PASSPORT HEALTH PLAN

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Mommy Steps

Complex Case Management

Diabetes Management

Healthy Heart Program

2016
Healthy Heart

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 Healthy Heart Program Evaluation

Program Title: Healthy Heart Program

Evaluation Period: January1, 2016 – December 31, 2016

Introduction: Designed to improve the health status and quality of life for members with heart disease and stroke through improved compliance of both members and clinicians with the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) Guidelines. Cardiovascular Disease Management is the process of coordinating health care interventions and communications for members with heart disease and stroke, management of heart disease and stroke, blood pressure management, reduce progression of heart disease, decrease the risks of a subsequent heart attack, stroke or sudden cardiac arrest, aneurysm, and peripheral artery disease (PAD) in which patient self-care efforts are significant, supporting clinician and 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:

- Increase the percentage of all adult members receiving (Lipid) LDL-C screening.
- Increase the percentage of members with known coronary vascular disease obtaining a LDL-C screening.
- Increase the percentage of members receiving lipid management.
- Increase the percentage of members receiving angiotensin-converting enzyme (ACE) inhibitors post-myocardial infarction (MI).
- Increase the percentage of members receiving angiotensin receptor blockers (ARB) post-MI.
- Increase the percentage of members receiving beta-blocker treatment in all post-MI patients unless contraindicated.
- Increase member adherence to the use of lipid lowering and anti-hypertensive drug therapy.
- Increase member awareness of those risk factors that increase the risk of coronary artery disease.
- Promote healthy lifestyle-diet and nutrition, weight management, physical activity, smoking cessation, routine physician office visits, screenings, and treatment.

2016 Program Objectives:

- Increase adherence to ACCF/AHA Guidelines medication management protocols for coronary vascular disease.
- Increase adherence to LDL-C monitoring in patients with coronary vascular disease or hypocholesteremia.
- Increase member adherence to the use of LDL-C lowering and anti-hypertensive drug therapy.
- Increase member awareness of those risk factors that increase the risk of heart disease and stroke.
- Promote healthy lifestyle-diet and nutrition, weight management, physical activity, smoking cessation, routine physician office visits, screenings, and treatment.

Measurements: Overall effectiveness of the Healthy Heart Program is measured through annual participation rates and audited HEDIS®[1] results.

Annual Participation Rate

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

	Healthy Heart Membership (avg)[2]	Opt Out	Participation Rate
2016	31,110[3]	69	99.99%
2015	8,630	0	100%
2014	4,001	0	100%

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

[2] Program membership numbers are annualized

[3] Membership include members with hypertension that were not included from the previous years

Healthy Heart Management

2016 HEDIS® Results

The 2016 HEDIS® Results are based on measurement year 2015 data.

1. **Controlling High Blood Pressure (CBP)**[4]
   The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.

   Findings: In measurement year 2015, a total of 12,643 members were identified with high BP. In a sample of 453 members, 243 (53.76%) had a controlled BP.

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
CBP	63.01%	62.97%	61.95%	51.66%	53.76%

   The goal to meet or exceed the 2016 Quality Compass® 90th Percentile for CBP (70.69%) was not met.

   Measurement 2015 CBP rate is in the 2016 Quality Compass® 33.33rd Percentile.

2. **Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)**
   The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

   Findings: In measurement year 2015, a total of 245 members were identified and 209 (85.31%) received 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®[5] 90th Percentile of 91.67% was not met.

   Measurement 2015 PBH rate is in the 2016 Quality Compass® 50th Percentile.

[4] Use the Hybrid Method for this measure. CBP will be looked at for NCQA Accreditation for 2016

[5] The source for data contained in this publication is Quality Compass® 201 (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.

3. Annual Monitoring for Patients on Persistent Medications (MPM)[6]

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 10,960 members were identified and 9,908 (90.43%) 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%	90.43%

The goals to meet or exceed the 2016 Quality Compass® 90th Percentile for MPM ACE/ARB (92.01%) was not met.

Measurement 2015 MPM ACE/ARB rate is in the 2016 Quality Compass® 75th Percentile.

4. Statin Therapy for Patients with Cardiovascular Disease (SPC)

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

- *Received Statin Therapy.* Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
- *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Findings: In measurement year 2015, a total of 932 members were identified as needing a statin medication. Of those members, 703 (75.43%) received a statin therapy and 578 (82.22%) of the 703 members had 80% adherence.

Measure	MY 2015
Received Statin Therapy	75.43%
Statin Adherence 80%	82.22%

SPC measures (Received Statin Therapy and Statin Adherence 80%) are first year measures. The 2016 Quality Compass® rates have not yet been established.

[6] HEDIS® Measure MPM also includes monitoring of diuretics, digoxin, and anticonvulsants.

Healthy Kentuckians (HK) Results

The 2016 HK Results are based on measurement year 2015 data.

1. Cholesterol Screening

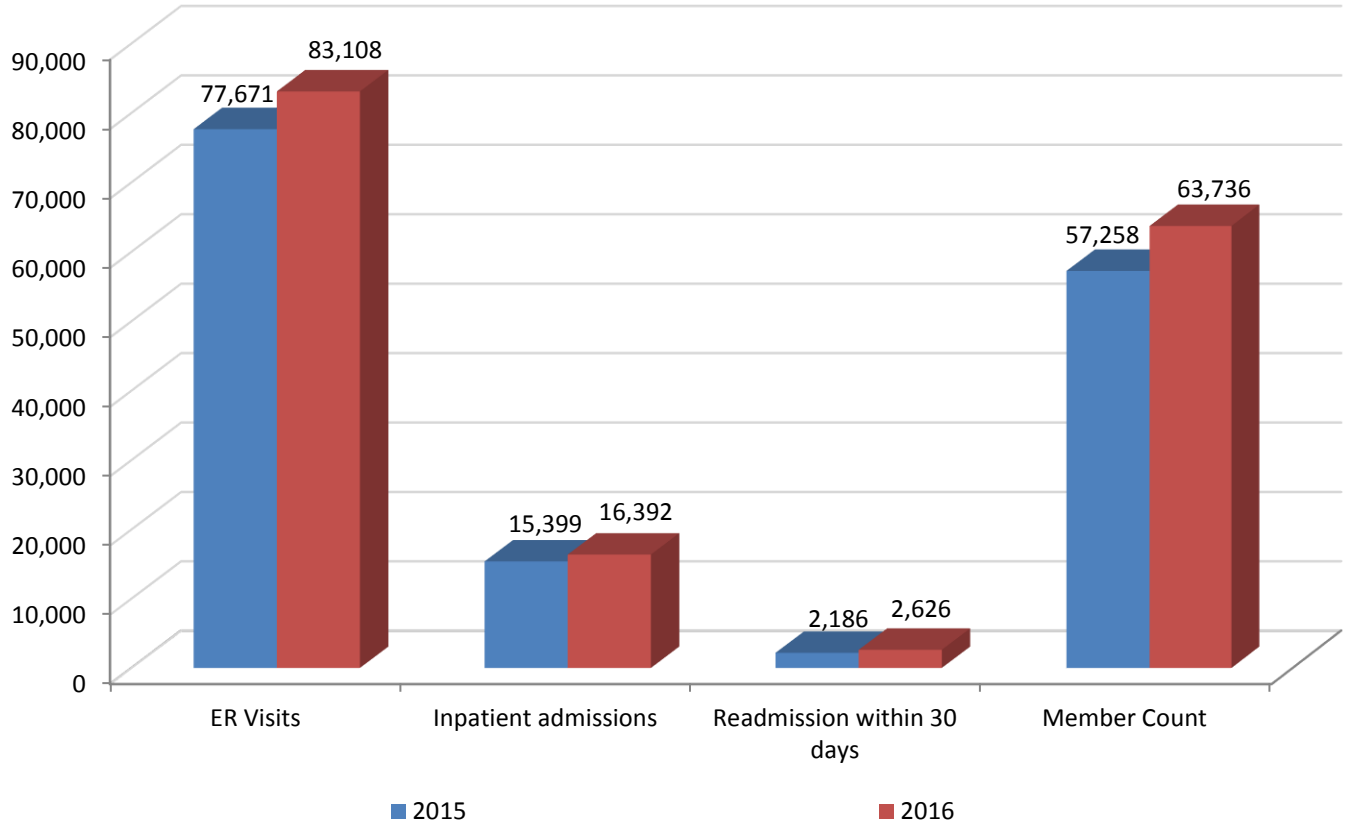
The percentage of male member >35 years of age and female members >45 years of age who had a LDL-C screening.

Findings: In measurement year 2015, a total of 40,165 members were identified in the appropriate age range, of those members 30,507 received a LDL-C Screening.

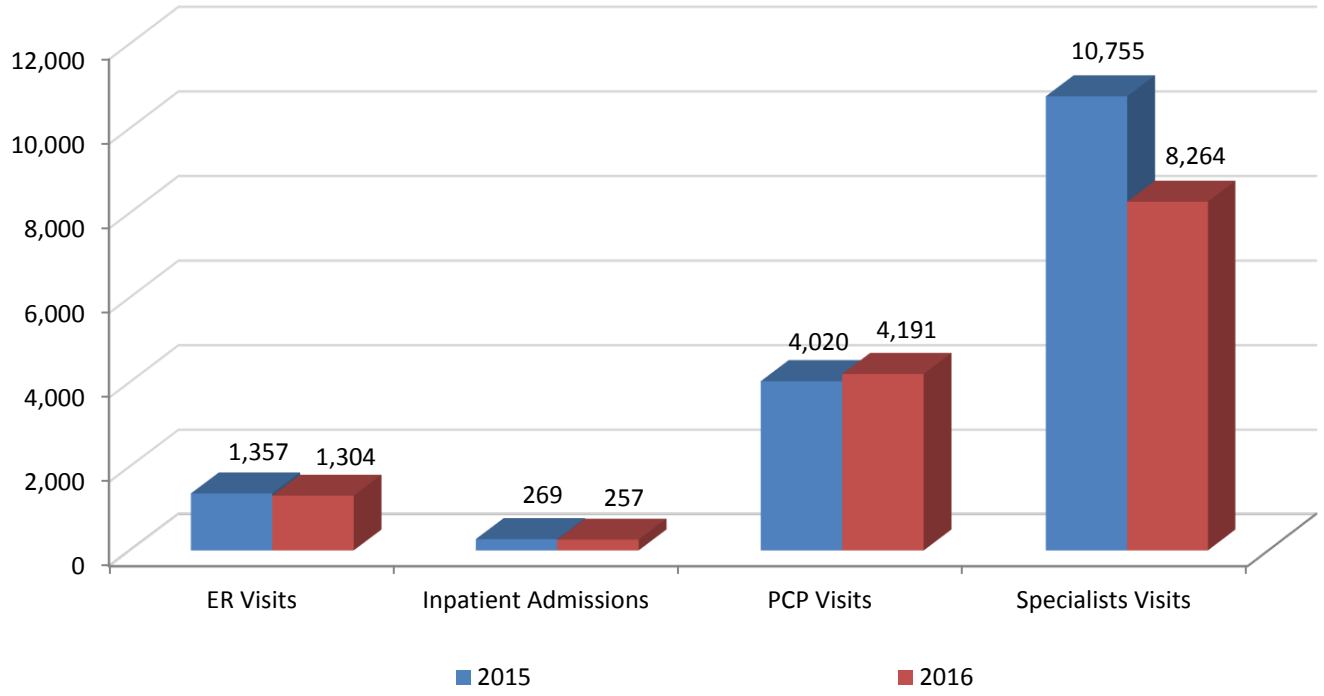
- Specific results include:
  - LDL-C Screening increased by 16.33 percentage points

Measure	MY 2011	MY 2012	MY 2013	MY 2014	MY 2015
LDL-C Screening	83.30%	84.23%	87.79%	59.62%	75.95%

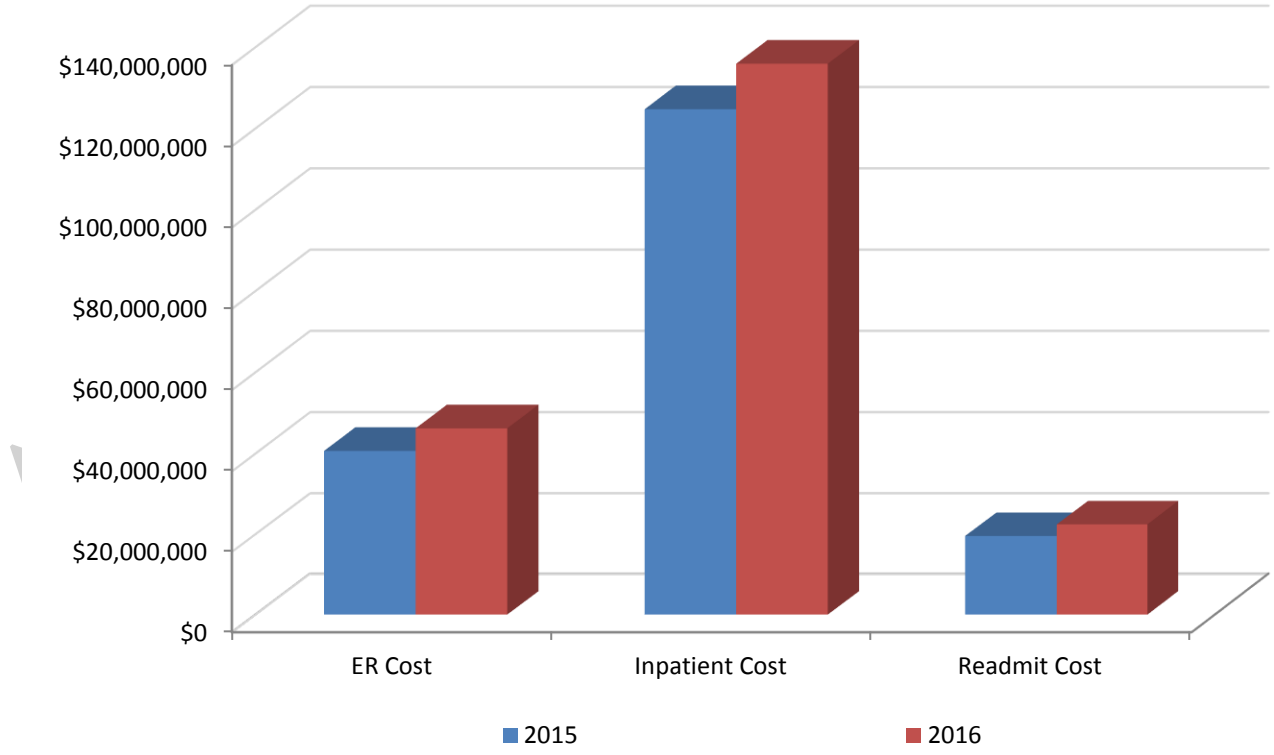
Hospital Utilization with a Primary Diagnosis of Heart Disease

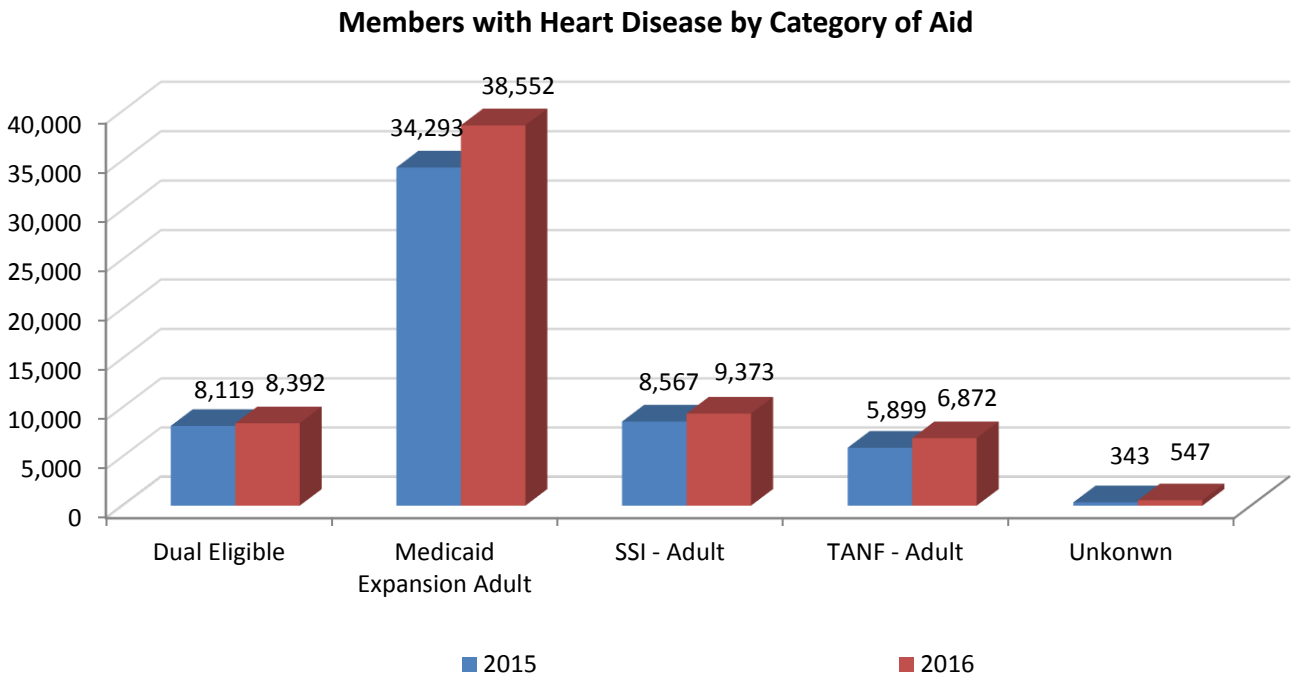


Utilization for Members with Heart Disease
(per 1,000)



Hospital Cost with a Primary Diagnosis of Heart Disease





Analysis

HEDIS®: Passport aspires to be in the Quality Compass® 90th Percentile for each measure. Results for HEDIS® 2016 (MY2015) for CBP indictor for members who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) indicated an increase of 2.10 percentage points and achieved the 2016 Quality Compass® 33.33rd Percentile.

Results for PBH indicator for members who were hospitalized and discharged with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge remained relatively the same with a slight decrease of 0.69 percentage points and achieved the 2016 Quality Compass® 50th Percentile.

Results for MPM indicator for members who received at least 180 days treatment on ACE inhibitors or ARB and had one therapeutic monitoring event noted a decrease of 1.57 percentage points and achieved the 2016 Quality Compass® 75th Percentile.

Member Engagement: Multiple member interventions are conducted to educate the member on the importance of testing to remind the member they need to follow the ACCF/AHA Guidelines on recommended screenings/testing. 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.

Community and Clinician Engagement: Clinicians received status updates on members enrolled in the Healthy Heart Program and provided reference information on the ACCF/AHA Guidelines on Passport's website. The Healthy Heart Program received facility-specific ER and readmission reports for identification and targeted mailing and telephonic member outreach. Members receive a new member packet upon identification along with monthly and quarterly mailings in addition to telephonic outreach to high risk members.

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

During 2016, an average of 31,110 members were enrolled in the Healthy Heart Program. Of those members enrolled, an average of 277 were identified as high risk, an increase of 61% from 2015. There were 364 members who were active with one-on-one telephonic outreach by the Healthy Heart Disease Manager. A total of 3,443 members were identified as newly diagnosed with cardiovascular disease. 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 Healthy Heart Disease Manager.

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

Program Materials

Member materials:

- Healthy Heart and Stroke Guide
- 10 Tips to a Great Plate
- Are You at Risk for Heart Disease or Stroke
- Getting on the Right Track
- Know the Signs of Stroke Bookmark
- Your Keys to a Healthy Heart and a Healthy You
- What is Peripheral Vascular Disease
- Take Care of Your Heart with Anticoagulants and Antiplatelets
- Coronary Artery Disease and Risk Factors
- AHA What is Angina
- AHA Strength and Balance Exercises
- Coronary Bypass Surgery – What to Expect
- Cholesterol and Triglycerides – What You Need to Know
- AHA Stretching/Flexibility Exercises
- AHA What Are the Warning Signs of Stroke
- AHA What is an Implantable Cardioverter-Defibrillator (ICD)
- AHA What is Heart Valve Surgery
- AHA What is a Pacemaker
- AHA How Can I Reduce High Blood Pressure
- AHA What Do My Cholesterol Levels Mean
- AHA What is a Heart Attack
- AHA What Is Coronary Angioplasty
- Atrial Fibrillation "AFib"
- AHA What is High Blood Pressure
- How Can I Lower My Cholesterol
- High Blood Pressure Medicine – What You Need to Know
- Medicine to Lower My Cholesterol
- Electrophysiologic Tests for Your Heart

Clinician Materials:

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

Barriers and Opportunities

Barrier: Lack of clinician awareness regarding ACCF/AHA Guidelines the diagnosis and treatment of cardiovascular disease.

Opportunity:

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

Barrier: Member lack of knowledge regarding cardiovascular disease.

Opportunity:

- Increase members and caregivers knowledge regarding the appropriate treatment and appropriate self-management skills for persons with cardiovascular disease.
- Collaborate with community agencies and statewide initiatives to increase awareness of cardiovascular disease management.
- Increase member and caregiver awareness regarding the appropriate treatment and appropriate self-management skills for persons with cardiovascular disease 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: Member lack of knowledge related to risk factors for cardiovascular disease.

Opportunity:

- Identify members with risk factors for cardiovascular disease to provide targeted member educational outreach.
- Collaborate with community agencies and statewide initiatives to increase awareness and management of risk factors for cardiovascular disease.
- Utilize the Care Connector Program to assist members with questions regarding risk factors for cardiovascular disease.
- Collaboration with ER Navigators for identification of members with risk factors to provide targeted member education.

Interventions completed in 2016:

Provider Education:

- Increased clinician awareness of the appropriate treatment for persons with cardiovascular conditions 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 cardiovascular conditions 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 Healthy Heart Program averaged 31,110 members.

- Identified members through pharmacy claims who had a lapse in their medication refill pattern and provided targeted outreach through collaboration with the Pharmacy Department.

- Continued efforts to educate members and/or caregivers in regards to cardiovascular disease, and smoking cessation.

- 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 48 members with 4% of the members with a positive screening. Further depression screenings (PHQ-9 for adults) were conducted with those members. There were two members referred for Behavioral Health (BH) services.

Identification Activities:

- 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.

Interventions completed in 2016 (Continued):

- 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, report from high volume participating ER, Norton Healthcare. The ER Coordinator reviewed this report 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.

- Collaborated with ER Navigators for identification of members for targeted mailing and telephonic educational outreach for members with cardiovascular conditions.

- 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 Healthy Heart Member Satisfaction Survey to members enrolled in the Healthy Heart 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 cardiovascular disease through:
  - Participated in the Kentucky Heart Disease and Stroke Prevention Task Force.
  - Participated in the KASH committee to identify new venues for the Care Collaborative Program to increase awareness on prevention and management of high blood pressure.
  - Collaborated with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.
  - Collaborated with Provider Relations and Embedded Case Managers to educate clinicians regarding available monthly Care Gap Reports for those members who are due an LDL-C screening.
  - Collaborated with the Embedded Case Managers, in the high volume clinician offices, to engage members in face-to-face education regarding cardiovascular conditions.

Interventions completed in 2016 (Continued):

- Collaborated with ER Navigators for identification of members for targeted mailing and telephonic educational outreach for members with cardiovascular conditions.
- Participated in the Region 8 Health Fair.

Planned Interventions for 2017:

<u>Continued Interventions</u>:

- Increased clinician awareness of the appropriate treatment for persons with cardiovascular conditions 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 members through pharmacy claims who have a lapse in their medication refill pattern and provide targeted outreach through collaboration with the Pharmacy Department.
- Educate members/caregivers regarding cardiovascular disease 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 cardiovascular disease, and smoking cessation.
- Review daily, and/or weekly report from high volume participating ER Norton Healthcare. The ER Coordinator reviews this report and outreaches to the members and/or guardians telephonically, to encourage clinician follow-up, identify barriers to compliance, and offer Passport assistance with scheduling appointments and/or transportation. In addition, the ER Coordinator completes a health risk assessment and makes referrals to clinical staff for additional outreach and education.
- 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.

Planned Interventions for 2017 (Continued):

- Administer the Patient Health Questionnaire PHQ-2 and PHQ-9 for prescreening and screening for depression in identified members with cardiovascular conditions and refer to the BH 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 cardiovascular disease through:
  - Continue to participate in the Kentucky Heart Disease and Stroke Prevention Task Force.
  - Continue to participate in the KASH committee to identify new venues for the Care Collaborative Program to increase awareness on prevention and management of high blood pressure.
  - 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.
  - Continue collaboration with the Embedded Case Managers, in the high volume clinician offices, to engage members in face-to-face education regarding cardiovascular conditions.
  - Continue collaboration with ER Navigators for identification of members for targeted mailing and telephonic educational outreach for members with cardiovascular conditions.

Overall the Healthy Heart Program saw improvements during 2016. The Healthy Heart Disease Manager continues to work to be involved in the various committees and community organizations to help spread the knowledge and benefits of the Healthy Heart Program. Passport continues to develop new and innovative initiatives to strive towards the overall goal of improving services to our members with cardiovascular conditions.