Our mission is to improve the health and quality of life of our members
2017 Coronary Artery Disease Program Evaluation

Program Title: Coronary Artery Disease Program

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

Introduction: The Coronary Artery Disease (CAD) Program is a system of coordinated healthcare interventions and communications for a population with a condition in which patient self-care efforts are significant. Evidence-based medicine and a team approach is used 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 CAD Program is to effectively identify members with potentially avoidable healthcare needs and intervene to positively impact the health outcomes and quality of life for patients with CAD. By using a multi-faceted approach to achieve the best possible outcomes the program can lower costs through preventing avoidable episodes of care and better coordination of care. Program goals include:

• Partner with member, their caregiver and their primary and specialty care clinicians to develop a plan of care or action plan by a health educator.

• Improve medication adherence.

• Facilitate appropriate communication across the entire care team.

• Optimize CAD management and close relevant gaps in evidence based care.

• Educate patients on CAD diagnosis and self-management.

2017 Program Objectives: Increase adherence to American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) Guidelines medication management protocols for coronary vascular disease.

• Increase the percentage of members receiving angiotensin-converting enzyme (ACE) inhibitors post-myocardial infarction (MI).
• Increase the percentage of members receiving beta-blocker treatment in all post-MI patients unless contraindicated.

• Increase the percentage of all adult members receiving (Lipid) LDL-C screening.

• 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 CAD Program is measured through annual participation rates and audited HEDIS<sup>®</sup> results.

**Annual Participation Rate**

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

<table>
<thead>
<tr>
<th>Year</th>
<th>CAD Membership (avg)&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Opt Out</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>33,441</td>
<td>84</td>
<td>99.99%</td>
</tr>
<tr>
<td>2016</td>
<td>31,110&lt;sup&gt;3&lt;/sup&gt;</td>
<td>69</td>
<td>99.99%</td>
</tr>
<tr>
<td>2015</td>
<td>8,630</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>2014</td>
<td>4,001</td>
<td>0</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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

<sup>3</sup> Membership include members with hypertension that were not included from the previous years
**CAD Management**

**2017 HEDIS® Results**

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

1. **Controlling High Blood Pressure (CBP)**  
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 2016, a total of 15,338 members were identified with high BP. In a sample of 432 members, 259 (59.95%) had a controlled BP.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CBP</td>
<td>62.97%</td>
<td>61.95%</td>
<td>51.66%</td>
<td>53.76%</td>
<td>59.95%</td>
</tr>
</tbody>
</table>

   The goal to meet or exceed the 2017 Quality Compass® 90th Percentile for CBP (71.69%) was not met.

   Measurement 2016 CBP rate is in the 2017 Quality Compass® 50th 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 2016, a total of 219 members were identified and 152 (69.41%) received 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.

   Measurement 2016 PBH rate is in the 2017 Quality Compass® 10th Percentile.

---

4The 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.
3. **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 goals 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.

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 2016, a total of 932 members were identified as needing a statin medication. Of those members, 702 (75.32%) received a statin therapy and 331 (47.15%) of the 702 members had 80% adherence.

<table>
<thead>
<tr>
<th>Measure</th>
<th>MY 2015</th>
<th>MY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received Statin Therapy</td>
<td>75.43%</td>
<td>75.32%</td>
</tr>
<tr>
<td>Statin Adherence 80%</td>
<td>82.22%</td>
<td>47.15%</td>
</tr>
</tbody>
</table>

SPC Received Statin Therapy met the 2017 Quality Compass® 33.33rd Percentile and SPC Statin Adherence 80% met the 2017 Quality Compass® 5th Percentile.
Healthy Kentuckians (HK) Results

The 2017 HK Results are based on measurement year 2016 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 during the measurement year or during the four years prior.

**Findings:** In measurement year 2016, a total of 46,547 members were identified in the appropriate age range, of those members 36,082 received a LDL-C Screening.

- Specific results include:
  - LDL-C Screening increased by 1.57 percentage points

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C Screening</td>
<td>84.23%</td>
<td>87.79%</td>
<td>59.62%</td>
<td>75.95%</td>
<td>77.52%</td>
</tr>
</tbody>
</table>
Members with Heart Disease by Category of Aid

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

HEDIS®: Passport aspires to be in the Quality Compass® 90th Percentile for each measure. Results for HEDIS® 2017 (MY 2016) for CBP indicator indicated an increase of 6.19 percentage points over MY 2016, and achieved the 2017 Quality Compass® 50th Percentile.

Results for PBH indicator indicated a decrease of 15.90 percentage points from MY 2016, and achieved the 2017 Quality Compass® 10th Percentile.

Results for MPM indicator noted a decrease of 1.11 percentage points for ACE Inhibitors or ARBs compared to MY 2016, 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.

Results for SPC indicator for Received Statin Therapy remains relatively the same compared to MY 2016, with a slight decrease of 0.11 percentage points and achieved the 2017 Quality Compass® 33.33rd Percentile and Statin Adherence 80% had a decrease of 35.07 percentage points and achieved the 2017 Quality Compass® 5th Percentile.

Member Engagement: Multiple member interventions were conducted to educate the member on the importance of screenings/tests needed based on the ACCF/AHA Guidelines. Providers are notified of members in need of screenings and provided with resources to track members with cardiovascular conditions. 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 CAD Program and provided reference information on the ACCF/AHA Guidelines on Passport’s website. Members receive a new member packet upon identification along with monthly mailings in addition to telephonic outreach to high risk members.

Risk Stratification: During 2017, an average of 33,441 members were enrolled in the CAD Program. Of those members enrolled, an average of 259 were identified as high risk, a decrease of 6% from 2016. There were 89 members who were active with one-on-one telephonic outreach by a CAD Health Educator. 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 CAD Health Educator. Because members with a cardiovascular diagnosis typically have multiple comorbid conditions, some members will continue to be stratified in the Complex Care Management Program versus the CAD Program.

Member Complaints: During 2017, there were no complaints received regarding the CAD Program or a CAD Health Educator.
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
- Women – Know the Signs of a Heart Attack
- 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
- Coronary Artery Disease Take Control, Live Better

**Clinician Materials:**
- Practitioner Program Overview
- Program Discharge Letter
- Discharge 1on1 Letter
- Beta-Blocker Medication Letter
- Unable to Contact Letter
- Member Opted-Out Letter
- Enrolled Letter
- Cholesterol Statin Medication Letter

**Barriers and Opportunities**

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

**Opportunity:**
- 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.

• Increase member and caregiver awareness regarding the appropriate treatment and appropriate self-management skills for persons with cardiovascular disease through:
  o Face-to-face outreach
  o Telephonic outreach
  o Member newsletters
  o On-hold SoundCare messages
  o Passport’s website
  o Member educational materials

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 CAD Program to educate members regarding risk factors for cardiovascular disease.

Interventions completed in 2017: Provider Education: • Increase provider 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.

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.

• In 2017, the Healthy Heart Program averaged 33,441 members.

• Continued efforts to educate members and/or caregivers in regard to cardiovascular disease, and smoking cessation.
Interventions completed in 2017 (Continued):

- Developed and implemented new telephonic Member Satisfaction Survey. Questions include how the program helped the member understand their health condition, if the Health Educator was professional and polite, if the program materials were helpful, if the Health Educator gave information that helped the member make decisions about their care, if the Health Educator helped the member deal with their health condition, and if their overall health and quality of life had improved since working with the Health Educator.

Screening Activities:
- Administered the Patient Health Questionnaire (PHQ) 2 with 74 members with 16% of the members with a positive screening. Further depression screenings (PHQ-9 for adults) were conducted with those members. There were 12 members referred for Behavioral Health (BH) services.

- Administered the Member Satisfaction Survey telephonically to members enrolled in the CAD 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:
- 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:
- Increased community initiatives related to the diagnosis and treatment of cardiovascular disease through:
  - Collaboration with community partners to provide supportive services to members/families who need advance illness management services without the requirement of discontinuing active treatments.
  - Collaboration with Provider Relations and Embedded Care Advisors to educate clinicians regarding available monthly Care Gap Reports for those members who are due an LDL-C screening.
  - Collaboration with Embedded Care Advisors in high-volume clinician offices, to engage members in face-to-face education regarding cardiovascular conditions.
  - School-based educational programs
  - Health and Wellness Fairs
  - Prevention Workshops
**Planned Interventions for 2018:**

**Continued Interventions:**

- 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.

- 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 regard to cardiovascular disease, and smoking cessation.

- 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 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 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 cardiovascular disease through:
  - 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.
Planned Interventions for 2018 (Continued):

- Collaboration with Embedded Care Advisors in high-volume clinician offices, to engage members in face-to-face education regarding cardiovascular conditions.
- School-based educational programs
- Health and Wellness Fairs
- Prevention Workshops

Overall the CAD Program noted increased membership, increased high risk engaged members, and overall improvements in 2017. 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 cardiovascular conditions.