Chronic Care Improvement Program (CCIP) 2013-2017
Decreasing Cardiovascular Disease
  5 YR PROJECT

Quality Improvement Program (QIP) 2016-2018
Promote Effective Management of Chronic Disease
  Congestive Heart Failure
  3 YR PROJECT
Reasons for required CCIP *

The required **CCIP mandatory** topic starting CY 2013 by Centers for Medicare and Medicaid (CMS) is

**Decreasing Cardiovascular Disease** - (5 yr. Project) – 2013 to 2017

- Prevalence of **diabetes** in Inter Valley Health Plan’s population: over 18% (3,400 members diagnosed with the condition).
- **Diabetes** also remains a top condition among co-morbidities in plan members.
- **Diabetes** is the fourth most common chronic condition, just behind:
  - heart disease (3,700 members/20%)
  - hypertension (4,100 members/22%)
  - hyperlipidemia (4,300 members/23%)

This topic is the focus of the national **Million Hearts Campaign**

* based on 2012 baseline data
**CCIP/QIP Reporting process**

**Plan-Do-Study-Act (PDSA) Quality Model**

**Plan**
Identify disease state, plan the program and implement policy to improve quality

**Do**
Implementation of the program, put plan into action

**Study**
Data collection and analysis, check if the plan has worked

**Act**
Next Steps, stabilize improvement or determine why plan did not work
<table>
<thead>
<tr>
<th>MEASUREMENTS</th>
<th>TARGET OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Aspirin Use</td>
<td>People at increased risk of cardiovascular disease who are taking aspirin</td>
</tr>
<tr>
<td><strong>B</strong> Blood pressure control</td>
<td>People with hypertension who have adequately controlled blood pressure</td>
</tr>
<tr>
<td><strong>C</strong> Cholesterol control</td>
<td>People with high cholesterol who have adequately controlled LDL</td>
</tr>
<tr>
<td><strong>S</strong> Smoking cessation</td>
<td>People trying to quit smoking who get counseling/treatment</td>
</tr>
</tbody>
</table>
Actions providers can take include the following:

**Focus on the “ABCS”**:  
- Aspirin use, Blood pressure control, Cholesterol control and Smoking cessation.

- **Prescribe**: aspirin, ACE/ARB’s, statin (unless contraindicated) and smoking cessation treatment.

- **Ask your patients**: about their smoking habits and provide smoking cessation counseling and tools for smokers. (1-800-NO-BUTTS).

- **Prioritize control**: of blood pressure, cholesterol management, aspirin use and smoking cessation. Help your patients follow treatment instructions and improve adherence.
Use of Clinical Practice Guidelines and algorithms: to promote best practices.

- American Diabetes Association in its Standards of Medical Care in Diabetes publication [2012 Update Release] (ADA Guidelines)
- ACCF-AHA 2013 Guideline for the Mgmt of HF

Support team-based approaches: Referral to specialist, CHF/Diabetes education programs, Cholesterol Management classes, Smoking Cessation programs, Exercise and Weight management classes.

Connect at-risk patients with community resources: Referral to social worker or other community resources to address barriers to adherence. Use culturally appropriate education materials, to address barriers to care.
# Managing Hgb A1C

<table>
<thead>
<tr>
<th>Measure – Hgb A1C</th>
<th>Baseline* - 2013</th>
<th>Yr 2 - 2014</th>
<th>Yr 3 - 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATUS</strong></td>
<td>Members</td>
<td>%</td>
<td>Members</td>
</tr>
<tr>
<td>&lt; 9 %</td>
<td>2,181</td>
<td>80.5</td>
<td>1,901</td>
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<tr>
<td>&gt; 9 %</td>
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<tr>
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<td>337</td>
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<tr>
<td>Grand Total</td>
<td>2,711**</td>
<td>100.0</td>
<td>2,517**</td>
</tr>
</tbody>
</table>

* The initial 2012 Baseline population was revised in 2013 to reflect a more manageable cohort size
** Based on continuous enrollment during measurement year
## Managing LDL

<table>
<thead>
<tr>
<th>Measure - LDL</th>
<th>Baseline* – 2013</th>
<th>Yr 2 - 2014</th>
<th>Yr 3 - 2015</th>
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</thead>
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</tr>
<tr>
<td>&lt;100</td>
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<tr>
<td>&gt;100</td>
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<td>614</td>
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<tr>
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<td>28.2</td>
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</tr>
<tr>
<td></td>
<td>4.4</td>
<td>4.1</td>
<td>5.5</td>
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<tr>
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<td>17</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>1.1</td>
<td>0.9</td>
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<tr>
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<tr>
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<td>95.6</td>
<td>95.9</td>
<td>94.5</td>
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<tr>
<td>Missing Screenings</td>
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<td>371</td>
<td>432</td>
</tr>
<tr>
<td></td>
<td>8.9</td>
<td>14.7</td>
<td>19</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,711**</td>
<td>2,517**</td>
<td>2,269**</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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** Based on continuous enrollment during measurement year
LESSONS LEARNED

- BP compliance rate remained stable at 77.37% as evidenced in our 2015 HEDIS score for “Controlling Blood Pressure”. The Plan also remained flat on “Smoking Cessation Counseling” based on our CAHPS scores at 73.08% in 2015.

- Overall, our CCIP performance over 3 years remained unchanged, as a result we need significant outreach to both members and practitioners through multiple interventions in able to achieve better performance and outcome results.
ACTION PLANS

- Continue providing reports to practitioner/provider groups to flag members who are missing care (labs/tests) with actionable interventions through care management, disease management or 5-Star intervention team.
- Increase engagement with members and physicians regarding overdue tests/exams, practice guidelines and clinical protocols.
- Collaboration with primary physicians, endocrinologists, diabetic nurse educators, IPA care management team and wellness clinics to promote best practices.
Reasons for QIP – 3 YR. PROJECT

- The required QIP topic starting CY 2016 - 2018 by Centers for Medicare and Medicaid (CMS) is

**Promote Effective Management of Chronic Disease – Congestive Heart Failure**

- IVHP has **2893** members with CHF diagnosis. Our analysis, showed that the impact of HF on utilization of services:
  - Baseline admissions – 649 with 61 readmits (9.4%)
  - ER utilization – 805 visits per thousand
  - Only (58%) on treatment for ACE/ARB or BB
  - Avg. day supply – 103 days/ACE, 62/ARB, 199/BB
  - Amongst the top 5 diagnoses for all inpatient admissions

**Target Goals:**

1. Improve average days supply of ACE/ARB/BB to at least 180 days
2. Improve service utilization by decreasing admission and ER visits by 3%
The Plan believes that timely screening, early intervention and careful treatment can significantly reduce or delay onset of medical complications, which in turn will lessen the financial, physical and mental burden to our members. In addition, the Plan seeks to improve clinical outcomes for members who were diagnosed with CHF.

Self-care regimen for members with HF is complex and multifaceted. Members need to understand how to monitor their symptoms and weight fluctuations, restrict their sodium intake, take medications as prescribed and stay physically active.

Accdg to the AHA's Heart Disease and Stroke Statistics-2015 update, 5.7 million people in the U.S. have HF, with the number expected to rise to eight million by 2030. Every year, 870,000 new cases are diagnosed and about 50 percent will die within five yrs of diagnosis.

HF is the leading cause of hospitalization among adults greater than 65 yrs of age. Despite dramatic improvement in outcomes with medical therapy, admission rates following heart failure remain high with greater than 50 percent of patients readmitted to hospital within 6 months of discharge (AHA 2013)

HF incidence increases with age, rising from approximately 20 per 1000 individuals 65 to 69 yrs of age to greater than 80 per 1000 individuals among those greater than 85 yrs of age. (Arch Intern Med 2008)
Disease Management: Six Required Elements

- **Population identification**
- **Evidence based guidelines**
- **Collaborative care** – dedicated Hospitalists Program, Inpatient CM and Discharge Coordinators, After Hours Support and Physician Champion
- **Patient self-management** – Self Management classes, programs
- **Process and outcome measures**
- **Routine reporting/feedback loop**
The success of these CCIP and QIP Projects depends on clinical interventions and utilization processes of both Provider Group partners and Inter Valley Health Plan:

**Comprehensive discharge planning** with timely communication between **patients, Hospitalist, SNF MD, CM/DC planners and PCP**.

**Having a strong transition plan**, prompt post-discharge communication, and follow-up care within 1-2 wks after discharge can significantly reduce re-hospitalizations.

Ancillary support such as home health evaluation and a post-acute telephonic follow-up call by coordinators or nurses are also proven beneficial.
• **Post-discharge support.** The strongest evidence is in the use of more stringent follow-up after discharge.
  - **Telephonic outreach** calls post-discharge by CM/coord.
  - **Setting appointment** to PCP/Specialist within 1-2 wks
  - **Home visit** evaluation/programs
  - **Report findings** to PCP/specialist
  - **Referral to SW** – community resources, AD/POLST

• **Patient education and self-management support.**
  - **Referral to CM/DM programs**
  - **Chronic self management program**/classes and promotion of preventive health measures – FLU/PNA vaccine
  - **HF ACTION PLAN/DIABETES ACTION PLAN** – detailed instructions for members to follow regarding symptom management, actions to take and whom to contact
Outreach such as - Diabetes/CHF classes, wt. mgmt, smoking cessation, exercise program.

**For questions:** contact Ray Whitt, RN QM Dept.
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