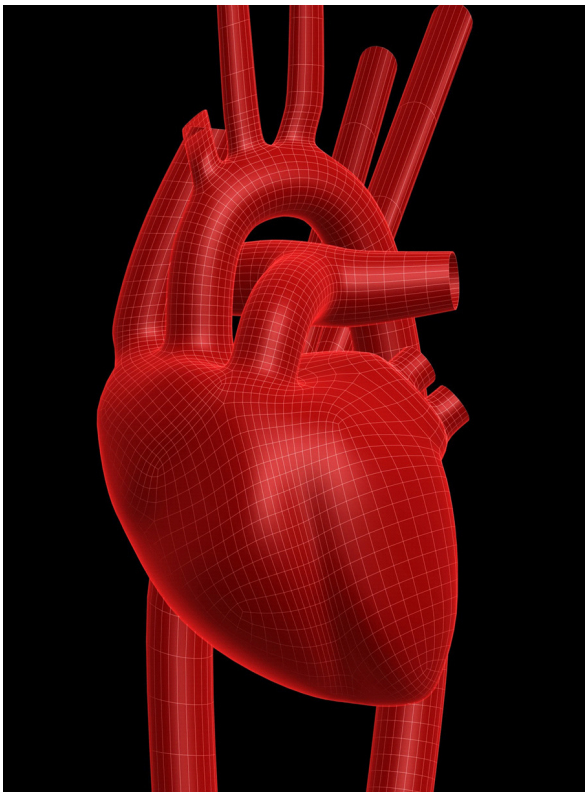
HealthCare Partners
Nevada

HealthCare Partners of Nevada

Heart Failure

Disease Management Program



2010

HF DISEASE MANAGEMENT PROGRAM

The HealthCare Partners of Nevada (HCPNV) offers a Disease Management program for members with Heart Failure. Improved self-management can improve the daily quality of life for members with a specific disease or condition, so HCPNV offers communication with a Registered Nurse or other health professional(s) to assist members with CHF and to manage their symptoms more effectively. This is a free service offered to our members.

The Disease Management Program focuses on monitoring and improving adherence to treatment plans by emphasizing patient education, and actively monitoring those members most at risk for signs and symptoms of decompensation.

Member Enrollment

Members are identified as potentially having HF through claims, or through referral by a PCP or specialist, are contacted by phone for confirmation and screening. Members may also self-refer by contacting provider, or designee, directly. Participation in the Program by members is voluntary and there is no additional cost to the member. All members receive educational materials about their disease.

INTRODUCTION

Heart failure is a common, costly, disabling and deadly condition. Heart failure is associated with significantly reduced physical and mental health, resulting in a markedly decreased quality of life. With the exception of heart failure caused by reversible conditions, the condition usually worsens with time.

SCOPE

Around 5 million people in the United States have heart failure. About 550 thousand new cases are diagnosed each year. More than 287 thousand people in the United States die each year with heart failure.[1]

- Hospitalizations for heart failure have increased substantially. They rose from 402,000 in 1979 to 1,101,000 in 2004. (National Hospital Discharge Survey)

- Heart failure is the most common reason for hospitalization among people on Medicare. Hospitalizations for heart failure are higher in black than white people on Medicare.

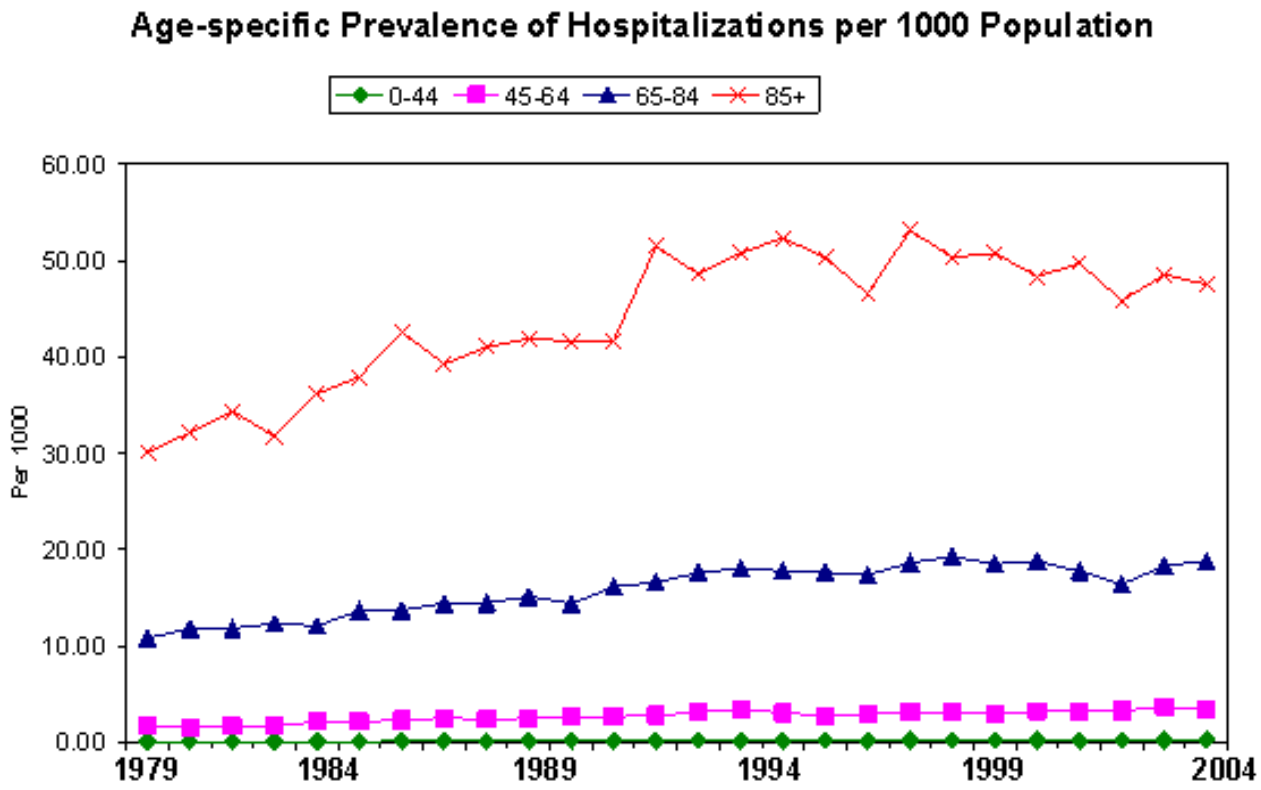
- The most common causes of heart failure are coronary artery disease, hypertension or high blood pressure, and diabetes. About 7 of 10 people with heart failure had high blood pressure before being diagnosed. About 22 percent of men and 46 percent of women will develop heart failure within 6 years of having a heart attack.

Heart failure as an underlying or contributing cause of death — 286,700 (2003). From 1993–2003, deaths from heart failure (ICD–9 428) increased 20.5%. In the same time period, the death rate declined 2%. The 2003 overall death rate for heart failure was 19.7

per 100,000. Death rates were 20.5 for white males, 23.4 for black males, 18.4 for white females and 20.4 for black females. The estimated direct cost for heart failure in 2006 is $29.6 billion in the United States.[1]

CDC FACT SHEET

Trends in Hospitalizations for Heart Failure by Age Group, 1979–2004, United States



SOURCE: Age - specific prevalence of hospitalizations per 1000 population/National Hospital Discharge survey.
CDC FACT SHEET

NEVADA STATISTICS

Heart disease and stroke, the first and third leading causes of death in the United States, are the most common cardiovascular diseases. Heart disease accounted for 27% of deaths in Nevada in • 2005, while stroke caused almost 5% deaths.

In 2007, 27% of adults in Nevada reported having high • blood pressure (hypertension) and 37% of those screened reported having high blood cholesterol, which puts them at greater risk for developing heart disease and stroke

PROGRAM STRUCTURE

The components of HCPNV's Heart Failure program are described below. The Program and the interventions are depicted in flow chart format in *Attachment 1*.

MEDICAL LEADERSHIP

The oversight of the Healthcare Partners of Nevada's heart failure program falls under the leadership of Dr. Amir Bacchus, Chief Medical Officer. Dr. Bacchus will ensure that all Federal, State rules and regulations, and Accreditation standards met by the group.

COMMUNICATION WITH GROUP-BASED PHYSICIANS AND/OR SPECIALTY PHYSICIANS

Dr. Amir Bacchus, and or his designee, will educate all group-based physicians on the requirements of the HF program. This may be accomplished during the new hire orientation period. An annual meeting is held for existing physicians within the practice to discuss the program and allow feedback. For those groups without multiple physician resources, external PCP colleagues or Cardiologists will be invited to the annual meeting.

Annually the group will review the current program, relevant policy and procedures, member program educational material, clinical practice guidelines, reports and trending, inclusive of patient satisfaction surveys, and will make recommendations for program enhancements

The written program description and policies will be distributed and readily available for physician review.

STAFF ROLE DESCRIPTIONS AND EXPECTATIONS

The staff members involved with the heart failure program and their role descriptions are outlined below:

Medical Director and/or Group Physician designee:

- Clinical Qualifications –
    - Appropriate Education and Post-Doctoral training
    - Professional experience and staff appointments
    - Board Certification in internal medicine and/or cardiovascular disease
    - Current licensure
    - Other sub-specialties as indicated
- Coordination/Chair of annual meeting
- Ongoing review of program
- Initial and ongoing education to physicians and staff
- Compliance monitoring of centers

- Annual CME requirement
- Patient care plan documentation
- Physician(s) education on documentation in the patient chart including coordination of care with social services, specialty care physicians and home health
- Physician(s) education on documentation in the patient chart including patient evaluation based on care plan, clinical guidelines and practice recommendations for HF

Nurse and/or Care Coordinator:

- Clinical qualifications –
    - RN licensed in the state of Nevada.
    - Five years in a professional setting such as hospital or clinic setting.
    - Minimum of two years actual work experience related to case management, utilization management, quality assurance, discharge planning or other cost management programs and/or other equivalent work experience.
- Documentation in chart of patient enrollment date
- Outreach calls to patients
- Anticipatory guidance
- Patient education on disease process and documentation
- Patient self-management training and documentation
- Review of patient files/checklists

Office Manager or Admin Staff:

- Quarterly reporting to Health Plan including outcomes and logs
- Responsible for maintaining program binders and updates

There is a formal orientation and training program for all new staff involved in the program. All existing staff will be assessed by the Medical Director, and/or his designee to ensure proper and consistent execution of the program. Please see HealthCare Partners of Nevada's policy for orientation and annual evaluation of staff. Documentation is maintained for all staff orientation, training and assessment activities.

ENGAGEMENT OF PROGRAM PARTICIPANTS, PHYSICIANS, OTHER TEAM PATIENTS

Timelines will be followed as per the HealthCare Partners of Nevada's Access Plan with regards to patient appointment availability. Emergent cases will be seen immediately. Urgent cases will be seen within 24 hours. Symptomatic routine cases will be seen in 7 calendar days and nonsymptomatic routine cases will be seen within 30 calendar days. After hours access will be available to HF patients via:

- HCPNV Customer support
- Answering service
- Physician or case manager phone contact number
- Directions to closest ER

PROGRAM MANAGEMENT

The clinical guidelines adopted by the HealthCare Partners of Nevada are based on the following nationally recognized guideline: 2009 Focused Update: ACCF/AHA Guidelines for the Diagnosis and Management of Heart Failure in Adults.
Refer to: http://content.onlinejacc.org/cgi/reprint/53/15/1343.pdf
Updates in these guidelines will initiate a change or modification to the program documentation. If no changes are made to the guidelines, annual review and approval will be documented within the meeting minutes.

Individualized patient intervention strategies and goals are developed in collaboration with all treating physicians and consistent with nationally accepted clinical guidelines. Our care plan outlines the activities/interventions in the program, both member-directed and interventions that the program delivers to the member.

Co-morbid conditions are considered and built into the individual patient's care plan. Collaboration with the health plan may occur to address participant needs beyond participation in the HF management program.

The following is the basic action plan for all HF program members:

- Physical assessment
- Medication profile
- Diagnostic testing results
- Disease entity education and self management techniques
- Lifestyle issues and education are addressed including smoking, lack of exercise, obesity, poor nutrition, and abuse of drugs or alcohol.
- Mental health and/or social needs of participants are considered and referral management is conducted where needed.
- Influenza and pneumococcus vaccination is administered, as available, to patients between the months of October and February.
- Patient and/or family discussions regarding treatment preferences, living wills, advance directives will occur as indicated. Hospice consultations may be addressed if the patient meets criteria for Hospice services.
- Condition monitoring is also included in the treatment plan. This includes:
    - Patient reminders given to alert patient's to testing that should be performed
    - Patient surveys to allow data collection on health status and functional ability
    - Outbound calls made to patients for purposes of health counseling sessions

Documentation in the patient chart will include adherence to the individual's action plan. This will include adherence with self-management, medications and attending needed office visits.

IDENTIFICATION OF MEMBERS

Identification of members with HF occurs monthly based on medical claims data and utilization management authorizations. Additional identification includes member health risk assessment, by self, family, or practitioner referral.

HCPNV uses the following mechanism to identify members who might benefit from HF Disease Management program:

- Claims data – Hospitalization / ER visits in the last 12 months, including twenty-three hour observation for HF.
- Health risk assessment results
- Referrals from utilization (UM) and care management (CM)
- Referrals from members and practitioners
- Other disease management programs, as applicable

Claims-based data sources are analyzed on a monthly basis to identify individuals newly diagnosed with HF. Referrals from UM processes/data, care managers, practitioners, and self-referral from members occur on an ongoing basis. All members diagnosed with HF and all those who may benefit from the HF disease management program are eligible.

HCPNV will provide evidence to the health plan that referral source methods are reviewed annually to assess effectiveness and recommendations are made for improvement if needed.

HCPNV provides interventions to members based on stratification. The Program and the interventions are depicted in flow chart format in *Attachment 1*. All members will receive an intervention based upon the member's stratification of classification of HF.

STRATIFICATION OF MEMBERS

Members are stratified into low, medium, and high risk. An "event" is defined as an emergency room visit, twenty-three hours observation, or inpatient admission – hospital or skilled nursing facility. Refer to *Attachment 2*.

All members enrolled in the program will be reassessed annually or more often as clinically indicated.

PROGRAM STEPS

Distribution of HCPNV HF disease management program information starts when we sent the member a general awareness welcome letter that introduces some of the components of the program and the concept of disease management. The mailing also notifies members of their access to a nurse care coordinator. In addition, all members may receive a home visit with environmental assessment after an emergency department or inpatient event for HF.

This is followed by a disease-specific mailing within 30 days which includes:

- Information about care coordination and condition monitoring including self-management of chronic disease.
- Description of services included, and how to opt out. A member presumed to be in the program unless they choose to "opt out".
- Explanation of how a member is identified as eligible for our program
- Information discussion CHF triggers identification, encouraging, goal setting and appropriate lifestyle modification around exercise, and smoking.
- Encouragement to work with their practitioner to develop and adhere to a HF care plan
- Encouragement to call a care coordinator with a focus on behavioral modification, overall assessment of other health conditions as they relate to HF and overall health, goal setting, and problem solving.

Condition monitoring occurs on an ongoing basis. The care coordinator will analyze the member's medical record and obtain data from member self report. If clinical gaps are identified for a medication and/or treatment, a telephonic intervention will be conducted by the Care Coordinator. The member is educated about the importance of filling their prescription or completion of a treatment, and is encouraged to seek additional care. The Care Coordinator will notify the member's PCP.

Care Coordinator Services

Care Coordinators provide support to individuals to facilitate improved behavior, motivation, confidence, decision-making skills, and knowledge and awareness of their disease and self-management.

Six dimensions of assistance to facilitate moving the member through the disease self-management continuum are provided to high-risk members:

1. Chronic condition support: Care Coordinators provide the HF with awareness and understanding of the condition, address gaps in care, address lifestyle changes and help the member overcome barriers related to treatment adherence.
2. Decision support: Care Coordinators assist the member to use decision-making skills through discussion of their current medical information, as related to tests and treatment.
3. Decision support for symptom support: Care Coordinators and members freely discuss the member's current medical information and make informed decisions regarding their symptoms.
4. Information support: Care Coordinators provide medical information, not directly associated with a decision, to a member.
5. Prevention support: Care Coordinators provide support to a member to help prevent complications, exacerbations or development of health problems not associated with a chronic condition.
6. Provider communication support: Care Coordinators educate and support a member having general communication difficulties with his/her practitioner.

On an annual basis, group-based physicians will receive, in writing, any formal changes made to the program as a result of the annual meeting. Changes will be made within the program description and distributed to the involved staff.

PERFORMANCE MEASUREMENT METHODOLOGY AND REPORTING PLAN

Participation rates are measured annually. Outreach success is monitored quarterly with a focus on successful outreach for high-risk members.

Program effectiveness is measured by:

- HEDIS criteria for HF is obtained from the respective Health Plan
- Trending of Emergency room and inpatient utilization
- Complaints and inquiries about the program is obtained from the respective Health Plan
- Member satisfaction with the program

Outcomes measurement for the HF program will be tracked, trended and reported to the health plan on a quarterly basis. Outcomes reporting as well as member logs will be presented to the health plan no later than 30 days following the close of each quarter.

- 1st quarter data will be reported by April 30*
- 2nd quarter data will be reported by July 31*
- 3rd quarter data will be reported by October 31*
- 4th quarter data will be reported by January 31*

*In the event that there are no members identified for the program, HCPNV, will report to the health plan in writing that there were no outcomes for the identified quarter.

The following indicators will be reported:

- # Members enrolled in program by stratification, data report to be generated by Complex Case Management Information System (CCMIS)
- # Members declined enrollment by stratification, data report to be generated by Complex Case Management Information System (CCMIS)
- Days/1000, data report to be generated by Health Care Economics (HCE)
- Admits/1000, data report to be generated by Health Care Economics (HCE)
- Average length of stay, data report to be generated by Health Care Economics (HCE)
- 30 day readmit rate, data report to be generated by Health Care Economics (HCE)

- % of members with follow-up within 30 days with PCP or specialist (if clinically indicated), data report to be generated by encounter data.
- % evidence of diagnostic studies, data report to be obtained from encounter data
    - CXR
    - Echo
    - Other
- % received education on disease specific information, data report to be generated by Complex Case Management Information System (CCMIS)
- Flu and/or pneumococcus vaccine rate, data report to be obtained from CAHPS report from HEDIS, per respective Health plan

On an annual basis, HCPNV records and reports the following:

- Member participation rates. The rate is calculated by dividing all members who have received any intervention, by the number of all members who are identified as eligible for the program, regardless of stratification or intervention level of enrollment. The data report to be obtained by Complex Case Management Information System (CCMIS)
- Annual Diabetes Report, to be obtained by Complex Case Management Information System (CCMIS) and member profile. Includes:
    - the number of diabetics participating the CHF management program
    - percent of diabetics reporting annual eye exam
    - percent of diabetics reporting semiannual A1C measurements

PROFESSIONAL APPROACH TO PARTICIPANTS

Education for staff interacting with HF program participants includes the following:

- HF Disease Process and Management
- Member rights
- Member confidentiality
- Member's right to use complaint/grievance process
- Courteous, respectful participant interactions
- Member involvement in program improvements
- Expressed support for participant/physician relationship

The staff member's immediate supervisor will monitor staff interactions to ensure compliance with the above. On an annual basis, staff will receive formal feedback regarding their compliance with the program as per internal policies and procedures.

COMPLAINT MANAGEMENT

HCPNV will make every effort to address member and provider concerns regarding the heart failure program. HCPNV will advise the health plan of any complaint regarding services provided to members. HCPNV will cooperate with the health plan in the complaint resolution of member and/or provider complaints. If HPCNV is unable to resolve complaints internally, HCPNV will refer the member to the Health Plans Customer Service and provide them with the toll-free telephone number.

Member and provider complaints and outcomes will be tracked and reported to the health plan on a quarterly basis.

Member adverse events will be reported to the Health Plan's Risk Manager within 24 hours of identification.

MEMBER EDUCATION

HCPNV heart failure program will introduce disease management services to members by:

- Introductory letters
- Phone Calls

Introductory information will include information and contact numbers for heart failure program as well as verbal and written consent for program participation. The member will be assigned a care coordinator with training in HF. A complete clinical assessment will be completed to include HF status, co-morbid conditions, medication regime and current treatment plan. A plan will be developed with the member regarding call and appointment schedules to encourage member participation in heart failure program.

Educational material will be:

- Integrated into clinical management system
- Consistent with best practice recommendations
- Designed to meet State and/or Federal cultural competency requirements
- Available in different learning modalities: written pamphlets, telephonic discussion,
- Reviewed on an annual basis for appropriateness and accuracy
- Designed to encourage member self management and monitoring

CONTINUOUS QUALITY IMPROVEMENT

HCPNV will submit a written description of CQI Plan on an annual basis to the Health plans. CQI outcomes will be incorporated into clinical and business processes.

OBSERVATION/REVIEW

HCPNV will provide the Health plans access, if requested, to perform side by side review of participant calls and/or interviews with staff delivering interventions. Review of participant mailings and educational material will also be completed.

The Health plan will also perform an annual file review. This will consist of a review of five files for compliance with audit elements:

- Physician Care Plan
- Evidence that performance is documented and evaluated based on care plan, clinical guidelines and practice recommendations for HF
- Evidence of outbound/outreach calls, follow up on physician care plan, outcome measurement
- Appropriate coordination of care if applicable
- Evidence of member education on HF program, disease process, and self management

Operations review will consist of the following:

- Evidence of member contact appropriate based on member acuity
- Consistently submitting complete outcomes reports and participant logs
- Consistently meeting reporting timelines

INFORMATION EXCHANGE

HPCNV will maintain protected health information per the Business Associate agreement with the Health plans. Methods for exchanging information meet HIPAA requirements. Member information will remain confidential and HCPNV will not disclose to any 3rd party except as permitted by law.

ANNUAL REVIEW AND APPROVAL

The HCPNV heart failure program will be updated annually and presented to the MSO HF program review committee for review and approval. The update process will include:

- Evaluation of prior year's activities, both subjective and objective
- Clinical outcomes trended
- Member program satisfaction evaluated and tracked
- Description of the new year's planned activities, including problems to be solved, and measurements of success

HEART FAILURE DISEASE MANAGEMENT PROGRAM

ACKNOWLEDGEMENT AND APPROVAL:

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