Clinical Summary
Chronic Disease Management: Cardiovascular Disease

Goal
Immediate: Identify individuals with cardiovascular disease (CVD), stratify risk level, and improve care coordination for highest risk individuals.

Long-term: Decrease rates of CVD-related complications in those with the disease. Improve blood pressure control. Improve hyperlipidemia. Empower individuals with CVD to implement successful self-management practices.

Focus Population
Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing CVD. Individuals with CVD are considered at high risk for complications if they are not currently taking aspirin or a statin, have uncontrolled blood pressure ≥140/90, and/or are smokers.

Key Project Elements
The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County’s transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the Chronic Care Model and the Million Hearts 2022 treatment protocols, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:
- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that a registry is in place to allow for identification of focus population, and establish a process for adding appropriate individuals to registry (e.g., individuals who have CVD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:
- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere’s recommended assessments which have yet to be determined.
- Identify and risk stratify individuals with CVD.
Implement Team-based Care:
- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual’s needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Ensure each member of the focus population has a planned CVD visit in which their CVD risk factors are assessed. This assessment should also include behavioral health, oral health, and social determinants of health. Refer individual to community support specialist (e.g., community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:
- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual’s needs.

Provide Self-Management Support:
- Provide all individuals with CVD with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from CVD to a community support specialist (e.g., community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
  a. Increase self-management skills
  b. Ensure personal goals are congruent with individual’s self-efficacy
  c. Improve continuity of care with primary care follow-up
  d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
  e. Practice advocacy by identifying key questions for PCPs/specialists
  f. Educate on health system navigation
  g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:
- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect the individual with appropriate resources, social services agencies and community based organizations depending on the individual’s needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual’s treatment and progress.
**Pay for Performance Metrics**

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Cardiovascular Disease project will agree to help HealthierHere improve the following set of metrics.

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<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (SPC) (Prescribed)</td>
<td>Percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: Received statin therapy: Members who were dispensed at least one high or moderate-intensity statin medication.</td>
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**Potential Reporting Metrics**

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

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<td>Aspirin When Appropriate</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic.</td>
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<tr>
<td>Blood Pressure Control</td>
<td>Hypertension (HTN): Controlling High Blood Pressure Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled.</td>
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<td>Smoking Cessation</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months  - Percentage of patients aged 18 years and older who were for screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
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<td>Cardiac Rehab</td>
<td><strong>Cardiac Rehabilitation Patient Referral from an Outpatient Setting:</strong> Percentage of eligible patients evaluated in an outpatient setting who are referred to an outpatient cardiac rehabilitation/secondary prevention program. <strong>Cardiac Rehabilitation Patient Referral from an Inpatient Setting:</strong> Percentage of eligible patients admitted to a hospital who are referred to an early outpatient cardiac rehabilitation/secondary prevention program.</td>
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<tr>
<td>Body Mass Index (BMI)</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Percentage of patients aged 18 years and older with a documented BMI and follow-up plan when appropriate.</td>
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References/Guidelines

The Chronic Care Model
http://www.improvingchroniccare.org/

Million Hearts 2022 Protocols
https://millionhearts.hhs.gov/tools-protocols/protocols.html

Practice Transformation for Physicians and Health Care Teams

Self-Management Resource Center
https://www.selfmanagementresource.com/