Our mission is to improve the health and quality of life of our members.
# 2018 Heart Failure Program Evaluation

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2018 Heart Failure Program Evaluation

Program Title: Heart Failure Program

Evaluation Period: January 1, 2018 – December 31, 2018

Program Purpose: The Heart Failure (HF) 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 assist in:

- Empowering members
- Supporting behavior modification
- Reducing incidence of complications
- Improving physical functioning
- Improving emotional well-being
- Supporting the clinician/patient relationship
- Emphasizing and reinforcing use of clinical practice guidelines

Program Goals: The goal of the HF 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 HF 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 Care Advisor
- Improve medication adherence
- Facilitate appropriate communication across the entire care team
- Optimize care management and close relevant gaps in evidence-based care
- Educate patients on HF diagnosis and self-management

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 HF 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 HF Program is measured through annual participation rates and audited HEDIS® results.

**Annual Participation Rate**

Eligible members are identified and passively enrolled in the HF Program. Members may “opt out” of the Program and elect not to receive services, by notifying the Care Advisor or the Care Connector Program, either telephonically or in writing. Participation Rates are tracked and reported annually.

Graph 1.

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

Care Advisors engaged 37 members in 2018. This represents a 32% increase from 2017. Members appropriate for this program have a diagnosis of HF. Care Advisors work with the members to decrease readmissions and ER utilization and to increase utilization of outpatient services and compliance with treatment and care plans.

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 HF Program.

Graph 2.
Heart Failure Management

2018 HEDIS® Results

The 2018 HEDIS® Results are based on measurement year 2017 data.

1. Persistent 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 acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Findings: In measurement year 2017, a total of 239 members were discharged alive with AMI diagnosis, of which 197 (82.43%) were on a beta-blocker treatment.

![Persistent of Beta-Blocker Treatment After a Heart Attack](chart)

Graph 3.

The goal to meet or exceed the 2018 Quality Compass® 90th Percentile of 88.75% was not met.

For measurement year 2017, PBH is in the 2018 Quality Compass® 50th Percentile.

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2 The source for data contained in this publication is Quality Compass® 2018 (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)**

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 diuretics.
- Total rate for annual monitoring.

**Findings:** In measurement year 2017, a total of 26,846 members were identified and 23,988 (89.35%) received monitoring.
The goal to meet or exceed the 2018 Quality Compass® 90th Percentile for MPM ACE/ARB (92.87%), MPM Diuretics (92.90%) and MPM Total Rate for Annual Monitoring (92.76%) were not met.

For measurement year 2018, MPM ACE/ARB, MPM Diuretics and MPM Total Rate for Annual Monitoring met the 2018 Quality Compass® 50th Percentile.
Analysis

HEDIS®: Results for HEDIS® 2018 (MY2017) for Persistent of Beta-Blocker Treatment After a Heart Attack had an increase of 13.02 percentage points, a slight increase of 0.07 percentage points for ACE Inhibitors or ARBs, a slight decrease of 0.58 percentage points for Diuretics, and a slight decrease of 0.13 percentage points for Total Rate for Annual Monitoring. All measures met the 2018 Quality Compass® 50th 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 ACCF/AHA Guidelines on recommended screenings/testing. Providers are notified of members in need of screenings and provided with resources to track members with HF. 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 HF Program and were provided reference information on the ACCF/AHA Guidelines for the Diagnosis and Management of HF on Passport’s website.

Risk Stratification: During 2018, an average of 97 members were identified via the stratification tool as having heart failure. Of those members, 28 received one-on-one telephonic outreach by a Care Advisor. 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 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 HF Program.

Member Complaints: During 2018, there were no complaints received regarding the HF Program or a Care Advisor.
Passport proactively identifies members for the HF Program through multiple resource avenues.

**Findings:**

Graph 7 represents referrals by source. The top three sources were:

1) Stratification
2) Utilization Management
3) Health Risk Assessment (HRA)

Multiple avenues are used to proactively identify members for the HF Program. Education and information are distributed via the Member and Provider Handbooks, Member Newsletter, New Member Packets, and Member and Provider Program brochures. Provider Request for Care Management Forms are available as well on the Passport website. Education is provided through internal department meetings and internal referrals between Care Management and Behavioral Health (BH) is encouraged. A daily report is obtained from the 24-7 Nurse Advice Line of identified members.

HRAs are utilized as a means of risk screening for the member. An attempt is made to obtain an HRA for all members.
Member Discharge Status

Graph 8.

Passport aims to reduce the inability to sustain engagement for HF members by identifying barriers and trends.

Findings:

Graph 8 represents reasons for member’s discharge from the HF Program during 2018. The top three reasons were:

1) Closed – Unable to Reach
2) Problem Resolved/Goals Met
3) Closed – Insurance Terminated

There were 50 (52%) members discharged due to the Care Advisor being unable to reach the member; 21 (22%) members were discharged/closed due to problem resolved/goals met and 7 (7%) members insurance terminated.

Discharge reasons remains consistent with 2017.
Emergency Department and Inpatient Utilization

Passport aims to reduce the rate of Emergency Department (ED) utilization, Inpatient Admission, and 30-day Readmissions.

**Findings:**

Graphs 9, 10, and 11 represents a sample of HF members and is a comparison of ED/Inpatient utilization six months prior to and after engagement.

After program involvement during 2018, the data demonstrates:

- A decrease in the numbers of **members** accessing the ED (-0.07%), utilizing Inpatient (-0.13%) and being readmitted (-100%).
- A decrease in the number of **visits** to the ED (0.0%), a decrease in readmissions (-100%), and inpatient utilization (-27.3%).
Passport aims to reduce cost related to ED utilization, Inpatient Admission, and 30-day Readmissions.

**Findings:**

Graphs 12 represents a sample of HF members analyzing utilization six months prior comparative to after engagement.

After program involvement during 2018, the data demonstrates:

- A slight increase of $367.51 in ED cost.
- A decrease of $80,903.94 in inpatient cost.
- A decrease of $24,985.05 in readmission cost.
Overall Impact for Identified Sample of HF Members

Summary:
Graphs 13 represents overall impact for the identified sample of HF members analyzing utilization six months prior comparative to after engagement.

After program involvement during 2018, the data demonstrates a potential cost savings of $105,521.48. This is not representative of the entire program, but instead of only the sample for analysis. This represents what is a potentially significant higher amount for the entire program year.
Passport aims to meet or exceed a rate of 90% of care plan goals partially or completely met for members enrolled in the HF Program.

**Findings:**
Graph 14 represents the status of care plan goals for members enrolled in the HF Program.

In 2018, 35 goals were “completed/partially completed.” There was a total of two (2) goals that were not met due to member not being able to meet the goal.

There was a goal completion rate of 94.59%. The goal to meet or exceed the target of 90% of care plan goals partially or completely met for members enrolled in HF Program was exceeded.
Passport aims to achieve or exceed a score of 90% or above in all areas of member satisfaction for the HF Program.

**Findings:**
Graph 15 represents the members' satisfaction regarding services received. The areas surveyed include:

1) Understand Health Condition
2) Professional and Courteous Manner
3) Value of Written Materials
4) Help with Making Decisions

The goal was to achieve 90% satisfaction for each area. For 2018, 22 telephonic member surveys were distributed, of which eight (8) were returned (36% response rate). Of the members who responded to the survey, 100% reported they could understand their health condition better, the Health Educator had a professional and courteous manner, the written materials they received had value and the Health Educator help with making decisions regarding their health. The target was exceeded in all areas.
Passport aims to maintain or exceed the goal of 75% or above in member's perception of improved overall health status and quality of life.

**Findings:**
Graph 16 represents the members’ satisfaction regarding improvement in health or quality of life. The areas surveyed include:
1) Deal with Health Condition
2) Quality of Life
3) Overall Health

The goal was to achieve 75% satisfaction/agreement for each topic. Of the eight (8) members who responded to the survey, 100% reported they could deal with their health condition, improvement in quality of life, and in overall health. The target was exceeded in all areas.
Barriers and Opportunities

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

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

Barrier:
Member lack of knowledge regarding HF control.

Opportunity:
- Increase members’ and caregivers’ knowledge regarding appropriate treatment and appropriate self-management skills for persons with HF.
- Increase member and caregiver awareness regarding the appropriate treatment and appropriate self-management skills for persons with HF through:
  - Face-to-face outreach
  - Telephonic outreach
  - Member newsletters
  - Passport’s website
  - Member educational materials

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

Opportunity:
- Identify members with inpatient admissions and ER visits with a diagnosis of HF for targeted member educational outreach.
- Utilize the Care Connector Program to assist members with urgent issues related to HF.
Interventions completed in 2018:

**Provider Education:**

- Increased clinician awareness of the appropriate treatment for persons with HF by posting current ACCF/AHA Guidelines on Passport’s website and through Provider Relations site visits.

**Member Education:**

- The HF Program had 28 members that were involved in one-on-one contact. Because members with a HF diagnosis typically have multiple comorbid conditions, these members will often be stratified in the Complex Care Management Program versus the HF Program.

- Educated members/caregivers regarding HF through face-to-face outreach, telephonic outreach, member newsletters, Passport’s website, and member educational material.

- Continued efforts to educate members and/or caregivers about HF, smoking cessation, how to prevent an exacerbation, and what to do when the member has an exacerbation.

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

**Screening Activities:**

- Administered the Patient Health Questionnaire (PHQ) 2, with 21 members screened. Two percent (2%) of those members had a positive result and the PHQ-9 was administered. Of those members, seven were referred for BH services.

- Administered the Member Satisfaction Survey telephonically to members enrolled in the HF 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:**

- Passport increased community initiatives related to the diagnosis and treatment of HF through:
  - Collaborated with community partners to continue to raise awareness of HF within the community through local departments of health.
  - Collaborated with community agencies and statewide initiatives to increase awareness of HF and HF management.
Continued distribution of educational materials at health fairs and special events.

- Participated in community forums to determine additional community resources and best practices related to a healthy lifestyle for our members including:
  - Educational programs
  - Health and Wellness Fairs
  - Prevention Workshops

**Planned Interventions for 2019:**

**Continued Interventions:**

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

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

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

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

- 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 HF 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.

• Increase community initiatives related to the diagnosis and treatment of HF through:
  o Continue collaboration with community partners to continue to raise awareness of HF within the community through local departments of health.
  o Continue collaboration with community agencies and statewide initiatives to increase awareness of HF and HF management.
  o Continue distribution of educational materials at health fairs and special events.

Overall the HF Program noted improvements in 2018, particularly in the number of members engaged in the program during the year. Based upon the 2018 evaluation, Passport developed new initiatives to strive towards the overall goal of improving the health and quality of life for our members with HF.