of clinical practice guidelines by Community Health Group's QIC, UM and P&T Committees. • Coordinate targeted mailing and/or telephone contact of patients with COPD upon hospital discharge from the hospital. Mailing to include COPD health education resource guide and case specific findings based on telephonic assessments if done prior to hospital admission.		
Expected Outcomes	Increase member and provider knowledge of the signs and symptoms of COPD.	• Increase knowledge of COPD and self-management • Decrease in avoidable hospitalizations and ED encounters • Increase in medication compliance • Increase practitioner compliance with treatment guidelines • Improved management of patients through increase use of anticholinergics and ACE-I's.	• Decrease in avoidable hospitalizations and ED encounters • Increase in utilization of outpatient services (PCP, pulmonology, health education). • Increase knowledge of COPD and self-management. • Increase in medication compliance through improved management of patients on anticholinergics and ACE-I's. • Increase practitioner compliance with treatment guidelines.
Measures	• Decrease overall cost of care post interventions.	• Decrease overall cost of care post interventions.	• Initial measurement of baseline data re: hospitalization and ED visits and re-measurement after 6 months of intense interventions. • Individualized case reviews of members followed by various initiatives based on utilization patterns and highest risk. • Decrease cost of care post interventions