

## Cardiac Disease Management Programs – 2008

The HealthPlus Cardiac Disease Management Programs are supported by evidence-based clinical practice guidelines developed and reviewed by physicians.

**Eligibility:** Members with cardiovascular disease, ages 18 years and up, are identified for both HWAYS and internally-administered programs through medical and pharmacy claims analysis and referrals, using any one of the following claims criteria or referral sources (without continuous enrollment requirements):

Cardiac Disease Management Programs	Eligible Members
HealthQuest Program administered by Healthways, Inc. (HWAYS)	Commercial HMO/POS, Fully Insured PPO, and Medicare Advantage <ul style="list-style-type: none"> <li>• AMI, angina pectoris, and/or chronic ischemic heart disease</li> <li>• CABG, stent and/or PTCA procedures</li> <li>• Heart Failure</li> </ul>
HealthPlus internally-administered program	Medicaid, TPA, and Supplemental Medicare <ol style="list-style-type: none"> <li>1. A hypertension diagnosis during the year; <b>or</b></li> <li>2. A coronary artery disease diagnosis during the year; <b>or</b></li> <li>3. A diagnosis of ischemic vascular disease during the year; <b>or</b></li> <li>4. A lipid-lowering prescription filled during the year; <b>or</b></li> <li>5. A cardiac event, an acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA); <b>or</b></li> <li>6. A diagnosis of heart failure (HF); <b>or</b></li> <li>7. Physician, UM or Case Management referral based on symptoms and treatment plan; <b>or</b></li> <li>8. Health Risk Appraisal; <b>or</b></li> <li>9. Member referral.</li> </ol> <p>Commercial HMO/POS and Medicare Advantage members are included in certain targeted initiatives such as post-inpatient discharge beta blocker and aspirin reminder mailings, hypertension-related initiatives, Healthy At Heart program invitations, and medication compliance-related reports to PCPs and members.</p>

**Enrollment and participation** in either the HWAYS or internally-administered program is automatic once HealthPlus identifies the member's eligibility. HWAYS and HealthPlus update cardiac program related registries monthly. Members may opt out of either program by calling 1-800-345-9956, ext. 1943, option 6, or by emailing [dismgmt@healthplus.org](mailto:dismgmt@healthplus.org).

Physicians may enroll a member in the programs and/or receive additional information about the cardiac programs by contacting HealthPlus at 800-345-9956, ext. 8944, to speak with a Disease Management Coordinator, or by e-mailing [dismgmt@healthplus.org](mailto:dismgmt@healthplus.org).

### Interventions based on stratification:

HWAYS risk stratification methods include utilization of clinical and financial data, predictive modeling capabilities, and self-reported information using proprietary tools. Members are stratified into one of four levels with Level 1 stratification comprising the lowest acuity level and Level 4 stratification representing the highest level.

The HealthPlus internally-administered program stratifies members into one of three mutually exclusive levels – low, moderate and high. Re-stratification occurs at least annually. Listed below are the stratification levels.

**High**

The member is diagnosed with a cardiovascular event as identified through claims data or inpatient daily census, with one or more of the following:

- An emergency room and/or inpatient visit with a primary diagnosis of a cardiac event: AMI, CABG, and/or PTCA
- At least one inpatient claim/encounter with a primary diagnosis of Heart Failure (HF)

**Moderate**

The member is diagnosed with cardiovascular disease, not previously identified as high risk, and has met one or more of the following cardiac risk factors and are missing services:

- Hyperlipidemia without an annual LDL
- Hypertension without medication refills

**Low**

The member is diagnosed with one of the following:

- Hypertension with or without medication
- Hyperlipidemia on lipid-lowering medication

**How the HealthQuest Program (an NCQA® Accredited Disease Management Program administered by HWAYS) works with physicians and their Commercial and Medicare Advantage patients:**

1. Members receive an introductory letter and welcome packet containing:
  - A welcome letter
  - The toll-free telephone number to the Care Enhancement Center RNs
  - Cardiac-specific personal health workbook
2. The member's primary care and/or treating physician receives a companion welcome packet when a member is enrolled containing:
  - A welcome letter
  - The toll-free telephone number
  - Cardiac-specific standards of care
  - A list of the cardiac-specific material the member receives in the welcome packet
3. HWAYS RNs provide follow-up contact to the primary care and/or treating physician; the HWAYS RNs provide and review reports which describe the PCP's members enrolled in one or more of the HWAYS programs, the risk stratification level of enrolled members (as determined by HWAYS), and whether the member is accepting calls from the program.
4. Members with unstable heart failure who meet criteria are offered the HWAYS home monitoring program.
5. Members with cardiac conditions are assessed for other chronic conditions through general health assessments conducted by the Care Enhancement RNs during member calls.
6. Members with a cardiac condition identified as having complex care needs are referred for case management evaluation.
7. Surveys are mailed annually to members; the surveys address satisfaction with the program, productivity, absenteeism, and perceived health status.
8. Surveys are mailed annually to physicians to measure satisfaction with the program.
9. Members with a cardiac condition receive a disease-specific newsletter quarterly.

**How the HealthPlus administered program works with eligible members:**

Note: TPA and Supplemental Medicare members receive informational mailings, and their PCPs receive profile reports; but they do not receive phone calls or case management related services.

**Member Interventions**

Risk Level → Intervention ↓	Low	Moderate	High
Case Management Telephonic Outreach			Each discharge
Assessment for Case Management			Each discharge
Post-AMI self-care material mailing			Annually

Missed standard of care services reminders		At least annually	At least annually
Nutrition Seminar	Annually	Annually	Annually
Healthy At Heart educational mailings (Pfizer opt-in program)	Monthly	Monthly	Monthly
Disease-specific newsletter articles	At least annually	At least annually	At least annually
Clinical guideline education & reminders	At least annually	At least annually	At least annually
Web-based personalized support and education	Ongoing	Ongoing	Ongoing

### Physician Support

Intervention	Frequency/Availability
Care Guidelines for People with Cardiovascular Disease	Initially and every two years (also on HealthPlus website)
Notification of AMI immediately post-discharge, and patient education material	Annually
Patient Care Profile - LDL Testing	At least annually
Healthplus.org Website Access to Cardiac Materials and other website sources: <ul style="list-style-type: none"> <li>Physician tools such as Framingham and BMI Calculators and Cardiac Guidelines of Care Flow Sheet</li> <li>Member education materials and sources</li> </ul>	Ongoing
Compliance reports, peer and benchmark data	Annually
Tobacco Cessation Program materials	Telephonic Resource/ Website
Depression screening materials	Telephonic Screening/Print Tools/Website
Weight Management Program	Print Materials/ Website

### Cardiovascular disease related services available to all eligible member groups:

1. Post-AMI self-care materials are mailed to members discharged post-AMI, providing educational materials on beta blocker, aspirin medication, and smoking cessation, and encouraging commitment to a *Take Action Against Heart Disease* Contract which encourages the member to monitor blood pressure, manage cholesterol levels, manage weight, quit smoking if a smoker, exercise, and manage stress.
2. Reminder mailings to members 3 months and 6 months after AMI to encourage them to remain on beta blocker medication, unless discontinued by their physician due to a contraindication.
3. Mailings to members identified as being post-cardiac event (AMI, CABG, PTCA) or diagnosed with other cardiovascular conditions in the previous 12 months without evidence of an LDL cholesterol test in the current year, educating about the importance of LDL-C testing.
4. Mailings to members identified as having been prescribed a lipid-lowering medication with a lower than expected prescription fill frequency (medication possession ratio <60%), educating about the importance of continuing a lipid-lowering medication when prescribed by their physician.
5. Automated telephone messages to members educating on recommendations for annual LDL-C testing and office visits to monitor hypertension.
6. Articles in general member newsletters educating all members about the risk factors for coronary artery disease.
7. Coordination with HealthPlus Tobacco Cessation, Weight Management, and Depression Screening services.
8. Case management: Members with complex care needs qualify for evaluation to enroll in the HealthPlus Case Management Program.
9. The HealthQuest Health & Wellness area of the HealthPlus website ([www.healthplus.org](http://www.healthplus.org)), which includes comprehensive disease management information, interactive tools, and links to additional websites such as the American Heart Association.
10. Healthy At Heart Program (offered by Pfizer Pharmaceuticals) – a sequenced 12-month series of mailings to members who opt in. This program is approved by the Michigan Department of Community Health for participation by Medicaid eligible members. Member mailings include newsletters addressing heart health, food, exercise, travel, total health, and doctor/patient communication topics. For members who also have diabetes, the supplemental Diabetes Control Network program addresses topics specific to diabetes management. PCPs of members who opt in are invited to opt in to receive recent and relevant information on managing dyslipidemia, hypertension or diabetes, epidemiologic updates, reports on clinical trials, and useful practice tips.
11. Blood pressure monitoring devices for members with uncontrolled hypertension.

**How the cardiac program administered by HealthPlus communicates with physicians:**

PCPs receive:

1. Post-AMI report on member sent immediately upon discharge with a diagnosis of AMI. Reinforces use of beta blocker and aspirin when no contraindications are present, and informing of related member mailing with information about self care and tobacco cessation referral, a depression screening HANDS tool, and a Heart Patient Contract.
2. Reports on members potentially non-compliant refilling prescribed beta blocker medication.
3. Reports on members identified as potentially non-compliant refilling prescribed lipid-lowering medications.
4. Reports on members potentially non-compliant refilling prescribed anti-hypertensive medications.
5. Reports on members with 2 or more claims for diagnosis of heart failure without ACEI/ARB or Beta-Blocker fills.
6. An annual report demonstrating individual PCP performance rates for the HEDIS Post-AMI Beta Blocker Therapy, Controlling High Blood Pressure, and Cholesterol Management for Patients With Cardiovascular Conditions measures.
7. Information on tools that may be helpful in educating members through mailings and [www.healthplus.org](http://www.healthplus.org) website.
8. Invitation to receive Pfizer Healthy At Heart recent and relevant information on managing dyslipidemia or hypertension, epidemiological updates, reports on clinical trends, and useful practice tips.

**Participation Rates:**

HealthPlus measures the participation rates for both the HWAYS and HealthPlus-administered cardiac programs annually. 2006 and 2007 rates are reported below.

	2006 Commercial	2007 Commercial	2006 Medicaid**	2007 Medicaid	2006 Med Adv	2007 Med Adv
Participants (numerator)	2,396	4,872	417	294	900	1,339
Diabetes population (denominator)	2,491	4,938	436	309	979	1,364
Participation rate	96.2%	98.7%	95.6%	95.2%	91.9%	98.2%

\*\*Medicaid members eligible for the 2006 HEDIS<sup>®</sup> Cholesterol Management for Patients with Cardiovascular Conditions measure.

**Measures of Effectiveness:**

HealthPlus employs and tracks performance measures for each disease management program. Measure components:

- Address a relevant process or outcome
- Produce a quantitative result
- Are population based
- Use data and methodology that are valid for the process or outcome measured
- Have been analyzed in comparison to a benchmark or goal

Measures include:

1. Controlling High Blood Pressure (HEDIS<sup>®</sup>)
2. Beta Blocker Treatment After a Heart Attack (HEDIS<sup>®</sup>)
3. Persistence of Beta Blocker Treatment After a Heart Attack (HEDIS<sup>®</sup>)
4. Cholesterol Management for Patients With Cardiovascular Conditions (HEDIS<sup>®</sup>)
5. Percent of members receiving a lipid-lowering medication who had an annual LDL test
6. Practitioner satisfaction with CAD program

Additional measures of effectiveness for the HWAYS-administered Cardiac and HF program:

- ACEI/ARB Compliance Within 90 Days of Discharge for Heart Failure (Medicare Advantage members only)
- Beta Blocker Compliance Within 90 Days of Discharge for Heart Failure (Medicare Advantage members only)
- Member satisfaction with CAD program
- CAD-related utilization (Discharges/1000, Days of Care/1000, and ER Vists/1000)
- Return On Investment (ROI)