



Heart Failure

Care Coordination

Heart Failure Introduction

People with heart failure may suffer from multiple chronic conditions, and/or have limited support systems, finances, and resources to access the healthcare system. This population requires both medical and social supports to address these issues. To be successful, Care Coordination must focus on:

- Establishing an interdisciplinary team
- Developing and implementing individualized care plans
- Coaching and behavior modification to promote participant self-care
- Coordinating care across all health care settings
- Providing for the social support needs of this population
- Providing condition specific physician and clinical practice guidelines
- Providing education and assistance to both providers and participants in meeting the recommended standards of care

These components support the Care Coordination philosophy of integration of clinical treatment guidelines, disease prevention strategies, participant self-care education, and social support services while demonstrating a quantifiable cost savings to the payer.

Clinical Practice Recommendations

Clinical Practice Guidelines are evidence based statements and recommendations written by clinicians and multidisciplinary panels.

The Heart Failure Care Coordination program is designed around the **American College of Cardiology/American Heart Association (ACC/AHA) “Guidelines for the Diagnosis and Management of Heart Failure in Adults”** and the Milliman Heart Failure Chronic Care Guidelines.

The combination of these guidelines considers not only the physician practice standards of care but also the appropriate clinical components of Care Coordination team interventions to ensure the participant has been properly educated, has appropriate medical and social resources, and is able to self-manage their disease process.

Care Coordination Protocols

The Heart Failure Care Coordination Program includes: transitional care interventions after an acute, inpatient stay, program introduction, in-person and written disease specific education, general health reminders, telephonic/in person health coaching and behavior modification, telephonic and/or in person disease assessments with a Care Coordinator, including medication adherence, coordination assistance with social/community resources, and the development of individualized plans of care for each participant based on national guidelines.

Heart Failure Background

Heart failure is a progressive condition in which the heart can no longer pump blood the way it should. It is a serious condition that currently has no cure. However, quality of life and life expectancy can be improved with early diagnosis and treatment. Once diagnosed, treatment focuses on controlling the symptoms of heart failure. It is estimated that seven of 10 people diagnosed with heart failure have an underlying condition of hypertension. Once the diagnosis of heart failure is made, participants often experience greater mortality and have more frequent encounters with the health system.

In recent studies there has been shown to be a link between the initiation of Care Coordination programs and an improved adherence to heart failure treatment therapy and self care. This, in turn, creates a higher quality of life for the participant and results in decreased financial burden to the client.

Objectives

The objectives of this program are consistent with those set forth by the American College of Cardiology/American Heart Association (ACC/AHA) “Guidelines for the Diagnosis and Management of Heart Failure in Adults.”

The program is a comprehensive approach to addressing heart failure treatment options and self-management within high risk populations. It focuses on both the participant and family/caregiver’s medical and social needs.

Objectives:

- Participant achievement of optimal health through the administration of a health risk assessment (HRA) and disease specific assessments, self care education, coaching and behavior modification, wellness screenings, in person and telephonic on-going engagement and resolution of barriers to care
- Promote adherence to the recommended drug therapy of heart failure including the use of diuretics, ACE inhibitors and beta blockers when not contraindicated
- Promote physician understanding and adherence of the ACC/AHA practice guidelines
- Reduce variation in treatment by monitoring and evaluating physician prescribed treatment plans against national standards and provider peers
- Provide education and instruction on self care measures related to the control of heart failure exacerbations including: daily weights, diet adherence, warning signs of exacerbations and what to do in those situations, and adequate control of hypertension when indicated
- Early identification of participants for earlier intervention by Care Coordination staff
- Promote a multidisciplinary approach to care of the high risk population
- Create a strong participant-physician-Care Coordinator relationship
- Demonstrate cost savings related to the integrated Care Coordination program
- Improve participant quality of life

Program Inclusion and Exclusion Criteria

Inclusion Criteria

- **1 or more inpatient discharges with a primary or secondary diagnosis codes:**
 - 398.91
 - 402.01
 - 402.11
 - 402.91
 - 404.01
 - 404.03
 - 404.11
 - 404.13

- 404.91
- 404.93
- 428*

OR

- **2 or more E and M or Cardiovascular encounters with CPT4 codes:**
 - 33000-36140
 - 92950-93799

OR

- **2 or more Outpatient facility charges including Emergency Room Visits with CPT4 codes:**
 - UB92 450-459

Exclusion Criteria

- End Stage Renal Disease (585.6)
- Transplants (996*, V42*, 33.6, 37.51-37.54, 37.60, 37.62, 37.63, 37.65, 37.66, 37.68)
- HIV/AIDS (042, 079.53)
- Hemophilia (286*)
- Hospice
- Non-skin cancers with evidence of active treatment (claims for chemotherapy, radiation therapy, etc.) **exclude all except 173*, 184*, 187*, 198*, 232*, 233*, 216*, 221.2, 238.2, 239.2, 239.5, 236.3, 236.6**

Severity Stratification

Eligible heart failure participants will be initially stratified into four severity levels based on claims data. Stratification is re-evaluated each time new clinical information is received, each time there is a Care Coordinator-participant encounter, and/or at least every six months for the entire population.

The severity assigned to a participant determines the type and intensity of interventions that the member will receive as part of Care Coordination.

Severity levels include:

Level 1 will include eligible participants with:

1. No inpatient or ER admissions related to the diagnosis of heart failure (primary diagnosis) within the last six months.
- OR**
2. Diagnosis of heart failure and 1 co-morbid condition (diabetes or hypertension) based on inpatient and/or outpatient claims. Principle or secondary diagnosis

Level 2 will include eligible participants with:

1. One or more inpatient hospitalizations within the last six months related to heart failure
- OR**
2. One or more ER admission within the last six months related to heart failure

OR

3. Reported Ejection Fraction 35-45% (this measure will assist in stratification after participant assessment; do not have access to this information prior to assessment)

OR

4. 2 or more uncomplicated (controlled) co-morbid conditions based on inpatient and/or outpatient claims. Principle or secondary diagnosis

Level 3 will include eligible participants with:

1. Reported Ejection Fraction 35-45% (this measure will assist in stratification after participant assessment; do not have access to this information prior to assessment)

OR

2. At least one complicated (uncontrolled) co-morbid condition (diabetes, hypertension, based on inpatient and/or outpatient claims – see below. Principal or secondary diagnosis. At least one claim for a co-morbidity category (see below).

OR

3. Heart failure and a diagnosis of depression

OR

4. Documentation of AICD placement. ICD procedure codes including 37.94, 37.95, 37.96, 37.97, 37.98, 37.75, 37.79, 37.75&37.79 (together), 37.77, 37.79, 37.77&37.79 (together)

OR

5. No documentation of the standard of care prescription pattern of ACE/ARB, Beta Blocker, and diuretic medications

Level 4 (end of life care) will include eligible participants with:

1. Documented chronic resynchronization therapy (CRT) which requires extensive education beyond basic heart failure self management

OR

2. Documented Stage IV heart failure

Stage A and B heart failure participants will be captured under other Care Coordination programs related to their primary diagnosis (CAD, Hypertension, and Diabetes).

Care Coordination staff will validate the participants' diagnosis of heart failure and their agreement to participate in the program. Any participant who does not willing want to participate in the program can opt out at any time.

Medium and high-risk participants who are unable to be contacted will receive low level interventions and are reevaluated every six months for updated demographic information.

All enrolled participants are processed through a tool to re-assess claims data every six months for current severity. If the stratification level has changed, related to changes in claims data, the Care Coordinator will be notified of the change, via a system notification, and the participant will be reassessed. If there is no change in the stratification, based on the claims data, the Care Coordinator proceeds with the current plan of care.

Participant Interventions

Participant Introductory Call/Visit

All participants will receive either an introductory phone call/visit or educational literature in addition to an informational welcome kit. The Care Coordinators will attempt to reach the participant within **60 days** of identification to perform an initial health risk assessment (HRA) and SF12. In addition, the

program welcome kit will provide the participant with information about the program, how they can opt-out if they do not wish to participate, and general asthma education.

If the Care Coordinator is unable to reach the participant by telephone or in person after five attempts (including at least one after normal business hours call), a written notification is sent to the participant. If the participant does not respond to any attempts at outreach within 30 days, the participant is transitioned to the low level of the program to receive mailed material.

Participant Follow Up Calls/Visits and Disease Specific Assessment

All participants enrolled in a program will receive at least one additional call/visit in addition to the HRA call/visit. Follow up will consist of a disease specific assessment to document if the participant understands the diagnosis and self-management of heart failure. Based on the assessment, the member may receive further Care Coordinator interactions at scheduled intervals.

Emergency Situations

In the event a participant is having an emergency situation while being assessed by the Care Coordinator (either in person or telephonically), the Care Coordinator will instruct a family member to call 911. If a family member is not present, the Care Coordinator will contact Emergency Medical Services while keeping the participant on the phone until emergency responders arrive on the scene. The Care Coordinator will also contact the participant's physician to notify him/her of the situation. If the situation is not life threatening, the Care Coordinator, if a Registered Nurse may decide, based on their clinical knowledge, the physician should be notified prior to emergency services. This will be up the Registered Nurse to use her clinical judgment and direct care appropriately.

Care Transition

If a Care Coordination participant is admitted to the hospital for any reason, the Care Coordinator will be notified at the time the participant enters the hospital. The Care Coordinator will then visit the participant while they are still in the acute setting. These participants will also be re-assigned to a High Severity level of management for the next 1-2months for intensive education, coaching and behavior modification of self-care measures, medication use and adherence, and follow up.

Participant Education

Education information will be sent to participants when deemed appropriate by the Care Coordinator. In addition, educational wellness and preventive care reminders will be sent to all program participants quarterly.

Multidisciplinary Team

A multidisciplinary team of healthcare professionals will collaborate to ensure the participants' needs are met. This is accomplished by addressing clinical, functional, financial, psychosocial, environmental, and support system needs. Team members include, but are not limited to, internal physician advisors, community physician advisors, treating physicians, registered nurses, pharmacists, and behavior health specialists. Any or all of these team members may participate in case conferences to coordinate care for individuals who require intense management.

Individualized Plan of Care

Every participant enrolled in the program will work collaboratively with the Care Coordinator to develop an individualized plan of care consistent with national guidelines and the physician treatment plan.

James Prochaska noted that in order for behavior change to be successful a person must want to make the change and must be involved in how the change will occur.

The Care Coordination system will identify a list of participant problems based on answers to the HRA and disease specific assessment tools. These problems will be reviewed with the participant, with Care Coordinator guidance, and the participant will be asked to provide input on resolving the problems and which problem they would like to work on first.

The Care Coordinator will supply the participant with any/all tools they may need to make informed decisions related to their problems and plan of care such as:

- Physician treatment plan
- Disease specific information
- Self-care education
- Referrals to community resources
- Medical equipment

Low, Medium and High Level Interventions

- Care Coordinator access
- Welcome kit
- Nurse Calls/Visits providing health education, behavior modification and/or health coaching.
 - **High level – At least 10 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
 - Call/Visit Schedule – Initial, then months 1, 2, 3, 4, 5, 6, 8, 10, and 12
 - **Medium level – At least 6 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
 - Call/Visit Schedule – Initial, then months 2, 4, 7, 10, and 12
 - **Low level- At least 2 scheduled calls/visits (*more calls may be completed per the Care Coordinator’s assessment*)**
 - Call/Visit schedule- initial and then month 2
- Assessment of the participants social environment and psychosocial support system (either telephonically or through Care Coordinator home visit when indicated)
- Access to community resources to assist with social, family, financial needs.
- Access to behavioral health resources to screen for depression/coping with chronic conditions
- Identification and resolving gaps in care (wellness visits, physician follow up schedule, recommended follow up testing, medication adherence, etc.)
- Education materials tailored to the participant’s primary language and reading level
- Ongoing collaboration with the primary care physician
- Assessment of uncontrolled co-morbidities and development of plan to address them
- Evaluation of medications and medication adherence
- Quarterly general health reminders (such as annual flu vaccines)
- Ongoing reassessment and adjustment of the plan of care
- Annual participant satisfaction survey
- Assessment and encouragement of daily weights and home blood pressure monitoring
- Coordination of all specialists with the designated primary care physician or medical home
- Education related to CRT when indicated

- Educate participants on the importance of follow up labs such as BMP, BNP, Digoxin levels, PT/INR, etc.

Physician Interventions

Local physician involvement is critical to Care Coordination. In order for participants to succeed in managing their chronic illnesses, they must be able to work with a primary care physician or an established medical home.

The heart failure Care Coordination program involves physicians/providers in the program by:

- Providing current ACC/AHA Heart Failure Management guidelines through a provider web portal
- Providing written and/or verbal notification of participant involvement in the Care Coordination
- Ongoing communications between the participant's Care Coordinator and the physician to notify the physician of urgent and emergent health issues and assist with participant adherence.
- Access to an annual participant profile highlighting Care Coordination activities over the last year and how the provider ranks in standards compliance
- Annual provider satisfaction survey
- Access to a provider report card which tracks and reports the physicians activity compared to his peers and national standards of care

Program Evaluation

Program Outcomes will be measured at least semi-annually. Participant outcome measures will be compared to pre-enrollment baseline data. In addition, participants will be measured against those eligible participants who elected to opt-out of the program.

Quality of Life Measure

- SF 12

Financial Measures (enrollees compared over time to eligible program participants who chose not to participate)

- Admits/thousand (program enrolled participants)
- Days/thousand (program enrolled participants)
- ALOS (program enrolled participants)
- % of total admissions for Heart Failure diagnosis (program enrolled participants)
- Admits/thousand for Heart Failure (program participants)
- # Heart Failure enrollees with ER visits
- # of total ER visits for Failure(for asthma enrollees)

Program Quality Measures

- Annual enrollee satisfaction
- Annual provider satisfaction