Successful implementation of a medication bundle for secondary prevention of cardiovascular outcomes among individuals with Medicare Advantage coverage

Background
Heart disease remains the leading cause of mortality in the U.S., accounting for one in every three deaths. In addition, heart disease and stroke cost America approximately $315 billion daily in medical costs and lost productivity. In a national effort to prevent heart disease and stroke, The Million Hearts Initiative prioritizes the prescription and adherence to appropriate medications.

Objective
To identify the optimal pathway for implementing broad use of a medication bundle for secondary prevention of cardiovascular/cerebrovascular conditions across 69 staff model primary care practices within 4 primary care groups.

Methods

Program Description – Initiation, December 2014:
- Content was based on literature from 2009 and 2014 cardiology guidelines for cholesterol management.
- Program introduction and education was completed via a single webinar.
- Patient-centered educational materials were developed and provided to eligible individuals.
- Program leadership resided primarily within the corporate setting.
- Regional market leaders attended program meetings and reviewed data.
- Responsible for reviewing monthly performance reports and providing group-specific details to participating physicians.
- Evaluation criteria:
  - Medicare Advantage enrollees age 65+ years.
  - Cardiovascular disease, cerebrovascular disease, peripheral vascular disease or other circulatory disease.
  - Diabetes for individuals age 55–75 years.
  - Lists of eligible individuals generated using ICD-9 codes from claims data.
- Exclusion criteria:
  - Pregnancy and chronic liver disease, identified from claims.
  - Physicians could also exclude individuals after evaluation.
- No centralized review or tracking of potential exclusions, including physicians with known contraindications.

Refinement, June 2016:
- Medication refill compliance (% of eligible patients with at least one medication refill in the previous 120 days).
- Included hypertension therapy (beta blocker/angiotensin converting enzyme inhibitor/angiotensin receptor blocker) and statin.

Results

Figure 1. Program Evolution

- December 2014:
  - Limited orientation and introduction for practice participants.
  - Compliance physicians were not involved in leadership meetings.
  - Compliance data for all guidelines was bundled into one large program report that was cumbersome to sort through.

- November 2015:
  - In-person program orientation and education provided across all practices.
  - Greater involvement of practice physicians in program evaluation and data interpretation.
  - Program exclusions were standardized.
  - Program reports provided greater detail about patient eligibility and were separated by practice.

- June 2016:
  - Program content was updated to reflect current evidence.
  - Program physician leader visited practices individually to provide program updates and encourage input from physicians and staff.
  - Processes for determining patient eligibility and exclusion were standardized.
  - Outcome measure updated to reflect 180-day compliance for statins only based on evidence.

Table 1. Change in Medication 120-day Compliance Rates

<table>
<thead>
<tr>
<th>Group</th>
<th>December 2014</th>
<th>May 2016</th>
<th>December 2014</th>
<th>May 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Drug Classes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAC</td>
<td>56%</td>
<td>60%</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>Continucare</td>
<td>54%</td>
<td>62%</td>
<td>65%</td>
<td>71%</td>
</tr>
<tr>
<td>Metcare</td>
<td>52%</td>
<td>54%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>Partners in Primary Care</td>
<td>57%</td>
<td>59%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>Overall</td>
<td>55%</td>
<td>59%</td>
<td>66%</td>
<td>69%</td>
</tr>
</tbody>
</table>

Figure 2. Trends in 120-Day Compliance

- The largest increase in compliance for statins and all drug classes combined occurred in the 2nd quarter of 2016.

Conclusions
- A successful program must be nimble enough to change with new medical knowledge and technical advancements.
- True success requires a team approach:
  - Full involvement of physicians and staff doing the work at the beginning.
  - Tailored reporting specific to a practice.
  - Active listening and incorporation of feedback.

Limitations
- A more formal implementation framework (i.e., PAR/HS) was not utilized at initiation.
- Future program evaluations to help understand the relative importance of core implementation elements via structured surveys and focus groups may enhance program success.

References
2. Wright JS, Wall HK, Yusuf S, Bosch J, Program physician leader visited practices individually to provide program updates and encourage input from physicians and staff.
3. Processes for determining patient eligibility and exclusion were standardized.
4. Outcome measure updated to reflect 180-day compliance for statins only based on evidence.

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