

*Mommy Steps*

*Complex Case Management*

*Diabetes Management*

**2016**

*Healthy Heart Program*

# **Congestive Heart Failure**

## **Program Evaluation**

*Obesity Management*

*Chronic Respiratory Management*

*Congestive Heart Failure Management*

***Our mission is to improve the health  
and quality of life of our members***

*EPSDT Program*

*Rapid Response Outreach Team*



## 2016 Congestive Heart Failure Program Evaluation

**Program Title:** Congestive Heart Failure Program

**Evaluation Period:** January 1, 2016 – December 31, 2016

**Introduction:** Designed to improve the health status and quality of life for members with congestive heart failure (CHF) through improved compliance of both members and clinicians with the American College of Cardiac Foundation/American Heart Association (ACCF/AHA) Guidelines. CHF Disease Management is the process of coordinating health care interventions and communications for members with CHF in which patient self-care efforts are significant, supporting clinician/member relationships and the established treatment care plan; emphasizing prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and evaluating clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

- 2016 Program Goals:**
- To increase clinician and member adherence to ACCF/AHA Guidelines regarding the use angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), diuretics, and/or beta-blockers unless contraindicated.
  - To increase member adherence with medications, sodium intake, and weight monitoring and management.
  - To decrease the frequency of CHF inpatient admissions, readmissions within 30 days, and emergency room (ER) visits.
  - To promote healthy lifestyle-diet and nutrition, daily measurement of weight, physical activity, and smoking cessation.

- 2016 Program Objectives:**
- Increase clinician adherence to ACCF/AHA Guidelines regarding the use of ACE inhibitors, ARBs, diuretics, or beta blockers unless contraindicated through review and analysis of clinical and pharmacy data.
  - Increase member adherence with medications, sodium intake, and weight monitoring and management through risk stratification, telephonic outreach and educational mailings.
  - Decrease the frequency of CHF inpatient admissions, readmissions within 30 days, and ER visits through monitoring of inpatient, ER and readmission reports telephonic outreach, and educational mailings.
  - Promote healthy lifestyle-diet and nutrition, daily measurement of weight, physical activity, and smoking cessation.

**Measurements:** Overall effectiveness of the CHF Program is measured through annual participation rates and audited HEDIS<sup>®1</sup> results.

## Annual Participation Rate

Eligible members are identified and passively enrolled in the CHF Program. Members may “opt out” of the Program, and elect not to receive disease management (DM) services, by notifying the CHF Disease Manager or the Care Connector Program, either telephonically or in writing. Participation Rates are tracked and reported annually.

	CHF Membership (avg) <sup>2</sup>	Opt Out	Participation Rate
2016	2,608	64	99.97%
2015	2,234	8	99.99%
2014	1,889	11	99.99%
2013	1,383	2	99.86%

## CHF Management

### 2016 HEDIS<sup>®</sup> Results

The 2016 HEDIS<sup>®</sup> Results are based on measurement year 2015 data.

#### 1. Persistent of Beta-Blocker Treatment After a Heart Attack (PBH)

The percentage of members 18 years of age and older who were hospitalized and discharged alive from July 1 – June 30 with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

**Findings:** In measurement year 2015, a total of 245 members were discharged alive with AMI diagnosis, of which 209 (85.31%) were on a beta-blocker treatment.

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
PBH	65.00%	73.42%	94.44%	86.00%	85.31%

The goal to meet or exceed the 2016 Quality Compass<sup>®3</sup> 90<sup>th</sup> Percentile of 91.67% was not met.

For measurement year 2015, PBH is in the 2016 Quality Compass<sup>®</sup> 50<sup>th</sup> Percentile.

<sup>1</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

<sup>2</sup> Program membership numbers are annualized

<sup>3</sup> The source for data contained in this publication is Quality Compass<sup>®</sup> 2015 (Medicaid) and is used with the permission of the NCQA. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

## 2. Annual Monitoring for Patients on Persistent Medications (MPM)<sup>4</sup>

The percentage of members 18 years of age or older who received at least 180 treatment days of on ACE inhibitors or ARB during the measurement year and at least one therapeutic monitoring event for the on ACE inhibitors or ARB in the measurement year.

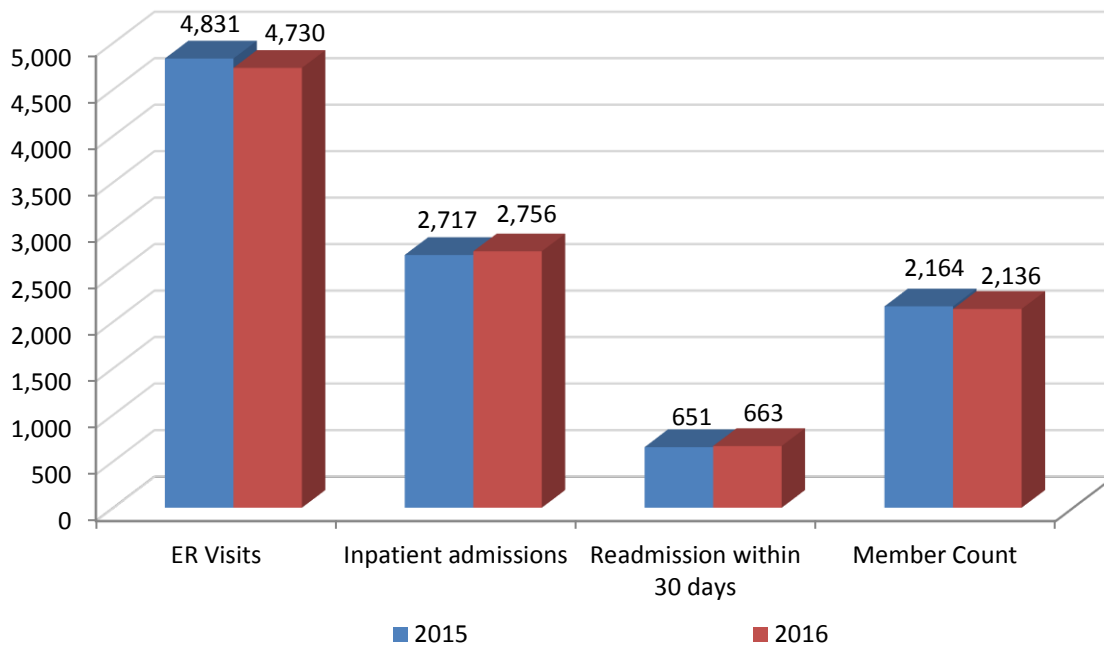
**Findings:** In measurement year 2015, a total of 19,143 members were identified and 17,288 (90.33%) received monitoring.

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
ACE Inhibitors or ARBs	91.56%	91.01%	91.78%	92.00%	90.33%

The goals to meet or exceed the 2016 Quality Compass<sup>®</sup> 90<sup>th</sup> Percentile for MPM ACE/ARB (92.13%) was not met.

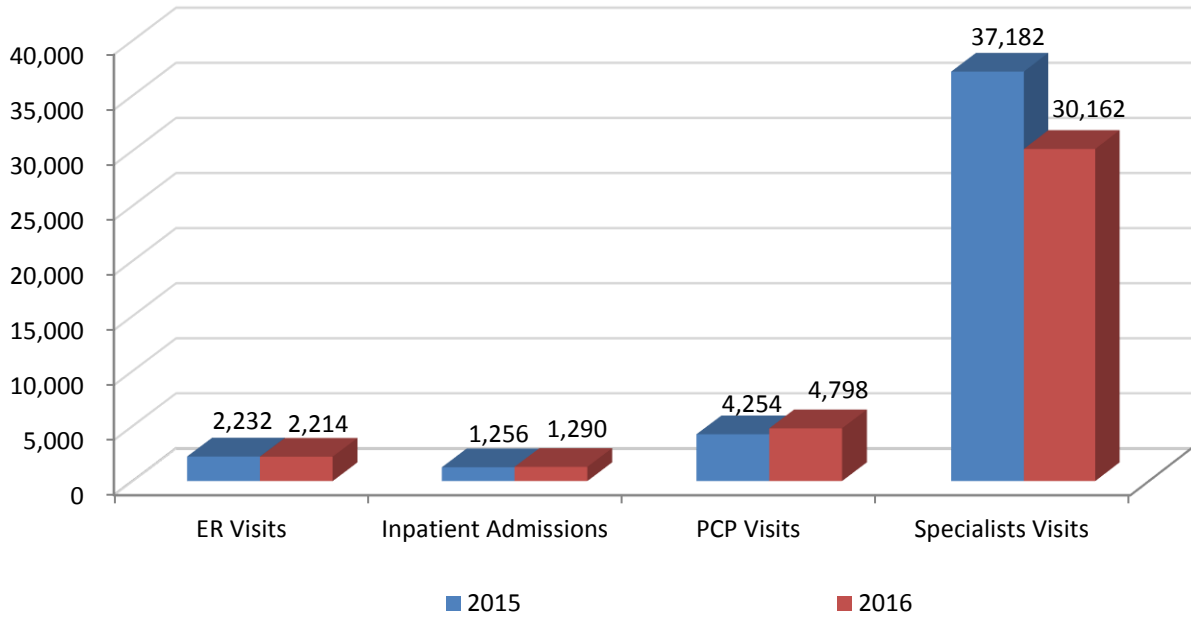
For measurement year 2015, MPM ACE/ARB is in the 2016 Quality Compass<sup>®</sup> 75<sup>th</sup> Percentile.

**Hospital Utilization with a Primary Diagnosis of CHF**

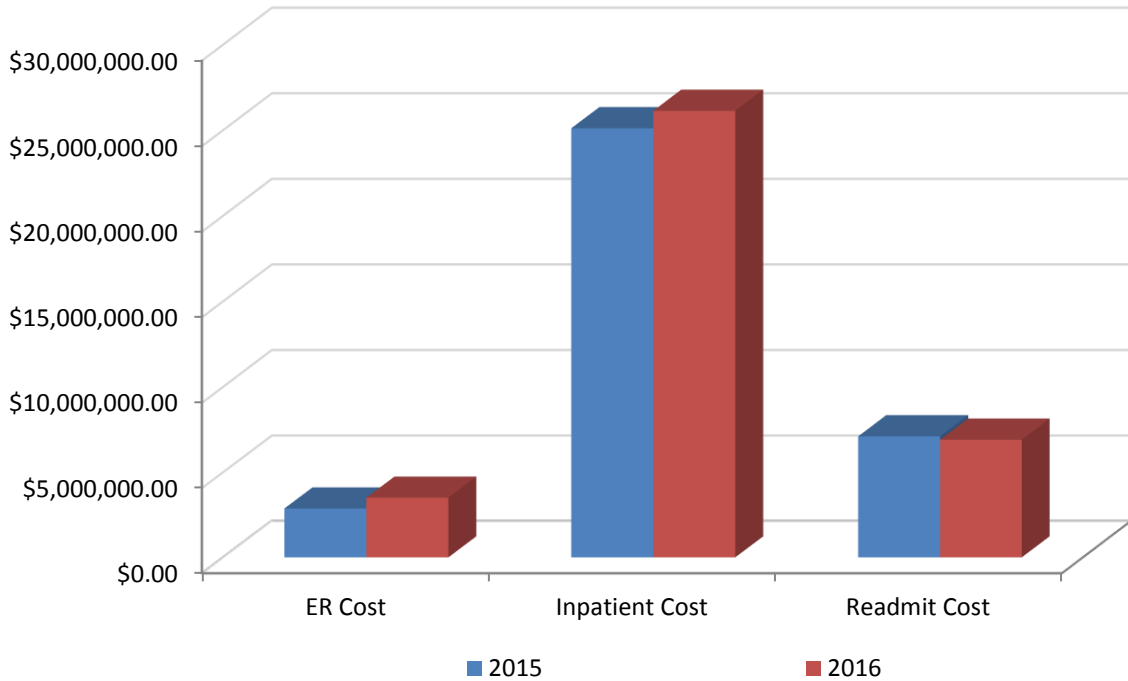


<sup>4</sup> HEDIS<sup>®</sup> Measure MPM also includes monitoring of diuretics, digoxin, and anticonvulsants.

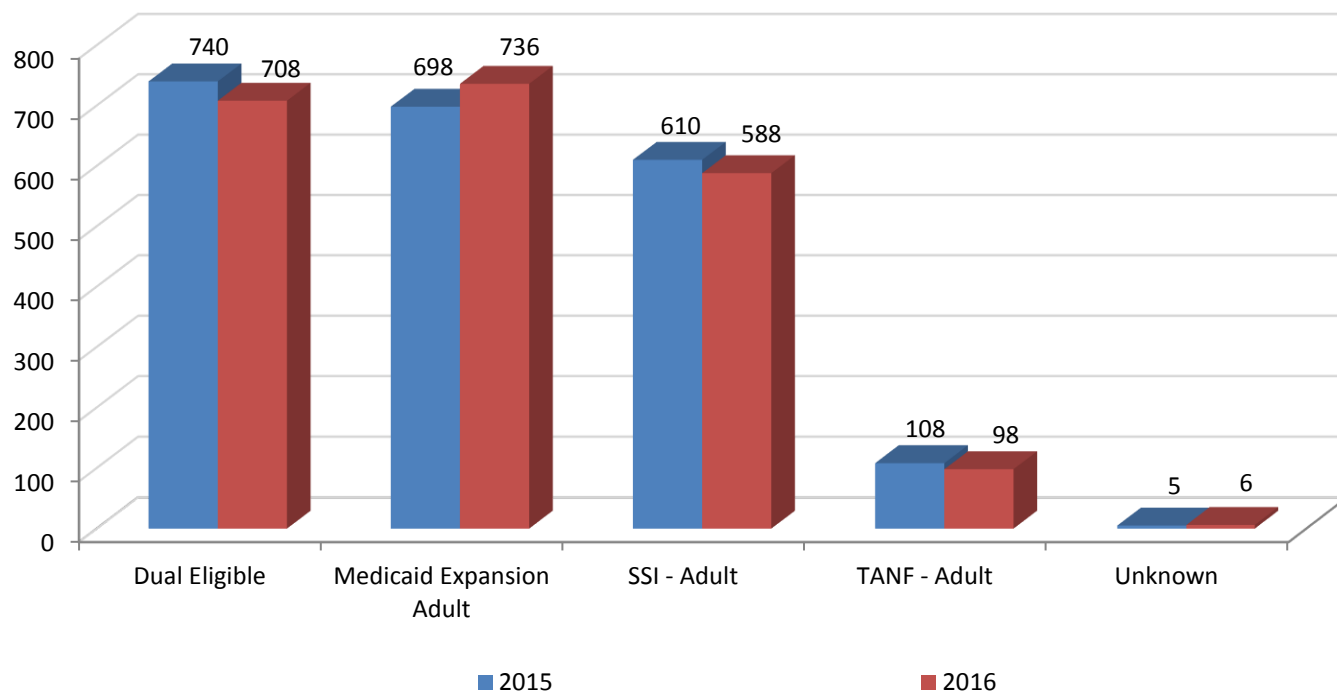
### Utilization for Members with CHF (per 1,000)



### Hospital Cost with a Primary Diagnosis of CHF



## Members with CHF by Category of Aid



### Analysis

**HEDIS®:** Results for HEDIS® 2016 (MY2015) remains relatively the same with a slight decrease of 0.69 percentage points for Persistent of Beta-Blocker Treatment After a Heart Attack which met the 2016 Quality Compass® 50<sup>th</sup> Percentile, and a decrease of 1.67 percentage points for ACE Inhibitors or ARBs which met the 2016 Quality Compass® 75<sup>th</sup> Percentile.

**Member Engagement:** Multiple member interventions are conducted to educate the member on the importance of testing and to remind the member they need to follow the ACCF/AHA Guidelines on recommended screenings/testing. Providers are notified of members in need of screenings and resources to track members with CHF. The Care Coordination Department has case managers in high volume/care gap clinician office in order to educate and encourage the members face-to-face to complete screenings. Members receive a new member packet upon identification along with monthly and quarterly mailings in addition to telephonic outreach to high risk members.

**Community and Clinician Engagement:** Clinicians received status updates on members enrolled in the CHF Program and provided reference information on the ACCF/AHA Guidelines for the Diagnosis and Management of CHF on Passport's website. Collaborated with a third party vendor to develop the Passport's Stay Healthy at Home Program to educate members on how to better manage their CHF while in the comfort of their homes. The CHF Program received facility-specific ER and readmission reports for identification and targeted mailing and telephonic member outreach.

Risk Stratification: The CHF Program collaborated with Passport's ER Navigators for targeted face-to-face education, mailing and telephonic outreach to members with CHF who have an ER visit.

During 2016, an average of 2,608 members were enrolled in the CHF Program, an 86% increase from 2015. Of those members enrolled, an average of 1,147 were identified as high risk, a 61% increase from 2015. There were 232 members who were active with one-on-one telephonic outreach by the CHF Disease Manager, an 81% increase from 2015. A total of 534 members were identified as newly diagnosed with CHF. Three separate attempts are made to contact the member. All members receive quarterly mailings, and high risk members receive individualized mailings based on assessment by the CHF Disease Manager.

Telehealth: During 2016, the Telehealth Program enrolled 69 members with CHF, a decrease of 57% from 2015. The Program includes the use of electronic scales and blood pressure devices for weight and blood pressure monitoring via a secured web portal. These biometric measures will be monitored and evaluated on a daily basis by the CHF Disease Manager, or their designee, to promote and assist members to learn healthy behaviors and self-manage. The goals of the Program will be to promote member self-efficacy, reduce ER and inpatient utilization.

Member Complaints: During 2016, there were no complaints received regarding the CHF Program or CHF Disease Manager.

## **Program Materials**

### *Member materials:*

- Congestive Heart Failure
- Heart Failure Booklet
- Track My Symptoms Chart
- Do You Know the Signs of Heart Failure
- Stay Active with Heart Failure
- Stay in the Green! Know the 3 Heart Failure Zones
- What is Heart Failure
- How Much Sodium (Salt) Am I Eating

### *Clinician Materials:*

- Care Coordination: Your Connection to Disease and Case Management Programs Brochure
- Admitted 1on1 Letter
- Unable to Contact Letter
- Discharge Letter
- Thank You Referral Letter
- Program Discharge Letter
- Member Opted-Out Letter
- Enrolled Letter
- Discharge 1on1 Letter

## Barriers and Opportunities

**Barrier:** Lack of clinician awareness regarding ACCF/AHA Guidelines for the diagnosis and treatment of CHF.

- Opportunity:**
- Collaborate with Provider Relations to educate clinicians during all site visits regarding the ACCF/AHA Guidelines and the diagnosis and treatment of CHF.
  - Increase clinician awareness of the appropriate treatment for persons with CHF by posting current ACCF/AHA Guidelines on Passport's website.

**Barrier:** Member lack of knowledge regarding CHF control.

- Opportunity:**
- Increase members and caregivers knowledge regarding the appropriate treatment and appropriate self-management skills for persons with CHF.
  - Collaborate with community agencies and statewide initiatives to increase awareness of CHF management.
  - Increase member and caregiver awareness regarding the appropriate treatment and appropriate self-management skills for persons with CHF through:
    - Face-to-face outreach
    - Telephonic outreach
    - Member newsletters
    - On-hold SoundCare messages
    - Passport's website
    - Member educational materials
  - Collaboration with ER Navigators for identification of members for targeted educational outreach.

**Barrier:** Lack of early recognition and treatment of CHF exacerbation leading to inpatient admissions and ER visits.

- Opportunity:**
- Identify members with inpatient admissions and ER visits with a diagnosis of CHF for targeted member educational outreach.
  - Distribute a follow-up educational letter to clinicians notifying them of members on their panel with an ER visit related to CHF.
  - Utilize the Care Connector Program to assist members with urgent issues related to CHF.
  - Collaborate with ER Navigators for identification of members for targeted educational outreach.



**Interventions  
completed in 2016:**

**Provider Education:**

- Increased clinician awareness of the appropriate treatment for persons with CHF by posting current ACCF/AHA Guidelines on Passport's website and through Provider Relations site visits.
- Worked with clinician committees to develop tools for the clinicians to utilize, in order to ensure thorough documentation regarding all aspects of the ACCF/AHA Guidelines. Passport conducted clinician outreach regarding the ACCF/AHA Guidelines and audited compliance with documentation.

**Member Education:**

- Educated members/caregivers regarding CHF through face-to-face outreach, telephonic outreach, member newsletters, on-hold SoundCare messages, Passport's website, and member educational material.
- Identified and outreached to members with inpatient admissions or ER visits. In 2016, the CHF program averaged 2,608 members.
- Identified members who had a lapse in their medication refill pattern and provide targeted outreach. The CHF Program averaged 58 members each quarter that were involved in one-on-one contact.
- Enrolled 69 appropriate members with CHF in the Stay Healthy at Home Program during 2016.
- Continued efforts to educate members and/or caregivers about CHF, smoking cessation, how to prevent an exacerbation, and what to do when the member has an exacerbation.
- Organized member educational materials to include a definition of CHF information regarding smoking cessation, medications, how to take medication, and clinician follow-up.
- Updated "Special Health Programs, Just for You!" brochure for member education on support programs available for them.
- Developed new Member Satisfaction Survey Postcard directing members to the Passport website to fill out their survey. There is a specific survey number based on the program the member was enrolled in. If the member would prefer to have a hard copy mailed to them, they can call into our Care Connector line and they will mail one to them to fill out and return.

**Screening Activities:**

- Administered the Patient Health Questionnaire (PHQ) 2 with 56 members screened and 11% of those members had a positive result and the PHQ-9 was administered. Of those members, six were referred for Behavioral Health (BH) services.

**Identification Activities:**

**Interventions  
completed in 2016  
(Continued):**

- Identified and outreached to members with inpatient admissions or ER visits.
- Evaluated all member materials to ensure each piece is clear and concise. Materials continued to be utilized for member mailings; in addition to face-to-face education with the members at the clinician's office.
- Leveraged the Care Connector Program to engage members in need of assistance making appointments.
- Expanded upon current processes to develop additional relationships with participating ERs and ER Navigators to promote discharge planning and education regarding appropriate ER use.
- Reviewed daily, and/or weekly reports from three high volume participating ERs, University of Louisville (U of L), Hardin Memorial Hospital (HMH) and Norton Healthcare). The ER Coordinator reviewed these reports and outreached to the members and/or guardians telephonically, to encourage clinician follow-up, identified barriers to compliance, and offered Passport assistance with scheduling appointments and/or transportation. In addition, the ER Coordinator completed a health risk assessment and made referrals to clinical staff for additional outreach and education.
- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.
- Distributed the CHF Member Satisfaction Survey to members enrolled in the CHF Program, reviewed surveys as received and conducted outreach to those members who indicate "fair" or "poor" responses on their survey (if the member completes contact information section of the survey tool) and monitored surveys for trends, none identified. Provided feedback to individual staff when appropriate and addressed any identified areas that needed improvement, none identified.

**Community Activities:**

- Increased community initiatives related to the diagnosis and treatment of CHF through:
  - Collaborated with Provider Relations and Embedded Case Managers to educate clinicians regarding available monthly Care Gap Reports.
  - Collaborated with the Embedded Case Managers, in the high volume clinician offices, to engage members in face-to-face education regarding CHF.
  - Collaborated with ER Navigators for identification of members for targeted mailing and telephonic educational outreach for members with CHF.

**Interventions completed in 2016 (Continued):**

- Collaborated with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.

**Planned Interventions for 2017:**

**New Enhancements:**

- Continue to develop the Telehealth tool to use a “step down” approach with members no longer needing the intense monitoring program to promote and assist members to learn healthy behaviors and self-manage. The goals of the using the telehealth tool will be to promote member self-efficacy, reduce ER and inpatient utilization.

**Continued Interventions:**

- Increase clinician awareness of the appropriate treatment for persons with CHF by posting current ACCF/AHA Guidelines on Passport’s website and through Provider Relations site visits.
- Work with clinician committees to develop tools for the clinicians to utilize, in order to ensure thorough documentation regarding all aspects of the ACCF/AHA Guidelines. Passport conducted clinician outreach regarding the ACCF/AHA Guidelines and audited compliance with documentation.
- Identify and outreach to members with inpatient admissions or ER visits.
- Identify and outreach to members who have a lapse in their medication refill pattern as demonstrated through the importance and encourage clinician follow-up and provide targeted outreach.
- Educate members/caregivers regarding CHF through:
  - Face-to-face outreach
  - Telephonic outreach
  - Member newsletters
  - On-hold SoundCare messages
  - Passport’s website
  - Member educational materials
- Continue efforts to educate members and/or caregivers in regards to CHF, smoking cessation, how to prevent an exacerbation, and what to do when the member has an exacerbation.
- Continue to develop Stay Healthy at Home Program to include routine physician orders to prevent hospital readmissions and ER visits.

**Planned Interventions for 2017 (Continued):**

- Expand upon current processes to develop additional relationships with participating ERs to promote discharge planning and education regarding appropriate ER use.
- Evaluate all new member materials to ensure each piece is clear and concise. Materials continued to be utilized for member mailings; in addition to face-to-face education with the members at the clinician's office.
- Administer the Patient Health Questionnaire PHQ-2 and PHQ-9 for prescreening and screening for depression in identified CHF members and refer to the behavioral health team as needed.
- Review surveys as received and conduct outreach to those members who indicate "fair" or "poor" responses on their survey (if the member completes contact information section of the survey tool).
- Monitor surveys for trends, provide feedback to individual staff and address any identified areas that needed improvement.
- Continue to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.
- Continue to leverage the Care Connector Program to engage members in need of assistance making appointments.
- Continue collaboration with Care Message vendor to provide healthy, helpful information to members through Passport sponsored cell phones.
- Increase community initiatives related to the diagnosis and treatment of CHF through:
  - Continue collaboration with Provider Relations and Embedded Case Managers to educate clinicians regarding available monthly Care Gap Reports.
  - Continue collaboration with the Embedded Case Managers, in the high volume clinician offices, to engage members in face-to-face education regarding CHF.
  - Continue collaboration with ER Navigators for identification of members for targeted mailing and telephonic educational outreach for members with CHF.
  - Continue collaboration with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.

Overall the CHF Program noted increased membership, increased high risk engaged members, and overall improvements in 2016. The telehealth program (Stay Healthy at Home) working with our CHF population was able to work with 69 members helping decrease hospital admissions, readmissions, and ER visits for those involved in the telehealth program. Based upon the 2016 evaluation, Passport developed new and innovative initiatives to strive towards the overall goal of improving the health and quality of life for our members with CHF.