Our mission is to improve the health and quality of life of our members.
2017 Congestive Heart Failure Program Evaluation

Program Title: Congestive Heart Failure Program

Evaluation Period: January 1, 2017 – December 31, 2017

Introduction: The Congestive Heart Failure (CHF) Program is a system of coordinated healthcare interventions and communications targeting a population with a condition in which patient self-care efforts are significant. Adherence to prescribed evidence-based medicine combined with a team approach helps to:

- Empower members
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the clinician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

2017 Program Goals: The goal of the CHF Program is to effectively identify patients with potentially avoidable healthcare needs and intervene to positively impact the health outcomes and quality of life for patients with heart failure. By using a multi-faceted approach to achieve the best possible outcomes the CHF Program can lower costs through preventing avoidable episodes of care and providing better coordination of care. Program goals include:

- Partner with members, their caregiver and their primary and specialty care clinicians to develop a plan of care or action plan by a nurse care advisor
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Optimize heart failure management and close relevant gaps in evidence based care
- Educate patients on heart failure diagnosis and self-management

2017 Program Objectives: Increase provider adherence to the American College of Cardiac Foundation/American Heart Association (ACCF/AHA) Guidelines regarding the use of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (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® 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.

| Year | CHF Membership (avg)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2,650</td>
</tr>
<tr>
<td>2016</td>
<td>2,608</td>
</tr>
<tr>
<td>2015</td>
<td>2,234</td>
</tr>
<tr>
<td>2014</td>
<td>1,889</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Opt Out</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>36</td>
<td>99.98%</td>
</tr>
<tr>
<td>2016</td>
<td>64</td>
<td>99.97%</td>
</tr>
<tr>
<td>2015</td>
<td>8</td>
<td>99.99%</td>
</tr>
<tr>
<td>2014</td>
<td>11</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

### CHF Management

#### 2017 HEDIS® Results

The 2017 HEDIS® Results are based on measurement year 2016 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.

---

1 HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)
2 Program membership numbers are annualized
Findings: In measurement year 2016, a total of 219 members were discharged alive with AMI diagnosis, of which 152 (69.41%) were on a beta-blocker treatment.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PBH</td>
<td>73.42%</td>
<td>94.44%</td>
<td>86.00%</td>
<td>85.31%</td>
<td>69.41%</td>
</tr>
</tbody>
</table>

The goal to meet or exceed the 2017 Quality Compass® 90th Percentile of 89.94% was not met.

For measurement year 2016, PBH is in the 2017 Quality Compass® 10th Percentile.

2. Annual Monitoring for Patients on Persistent Medications (MPM)

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.

- Annual monitoring for members on ACE inhibitors or ARB.
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.

Findings: In measurement year 2016, a total of 16,300 members were identified and 14,585 (89.48%) received monitoring.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitors or ARBs</td>
<td>91.01%</td>
<td>91.78%</td>
<td>92.00%</td>
<td>90.33%</td>
<td>89.22%</td>
</tr>
<tr>
<td>Digoxin</td>
<td>91.45%</td>
<td>93.75%</td>
<td>61.46%</td>
<td>50.93%</td>
<td>65.31%</td>
</tr>
<tr>
<td>Diuretics</td>
<td>91.02%</td>
<td>92.95%</td>
<td>92.68%</td>
<td>90.71%</td>
<td>90.02%</td>
</tr>
</tbody>
</table>

The goal to meet or exceed the 2017 Quality Compass® 90th Percentile for MPM ACE/ARB (92.79%), MPM Digoxin (65.64%) and MPM Diuretics (92.47%) was not met.

For measurement year 2016, MPM ACE/ARB met the 2017 Quality Compass® 50th Percentile, MPM Digoxin met the 2017 Quality Compass® 75th Percentile and MPM Diuretics met the 2017 Quality Compass® 66.67th Percentile.

---

3 The source for data contained in this publication is Quality Compass® 2017 (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.
Hospital Utilization with a Primary Diagnosis of CHF

- Readmission within 30 days: 663 (2016), 546 (2017)
- Member Count: 2,136 (2016), 2,142 (2017)

Hospital Cost with a Primary Diagnosis of CHF

- ER Cost: $5,000,000.00 (2016), $10,000,000.00 (2017)
- Inpatient Cost: $15,000,000.00 (2016), $30,000,000.00 (2017)
- Readmit Cost: $5,000,000.00 (2016), $10,000,000.00 (2017)
Members with CHF by Category of Aid

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

HEDIS®: Results for HEDIS® 2017 (MY2016) for Persistent of Beta-Blocker Treatment After a Heart Attack had a decrease of 15.90 percentage points which met the 2017 Quality Compass® 10th Percentile, a decrease of 1.11 percentage points for ACE Inhibitors or ARBs which met the 2017 Quality Compass® 50th Percentile, an increase of 14.38 percentage points for Digoxin which met the 2017 Quality Compass® 75th Percentile and a slight decrease of 0.69 percentage points which met the 2017 Quality Compass® 66.67th Percentile.

Member Engagement: Multiple member interventions are conducted to educate the member on the importance of adhering to prescribed medications and to remind the member they need to follow the American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) Guidelines on recommended screenings/testing. Providers are notified of members in need of screenings and provided with resources to track members with CHF. Members receive a new member packet upon identification along with monthly mailings in addition to telephonic outreach to high risk members.

Community and Clinician Engagement: Providers received status updates on members enrolled in the CHF Program and were provided reference information on the ACCF/AHA Guidelines for the Diagnosis and Management of CHF on Passport’s website. Passport offered the 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: During 2017, an average of 2,650 members were enrolled in the CHF Program, a 1% increase from 2016. Of those members enrolled, an average of 68 were identified as high risk, a 940% decrease from 2016. There were 50 members who were active with one-on-one telephonic outreach by a CHF Care Advisor, a 78% decrease from 2016. Three separate attempts are made to contact the member. All members receive an initial mailing, and high-risk members receive individualized mailings based on assessment by a CHF Care Advisor. Because members with a heart failure diagnosis typically have multiple comorbid conditions, some members will continue to be stratified in the Complex Care Management Program versus the CHF Program.

Remote Care Monitoring: During 2017, the Stay Healthy at Home Program enrolled 46 members with CHF, a decrease of 33% from 2016. The Program included the use of electronic scales and blood pressure devices for weight and blood pressure monitoring via a secured web portal. These biometric measures were monitored and evaluated daily by the CHF Care Advisor, or their designee, to promote and assist members to learn healthy behaviors and self-manage. The goals of the Program were to promote member self-efficacy, reduce ER and inpatient utilization.

Member Complaints: During 2017, there were no complaints received regarding the CHF Program or a CHF Care Advisor.
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 (AHA)
- How Much Sodium (Salt) Am I Eating
- Heart Failure Take Control, Live Better

**Clinician Materials:**
- Practitioner Program Overview
- Enrolled Letter
- Member Opted-Out Letter
- Unable to Contact Letter
- Discharge 1on1 Letter
- Program Discharge 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 appropriate treatment and appropriate self-management skills for persons with CHF.
- 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
  - Passport’s website
  - Member educational materials
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.
- Utilize the Care Connector Program to assist members with urgent issues related to CHF.

Interventions completed in 2017: 
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.

Member Education: 
- Educated members/caregivers regarding CHF through face-to-face outreach, telephonic outreach, member newsletters, Passport’s website, and member educational material.
- Identified and outreached to members with inpatient admissions or ER visits. In 2017, the CHF program averaged 2,650 members.
- Identified members who had a lapse in their medication refill pattern and provide targeted outreach. The CHF Program had 50 members that were involved in one-on-one contact. Because members with a heart failure diagnosis typically have multiple comorbid conditions, these members will often be stratified in the Complex Care Management Program versus the CHF Program.
- Enrolled 46 appropriate members with CHF in the Stay Healthy at Home Program during 2017.
- 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.
- Developed and implemented new telephonic Member Satisfaction Survey. Questions include how the program helped the member understand their health condition, if the Care Advisor was professional and polite, if the program materials were helpful, if the Care Advisor gave information that helped the member make decisions about their care, if the Care Advisor helped the member deal with their health condition, and if their overall health and quality of life had improved since working with the Care Advisor.
Interventions completed in 2017 (Continued):

Screening Activities:
- Administered the Patient Health Questionnaire (PHQ) 2, with 42 members screened. Two percent (2%) of those members had a positive result and the PHQ-9 was administered. Of those members, one was referred for Behavioral Health (BH) services.

- Administered the Member Satisfaction Survey telephonically 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.

Identification Activities:
- Identified and outreached to members with inpatient admissions or ER visits.

- Leveraged the Care Connector Program to engage members in need of assistance making appointments.

- Continued to improve integration and collaboration with BH to improve overall coordination of care for members with co-existing medical and BH diagnoses/conditions.

Community Activities:
- Passport increased community initiatives related to the diagnosis and treatment of CHF through:
  o Collaboration with Provider Relations and Embedded Care Advisors to educate clinicians regarding available monthly Care Gap Reports.
  o Collaboration 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 2018:

Continued Interventions:
- Increase clinician awareness of the appropriate treatment for persons with CHF by maintaining current ACCF/AHA Guidelines on Passport’s website and through Provider Relations site visits.

- Identify and outreach to members with inpatient admissions or ER visits.

- Educate members/caregivers regarding CHF through:
  o Face-to-face outreach
  o Telephonic outreach
  o Member newsletters
• Passport’s website
• Member educational materials

• Continue efforts to educate members and/or caregivers regarding CHF, smoking cessation, how to prevent an exacerbation, and what to do when the member has an exacerbation.

• 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 need 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 CareMessage vendor to provide helpful information to members with Passport sponsored cell phones.

• Increase community initiatives related to the diagnosis and treatment of CHF through:
  o Collaboration with Provider Relations, Population Health Managers, and Embedded Care Advisors to educate clinicians regarding available monthly Care Gap Reports.
  o 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 2017. The Stay Healthy at Home Program was able to work with 46 members, helping to decrease hospital admissions, readmissions, and ER visits for those involved in the program. Based upon the 2017 evaluation, Passport developed new initiatives to strive towards the overall goal of improving the health and quality of life for our members with CHF.