

## SECTION U – QUALITY MANAGEMENT

*U.1 Declare whether or not the proposer submitted HEDIS measures in measurement year 2013. Indicate whether the measures were reported for a State Medicaid, CHIP, and/or Commercial product line. Five points will be awarded to proposers with this experience reporting HEDIS measures.*

Louisiana Healthcare Connections submitted HEDIS measures to NCQA for measurement year 2013. Centene uses Inovalon’s Quality Spectrum Insight (QSI®) product, an NCQA certified HEDIS software, to calculate HEDIS rates. Rates are audited by Attest Health Care Advisors, our NCQA certified HEDIS auditor. Centene contracts with Outcomes Health Information Solutions™ (Outcomes) to conduct medical record reviews for select measures as required by HEDIS technical specifications or as otherwise selected by the health plan. In addition to LHCC, the following Centene affiliate health plans reported HEDIS for measurement year 2013:

State	Health Plan Name	Product	Notes
FL	Sunshine State Health Plan	Medicaid and CHIP	Separate reports for Reform and Non-Reform counties
GA	Peach State Health Plan	Medicaid and CHIP	n/a
IL	IlliniCare Health Plan	Medicaid	n/a
IN	Managed Health Services	Medicaid and CHIP combined and Medicaid Expansion	Medicaid/CHIP reported separately from Medicaid Expansion
KS	Sunflower Health Plan	Medicaid and CHIP	n/a
MO	Home State Health Plan	Medicaid and CHIP	Regional reports (Central, Eastern and Western regions)
MS	Magnolia Health Plan	Medicaid	n/a
OH	Buckeye Community Health Plan	Medicaid and CHIP	n/a
SC	Absolute Total Care	Medicaid and CHIP	n/a
TX	Superior Health Plan	Medicaid and CHIP	n/a
WA	Coordinator Care	Medicaid and CHIP	n/a
WI	Managed Health Services	Medicaid and CHIP	n/a

Requested HEDIS measures and NCQA IDSS submission tools for each of these health plans are available as part of our response to U.2.

***U.2 Complete appendix WW, HEDIS Scoring Tool by submitting the Proposer's results for the HEDIS measures specified below for measurement year 2013, for each of your State Medicaid contracts.***

- ***Adults' Access to Preventive/Ambulatory Health Services***
- ***Comprehensive Diabetes Care- HgbA1C component***
- ***Chlamydia Screening in Women***
- ***Well-Child Visits in the 3,4,5,6 years of life***
- ***Adolescent well-Care.***
- ***Ambulatory Care - ER utilization***
- ***Childhood Immunization status***
- ***Breast Cancer Screening***
- ***Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents***
- ***Follow-Up Care for Children Prescribed ADHD Medication***

***Include the Proposer's legal business name, as defined by L.R.S.12:23, AND the product line name or dba.***

***If the average of seven or more measures for state Medicaid contracts is above the 2013 NCQA HMO National 50<sup>th</sup> Percentile for Medicaid Product Lines, ten points will be awarded.***

***If the average of all measures for state Medicaid contracts is above the 2013 NCQA HMO National 25<sup>th</sup> Percentile for Medicaid Product Lines, five points will be awarded. No points will be awarded if all measures do not meet at least the 2013 NCQA HMO National 25<sup>th</sup> Percentile for Medicaid Product Lines. DHH Reserves the right to independently verify all information provided in Appendix WW.***

Please see ***Attachment U.2\_Appendix WW\_HEDIS Rates*** All Plans which includes the scores for the measures requested above as well as the average of scores across Centene health plans that reported scores to NCQA for measurement year 2013.

The ***Attachments U.2.A through U.2.Q for the NCQA HEDIS IDSS submission tools*** for Louisiana Healthcare Connections (LHCC) and all other Centene Medicaid plans that reported scores to NCQA for measurement year 2013 are **provided electronically on the Proposal Submission CD.**

Scores were not reported for plans before they were operational or when continuous enrollment during start-up was insufficient for reporting or where the State contract does not require HEDIS reporting. The following affiliate health plans did not submit HEDIS for measurement year 2013: Bridgeway Health Solutions (AZ), California Health & Wellness, CeltiCare Health (MA), and New Hampshire Healthy Families.

***U.3 Document experience in other States or previous Louisiana Medicaid managed care experience Describe experience in using results of performance measures, member satisfaction surveys, and other data will be used to drive changes and to positively impact the healthcare status of Medicaid and or CHIP populations.. Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following:***

- ***Management of high risk pregnancy***
- ***Management of HIV***
- ***Sickle cell disease management***
- ***Reductions in low birth weight babies***
- ***Pediatric Obesity (children under the age of 19)***
- ***Reduction of inappropriate utilization of emergent services***
- ***Children with special health care needs***
- ***Asthma***
- ***Diabetes***

- *Cardiovascular diseases*
- *Reduction in racial and ethnic health care disparities to improve health status*
- *Hospital readmissions and avoidable hospitalizations*
- *Reduction in incidence of sexually transmitted infections*

## Overview

LHCC used performance data to improve the health status of our Bayou Health members (currently almost 150,000 members) in Louisiana since February 2012, as has Community Health Solutions (currently with over 208,000 members). Centene Corporation, our parent company, has more than **30 years** of experience using performance measures while administering full-risk managed care for TANF, CHIP, Aged Blind and Disabled (ABD), and other similar populations. Centene currently serves more than **3.1 million members** in managed care programs in **20 states**: Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Tennessee, Texas, Washington, and Wisconsin.

LHCC analyzes and uses data to support the **Triple Aim** of improving health outcomes for our population of members, improving the experience of care for each member, and reducing the cost per member - a framework developed by the Institute for Healthcare Improvement and adopted by CMS to optimize health system performance.



Centelligence™, our award-winning family of integrated decision support and health care informatics solutions, facilitates our use of data by collecting, integrating, storing, analyzing, and reporting data from all sources. Centelligence™ provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator Dashboards with “drill down” capability.

Centelligence™ also powers our provider practice patterns and provider clinical quality and cost reporting information products. Through Centelligence™, we have the ability to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, and other critical aspects of our operations. Centelligence™ also includes a suite of best-of-breed predictive modeling solutions incorporating evidence-based, proprietary Care Gap/Health Risk identification applications that identify and report significant health risks at population, member, and provider levels. These Care Gaps and Health Risk “alerts” power our Online Care Gaps feature – allowing our members and Providers to securely access actionable health information via our member and provider Portals.

It is important to note that the three-phased Bayou Health enrollment roll-out (go-live dates : GSA A – February 2012; GSA B – April 2012; GSA C – June 2012) impacted CY 2012 data and impaired subsequent trending of HEDIS and other performance measures by directly impacting continuous enrollment. Continuous enrollment specifies the minimum amount of time in a calendar year that a member must be enrolled in the Plan during a reporting year before becoming eligible for a measure. It ensures that we have enough time to render services and begin to influence member behavior through our various programs and initiatives.

LHCC understands and will comply with all DHH requirements for Quality Management including but not limited to Section 14.0 Quality Management and all other relevant contractual, State and federal requirements.

## Experience Using Performance Measures

LHCC has used performance measure, satisfaction, and other data to assess our members' health status and develop programs or process changes to improve outcomes. Targeted areas of focus have included transition of care after inpatient care; inappropriate ED utilization; preventive health visits and services; sickle cell disease; and diabetes management, for example. Some examples of programs that have achieved improvements in outcomes for our affiliate health plans include asthma and diabetes management; children with special health care needs; women's preventive health; depression; well child care; prenatal, postpartum and neonatal care; and coordination of medical and behavioral health care.

*Provide an example of changes implemented as a result of data collection to improve the health outcomes of your membership in Louisiana or another state Medicaid program. Examples of areas of interest include, but are not limited to the following:*

- *Management of high risk pregnancy*

## Examples of Implemented Data-Driven Changes

The following are examples of programs and initiatives implemented or enhanced by LHCC or affiliate health plans using the results of performance measure, satisfaction, or other data. We describe our experience with the management of high risk pregnancy in some detail and then review additional examples of programs or initiatives to improve health outcomes.

**Management of High Risk Pregnancy.** LHCC's preterm birth rate was 15.53% in CY 2012. Babies who are born prematurely are at a higher risk of developing health complications that can adversely affect vision, hearing, heart rate, blood health, immune systems and breathing. Autism and cerebral palsy also have been linked to preterm birth.<sup>1,2</sup> Poor birth outcomes, including low birth weight, prematurity, and NICU admissions, are a significant cost driver for our population.

LHCC has implemented, and continually enhanced, a comprehensive approach to managing high risk pregnancy that aims to increase member access to appropriate prenatal care, education, and needed community resources; as well as to decrease admissions to the NICU and shorten NICU hospital stays, decrease preterm births, increase birth weights, and generally reduce both infant and maternal morbidity and mortality.

**Start Smart for Your Baby®.** Start Smart, LHCC's comprehensive pregnancy management program, improves birth outcomes by focusing on early identification and risk screening, member education, and

### LHCC in Action...

*MCR J. St. Mary conducted a home visit to member L. F in 2014. Member was pregnant and grateful that MCR had come by to conduct the home visit. She received a packet of information in the mail but did not take the time to review the materials. MCR reviewed the packet with the member and explained the Start Smart for Your Baby® Program and all the benefits of enrolling. Member was grateful and allowed the MCR to complete the Notification of Pregnancy form. Member stated that she was glad that MCR conducted the home visit because it made her take the time to complete the necessary paperwork. She stated that she is very satisfied with LHCC and hopes that we continue to help people understand their benefits.*

<sup>1</sup> Catherine Limperopoulos, PhD, Haim Bassan, MD, Nancy R. Sullivan, PhD, Janet S. Soul, MD, Richard L. Robertson, Jr, MD, Marianne Moore, BA, RN, Steven A. Ringer, MD, PhD, Joseph J. Volpe, MD, and Adré J. du Plessis, MBChB, MPH, Positive Screening for Autism in Ex-preterm Infants: Prevalence and Risk Factors, *Pediatrics*. Apr 2008; 121(4): 758–765.

<sup>2</sup> Trønnes H1, Wilcox AJ, Lie RT, Markestad T, Moster D. Risk of cerebral palsy in relation to pregnancy disorders and preterm birth: a national cohort study, *Dev Med Child Neurol*. 2014 Aug;56(8):779-85

empowerment for all pregnant members. Start Smart is an all-encompassing pregnancy and postpartum management program, extending into the child's first year of life, that incorporates the concepts of Case Management, Care Coordination, and Chronic Care Management. Our multi-faceted approach to high-risk prenatal and postpartum care is a team effort by our plan staff and our providers, and includes enhanced member outreach, health screenings, wellness materials, intensive case management, and provider incentives. Our MemberConnections™ Representatives (MCRs – community outreach workers) help us identify and establish contact with high risk pregnant members. Members attending prenatal, postpartum and well child visits receive incentives through our CentAccount™ Member Rewards Program.

Upon initial implementation of the Start Smart program, Centene affiliates demonstrated lower ED utilization and inpatient length of stay, and higher primary care utilization for babies born to Start Smart participants in several Medicaid programs compared to those of non-participants.

**High Risk OB Program.** LHCC's High Risk OB Program targets *members at risk for poor birth outcomes*. Our comprehensive pregnancy assessment, administered by an experienced obstetrical RN Case Manager, helps to immediately identify risk and is the starting point for development of a member-specific Care Plan and continued outreach, monitoring, and member engagement. The highly trained High Risk OB Program staff are available to assist members with both medical and psychosocial issues. Pregnant members identified with a co-occurring chronic condition such as diabetes, HIV/AIDS, or, behavioral health or substance use disorders, for example, are referred for appropriate treatment and follow up.

The Case Manager follows the member throughout pregnancy and delivery. LHCC partners with Alere to augment our program with services such as preterm labor management including provision of 17 alpha hydroxyprogesterone (17P), hypertension management, gestational diabetes, coagulation disorder management, hyperemesis management, and fetal surveillance that may include, for example, patient education, home and telephonic assessment, clinical surveillance of medications, home uterine monitoring, and 24/7 nursing and pharmacist support. Start Smart staff document Alere monitoring results in our clinical documentation system to ensure that all staff have access to a full record of all member contact and monitoring information.

**Notification of Pregnancy.** Early identification and assessment are key to improving pregnancy outcomes. LHCC uses our Notification of Pregnancy (NOP) screening form as the vehicle for identifying pregnant members and collecting information on risk factors. This simple and easy-to-complete form includes questions to help us identify medical, behavioral and social risk factors, such as, pregnancy complications, previous preterm birth, smoking, alcohol, or drug use, and domestic violence. The NOP can be completed by the physician telephonically or via the secure Provider Portal; or by the member online on our website, telephonically with a CM, or by mail. Each of our employees is trained to identify pregnant members during any interaction. Staff with NurseWise, our 24/7 nurse advice line affiliate; Customer Service, Concurrent Review, and Chronic Care Management staff all assist the pregnant member with completing the NOP form or refer the member to the Start Smart staff. Case and Utilization Management staff review enrollment and other data (such as pharmacy data) we receive about a new member to identify members who may be pregnant. We also review DHH historical claims data for recent claims for prenatal vitamins or OB/GYN services.

Start Smart staff review all NOP screening forms submitted and based on identified risk factors, stratify the member as low, medium, or high risk. A high or medium risk triggers outreach by a specially trained Case Manager who completes the comprehensive pregnancy assessment and offers the member an opportunity to participate in the High Risk OB Program. All identified pregnant members are eligible for our Start Smart pregnancy management program.

**Change.** LHCC has continued to improve the % of pregnant members and/or their providers who submit the completed NOP form within eight months prior to delivery. After start up in 2012, QI staff assessed the rate of NOPs received and found it to be only 30.71 % of births. A root cause analysis revealed that providers and members were unclear about the importance of the form and how the information was used by LHCC. In Q4 2012, LHCC developed and initiated an intensive member and provider outreach and education campaign by QI, Start Smart, and Provider Relations staff that focused on explaining why the NOP is important and how it can help us help our pregnant members have a healthy pregnancy and healthy baby.

As a result of our NOP outreach efforts, as well as our Start Smart and High Risk OB Programs, LHCC has achieved improved outcomes in a number of areas such as:

- An 83.1 % improvement in NOPs received (29.31% to 53.67%) 2012 to 2013
- An 7.9% decrease in preterm birth rate (<37 weeks) (15.35% to 14.13%) 2012 to 2013
- A 32.9% decrease in NICU admission rate (6.24% to 4.19%) 2012 to 2013
- A 35.2% decrease in NICU days per 1000 births (879 to 565), 2012 to 2013

#### • *Management of HIV*

According to the CDC, using 2011 data, New Orleans ranked second and Baton Rouge ranked third in US cities with the highest rates of HIV diagnoses. Also CDC's report "HIV Stages of Care", July 2012 states that only 25% of the people infected with HIV are virally suppressed. HIV/AIDS present challenges not only in detection but also in member access and use of appropriate care. It also presents challenges due to the common occurrence of co-morbid conditions that can exacerbate or complicate care, including the compliance and use of needed ARV drug therapies. LHCC's approach to engaging members with HIV/AIDS has been multipronged and evidence-based, integrating Case Management, Care Coordination and Pharmacy Management. We have successfully outreached to 53% of our members with HIV/AIDS and Case Management staff have assessed medication and treatment plan compliance, assisted with coordinating services and care, and provided educational materials. Although there are no prior authorization requirements for HIV/AIDS medications, our pharmacy staff still monitor safety edits that place restrictions on claims to prevent members from receiving combination drug regimens that are contraindicated, or have been deemed toxic and potentially life threatening. Potential for high dose is limited by the maximum daily dose limits placed on some of the HIV medications. Quantity Limits are also in place to decrease fraud or waste of HIV medications. Our Start Smart for Your Baby pregnancy management program has a strong focus on timely screening of pregnant members for HIV and other sexually transmitted infections to insure timely diagnosis and management.

In view of the complexity of needs and the critical role of member engagement in improving outcomes, LHCC will implement a new Chronic Care Management Program (CCMP) for HIV/AIDS in collaboration with the AIDS Healthcare Foundation's NCQA accredited Positive Healthcare HIV/AIDS disease management program. The program uses a Case Manager to create a Care Plan in collaboration with the member, providers, family, and an AIDS Services Organization case manager, if applicable. The Care Plan also addresses all co-morbid conditions, such as hepatitis B & C, tuberculosis, and cancer. Our Case Managers also will work closely, as needed, with our other CCMP staff to address conditions such anxiety, asthma, congestive heart failure, depression, diabetes, hypertension, pain management, and will coordinate palliative and hospice care.

Because of the important role of antiretroviral (ARV) therapies, this program will also provide specialized medication therapy monitoring to assist with ARV drug adherence and other co-morbid condition

medication regimens. Care Plan goals will include supporting independence, self-sufficiency, effective family functioning and caregiver assistance, and use of appropriate health services. LHCC also will use Member Connections Representatives (MCRs) who are certified by OPH in HIV Prevention Counseling and Rapid Testing to provide in-home education and support.

• ***Sickle cell disease management***

LHCC recognizes sickle cell disease as a serious health problem among African-Americans, who comprise 59.3% of our membership. During 2012, LHCC had an average of 275 members with sickle cell disease. By 2013, the number increased by 29.8% to 357 members. Hydroxyurea, an antineoplastic drug, is currently approved by the U.S. Food and Drug Administration for the treatment of sickle cell disease in adults. It reduces the frequency of severe pain crises, acute chest syndrome, and the need for blood transfusions. Our review of medical and pharmacy claims data and completed member sickle cell questionnaires indicated that as of December 31, 2012 only 19.2 % of LHCC members with sickle cell disease were prescribed hydroxyurea. As a result of this analysis, we implemented our Sickle Cell Program for high and medium risk members. All members who engage enrolled in our Sickle Cell Program receive a comprehensive risk assessment and individualized Care Plan, as well as education, support, and coordination of medical care. We may also provide services such as home visits, or a pre-programmed Connections Plus® cell phone so that members can stay connected with their providers, Case Manager, pharmacist and NurseWise, a 24/7 nurse advice line. Program staff also provide training to providers about the program, and the efficacy of hydroxyurea.

**Change:** In LHCC, the use of hydroxyurea by members with sickle cell disease who engaged with our Program increased 19.6% from a baseline of 35.7% on 1/31/2013 to 42.7% for CY 2013.

Across Centene affiliate plans that use this program, the number of filled hydroxyurea prescriptions increased 11.4% in CY 2011, the first year of implementation. In addition, ED visits by members with sickle cell decreased in Q1 2012 by 16%.

• ***Reductions in low birth weight babies***

Low birth weight is caused either by preterm birth or by the baby being small for gestational age. Our Start Smart and High Risk OB Programs help address factors such as placental dysfunction or intrauterine infection that contribute to babies who are small for gestational age. 17P has demonstrated proven efficacy in reducing the risk of preterm delivery in women *with a previous spontaneous preterm birth*. Among our most effective interventions in managing high risk pregnancy, our **17P Program** identifies women less than 28 weeks gestation who may qualify for weekly injections of 17P and facilitates their treatment. When used according to protocol, 17P has produced up to a 73% reduction in preterm deliveries for at-risk women. Additionally, infants delivered to mothers who received 17P demonstrated significantly lower rates of necrotizing enterocolitis, intraventricular hemorrhage, and the need for supplemental oxygen.

**Change:** In 2013, LHCC provided 17P to 91 pregnant members with a history of preterm birth with promising outcomes such as:

- An overall 8.1% decrease in low birth weight births (< 2500 g) (13.31% of births CY2012 to 12.23% CY2013)
- A 7.9% decrease in the rate of births prior to 37 weeks (15.35% of births CY2012 to 14.13% CY2013)

- Only 25.93% of LHCC members receiving the full course of 17P had preterm births (<37 weeks) in 2013, similar to the 25.81% of members in all Centene plans who received the full course and well below the 51.67% of Centene control members (at risk for recurrent preterm birth) not receiving 17P.<sup>3</sup>

In order to further decrease our preterm births, we plan to phase-in implementation of universal cervical length screening for women *without a previous history of preterm birth*. We are currently negotiating with three of our high volume clinics to begin piloting cervical length screening in January 2015. The pilot will allow us to analyze, evaluate, and improve processes and preliminary outcomes prior to network-wide implementation. These providers will complete cervical length screening by cervicometer or transvaginal ultrasound for all singleton pregnancies with a history of preterm birth. We will provide the practices with preterm birth algorithms, coding guidance, and options for prescribing vaginal progesterone and 17P.

#### • *Pediatric Obesity (children under the age of 19)*

Childhood obesity is a serious health concern in Louisiana and the United States. Louisiana ranks 45 in overall prevalence with 35.9% of children considered either overweight or obese. The Louisiana prevalence of overweight and obese children has risen since 2003.<sup>4</sup> Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.<sup>5</sup>

LHCC is proposing a performance improvement project targeting childhood obesity (described in U.5). We will benefit from best practices and lessons learned by our Georgia affiliate's recent implementation of a family-centered pediatric obesity program. They educated providers on recommendations and coding requirements regarding assessment and documentation of BMI and on the importance of reducing obesity. Their approach to members was two-fold, addressing prevention and addressing treatment.

The **prevention component** targeted communities and schools and included age appropriate educational material, family oriented events, and community partnerships. The **treatment component** identified overweight or obese members through claims and direct referral. Upon enrollment into the program, each member completed an initial health risk assessment questionnaire, from which the program staff developed an individualized Care Plan with the member and family. Clinical and non-clinical staff used three member engagement strategies (telephonic outreach, face-to-face home visits, and educational materials) to identify and remove barriers, and to address cultural influences and social concerns.

**Change:** This program has achieved the following improvements in HEDIS rates since 2009:

- 19.04 % improvement in documented BMI
- 21.36% improvement in nutritional counseling
- 26.41% improvement in physical activity counseling

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<sup>3</sup> Mason MV, Poole-Yeager A et al, Impact of 17P Usage on NICU Admissions in a Managed Medicaid Population – A Five Year Review, *Managed Care* 19;2:46-52 Feb 2010

<sup>4</sup> <http://www.childhealthdata.org/docs/nsch-docs/louisiana->

<sup>5</sup> Freedman DS, Zuguo M, Srinivasan SR, Berenson GS, Dietz WH. Cardiovascular risk factors and excess adiposity among overweight children and adolescents: the Bogalusa Heart Study. *Journal of Pediatrics* 2007;150(1):12-17

- ***Reduction of inappropriate utilization of emergent services***

We prevent and reduce non-emergent ED use through multiple strategies, such as promoting primary care through the medical home, ensuring availability of appropriate urgent care settings, interventions targeted to super-utilizers, and other strategies described in the relevant sections below. In addition, we educate members and providers regarding appropriate utilization of ED services, including behavioral health emergencies, and monitor emergency services utilization by provider and member.

Following a two year DHH-required Performance Improvement Project, the reduction of inappropriate ED visits continues to be a leading strategic initiative for LHCC. During 2013, the plan identified 1,254 members in quarterly cohorts who were high utilizers of the ED, with three or more ED visits in the previous 90 days. Staff conducted outreach to identified members and attempted to enroll them in our Case Management Program. MCRs visited the homes of members who could not be reached by phone to discuss other options for care for non-urgent services. Our MCRs educated members about the importance of a medical home and how to access it, appropriate options for non-emergent health care needs, and alternatives to utilizing the ED, such as the availability of after-hours appointments and urgent care clinics in the member's area. MCRs also educated members about how to contact NurseWise, our 24/7 nurse advice line, for questions; and the availability of scheduling and transportation assistance. Members who agreed to participate in our Case Management Program were assigned a Case Manager to complete a comprehensive assessment and care plan that addressed the member's full range of needs, including but not limited to BH needs requiring a referral to the Statewide Management Organization (SMO) for specialty BH services. Case Managers conducted additional education and provided scheduling and transportation assistance as needed.

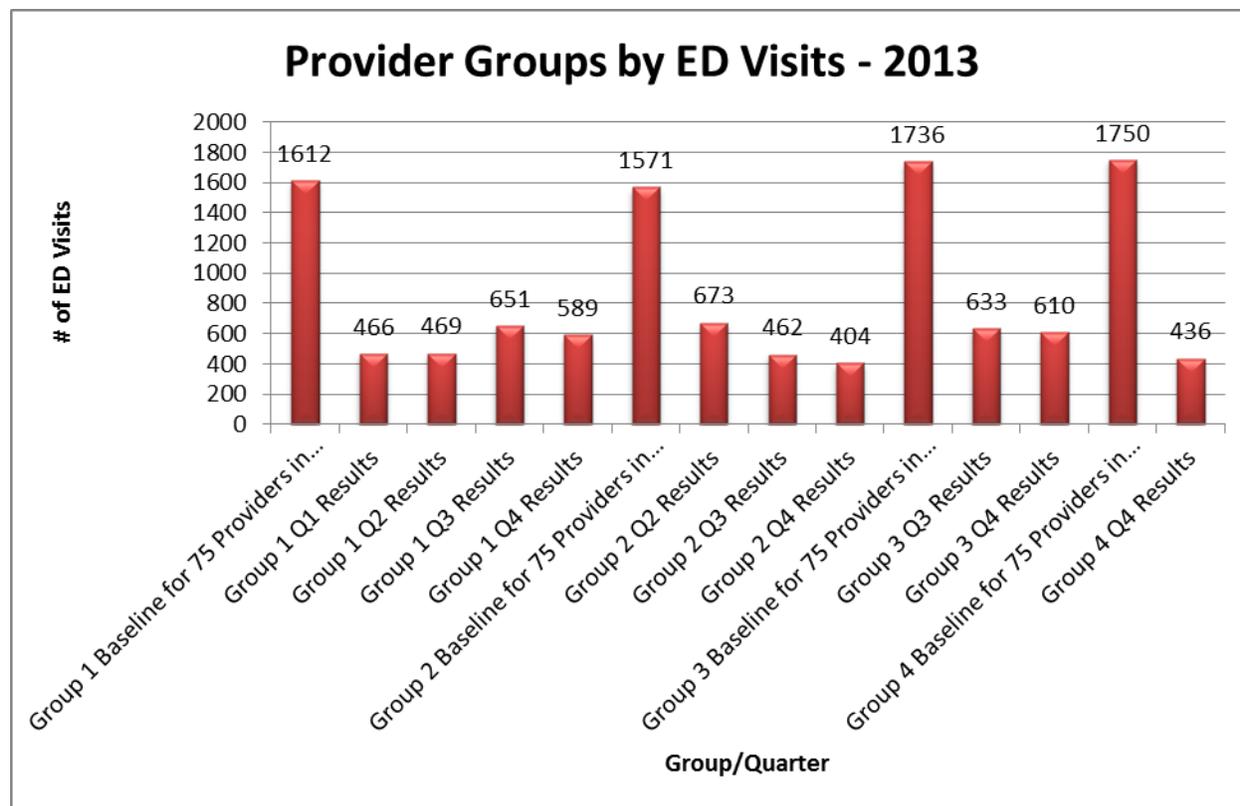
Our Provider Relations Specialists (PR Specialists) contacted the 75 practices with the highest ED utilization each quarter, along with our network FQHCs, Medical Home eligible providers, and other providers. PR staff provided each with information on their ED rates; and encouraged them to contact their patients on the ED list to provide education, offer preventive and primary care appointments, and ensure their office schedules could accommodate our members. PR Specialists also discussed the member's barriers that contributed to their high utilization rates to help the provider tailor their own outreach to the member.

We will continue the member and provider outreach strategies described above, and increase in-person outreach by MCRs for members who cannot be reached by phone and those who need more intensive assistance. We will also track the names of members who visit the ED and that we share with the SMO. QI staff will generate and distribute monthly reports to the SMO that include the names of these members and dates of service. Case Managers will discuss identified ED utilization during bi-weekly rounds with the SMO for co-managed members, and facilitate development of outreach, education, and other strategies to address the utilization collaboratively with the SMO.

***Change:*** The quarterly cohorts of members who participated in case management demonstrated an average 56.6% decrease in ED visits per member by the quarter following their enrollment. In addition during 2013, Provider Relations targeted 75 practices with the highest ED utilization each quarter. As demonstrated on the following graph, the number of ED visits per quarter for each group of providers promptly decreased in the subsequent quarters:

- Group 1 yielded a 63.5% reduction from baseline over 4 quarters
- Group 2 yielded a 74.3% reduction from baseline over 3 quarters
- Group 3 yielded a 64.9% reduction from baseline over 2 quarters

- Group 4 yielded a 75.1% reduction from baseline over 1 quarter



**• Children with special health care needs**

LHCC’s member-centric Care Management model ensures that children with special needs have access to the full range of needed covered and non-covered services with no gaps or duplications in care. The multidisciplinary care team focuses particularly on preventive services, which special needs members may underutilize due to the intensity of specialty services they receive. They also focused on co-morbidities, which are frequent within the special needs population. Using methods such as in person, fax, phone, and certified mail communication, joint case rounds and joint assessments, the Case Manager (with assistance from other support and outreach staff) facilitates communication among the member, family, primary care provider, specialists, and other involved parties to share information, plan and coordinate services, and monitor member progress.

The Myers Group, an NCQA certified HEDIS Survey Vendor, was selected by LHCC to conduct its 2013 CAHPS 5.0 Medicaid Children with Chronic Care Conditions (CCC) survey. The CCC set for children consists of two groups of items: A set of 24 supplemental questions that ask about the health care experiences of children with chronic conditions and a five-item screener that classifies children with chronic conditions during the analysis stage after the survey has been administered. Listed below are the results of five key composite scores from the CCC survey:

- 81.6 % were satisfied with Access to Prescription Medicines

- 71.9 % were satisfied with Access to Specialized Services
- 82.9 % were satisfied with Personal Doctor Who Knows the Child
- 85.75 % were satisfied with Getting Needed Information
- 78.1 % were satisfied with Coordination of Care

#### • *Asthma*

More than 16,700 LHCC members are diagnosed with asthma. Asthma drugs rank third highest in LHCC's pharmacy expenditures, costing approximately \$430,000 per month in Q2 2014. Medication compliance – taking the right drugs such as controller medications vs rescue medications – at the right time is critical for managing chronic asthma conditions. LHCC implemented our Asthma Program to improve the health status of our members with asthma, and we continuously update the program based on member needs and advances in member engagement and health education methodologies and asthma care. We identify members for enrollment based on medical and pharmacy claim data, health risk screening, or referral by a provider, Case Manager, or self-referral.

Following mail and telephonic outreach, a Health Coach (respiratory therapist) completes an assessment with the member and develops an individualized Care Plan based on member or caregiver knowledge of their condition, lifestyle behaviors, and readiness to change. The program's focus includes promoting member adherence to asthma treatment guidelines, preventing exacerbations and optimizing functional status. Coaching is provided both telephonically and in the home and focuses on proper use and maintenance of respiratory equipment, improving exercise tolerance and tobacco cessation.

Throughout the program, the Health Coach works with the Member and caregiver to identify barriers to Care Plan compliance and addresses questions regarding condition management. Members who are not interested in telephonic counseling at enrollment may call in to speak with a Health Coach at any time to ask questions or to opt into telephonic counseling, and receive quarterly newsletters. In 2013, we identified 2,238 members as eligible for the program, 778 members actively participated with a Health Coach and 313 chose educational mailings only.

**Change:** Examples of improved outcomes from LHCC's Asthma Program from CY2012 to CY2013 (comparison of limited value due to the small number of participating members in 2012):

- The number of participants using controller medications increased from 35% to 42%
- The number of participants using peak flow meters increased from 11% to 20%
- ED visits per 1,000 participants decreased from 416 to 374

In CY2013, Centene affiliate plans that use this program demonstrated the following outcomes relative to their propensity score matched with a non-participant control group:

- Children had 24.6% fewer ER visits; saw their physicians 7.7% more regularly; used controller medications at a 22.2% higher rate and had an astounding 47.4% more frequent pulmonary function testing
- Adults had 12.5% fewer ER visits and 17.2% fewer inpatient visits; had 12.4% more frequent pulmonary function testing and a 7.5% higher rate of flu vaccination.

#### • *Diabetes*

LHCC implemented our diabetes program to improve the health status of our members with diabetes, and we continuously update the program based on member needs and advances in member engagement and health education methodologies and diabetes care. We identify members for enrollment based on medical and pharmacy claim data, health risk screening, or referral by a provider, Case Manager, or self-referral. Following mail and telephonic outreach, a Health Coach (certified diabetes educator) or Case Manager completes an assessment with the member and develops an individualized Care Plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors, and readiness to change.

The Program focuses on promoting member understanding and adherence to approaches that optimize blood glucose, blood pressure and lipid control; medication understanding and adherence; self-blood glucose monitoring; recognizing signs of high and low blood glucose levels; nutrition counseling for carbohydrate counting and weight management; recommended screenings for diabetic complications; blood pressure and cholesterol management; optimizing physical activity levels; and tobacco cessation.

Throughout the program, the Health Coach works with the member and caregiver if relevant to identify barriers to Care Plan compliance and addresses questions regarding condition management. Members who are not interested in telephonic counseling at enrollment may call in to speak with a Case Manager/Health Coach at any time to ask questions, opt into telephonic counseling, and receive quarterly newsletters. In addition, we offer an incentive of \$50 each year to all members with diabetes through our CentAccount™ Member Rewards Program if they complete HbA1c testing, diabetic eye exam, LDL-C and nephropathy screenings.

**Change:** In 2013, 1,824 members were identified as eligible for the program, 1,333 members actively participated with a Health Coach and 389 chose educational mailings only.

Examples of improved outcomes from CY2012 to CY2013 (comparison of limited value due to the relatively small number of participating members in 2012) include:

- The number of participants using ACE/ARB medication increased from 41% to 64%
- The number of participants completing their HbA1c testing increased from 20% to 64%
- The number of participants having an annual eye exam increased from 41% to 86%
- Inpatient admissions per 1,000 participants decreased from 152 to 51.
- Members who reported testing their blood sugar (self-monitored blood sugar) increased from 15% to 53%

#### • *Cardiovascular diseases*

About 1,650 LHCC members have a diagnosis of heart failure. According to the CDC, 1 in 9 deaths include CHF as a contributing cause, and about half of people who develop CHF die within 5 years of diagnosis. LHCC implemented two cardiovascular disease programs, congestive heart failure in 2012 and hypertension in 2013, to improve the health status of our members with those cardiovascular conditions. We continuously update the programs based on member needs and advances in member engagement and health education methodologies and cardiovascular care. We identify members for enrollment based on analysis of medical and pharmacy claim data, including predictive modeling; health risk screenings; provider referrals; referrals from Case Managers; or self-referral. Both programs prioritize early identification of members with, or at risk for, cardiovascular diseases and co-morbidities.

**Congestive Heart Failure.** Following mail and telephonic outreach, a Health Coach (RN with expertise in heart failure and heart disease) completes an assessment with the member and develops an individualized Care Plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors, and readiness to change. The program's focus includes promoting member understanding and adherence to heart failure treatment guidelines, medication use, and sodium restrictions as recommended by the treating physician; self-monitoring for signs of decompensation and fluid overload; blood pressure and cholesterol management; heart healthy nutrition; weight management and optimizing physical activity; and tobacco cessation.

For certain high-risk members, in addition to health coaching we offer Telemonitoring Enhanced Care for real time monitoring of biometric data using web-based technology and in home devices such as a pulse oximeter, scale, and blood pressure cuff. Throughout the Program, the Health Coach works with the member and caregiver to identify barriers to Care Plan compliance and addresses questions regarding condition management. For those members who are not interested in telephonic counseling at enrollment, we send quarterly newsletters and encourage them to call in to speak with a Health Coach at any time to ask questions or to opt into telephonic counseling.

In 2013, 3088 members were identified as eligible for the Program; 549 members actively participated with a Health Coach; and 72 chose educational mailings only.

**Change:** Examples of improved outcomes from LHCC's Congestive Heart Failure Program from CY2012 to CY2013 (comparison of limited value due to the relatively small number of participating members in 2012) include:

- ACE/ARB use among participants increased from 55% in 2012 to 66% in 2013
- Blood pressure screenings and control both improved year over year; BP Screenings increased from 9% to 37% and control levels ( $<130/80$ ) increased from 8% to 31%
- LDL-C screenings increased among participants from 24% in 2012 to 55% in 2013.

**Hypertension.** Following mail and telephonic outreach, a Health Coach (RN, dietician, or exercise physiologist) completes an assessment with the member and develops an individualized Care Plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors, and readiness to change. The Program focuses on promoting member understanding and adherence to medication and treatment guidelines; improving self-management skills to reduce the risk of heart attack, stroke and kidney disease; nutrition and physical activity guidelines; and tobacco cessation. This Program assists all eligible members with hypertension.

Our Health Coaches are knowledgeable about and well trained on the role hypertension plays as a precursor to heart disease, especially among the African-American population, and incorporate that understanding when working with LHCC members. Throughout the Program, our Health Coach works with the member and caregiver to identify barriers to Care Plan compliance and addresses questions regarding condition management. For those members who are not interested in telephonic counseling at enrollment, we send quarterly newsletters and encourage them to call in to speak with a Health Coach at any time to ask questions or to opt into telephonic counseling.

In 2013, 25,121 members were identified as eligible for the Program. Of those, 2,093 members actively participated with a Health Coach and 0 chose educational mailings only.

**Change:** Examples of improved outcomes from LHCC's Hypertension Program from CY2012 to CY2013 (comparison of limited value due to the relatively small number of participating members in 2012) include:

- Blood pressure screenings and control improved year over year; BP Screenings increased from 11% to 29% and control levels ( $<130/80$ ) increased from 25% to 37%

- Proper hypertension medication use (Rx adherence) increased from 44% in 2012 to 61% in 2013
- LDL-C screenings increased among participants from 11% in 2012 to 42% in 2013

### **Additional Data Driven Initiatives**

**Back Pain.** In addition to the programs previously described, LHCC also implemented our Back Pain Program in 2012 to improve the health status of our members with chronic back pain. We continuously update the Program based on member needs and advances in member engagement and health education methodologies, and in pain management.

We identify members for enrollment based on analysis of medical and pharmacy claim data, health risk screenings, provider referrals, Case Manager referrals, or self-referral. Following mail and telephonic outreach, a Health Coach (Exercise Physiologist) completes an assessment with the member and develops an individualized Care Plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors, and readiness to change.

The Program focuses on development of muscle endurance, strength and flexibility of the core stabilizer muscles, assessment and optimization of body mechanics and posture, review of occupational workstation ergonomics, medication understanding and adherence, pain management strategies, stress management, including visualization and relaxation techniques, symptom-specific education, and emotional support.

Throughout the Program, the Health Coach and a Behavioral Health Coach work with the member and caregiver to identify barriers to Care Plan compliance and address questions regarding condition management. We also offer Program participants unlimited inbound calls to the Health Coaches and six issues of our Back Pain Management Newsletter over a 12 month enrollment period.

In 2013, 219 members actively participated with a Health Coach.

**Change:** Examples of improved outcomes from LHCC's back pain program from CY2012 to CY2013 (comparison of limited value due to the relatively small number of participating members in 2012) include:

- ED visits per 1,000 participants decreased from 629 to 459
- The number of participants reporting at least a 20% decrease in pain scale increased from 12% to 33%.

**Adult Weight Management Program.** LHCC implemented our adult weight loss program to improve nutrition and exercise patterns, and minimize health risk factors of our members with obesity, and we continuously update the program based on member needs and advances in member engagement and health education methodologies. We identify members for enrollment based on referral by a provider, Case Manager, or self-referral. Following mail and telephonic outreach and an initial health assessment, a Health Coach (Registered Dietitian) develops an individualized Care Plan with the member based on the member's physical activity limitations, presence of co-morbidities, dietary intake, knowledge of their condition, lifestyle behaviors, and readiness to change.

The program's focus includes nutritional counseling; behavior modification skills for long term weight control; shopping, food preparation and portion control methods; strategies when eating out; optimizing physical activity levels to meet recommended guidelines; lifestyle approaches to physical activity; and tips to keep motivated with exercise. Throughout the program, the Health Coach and an Exercise Physiologist works with the member and caregiver to identify barriers to Care Plan compliance. We offer program participants unlimited inbound calls to the Health Coaches and access to educational materials.

**Change:** From CY2012 to CY2013, 53% of participants in LHCC's Adult Weight Management Program reported a reduction in BMI.

• *Reduction in racial and ethnic health care disparities to improve health status*

**Reduction in Racial and Ethnic Disparities to Improve Health Status.** LHCC uses health plan operational strategies and provider strategies to address disparities in treatment and respond to the health care needs of all members, regardless of their racial, ethnic, cultural or religious backgrounds. LHCC has implemented all of the national Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards, developed by the U.S. Department of Health and Human Services’ Office of Minority Health, are organized by themes: Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence. While not required, implementing CLAS standards provides us clear direction to ensure that we provide culturally competent services to our Members.

Addressing disparities is a required component of our QAPI Program and the focus of the LHCC Cultural Competency Plan. LHCC employs local staff that mirror the demographic composition of the communities we serve; who can understand the health care needs, social issues, and cultural beliefs of our members; and who daily educates the rest of the staff on racial/ethnic and cultural differences. All of our employees complete cultural competency training as part of New Employee Orientation and periodically thereafter.

As demonstrated in the following table, our data on the demographics of our membership is quite complete, with fewer than 5% of members categorized as either ‘unidentified’ or ‘not provided’. Nearly 60% of our members identify themselves as Black.

<b>LHCC Membership Demographics 9/5/2014</b>			
	<b>Gender</b>		<b>Total</b>
<b>Race/Ethnicity</b>	Females	Males	
American Indian or Alaskan	55.53%	44.47%	0.29%
Asian or Pacific Islander	56.91%	43.09%	0.99%
Black	55.39%	44.61%	59.28%
Hispanic	54.94%	45.06%	2.55%
Mutually Defined	54.31%	45.69%	1.03%
Native Hawaiian	56.84%	43.16%	0.06%
Not Provided	49.37%	50.63%	3.41%
Unidentified	65.90%	34.10%	1.17%
White (non-Hispanic)	55.20%	44.80%	31.22%
<b>Grand Total</b>	<b>55.24%</b>	<b>44.76%</b>	<b>100.00%</b>
<b>Total Membership</b>	<b>151,783.00</b>		

LHCC focuses clinical initiatives, Case and Chronic Care Management activities, and clinical practice guideline development on conditions for which African-Americans are at higher risk (and subject to disparities in treatment and outcome), such as HIV, sickle cell disease, heart disease, stroke, and breast and cervical cancer.

When Case Managers and Health Coaches work with members, they provide information about any increased risk for particular diseases related to the member’s race or ethnicity, and provide information about behaviors that members can change to mitigate identified risks. We track the success of our Case

Management activities to ensure that members with HIV/AIDS or sickle cell disease, well over 80% of who are African-American, receive recommended screenings and treatment. We will expand upon these efforts in 2015 by implementing new Chronic Care Management Programs for members with HIV/AIDS and sickle cell disease.

Because of the prevalence of HIV infection among young African American men in Louisiana, we participated in an event targeting that population that was organized in part by the Office of Public Health (OPH) and the Baton Rouge AIDS Society, an OPH-contracted HIV/STD Program community organization. We will continue to find opportunities to work with providers and community organizations involved with the OPH HIV/STD program to leverage their experience in addressing this sensitive issue. We encourage members to receive screening at OPH clinics or OPH-certified school-based clinics if they are reluctant to receive screening at their usual source of care.

As seen in the following tables, our data on language preference is incomplete, with nearly 80% of members undetermined. However, of those members for whom we have data, over 3% prefer Spanish. Also, a number of members preferred Vietnamese or Arabic. LHCC has a language line for translation services that is available to all members. We provide educational materials in alternate languages, including Spanish, Vietnamese, and Arabic, upon request. No member complaints related to language/cultural issues were received by the Quality Department during the 2013 calendar year.

<b>LHCC Membership Language 9/5/2014</b>		
<b>Language</b>	<b>Count of Members</b>	<b>%</b>
ARABIC	39	0.03%
ENGLISH	32,711	21.55%
FRENCH	2	0.00%
HINDI	1	0.00%
KOREAN	3	0.00%
LOAO	3	0.00%
PORTUGUESE	3	0.00%
SPANISH	1,106	0.73%
UNDETERMINED	117,755	77.58%
Unidentified	94	0.06%
VIETNAMESE	66	0.04%
<b>Grand Total</b>	<b>151,783.00</b>	<b>100.00%</b>

<b>LHCC Membership with Known Language Preference</b>		
<b>Language</b>	<b>Count of Members</b>	<b>%</b>
ARABIC	39	0.11%
ENGLISH	32,711	96.40%
FRENCH	2	0.01%
HINDI	1	0.00%
KOREAN	3	0.01%
LOAO	3	0.01%
PORTUGUESE	3	0.01%

<b>LHCC Membership with Known Language Preference</b>		
SPANISH	1,106	3.26%
VIETNAMESE	66	0.19%
<b>Grand Total</b>	<b>33,934.00</b>	<b>100.00%</b>

**• Hospital readmissions and avoidable hospitalizations**

LHCC implemented a pilot Transition of Care (TOC) program in 2013. The program is designed to improve the overall health outcomes of our members by decreasing hospital readmissions and unnecessary ED visits following hospital discharge. Prior to hospital discharge, our Concurrent Review nurses identify opportunities for care coordination such as assistance with medication, supplies, transportation, caregiver support, and physician follow-up visits post hospitalization. Our TOC pilot added a TOC Coordinator to contact targeted members within 72 hours of discharge to confirm that services are in place and to assist with any unmet needs. The pilot targeted members admitted with sickle cell disease, any admissions of children in foster care, and SSI members admitted with cardiac disease, pneumonia, or diabetes. The 26 members in the initial TOC pilot had a 56.9% decrease in inpatient utilization comparing the number of admissions within 90 days prior to the index discharge to the number of readmissions within 90 days post index discharge.

The graphic shown below depicts the TOC methodology in place for the pilot program.



Our evaluation of this pilot led to changes in the documentation process, a change in the role of the TOC Coordinator, and the initiation of another related project to review the concurrent review process for all admissions. We also identified the need for a social worker to support the concurrent review process. The social worker assists in proactively identifying social barriers that may impact a successful discharge. Both the social worker and Concurrent Review Nurse have been tasked with identifying the root causes for any member's readmission.

We have continued the TOC pilot program for targeted members, now enhanced by the changes in the concurrent review process for all admitted members. For the first two quarters in 2014, results for 237 members, comparing utilization within 90 days prior to the index discharge to utilization within 90 days post index discharge, include:

- A 43.1% decrease in inpatient readmissions (from 218 to 94)
- A 39.2% decrease in ED visits (from 130 to 51)

• *Reduction in incidence of sexually transmitted infections (STIs)*

Education, outreach and endorsement of the Centers for Disease Control (CDC) treatment guidelines are at the core of our approach to reducing the incidence and reducing the spread of STIs. Recognizing that many STIs can be asymptomatic, our focus centers on member education and counseling, provider education, effective diagnosis and treatment, and encouraging eligible members to receive timely recommended screening as well as the human papillomavirus (HPV) vaccine.

Although most adolescents are relatively healthy by traditional medical standards, they face a number of significant threats to their health, many of which are preventable. The most serious, costly, widespread adolescent health problems are attributable primarily to health-damaging behaviors. Preventive services recommended for adolescents by all of the major guidelines include screening for depression, eating disorders, hypertension, sexual behavior, sexually transmitted infections (STIs), suicide risk, tuberculosis, and substance use; counseling for diet, exercise, injury prevention, sexual behavior, substance use and violence prevention; and immunizations for measles, mumps, rubella, tetanus, diphtheria, and Hepatitis B (for sexually active youth).<sup>6</sup>

We provide STI member education material in English and Spanish on our website and available in other languages by request. The materials are geared toward both adults and teens, and topics covered include chlamydia, HPV, syphilis, and gonorrhea, for example. In addition, LHCC has programs in place, such as Care Gaps, to remind members to visit their provider at least annually for a well visit for preventive services including STI screening and counseling. Our CentAccount™ Member Rewards Program offers adolescent and adult members a \$25 incentive each year for attending a well visit, and offers a \$20 incentive for receiving annual chlamydia screening. In addition, LHCC has invested in provider incentives for PCPs who conduct STI screenings and early detection including, but not limited to syphilis, herpes type 1 and 2, HIV 1, 2 tests; single result, Hepatitis B tests; and chlamydia tests.

Because LHCC has only one complete year of HEDIS results (HEDIS 2014), we have compared our progress year-to-date in CY2014 to that for the same period in CY2013 to help assess our progress. For January through July 2014, we are 38% ahead of the same period last year in members 9 -13 years old receiving HPV vaccines (13.84% compared to 10.05%). Similarly, our performance on the Adolescent Well Care measure is progressing 36% better this year (January through July) than the same period last year (23.56% compared to 17.33%).

Using similar programs, our affiliate health plan in South Carolina achieved a 28.26% improvement in Adolescent Well Care screening from CY 2011 to CY 2013.

We have learned that members, particularly adolescents, are sometimes uncomfortable going to their PCPs for services and screenings related to sexually transmitted diseases. Because of the importance of these screenings, we pay claims from any Medicaid-eligible providers and urge members to complete testing at any location, though we prefer, encourage, and support access to care through the member's medical home. We also understand that adolescents may be more likely to seek HIV/STI counseling and education through a Parish Health Unit or SBHC. Our statewide contract with OPH includes school based services in 64 locations throughout Louisiana, while the OPH clinics provide an additional 55 Full-Time Sites and 9 Part-Time Sites. We are also contracted with Access Health and two other FQHCs that provide School Based services (RKM and St. Gabriel Community Health Center).

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<sup>6</sup> [1] National Adolescent Health Information Center; <http://nahic.ucsf.edu/downloads/CPHS.pdf>

## Additional Initiatives

### Patient Centered Medical Home (PCMH) Program

The PCMH model emphasizes care coordination and communication. We recognize that by investing in medical homes our members will receive higher quality of care, in the right place and at the right cost and will improve both members and providers experience of care. LHCC is one of the few Medicaid plans in Louisiana with Certified Content Experts (CCE) certified by NCQA and with dedicated PCMH staff to support providers in achieving their goals of attaining medical home recognition or certification.

Achieving NCQA PCMH Recognition or Joint Commission Primary Care Medical Home Certification demonstrates that a physician practice has successfully transformed to an advanced model of primary care that improves health outcomes. Currently 89 practice sites within the LHCC network, with 75 individual practitioners have achieved this status. Of these, 15 sites with 41 practitioners were assisted in this achievement by our PCMH staff and technical resources. For more information, please see Section G.1 Network Management Plan.

*U.4 Submit a preliminary description of your Quality Assessment and Performance Improvement Program (QAPI), as described in Section 14.1 of the RFP. Such description should address the following. Proposers may submit information from another state Medicaid program showing proposed adaptations to be made for the Louisiana population.*

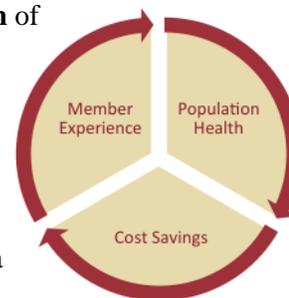
### Overview

LHCC is committed to the provision of a well-designed and well implemented Quality Assessment and Performance Improvement (QAPI) Program. Our culture, systems, and processes are structured around our mission to improve the health outcomes of all members and the **Triple Aim** of simultaneously improving health, enhancing experience and outcomes, and reducing cost, a framework developed by the Institute for Healthcare Improvement and adopted by CMS to optimize health system performance.

The QAPI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This comprehensive approach to quality improvement provides a continuous cycle for assessing both the quality and safety of clinical care and quality of services provided to LHCC's members and providers, including medical, behavioral health (BH), dental, and vision care. We document improved health outcomes using established Performance Measures, including those developed by DHH and outlined in Appendix J: Performance Measure Reporting.

Our Chief Medical Director, David Thomas MD, PhD, is a board certified pediatrician and pediatric pulmonologist with past experience successfully improving the performance of a private practice, using Plan-Do-Study-Act (PDSA) improvement methodology. Quality management and improvement are an integral part of his approach to business management and a core business strategy for LHCC. Our Quality Team, under his leadership, takes a data-driven approach to performance improvement every day. He and the Team drive improvement and innovation throughout the organization, champion our QAPI Program and improvement initiatives, and convey our commitment to improving quality to all stakeholders.

We adhere to the Six Sigma methodology and are pursuing certification of key individuals across the health plan. Currently, our Chief Operating Officer (COO) and one of our QI Managers are certified Lean Six Sigma Black Belts, and 10 other employees are certified Lean Six Sigma Green Belts. All quality project managers are certified in Six Sigma. LHCC is committed to retaining an experienced organization



to provide LHCC with Six Sigma training materials and tool kits designed especially for health care organizations. Our goal is to eventually have all departmental managers Six Sigma certified.

All staff within LHCC clearly understand the mission and vision of the organization, and are committed to quality improvement as part of their daily routines. We incorporate quality into every aspect of our culture, and strive to achieve statistically significant improvements in areas such as focused performance improvement projects (PIPs) and our performance on HEDIS measures. Since our inception in 2012, we have consistently aligned our QAPI Program with DHH goals, focusing our efforts on high-impact shared priorities such as improved member outcomes, choice, and independence. LHCC further demonstrates our commitment to quality by achieving *Health Plan Accreditation by the National Committee for Quality Assurance (NCQA)* in **June 2014**.



**Process for Using Evidence-based Practices.** We use evidence-based guidelines, current and measurable industry standards, and contractual requirements as the foundation for developing performance indicators, setting benchmarks and/or performance targets, developing clinical practice guidelines, and designing projects and programs that assist providers and members in improving health outcomes. We comply with NCQA's standardized, nationally recognized, evidence-based standards for health plan operations and services. We monitor standardized, nationally benchmarked HEDIS quality measures and DHH Performance Measures. Our clinical and preventive health guidelines are evidence-based, consistent with national standards for prevention and management, and reflect specific recommendations published in peer-reviewed literature and by nationally recognized organizations. All utilization management (UM) criteria, coverage decisions, clinical programs, member and provider education materials, and benefit information are consistent with evidence-based guidelines.

LHCC's QAPI Program complies with the MCO Quality Companion Guide; we actively collaborate with DHH to improve outcomes for our members; and our executive leadership participates in the DHH Quality Leadership Team. Our QI leadership and staff participate in the DHH Quality Task Force, sharing ad hoc reports and updates on improvement activities such as Emergency Room Diversion and EPSDT compliance in collaboration with DHH. We adhere to DHH reporting requirements, including the formats prescribed by DHH, and we cooperate with the DHH's External Quality Review Organization, including timely document submission of documents and onsite review.

**Use of Data to Design, Implement and Evaluate the Effectiveness of the Program.** LHCC uses a data-driven QI approach to design, implement, and continuously evaluate and improve our QAPI and other programs and services. We use data to identify and select improvement opportunities that are relevant to our population, establish performance measures and goals (in alignment with DHH Performance Measures and goals), develop and implement interventions, measure improvement, and develop post-measurement activities. We developed and implemented our QAPI Program after an exhaustive analysis of demographic and epidemiologic data, as well as historical data, about the DHH population.

We employ our integrated Enterprise Data Warehouse and Centelligence™ suite of data informatics and reporting solutions to monitor key performance indicators and DHH Performance Measures, and to track our progress in meeting initiative, QAPI Program, and DHH goals. We will conduct a semi-annual audit of QAPI systems, as well as a comprehensive Annual QAPI Program Evaluation (QI Evaluation). Both the audit and QI Evaluation are reviewed by our Board of Directors and submitted to DHH, to document our analyses and evaluation of system performance, and the effectiveness of clinical and non-clinical initiatives and other components of our QAPI Program. LHCC has publicly reported results of our QAPI Program, and we will annually make available to members and providers DHH-approved information about the QAPI Program and our progress in achieving program goals.

LHCC understands and will comply with all DHH requirements for Quality Management, including, but not limited to Section 14 Quality Management and all other relevant contractual, State, and federal requirements.

### **QAPI Program Scope**

The QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to LHCC’s members and providers, including medical, BH, dental, and vision care. Our Program includes assessment of access to care, barriers to care, quality of care, Case Management, and continuity of services, for example. Our QAPI Program policies and procedures incorporate all demographic groups, lines of business, benefit packages, care settings, and services in our QI activities, including preventive, emergency, primary, specialty, acute and short-term care, and ancillary services. Areas subject to quality oversight include member safety; credentialing and recredentialing of providers; adoption and compliance with preventive health and practice guidelines; case management for acute and chronic conditions; vision and dental health care; pharmacy benefit utilization and oversight, under- and over- utilization; continuity and coordination of care; appointment availability/network access; member/provider satisfaction; Grievances and Appeals; departmental performance and service; cultural competency; delegated entity oversight; and member confidentiality.

### **Program Accountability**

LHCC’s commitment to QI starts at the top with our Board of Directors. The Board of Directors oversees the development, implementation, and evaluation of the QAPI Program, including review and approval of the annual QI Program Description, Work Plan, and Annual Evaluation, which describe the goals, methodologies, and achievements of our Program. The Board of Directors ensures the Program has adequate resources and is incorporated throughout the organization, and monitors the Program’s effectiveness. The Board ensures full cooperation with the state’s External Quality Review Organization, and timely completion of any DHH corrective action plan. As seen in our QI committee chart below, the Board of Directors has formally designated the QAPI Committee to oversee and evaluate the effectiveness of all aspects of our QAPI Program.

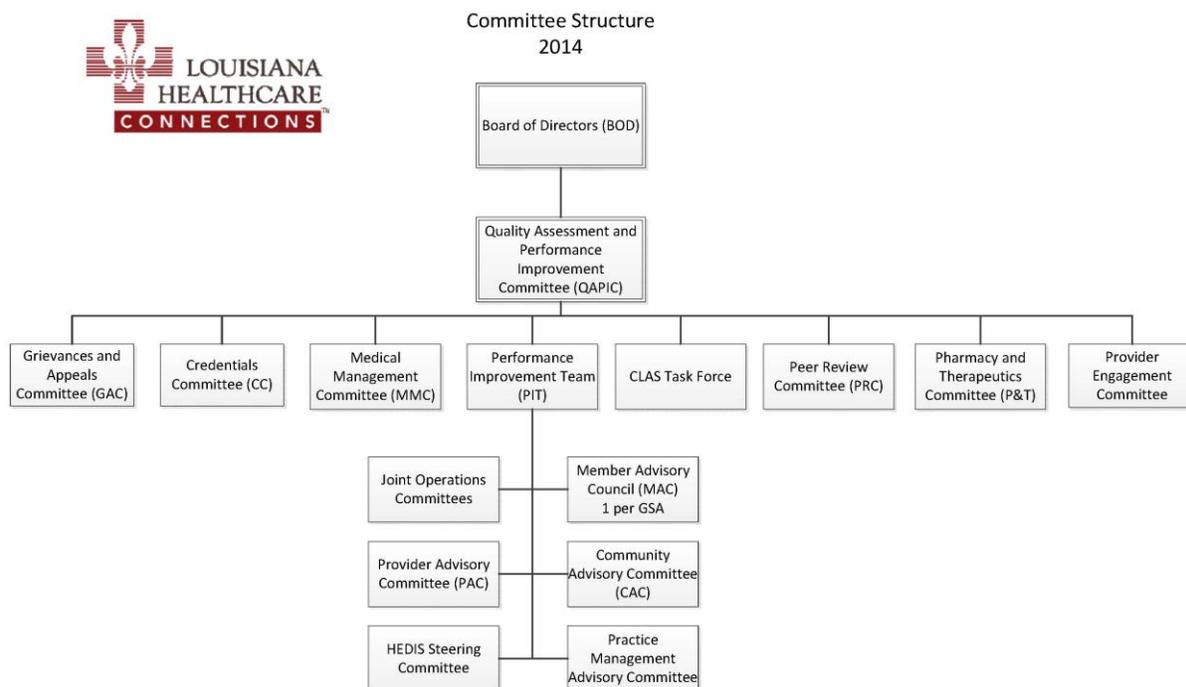
The Board of Directors has designated our CEO as Senior Executive for Quality Improvement, with the authority and responsibility to establish, maintain and support an effective Program on a continuous basis. The CEO informs and receives direction from the Board of Directors regarding the QAPI Program. The CEO assures the substantial involvement of the Chief Medical Director in the QAPI Program, and the Chief Medical Director chairs the QAPI Committee, Credentialing, Utilization Management, Pharmacy and Therapeutics (P&T) Committee, and Peer Review Committees. By participating on these committees, the Chief Medical Director can monitor the progress of the QAPI Program; the development and implementation of the Annual QI Work Plan and Program Evaluation; and the development, implementation, monitoring, and evaluation of individual QI studies and initiatives.

### **Quality Infrastructure**

Our QAPI Program is administered through a comprehensive committee structure, a dedicated QI Department, and is integrated throughout the organization.

**Quality Committee Structure.** Executive leadership and contracted providers anchor our commitment to data-driven improvement throughout the organization as members of our Quality Assessment and Performance Improvement Committee (QAPI Committee) and QAPI subcommittees. They oversee all service and clinical improvement efforts, and ensure adequate resources and compliance with all DHH requirements. The QAPI Committee and its subcommittees include representation from all operational

areas relevant for each committee’s charge. QI staff support these subcommittees and all quality initiatives regardless of their operational focus. All departments are involved with improvement activities, and each area integrates its activities with other relevant departments and with the QI Department. The chart below depicts LHCC’s Quality Committee Structure. The scope of responsibility for the QAPI Committee each subcommittee is detailed below under the Proposed Membership of the QAPI Committee.



Accountable Staff. Quality Improvement (QI) Department staff, located in Baton Rouge, Louisiana, are responsible for day-to-day implementation of QAPI Program activities, and report to the COO. Departmental staff include, but are not limited to:

- **Senior Director, Quality Improvement (Sr. QI Director).** The Sr. QI Director is a registered nurse with certification as a Certified Professional in Healthcare Quality (CPHQ). The Sr. QI Director directs the activities of the QI Department and works in conjunction with all management staff to monitor clinical and non-clinical processes and outcomes, and to improve member health status and experience. The Sr. QI Director also assists clinical and non-clinical executive staff in ensuring that LHCC meets NCQA standards and State Contract requirements, such as Early and Periodic Screening, Diagnostic, and Testing (EPSDT) compliance.
- **Manager, Quality Improvement (QI Manager).** The QI Manager, a Licensed Master Social Worker (LMSW) and MPH, collaborates with other departments to facilitate quality improvement activities throughout LHCC. The QI Manager oversees quality audits, risk management, data collection and

analysis, and implementation of improvement activities. The QI Manager attends the DHH Quality Task Force meetings and facilitates the initiation and implementation of activities/initiatives assigned by DHH with the LHCC Quality team.

- ***QI Coordinators.*** QI Coordinators report to the Managers in QI according to their scope of work. They are either registered or licensed practical nurses. Areas of responsibility include medical record audits; data collection and analysis for, and implementation of, quality improvement activities; and review of complaints and adverse events. QI Coordinators—EPSDT. These QI Coordinators interface with members, providers, and community partners to facilitate member utilization of EPSDT services, and to promote preventive health strategies. QI Coordinator—HEDIS. This QI Coordinator works closely with Provider Relations to provide education to targeted providers about adherence to clinical practice guidelines, HEDIS measures, and proper coding.
- ***Manager, Medical Home/Health Home.*** The Medical Home/Health Home Manager is a Registered Nurse, reports to the Sr. QI Director and facilitates transformation of selected primary care practices to recognized Patient Center Medical Homes (PCMHs) using workflow redesign, patient registries and electronic health records, and appropriate use of practice and LHCC data to improve member outcomes. The Manager is currently a certified Lean Six Sigma black belt and an NCQA **Certified Content Expert**, and also participates on the NCQA PCMH Advisory Board.
- ***Manager, Accreditation.*** Using multidisciplinary teams, the Accreditation Manager reports to the Sr. QI Director and manages the work plans necessary to achieve and maintain NCQA accreditation. The Manager ensures HEDIS data quality, oversees data validation and analysis, and is responsible for ensuring that delegated vendors comply with accreditation standards and HEDIS requirements. Currently, the Accreditation Manager is a certified Lean Six Sigma green belt and a Louisiana Quality Foundation State Examiner for the Malcom Baldrige Award program.
- ***Manager of Grievances & Appeals.*** The Manager of G&A reports to the Sr. QI Director and responds to all grievances and appeals; tracks, analyzes, and reports data and trends; and coordinates review of cases and trends with the GAC.
- ***Grievance and Appeals (G&A) Coordinator.*** The G&A Coordinator coordinates all grievances and ensures timeliness of the response by the health plan.
- ***Clinical Appeals Coordinator.*** The Clinical Appeals Coordinator is a registered nurse and reports to the Manager of G&A and coordinates all appeals, state fair hearings, review organization proceedings, and other external appeals; and ensures timeliness of all appeal letters in compliance with both State and NCQA requirements.

• ***Proposed membership of the QAPI Committee including roles and responsibilities***

**Quality Assessment and Performance Improvement Committee (QAPI Committee).** The QAPI Committee is LHCC’s senior level quality committee accountable directly to the Board of Directors. The QAPI Committee, chaired by the Chief Medical Director, meets quarterly or more frequently, as needed, and promotes a system-wide approach to quality improvement. The QAPI Committee provides oversight and direction in assessing the appropriateness of care and services delivered; oversees efforts to continuously enhance and improve the quality of care and services provided to members and providers; and establishes standards and criteria for delivery of care and service. The QAPI Committee also oversees the UM Program and reviews and approves medical necessity criteria, protocols, and UM policies and procedures. The QAPI Committee approves the Provider Profiling Program each year, including participation criteria and quality measures. Performance improvement projects, medical record audits,

member and provider satisfaction surveys, and all quality improvement initiatives are vetted by and reported to the QAPI Committee.

The QAPI Committee membership includes the Chief Executive Officer (CEO); Chief Operating Officer (COO); Chief Medical Officer (CMO); Vice Presidents of Medical Management, Operations, Network Development, and Finance; Senior Director of Quality; Compliance (Program Integrity) Officer; Directors of Member and Provider Services; and network physicians and nurse practitioners (including Family Practice, Internal Medicine, OB/GYN, Pediatrics, and other high-volume specialists as appropriate) representing the range of practitioners within the network and across the regions in which we operate. Because of the prevalence of BH conditions in the Medicaid population, our BH Medical Director will also be a member of the QAPI Committee, and will provide a link to BH-related QI activities. Beginning in 2015, LHCC will also include a DHH representative, and encourage a member advocate to attend our QAPI Committee meetings. The QAPI Committee maintains records that document the committee's activities, findings, recommendations, actions, and results. Physician members of this committee may also serve as peer reviewers for clinical issues, as appropriate.

All committees described below meet quarterly (unless otherwise indicated) and report to the QAPI Committee, and activities from all committees are reported quarterly to the Board of Directors through the QAPI Committee.

#### **QAPI Subcommittees.**

***Medical Management Committee (MMC).*** The MMC, serving as LHCC's Utilization Management Committee, is chaired by the Chief Medical Director (CMD) and has operating authority for the Medical Management Program, policies, procedures, and activities. The MMC analyzes medical management data, identifies trends, and addresses identified issues, such as patterns of potential or actual inappropriate under- or over-utilization, which may impact health care services and member and provider satisfaction with the Medical Management process. The MMC includes representation from Medical Management, Case Management, QI, and Compliance (Program Integrity) departments.

***Performance Improvement Team (PIT).*** The PIT, the linchpin of our plan-wide commitment to QI, is an internal, management-level, cross-functional QI team that operationally integrates QI throughout all of our programs and departments. The PIT, chaired by the Sr. QI Director, monitors key clinical and operational metrics, including Grievances and Appeals and member and provider satisfaction; performs barrier and root cause analyses for indicators that fall below desired performance, and makes recommendations regarding interventions. The PIT also oversees the implementation of all QI initiatives and reports outcomes to the QAPI Committee. PIT members disseminate recommendations to their staff and information about QI activities throughout the organization. The PIT also oversees the implementation of recommended corrective action plans and interventions directed from the QAPI Committee and/or its supporting subcommittees, and reports results back to the designated committee(s).

***Pharmacy and Therapeutics (P&T) Committee.*** The P&T Committee, chaired by the Chief Medical Director, is responsible for the development and annual review of the Pharmacy Program, and associated policies and procedures. The P&T Committee includes representation from a range of network physicians and other providers, clinical pharmacist(s), and the Director of Pharmacy. The P&T Committee reviews pharmacy utilization data and prescribing practice patterns, recommends corrective actions, oversees our Pharmacy Benefit Manager and reviews pharmacy-related complaints, Grievances, and Appeals.

***Credentialing Committee (CC).*** The CC, chaired by the CMD, is responsible for overseeing the Credentialing Program. The CC has representation from a range of contracted providers, including the specialties and types of practitioners it reviews. The CC reviews and assesses provider credentials; establishes that each provider is qualified by training, experience, and performance (based on accepted credentialing standards) to participate as an LHCC provider; and certifies to DHH that all contracted

providers, and any outside providers to whom enrollees may be referred, are properly licensed, eligible to participate in the Medicaid program, and meet all other DHH and regulatory requirements. The CC has final authority for review, and appropriate approval of licensed physicians, other licensed healthcare professionals, and certain facilities who have an independent relationship with LHCC. In accordance with section 14.5.2, we have attached our Credentialing Policies and Procedures to this proposal. See Attachments U.4 A through G for LHCC Credentialing and Recredentialing Policies and Procedures.

**Peer Review Committee (PRC).** The PRC, an ad-hoc committee chaired by the CMD, reviews alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential for a severe adverse outcome. PRC members use their clinical judgment in assessing the appropriateness of clinical care and recommending an appropriate corrective action plan. The PRC includes three or more peer contracted providers, representing a range of specialties, including at least one physician with the same or similar specialty as the case under review. Reviews resulting in the reduction, suspension, or termination of a provider's participation are reported to the National Practitioner Data Bank.

**Provider Engagement Committee (PEC).** This is a new subcommittee of the QAPI Committee. The PEC is a committee designed to review and make recommendations on provider profiling, provider payment innovations, claims issues, gaps in care, and pharmacy trends, for example. Another key function of the committee will be to identify organization-wide and individual provider issues, and develop strategic initiatives to remediate such issues. The Chief Medical Officer chairs the PEC and participants represent the Quality, Pharmacy, Network, Provider Relations and Medical Management Departments. Meetings will be held weekly beginning in October 2014, and at least monthly thereafter.

**Grievance and Appeals Committee (GAC).** The GAC is responsible for maintaining compliance with contractual, federal, State, and NCQA requirements related to the processing of Grievances and Appeals. The GAC, chaired by the Sr. QI Director or designee, tracks and analyzes Grievances and Appeals, including type and timeliness of resolution, performs barrier and root cause analysis, and makes recommendations regarding corrective actions, as needed.

**The Culturally and Linguistically Appropriate Services (CLAS) Task Force.** The Culturally and Linguistically Appropriate Services Task Force is responsible for the oversight and maintenance of LHCC's Cultural Competency Plan. The Cultural Competency Plan is the LHCC's framework and commitment that enrollees receive care and services that are delivered in a culturally and linguistically sensitive manner.

**HEDIS Steering Committee (HSC).** The HSC is a subcommittee of the PIT and is chaired by the Sr. Director of Quality or a designee from the Quality leadership team. The HSC oversees LHCC's HEDIS processes, reviews HEDIS performance, and identifies improvement opportunities. The committee reviews, approves, and implements clinical, non-clinical member and provider initiatives to improve selected HEDIS measures. The HSC also establishes performance goals, and manages delegated vendors and oversees their role in improving HEDIS scores. Members of the HSC include the executive management team and staff from Network Development and Contracting, QI, Member Services, Provider Services Management, Pharmacy, and other members as deemed necessary.

**Joint Operations Committees (JOC).** The JOCs are action subcommittees of the PIT. These intradepartmental committees oversee the operations and performance of each subcontractor, review clinical and operational metrics, oversee initial audits and annual re-audits, ensure compliance with all NCQA and DHH standards, discuss improvement activities, and recommend and monitor corrective action plans when appropriate. In addition to oversight activities, each JOC ensures compliance with all NCQA standards and regulations related to the delegation relationship, and recommends actions to address any identified opportunities for improvement in delegated services. Compliance, Medical Management, and QI staff monitor performance metrics and improvement efforts of our delegated entities

on a quarterly basis at the JOC meetings held with each subcontractor. The Sr. QI Director or a designee chairs each JOC.

**Member Advisory Committees (MAC).** The MACs, chaired by the Director, Member and Provider Services, are advisory subcommittees of the PIT that solicit member input on the quality of care and services offered by LHCC, and possible improvements in policies and procedures. The Compliance Director communicates suggestions regarding DHH policies to DHH. There is one MAC for each GSA. The MACs review member satisfaction survey results; Call Center performance; and member educational materials for relevance, understanding, and ease of use. Regional MACs meet at least two times per year, and include members and parents/foster parents/guardians.

**Provider Advisory Committee (PAC).** The Provider Advisory Committee reflects our commitment to building better relationships with our providers. As a subcommittee of the PIT, it provides a forum for open dialogue regarding programs and processes, allowing for immediate and face-to-face reaction and discussion. The members of the Physician Advisory Committee represent diverse geographies, practices and perspectives. The Director of Contracting/Network Management chairs this ad hoc committee.

**Community Advisory Committee (CAC).** The CAC is an ad hoc community-wide advisory committee that provides a platform for members and stakeholders to provide input on existing programs and initiatives, and ideas for future programs. The primary purpose is to promote collaborative efforts to enhance the service delivery system in local communities while maintaining member focus, and allow participation in providing input on policy and programs. CAC members may include advocacy groups, community organizations, parents, guardians, and LHC staff as appropriate. Our CEO or designee chairs this committee.

**Practice Management Advisory Committee.** LHCC recognizes the importance and value of engaging practice management staff in improving quality measures, accurate data capture to address care gaps and ways to create efficiencies within the provider practice. We recently developed a practice management advisory committee that will meet on a quarterly basis, to discuss plan and regulatory requirements and identify operational efficiencies to help practices be more successful in providing quality of care and capturing their performance.

***o Proposed QAPI Work plan including a detailed descriptions of how the QAPI Committee will work with the MCO leadership to monitor quality improvement work, specifically:***

**QAPI Work Plan.** The QAPI Work Plan is a detailed and overarching work plan for our clinical and service quality improvement activities. The Work Plan outlines specific operational and clinical quality activities, is developed by quality leadership and the QAPI Committee, and is approved by the Board of Directors. It is developed as an extension of the evaluation of the previous year's quality activities, organizational priorities, and program requirements. The purpose of the Work Plan is to provide a formal, ongoing process by which LHCC utilizes objective measures to monitor and evaluate the quality of services, clinical and operational, provided to our members. The involvement of LHCC leadership is critical to the successful execution of the Work Plan.

**How the QAPI Committee works with LHCC Leadership.** LHCC key executives play an active role in the quality improvement process demonstrated by committee participation, and inclusion in PIP development and intervention deployment. They also ensure that all levels of the organization are aware of, and participate in, quality improvement activities by ensuring participation in specific QAPI projects or other activities throughout the organization, promoting engagement of staff and providers in the QAPI Program, and ensuring that opportunities for improvement throughout the organization come to the QAPI Committee.

*o performance improvement projects;*

Our improvement strategies include ongoing PIPs that focus on clinical and non-clinical performance measures. We will perform a minimum of two DHH-approved PIPs in each contract year, including those identified in Appendix DD, as well as other clinical and non-clinical improvement initiatives that are relevant to our membership and operations. We will continue our work in the areas such as reducing non-emergent emergency department visits, transitioning care across the continuum, improving birth outcomes, improving use of preventive care and services (including EPSDT services), and addressing special health care needs.

*o medical record audits;*

LHCC assesses the medical records of high volume primary care physicians (PCPs) with 50 or more linked members and practice sites, including individual offices and large group facilities, at least once every two years. Through our review process, we verify that members received the services for which reimbursement was made. Our policies and procedures describe our sampling methodology and requirements for each member's medical record. We inform providers of these requirements during orientations, and in the Provider Manual. The QI Department tracks and trends medical record review results, and providers must meet 80% of the requirements for medical recordkeeping, or be subject to corrective action. LHCC reports the results of these reviews to the QAPI Committee on an ongoing basis and DHH quarterly.

*o performance measures;*

Staff and leadership continuously monitor all Appendix J measures and other key metrics, including, but not limited to, credentialing, call center metrics, UM metrics, provider after-hours access, claims, and Grievance and Appeal metrics to identify improvement opportunities for discussion/action by the QAPI Committee. LHCC reports performance against these key metrics to DHH and the External Quality Review Organization. We also use DHH required performance measures as a key source for performance indicators for our Provider Profiling and Provider Incentive Programs.

*o Plan-Do-Study-Act cycles or continuous quality improvement activities;*

LHCC's QAPI Program uses an integrated, data-driven performance monitoring and improvement model, incorporating the Plan-Do-Study-Act (PDSA) rapid-cycle change methodology to ensure effective, efficient delivery of quality care and service. The steps in the PDSA cycle are:

- **Plan**—Plan the test or observation, including a plan for collecting data
- **Do**—Try out the test on a small scale
- **Study**—Set aside time to analyze the data and study the results
- **Act**—Refine the change, based on what was learned from the test.

We then repeat the cycle with incremental changes to the interventions until improvement is achieved and sustained.

**Six Sigma.** Six Sigma’s ability to reduce errors, improve customer satisfaction, and bring in cost effectiveness aligns well with our Triple Aim priority. LHCC began incorporating Six Sigma into the quality improvement activities because of the defined sequence of steps and supportive tools and techniques. LHCC follows the DMADV project methodology, known as DFSS "Design For Six Sigma"), when developing a *new process or procedure*, ensuring that we focus on meeting customer needs and expectations, and finish on time and on budget. DFSS features five phases as portrayed in this graphic.



LHCC uses Six Sigma DMAIC methodology as well as PDSA to achieve *incremental improvement* as indicated by performance monitoring, and to test incremental changes in PIP interventions and other initiatives. The DMAIC project methodology is portrayed in this graphic.



***o member and/or provider surveys; and***

**Member Satisfaction Surveys.** LHCC conducts an annual member satisfaction survey and selected The Meyers Group, a National Committee for Quality Assurance (NCQA) certified vendor, to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey to a sample of our adult and child members. The CAHPS survey provides information on the experiences of health plan members, and gives a general indication of how well the plan meets member expectations. LHCC selected The Myers Group to conduct its 2013 adult and child satisfaction surveys. This survey was conducted using mail with telephone follow up.

Based on member feedback, LHCC implemented actions to improve the member experience, including, but not limited to, enhancing the processes by which we outreach to members and to disseminate educational materials. Most notably, we changed our main phone number utilized for member outreach from an “800” number to a local extension to improve communications with our members. We recognized that members were reluctant to call an “800” number, but trusted a phone number with a local area code.

**Case Management Surveys.** LHCC also deploys a systematic method of evaluating member satisfaction with all areas of Case Management services. Our Case Management Member Satisfaction Survey measures the frequency of contact and satisfaction with the Case Manager; the member's perceived improvement of overall quality of life; the member's perceived improvement in pain control or management, if applicable; and the member's perceived improvement in their overall health status. The survey results are tracked and analyzed to identify opportunities to improve satisfaction with our Complex Case Management Program. Members responding to our survey in 2013 reported an 88.5% satisfaction rating.

**Provider Satisfaction Surveys.** LHCC conducts an annual provider satisfaction survey and selected The Myers Group, a National Committee for Quality Assurance (NCQA) certified vendor, to conduct our 2013 provider satisfaction survey. Information obtained from these surveys allows LHCC to measure how well we are meeting provider’s needs and expectations. Based on the data collected, we are able to

identify strengths and opportunities. The survey was conducted by mail and internet with a telephonic follow up.

Based on provider feedback from the 2013 survey, LHCC implemented a number of actions to improve provider experiences that included establishing a threshold for the number of weekly provider visits by Provider Relations field staff, using Certified Professional Coders to assist with claim issues, enhancing the provider orientation program for new providers, and continuing to strengthen our communication efforts on LHCC programs and our referral process.

***o activities that address health disparities identified through data collection.***

LHCC will assess key utilization and outcome measures for disparities among race/ethnicity groups, and between rural and urban members, using enrollment file and other data. In 2014, we performed a demographic analysis of our membership that revealed that 59.3% of our membership is African-American, clustered in the urban areas of Orleans, East Baton Rouge and Jefferson parishes, with a disproportionate risk for diabetes, overweight/obesity, HIV/AIDS, and sickle cell disease. Surprisingly, our African-American members did not have a disproportionate risk for preterm births compared to other members.

LHCC recognizes the role we can play in reducing racial and ethnic health care disparities experienced by our membership. For example, we track the success of our Case Management activities to ensure that members with HIV and sickle cell disease, well over 80% of whom are African-American, receive recommended screenings and treatment. We will expand upon these efforts in 2015 by implementing new Chronic Care Management Programs (CCMPs) for members with HIV/AIDS and sickle cell disease.

**HIV/AIDS CCMP.** LHCC will partner with the AIDS Healthcare Foundation's NCQA accredited Positive Healthcare HIV/AIDS disease management program to implement and continuously improve our new CCMP for HIV/AIDS. The CCMP will encompass all co-morbid conditions, interface with our other CCMPs, and coordinate palliative and hospice care. The program will support independence, self-sufficiency, effective family functioning and caregiver assistance, and use of appropriate health services. We will focus specifically on identifying and overcoming social, cultural, and other barriers to improved outcomes, and will include specialized medication therapy monitoring to assist with antiretroviral drug adherence and other co-morbid condition medication regimens.

Because of the prevalence of HIV infection among young African American men in Louisiana, we participated in an event targeting that population that was organized in part by the Office of Public Health and the Baton Rouge AIDS Society. We will continue to find opportunities to work with providers and community organizations involved with the OPH HIV/STD program to leverage their experience in addressing this sensitive issue.

**Sickle Cell CCMP.** LHCC will transition our current award-winning Sickle Cell Case Management Program into a comprehensive CCMP by establishing coordinated health care interventions and communications meeting all CCMP requirements. We will educate program participants about inheritance patterns, disease complications, symptoms and treatment, comorbid conditions, and special issues that arise with children and adolescents. The CCMP also will promote the use of hydroxyurea to reduce episodes of acute chest syndrome and vaso-occlusive painful crises, and the need for blood transfusions and inpatient and emergency room utilization. We also will outreach to local experts, such as the Sickle Cell Foundation, to identify opportunities to collaborate and provide enhanced services to our members.

**Culturally Competent Support.** LHCC will continue to perform our periodic data analyses to gain valuable insight into our populations and sub-populations. This analysis is a key component in developing culturally and linguistically sensitive programs and focused interventions that enhance the experience of care and improve the general health and well-being of our membership. We recognize that while our

members may face similar barriers, the way each member meets those challenges is unique and specific to their beliefs and culture. LHCC nurses and support staff take time to develop respectful and trusting relationships with each member and/or family in order to identify and resolve barriers to care and service. Recognizing that communication is essential to quality care, LHCC strives to hire bilingual staff and contract with bilingual physicians representative of our membership. While we cannot directly measure the effectiveness of hiring bilingual staff and contracting with bilingual physicians, we are convinced that effective communication leads to improving health outcomes for the members we serve.

People with disabilities face many barriers to good health. Studies show that individuals with disabilities are more likely than people without disabilities to report:

- Having poorer overall health.
- Having less access to adequate health care.
- Engaging in risky health behaviors, including smoking and physical inactivity.

People with disabilities often are more susceptible to preventable health problems that decrease their overall health and quality of life. Secondary conditions such as pain, fatigue, obesity, and depression can occur as a result of having a disabling condition.<sup>7</sup>

LHCC recognizes that members with disabilities, including hearing impairments and communication disorders are particularly vulnerable. Disorders that affect someone's ability to communicate are complex and challenging. We provide the necessary interpretive assistance, communication/hearing devices, and alternative format of written materials that enable our members to fully participate in their own care.

Our programs and initiatives are geared toward empowering our members to make informed, meaningful choices and fully understand their options. Knowing that our members with disabilities require individualized treatment plans and integrated coordination efforts, our overarching focus is on encouraging participation, independence and promotion of preventive services and screenings.

LHCC's Culturally and Linguistically Appropriate Services (CLAS) Task Force is responsible for the oversight and maintenance of our framework and commitment to ensure that members receive care and services that are delivered in a culturally and linguistically sensitive manner. The objectives of the CLAS Task Force include, but are not limited to providing competent translation/interpreter services to members who request communication in their preferred language, and providing members with limited English proficiency the assistance they need to understand the care provided. LHCC's data indicates that the majority of calls received by the health plan requiring translation/interpretive services are for members with limited English proficiency whose primary language is Spanish. LHCC's website and educational materials are all available in English and Spanish.

***• Work the QAPI will undergo to improve the health care status of the Louisiana Medicaid population.***

The QAPI Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care. These activities will be both clinical and non-clinical in nature and include, but not be limited to the following:

- Patient Safety/Quality of Care reviews
- Monitoring access and availability
- Continuity and coordination of care

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<sup>7</sup> <http://www.cdc.gov/ncbddd/disabilityandhealth/hcp.html>, accessed 9/18/2014

- Monitoring over/under utilization
- Preventive health reminder programs
- CCMP/Case Management programs
- Provider performance monitoring and profiling
- Coordination with Behavioral Health
- Monitoring services to members with Special Health Care Needs
- Drug Utilization Review.

LHCC continues to pursue multifaceted efforts to improve the health status of our membership. Through our focused activities, we are able to measure, monitor and, over time, improve and most importantly, sustain improved health outcomes. Our ongoing QI projects and our member-centric programs address a range of areas, including health promotion and prevention, maternal and child health, behavioral health, and chronic conditions. LHCC is committed to improving HEDIS rates as an indication of the quality of care and service provided to our members, developing PIPs, supporting the role of the medical home, and providing best-in-class care and chronic care management programs. We do this by engaging our members, providers, community organizations, and all stakeholders in the continuum of care. Throughout the remainder of this response, we discuss a number of the programs the QAPI Program will direct and oversee to improve the health care status of the Louisiana Medicaid population.

***• Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.***

### **Rationale and Process for Selecting Areas of Focus and New Programs**

LHCC QI staff use our Centelligence™ informatics tools to identify potential areas of focus for improvement or for development of new programs. Our Enterprise Data Warehouse integrates data from both internal/external and clinical/non-clinical sources, and enables reporting on areas such as member demographic information relevant to health risks, and external data related to conditions or risks for similar populations; access and availability studies; HEDIS performance; utilization trends, and member and provider complaint/Grievance trends; adverse event monitoring; focused studies; claims payment statistics; and member and provider satisfaction survey results.

We also identify potential issues and potential interventions, including new programs, through stakeholder input, including DHH priorities, Case Management or other staff suggestions, and feedback from contracted providers, members, and community advocates participating on our quality committees. We use tools such as root cause, barrier, Pareto, and process flow analysis to identify underlying causes of identified issues and to prioritize issues and interventions. QI staff review data to identify the most prevalent issues, those impacting multiple departments, those most relevant to members with special health care needs, and those relating to racial, ethnic, or regional disparities. The PIT selects priority areas and presents them, with supporting data, for approval to the QAPI Committee. The QAPI Committee obtains input from quality committees relevant to the area of focus being considered.

LHCC routinely conducts a population health analysis to determine the status of our membership, and which programs would be most beneficial. Our 2014 population health analysis showed behavioral health disorders, diabetes, and asthma as particularly prevalent chronic conditions. We also identified pre-term and low-birth-weight births as particular areas of concern for our population. Studies conducted of the

Louisiana population overall show concerning levels of obesity; hypertension; pre-term, low birth weight, and teen births; and sexually transmitted infections, including HIV/AIDS.

As a result of our population health analyses, ongoing monitoring of our membership, and DHH priorities, we have implemented Chronic Care Management Programs (CCMPs) that focus on our members with asthma, congestive heart failure, diabetes, hypertension, low back pain, and obesity. LHCC's Case Management Programs focus on members with sickle cell disease and high risk pregnancies, as well as on members with other high risk conditions. To further address the needs of our member population, we will implement new CCMPs for members with behavioral health conditions (including anxiety, depression, and perinatal substance abuse disorder), HIV/AIDS, hepatitis C, sickle cell disease, pediatric obesity, and chronic pain.

***How the proposer will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.***

LHCC will keep DHH informed of QAPI Programs, actions, recommendations, and outcomes in a timely manner in part by including a representative of DHH as a member of the QAPI Committee. As mentioned previously, our QI Manager attends all DHH Quality Task Force Meetings, with specific updates on our activities and progress in PIPs and other DHH priorities. In addition, we will submit QAPI reports annually, including the QAPI Program Description, QAPI Annual Evaluation, and QAPI Work Plan that describe our QAPI Program, achievements of the Program, and planned activities. We will submit all clinical and administrative performance data contained in Appendix J on a semi-annual and annual basis, as specified by DHH, and in accordance with the specifications of the MCO Quality Companion Guide.

***• How the proposed QAPIs may include, but is not necessarily, limited to the following:  
o New innovative programs and processes.***

### **Innovative Programs**

LHCC's comprehensive QAPI strategy includes the development and implementation of innovative programs and educational materials that are designed to support our members and encourage them to proactively take charge of their own health and well-being. We focus on providing materials and programs that are easily understood and comprehended. Below we have highlighted some, but not all of the innovative programs LHCC has developed and/or implemented to address the identified needs of our membership and communities we serve.

**Home Based Primary Care.** In order to better address the needs of our home bound and other at risk members, LHCC has partnered with our affiliate, U.S. Medical Management (USMM), a national leader in house call medicine for over 20 years, conducting more than 500,000 in-home patient visits annually. The USMM model is the only physician house call practice to participate in one of the original CMS pilot Pioneer Accountable Care Organizations. In the first year of participation, USMM helped reduce hospitalizations by over 5% and annual beneficiary medical expense by more than 12%.

When Case Managers determine that a member is homebound, they can explore the option of an in-home visit by a USMM physician. If the member is agreeable to such a house call, a physician will visit the member, perform an initial assessment including wellness screens, and render or arrange for any necessary treatment. The USMM physician also will discuss with the member whether a visiting physician model might be a better option for receiving ongoing care and whether they would like USMM to provide this care and serve as the member's PCP. Our Case Managers will assist the member with

helping to decide if this is the best alternative for receiving needed medical care and if so, assist with transferring the member's care from the existing PCP to the USMM provider as indicated.

**Community Paramedicine Pilot.** This program, co-developed by LHCC and Acadian Ambulance, provides real time support including triage, home assessment, and appropriate redirection, with a goal of decreasing unnecessary emergency room visits and inpatient stays. We refer identified eligible members to Acadian, and Acadian outreaches to the member and the member's PCP to obtain their commitment to engage. Upon member enrollment, a paramedic visits the member's home to conduct an assessment that focuses on environmental triggers, knowledge of medications and compliance, and level of support available. Acadian also, as needed, will send a paramedic to the home to treat the member using recognized community paramedicine protocols, or transport the member to an appropriate higher level of care, such as an urgent care center.

**In-Home Telemonitoring.** LHCC provides in-home telemonitoring services to the highest-risk members (with multiple co-morbidities), for whom intensive monitoring is necessary and clinically appropriate. This FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone), or VOIP communications links.

Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level for a member with diabetes or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the monitoring nurse, evaluated against patient-specific or national guidelines, and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the monitoring nurse, trigger an Interactive Voice Response phone call to the member, and/or alert others on the member's Case Management team or the member's provider. The technology is entirely web-enabled; all members are provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at any time, as long as they have access to the Internet.

**Telemedicine – Providing a Solution for Rural Access.** LHCC is working on a collaborative telemedicine solution to improve access to specialty providers in rural and underserved parts of the state. This program will allow us to ensure closer monitoring of members with post-discharge home health needs who also require specialty care, through increased member interaction with specialists from whom our Transition of Care Teams and Case Management staff will solicit feedback on member progress.

We are actively engaged in discussions with Louisiana State University (LSU) Hospital Services Division (HCSD), LSU Health Science Center New Orleans, and LSU Health Care Network Clinics to develop a partnership for a telemedicine program across the state. This partnership may also include LCMC Integrated Health System (including Children's Hospital, Interim LSU Hospital [ILH], Touro, and the future University Medical Center).

**Phase I** of program implementation will be **traditional telemedicine**. We will use existing LSU telemedicine infrastructure, with some additions by LHCC where needed. Members in certain geographic areas will access a local medical clinic or hospital for a telemedicine visit with a specialist. **In Phase 2**, we will be **developing an innovative in-home telemedicine** approach. During this phase, we will evaluate LSU's current telemedicine platform to determine the feasibility of using it on mobile devices. If feasible, this will allow our Case Management staff to serve as the receiving end of a telemedicine visit in the member's home. In addition, to enhancing the member's specialty care access, this will facilitate our monitoring of the member's post-discharge home care services, the member's progress, and any unmet needs.

**Transition of Care Program.** Through our TOC Program, our concurrent review nurses (CRNs) and our dedicated Transition of Care Team (TOC Team) of RNs and social workers, collaborate to handle care transitions, including inpatient care coordination and follow-up, for high-risk members, including those

who require home care and other post-discharge services. CRNs work with facility staff, providers, and the member to coordinate care, ensure a safe discharge, and reduce readmission risk. TOC Team staff coordinate post-discharge authorizations and service initiation, follow up with the member after discharge, and monitor services during the transition period to ensure the member receives needed care, adheres to medication and treatment regimens, and avoids readmission or ED visits.

To expand our TOC Program capabilities further, we are adding BH clinicians to our Case Management staff, which will enable our TOC Program staff to access behavioral health expertise and support. A BH Case Manager will provide clinical input to CRNs and TOC Team staff, and coordinate with the Statewide Management Organization (SMO) for members with a BH admission.

We also are adding field-based Case Managers to increase our ability to provide in-person assessment and support to members, including but not limited to accompanying high risk members to post-discharge follow-up PCP visits when appropriate. Through our **Medication Therapy Management (MTM) Program**, we offer an individualized medication review and consultation by a pharmacist.

**Mobile Case Management Flexibility and Support.** LHCC's Case Management staff will use *TruCare on the Go*, our mobile-enabled, secure software which is totally integrated with our enterprise TruCare health management collaborative care platform. Using tablet technology, our Case Managers will use TruCare on the Go to facilitate interaction with the member, family, and caregivers, by showing them real-time information such as assessments, Care Plans, and other important data. TruCare on the Go is HIPAA-compliant, remote technology that will also allow our Case Managers to provide on-screen video education and conduct real-time assessments.

This mobile technology will enable Case Managers to spend more time in the field, face-to-face with members, caregivers, and providers. Additionally, our TruScan system will allow our Case Manager to take photos of documents (such as documents in a provider's medical chart for the member), tag them for the appropriate member record and then later, securely upload those documents to the member's master record in TruCare.

**MemberConnections™.** LHCC's MemberConnections community outreach staff visit high risk members where they live and work to help them navigate the complex healthcare system and get them the community resources they need. In 2013, our MemberConnections™ representatives (MCRs) made 1,205 at-home visits to high risk members, meeting them face-to-face and providing valuable follow up after an emergency room visit or hospitalization. During these visits, we discuss important health information, provide health education materials, and conduct in-home safety assessments. MCR outreach workers are hired from within the communities we serve to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of our members.

**24/7 Nurse Advice Line.** All Bayou Health members, caregivers, and providers can call NurseWise, our 24/7 nurse advice line affiliate to speak with a live person. In our best practice model, a Customer Care Professional (CCP) answers the call and uses active listening and interview skills to determine the purpose of the call and screen for health-related emergent issues. If there is a health issue or health-related question, the CCP warm transfers the call to a registered nurse for triage or health guidance.

We utilize a nursing model of care delivered by licensed staff members who average more than 20 years of clinical experience. Our staff adhere to the nationally-recognized, evidence-based Schmitt-Thompson Triage Protocols which were developed with input from over 200 practicing physicians, call center nurse managers, and medical directors. The Protocols, which are reviewed and updated as needed annually, cover 99+% of all symptom calls. The Triage Protocols are embedded in the NurseWise clinical documentation system to ensure accurate and consistent application. Additionally, NurseWise sends a Daily Activity Report to the LHCC Case Management Team listing all calls from the previous day, including inquiries requiring follow-up from the Case Management Team.

We encourage participants to contact NurseWise if they have any questions about appropriate access or to determine the potential need for emergency room services. If a member's condition appears emergent, NurseWise nurses will warm transfer the member to 911 and stay on the line. Alternately, when the medical condition does not warrant emergency care per the Triage Protocols, the nurse will advise the member to seek urgent care, immediately contact the PCP, or schedule an appointment with the PCP the next business day. The nurse provides self-care alternatives to manage the symptoms at home such as increased fluids, fever reducing medicine or ice compress as applicable.

**Integrating Physical and Behavioral Health.** Consistent with our patient-centered, holistic approach to care, LHCC will identify and implement provider-driven screening tools that assist both physical and BH providers with performing evidence-based screenings in their offices. Regular screenings in primary care and other healthcare settings enables earlier identification of mental health and substance use disorders, which translates into earlier care.<sup>8</sup> We will educate providers about how to access and use standard screening tools that are brief, practical to administer, affordable to providers, and relevant to the Bayou Health population. We will distribute toolkits with information about the screening tools and educational materials that support our clinical practice guidelines. Tools that are particularly relevant to the needs of the Bayou Health population include those for depression, drug and alcohol use, suicide risk, and anxiety disorders, for example. LHCC recommends screening tools such as:

- CAGE AID for drug and alcohol use
- GAD-7 for anxiety
- Patient Health Questionnaire (PHQ-9) for depression
- Vanderbilt Assessment Scale for ADHD.

Whenever possible, we recommend that PCPs implement these screening tools as part of the patient check in process, allowing the member to complete the screening tool prior to meeting with the physician. Based on the results of these screenings, providers are asked to make appropriate referrals and to notify LHCC by telephone, or secure email, to facilitate appropriate follow up that may include reassessment and re-stratification into a higher level of case management.

**Behavioral Health Clinical Trainer.** To supplement the continuing efforts of our Provider Relations and Quality Improvement staff and to offer targeted support and practical assistance to our providers, LHCC will hire a licensed BH clinician to serve as a Clinical Trainer. The Clinical Trainer will provide training and technical assistance in 1:1 or group settings and webinars to implement evidenced based practices for BH screening in primary care. Our Clinical Trainer will educate providers on topics such as how to screen for, identify, and treat BH disorders; how to identify and treat co-existing mental health and substance abuse disorders; when and how to refer members for BH treatment; and best PCP practices in coordination of BH treatment.

**Training Schools on Behavioral Health.** Our Clinical Trainer also will support training of school nurses, teachers, and administrative staff on BH topics important in the school environment. As an example of this best practice, our Indiana affiliate plan conducted training in August 2014 at a local elementary school on crisis intervention and de-escalation for 39 staff, including school administration, teachers, and support staff. The training included a presentation, demonstrations, and participant involvement.

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<sup>8</sup>Substance Abuse Mental Health Society of America (SALHCCA). Screening tools. Retrieved Aug. 2014 from: <http://www.integration.saLhcca.gov/clinical-practice/screening-tools>

**Provider Recognition.** LHCC recognizes that provider partnerships are the key to providing outstanding care to members and successful network management. One way in which LHCC builds and strengthens our relationships with providers is our annual **Summit Award**. This award honors the exceptional

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**The 2013 LHCC Summit Award was presented to Brian Sibley M.D., a pediatrician, with offices in and around Lafayette, Louisiana**

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providers who, compared to their peers, have demonstrated the most exemplary care in the following areas: follow up after emergency room visits; routine preventive and well care services for both adults and children; and establishing a medical home for new members. Each practice receives an engraved plaque

presented by one or more members of LHCC's leadership team, and a catered lunch for their office staff. In addition, we recognize them in national and local press releases, social media updates, on LHCC's website, and in the LHCC Provider Newsletter. Keith Perrin, M.D. (New Orleans) has been selected to receive the 2014 Summit Award.

In 2015, we will introduce our **Excellence in Obstetric Care Award** to recognize outstanding prenatal and perinatal care. The three awardees each year will receive the same recognition as for the Summit Award.

**Online Provider Support Tools.** We support our participating provider's ability to monitor and coordinate care with an integrated family of secure, web-based tools for clinical quality improvement, administrative productivity, and operational efficiency. Our secure Provider Portal (subject to HIPAA Minimum Necessary Rules) allows all of our authorized participating providers (and authorized non-participating providers who have executed a Single Case Agreement) to perform self-service functions online, as well as access features such as:

- **Member Health Record (Health Record).** Our comprehensive Online Health Record offers a well-organized view of a member's cursory clinical "face sheet" and detailed clinical tabs for each member for whom we have supporting data. The Health Record is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in our Centelligence™ systems platform. Providers also access a detailed level of claim based utilization showing all member level claims, including physical and behavioral health and pharmacy data for the past 18 months.
- **Online Care Gap Alerts.** Network providers have access to our Online Care Gap Alerts feature that pushes alerts to the provider (when checking member eligibility) when the member's record indicates that s/he is due for or missing a service recommended by evidence-based guidelines. Providers can view clinical quality and cost utilization drill down reports generated by our Centelligence™ system that encompass data for all services delivered to the member by that provider, when we have sufficient claims data from that provider to display meaningful information.

**Health Information Exchange that Improve Data Capture.** LHCC will support DHH's and LaHIE's vision of creating widespread health information exchange by replicating the early and rapid success of our affiliate health plan in Florida in implementing secure, yet quickly established direct transfers of admission, discharge, and transfer (ADT) data from network hospitals. Over a period of one year, our affiliate has implemented direct ADT submission capabilities with over 20 hospitals, while the state continues to build health information exchange (HIE) capabilities.

LHCC will require our hospitals and their Emergency Departments to submit ADT data to LaHIE, but we also will offer these providers the option of a free, direct, and secure connection to LHCC for receipt of ADT transactions. LHCC will serve as a collection point of ADT data for LaHIE and, subject to the execution of a HIPAA Business Associate Agreement with LaHIE, we will batch and forward collected ADT data to LaHIE for populating the ED Visit Registry. In our view, it is critical that hospitals and EDs

see a near term benefit of ADT transaction submissions. For this reason, we also will incent our providers by waiving the need for inpatient admission notices to LHCC for any providers sending us ADT data. This represents a significant opportunity for LHCCS to remove a substantive administrative burden from our network hospitals and EDs.

Through this creative and provider friendly initiative, LHCC will significantly improve the quality and completeness of data we receive from hospitals, which will enhance our data capture for QI initiatives.

**Providing Reliable Phone Support.** LHCC has partnered with *Safelink* to provide free cell phones to our members. This federal program provides free cell phones to individuals that are in a certain low-income bracket. Through our partnership, LHCC members receive the standard 250 minutes per month although calls and texts to and from LHCC are free. Additionally, our Case Management staff can upgrade minutes based on clinical need.

When SafeLink is not an option for members, LHCC may offer our *Connections Plus*® Program which provides restricted-use cell phones to certain high-risk members. *ConnectionsPlus*® phones are pre-programmed with numbers for our Complex Case Management team, NurseWise, 911, the PCP and other treating providers. LHCC Case Management Team staff will use the phones to contact members for education, appointment reminders and ongoing coaching and support for wellness and compliance. With the members consent, we will also send text messages with health information targeted to the member's condition.

**Member Resource Center.** Our Krames Online health library located on our website ensures our members have the resources they need, when they need them. With access to more than 4,000 health and medicine-related topics online, our members have the ability to find answers to most questions big or *small*.

**Flu Prevention.** This educational program is designed to promote healthy behaviors, including immunization and hygiene practices that can protect members from the seasonal flu. Our Flu Prevention campaign directly targets the populations considered to be at higher risk by the Center for Disease Control and Prevention (CDC) from influenza infection with mailings and phone calls, and provide general education for all members. Along with member education, this campaign also provides network providers with updated information and resources. All material and information provided to both members and providers aligns with CDC guidelines. As a result of our Flu Prevention campaign, LHCC experienced a 32.7% increase in the number of members receiving flu vaccines from CY 2012 to CY 2013.



**Children's Healthy Living.** Comic books may seem like an unlikely way to get kids excited about healthy living, but among the thousands of children who have been touched by Centene Corporation's Adopt-a-School program, the adventures of comic-book characters like Darby Boingg are a huge hit. Since 2009, more than 7,000 children ages 4-9 in low-income school districts have learned about healthy eating, exercise, and the dangers of smoking through a series of visits from the author of the books, along with school-wide assemblies featuring group activities and appearances by the books' mascot. Children



receive free copies of the books, along with parent guides. In 2010, students also had the chance to enter a contest for the best healthy snack recipe. Fifteen recipes were chosen for the *Super Centeam 5 Cookbook*, now available from school nurses and free clinics in the 18 states where Centene operates.

*o Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics or other non-traditional health care settings.*

**Parish Health Clinics and School-based Care Delivery.** LHCC has contracted with all OPH local parish health clinics, and 95% of OPH-certified school-based clinics statewide. Our MemberConnections™ outreach and other staff have actively collaborated with the parish health clinics to encourage our members who are not engaged with a medical home, or who are uncomfortable bringing certain concerns to their PCP, to obtain immunizations, such as the influenza vaccine and routine childhood immunizations; screening, including STI and HIV screening; and family planning services.

In addition, our QI staff is working with DHH and OPH staff to improve reporting of services delivered by school nurses. These registered nurses are not eligible Medicaid providers, and therefore do not bill for their services. Our objective has been to get these nurses Medicaid-eligible so we can reimburse the schools for their services, and so the claims data submitted will be available to increase the accuracy of LHCC HEDIS and other outcome reporting.

**Peer Counseling Pilot.** LHCC will support the Ochsner Health System (Ochsner) Breastfeeding Peer Counselor Program, currently a proposed pilot project that builds on the WIC “Loving Support Peer Training Counseling” program and local breastfeeding awareness and education efforts. Peer breastfeeding support and education that continues as new mothers return home post-delivery is anticipated to improve breastfeeding exclusivity at discharge and 3 months of life by 20-40%, duration of breastfeeding up to 6 months, mothers’ breastfeeding self-efficacy, community awareness of breastfeeding benefits, and reduce the number of urgent care visits and related expenditures.

We provided a letter of commitment for Ochsner’s grant application to the Kellogg Foundation, pledging to assist Ochsner in developing a sustainable reimbursement model; including defining covered services, eligibility criteria, and Peer Counselor qualifications. We also will establish a system for referring to the program eligible members from our Start Smart for Your Baby program and to coordinate education and outreach to support breastfeeding.

**Community Partnerships.** LHCC strives to continuously develop community partners who share the same interests in promoting better healthcare practices. Statewide, LHCC partners with 12 schools in participating and facilitating events, such as health literacy readings, math and science fairs, healthy snacking to decrease childhood obesity, physical fitness exercises, anti-bullying programs, hygiene presentations for junior high students, and pep rallies to get students motivated for LEAP educational assessment testing. In addition, LHCC has worked closely with the senior citizen community since 2013 by introducing interactive fitness programs and presentations on healthy living and eating. We also work with feeding the homeless, women and children’s shelter and community beautification and clean-up programs. These collaborations have fostered wide community support, influx of networking, partnership building, and increased the health consciousness of Louisiana residents.

**LHCC Mini Health Grants.** This program will work with non-profit agencies to develop or support innovative programs or services that target subgroups of our members, such as children in Case Management or members facing healthcare disparities, for example. The focus of each grant might be facilitating health care delivery, mentoring, improving health literacy, or creative approaches to community outreach, for example.

*U.5 Describe the process that will be utilized to develop the performance improvement projects (PIPs) identified in Appendix DD of the RFP. Include a preliminary plan for at least one (1) required PIP including the following:*

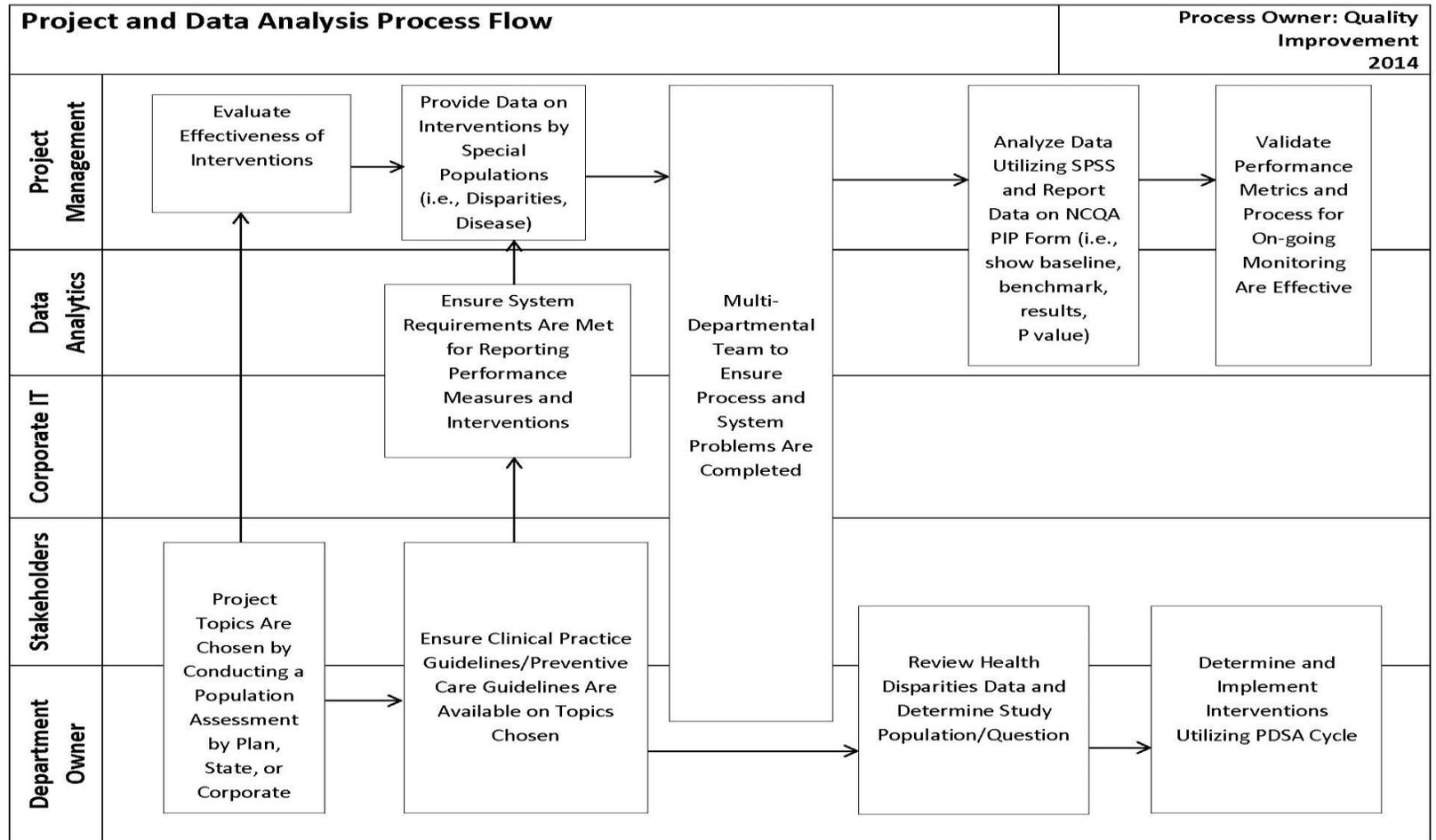
- *The study question;*
- *The study population;*
- *The quantifiable measures to be used;*
- *Baseline methodology;*
- *Data sources;*
- *Data collection methodology and plan;*
- *Data collection plan and cycle;*

## **Overview**

Louisiana Health Care Connection's (LHCC) Quality Assessment and Performance Improvement (QAPI) Program is an ongoing, comprehensive, and integrated system that sets the quality foundation for the entire company. LHCC maintains a company-wide commitment to continuous quality improvement, improving member experience, and reducing cost. We assess each step in our Performance Improvement Project (PIP) process for compliance with external quality review (EQR), NCQA, and CMS PIP protocols. We describe in this response the process LHCC utilizes to develop PIPs, including those identified in Appendix DD.

LHCC uses the Six Sigma style of process mapping, referred to as a swim lane diagram, to organize actions into groups based on who is responsible for the various steps within the process flow. The swim lane diagram illustrated below details the process and responsible functional areas contributing to PIP development, implementation, and monitoring.

LHCC understands and will comply with all LHCC requirements all RFP and contractual requirements related to Quality Management including but not limited to Section 14.0, Quality Management, and all other contractual and regulatory requirements.



## Methodology for Developing Performance Improvement Projects

**Identify/Review the Study Topic.** LHCC’s innovative Performance Improvement Team (PIT), a working, management-level, cross-functional committee representing all relevant operational areas, has a central role in the selection, design, and implementation of PIPs. LHCC’s QI staff collects and facilitates analysis of LHCC and subcontractor data in order to identify potential study topics. Centelligence™, our integrated decision support and health care informatics solution, provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator Dashboards with “drill down” capability. Using Centelligence-generated data, the PIT identifies those study topics where improvements in clinical and non-clinical outcomes or service delivery would best address member needs. We assess member need through analysis of demographic and condition prevalence data, potential risks, and service needs of LHCC’s member population. Topics aim to improve care and service for a significant portion of our membership or for members with the highest needs.

**The Study Question.** The PIT clearly defines the study question(s) the PIP is designed to address. The questions directly relate to the core issues in the selected study topic and are stated so that they can be answered quantitatively or qualitatively. They create the framework for identifying, collecting, analyzing, and interpreting study data, and for assessing the success of the PIP.

**The Study Population.** The PIT also clearly defines the study population so that all LHCC members for whom the study topic is relevant are either included or represented in the study. LHCC determines the study population through careful analysis of utilization, enrollment, medical and pharmacy claims, and encounter data, using tools such as Centelligence™ stratification algorithms. We also look at other administrative data such as information obtained through case management assessments or other case management documentation. This comprehensive process ensures that the population studied reflects the membership served in terms of age groups, disease categories, and special at-risk status. The specific health service delivery issue or specific condition targeted in each PIP is defined, and the methodology determines whether the study population will be the entire membership, a sub-set of the membership, or a representative sample of the membership.

**Quantifiable Measures.** Whenever possible, we derive objective study measures from clinical care standards and/or evidence-based clinical practice guidelines implemented to screen and monitor care and services delivered, and the DHH-required performance measures in Appendix J of this RFP. Each PIP will have at least one quantifiable primary measure for tracking performance improvement. We design measures to be objective, measurable, unambiguous statements of an aspect of quality to be measured. Indicators are capable of measuring member outcomes, member experience, or care/service processes. They clearly identify **who**, -the eligible population, **what** – the care or service being evaluated, and **when** – the specific care or service time frame. The indicator descriptions include:

- Definition of the denominator
- Definition of the numerator
- Dates of service, procedure codes for administrative data, or acceptable medical records data
- The basis for adopting the indicator.

**Baseline Methodology.** When the study population includes the entire eligible membership, our data collection approach captures all eligible members, or a representative sample. For clinical and service conditions being studied for the first time, true prevalence or incidence is not likely to be known. In those cases, LHCC will use the entire membership or a large sample size to establish a valid baseline. Baseline methodology includes the rationale for the sample size based on the eligible population, the prevalence of

the condition being studied, and estimated statistical confidence intervals. When we choose to use a sample, it is always large enough to allow for calculation of statistically meaningful comparisons.

**Interventions.** Targeted, effective interventions designed to influence behavior of members and providers are critical to the success of each PIP. LHCC understands the complexities of our membership and strives to develop interventions that are flexible and member centric. We use tools such as root cause analysis, barrier analysis, and fishbone diagrams to select interventions that are targeted to the specific issues of the target population, and to understand the barriers to effective implementation of the interventions unique to the target population.

The PIT monitors study indicator outcomes frequently and consistently to assess the effectiveness of interventions and, when indicated, uses rapid cycle PDSA (Plan-Do-Study-Act) methodology to test changes in those interventions to improve their effectiveness. Interventions are designed to remove barriers to care and service, to take into consideration ethnicity, linguistic needs, disabilities, and geography, and are rooted in the analysis of our data, including member and provider feedback. We understand that influencing member or provider behavior is not a one-size-fits-all approach. LHCC is committed to developing interventions that are meaningful to our members, can be sustained over time, and provide the backdrop for profound change.

**Data Sources.** QI staff review qualitative and quantitative data using a variety of QI tools to identify the most prevalent issues and those impacting multiple departments. Centene supports our efforts by providing sophisticated data informatics and analytical capabilities for data collection, indicator measurement, and analysis of outcomes, ensuring that our data are valid and reliable. Qualified health professionals, including our Chief Medical Director, Medical Directors, Sr. Director of Quality, Vice President of Medical Management (Registered Nurse), along with other staff, analyze the clinical data and reports produced to determine relevance to our membership and recommend priorities to the PIT. Data sources include, but are not limited to:

- HEDIS or other standardized quality measures
- Claims/encounters reflecting utilization and condition prevalence trends
- Medical records
- Member health and Case Management assessments
- Demographic information relevant to health risks
- External data related to conditions or risks for similar populations
- Access and availability studies
- Member and Provider satisfaction survey results
- Member and Provider input obtained during advisory committee participation
- Quality of care complaint data, indicating underlying issues in care or service
- Member and Provider appeals and grievance data
- Administrative performance data.

**Data Collection Methodology.** LHCC's systematic data collection process ensures valid and reliable data for each indicator measure. Validity reflects the accuracy of information collected and reliability indicates the reproducibility of a measurement. The PIP design clearly specifies the data to be collected and assigns a priority, and we clearly identify data sources for each measure. Timeframes for collection of baseline and re-measurement are also clearly specified.

We consider data to be complete when the data submitted and collected follows all established data specifications and algorithms. For manual data abstraction, such as medical record abstraction, we

consider data to be complete when documented steps outlined on the data collection tool demonstrate consistency of the extracted information. We clearly identify the data abstraction process, including the data collection tool. We build reviewer training, oversight, and inter-rater reliability into each PIP. There is often more than one way to collect data to answer a study question. Some questions are best answered by using a combination of data collection methods.

**Data Collection Plan and Cycle.** LHCC includes in each PIP a data analysis plan that indicates the following:

- Whether data collected will be qualitative, quantitative, or a combination
- Whether data collected represents the entire membership, a subset, or a representative sample
- Whether measures are to be compared to previous results or similar studies
- Whether the PIP will compare outcomes by geographic areas (such as urban vs. rural), race/ethnicity, primary language, or the presence of special health care needs or disability
- The frequency (no less than monthly as specified in RFP Section 14.2.8.4) and timeframe for data collection.

**Data Analysis and Interpretation.** The PIT tracks all study indicator outcomes over time. The first measurement is the baseline, and successive measurements allow evaluation of the impact of PIP interventions. We use tools such as run charts and control charts, as well as dashboard and other reports, to visually display performance improvement trends. When interpreting results, we compute the statistical significance of the results, and identify any factors that might compromise the validity of the results. Most importantly, we assess the likelihood that the reported improvement is “real” improvement and not due to a short-term event unrelated to the interventions or to chance.

### **Preliminary Plan for a PIP to Address Prematurity**

Louisiana ranks second in the United States for preterm births. The state was one of three to earn an “F” grade from the March of Dimes for its high incidence of infants born before 37 weeks gestation.<sup>9</sup> In 2012, the preterm birth rate in Louisiana was 15.3 % of all live births, compared to a national average of 11.5 %.<sup>1011</sup> LHCC had a preterm birth rate of 14.08 % of live births in 2013. The recommendation for pregnant women with a known history of prior preterm birth is to administer 17 alpha-hydroxyprogesterone caproate (17P) weekly starting between 16 to 20 weeks and continuing until 36 6/7 weeks. However, prior history of spontaneous preterm birth only accounts for 15% of all preterm births.

The American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, and the Society for Maternal Fetal Medicine each published practice guidelines in 2012 supporting the addition of universal cervical length screening to routine prenatal care to diagnose prematurely shortened cervix.<sup>121314</sup> A short cervix in the second trimester is the most powerful predictor of preterm birth risk. Intervention with vaginal progesterone, an inexpensive generic drug, is recommended by these

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<sup>9</sup> <http://www.marchofdimes.org/mission/prematurity-reportcard.aspx>

<sup>10</sup> <http://www.marchofdimes.org/materials/premature-birth-report-card-louisiana.pdf>

<sup>11</sup> <http://www.marchofdimes.org/materials/premature-birth-report-card-united-states.pdf>

<sup>12</sup> American College of Obstetricians and Gynecologists (ACOG). ACOG practice bulletin no.130: prediction and prevention of preterm birth. *Obstet Gynecol* 2012 Oct;120(4):964-73

<sup>13</sup> Society for Maternal-Fetal Medicine Publications Committee with the assistance of Vincenzo Berghella, MD. Progesterone and preterm birth prevention: translating clinical trials data into clinical practice. *Am J Obstet Gynecol* 2012;206:376-386

<sup>14</sup> American College of Nurse-Midwives, Division of Standards and Practice, Clinical Standards and Documents Section. ACNM position statement on preterm labor and preterm birth. Approved by the ACNM Board of Directors, June 2012

organizations as an evidence-based strategy with significant potential to reduce preterm births and infant mortality.<sup>15</sup>

Below, we provide the details of our proposed Performance Improvement Plan for Reducing Preterm Deliveries.

<b>Improving Birth Outcomes by Reducing Preterm Deliveries</b>	
<b>Study questions</b>	Will LHCC’s efforts to increase cervical length screening and the use of progesterone reduce the number of premature births?
<b>Study population</b>	All LHCC pregnant members
<b>Quantifiable measures to be used</b>	Primary Performance Measure: Preterm delivery rate. Goal: 5% decrease in year one; 15 % decrease by the end of year three Secondary Performance Measures: Total NICU paid amount. Goal: 5% decrease. in year one Cervical length screening rate. Goal: 2015 will be baseline period Notification of pregnancy (NOP) form submission rate. Goal: 10% increase in year one
<b>Baseline methodology</b>	The initial measurement period will be January 1, 2015 to December 31, 2015. The study population will be limited to all pregnant members at three proposed practice sites for the first year pilot.
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Educate OB providers on current guideline recommendations and on resources available to them and to members through the Provider Newsletter, provider orientation, and onsite Provider Relations visits.</li> <li>• Distribute tools to OB providers including preterm birth screening algorithms, options for prescribing progesterone, and unique billing codes for cervical length screening by cervicometer or transvaginal ultrasound.</li> <li>• Implement provider incentives for cervical length screening on all pregnant women and for timely submission of NOP screening forms.</li> <li>• Remove prior authorization requirement for vaginal progesterone.</li> </ul>
<b>Data sources</b>	Medical and pharmacy claims  High Risk OB Case Management log reports
<b>Data collection methodology and plan</b>	Data will be collected monthly from data sources and reported to the QAPI Committee on a quarterly basis. Claims data will be reported with a three month lag to allow time for claims run out. Data will be stratified by race, ethnicity, primary language, disability, and geography as required by section 14.1.10.
<b>Data collection plan and cycle</b>	We will evaluate PIP outcomes on a 12-month cycle, with interim analysis monthly. We will report results to DHH as required in section 14.2.9 of this RFP.

### Preliminary Plan for a PIP to Address Childhood Obesity

Childhood obesity prevalence remains high. Overall, obesity among our nation’s young people, aged 2 to 19 years, has not changed significantly since 2003-2004 and remains at about 17% or 12.5 million children and adolescents.<sup>16</sup>

<sup>15</sup> Iams JD, Goldenberg RL, Meis PJ, et al. The length of the cervix and the risk of spontaneous premature delivery. N Engl J Med 1996;334:567-572

<sup>16</sup> <http://www.cdc.gov/obesity/data/childhood.html>, accessed 9/18/2014

Louisiana ranks 1st in the nation for its high prevalence of adult obesity and 6th in the nation for childhood obesity. With approximately one in three Louisiana children and adolescents weighing in as overweight or obese, the state earned a stagnant grade of “F” for obesity in Pennington Biomedical Research Center’s annual Report Card on Physical Activity and Health for Children & Youth every year since its inception in 2008.<sup>17</sup> Children who are overweight or obese are also more likely to develop chronic diseases, including Type 2 diabetes, heart disease, osteoarthritis, and some cancers. In addition, overweight kids are often more likely have an elevated risk of social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood.<sup>18</sup>

The good news is that childhood obesity can be confronted and improved outcomes realized. Targeted educational programs focusing on healthy lifestyles promotes positive behavior change and empowers children and their parents or guardians to make better choices regarding diet and exercise. Below, we provide the details of our proposed Performance Improvement Plan for Improving Outcomes for Overweight and Obese Children.

<b>Improving the Identification and Outcomes of Overweight and Obese Children</b>	
<b>Study question</b>	Will the targeted interventions implemented increase the documentation of BMI and decrease obesity in the study population?
<b>Study population</b>	Members 3 to 17 years of age as described in the NCQA HEDIS Volume 2 2015 Technical Specifications
<b>Quantifiable measures to be used</b>	Primary Performance Measures: HEDIS: Weight Assessment and Counseling for Nutrition and Physical Activity – BMI Percentile Total: The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during calendar year 2015. Goal: 20% increase in year one The percentage of members 3-17 years of age with a diagnosis of obesity. Goal: 10% decrease in year one.
<b>Baseline methodology</b>	The initial measurement period will be January 1, 2015 to December 31, 2015. The study population will not be limited. We will use NCQA specifications to determine the sample size for hybrid methodology.
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Telephonic outreach and support services for parents and guardians</li> <li>• Educate members on importance of healthy diet and physical activity through the member newsletter (available via our website or mobile devices), and community and school-based outreach events</li> <li>• Care Management staff will include diet and physical activity in member assessments and care plans for members receiving case management</li> <li>• Implement pilot Chronic Care Management Program for pediatric obesity that provides:               <ul style="list-style-type: none"> <li>○ Health coaching by registered dietitians</li> <li>○ Exercise physiologist coaching on the benefits of physical activity</li> <li>○ Facebook private group to leverage the power of peer support and social networking</li> <li>○ Motivational information including recipes, meal preparation tips, food comparison tips, fun and fast educational surveys and hydration tips</li> </ul> </li> <li>• Member incentive to complete an annual well visit</li> <li>• Educate providers on the guideline and coding requirements regarding assessment and documentation of BMI and the importance of reducing obesity through the provider newsletter, provider orientation, and onsite Provider Relations visits.</li> </ul>

<sup>17</sup> [http://www.pbrc.edu/prism/docs/PRISMReport\\_web.pdf](http://www.pbrc.edu/prism/docs/PRISMReport_web.pdf) , accessed 9/18/2014

<sup>18</sup> <http://www.kidsdashboard.la.gov>, accessed 9/18/2014

<b>Improving the Identification and Outcomes of Overweight and Obese Children</b>	
<b>Data sources</b>	Medical claims Medical/treatment records
<b>Data collection methodology and plan</b>	HEDIS: Weight Assessment and Counseling: we will collect both medical/treatment record and administrative claims data per NCQA specifications. We will use hybrid methodology to assess this measure annually, but use administrative claims data only for monthly reports. % of Members with Obesity: we will collect administrative claims data for the entire study population both monthly and annually. Claims data will be reported with a three month lag to allow time for claims run out. Data will be stratified by race, ethnicity, primary language, disability, and geography as required by section 14.1.10.
<b>Data collection plan and cycle</b>	We will evaluate PIP outcomes on a 12-month cycle, with interim analysis monthly. We will report results to DHH as required in section 14.2.9 of this RFP.