Improve Outcomes for Members with Hypertension

2022

Milestone #5

Conduct continuous quality improvement activities.

This report provides an overview of the Network Providers' efforts to conduct continuous quality improvement activities within the Plan-Do-Study-Act framework for continuous quality improvement. The first sections provide an introduction and overview of the Hypertension Project, its place in the Managed Care Incentive Payment program, and a summary of the report. The next section describes the Plan-Do-Study-Act model and how it has been and will be applied to the Hypertension Project. The final section describes the continuous quality improvement activities, how they were conducted, their effectiveness, barriers to their implementation, and areas for potential improvement.

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I. *INTRODUCTION*

The Louisiana Department of Health ("LDH"), as part of its contracts with each Louisiana managed care organization, authorizes additional payments to any Medicaid managed care organizations that implement an LDH initiative to track and improve health outcomes for Healthy Louisiana enrollees with hypertension ("Hypertension Project").

The Louisiana Medicaid managed care organizations that chose to work with LDH in the Hypertension Project hired an extensive network of physicians, mid-level providers, clinics, and hospitals that is capable of reaching Healthy Louisiana enrollees across the State ("ACO") to assist the Medicaid managed care organizations related to their participation in the Hypertension Project (the Medicaid managed care organizations and ACO are collectively referred to as the "MCO"). As part of the Hypertension Project, the MCO must conduct continuous quality improvement activities ("CQI Activities") that include information identifying the impact of the Hypertension Project, lessons learned, opportunities to scale the Hypertension Project to a broader population, and key challenges associated with expansion of the Hypertension Project. This goal has been accomplished, in part, due to the feedback from the hospitals participating in the ACO ("Network Providers").

The following report summarizes the MCO's continued efforts to utilize a data-driven approach to improve health outcomes for Healthy Louisiana enrollees with hypertension.

II. *OVERVIEW*

CQI is the "systematic process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions.[1] A CQI Plan codifies the method for collecting the relevant data and utilizing it to inform decisions designed to continuously improve processes.[2] Following the late 2019 launch of the Hypertension Registry,[3] the MCO created a CQI Plan for the Hypertension Project. The Project's CQI Plan guides the development, evaluation, and improvement of Registry data, processes, and quality strategies aimed at improving health outcomes of members with hypertension

To achieve the desired objectives under the CQI Plan, the MCO and Network Providers selected a data driven quality strategy to evaluate elements of the CQI Plan based the on Institute for

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[1] *Continuous Quality Improvement*, U.S. DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF ADOLESCENT HEALTH, *available at* https://www.hhs.gov/ash/oah/sites/default/files/cqi-intro.pdf.
[2] *Id*
[3] The registry is repository of patient data used to measure and monitor health outcomes and inform quality initiative strategies for Healthy Louisiana members with hypertension.

Healthcare Improvement's Plan-Do-Study-Act (PDSA) model.[4] For the 2022 period, the MCO focused its PDSA analyses on: (1) increasing Registry enrollment, (2) improving health outcomes; and (3) increasing Registry member participation in activities to improve blood pressure control. The PDSA analyses are also designed to inform opportunities to scale the Project to a broader population in future years and identify key challenges associated with the expansion. An updated PDSA CQI Plan diagram and timeline are presented in Appendix A. PDSA activities were integrated with complementary CQI activities accomplished in 2022, including:

1. 2021 performance reporting for registry enrollment and health outcome measures
2. Continuing activities and Registry member participation in activities to improve blood pressure control
3. Review and modify Registry data fields, as necessary
4. Review & revise milestone specifications and Registry protocol, as necessary
5. Conduct continuous provider education
6. Conduct two CQI workshops in February 2022 and April 2022 where all Network Providers are required to participate. The CQI workshops promote Network Provider collaboration, determine Project impacts, assess lessons learned, consider opportunities to scale the Project to a broader population, and address key challenges associated with Project expansion
7. Monthly Group Discussions with Network Providers
8. Annual Meeting with key stakeholders
9. Annual Report

III. *PLAN-DO-STUDY-ACT (PDSA) CQI PLAN IN 2022*

The Project uses data driven quality strategy to evaluate elements of the CQI Plan based the on Institute for Healthcare Improvement's Plan-Do-Study-Act (PDSA) model.[5] Having already laid the groundwork for the Hypertension Project by defining the population, goals, and initial challenges as well as taking some of the first steps in the process of improvement,[6] the MCO has been engaging the PDSA process to evaluate and refine so that future efforts incorporate the benefits of experience.

In 2022, the MCO focused PDSA activities in three areas: 1) Increasing registry enrollment; 2) Improving health outcomes; and 3) Increasing participation among Registry members in activities to improve blood pressure control. The 2022 PDSA focus areas build on prior activities dating back to the beginning of the project and advance project goals of improving blood pressure control for Registry members. The 2020 PDSA focus areas and activities are included in Appendix B.

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[4] *Science of Improvement: Testing Changes*, INSTITUTE FOR HEALTHCARE IMPROVEMENT, *available at* http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

[5] *Id*

[6] *See generally* Hypertension Project Milestone 2.11.

A. PDSA ELEMENTS

The PDSA's four elements include:

- **Plan.** Plan the test or observation, including a plan for collecting data.
  - State the objective of the test.
  - Make predictions about will happen and why.
  - Develop a plan to test the change.

- **Do.** Try out the test on a small scale.
  - Carry out the test.
  - Document problems and unexpected observations.

- **Study.** Set aside time to analyze the data and study the results.
  - Complete the analysis of the data.
  - Compare the data to the predictions.
  - Summarize and reflect on what you learned.

- **Act.** Refine the change based on what was learned from the test.
  - Determine what modifications should be made.
  - Prepare a plan for the next test.

These principles have guided the efforts of the MCO since the CQI plan's inception and will continue to do so as the MCO completes the PDSA cycle and continues to refine in future years.

B. PDSA: INCREASE REGISTRY ENROLLMENT

The 2022 PDSA activity builds on prior accomplishments related to Hypertension Registry enrollment. Prior to 2022, the MCO completed the following activities:

- Established and launched the Hypertension Registry;
- Developed the Registry protocol;
- Trained Network Providers on the Registry and Registry Modifications;
- Instructed Registry Administrators to monitor data and make necessary corrections;
- Established a 2020 baseline of Registry members; and
- Established a 2021 performance target for increasing Registry enrollment.

The 2022 PDSA will continue these activities and focus efforts on achieving a 2022 enrollment goal, to be developed. The MCO shared 2021 performance results with Network Providers, which is discussed in more detail in Section V Evaluation below.

C. PDSA: IMPROVE HEALTH OUTCOMES

The 2022 PDSA activity builds on prior accomplishments related to improving health outcomes. Prior to 2022, the MCO completed the following activities:

- Selected health outcomes to improve blood pressure control and developed measure specifications;
- Educated Network Providers on the milestone specifications
- Calculated CY 2020 baselines for the health outcomes; and
- Established 2021 performance targets for improving blood pressure control in Registry members

The 2022 PDSA will focus efforts on improving blood pressure control in 2022 for Registry members and achieving 2022 performance targets. The MCO shared 2021 performance results with Network Providers, which is discussed in more detail in Section V Evaluation below.

D. PDSA: INCREASE REGISTRY MEMBER PARTICIPATION IN ACTIVITIES TO IMPROVE BP CONTROL

The 2022 PDSA builds on prior accomplishments related to addressing treatment gaps and root causes for poor blood pressure control among Registry members. Prior to 2022, the MCO completed the following activities:

- Studied treatment gaps and root causes of poor blood pressure control and developed action items to address both;
- Implemented the action items in 2021;
- Assessed action items and selected specific activities to continue in 2022 aimed at improving blood pressure control for Registry members; and
- Developed a 2021 baseline of 37,570 Registry members participating in the activities.

Network Providers selected the following activities to continue in 2022:

- Thirty-two Network Providers chose to ask members about their tobacco use at each visit and track data in the member's medical record.
- One Network Provider chose to educate registry members on transportation services within the community to refer to members with transportation issues.
- Two Network Providers chose to incorporate flexible scheduling (*e.g.*, same day appointments, walk-ins, or evening or weekend appointments).

The Network Providers will increase Registry member participation in these activities in 2022, and seek to achieve a performance goal, to be determined. Specific Network Provider selections are presented in Appendix C.

IV. *COMPLEMENTARY CQI ACTIVITIES CONDUCTED IN 2022*

The PDSA activities implemented in 2022 are supported and complemented by additional CQI activities performed on behalf of the Hypertension Project. These activities include CQI workshops, Network Provider continuous education, improvements to the Hypertension milestone specifications and protocols, Registry updates, monthly group discussions, the MCIP annual meeting, and the annual report.

A. CQI WORKSHOPS

The MCO held two virtual Hypertension CQI Workshops in 2022 to promote shared learning among Network Providers participating in the Hypertension Project. All Network Providers were required to participate in the CQI workshops and share their experiences on selected topics pertaining to the Hypertension Project that were of interest to all participants. The presentations spurred fruitful discussions among Network Providers on challenges, successes, and areas improvements for the project. The MCO also took the opportunity at the workshops to provide Hypertension Project updates and to present registry data to the Network Providers. The data presentations included reports on 2021 performance rates for Hypertension Project measures and information on Registry members. The Network Providers indicated that the workshops were helpful in facilitating increased collaboration and shared learning that they may apply to their own issues.

The first CQI workshop was held in February 2022. At this workshop, the Network Providers discussed project impacts, lessons learned, areas of improvement, and opportunities for project expansion and replication. For more information regarding the February Workshop and to review the detailed minutes outlining the topics discussed, please refer to Appendix E.

The second CQI workshop was held in April 2022. At this workshop, the Network Providers discussed 2021 performance, patient treatment gaps, improvement activities, and lesson learned. For more information regarding the April Workshop and to review the detailed minutes outlining the topics discussed, please refer to Appendix F.

B. CONTINUING PROVIDER EDUCATION

During 2022, all Network Providers were required to perform continuing education for providers related to the Hypertension Project. The education sessions provided updated information related to 2022 initiatives and milestones, 2021 performance, baseline development for a new milestone, Registry Administrator responsibilities, and Registry modifications effective in 2022. The continuous education sessions are designed to ensure continued progress under the CQI plan by ensuring that new providers are familiar with the Project and its goals. Additionally, the education sessions may serve as refresher courses for providers that are familiar with the Project. The Hypertension Project 2022 provider education support may be found in Appendix G.

C. REVISIONS TO MILESTONE SPECIFICATIONS AND PROTOCOL

The MCO created two resources to help Network Providers administer the Hypertension Project: (1) the Milestone Specifications and (2) the Protocol. The Milestone Specifications define the eligibility requirements for members enrolled in the Registry and provide Network Providers with a guide related to the calculation of milestone performance. The Protocol was created to assist Network Providers with the data collection process and Registry maintenance. The MCO continuously improves each of these resources as necessary to complement the Registry. For example, the MCO updated the Protocol and Milestone Specifications to incorporate the additional data fields included in the Registry for 2021. Appendix D contains the latest versions of the Milestone Specifications and Protocol. In 2022, the MCO incorporated several modifications to both the Milestones Specifications and Protocol to comport with Registry modifications discussed in Section D below, as well as included a clarification to remove deceased individuals from the Registry.

D. REGISTRY MODIFICATIONS

The MCO is continuously improving the Registry as necessary. In 2022, the MCO made several technical modifications and clarifications to the Registry, including:

(1) Clarified eligible encounters to include in the Registry. The MCO instructed Network Providers that encounters that were only used for allergy shots or vaccinations (e.g. COVID vaccination), must be excluded from the registry; and
(2) Modified the registry format to improve use. The MCO revised the registry format and date format to promote consistency and improve use across all Network providers.

The MCO will continue to assess and identify potential modifications to the Registry during 2022.

E. MONTHLY GROUP DISCUSSIONS

Like the CQI workshops, the monthly group discussions provide Network Providers with an opportunity to raise any issues related to the Project. During the discussions, the MCO summarized upcoming deadlines, educates Network Providers, answers questions related to Milestone Specifications or administration of the Registry, and provides Project updates. After each group discussion, the MCO sends summaries to the Network Providers to memorialize the discussion and provide a written synopsis for providers that were unable to attend.

F. ANNUAL MEETING

In addition to the CQI workshops, the MCO conducts an annual meeting that brings together all key players in the Hypertension Project, including the MCOs, Network Providers, and LDH, to review and assess the year's accomplishments and plan for the upcoming year. The 2022 annual meeting will be held in the fall.

G. ANNUAL REPORT

Each year, the MCO develops an annual report that summarize the year's MCIP activities and accomplishments. The report provides an opportunity to reflect on the past year and serve as a guide to inform project improvements for the upcoming year. The 2022 report is currently under development.

V. *EVALUATION OF THE EFFECTIVENESS CQI ACTIVITIES*

Starting this year, the MCO has the first opportunity to measure Network Provider performance on key milestones included in the Hypertension Project and to analyze a repository of Registry data collected over the past two years. This section presents 2021 Network Provider performance results on registry enrollment and health outcome measures, summarizes results of Registry data analyses performed, and discusses, barriers, lessons learned, and areas of improvement.

A. NETWORK PROVIDER PERFORMANCE IN 2021

The MCO shared 2021 performance achievement results with Network Providers for key measures included in the Hypertension project. The measures include registry enrollment and improved blood pressure control for the two age cohorts included in the project (see results in the table below). The achievement results show that the Network Providers exceeded the 2021 registry enrollment goal and partially achieved 2021 goals to achieve adequate blood pressure control for Registry members. The Network Providers achieved slightly higher performance with the younger age cohort aged 18-59 compared to the older age cohort 60 to 85. However, the older age cohort overall had higher levels of blood pressure control in 2021 (79.48%) compared to the younger age cohort (59.16%).

2021 Performance Achievement Results

Measure	2020 Baseline	2021 Goal	2021 Performance	2021 Achievement
Hypertension Registry Enrollment	83,218	87,379	92,619	100%
Percentage of Members Aged 18-59 whose Blood Pressure was Adequately Controlled (<140/90)	56.64%	59.47%	59.16%	89.05%
Percentage of Members Aged 60-85 whose Blood Pressure was Adequately Controlled (<150/90)	77.21%	81.07%	79.48%	58.81%

The MCO also provided individual performance reports to each network provider, to educate and inform future activities to improve performance.

The 2021 performance rates show meaningful progress in improving blood pressure control for Healthy Louisiana members. According to Louisiana state sources, the Healthy Louisiana statewide average blood pressure control rate for individuals aged 18-85 (<140/90) in 2020 was 48.24%.[7] Both younger and older age cohorts participating in the Hypertension project outperform the statewide average and the MCO expects to continue improving performance in 2022.

B. REGISTRY DATA ANALYSES

In 2021, the Network Providers began reporting additional information on Registry members, including race, tobacco use, and participation in activities to improve blood pressure control. The MCO performed analyses of these hypertension registry data and shared their findings with Network Providers at the April CQI workshop.

The MCO data analyses include the following findings:

- In 2021, 92,619 individuals were enrolled in the Hypertension Registry; of this number, more than 60 percent or 56,163 fell in the cohort group aged 18-59, compared to approximately 40 percent or 35,562 that fell in the cohort group aged 60-85.
- African Americans make up most Registry members (58%), followed by White/Caucasians (38%) and all other groups (4%).
- Across all age groups, African Americans had worse blood pressure control (63%) compared to Whites/Caucasians (73%) and other groups (67%).
- Approximately 35% of Registry members state that they use tobacco; the younger cohort group aged 18-59 have a higher usage rate (40%) compared to the older cohort group aged 60-85 (28%).
- Across all Registry members, the median number of medical visits during 2021 was 5 visits; 7% of Registry members were super high utilizers of medical care, having more than 25 medical visits during the year. By contrast, 14% of Registry members had only 1 medical visit during the year.
- Members aged 18-59 engaging in tobacco use had slightly lower rates of blood pressure control (58%) compared to the entire cohort (59%); Members aged 60-85 engaging in tobacco use also had slightly lower blood pressure control (78%) compared to the entire cohort (79%).
- Members aged 18-59 participating in activities to improve blood pressure control had comparable rates of blood pressure control (59%) compared to the entire cohort (59%); Members aged 60-85 had lower blood pressure control (74%) compared to the entire cohort (79%).

[7] Please see https://qualitydashboard.ldh.la.gov/

Data analyses presentation may be found in April CQI workshop presentation in Appendix F.

C. BARRIERS TO IMPROVEMENT

The CQI plan requires the MCO to evaluate barriers to improvement. As part of the analysis, the MCO reviewed the 2021 Registry information to determine the root causes affecting the members enrolled in the Registry. Additionally, the MCO solicited feedback from the Network Providers to determine barriers to improvement identified at the facility level.

(1) Root Causes Identified in the Registry

In 2021, Network Providers gathered information on primary root causes for hypertension diagnosis for members enrolled in the Hypertension Registry. In 2022, the MCO reviewed the CY21 data to determine the most common primary root causes for hypertension diagnoses.[8] The most common primary root cause among Registry members was co-morbidity with other chronic conditions (82%), such as obesity or diabetes. The second most common root cause was attributed to behavioral factors such as poor diet, lack of exercise, alcohol and tobacco use, or drug use (6%). The third most common root cause cited lower socio-economic status of patients (5%). The MCO plans to use this information to make Network Providers aware of these issues and hopefully find ways to address them in the future.

(2) Barriers to Improvement Identified by Network Providers

During the CQI workshops, Network Providers discussed implementation barriers that affected project performance. In all cases, the Network Providers implemented strategies to address the barriers and improve performance. These challenges include:

- Patients faced challenges monitoring their blood pressure at home and/or providing BP readings to their physician's office.
- The COVID-19 pandemic continues to make patients wary of visiting the doctor's office, which in turn makes it challenging to provide ongoing patient care and monitoring.
- Providers fail to document a patient's blood pressure in the medical record or fails to input patient data correctly into the Registry
- Electronic health record systems are not compatible with the Hypertension Registry, making it challenging to transfer patient information.

[8] This analysis used encounter data and was not calculated based on individuals in the Registry.

- Lack of transportation, especially in rural areas, causes patients to miss appointments and receive ongoing care.

The Network Providers discussed using a variety of strategies, including greater investments in telemedicine, provider education, new electronic health systems, and patient education to help mitigate these barriers. The MCO will continue to solicit feedback from Network Providers regarding barriers faced and share information on successful strategies adopted to address barriers identified.

D. AREAS FOR POTENTIAL IMPROVEMENT

The MCO plans to use the results of 2021 performance rates to determine areas for improvement related to patient outcomes. While the Network Providers made measurable progress in improving blood pressure control rates for Registry members, additional improvements can be made. Additionally, the MCO will solicit feedback from the Network Providers related to Project improvements that could help effect positive impacts for Registry members. The MCO believes that incorporation of Network Provider feedback related to the Project has been very beneficial in effecting positive changes for Registry members.

The MCO will also continue to modify the Registry as necessary to capture information relevant to the Project's goals. To do so, the MCO will evaluate whether the Registry should be revised to include additional data or remove certain data fields. The MCO will continue to solicit Network Provider feedback as necessary to ensure that the Registry is user-friendly and effective.

The MCO will also evaluate whether to expand the Registry requirements to additional populations, such as to younger populations under age 18. Lastly, the MCO will evaluate additional activities to implement in future years to that help to improve blood pressure control for Registry members.

VI. *CONCLUSION*

The CQI plan aims to improve the Project and result in better health outcomes for members with hypertension enrolled in the Registry. The CQI plan will assist the MCO to continue to assess project impacts, lessons learned, Registry modifications needed, and analyze whether to scale the Project to a broader population while considering key challenges associated with Project expansion.

During 2022, the MCO and Network Providers continued to implement key components of the CQI plan. Specifically, Network Providers implemented activities to improve blood pressure control for Registry members. The Network Providers also worked to conduct continuous provider education to ensure that providers are furnishing the highest quality care possible to Registry members. Additionally, the MCO conducted CQI workshops and held monthly group discussions designed to assist Network Providers in collaborating and sharing ideas regarding ways to help improve health outcomes for the Healthy Louisiana population.

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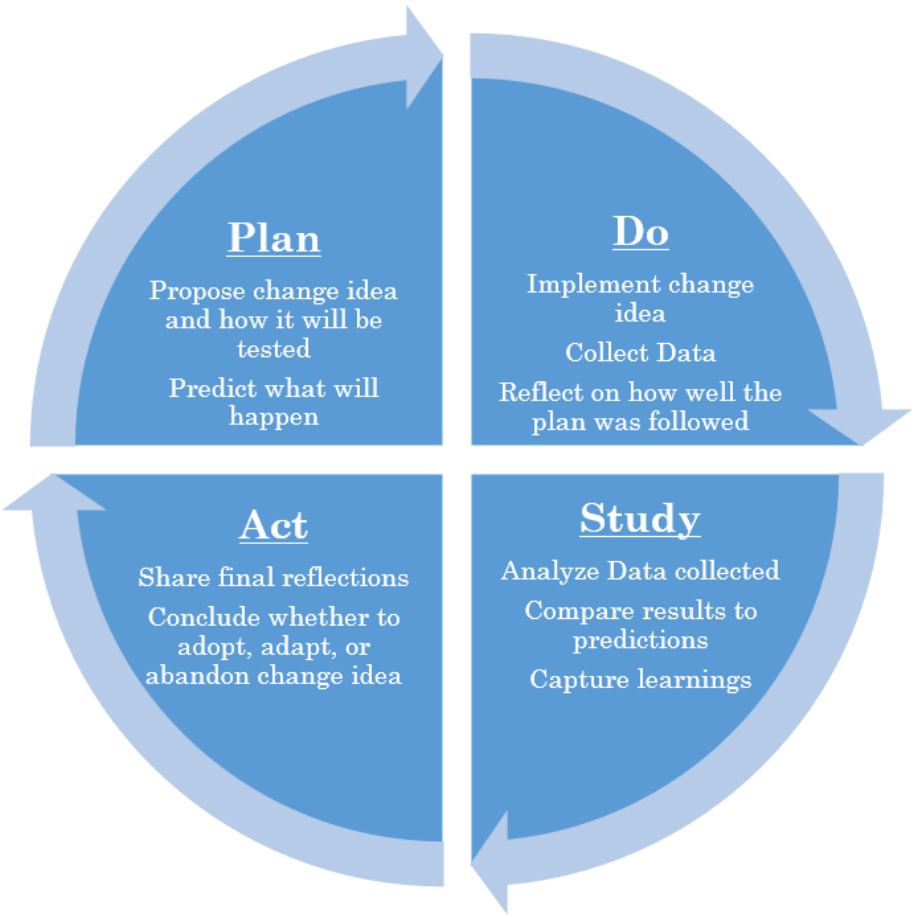
APPENDIX A: CQI Plan Diagram & Timeline



Key Partners

Network Providers

MCOs

Healthy Louisiana Enrollees

LDH

Resource Supports

Continuous Provider Education

Monthly Group Discussions

CQI Workshops

Annual Report & Meeting

Data Support Tools

Hypertension Registry

EHR

Data analyses

Registry protocol

Milestone specifications

PDSA Focus Areas (2022)

Increase registry enrollment

Improve health outcomes

Increase registry member participation in activities to improve blood pressure control

Hypertension CQI Plan Timeline

2019	2020	2021	2022	2023
Launch Registry	Enroll Members and measure baseline Registry enrollees Measure baseline for enrolled members aged 18-59 with poor BP control Measure baseline for enrolled members aged 60-85 with poor BP control	Improve baselines; assess Network Provider performance relative to improvement targets; analyze individual Network Provider performance and disseminate data analyses to Network Providers; identify areas of improvement for improving performance	Improve baselines; assess Network Provider performance relative to improvement targets; analyze individual Network Provider performance and disseminate data analyses to Network Providers; identify areas of improvement for improving performance	Improve baselines; assess Network Provider performance relative to improvement targets; analyze individual Network Provider performance and disseminate data analyses to Network Providers; identify areas of improvement for improving performance
Identify and Study Root Causes of poor BP control	Create action items to address root causes of poor BP control Identify and Study Treatment gaps specific to patients enrolled in registry	Implement activities to address treatment gaps identified and to increase Registry members participation in activities to improve blood pressure control	Evaluate whether action items are improving health outcomes; make changes to activities as necessary	Evaluate whether action items are improving health outcomes; make changes to activities as necessary
Create Milestone Specifications & Registry Protocol (e.g., eligibility requirements, staff member roles, sites of service)	Review and revise Milestone Specifications and Registry Protocol	Continue to review and revise Milestone Specifications and Registry Protocol as necessary	Continue to review and revise Milestone Specifications and Registry Protocol as necessary	Continue to review and revise Milestone Specifications and Registry Protocol as necessary
Conduct education and training of Network Providers	Continue providing education for Network Providers; implement Monthly Technical calls with Network Providers	Continue providing education for Network Providers; continue Monthly Technical calls with Network Providers	Continue providing education for Network Providers; continue Monthly Technical calls with Network Providers	Continue providing education for Network Providers; continue Monthly Technical calls with Network Providers
	Create a CQI plan, including information identifying project impacts, registry modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges associated with expansion of project.	Conduct CQI activities	Assess impact and success of CQI activities conducted in preceding year; increase or alter activites as necessary; continue conducting CQI activities	Assess impact and success of CQI activities conducted in preceding years; increase or alter activities as necessary; continue conducting CQI activities
	Registry Modifications Needed: Review Registry data fields and make modifications	Registry Modifications Needed: Review Registry data fields and make modifications, as necessary	Registry Modifications Needed: Review Registry data fields and make modifications, as necessary	Registry Modifications Needed: Review Registry data fields and make modifications, as necessary
	Lessons Learned: Assess lessons learned and identify areas of improvement	Lessons Learned: Implement one or more activities from CQI Plan Survey and work with Network Providers to assess lessons learned and areas of improvement	Lessons Learned: Implement one or more activities from CQI Plan Survey and work with Network Providers to assess lessons learned and areas of improvement	Lessons Learned: Implement one or more activities from CQI Plan Survey and work with Network Providers to assess lessons learned and areas of improvement
	Identify Project expansion opportunities and key challenges associated with potential Project expansion	Analyze whether scaling Project to a broader population will improve Project and determine if key challenges associated with Project outweigh expansion benefits	Analyze whether scaling Project to a broader population will improve Project and determine if key challenges associated with Project outweigh expansion benefits	Assess Project expansion if implemented

APPENDIX B: PDSA Activities

Increase Registry Enrollment

PLAN (2021)	DO (2022)	STUDY (2022)	ACT (2022)
MCO disseminates 2020 registry enrollment baselines and 2021performance goals to Network Providers Network Providers assess collective and individual baselines on registry enrollment. The MCO updates education and training materials on registry enrollment and disseminates instructions to Network Providers	Network Providers continue to enroll eligible patients in Registry Registry Administrator monitors data and makes necessary corrections Network Providers receive ongoing training and education on Registry and registry modifications MCO calculates 2021 Registry enrollment performance rates	MCO assesses 2021 performance relative to improvement target MCO disseminates registry enrollment performance and analyzes individual Network Provider performance MCO identifies areas of improvement for Registry enrollment and performance MCO assesses opportunities and challenges to expand Registry to broader population	MCO shares lessons learned and best practices among Network Providers MCO disseminates data analyses to Network Providers to improve Registry enrollment performance

Improve Health Outcomes

PLAN (2021)	DO (2022)	STUDY (2022)	ACT (2022)
MCO disseminates CY 2020 baselines and 2021 goals on blood pressure (BP) control for two age cohorts 18-59 and 60-85. Network Providers assess collective and individual baselines on health outcome measures MCO updates education and training materials on health outcome data collection and disseminates to Network Providers	MCO continues to report BP rates and service information for members enrolled in the Hypertension Registry. MCO calculates CY 2021 BP control performance for Registry members (ages 18-59) MCO calculates CY 2021 BP control performance for Registry members (ages 60-85) Network Providers monitor Registry member participation in activities to improve blood pressure control	MCO assesses 2021 performance relative to improvement targets MCO analyzes individual Network Provider performance MCO identifies areas of improvement for improving performance	The MCO shares lessons learned and best practices among Network Providers The MCO disseminates data analyses to Network Providers to improve health outcome performance The MCO updates milestone specifications and Provider education as needed to reflect lessons learned and best practices

Increase Registry Member Participation in Activities to Improve BP Control

PLAN (2021)	DO (2022)	STUDY (2022)	ACT (2022)
The MCO develops and disseminates activity options for improving BP control to Network Providers Network Providers select and implement activity to improve BP control for Registry members. The MCO educates Network Providers on documentation requirements for selected activity. Registry is updated to report Members participating in the selected activity	The MCO calculates a 2021 baseline of Registry Members participating in activities to improve BP control Network Providers confirm activity selection to continue in 2022 Network Providers continue enrolling and documenting Registry members participating in the selected activity Network Providers submit documentation to the MCO on Registry member participation in the selected activity	MCO analyzes patient characteristics of Registry enrollees participating in activities to improve BP control MCO identifies areas of improvement to increase performance	The MCO disseminates data analyses to Network Providers MCO and LDH develop 2022 performance target goal for participation in activities The MCO updates Provider education as needed to reflect lessons learned and best practices

Appendix C: Network Provider Activity Selection

Network Provider Name	Hypertension Milestone 4.1 (CY22) Increase percentage of registry members participating in activities designed to increase adequate BP control.
Abbeville General Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Allen Parish Community Healthcare	Ask members about their tobacco use at each visit and track data in the member's medical record.
Baton Rouge General Medical Center	Ask members about their tobacco use at each visit and track data in the member's medical record.
CHRISTUS Coushatta Health Care Center	Educate members on transportation services within the community.
CHRISTUS Health Shreveport-Bossier	Ask members about their tobacco use at each visit and track data in the member's medical record.
CHRISTUS Ochsner Lake Area Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
CHRISTUS Ochsner St. Patrick Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
CHRISTUS St. Frances Cabrini Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Iberia Medical Center	Ask members about their tobacco use at each visit and track data in the member's medical record.
North Caddo Medical Center	Incorporate flexible scheduling (i.e. same day appointments, walk-ins, evening or weekend appointments).
Ochsner Abrom Kaplan Memorial Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Acadia General Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Lafayette General	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner LSU Health Monroe	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner LSU Health Shreveport	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Medical Center	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Medical Center - Baton Rouge	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Medical Center - Kenner	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner Medical Center - North Shore	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner St. Anne General Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner St. Mary	Ask members about their tobacco use at each visit and track data in the member's medical record.
Ochsner University Hospital and Clinics	Ask members about their tobacco use at each visit and track data in the member's medical record.
Opelousas General	Ask members about their tobacco use at each visit and track data in the member's medical record.
Pointe Coupee General Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Rapides Regional Medical Center	Ask members about their tobacco use at each visit and track data in the member's medical record.
Savoy Medical Center	Incorporate flexible scheduling (i.e. same day appointments, walk-ins, evening or weekend appointments).
Slidell Memorial Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Southern Regional Medical Corporation	Ask members about their tobacco use at each visit and track data in the member's medical record.
St. Bernard Parish Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.

Network Provider Name	Hypertension Milestone 4.1 (CY22) Increase percentage of registry members participating in activities designed to increase adequate BP control.
St. Charles Parish Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
St. Martin Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
St. Tammany Parish Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Terrebonne General Medical Center	Ask members about their tobacco use at each visit and track data in the member's medical record.
The General Hospital	Ask members about their tobacco use at each visit and track data in the member's medical record.
Tulane University Hospital and Clinic	Ask members about their tobacco use at each visit and track data in the member's medical record.

Appendix D: Milestone Specifications & Protocol

IMPROVE OUTCOMES FOR MEMBERS WITH HYPERTENSION
MILESTONE SPECIFICATIONS

I. Hypertension Registry Enrollment

A. Description

Enroll in the Hypertension Registry Members aged 18-85 with a Hypertension Diagnosis that have an Encounter with a Network Provider during the Data Entry Year.

B. Data Source

Claims and/or Electronic Health Record (EHR) Data.

C. Unit of Measurement

Individuals

D. Definitions

1. Data Entry Year: The data entry year is a twelve-month period, beginning on January 1. The first data entry year (January 1 – December 31, 2020) will constitute the Hypertension Registry Baseline. Each subsequent data entry year will be compared to the Baseline.

2. Encounter: An Encounter includes any face-to-face inpatient or outpatient hospital encounter (including emergency department and observation visits), office visit, clinic visit, face-to-face interaction, annual wellness visit, preventative care visit, or lab visit. Encounters do not include x-ray visits, allergy shot visits, or vaccination visits. If the Encounter is longer than one day, calculate encounter date based on discharge date.

3. Facilities: The Facility is the site of service (e.g., hospital, clinic, freestanding emergency department, physician's office) where the Member received care within the Network Provider's system. For example, if a Network Provider's system includes General Hospital, Center Clinic, and West Clinic, the Facility for a Member would be one of those three sites of service.

4. Hypertension Diagnosis: Members with the following ICD–10–CM code for Essential Hypertension (not limited to primary diagnosis): I10

5. Measurement Periods

   - Data Entry Year 1: Baseline – CY2020
   - Data Entry Year 2: CY2021
   - Data Entry Year 3: CY2022
   - Data Entry Year 4: CY2023

6. Member: A Member is a patient enrolled in the Healthy Louisiana program at the time of the Member's Encounter with a Network Provider.

7. Member Age: Members 18-85 years of age, based on Encounter date during the Data Entry Year. If the Encounter is longer than one day, calculate age based on discharge date.

8. Network Provider: The Network Provider is the health system that has requested and been approved by the Participating Louisiana Medicaid Managed Care Organizations or their designee to participate in the Hypertension project as part of the Louisiana Managed Care Incentive Payment Program. The Network Provider includes all facilities (e.g., hospital, clinic, freestanding emergency department, physician's office) within the Network Provider's health system.

E. Encounters and Data Fields (as defined by the Hypertension Registry protocol)

For Members enrolled in the Hypertension Registry, report all Encounters and blood pressure readings in each Data Entry Year with the following information:

1. Network Provider
2. Unique Medicaid Identification Number (Assigned Patient Medicaid ID #)
3. Unique System Identification Number for Patient not unique to visit (e.g., Medical Record Number)
4. First Name
5. Last Name
6. DOB
7. Gender
8. Zip Code
9. PMCO (the MCO in which Patient is a Member)
10. Facility (site of service, e.g., hospital, clinic, freestanding emergency department, physician's office)
11. Encounter Identification Number
12. Admission Date
13. Discharge Date
14. Hypertension/High Blood Pressure Dx Code(s)
15. Hypertension/High Blood Pressure Dx Description
16. Systolic Blood Pressure(s)
17. Diastolic Blood Pressure(s)
18. Date of Blood Pressure Reading(s)
19. Race
20. Tobacco Use
21. Member Participation in Activities Designed to Improve BP Control

F. Performance Calculation

For each Data Entry Year, Network Providers will include all Members that met the requirements for enrollment and were enrolled in the Hypertension Registry during the Data Entry Year.

The baseline will be comprised of the number of Members enrolled in the Hypertension Registry for Data Entry Year 1. In the following years (Data Entry Years 2-4) the percentage increase/decrease of total enrollment in the Hypertension Registry will be calculated as follows:

$$\big((new\ value - old\ value) \div old\ value\big) \times 100 = percentage\ increase\ or\ decrease$$

G. Additional Guidance

Network Providers must enroll all Members that have at least two Encounters with the Network Provider during the Data Entry Year and the 12-month period prior to the Data Entry Year. At least one of the Encounters must have taken place during the Data Entry Year. A laboratory visit is not an eligible encounter for determining whether a Member meets the above criteria.

Network Providers may limit Hypertension Registry enrollment to certain sites (i.e., emergency departments, clinics, inpatient or outpatient, etc.). Once selected, Network Providers must continue to enroll Members from these sites in all Data Entry Years.

If multiple blood pressure readings occur during an Encounter, enter into Registry the last systolic and diastolic readings performed during the Encounter

Network Providers may exclude the following individuals from the Registry:

- Member was pregnant during the Data Entry Year
- Member has a diagnosis of end stage renal disease during the Data Entry Year
- Member received hospice services during the Data Entry Year
- Member resided in a long term care facility during the Data Entry Year

Network Providers **must** deceased members from the Registry.

If the Network Provider elects to apply optional exclusions, the Network Provider must continue the same exclusions in all Data Entry Years. The Network Provider shall identify elected exclusions during the first Data Entry Year.

II. Controlling High Blood Pressure (Members Aged 18-59)

A. Description

Increase the percentage of Members ages 18-59 enrolled in the Hypertension Registry whose blood pressure was adequately controlled (<140/90).

B. Data Source

Hypertension Registry

C. Unit of Measurement

Individuals

D. Definitions

1. Data Entry Year: The data entry year is a twelve-month period, beginning on January 1. The first data entry year (January 1 – December 31, 2020) will constitute the Hypertension Registry Baseline. Each subsequent data entry year will be compared to the Baseline.

2. Encounter: An Encounter includes any face-to-face inpatient or outpatient hospital encounter (including emergency department and observation visits), office visit, clinic visit, face-to-face interaction, annual wellness visit, preventative care visit, or laboratory visit. Encounters do not include x-ray visits, allergy shot visits, or vaccination visits. If the Encounter is longer than one day, calculate encounter date based on discharge date.

3. Facilities: The Facility is the site of service (e.g., hospital, clinic, freestanding emergency department, physician's office) where the Member received care within the Network Provider's system. For example, if a Network Provider's system includes General Hospital, Center Clinic, and West Clinic, the Facility for a Member would be one of those three sites of service.

4. Measurement Periods:

   - Data Entry Year 1: Baseline – CY2020
   - Data Entry Year 2: CY2021
   - Data Entry Year 3: CY2022
   - Data Entry Year 4: CY2023

5. Member: A Member is a patient enrolled in the Healthy Louisiana program at the time of the Member's Encounter with a Network Provider.

6. Member Age: Members 18-59 years of age on the last Encounter of the Data Entry Year. If Encounter is longer than one day, calculate age based on discharge date.

7. Network Provider: The Network Provider is the health system that has requested and been approved by the Participating Louisiana Medicaid Managed Care Organizations or their designee to participate in the Hypertension project as part of the Louisiana Managed Care Incentive Payment Program. The Network Provider includes all facilities (e.g., hospital, clinic, freestanding emergency department, physician's office) within the Network Provider's health system.

E. Denominator

Members 18-59 years of age on the last Encounter date during the Data Entry Year who are enrolled in the Hypertension Registry with at least one documented systolic and diastolic blood pressure reading.

Required Denominator Exclusions:

- Exclude Members who had fewer than two Encounters with Network Providers over a 24-month period ending on the last day of the Data Entry Year. Laboratory visits and self-reported blood pressure readings are not eligible encounters for determining whether a Member meets the above criteria.
- Exclude deceased Members.

F. Numerator

The numerator is comprised of Members included in the denominator whose blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the Data Entry Year.

G. Performance Calculation

Calculate the percentage of Members whose blood pressure was adequately controlled by dividing the Numerator by the Denominator.

H. Additional Guidance

The Numerator under II.F shall be based on the median calculation of systolic blood pressure readings and diastolic blood pressure readings during the Data Entry Year and recorded in the Registry. Systolic blood pressure readings and diastolic blood pressure readings should be reported separately.

For purposes of calculating the median blood pressure rates for this milestone, Network Providers may include patient's self-reported blood pressure readings, as long as the reading is documented in the patient's medical record.

III. Controlling High Blood Pressure (Members Aged 60-85)

A. Description

Increase the percentage of Members aged 60-85 enrolled in the Hypertension Registry whose blood pressure was adequately controlled (<150/90).

B. Data Source

Hypertension Registry

C. Unit of Measurement

Individuals

D. Definitions

1. Data Entry Year: The data entry year is a twelve-month period, beginning on January 1. The first data entry year (January 1 – December 31, 2020) will constitute the Hypertension Registry Baseline. Each subsequent data entry year will be compared to the Baseline.

2. Encounter: An Encounter includes any face-to-face inpatient or outpatient hospital encounter (including emergency department and observation visits), office visit, clinic visit, face-to-face interaction, annual wellness visit, preventative care visit, or laboratory visit. Encounters do not include x-ray visits, allergy shot visits, or vaccination visits. If the Encounter is longer than one day, calculate encounter date based on discharge date.

3. Facilities: The Facility is the site of service (e.g., hospital, clinic, freestanding emergency department, physician's office) where the Member received care within the Network Provider's system. For example, if a Network Provider's system includes General Hospital, Center Clinic, and West Clinic, the Facility for a Member would be one of those three sites of service.

4. Measurement Periods
   - Data Entry Year 1: Baseline – CY2020
   - Data Entry Year 2: CY2021
   - Data Entry Year 3: CY2022
   - Data Entry Year 4: CY2023

5. Member: A Member is a patient enrolled in the Healthy Louisiana program at the time of the Member's Encounter with a Network Provider.

6. Member Age: Members 60-85 years of age on the last Encounter date of the Data Entry Year. If Encounter is longer than one day, calculate age based on discharge date.

7. Network Provider: The Network Provider is the health system that has requested and been approved by the Participating Louisiana Medicaid Managed Care Organizations or their designee to participate in the Hypertension project as part of the Louisiana Managed Care Incentive Payment Program. The Network Provider includes all facilities (e.g., hospital, clinic, freestanding emergency department, physician's office) within the Network Provider's health system.

E. Denominator

Members 60-85 years of age on the last Encounter date during the Data Entry Year who are enrolled in the Hypertension Registry with at least one documented systolic and diastolic blood pressure reading.

Required Denominator Exclusions:

- Exclude Members who had fewer than two Encounters with Network Providers over a 24-month period ending on the last day of the Data Entry Year. Laboratory visits and patient self-reported blood pressure readings are not eligible encounters for determining whether a Member meets the above criteria.
- Exclude deceased Members.

F. Numerator

The Numerator is comprised of Members included in the denominator whose blood pressure is adequately controlled (systolic blood pressure < 150 mmHg and diastolic blood pressure < 90 mmHg) during the Data Entry Year.

G. Performance Calculation

Calculate the percentage of Members whose blood pressure was adequately controlled by dividing the Numerator by the Denominator.

H. Additional Guidance

The Numerator under III.F shall be based on the median calculation of systolic blood pressure readings and diastolic blood pressure readings during the Data Entry Year and recorded in the Registry. Systolic blood pressure readings and diastolic blood pressure readings should be reported separately.

For purposes of calculating the median blood pressure rates for this milestone, Network Providers may include patient's self-reported blood pressure readings, as long as the reading is documented in the patient's medical record.

LOUISIANA MEDICAID MANAGED CARE ORGANIZATION
HYPERTENSION REGISTRY PROTOCOL

Issue Date: 06/30/2019 Number: 8
Date(s) Revised: 9/30/2019; 10/11/2019; 1/15/2020, 1/31/2020, 2/4/2020; 9/29/2020; 6/24/2021; 3/22/2022

PURPOSE:

1. To comply with national quality measure sets as metrics for evaluation of care provided to patients with hypertension. These measure sets contain key health indicators supported by evidence to facilitate optimal patient outcomes and evaluate provider performance with implementation.
2. To establish guidelines for the collection and dissemination of provider performance data in order to create a hypertension and blood pressure control registry database for members and improve population health management.

GOAL: To measure and improve rates of controlled blood pressure (<140/90 for ages 18-59; <150/90 for ages 60-85) for hypertensive Louisiana Medicaid managed care enrollees.

DEFINITIONS:

Baseline – The Baseline refers to the twelve-month period used to compare improvements achieved in subsequent years of the registry use. The Baseline period will be January 1 – December 31, 2020.

Data Entry Year – The data entry year is a twelve-month period, beginning on January 1, 2020. The first data entry year (January 1 – December 31, 2020) will constitute the hypertension registry Baseline. Each subsequent data entry year will be compared to the Baseline.

Encounter Identification Number (ID) – This number refers to a unique identification number assigned by a facility for each patient encounter performed at the facility.

Facility – The facility is the site of service (e.g. hospital, clinic, freestanding emergency department, physician's office) where the patient received care within the Provider's system. For example, if a Provider's system includes General Hospital, Center Clinic, and West Clinic, the facility for a patient would be one of those three sites of service.

Louisiana Medicaid Managed Care Organization (LMCO) – An LMCO is a Medicaid managed care organization contracted with the state of Louisiana to deliver Medicaid health benefits and services to the Medicaid population.

Patient Medicaid Managed Care Organization (PMCO) – A PMCO is the specific LMCO that a patient is enrolled with for the time period reported in the registry. All records must have a specific PMCO listed for each patient at the time of the encounter. The registry should only include patients enrolled with an LMCO.

Provider – The Provider is the healthcare entity contracted with an LMCO or LMCO designee (jointly "MCO") that is participating in the Louisiana Managed Care Incentive Payment Program.

System – All facilities under common ownership and/or control of the Provider and all affiliated entities.

Unique Medicaid Identification Number – This number refers to the 13-digit Medicaid ID number assigned by the State to all Louisiana Medicaid patients. This number is unique to each patient and remains consistent across all Providers and PMCOs.

PROTOCOL:

I. Registry Implementation

A. Each Provider must designate someone within its system who will be responsible for overseeing the Hypertension Registry creation, maintenance, and necessary data entry (Hypertension Registry Administrator).

B. Each Provider must notify MCO no later than August 1, 2019 of the name and title of the Hypertension Registry Administrator. If a Provider later changes the person designated as the Hypertension Registry Administrator, the Provider must notify MCO of this change within thirty (30) calendar days.

C. Beginning on January 1, 2020, each Provider must maintain a registry of all patients enrolled with an LMCO treated in the Provider's system and diagnosed with hypertension. The registry should include the following data fields:

   a. Network Provider
   b. Unique Medicaid Identification Number (Assigned Patient Medicaid ID #)
   c. Unique System Identification Number for Patient not unique to visit (e.g. Medical Record Number)
   d. First Name
   e. Last Name
   f. DOB
   g. Gender
   h. Zip Code
   i. PMCO
   j. Facility
   k. Encounter Identification Number
   l. Admission Date
   m. Discharge Date
   n. Hypertension/High Blood Pressure Dx Code(s)
   o. Hypertension/High Blood Pressure Dx Description
   p. Systolic Blood Pressure
   q. Diastolic Blood Pressure
   r. Date(s) of Blood Pressure Reading
   s. Race
   t. Tobacco Use
   u. Member Participation in Activities Designed to Improve BP Control

D. For each hypertensive LMCO enrollee added to the registry, the Provider must include a record of each encounter the patient has within the Provider's system during the Data Entry Year.

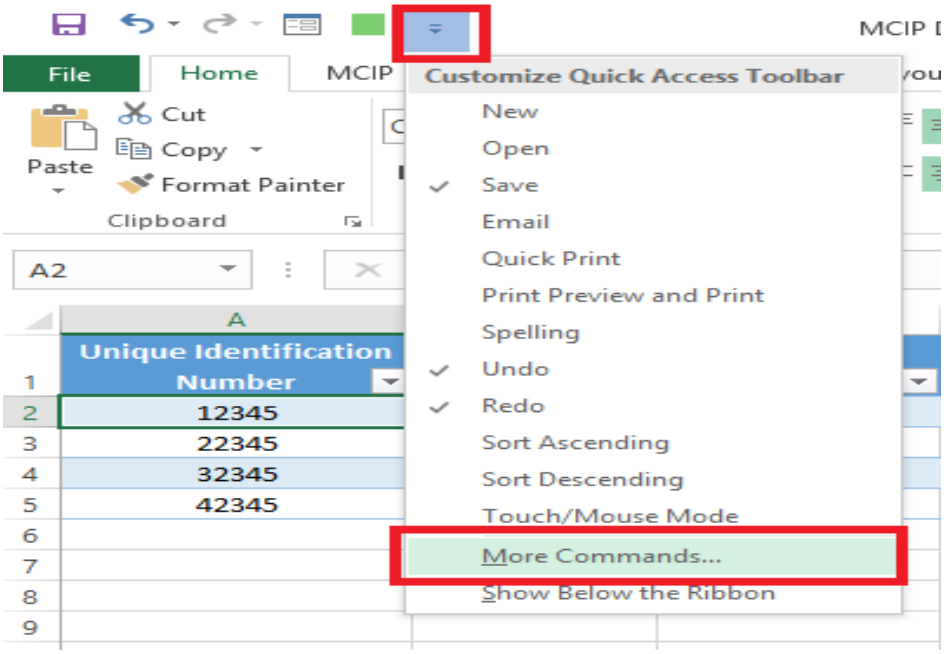
E. Providers with an electronic health record (EHR) may utilize the existing recordkeeping to compile this data, assuming the Provider's EHR has the data capabilities to track each data field listed in I.C.

F. Each Provider that does not have an EHR or whose EHR cannot track the necessary data fields or who prefers to use a manual registry must request a Hypertension Registry template from MCO (reporting@lamcip.org). MCO will send the Provider a Hypertension Registry template in a ready-to-use Microsoft Excel file within seven (7) days of the Provider's request.

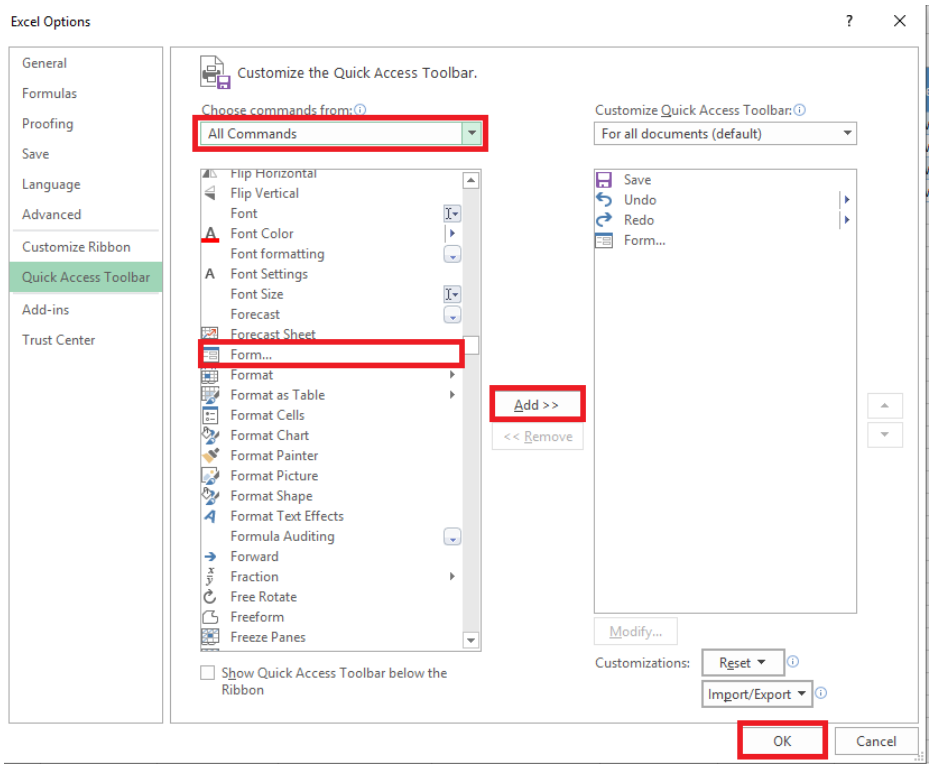
G. There are two methods to add a new patient encounter to the Hypertension Registry template.

a. Line Entry – Each row in the template will hold data for an individual patient encounter. Click in the cell where the Provider wants to add data, and fill in each column in that row with the patient's data.

b. Form Entry
   i. Click on a cell in Row 2 that includes the sample data.
   ii. Add the Form icon to the quick access toolbar by clicking on the small arrow in the top left corner.
   iii. Then choose "More Commands."



   iv. Choose "All Commands" from the dropdown menu.
   v. Then choose "Form" from the list of commands and click "Add." Then click "Ok."



vi. Click on the "Form" icon on the quick access toolbar at the top left of the MS Excel spreadsheet. (The Provider will only need to go through the process of adding the "Form" icon to the quick access toolbar once. After saving the file, the "Form" icon should be present every time the Provider opens the file.)

vii. Excel will display a grey Form that lists the data fields with boxes to enter the data for each patient.

viii. To begin a record for a patient, click "New" in the upper right corner of the box.

ix. After entering the Unique Identification Number, use the Tab key to move to the next data field. Once all data fields are complete, click the Enter key on your keyboard to complete the entry process for this record.

x. After completing one entry, a new, blank form will appear. If you need to enter another record, begin entering the data. If you want to close the form, click "Close" or the X in the top right corner of the Form box.

xi. If you need to move between the records to revise the data, use the "Find Prev" or "Find Next" buttons. Alternatively, if the Form box is closed, you can revise data by clicking in the cell and entering the revised entry/value.

II. Registry Maintenance

A. For the first Data Entry Year, the Hypertension Registry Administrator will review the registry each month to ensure the data is entered and maintained appropriately. The Hypertension Registry Administrator should also review to ensure that deceased members are removed from the registry. If the Hypertension Registry Administrator identifies gaps or errors in the data entry, the Hypertension Registry Administrator will work to correct those gaps or errors within seven (7) days. The Hypertension Registry Administrator must maintain a record of changes made to the Provider's standard data entry processes as a result of this monthly review.

B. For each subsequent Data Entry Year, the Hypertension Registry Administrator will review the registry no less than quarterly to ensure the data is entered and maintained appropriately. If the Hypertension Registry Administrator identifies gaps or errors in the data entry, the Hypertension Registry Administrator will work to correct those gaps or errors within thirty (30) days. The Hypertension Registry Administrator will maintain a record of changes made to the Provider's standard data entry processes as a result of this quarterly review.

III. Registry Submission

A. In each subsequent Data Entry Year, MCO shall request a report of registry data for all hypertension patients enrolled with an LMCO at least annually but no more than quarterly. MCO shall give Providers at least ten (10) business days to compile the data requested, and the request will include the specific date range that Provider should include in their data. Providers will submit the data to MCO (contact email from I.F.).

B. Providers with an EHR may submit a data pull from their EHR in a searchable excel or Microsoft Access file that includes all data fields listed in I.C.

C. Providers using the Hypertension Registry template will submit a completed template.

IV. HIPAA Compliance

A. Each Provider must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and the privacy and security rules promulgated thereunder (collectively "HIPAA").

B. When submitting data to MCO, each Provider must submit the Protected Health Information (PHI) via secure means.

    a. If the Provider has the technological capabilities to send a secure file to MCO through the Provider's own secure platform that is an acceptable method. This platform must require the MCO recipient to access the data through a unique password associated with the MCO recipient's email address.

    b. Alternatively, a Provider may request a secure upload link from MCO (contact email from I.F.). After receiving a request, MCO will send the secure upload link within two (2) business days.

V. Registry Analysis

A. After MCO receives the twelve-month data pulls/completed registries from each Provider, MCO will aggregate the data and prepare analyses for review. The analyses for the first Data Entry Year will constitute the Baseline for comparing to future years' data and assessing progress toward overall improvement goals. These analyses will include:

   a. Blood Pressure Control for Members ages 18-59 (<140/90)
      i. Numerator – number of hypertensive LMCO enrollees ages 18-59 with systolic blood pressure less than 140 AND diastolic blood pressure less than 90.
      ii. Denominator – total number of hypertensive LMCO enrollees in the registry ages 18-59 with at least one documented systolic and diastolic blood pressure reading.

   b. Blood Pressure Control for Members' ages 60-85 (<150/90)
      i. Numerator – number of hypertensive LMCO enrollees ages 60-85 with systolic blood pressure less than 150 AND diastolic blood pressure less than 90.
      ii. Denominator – total number of hypertensive LMCO enrollees in the registry ages 60-85 with at least one documented systolic and diastolic blood pressure reading.

B. MCO will review the analyses and identify action items to improve hypertensive LMCO enrollees' blood pressure control.

C. MCO will submit Provider-specific analyses to each Provider, with the data broken out for rates attributable to each LMCO, based on the Provider's twelve-month data submitted to MCO.

D. After the Louisiana Department of Health (LDH) determines improvement goals for the subsequent twelve-month period, MCO will communicate with each Provider regarding the action items MCO identified for improving hypertensive LMCO enrollees' blood pressure control along with the improvement goals for the subsequent twelve-month period (e.g. reduce the number of LMCO enrollees with systolic blood pressure over 140 AND diastolic blood pressure over 90 by 5%).

VI. Provider Application of Registry Functionality

A. During the Baseline year, each Provider should assess the possible added functionality that could be included in the registry in subsequent Data Entry Years in order to increase the likelihood of successfully improving patients' hypertension management. The added functionality could include:

   a. Alerts or notifications that will flag for follow up when patients fall into specific categories such as when a patient is due for a blood pressure reading.

   b. Periodic analyses that will assist Providers in identifying patients that need additional assistance in order to manage their blood pressure control.

   c. Additional next steps and patient education necessary to improve patients' self-management of their disease.

B. At the end of the Baseline year, each Provider that identified possible beneficial additions to the registry's functionality must submit a list to MCO.

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Appendix E: February CQI Workshop

AGENDA
MCIP HYPERTENSION
CONTINUOUS QUALITY IMPROVEMENT (CQI) WORKSHOP
FEBRUARY 23, 2022
(VIA ZOOM | 2:00PM – 4:00PM)

TIME	PRESENTER
1:45pm – 2:00pm	• ***Login (including technical troubleshooting)***
2:00pm – 2:05pm	• ***Opening Remarks*** o Quality and Outcome Improvement Network, Inc.
PART I: PROJECT IMPACTS AND EVALUATION	
2:05pm – 2:10pm	• ***Ochsner LaFayette General: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures*** o Tena Turnage, RN, Manager Clinic Operations Ochsner Abrom Kaplan Memorial Hospital Ochsner Acadia General Hospital Ochsner Lafayette General Ochsner St. Martin Hospital Ochsner University Hospital and Clinics
2:10pm – 2:15pm	• ***Iberia: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures*** o Meagan Trahan, RN, Care Manager Iberia Medical Center
2:15pm – 2:20pm	• ***Milestone 3.1 Activity Impacts to Address Treatment Gaps*** o Penny Hutson, CFO PRN, HCA MidAmerica Division Rapides Regional Medical Center Tulane University Hospital and Clinic
2:20pm – 2:25pm	• ***Addressing Project Implementation Barriers in the Hypertension Project*** o Shelly Martinez, Administrative Director – Clinical Quality Baton Rouge General Medical Center The General Hospital
PART II: LESSONS LEARNED	
2:25pm – 2:30pm	• ***Opelousas: Lessons Learned to Date*** o Tim Marks, RN, Chief Population Health & Clinical Integration Officer o Marsha Gauthier, RN, Population Health Opelousas General
2:30pm – 2:35pm	• ***North Caddo: Lessons Learned to Date*** o Michele Heflin, LPN, Clinical Integration Specialist North Caddo Medical Center
2:35pm – 2:40pm	• ***CHRISTUS Health: Lessons Learned to Date*** o Nathan Kawamura, Data Analytics Engineer, Information Services CHRISTUS Coushatta Health Care Center CHRISTUS Health Shreveport-Bossier CHRISTUS Ochsner Lake Area Hospital CHRISTUS Ochsner St. Patrick Hospital CHRISTUS St. Frances Cabrini Hospital Savoy Medical Center

TIME	PRESENTER
PART III: AREAS OF IMPROVEMENT	
2:40pm – 2:45pm	• ***Hypertension Registry Updates and Recommended Registry Improvements*** o Tina Faulk, BSN, RN, CDCES, MCIPs/Diabetes Program Coordinator Abbeville General Hospital
2:45pm – 2:50pm	• ***Patient Participation and Ideas to Improve Patient Engagement*** o Kandace Fontenot, MHA, Director of Clinical Informatics and Information Systems Allen Parish Hospital
2:50pm – 2:55pm	• ***Ideas to Improve the Hypertension Project*** o Cameron Jenkins, MBA, Clinical Quality Coordinator, STQN St. Tammany Parish Hospital
2:55pm – 3:00pm	BREAK
PART IV: PROJECT EXPANSION & REPLICATION	
3:00pm – 3:20pm	• ***Best Practices That May Be Adopted by Other Network Providers or Replicated in other Projects*** o Susan Montz, AVP Performance Improvement, Care Management Ochsner LSU Health Monroe Ochsner LSU Health Shreveport Ochsner Medical Center, Ochsner Medical Center – Baton Rouge Ochsner Medical Center – Kenner Ochsner Medical Center – North Shore Ochsner St. Anne General Hospital Ochsner St. Mary Slidell Memorial Hospital Southern Regional Medical Corporation St. Bernard Parish Hospital St. Charles Parish Hospital Terrebonne General Medical Center
3:20pm – 3:25pm	• ***Expanding Hypertension Project Activities to New Populations*** o Jeanine Thibodeaux, RN, Administrator Pointe Coupee General Hospital
PART V: PROJECT PROGRESS AND UPDATES	
3:25pm – 3:40pm	• ***2021 in Review and Expectations for 2022*** o Lillian Spuria, Gjerset & Lorenz, LLP
PART VI: CONCLUSION	
3:40pm – 3:55pm	• ***Group Discussion/Questions & Answers Session*** o All Network Providers
3:55pm – 4:00pm	• ***Closing Remarks*** o Lillian Spuria, Gjerset & Lorenz, LLP

****Please note: the next Hypertension CQI workshop is scheduled for April 20, 2022 at 2 p.m.****

MANAGED CARE INCENTIVE PAYMENT PROGRAM

HYPERTENSION CONTINUOUS QUALITY IMPROVEMENT ("CQI") PLAN VIRTUAL WORKSHOP MINUTES

FEBRUARY 23, 2022

I. INTRODUCTIONS

Opening Remarks
(QIN) Quality and Outcome Improvement Network, Inc.

QIN opened the CQI workshop by welcoming everyone and commending the Network Providers for doing a great job on their data submissions. QIN gave a brief overview of workshop discussion topics, which included project impacts and evaluation, lessons learned, areas of improvement, and project expansion & replication. QIN finished the introduction by introducing the first topic of discussion: project impacts and evaluation.

II. PROJECT IMPACTS AND EVALUATION

Ochsner Lafayette General: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures
Tena Turnage, RN, Manager Clinic Operations
Ochsner Abrom Kaplan Memorial Hospital
Ochsner Acadia General Hospital
Ochsner Lafayette General
Ochsner St. Martin Hospital
Ochsner University Hospital and Clinics

Ms. Tena Turnage from Ochsner Lafayette General focused her presentation on project impacts on the delivery of care and hospital procedures. She began her presentation by discussing the education in place for staff and providers. Ochsner Lafayette General provided guidelines to staff and providers to follow for taking a blood pressure measurement. Ms. Turnage also mentioned that they offered pamphlets to patients for healthy diets and implemented Social Determinants of Health (SDOH) assessments and education. These education pieces were essential to the delivery of care for Ochsner Lafayette General.

Ms. Turnage finished her presentation by documenting the challenges of recording and controlling blood pressure in their patients. One key challenge discussed was that very few patients were able to monitor blood pressures at home and report readings to navigators. Patients are not able to monitor blood pressure at home due to not having a monitor and some pharmacies do not have monitors due to COVID. The biggest challenge for most providers has been COVID. It has been difficult for many providers to obtain blood pressure readings through telemedicine.

Iberia: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures
Meagan Trahan, RN, Care Manager
Iberia Medical Center

Ms. Meagan Trahan from Iberia Medical Center also focused on the project impacts on the delivery of care and hospital procedures. Like Ochsner Lafayette General, Ms. Trahan discussed that Iberia focused attention on dietary education and improvements to blood pressure documentation. She mentioned that Iberia worked to create an itemized dietary shopping list for patients with specific cases. As for blood pressure documentation, Ms. Trahan also stated that Iberia's IT department was working to include a documentation prompt into their system.

Milestone 3.1 Activity Impacts to Address Treatment Gaps
Penny Hutson, CFO PRN, HCA MidAmerica Division
Rapides Regional Medical Center
Tulane University Hospital and Clinic

Ms. Penny Hutson from Rapides Regional and Tulane University Hospital focused her presentation on Milestone 3.1 Activity Impacts to Address Treatment Gaps. Ms. Hutson stated that both Rapides and Tulane implemented telemedicine services for patients, which became a valuable and effective tool during the COVID spike. Ms. Hutson also discussed that telemedicine offered providers an opportunity to become more engaged with their patients by addressing questions and having more frequent interactions. She mentioned that providers focused on discussing medication adherence and blood pressure control with patients during the telemedicine visits.

Addressing Project Implementation Barriers in the Hypertension Project
Shelly Martinez, Administrative Director – Clinical Quality
Baton Rouge General Medical Center
The General Hospital

Ms. Shelly Martinez from Baton Rouge General Medical Center (BRGMC) focused her discussion on addressing project implementation barriers in the hypertension project. The main talking point that Ms. Martinez focused on was blood pressure workflow and documentation. She described the workflow process to include documenting each patient's blood pressure and based on the results, implementing a follow-up plan with the patient. However, Ms. Martinez noted that BRGMC faced implementation barriers because in some instances providers failed to recheck or document a patient's blood pressure reading during a follow-up visit. To address this issue, BRGMC implemented regular provider education to improve and standardize blood pressure reading documentation across the health system.

III. LESSONS LEARNED

Opelousas: Lessons Learned to Date
Tim Marks, RN, Chief Population Health & Clinical Integration Officer
Marsha Gauthier, RN, Population Health

Opelousas General

Ms. Marsha Gauthier from Opelousas General focused her presentation on the lessons learned to date. She began by discussing several challenges that Opelousas faced including COVID, staff turnover, and electronic health record (EHR) conversion. These challenges impacted reporting and documentation for Opelousas' hypertension project. However, Opelousas is addressing these challenges through provider education and engagement to increase awareness and understanding of the hypertension project.

North Caddo: Lessons Learned to Date
Michele Heflin, LPN, Clinical Integration Specialist
North Caddo Medical Center

Ms. Michele Heflin from North Caddo focused her presentation on lessons learned regarding the hypertension registry. North Caddo initially faced challenges extracting data from their EHR system to input into the registry and documenting all required registry data elements. However, she mentioned that with the implementation and use of All Scripts at North Caddo, inputting, maintaining, and tracking patient data in the hypertension registry has improved. The new software allowed North Caddo to filter patient data more effectively and efficiently. Ms. Heflin finished her presentation by discussing how North Caddo has added a SDOH questionnaire into each patient's chart.

CHRISTUS Health: Lessons Learned to Date
Nathan Kawamura, Data Analytics Engineer, Information Services
CHRISTUS Coushatta Health Care Center
CHRISTUS Health Shreveport-Bossier744440
CHRISTUS Ochsner Lake Area Hospital
CHRISTUS Ochsner St. Patrick Hospital
CHRISTUS St. Frances Cabrini Hospital
Savoy Medical Center

Mr. Nathan Kawamura from CHRISTUS Health focused his presentation on lessons learned to date regarding data reporting. Mr. Kawamura discussed challenges CHRISTUS Health faced during initial data submission in support of clinical measure reporting. He noted that in the beginning, data was inputted into the registry incorrectly and staff faced technical challenges with excel software. He noted that CHRISTUS Health appreciated receiving feedback on their registry data during interim reviews and receiving extra time to make corrections and finalize the registry data submission. Mr. Kawamura ended his presentation by discussing possible solutions for the future, which included giving providers extra time to gather data and submit to the ShareFile website.

IV. AREAS OF IMPROVEMENT

Hypertension Registry Updates and Recommended Registry Improvements
Tina Faulk, BSN, RN, CDCES, MCIPs/Diabetes Program Coordinator
Abbeville General Hospital

Ms. Tina Faulk from Abbeville General focused her presentation on updates and recommended registry improvements. Ms. Faulk discussed unique challenges faced by smaller hospitals regarding the ability to extract data from the EHR system. She noted that more work and investments are needed to help smaller hospitals optimize their data registries. Ms. Faulk mentioned that it helped to test the system before the data was pulled. Ms. Faulk concluded her remarks by presenting recommendations to improve the hypertension registry. Ms. Faulk recommended removing the race/ethnicity column from the hypertension registry because she believed this field was not as an important. She also recommended adding BMI (body mass index) data to the registry, which would help to prompt patient education on healthy living.

Patient Participation and Ideas to Improve Patient Engagement
Kandace Fontenot, MHA, Director of Clinical Informatics and Information Systems
Allen Parish Hospital

Ms. Kandace Fontenot from Allen Parish Hospital focused her presentation on patient participation and ideas to improve patient engagement. Ms. Fontenot discussed Allen Parish's multi-pronged approach to engage patients, which includes identifying high-risk patients in need of additional engagement, educating providers on how to collaborate with the patients in a culturally competent manner, interacting with the patient on a regular basis, and removing barriers to patient care. With focus on these factors and communication, Allen Parish was able to decrease their hospitalizations by 66%. Allen Parish's overall goal to improve patient engagement was to minimize barriers to care to allow patients to receive the attention they need.

Ideas to Improve the Hypertension Project
Cameron Jenkins, MBA, Clinical Quality Coordinator, STQN
St. Tammany Parish Hospital

Mr. Cameron Jenkins from St. Tammany Parish Hospital focused his presentation on ideas to improve the hypertension project. He mentioned that St. Tammany focused on implementing a digital medicine program to monitor patient blood pressure control more easily and to implement follow up care and patient education as needed. For in-person visits, St. Tammany makes sure to check a patient's blood pressure at every visit and if the initial blood pressure reading is elevated, a second reading is performed at the end of the visit. If the blood pressure reading remains elevated at the second reading, St. Tammany schedules a follow-up visit within two weeks to inform whether blood pressure medication should be prescribed.

V. PROJECT EXPANSION & REPLICATION

Best Practices That May Be Adopted by Other Network Providers or Replicated in other Projects
Susan Montz, AVP Performance Improvement, Care Management
Ochsner LSU Health Monroe
Ochsner LSU Health Shreveport
Ochsner Medical Center, Ochsner Medical Center – Baton Rouge
Ochsner Medical Center – Kenner
Ochsner Medical Center – North Shore
Ochsner St. Anne General Hospital
Ochsner St. Mary
Slidell Memorial Hospital
Southern Regional Medical Corporation
St. Bernard Parish Hospital
St. Charles Parish Hospital
Terrebonne General Medical Center

Ms. Susan Montz from Ochsner Health presented best practices implemented by Ochsner to improve care for patients with hypertension. The best practices include: (1) following the "Measure Up Pressure Down" protocol when measuring a patient's blood pressure to optimize blood pressure reading accuracy; (2) making sure to schedule a follow-up appointment before a patient leaves an appointment; (3) following the Primary Care Hypertension Guideline Algorithm, which outlines treatment steps for patients presenting with uncontrolled blood pressure; and (4) enrolling patients into the Digital Medicine Hypertension Program.

Expanding Hypertension Project Activities to New Populations
Jeanine Thibodeaux, RN, Administrator
Pointe Coupee General Hospital

Ms. Jeanine Thibodeaux from Pointe Coupee focused on expanding the hypertension project activities to new populations. Ms. Thibodeaux believed that it would be beneficial to reach a younger population. She mentioned that children with unhealthy higher weights and who lack exercise tend to have more cases of hypertension. Ms. Thibodeaux believes reaching these kids at a younger age would help to prevent onset of hypertension in this population.

VI. PROJECT PROGRESS AND UPDATES

2021 in Review and Expectations for 2022
QIN

QIN discussed the overall objective of the hypertension project within MCIP and laid out the continuous quality improvement (CQI) plan. The plan consists of project impacts, necessary hypertension registry modifications, lessons learned, opportunities to expand the program, and key challenges with project expansion. The

hypertension project uses the plan-do-study-act (PDSA) model for testing change -- by planning it, trying it, observing the results, and acting on what is learned. The hypertension project PDSA focus areas include increasing registry enrollment, improving health outcomes, impacting root causes of hypertension and poor blood pressure control, addressing treatment gaps, and identifying and implement registry modifications.

QIN then discussed CY2021 milestone achievement and next steps for CY2022. QIN mentioned that the network met 100% of its goal for member enrollment, 89.05% of its goal for adequate blood pressure control for ages 18-59, and 58.81% of its goal for adequate blood pressure control for ages 60-85. For CY2022, QIN addressed what activities implemented by Network Providers to improve blood pressure control for registry members with hypertension. QIN concluded the presentation by reminding the Network Providers about the upcoming continuous education events in April and May.

VII. CONCLUSION

Closing Remarks
QIN

QIN concluded the CQI workshop by thanking each of the Network Providers for their attendance. QIN commended them on their hard work and insights during the workshop.

#220501

Louisiana MCIP Hypertension Project

Continuing Quality Improvement ("CQI") Workshop

February 23, 2022

- Network Providers to discuss:
  - Project impacts and evaluation
  - Lessons Learned
  - Areas of Improvement
  - Project Expansion & Replication

- Project Progress and Updates
  - 2021 in Review
  - Expectations for 2022

- Group Discussion/Questions & Answers

Goals for Today's CQI Meeting

Ochsner Lafayette General: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures

- Tena Turnage, RN, Manager Clinic Operations
  - Ochsner Abrom Kaplan Memorial Hospital
  - Ochsner Acadia General Hospital
  - Ochsner Lafayette General
  - Ochsner St. Martin Hospital
  - Ochsner University Hospital and Clinics

Iberia: Hypertension Project Impacts on the Delivery of Care and Hospital Procedures

- Meagan Trahan, RN, Care Manager
  - Iberia Medical Center

Milestone 3.1 Activity Impacts to Address Treatment Gaps

- Penny Hutson, CFO PRN, HCA MidAmerica Division
  - Rapides Regional Medical Center
  - Tulane University Hospital and Clinic

Addressing Project Implementation Barriers in the Hypertension Project

- Shelly Martinez, Administrative Director – Clinical Quality
  - Baton Rouge Medical Center
    - The General Hospital

Opelousas: Lessons Learned to Date

- Tim Marks, RN, Chief Population Health & Clinical Integration Officer
- Marsha Gauthier, RN, Population Health
  - Opelousas General

North Caddo: Lessons Learned to Date

- Michele Heflin, LPN, Clinical Integration Specialist
  - North Caddo Medical Center

CHRISTUS Health: Lessons Learned to Date

- Nathan Kawamura, Data Analytics Engineer, Information Services
  - CHRISTUS Coushatta Health Care Center
  - CHRISTUS Health Shreveport-Bossier
  - CHRISTUS Ochsner Lake Area Hospital
  - CHRISTUS Ochsner St. Patrick Hospital
  - CHRISTUS St. Frances Cabrini Hospital
  - Savoy Medical Center

Hypertension Registry Updates and Recommended Registry Improvements

- Tina Faulk, BSN, RN, CDCES, MCIPs/ Diabetes Program Coordinator
  - Abbeville General Hospital

Patient Participation and Ideas to Improve Patient Engagement

- Kandace Fontenot, MHA, Director of Clinical Informatics and Information Systems
  - Allen Parish Hospital

Ideas to Improve the Hypertension Project

- Cameron Jenkins, MBA, Clinical Quality Coordinator, STQN
  - St. Tammany Parish Hospital

Break

Best Practices That May Be Adopted by Other Network Providers or Replicated in other Projects

- Susan Montz, AVP Performance Improvement, Care Management
  - Ochsner LSU Health Monroe
  - Ochsner LSU Health Shreveport
  - Ochsner Medical Center
  - Ochsner Medical Center – Baton Rouge
  - Ochsner Medical Center – Kenner
  - Ochsner Medical Center – North Shore
  - Ochsner St. Anne General Hospital
  - Ochsner St. Mary
  - Slidell Memorial Hospital
  - Southern Regional Medical Corporation
  - St. Bernard Parish Hospital
  - St. Charles Parish Hospital
  - Terrebonne General Medical Center

Expanding Hypertension Project Activities to New Populations

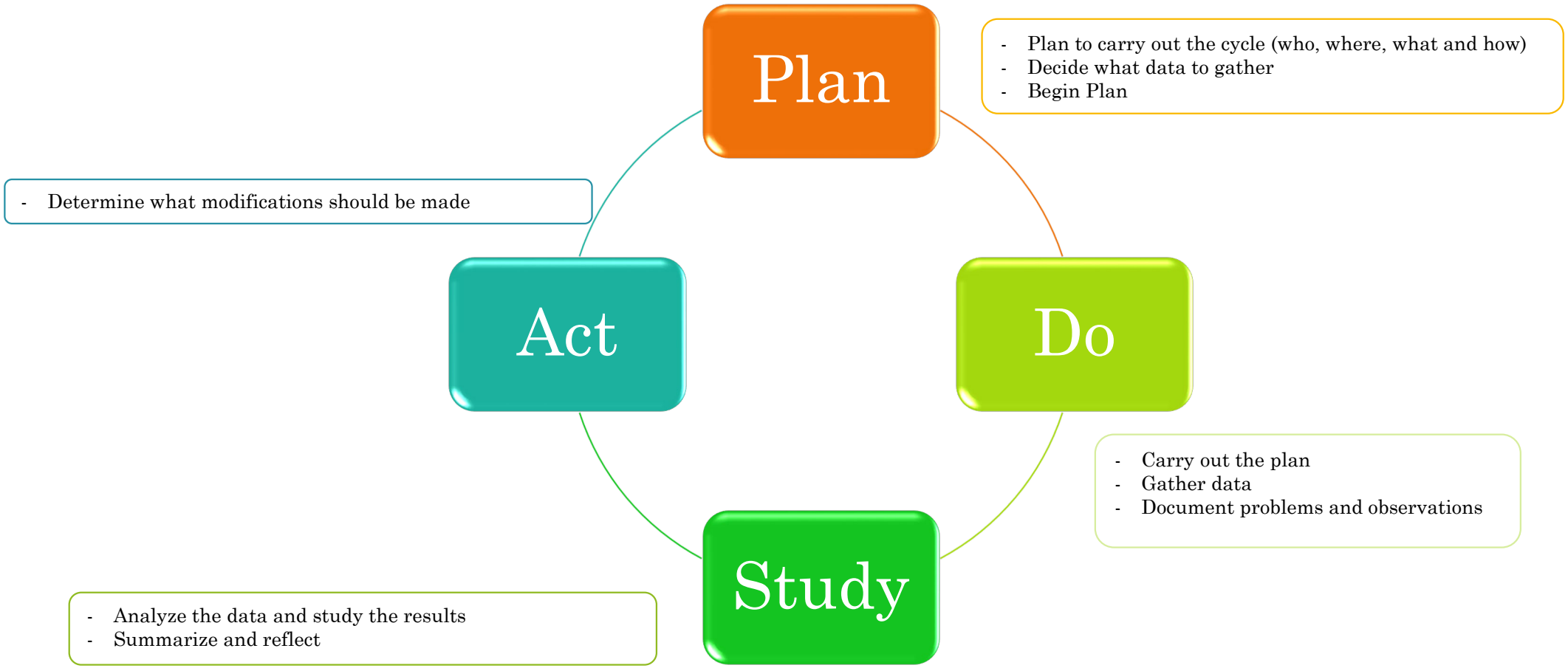
- Jeanine Thibodeaux, RN, Administrator
  - Pointe Coupee General Hospital

2021 In Review and Expectations for 2022

- Lillian Spuria
  - Gjerset & Lorenz, LLP

Hypertension Project CQI Plan Overview

- The Louisiana Managed Care Incentive Payment ("MCIP") Program is an incentive arrangement designed to track and improve health outcomes for adult Healthy Louisiana enrollees with hypertension (the "Hypertension Project").
- Participating Network Providers record patient information and report participation in activities designed to improve health outcomes for members in the Hypertension Registry.
- To ensure the Hypertension Project's success, the Network developed a continuous quality improvement ("CQI") plan. The CQI plan will help the Network to identify:
  - Project Impacts
  - Necessary Hypertension Registry modifications
  - Lessons Learned
  - Opportunities to Expand the Program
  - Key Challenges with Project Expansion



Hypertension CQI Plan: Plan – Do – Study – Act ("PDSA") Model

- Increase registry enrollment
- Improve health outcomes
- Impact root causes of hypertension and poor blood pressure control
- Address treatment gaps
- Identify and implement registry modifications

Project Goals:

- **Goal #1:** Increase members ages 18-59 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90)
- **Goal #2:** Increase members ages 60-85 who had a diagnosis of hypertension and whose BP was adequately controlled (<150/90)

Achieving Project Goals:

- Enrolling all eligible members (i.e., members ages 18 to 85 with diagnosed hypertension) in the Hypertension Registry
- Recording blood pressure results for each member encounter
- Reviewing registry data proactively to ensure data is complete
- Educating providers and members on methods to improve blood pressure control
- Conducting activities designed to assist members with improving blood pressure control
- Conducting continuous quality improvement activities designed to improve outcomes

Network Provider 2021 Data Submission

- Work individually with each Network Provider to correct errors and finalize the data submitted
- Consolidate data for each Network Provider and use milestone specifications to calculate performance rates for each milestone
- The performance rates are calculated for the entire Network in order to report to LDH. However, QIN will also provide each of the Network Providers with individual baseline calculations so that the Network Providers can measure individual performance.

2020 Milestone Baselines & 2021 Achievement

Note – 2021 achievement has not yet been reported and is subject to change.

Milestone	2020 Baseline	2021 Target	2021 Actual	% 2021 Goal Achieved
Members Ages 18-85 Enrolled in Hypertension Registry	83,218	87,379	92,619	100%
Members Ages 18-59 with Adequate Blood Pressure Control (<140/90)	56.64%	59.47%	59.16%	89.05%
Members Ages 60-85 with Adequate Blood Pressure Control (<150/90)	77.21%	81.07%	79.48%	58.81%
Member Participation in Activities to Increase Blood Pressure Control	N/A	N/A	37,570	N/A

2021 by the Numbers

Note – 2021 achievement has not yet been reported and is subject to change.

Milestone	CY20 Numerator	CY20 Denominator	CY21 Numerator	CY21 Denominator
Members Ages 18-85 Enrolled in Hypertension Registry	83,218	--	92,619	--
Members Ages 18-59 with Adequate Blood Pressure Control (<140/90)*	29,249	51,643	33,222	56,153
Members Ages 60-85 with Adequate Blood Pressure Control (<150/90)*	23,164	30,000	28,264	35,562

***2021 achievement was calculated based on percentage, but:**

- QIN increased number of members ages 18-59 with controlled blood pressure by over 13%
- QIN increased number of members ages 60-85 with controlled blood pressure by 22%

2022: Next Steps

Continue Activity for 2022

2021 Activities designed to increase registry members with hypertension whose BP was adequately controlled	2021 Number of Network Providers
Ask members about their tobacco use at each visit and track data in the member's medical record.	32
Educate providers on transportation services within the community to refer to members with transportation issues.	1
Incorporate flexible scheduling (i.e., same day appointments, walk-ins, evening or weekend appointments).	2
Total:	**35**

- 2022 Activity to Address Poor Blood Pressure Control
  - Network Providers will increase registry members' participation in network providers' CY21 activity.
  - Network Providers must track member participation for each member for every encounter in the hypertension registry in the field provided.
  - NOTE: If Network Provider chooses the activity "Ask members about their tobacco use at each visit," the member must have "yes" selected at all encounters in the registry to be included in 2022 achievement.
  - Activity support due to QIN by 8/15/22.
- Continuous Education
  - April 20, 2022 – CQI Workshop
  - Due to QIN by May 16, 2022

Upcoming Hypertension Milestones and Timelines

- 4.1 Increase in percentage of registry members that are participating in activities designed to increase adequate BP control.
- 4.2 Additional increase in number of members ages 18-85 with hypertension enrolled in the registry.
- 4.3 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59).
- 4.4 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85).

Continuation of Current CQI Activities

- Continue PDSA Focus Areas
- Continued collaboration with MCOs
- Monthly group discussions
- CQI workshops
- QIN website
- Solicitation of Network Provider feedback

Group Discussion/ Questions & Answers

All Network Providers

Closing Remarks

Lillian Spuria

Gjerset & Lorenz, LLP.

Additional Questions?

Please direct any additional questions to QIN at reporting@lamcip.org

MCIP

Hypertension Management
February 23, 2022

Ochsner Health

1

HTN Control: Challenges

- Overall lack of engagement due to COVID surges & Hurricane Ida
- Lack of Digital Health Literacy
  - Our HTN 60–85-year-old patients are not as tech savvy, and this makes Digital Program enrollment challenging. Digital requires virtual visits and MyChart enrollment.
- Reduced outreach engagement when using technical means such as text and portal messaging vs. phone outreach.

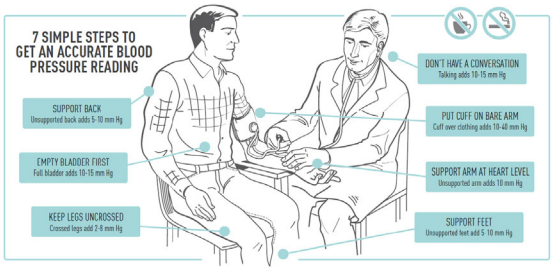
2

Remember Your Tools (aka Best Practices): Hypertension Management

- **Measure Up Pressure Down Protocol**
- **Follow the Primary Care Hypertension Guideline Algorithm**
- **All patients should have a follow up visit scheduled before leaving their appointment**
- **Enroll eligible patient into the Digital Medicine Hypertension Program**
- **Remember the workflow for a patient with an elevated BP at a visit:**
  - **Recheck the BP at the end of the visit by the provider, nurse, or MA (REMEMBER TO DOCUMENT)**
    - **Follow up in 2 weeks if it is still elevated**
  - **At the 2 week follow up nurse visit**
    - **If BP is still elevated, medication changes are recommended & provider visit should be scheduled**
- **Weekly Missed Opportunities Report**
  - **Outreach patients via telephone or MYO encounter for self-reported BP reading**
  - **Includes:**
    - **List of staff who did not take a 2nd BP reading on an uncontrolled patient**
    - **List of patients who left the OV without follow up nurse BP visit**

3

Measure Up Pressure Down Protocol



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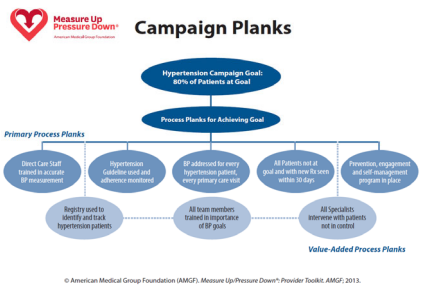
Measure Up Pressure Down Protocol



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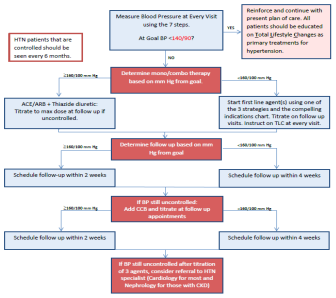
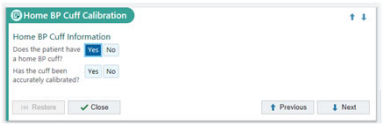
Primary Care Hypertension Guideline Algorithm



6

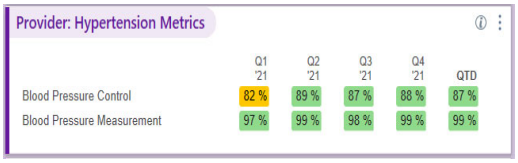
BP Cuff Calibration



- Compare the difference between the readings from the two cuffs.
  - BP readings will usually decline over the five measurements. The final systolic blood pressure reading may be as much as 10 mm Hg lower than the first.
  - If the difference is 5 mm Hg or less, the comparison is acceptable.
  - Do the calibration again if the difference is greater than 5 mm Hg but less than 10 mm Hg. d. The device may not be accurate if the difference is greater than 10 mm Hg.

7

Hypertension Dashboard Registry

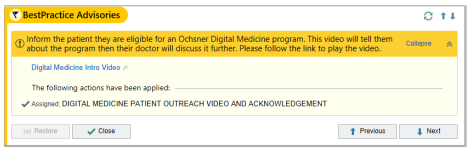


	Q1 '21	Q2 '21	Q3 '21	Q4 '21	QTD
Blood Pressure Control	82 %	89 %	87 %	88 %	87 %
Blood Pressure Measurement	97 %	99 %	98 %	99 %	99 %

8

Digital HTN Enrollment

- Digital Medicine Eligibility displayed in rooming under 'Best Practice Advisories' as a yellow banner.
- Clicking on hyperlink within banner will navigate to patient's MyChart account where they can play informational videos, sign consent, and answer questionnaires while waiting for provider to enter room



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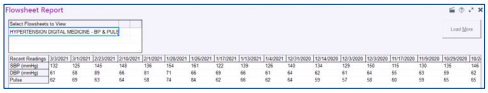
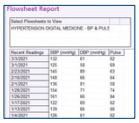
Digital Medicine Readings Flowsheet cont.

- View of "Complete Flowsheet"… at bottom of this page, you can change the view
  - Column view:

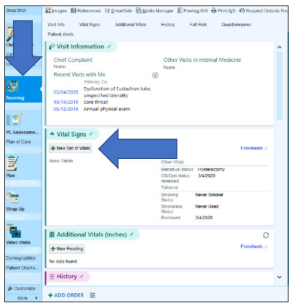


  - Row view:



10

Adding Virtual Blood Pressures to Epic Discrete Field



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Appendix F: April CQI Workshop

MCIP AGENDA
2022 HYPERTENSION CQI WORKSHOP
APRIL 20, 2022
(VIA ZOOM: 2:00-4:00PM)

TIME	PRESENTER
1:45 – 2:00	• ***Login (including technical troubleshooting)***
2:00 – 2:05	• ***Quality and Outcome Improvement Network, Inc.*** o Welcome and Introductions
PART I: HYPERTENSION CQI PROJECT UPDATES	
2:05 – 2:20	• ***Lillian Spuria, Gjerset & Lorenz, LLP*** o 2021 Performance & 2022 Activities
PART II: EVALUATION AND REVIEW OF 2021 PERFORMANCE	
2:20 – 2:25	• ***Kandace Fontenot, Director of Clinical Informatics and Information Systems*** Allen Parish Community Healthcare
2:25 – 2:30	• ***Tina Faulk, BSN, RN, CDCES, Diabetes Education Program Coordinator*** Abbeville General Hospital
2:30 – 2:50	• ***Candi Meridith, MPH, Director Value Based Performance and ACO Operations MCIP Program*** Ochsner Medical Center Ochsner Medical Center – Kenner Ochsner Medical Center – Baton Rouge Ochsner Medical Center – North Shore Ochsner LSU Health Monroe Ochsner LSU Health Shreveport Slidell Memorial Hospital Southern Regional Medical Corporation St. Bernard Parish Hospital St. Charles Parish Hospital Ochsner St. Anne General Hospital Ochsner St. Mary
2:50 – 2:55	• ***Tabitha Brown, Clinical Navigator and Data Analyst, Quality and Patient Safety*** Terrebonne General Medical Center
2:55 – 3:00	***BREAK***
PART III: PATIENT TREATMENT GAPS	
3:00 – 3:05	• ***Penny Hutson, CFO, HCA MidAmerica Division*** Rapides Regional Medical Center Tulane University Hospital and Clinic

TIME	PRESENTER
3:05 – 3:10	• ***Tena Turnage, RN, Manager - Clinic Operations, Population Health*** Ochsner Abrom Kaplan Memorial Hospital Ochsner Acadia General Hospital Ochsner Lafayette General Ochsner St. Martin Hospital Ochsner University Hospital and Clinics
3:10 – 3:15	• ***Marsha Gauthier, RN, Population Health*** Opelousas General
PART IV: 2022 IMPROVEMENT ACTIVITIES	
3:15 – 3:20	• ***Shelly Martinez, RN, Administrative Director - Clinical Quality*** Baton Rouge General The General Hospital
3:20 – 3:25	• ***Michele Heflin, Clinical Integration Specialist*** North Caddo Medical Center
3:25 – 3:30	• ***Tonya Corley, Office Manager, Group Operations*** CHRISTUS Coushatta Health Care Center CHRISTUS Health Shreveport-Bossier CHRISTUS Ochsner Lake Area Hospital CHRISTUS Ochsner St. Patrick Hospital CHRISTUS St. Frances Cabrini Hospital Savoy Medical Center
3:30 – 3:35	• ***Cameron Jenkins, Clinical Quality Coordinator*** St. Tammany Parish Hospital
PART V: LESSONS LEARNED	
3:35 – 3:40	• ***Meagan Trahan, RN, Care Manager*** Iberia Medical Center
3:40 – 3:45	• ***Jeanine Thibodeaux, RN, Administrator*** Pointe Coupee General Hospital
PART VI: CONCLUSION	
3:45 – 3:55	• ***Group Discussion/Questions & Answer Session*** All Network Providers
3:55 – 4:00	• ***Closing Remarks*** Lillian Spuria, Gjerset & Lorenz, LLP

221341

MANAGED CARE INCENTIVE PAYMENT PROGRAM
HYPERTENSION CONTINUOUS QUALITY IMPROVEMENT ("CQI") PLAN
VIRTUAL WORKSHOP MINUTES
APRIL 20, 2022

I. WELCOME AND INTRODUCTIONS

Opening Remarks
QIN (Quality and Outcome Improvement Network, Inc.)

QIN opened the meeting by welcoming everyone to the workshop. QIN acknowledged that everyone is busy but emphasized the value of coming together to discuss the hypertension projects. This workshop will include a review of 2021 accomplishments, improvement activities for 2022, and a discussion of lessons learned and ideas for improvement moving forward. Finally, QIN thanked the Network Providers for their hard work. MCIP has made tremendous strides in improving care for the Louisiana Medicaid population.

II. HYPERTENSION CQI PROJECT UPDATES

2021 Performance & 2022 Activities
QIN

QIN began its presentation with a reminder that this workshop is designed to gather insights from individual systems and share information among Network Providers to promote shared learning. Shared learning in these workshops help the Network improve activities in the future, all with the goal of improving the quality of care to the members of the target population.

In 2020, the Network Providers laid the groundwork for the hypertension project and measured baselines, developed activities to improve care and conducted provider education. In 2021, the Network began to measure performance and build off the trainings conducted in 2020. In 2022, the Network will continue to develop quality improvement activities and overcome barriers to care in the Louisiana Medicaid population.

In 2021, the hypertension project focused on three overarching goals:
1. Increase number of members ages 18-85 with hypertension enrolled in a registry.
2. Increase members ages 18-59 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90).
3. Increase members ages 60-85 who had a diagnosis of hypertension and whose BP was adequately controlled (<150/90).

An essential component of meeting these goals is measuring performance. QIN discussed 2021 performance achievement with Network Providers. First, QIN explained that the Network achieved 100% of its enrollment goal, and in fact exceeded the goal by more than 5,000 patients. For blood pressure (BP) control in the populated

aged 18-59, the Network achieved 89.05% of its goal. Finally, for members aged 60-85, the performance achievement was 58.81%.

The Network also established a 2021 baseline of 37,350 registry members participating in activities aimed at improving blood pressure control. Registry members participated in one of three activities implemented by network providers:

- Ask members about their tobacco use at each visit and track data in the member's medical record.
- Educate registry members on transportation services within the community to refer to members with transportation issues.
- Incorporate flexible scheduling (i.e., same day appointments, walk-ins, evening or weekend appointments).

Most providers (32 out of 35) chose to implement the activity asking members about tobacco use and recording it in the medical record.

Data Analysis

QIN analyzed hypertension registry data to learn more about the demographics of the target population. QIN found that a higher share of registry members falls in the age cohort 18-59 (61%) compared to age cohort 60-85 (39%). African American are the largest group in the registry at 58%, followed by Whites/Caucasians at 38%. The remaining 4% represent other races, including, Asian American Pacific Islander, Hispanic, and Native Alaskans.

QIN also examined service use among registry members. About 7% of registry members had more than 25 encounters during 2021; the older cohort aged 60-85 had a slightly higher share of members that fell into this high utilizer group (8%) compared to the younger cohort aged 18-59 (6%). More than half of registry members had five or fewer encounters during 2021; the younger cohort aged 18-59 had a higher share of members that fell into this low utilizer group (56%) compared to the older cohort aged 60-85 (48%).

Next, QIN presented findings on tobacco use and blood pressure control among registry members. QIN's analysis found:

- More than a third of all registry members used tobacco, and younger members aged 18-59 had higher tobacco use (40%) compared to older members aged 60-85 (28%).
- Registry members in the cohort aged 18-59 who participated in 2021 activities had about the same blood pressure control (59%) compared to all registry members in their age group (also 59%). Those who used tobacco had slightly worse blood pressure control (58%) compared to all registry members in their age group.
- Registry members in the cohort aged 60-85 who participated in 2021 activities had lower blood pressure control (74%) compared to all registry members in their age group (79%). Those who used tobacco had slightly worse blood pressure control (78%) compared to all registry members in their age group.

Finally, QIN conducted an analysis of the root cause of registry member's poor BP control based on physician notes in the patient's electronic medical record (EMR). The data showed that "co-morbidities" (e.g., diabetes, obesity, etc.) was by far the

most common root cause of poor blood pressure control, accounting for 82% registry members. This demonstrates the interconnectedness of the MCIP projects and the positive downstream effects on can have on another. For example, if a patient successful quits smoking, this might improve her health across Hypertension, Diabetes, Tobacco Cessation, Maternal Care and other projects.

2022 Activities

QIN discussed the four milestones for the hypertension project in 2022:
4.1 – Increase in percentage of registry members that are participating in activities designed to increase adequate BP control.
4.2 – Additional increase in number of members ages 18-85 with hypertension enrolled in the registry.
4.3 – Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59).
4.4 – Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85).
The documentation for provider activities is due to QIN by August 15, 2022.

In addition to 2022 activities, providers will continue their 2021 CQI activities. This includes:

- Continued collaboration with MCOs
- Monthly group discussions
- Improvements/revisions to the Network Provider timeline
- Participating in CQI workshops
- Using the QIN website
- Providing feedback to QIN
- Network Provider training and education (submissions are due May 16)

Registry

QIN highlighted several changes to the registry template to simplify reporting:

- Race Drop Down – The drop-down menu in the "Race" data field has been removed to make the template more user-friendly. Network providers must still complete this field.
- Table Format & Primary Root Cause:
    - The registry will now be a standard Excel worksheet. The table format has been removed.
    - The "Primary Root Cause" data field has also been removed from the registry.
- 'Short Date' Format – All data fields containing dates will be placed in 'Short Date' format (ex. MM/DD/YYYY).

QIN will post the slides from today's presentation on lamcip.org, which offers a variety of helpful resources including a provider forum.

III. EVALUATION AND REVIEW OF 2021 PERFORMANCE

Kandace Fontenot, Director of Clinical Informatics and Information Systems
Allen Parish Community Healthcare

Ms. Fontenot opened her presentation with a review of Allen Parish Community Healthcare's (APCH) 2021 experience. Her facility's major strategy is to implement team-based care. This strategy is applied to the improvement of BP control and overall patient care. The APCH team implemented patient follow up, medication management, patient self-management support, and self-measured BP tools for patients to record their BP from home. These practices help patients control their BP.

APCH also worked to identify additional patients with uncontrolled BP to include in the registry. Pulling and analyzing the data is not an easy task, but APCH is improving as it gains more experience.

Tina Faulk, BSN, RN, CDCES, Diabetes Education Program Coordinator
Abbeville General Hospital

Ms. Faulk explained that every Medicaid patient with a hypertension diagnosis is automatically enrolled in the hypertension registry. This makes it difficult for Abbeville to improve its numbers because the only way to increase its percentage of hypertensive patients with BP control is to enroll new patients or for pre-existing patients to develop hypertension. An increase in members in the registry would mean that more patients have developed hypertension. Fortunately, Abbeville has a variety of reports to identify new patients for outreach.

Despite these challenges, Abbeville improved over 2020 and exceeded the Network's goal. The key to this success has been educating providers about the goals of the hypertension project. Abbeville conducted an audit of patient records and determined that providers are consistently documenting patient concerns, root causes, and time spent with patients. Providers are also suggesting lifestyle modifications as appropriate.

Abbeville also analyzed differences between age groups. Abbeville found that younger patients are more open to lifestyle changes than to medication, but it takes a while for those habits to be consistent or for the effects of lifestyle modifications to kick in. The younger age range is also less able to comply with medication, more stressed due to holding multiple jobs or being in school, and simply does not take the time for their health like older members do. Finally, young patients are not well educated in the need for a primary care provider. Older patients, on the other hand, are more likely to comply with physician recommendations, especially if they've already been struggling with their BP and had complications.

Ms. Faulk then spoke about the challenge of recording patient data in the electronic health record (EHR). Abbeville records patient tobacco use at every visit. This requires an ongoing process of educating providers on asking and recording tobacco use, auditing patient records to ensure compliance and working with the software provider to resolve issues as they arise. This is a challenging process but one that Abbeville hopes to streamline moving forward to continue improving health outcomes for its patients.

Candi Meridith, MPH, Director Value Based Performance and ACO Operations
MCIP Program
Ochsner Medical Center

Ochsner Medical Center – Kenner
Ochsner Medical Center – Baton Rouge
Ochsner Medical Center – North Shore
Ochsner LSU Health Monroe
Ochsner LSU Health Shreveport
Slidell Memorial Hospital
Southern Regional Medical Corporation
St. Bernard Parish Hospital
St. Charles Parish Hospital
Ochsner St. Anne General Hospital
Ochsner St. Mary

Ms. Meridith noted her pride in the achievements of the MCIP program and the improved outcomes the program has been able to deliver to the target population. Ochsner improved over its baselines for every milestone in the hypertension project, but there is still room for improvement.

Outreach

All Ochsner facilities utilize the "measure up, pressure down" initiative. If a patient presents with elevated BP, Ochsner immediately schedules a follow up nurse visit. Ochsner also utilized clinical care coordinators (CCC) to conduct additional follow up. They engage the patient with weekly outreach (by phone and on the online portal). The CCCs schedule patients with a primary care provider (PCP) appointment if the patient doesn't routinely measure their own BP. Ochsner reiterates to patients that appointments are free.

Ochsner also uses analytics to identify patients who would benefit from outreach. For example, Ochsner runs a report of patients who have gone more than 12 months without a PCP visit and conducts outreach to them.

Many Medicaid patients use the ED as a clinic rather than scheduling an appointment with a primary care provider due to low health literacy and long-term habits. It is difficult for providers to train patients into new health literacy habits when they have been using the ED as a clinic for years.

This practice is unsustainable because the ED is typically overwhelmed both in terms of volume and in terms of more urgent patient needs. This results in patients being sent away without receiving the full treatment they would receive in a primary care environment. This also means patients are unable to develop long term relationships with their doctors, making it harder for physicians to identify trends and build patient trust. The outreach Ochsner conducts to patients without PCPs is designed to combat this barrier to care.

Ochsner also utilizes a "missed opportunity" report. For example, if a patient presents with uncontrolled BP, it may be that they have "white coat syndrome" (nerves of being in a hospital causing a spike in BP) or they may have elevated BP due to being in pain. Ochsner checks a patient's BP at the beginning and end of a visit, and if BP is still uncontrolled, they schedule a follow up. If the patient does not want to schedule, that patient goes on the "missed opportunity" report. Patients who have elevated BP

without prescribed follow-ups are described as missed opportunity patients, and Ochsner can now conduct outreach to them.

Ochsner's ED navigators have made over 40,000 outreach contacts. This includes working with patients to book appointments with PCPs, getting patients into virtual visits, referring patients to community health clinics, and more. This is a huge advancement in the delivery of care to the Medicaid population.

Despite this success, there are barriers to outreach. Some patients are difficult to reach because they do not have cell phones. Some patients (and staff) have been displaced due to Hurricane Ida. In fact, some Ochsner team members lost homes due to the storms. Some team members also faced serious issues related to the pandemic. Despite these challenges, Ochsner is proud of the work it is doing to reach the Medicaid population.

Telehealth

Ms. Meridith pointed out that some patients continue to have anxiety about COVID-19 and transportation issues, which exacerbates the need for moving to a more digital/automated system.

Digital literacy is a big issue in the Medicaid population. Some patients do not have a smart phone, or a phone at all, or are not literate enough to access the online portals. This illiteracy means fewer opportunities to link patients with digital medicine programs. This is a loss for patient care because Ochsner has pharmacists dedicated to digital medicine, and that resource is not maximized when patients can't engage with the digital platform.

In addition to digital literacy issues, Ms. Meridith suggested that some patients are suffering from outreach fatigue. Although moving patients into a digital health environment is a huge benefit, patients can become burned out and disengaged when they receive too much outreach to the point that it becomes spam. If a patient has multiple co-morbidities, they likely are receiving multiple texts from Ochsner and from other providers.

Treatment of Age Cohorts

Finally, Ms. Meridith explained several differences she has observed in treating the different age cohorts. Older patients are generally less tech savvy, meaning they don't text, attend virtual visits, use Ochsner's online portal, etc. Young patients have the opposite problem – they don't answer their phones like older people do. Young people are also busier with school, work or young families and do not have time to come into the clinic.

Finally, vaping is on the rise and is much more common among young people, who often do not realize it is unhealthy. Patients who vape often do not consider themselves tobacco users. Ms. Meridith advocated for improving the messaging that vaping is indeed tobacco use.

Ms. Meridith concluded by congratulating the Network for improving so dramatically, especially in a year with both national and local devastation.

Tabitha Brown, Clinical Navigator and Data Analyst, Quality and Patient Safety
Terrebonne General Medical Center

Ms. Brown also spoke briefly about the differences between older and younger patients. Although older patients tend to be more engaged with their health and have more time for visits, they also forget to take their medication and struggle to adapt to digital health technology. Network Providers should take these insights to adapt to the unique needs of their patient populations.

Ms. Brown praised the staff at her clinic for their work in the rigorous measurement process. Showing improvement, especially in a year where clinics were closed for weeks due to Hurricane Ida, is a remarkable achievement and a testament to the patient-focused dedication of the hospital staff.

IV. PATIENT TREATMENT GAPS

Penny Hutson, CFO, HCA MidAmerica Division
Rapides Regional Medical Center
Tulane University Hospital and Clinic

Ms. Hutson spoke about Tulane's efforts to implement its activity of assessing member tobacco use at every visit. Tulane physicians discuss tobacco cessation with the patient regardless of the original purpose of the visit. Echoing Ms. Meridith's point, Ms. Hutson explained that many young people do not realize the impact of vaping and tobacco use on their hypertension.

Adherence to medication is also a chronic problem, especially among older patients. Some physicians are asking their older patients to bring in their pill bottles so that the physician can inspect whether they have been taking the proper dosages.

Further, Ms. Hutson discussed the limits of telehealth. Like other providers, due to the pandemic, Tulane has implemented broad telehealth measures. While telehealth is an invaluable resource for patients who are not able to visit the hospital, there are limits to its utility. For example, physicians cannot record a patient's BP over a virtual platform and must rely on the patient to take their own BP. This can be unreliable and lead to gaps in the patient's medical record.

Ms. Hutson concluded that these measures are making a difference in patient health and her facilities will continue their efforts in patient education.

Tena Turnage, RN, Manager - Clinic Operations, Population Health
Ochsner Abrom Kaplan Memorial Hospital
Ochsner Acadia General Hospital
Ochsner Lafayette General
Ochsner St. Martin Hospital
Ochsner University Hospital and Clinics

Ms. Turnage echoed other Network Provider insights on telehealth. Telehealth is an incredible tool to deliver service to patients facing transportation issues or to deliver

care in a socially distanced environment, but it cannot replace traditional practices like an in-person BP reading. To remedy this, the Ochsner facilities are encouraging patients to use BP cuffs at home and instructing them on proper use via telehealth visits.

Ms. Turnage further explained that piecing together an accurate picture of a patient's BP is complex. BP readings are gathered at various points of contact: PCP visits, nurse practitioner visits, and self-reported from patient call ins. Each of these touchpoints create an opportunity for patient education on how to control their BP (diet, medication, etc.). However, filling in the whole picture can be complex because some patients might intentionally refrain from smoking before a visit, knowing it will keep their BP lower than normal.

Ms. Turnage went on to discuss the ED navigators and the impact they are having on patient management of chronic disease. The navigators guide patients in the management of their disease so effectively that some patients are now calling the navigators (rather than the other way around) when they take their own BP and find that it is high. This process helps develop rapport with patients, so much so that some patients are calling their navigators even after they are no longer Ochsner patients.

Finally, Ms. Turnage discussed digital literacy between the age cohorts. She explained that starting at the age of 45 or so, there is a drop off in interest in telehealth. Older patients remain interested in phone contact, but this is a service that is being phased out in favor of virtual appoints on the Ochsner telehealth platform. Further, Ms. Turnage explained that the telehealth platforms are not always intuitive, even for tech literate patients. The software was in some cases rushed out due to the pandemic and will certainly improve over time.

Marsha Gauthier, RN, Population Health
Opelousas General

Ms. Gauthier spoke about several barriers to care that her clinic has faced in treating its patients. First, Opelousas is a rural facility, and transportation barriers are especially acute for rural patients. Without transportation access, patients miss appointments and run out of medication. In 2022, Opelousas will be educating patients on transportation services available within the community, but Ms. Gauthier mentioned that Medicaid transportation is unfortunately unreliable.

Another issue facing her facility is mental health, an issue on the rise in many communities across the country. PCPs are often unequipped to adequately handle mental health issues, and it is common for these patients to come to the ED. Mental health issues also intersect with hypertension because chronic anxiety can cause elevated BP. Opelousas is working to combat knowledge deficits among patients and physicians, and to always approach mental health issues with compassion against a societal backdrop where mental health issues are often stigmatized.

To help address these barriers to care, Opelousas has provided a resource guide on its website. Opelousas also developed transportation fliers including QR codes to distribute to patients. Further, Opelousas displayed patient education on monitors throughout the hospital and created a steering committee to examine social

determinants of health to help close the gap in health inequities between Medicaid patients and the general population. Ms. Gauthier also noted that Medicaid and Medicare often have overlapping incentive programs, and Opelousas will leverage this to the benefit of its patients wherever possible.

V. 2022 IMPROVEMENT ACTIVITIES

Shelly Martinez, RN, Administrative Director - Clinical Quality
Baton Rouge General
The General Hospital

In 2021, Ms. Martinez' facilities picked both asked members about their tobacco use at every visit and tracked the data in the member's medical record. Ms. Martinez reported that her facilities had difficulties with physicians not properly tracking member interactions.

To combat this problem, Baton Rouge General and The General Hospital implemented a system of tracking and ranking physician individual performance in terms of hypertension and tobacco. Ms. Martinez reported that using quality scores helped keep physicians engaged in the process. Further, her facilities encourage physicians to be engaged by including them in the additional savings of the program. Putting clinics and physicians in competition with each other helps motivate everyone to improve.

Moving forward, nurse navigators will audit patient records to ensure tobacco use and BP are being documented properly.

Michele Heflin, Clinical Integration Specialist
North Caddo Medical Center

North Caddo's 2021 activity was to incorporate flexible scheduling (i.e. same day appointments, walk-ins, evening or weekend appointments). Providers at North Caddo were concerned that not booking every appointment in advance would lead to lost volume. Ms. Heflin reported that instead of losing volume, the walk-in volume is so great that her facility still must turn some patients away. All four of North Caddo's clinics now incorporate flexible scheduling since it has been a big success. Moving forward, North Caddo will continue this activity in addition to asking patients about tobacco use.

Tonya Corley, Office Manager, Group Operations
CHRISTUS Coushatta Health Care Center
CHRISTUS Health Shreveport-Bossier
CHRISTUS Ochsner Lake Area Hospital
CHRISTUS Ochsner St. Patrick Hospital
CHRISTUS St. Frances Cabrini Hospital
Savoy Medical Center

Ms. Corley explained that she is new to the MCIP program, and she finds the CQI workshops to be extremely informative.

Coushatta's activity was to educate patients on transportation resources. It was the only facility implementing this activity for the hypertension project. Ms. Corley reported that her facility often found the education fliers in the waiting room or parking lot, leaving her staff unsure if the education was having any impact on patients

A significant barrier to transportation is the fact that travel must be scheduled 72 hours in advance. Even if a patient is thinking ahead about their appointment with a physician, they might not have transportation to the pharmacist afterward if they receive a prescription.

Several CHRISTUS facilities opted to ask patients about tobacco use. The key barrier here was staff compliance: some providers were not asking/documenting a tobacco assessment at every visit. To overcome this, CHRISTUS is retraining staff and hopes to see improvement in 2022.

Cameron Jenkins, Clinical Quality Coordinator
St. Tammany Parish Hospital

St. Tammany also chose to ask members about tobacco use and document their response in the member's medical record. The challenge has been provider adaptation to the process of documenting tobacco use in the medical record, and patient transparency about tobacco use. In some cases, patients do not consider themselves tobacco users even if they are (e.g., vaping). St. Tammany will continue this activity and hopes to see improvement in 2022.

VI. LESSONS LEARNED

Meagan Trahan, RN, Care Manager
Iberia Medical Center

Ms. Trahan spoke about various cultural factors that impact the delivery of care in the hypertension project. She acknowledged that the Louisiana culture includes some unhealthy habits in terms of diet and lifestyle. To combat this, Iberia conducts dietary education, including an education with heart healthy food items for patients. Low health literacy is also a factor impacting care, so Iberia engages in ongoing efforts to educate patients.

Jeanine Thibodeaux, RN, Administrator
Pointe Coupee General Hospital

Ms. Thibodeaux explained that the root cause questionnaire was impactful for Pointe Coupee to identify and address problems. The questionnaire informed the activities Pointe Coupee created and has driven positive outcomes.

The MCIP summary showed 67% of members controlled their hypertension, a 17% increase. This is a significant increase, especially considering the population we are targeting. This shows that the MCIP program is making a difference in the health of the state's Medicaid population and making big strides in a short timeframe.

Ms. Thibodeaux closed with a quote: "People don't do what you expect; they do what you inspect." The rigorous documentation required by the MCIP program creates a layer of accountability that is changing lives in Louisiana.

VII. CONCLUSION

Group Discussion/Questions & Answers Session
All Network Providers

Ms. Thibodeaux shared her view that in a few short years, telehealth will grow as the influence of Gen X on the medical landscape grows (roughly defined as those in their 40s and 50s today). Ms. Thibodeaux agreed with other providers that members do not want to be inundated with texts, and Network Providers should work to find the proper balance of outreach.

QIN explained that the last year was a very challenging time for the country and for the Medicaid population. Nonetheless, Network Providers helped 61,000 people control their BP, a significant increase over the prior year. These improvements compare very favorably to nationwide numbers. The MCIP program shows that small changes can lead to incremental improvements, and over time, this leads to major achievements.

Finally, a Network Provider asked whether members remain on the registry once their BP is controlled. QIN clarified that Network Providers should keep members on the registry as long as they have a diagnosis of hypertension, even if their BP is now controlled.

Closing Remarks
QIN

QIN closed by congratulating Network Providers on their achievement. QIN reminded Network Providers that the ED workshop will be held the next week, and that the discussion is ongoing – providers can always reach out to QIN with questions or engage with each other on the lamcip.org forum.

221675

Louisiana MCIP Hypertension Project

Continuous Quality Improvement ("CQI") Workshop

April 20, 2022

Goals for Today's Hypertension CQI Workshop

Goals for Today's CQI Workshop:

CQI Project Update

- CQI Overview
- CY2021 Performance
- 2021 Data Analyses
- 2022 Activities

- Network Providers to discuss the following components of the CQI plan:
  - 2021 Performance
  - Patient Treatment Gaps
  - 2022 Improvement Activities
  - Lessons Learned
- Collaborative discussions for all attendees regarding any hypertension project questions.

Part I: Hypertension CQI Project Updates

Lillian Spuria,
Gjerset & Lorenz, LLP

CQI Overview

Hypertension CQI Plan

To ensure the Hypertension Project success, the Network researched and developed a continuous quality improvement ("CQI") plan. The CQI plan will help the Network to identify:

- Project impacts
- Lessons learned
- Plans for future activities
- Key challenges with ongoing and future program projects
- Barriers and areas of improvement

Hypertension CQI Activities

2020

In 2020, Network Providers:

- Enrolled Members into the Hypertension Registry
- Measured baselines
- Conducted ongoing training and education for providers
- Created action items to address treatment gaps and root causes for uncontrolled blood pressure
- Created a continuous quality improvement plan

2021

In 2021, Network Providers:

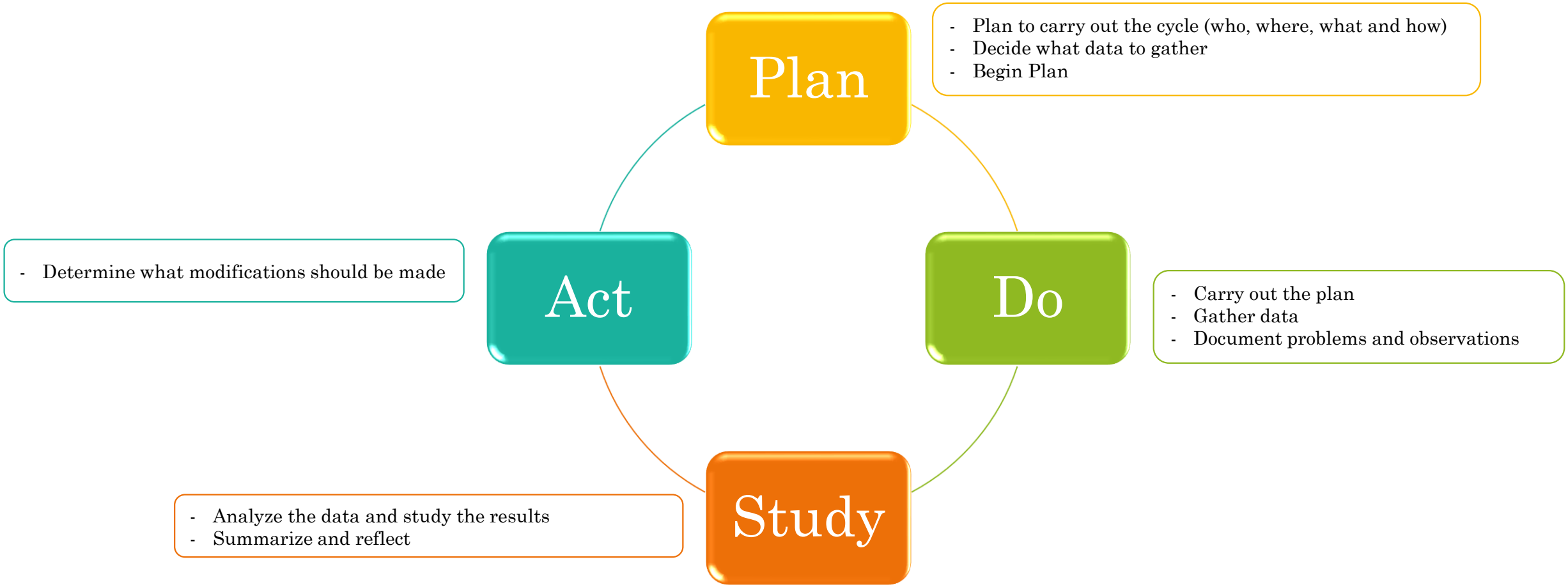
- Continued to enroll Members into the Hypertension Registry
- Measured performance
- Conducted ongoing training and education for providers
- Selected and implemented activities designed to address treatment gaps and root causes for uncontrolled blood pressure
- Conducted continuous quality improvement activities

2022

In 2022, Network Providers will:

- Continue to enroll Members into the Hypertension Registry
- Measure performance
- Conduct ongoing training and education for providers
- Continue activities designed to improve blood pressure control for Registry Members
- Conduct continuous quality improvement activities

Hypertension CQI Plan: Plan – Do – Study – Act ("PDSA") Model



Project Goals

- **Goal #1:** Increase number of members ages 18-85 with hypertension enrolled in a registry
- **Goal #2:** Increase members ages 18-59 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90)
- **Goal #3:** Increase members ages 60-85 who had a diagnosis of hypertension and whose BP was adequately controlled (<150/90)

Hypertension Project: Measure Calculations

Process to Calculate Milestone Performance

- Network Provider Data Submission
- Work individually with each Network Provider to correct errors and finalize the data submitted
- Consolidate data for each Network Provider and use milestone specifications to calculate rates for each milestone
- The rates are calculated for the entire Network in order to report to LDH. However, the Network also provided each of the Network Providers with individual performance calculations in order for the Network Providers to evaluate individual performance.

CY2021 Performance

CY2021 Milestone Results

Members enrolled in the Hypertension Registry:
100% Achievement

- CY2020 Network Baseline: 83,218
- CY2021 Network Goal: 87,379
- CY2021 Network Performance: 92,619

CY2021 Milestone Results

Percentage of Members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59):
89.05% Achievement

- CY2020 Network Baseline: 56.64%
- CY2021 Network Goal: 59.47%
- CY2021 Network Performance: 59.16%

CY2021 Milestone Results

Percentage of Members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85):

58.81% Achievement

- CY2020 Network Baseline: 77.21%
- CY2021 Network Goal: 81.07%
- CY2021 Network Performance: 79.48%

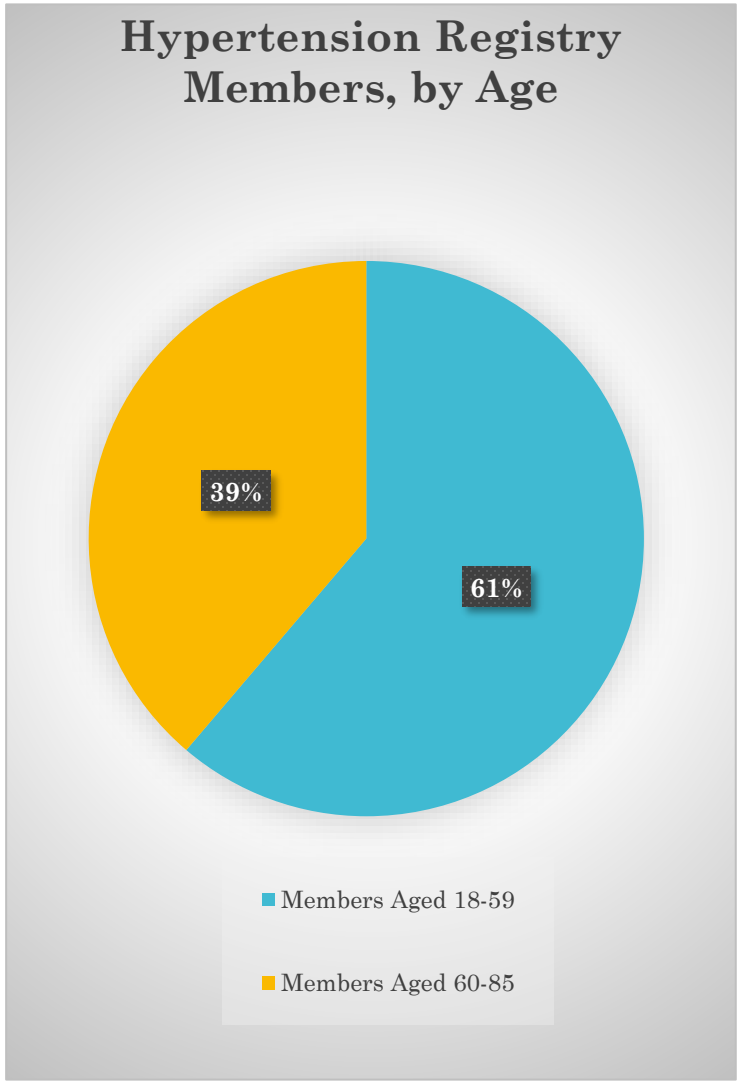
CY2021 Member Participation Baselines

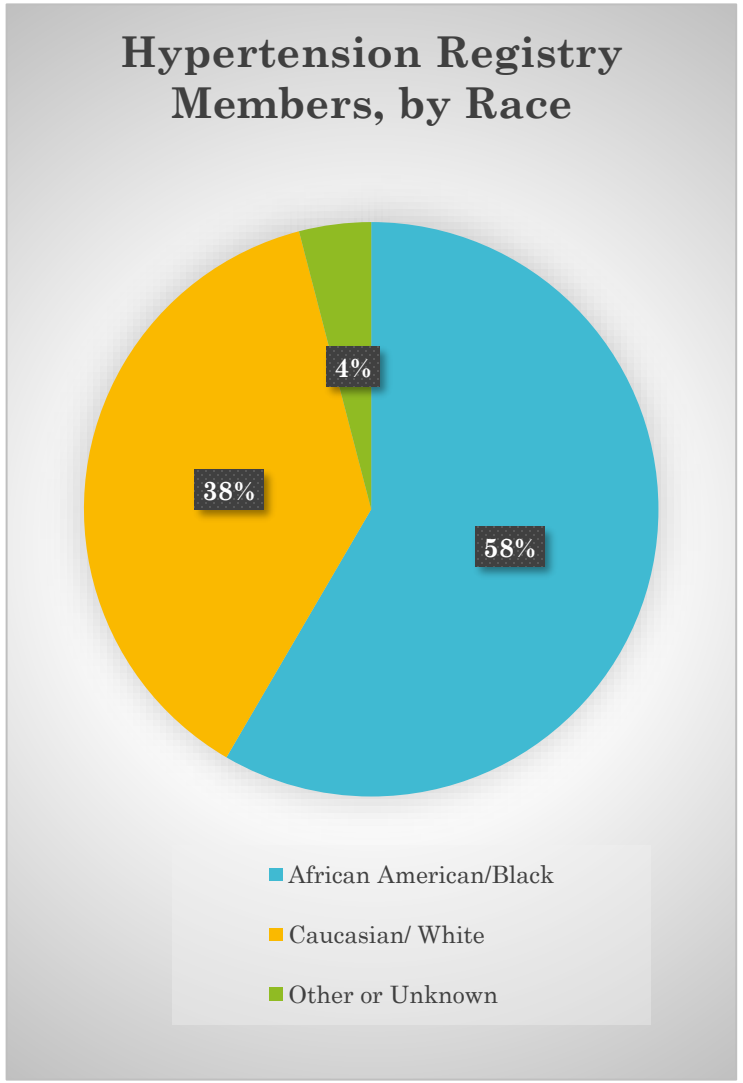
Member participation in activities designed to increase number of registry members with adequate BP control

- Providers chose the following activities:
  - Ask members about their tobacco use at each visit and track data in the member's medical record.
  - Educate providers on transportation services within the community to refer to members with transportation issues.
  - Incorporate flexible scheduling (i.e., same day appointments, walk-ins, evening or weekend appointments).
  - CY2021 Baseline: 37,570

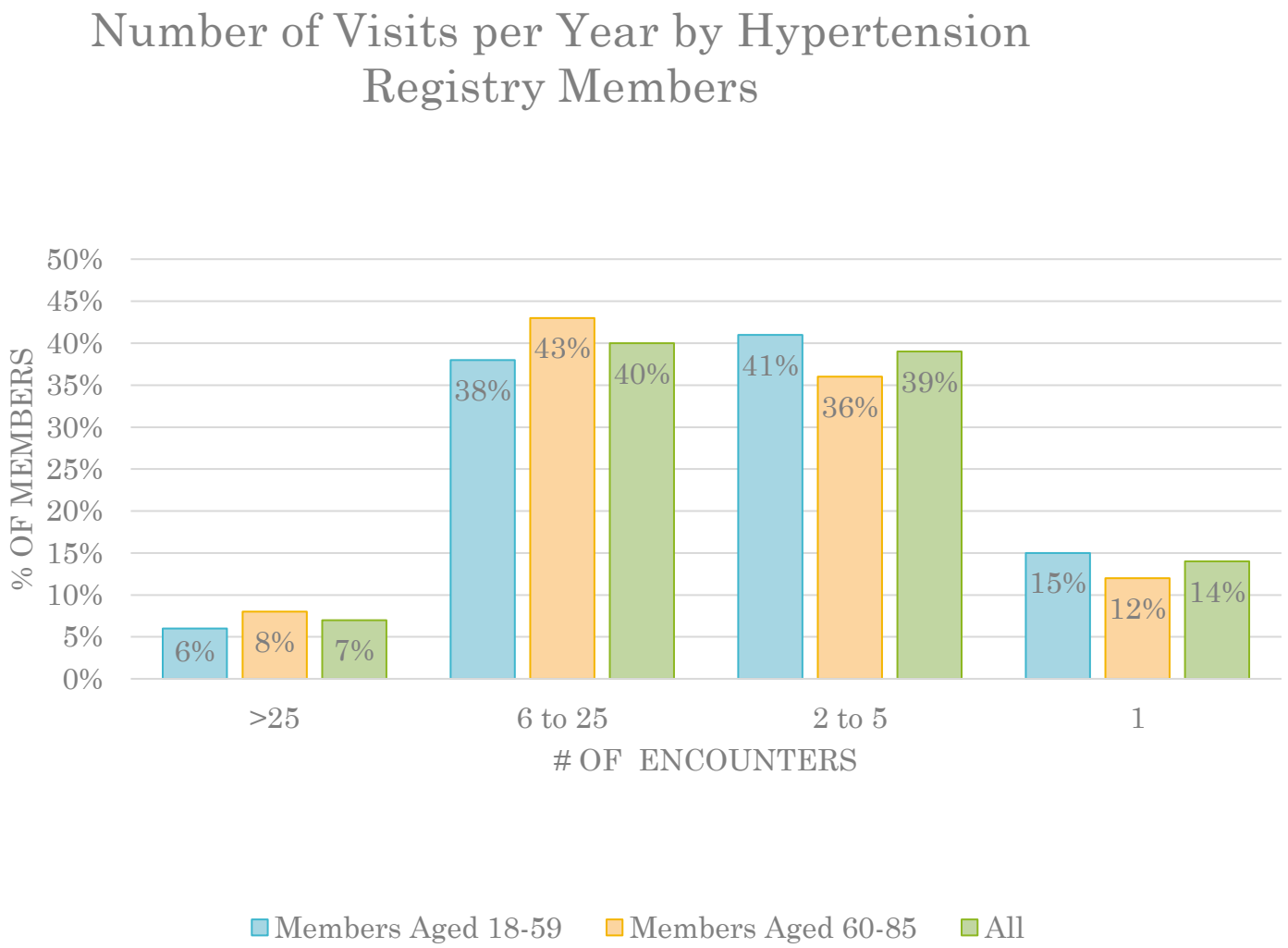
Data Analyses

Profile of Hypertension Registry Members

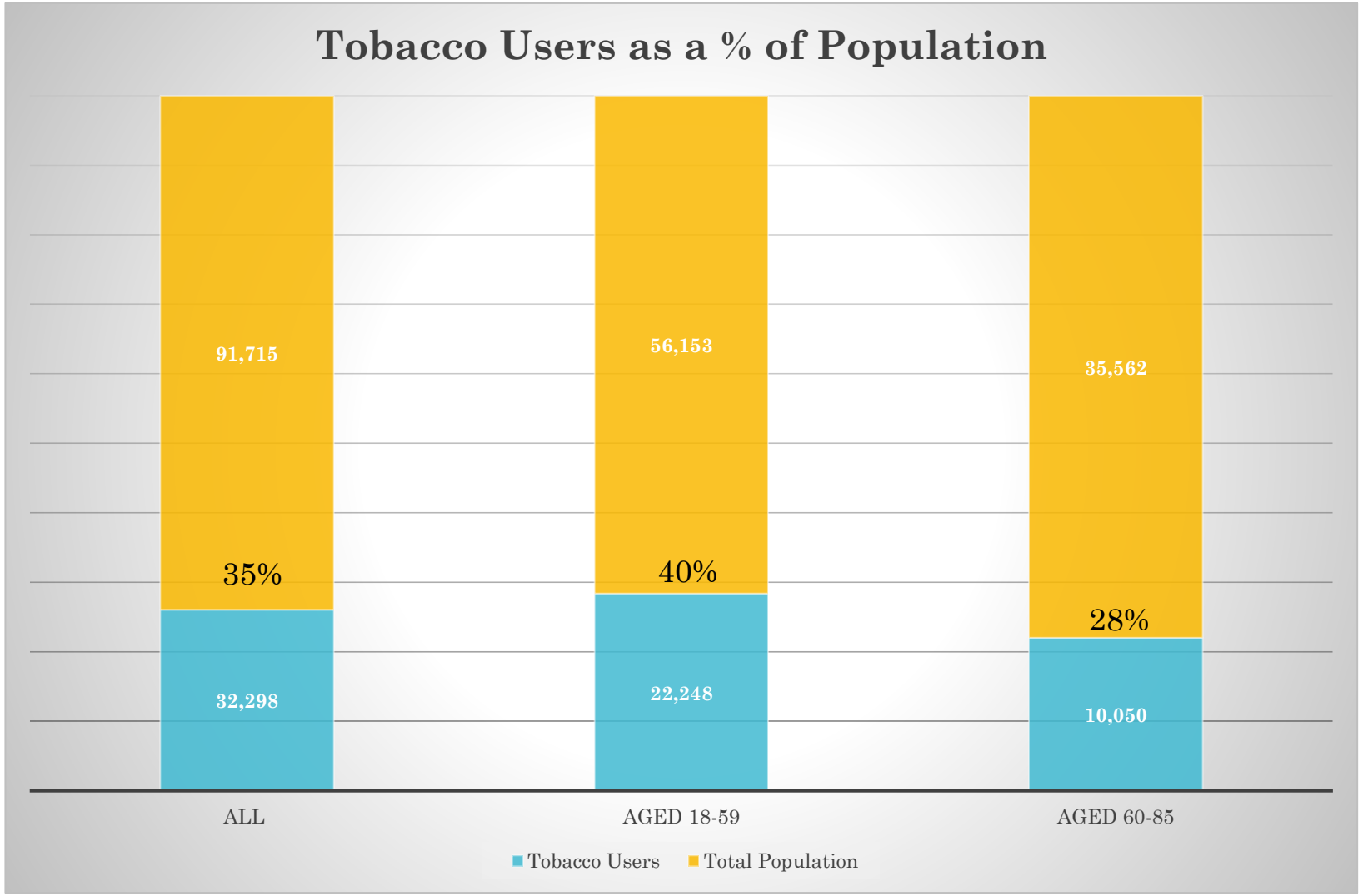




2021 Encounters



Tobacco Use Among Hypertension Registry Members



CONTROLLED BLOOD PRESSURE

Members enrolled in the registry whose BP was adequately controlled, by race

Age	All Registry Members	African American/ Black	Caucasian/ White	Other*
18-59	59%	55%	66%	63%
Total Members (Aged 18-59)	56,163	33,758	20,281	2,114
60-85	79%	76%	83%	82%
Total Members (Aged 60-85)	35,562	19,811	14,153	1,598

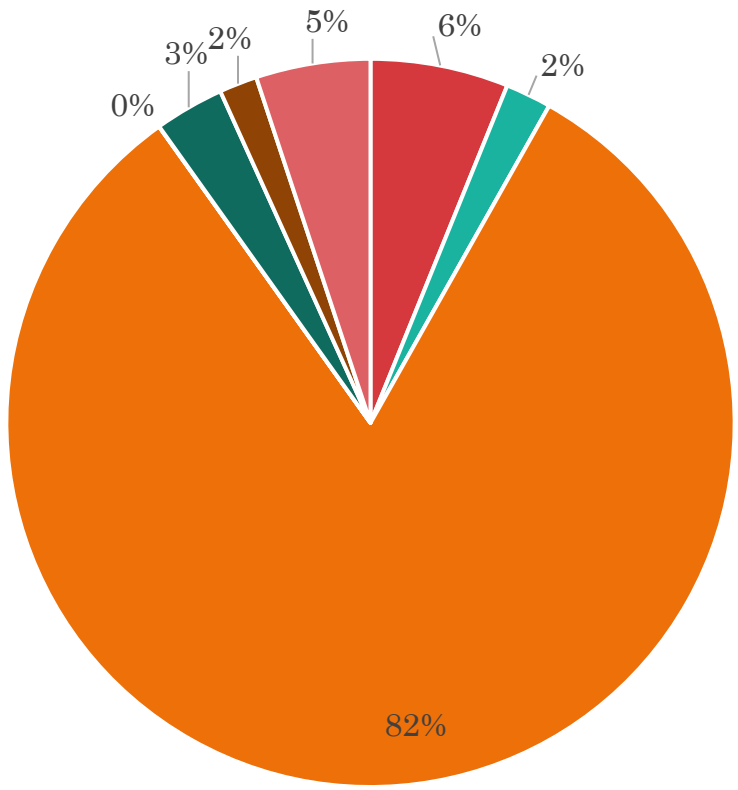
*Other includes Asians, American Indians/Native Alaskans, and Other Individuals.

CONTROLLED BLOOD PRESSURE

Members enrolled in the registry whose BP was adequately controlled, by tobacco use and activity participation

Age	All Registry Members	Tobacco Users	Participate in Activities
18-59	59%	58%	59%
Total Members (Aged 18-59)	56,163	22,248	23,970
60-85	79%	78%	74%
Total Members (Aged 60-85)	35,562	10,050	13,312

2021 Hypertension Root Causes



Behavioral factors (e.g., Diet, Exercise, Alcohol, Tobacco, or Drug use)	5,672
Communication	1,884
Co-morbidity (e.g. Obesity, Diabetes, etc.)	75,828
Lack of Transportation	9
Linkages to Care Management	2,858
Low Levels Health Literacy	1,559
Lower Socioeconomic Status	4,703
Grand Total	92,513

2022 Activities

2022 Performance Milestones

- 4.1 Increase in percentage of registry members that are participating in activities designed to increase adequate BP control.
- 4.2 Additional increase in number of members ages 18-85 with hypertension enrolled in the registry.
- 4.3 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<140/90 ages 18-59).
- 4.4 Additional increase in percentage of members enrolled in the registry whose BP was adequately controlled (<150/90 ages 60-85).

Continue Activity in 2022

2021 Activities designed to increase registry members with hypertension whose BP was adequately controlled	2021 Number of Network Providers
Ask members about their tobacco use at each visit and track data in the member's medical record.	32
Educate providers on transportation services within the community to refer to members with transportation issues.	1
Incorporate flexible scheduling (i.e., same day appointments, walk-ins, evening or weekend appointments).	2
Total:	**35**
Activity Documentation is due 8/15/22	

CY2022 Registry Modifications

- **Race Drop Down**
  - The drop-down menu in the "Race" data field has been removed to make the template more user-friendly. Network providers must still complete this field.
- **Table Format & Primary Root Cause**
  - The registry will now be a standard Excel worksheet. The table format has been removed.
  - The "Primary Root Cause" data field has also been removed from the registry.
- **'Short Date' Format**
  - All data fields containing dates will be placed in 'Short Date' format (ex. MM/DD/YYYY).

2022 Continuation of Current CQI Activities

- Continued collaboration with MCOs
- Monthly group discussions
- Improvements/revisions to the Network Provider timeline
- CQI workshops
- QIN website
- Solicitation of Network Provider feedback
- Network Provider training and education (submissions due May 16)

Part II: Evaluation and Review of 2021 Performance

Evaluation & Review of 2021 Performance

Allen Parish: 2021 performance in improving blood pressure control for registry members and findings for each age cohort 18-59 years old and 60-85 years old

Kandace Fontenot, MHA, Director of Clinical Informatics and Information Systems

On behalf of

Allen Parish Hospital

Evaluation & Review of 2021 Performance

Abbeville: 2021 performance in improving blood pressure control for registry members and findings for each age cohort 18-59 years old and 60-85 years old

Tina Faulk, BSN, RN, CDCES, Diabetes Education Program Coordinator

On behalf of

Abbeville General Hospital

Evaluation & Review of 2021 Performance

Ochsner: 2021 performance in improving blood pressure control for registry members and findings for each age cohort 18-59 years old and aged 60-85 years old

Candi Meridith, MPH, Director Value Based Performance and ACO Operations MCIP Program

On behalf of

Ochsner LSU Health Monroe
Ochsner LSU Health Shreveport
Ochsner Medical Center
Ochsner Medical Center – Baton Rouge
Ochsner Medical Center – Kenner
Ochsner Medical Center – North Shore
Ochsner St. Anne General Hospital
Ochsner St. Mary
Slidell Memorial Hospital
Southern Regional Medical Corporation
St. Bernard Parish Hospital
St. Charles Parish Hospital

Evaluation & Review of 2021 Performance

Terrebonne: 2021 performance in improving blood pressure control for registry members and findings for each age cohort 18-59 years old and aged 60-85 years old

Tabitha Brown, Clinical Navigator and Data Analyst, Quality and Patient Safety

On behalf of

Terrebonne General Medical Center

Break

Part III: Patient Treatment Gaps

Patient Treatment Gaps

HCA: Addressing patient treatment gaps

Penny Hutson, CFO, HCA MidAmerica Division

On behalf of

Rapides Regional Medical Center

Tulane University Hospital and Clinic

Patient Treatment Gaps

Ochsner Lafayette General: Addressing patient treatment gaps

Tena Turnage, RN, Manager – Clinic Operations, Population Health

On behalf of

Ochsner Abrom Kaplan Memorial Hospital
Ochsner Acadia General Hospital
Ochsner Lafayette General
Ochsner St. Martin Hospital
Ochsner University Hospital and Clinics

Patient Treatment Gaps

Opelousas: Addressing patient treatment gaps

Marsha Gauthier, RN, Population Health

On behalf of

Opelousas General

Part IV: 2022 Improvement Activities

2022 Improvement Activities

Baton Rouge General: Challenges and Approaches to increase participation in 2022 improvement activities

Shelly Martinez, RN, Administrative Director – Clinical Quality

On behalf of

Baton Rouge General Medical Center

The General Hospital

2022 Improvement Activities

North Caddo: Challenges and approaches to increase participation in 2022 improvement activities

Michele Heflin, LPN, Clinical Integration Specialist

On behalf of

North Caddo Medical Center

2022 Improvement Activities

CHRISTUS Health: Challenges and approaches to increase participation in 2022 improvement activities

Tonya Corley, Office Manager, Group Operations

On behalf of

CHRISTUS Coushatta Health Care Center
CHRISTUS Health Shreveport-Bossier
CHRISTUS Ochsner Lake Area Hospital
CHRISTUS Ochsner St. Patrick Hospital
CHRISTUS St. Frances Cabrini Hospital
Savoy Medical Center

2022 Improvement Activities

St. Tammany: 2021 Hypertension registry enrollment performance: challenges and areas of improvement

Cameron Jenkins, MBA, Clinical Quality Coordinator

On behalf of

St. Tammany Parish Hospital

Part V: Lessons Learned

Lessons Learned

Iberia: Incorporating lessons learned through the CQI workshops to improve the hypertension project

Meagan Trahan, RN, Care Manager

On behalf of

Iberia Medical Center

Lessons Learned

Pointe Coupee: Incorporating lessons learned through the CQI workshops to improve the hypertension project

Jeanine Thibodeaux, RN, Administrator

On behalf of

Pointe Coupee General Hospital

Part VI: Conclusion

Conclusion

Group Discussion / Q & A Session

All Network Providers

Conclusion

Lillian Spuria, Gjerset & Lorenz, LLP

Closing Remarks

Questions?

Please direct any additional questions to QIN at reporting@lamcip.org

Appendix G: Provider Education Materials

Due to file size constraints, the education materials for Appendix G are included in a separate file submitted contemporaneously with this report.