

Improving quality
and outcomes through
digital heart health
management



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Cardiology organizations today are under increasing pressure to improve quality performance across a variety of measures, whether it's an organizational priority, regulatory need, or quality improvement initiative. And the stakes are high: organizations who don't succeed could be risking penalties or leaving revenue on the table for risk-based contracts, readmissions, bundled payments, and MIPS.

Patients need continued guidance between visits

As your organization considers quality improvement strategy, bear in mind that it has been proven that patients need long-term, comprehensive support outside the four walls of traditional care delivery to affect cardiac risk factors and enable early interventions:



80% of the variance in health outcomes is determined by what happens at home, such as social determinant factors, lifestyle choices, and behavioral health¹



40-80% of the information that's relayed to patients in the doctor's office is forgotten²



8+ sessions with a clinician to drive a **25.7%** smoking abstinence rate³



42-96% dual antiplatelet therapy adherence rates after 1-year; a significant decrease to the adherence rates after 1-month of 85-98%⁴

But the challenge remains that most cardiology teams simply don't have the right resources, tools, or technologies to engage, educate, and support patients in the manner they need to improve outcomes.

Introducing digital heart health management

We've observed that successful cardiology teams have been able to improve quality outcomes by taking a digital heart health management approach. Through this approach, they are able to support patients with interactive, personalized education and guidance beyond the walls of care delivery.

Organizations who will succeed at improving quality and outcomes performance will make sure to invest in digital heart health management solutions with the following capabilities:

- » **Delivers preventative support**
- » **Enables targeted interventions**
- » **Provides data to support quality and outcomes reporting**

Deliver preventative support

In the smartphone era, your patients want options for convenient, support through their preferred communication channels when it comes to managing their health and care. We've heard patients voice a preference for two-way mobile messaging, so they can respond on their own time and avoid playing phone tag, as well as a preference for more frequent support and guidance rather than intermittent calls. So it's no surprise that many successful cardiology teams offer mobile apps to connect their patients to personalized, long-term, and interactive health support. In doing so, organizations can improve their quality and outcomes performance by encouraging patients to adopt a new perspective on all the factors that contribute to their health.

Take follow-up appointment attendance for example. While follow-ups are critical for reducing readmissions, your patient may be too overwhelmed to make the necessary arrangements—or they simply may not understand why it's important for their health. But by reinforcing the importance of a follow-up visit through engaging mobile articles, videos, and reminders, your patient will feel more engaged in their health and have a better understanding of why this appointment is important.

Medication adherence presents another opportunity to deliver preventative support that can improve outcomes. By delivering long-term mobile education on the importance of dual-antiplatelet therapies, for example, patients can understand why adhering to their regimen is so critical to their recovery.

When cardiology teams can deliver age, gender, and condition-specific support, patients will feel more engaged in their health

1. County health rankings; relationships between determinant factors and health outcomes. *Am J Prev Med*. 2015. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC539473>

2. Patients' memory for medical information. National Institutes of Health.

3. Treating Tobacco Use and Dependence: 2008 Update.

4. Dual antiplatelet therapy adherence rate decreases significantly over a one-year period. After month 1, adherence ranged from 85-98%; after year 1, adherence ranged from 42-96%

and have a better understanding of why certain appointments and treatments are needed—making your organization better positioned for success with quality and outcomes initiatives.

Enable targeted interventions

In addition to offering personalized, preventative support via mobile, the right digital heart health management approach can also help cardiology organizations identify patients in need, and help them take action to prevent adverse health outcomes. That's why it's critical to make sure your organization offers more than just digital educational content alone. Instead, your solution must also be able to capture unique insights into patient behavior outside the four walls.

One mechanism for capturing actionable patient information is by delivering short mobile surveys at regular intervals to your patients. For example, for a patient with CHF, survey questions might be sent to assess whether the patient understands how to adhere to a low-salt diet. The patient's response will inform their care team in real time, offering the dietary insights clinicians need to provide better, more personalized guidance to help improve their patients' heart health.

Another valuable method for identifying patients in need is through secure mobile messaging. By engaging patients on their own terms, through their preferred channels, care teams will be able to build a long-term, trusted relationship, which in turn can surface more insights they wouldn't have access to otherwise. For example, after receiving those same dietary survey results, a clinician can respond via mobile messaging to offer the patient nutritional guidance. In conversation, the clinician may learn that the patient hasn't been sticking to a low-sodium diet simply because they dine out frequently. Based on this new insight, a care team member can then suggest easy, healthy recipes, or share digestible, mobile articles on how to follow a low-salt diet at restaurants, and help the patient understand why this important for symptom management and to avoid Emergency Department visits or readmissions.

Data to support quality and outcomes reporting

By delivering preventative support and targeted interventions, a digital heart health management approach arms cardiology teams with the tools and insights they need to engage patients toward better outcomes outside the four walls. But of course, to improve your quality performance, it's critical to be able to easily access the data you need to support your reporting.

Organizations should consider solutions that utilize data from clinician workflows, insights from patient activity, and screening/survey responses to generate both real-time feedback as well as reports you can input into your quality reporting workflow.

As a result, you can avoid double-documentation to promote an efficient workflow and facilitate more touch points with patients—without logging them manually.

Digital heart health management in action: One patient's journey

PATIENT PROFILE:

Name: Jim Smith

Age: 66

Profession: Retired

Condition: Has known CAD

PATIENT JOURNEY:



- » Experiences chest pain, goes to the hospital
- » Has a PCI



- » Care team helps him enroll in the Wellframe mobile app at the hospital prior to discharge



- » On the way home, goes to pick up meds. Jim finds out antiplatelet meds have a high copay and doesn't fill his script.
- » Arrives home



- » Receives in-app survey about trouble picking up meds
- » Survey response triggers alert for his care team, who messages with Jim to help him find a program for affordable medications



- » The care team also sends him a message: "Did you see the article in your checklist about the importance of dual antiplatelet meds?"
- » Wellframe app prompts Jim via a survey check-in to see if he's enrolled in cardiac rehab. Jim answers "no."



- » Jim then calls the hospital to enroll in cardiac rehab
- » He uses Wellframe messaging to reschedule cardiac rehab appointments and adhere to his program
- » Jim has persistent heart failure (CHF) and reports in a daily Wellframe survey that he's gaining weight
- » Care team adjusts his meds to prevent admission

Quality programs addressed

Bundled Payments for Care Improvement (BPCI) Advanced

Example measures:

- » All-cause Hospital Readmission Measure (NQF #1789)
- » Transitional care programs incorporate evidence-based strategies tested through Project RED (from Boston University Medical Center) that focus on improving the hospital discharge process to promote patient safety and reduce readmissions
- » Wellframe can ask heart failure patients a daily screening question if they've gained a few pounds as an intervention to address a common reason for readmission

Merit-based Incentive Payment System (MIPS)

Example measures:

- » Quality ID #226 (NQF #0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- » Wellframe asks screening questions to identify whether the patient is a smoker
- » Wellframe delivers targeted programs around smoking cessation

American Association for Cardiovascular and Pulmonary Rehabilitation (AACVPR) accreditation

Example measures:

- » Performance Measure for Optimal Blood Pressure Control at Completion of Cardiac Rehabilitation
- » Wellframe can deliver a blood pressure logging survey to give care teams tools to help them more efficiently and effectively check in with and communicate with patients about their BP more frequently than in-person visits

American College of Cardiology / American Heart Association (ACC/AHA) programs

Example measures:

- » QM-2: Cardiac Rehabilitation Adherence (≥ 36 sessions)
- » Wellframe can deliver at least 12 weeks of education to patients to help keep them reminded daily about their cardiac rehab work

Key takeaways

To succeed with quality initiatives, patients need comprehensive, personalized support to impact cardiac risk factors and enable early interventions. But most cardiology teams lack the resources to offer the long-term guidance necessary to improve outcomes.

With a digital heart health management approach, cardiology teams will be able to achieve the following capabilities necessary in order to support the holistic needs of patients outside the four walls:

- » Delivers preventative support
- » Enables targeted interventions
- » Provides data to support quality and outcomes reporting

Learn more at
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