Heart and Vascular Disease Management Program

Element A: Program Content

GHC-SCW is committed to helping members and their practitioners, manage chronic illness by providing tools and resources to empower members to take action to improve their health and chronic conditions. Heart and vascular diseases (HVD) are a major concern for GHC-SCW due to the increase in number of members being diagnosed and the health risks and costs associated with poor control. GHC-SCW has approximately 1,500 members with a diagnosis of HVD. Proactive practitioner intervention and support, in collaboration with health education and clinical outreach, helps members manage their chronic conditions to include coronary heart disease (CHD) and peripheral arterial disease, all of presumed atherosclerotic origin.

GHC-SCW has designed the program to educate members, teach members how to self-manage their disease, emphasize the importance of regular care, and provide support tools and screenings for disease management. GHC-SCW’s patient focused Healthy Heart brochure was developed to help members self-manage and reduce related complications, morbidities and death. The content of the HVD program includes condition monitoring, patient adherence to treatment plans, consideration of other health conditions, lifestyle issues and ongoing screening for behavioral health concerns. The organizations adopted clinical practice guidelines for cardiovascular disease care and hypertension management listed in Appendix A are the clinical basis for the program. Current guidelines are posted on ghcscw.com.

Factor 1 - Condition monitoring

GHC monitors the following indicators for all members in the program:
- Dates and results of most recent fasting lipid panel (including LDL, HDL, total cholesterol, and triglycerides) - if past due, outreach calls and letters are sent to the member quarterly
- Date of last creatinine and result
- Prescriptions for lipid lowering agents (date prescribed, date filled)
- Prescriptions for hypertension (date prescribed, date filled)
- New prescription and dosage change follow up calls and blood monitoring
- Co-morbidities (asthma, hypertension, diabetes, hyperlipidemia)
- Date and result of most recent blood pressure measurement
- Members can access their future appointments, outstanding orders for labs and diagnostics, medication lists, lab and diagnostic results through GHCMyChart™ – a secure interactive online patient health portal.
- Members with HVD who have GHCMyChart™ accounts have access to disease management information via Healthwise an interactive shared learning tool.
- All encounters with health educators are documented in the EMR.
Factor 2 - Adherence to treatment plans

Members may work with Health Educators, Registered Dieticians, Tobacco Cessation Counselor, nursing staff and/or their primary care practitioner who monitors patient adherence in the following areas:

- Modification of risk factors
- Weight control
- Blood Pressure control
- Medication compliance
- Nutritional Guidelines
- Scheduling regular practitioner appointments
- Physical Activity Level
- Tobacco Cessation
- Clinical Practice Guidelines (See Appendix A)

Factor 3 - Medical and Behavioral Health comorbidities and other health conditions

GHC-SCW is committed to a collaborative approach to disease management, especially for those members with multiple co-morbidities. The HVD registry is updated weekly and includes current lab, prescription and risk factor data. GHC-SCW identifies members with HVD who may also have asthma, diabetes, and/or depression. Practitioners are encouraged to refer members to health educators and complementary therapists as well as to outside resources. GHCSCW is the only local practice group and HMO plan to offer complementary medicine to its members. Our experts in Complementary Medicine teach people to alter their responses to the stress of daily life through self-care, a healthy diet and various manual and energy therapies.

Members have several opportunities for a collaborative management approach to HVD care included in their insurance coverage. Prior to creating the patient driven treatment plan, consideration is given to learning style preferences, cognitive abilities, socio-economic factors, and physical limitations.

GHC-SCW utilizes a care team approach which ensures collaboration for those members with multiple co-morbidities requiring more intensive care.

- Clinic staff (includes pharmacy, lab, radiology, CMA’s, LPN’s, RN’s, practitioners) have access to the electronic medical record and can see the problem list for each member.
- Practitioners have the opportunity to refer patients to a variety of other practitioners to support the needs of the patient, such as Nurse Educators and/or Behavioral Health specialists.
- Registered Dietitians also have access to the EMR and document encounters contributing to the plan of care.
- A case manager can also be utilized to ensure appropriate care for those with more complex needs.

Factor 4 - Health Behaviors

Behavior modification is an essential component of a HVD program. GHC-SCW Health Educators (I.e. Nurses, Tobacco Cessation Counselor, and Registered Dietitians) work with members who have HVD to provide personalized supportive education and to promote healthy lifestyle options. Members may have individual counseling sessions as needed along with available offerings of classes. Members with HVD who have documented tobacco use also receive outreach mailings providing them with cessation resources. These resources include individual counseling sessions with a tobacco cessation counselor,
and information on community resources such as the Wisconsin Quit Line. In addition, GHC-SCW covers tobacco cessation medications on its formulary at 100% for the majority of its members. For those members who participate in the annual Great American Smokeout campaign, there is no copay for smoking cessation medications and they get free counseling for one year from the Tobacco Cessation Counselor.

Members are requested to complete a pre-physical General Medical History Form every time they schedule a physical. They are mailed this before the appointment and are to bring it with them for review during the appointment. In the survey are questions about health behaviors such as alcohol consumption, tobacco use, hobby hazards, wearing seat belts, helmets and preventive self-exams. Based on responses to these questions, practitioners can counsel on at risk behaviors.

Factor 5 – Psychosocial Issues

GHC-SCW’s Primary Care providers collaborate with Clinical Health Educators, Nursing, Case Management and Behavioral Health staff to identify possible psychosocial issues that may be significant in the member conditions being managed and strive to identify interventions or resources available to overcome the issues. Psychosocial issues which have potential to affect adherence to a treatment plan may include but not be limited to:

- Beliefs and concerns about the condition and treatment
- Perceived barriers to meeting treatment requirements
- Access, transportation and financial barriers to obtaining treatment
- Cultural, religious and ethnic considerations

Member assessment tools available to Primary Care and/or Behavioral Health staff may also play a role to evaluate perceived barriers or generalized level of anxiety about their condition.

GHC-SCW has incorporated the anxiety screening tool GAD-7 into its electronic health record. This is a seven item questionnaire that has been developed and validated in a primary care setting. It is a patient self-assessment tool that can be done independently or in conjunction with the practitioner and reviewed at their appointment. The assessment is documented in the members EMR under “Screening Tools”.

Factor 6 – Depression Screening

GHC-SCW has incorporated the Depression Screening tool, PHQ-9 for monitoring symptoms of depression into its electronic health record. Primary Care and/or Behavioral Health providers may obtain depression screening results on members in the program and make recommendations for treatment if screening is positive.

The Patient Health Questionnaire-9 is the standard screening measure for major depression and has been extensively studied in primary care settings. It is a patient self-assessment tool that can be done in the office jointly with the practitioner or independently and reviewed at a follow-up appointment. The assessment is documented within the members EMR under “Screening Tools”.

Factor 7 – Information about the patient’s condition provided to caregivers who have the patient consent

Family members and/or caregivers who want or need access to the patient’s medical record are
required to file a patient signed “Release of Information” consent form, indicating they may have access to the members’ records. Patients may choose to share electronic access to their medical record by sharing password information to their GHCMyChart\textsuperscript{SM} account with family members and/or caregivers. Family members and/or caregivers who are GHC-SCW members have access to Healthwise, an interactive shared learning tool resource available via GHCMyChart\textsuperscript{SM}. Members with HVD are given a brochure called “How Families Can Help”. Each member can also see a Health Educator who can help them create an action plan that can be shared with the member’s family, and is available to the member’s health care team.

Factor 8 – Encouraging patients to communicate with their practitioners about their health conditions and treatment

Members have the ability to utilize GHCMyChart\textsuperscript{SM} which is a secure patient portal within the electronic medical record. They can send messages directly to care team staff (practitioner, nursing, pharmacy) or member services, as well as make appointments, sign up for classes and see lab or diagnostic results. All members are encouraged to sign up for a GHCMyChart\textsuperscript{SM} account. The MyChart App is now available on both Apple and Android smart devices making it convenient for members to access should they have these devices. Members who are registered will automatically get care reminders via their account. In addition, if a member completes a Health Risk Assessment (HRA) with indicated results, they are encouraged to follow up with their practitioner and can click a link in their account that takes them directly to scheduling an appointment.

Outreach letters sent to members in the HVD Registry encourage them to contact their practitioner and stress the importance of communication.

Factor 9 – Additional resources external to the organization

GHC-SCW recommends members living with chronic conditions to participate in programs available through community resources such as the self-management support program “Living Well”. This is a high-level, evidence based program administered and supported by the Wisconsin Institute for Healthy Aging (https://wihealthyaging.org/wiha-programs), researched and proven to help people live healthier, more active lives. Developed at Stanford University, the Living Well workshop meets for 2-1/2 hours a week for six weeks. Classes are highly participative, where mutual support and success build participants’ confidence in their ability to manage their health condition to maintain active and fulfilling lives. It is facilitated by two trained leaders in a classroom style, but most of the learning comes from sharing and helping others with similar challenges. Members can use the WIHA website to find the workshop by the program title and county they live in across most of Wisconsin.

In addition, all GHC-SCW members are encouraged to complete a Health Risk Assessment (HRA) that is available free of charge through their employer or via GHCMyChart\textsuperscript{SM}.

Members also have access to Healthwise, a shared decision making tool and health resource that is available via GHCMyChart\textsuperscript{SM}. Healthwise information may also be printed during a visit for members to take home with them.
Element B: Identifying Members for Disease Management programs

GHC-SCW uses the following data sources to identify members for the HVD program:
- Claims or encounter data
- Prescription data
- Problem list in the electronic medical record
- Laboratory results
- Health risk assessment results
- Data collected through the utilization management or care management process
- Member referral
- Practitioner referral
- Clinical Care Management referral

GHC-SCW does not use continuous enrollment criteria for identifying members. The HVD registry updates weekly.

Element C: Frequency of Member Identification

The GHC-SCW HVD disease registry updates weekly and is run quarterly to identify members who have outstanding or overdue tests including:
- no LDL in over 13 months
- LDL over 100 in past 6-13 months, or if result cannot be calculated
- Blood pressure not recorded for 6 months and/or >140/90 mmHg

Element D: Providing Members with Information

How to use services - GHC-SCW sends a letter and the brochure “Healthy Heart” to eligible members annually. These communications explain the importance of managing HVD and the resources available to them both internally and externally along with GHC-SCW contact information.

How members become eligible to participate - On a monthly basis, any newly diagnosed member with cardiovascular disease will receive an outreach communication “welcoming” them to the DM program and informing them about the program services available to them. Newly diagnosed members receive the brochure “Healthy Heart” that highlights the resources available both internally and externally and contains important contact information.

How to opt in or out - The brochure “Healthy Heart” explains to members how they can opt out of the outreach associated with being on the registry by contacting GHC-SCW QM staff.

Element E: Interventions Based on Assessment

GHC-SCW provides interventions for heart and vascular disease members based on stratification. Different interventions for members are based on severity of illness, completion of tests and examinations and the results of those tests and examinations.
Tier 1: All members with HVD

- Interventions
  - Initial letter sent to new diagnosis of HVD describing the program and resources available to them
  - Annual HVD management program letter and brochure mailed to all registry members
  - Access to health educators and/or primary care practitioner
  - Clinical staff notified of quarterly HVD mailings

Tier 2: Subset of members contacted if they meet one or more of the following criteria:

- Had LDL done 6 or more months ago and result was >100mg/dL OR
- No LDL done in the last 13 months OR
- Had LDL in last 6-13 months and result was incalculable
- BP not recorded for 6 months and/or >140/90
- Beta-Blocker treatment after AMI

Interventions: Same as Tier 1 and including

- Contact by mail or phone for needed tests or treatment
- Appointments with health educators and/or PCP

Element F: Eligible Member Active Participation

GHC-SCW annually reports the member participation rate to the Clinical and Service Quality Committee. The report presents the number of members with at least one interactive contact in the year analyzed. An interactive contact is defined as a two-way interaction in which the member receives self-management support. This includes anyone who utilized a health educator or specialist, a health coach or a phone or online consultation related to diabetes, cardiovascular disease or asthma. Disease management survey participation is also considered an interactive contact.

Element G: Informing and Education Practitioners

Instructions on how to use the HVD Program

Practitioners are informed of the HVD Management Program in the following ways:

- The Provider Resource Manual contains a copy of the HVD Management Program description
- Practitioners receive a copy of the HVD Management Program brochure
- Notification when outreach is done on members
- Updates in organizational newsletters
- Health Maintenance Modifiers for labs and screening
- Best Practice Alerts

How the organization works with practitioners’ patients in the program

Practitioners have access to see an encounter in Chart Review for all contacts the member has with health educators, care management and case management. They can communicate using electronic messaging, telephone calls and/or in person.
Element H: Integrating Member Information

GHC-SCW utilizes a common electronic medical record (EpicCare) which allows for integration of member information for continuity of care. This information is extracted into a variety of reporting tools and reports utilized by GHC-SCW. The reports focus on this member population to ensure relevant interventions and allow for comprehensive resources for the following departments: health information line, case management program, utilization management program, quality management outreach program and health education.

GHC-SCW utilizes two other EMR resources to integrate member information. CareLink allows staff to see the patients’ medical record if they have been seen by a partnering facility utilizing Epic. In addition, GHC-SCW participates in Care Everywhere, another tool developed by Epic to ensure access to patient information while they are traveling and out of the service area.

Element I: Experience with Disease Management

GHC-SCW members in the HVD registry are surveyed for feedback on their thoughts and experiences with the program. Additionally, members with HVD who utilized care management are surveyed through the PAM and Complex Case Management survey tools. GHC-SCW also utilizes Press Ganey to randomly select members who had a practitioner or health education visit to gather member experience information related to these visits. Members are also randomly sampled annually as part of GHC-SCW’s health plan accreditation process via the CAHPS survey. All complaints are managed through Member Services per protocol.

Element J: Measuring Effectiveness

HEDIS results are analyzed monthly to look for trends or changes in compliance. GHC-SCW’s Quality Management team, along with other stakeholders in the organization, pursues opportunities throughout the year. These typically target areas where a measure is below the 50th percentile as well as ensuring measures stay above the 90th and 95th percentile. The projects will:
1) Address a relevant process or outcome
2) Produce a quantitative result
3) Be population based
4) Have valid data and methodology
5) Compare benchmarks and goals - use the HEDIS national 90th percentile levels as goals for cardiovascular disease measures.
Appendix A
Heart and Vascular Disease Management Program
Clinical Practice Guidelines

1. Hypertension - Adult Clinical Practice Guideline 2014 (UW Health multi-disciplinary group)

2. ACC/AHA Guideline on the Treatment of Blood Cholesterol to reduce Atherosclerotic Cardiovascular Risk in Adults

3. Chronic Left Ventricular Systolic Heart Failure - Adult Clinical Practice Guideline 2014 (UW Health Multi-disciplinary group)