POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	**DOCUMENT NAME:** Quality Performance Improvement Projects
PAGE: 1 of 11	**REPLACES DOCUMENT:**
APPROVED DATE: 09/11	**RETIRED:**
EFFECTIVE DATE: 01/12, 12/15	**REVIEWED/REVISED:** 09/13, 5/14, 7/14, 5/15, 9/15, 8/16 7/17, 7/18, 6/19, 4/20
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.QI.12

SCOPE:
Louisiana Healthcare Connections (Plan) Quality Improvement department

PURPOSE:
To outline the process by which the Plan measures quality and demonstrates improvement that positively affects the clinical quality of care and quality of service that members receive.

POLICY:
The Plan shall continuously monitor its performance on a variety of dimensions of care and service for enrollees. The Plan will identify its own areas for potential improvement, carry out individual projects to undertake system interventions to improve care, and monitor the effectiveness of those interventions.

The Plan must take timely action to correct significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

PROCEDURE:
I. The Plan shall conduct quality improvement projects that achieve, through ongoing measurement and intervention, demonstrable improvement in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction (or as outlined in State contract, if more stringent).
   a. Plan must be engaged in at least two LDH approved performance improvement projects (PIPs) as listed in ~~Appendix DD~~ **SECTION 14.2.8** – Performance Improvement Projects for the ~~initial three-year~~ term of the contract LDH may require up to two (2) additional projects for a maximum of four (4) projects. Additionally, the plan must be engaged in at least one LDH approved behavioral-health performance improvement project each contract year.
   b. Projects may be single-year or multi-year in length.
   c. The detailed PIP description must include all aspects included in ~~Amendment 11~~ **Contract Extension**, SECTION 14.2.8.4
   d. Plan must submit to LDH, in writing, a general and a detailed description of each PIP to LDH for approval within three (3) months of

the execution of the contract and at the beginning of each contract year thereafter.

II. The development and selection of clinical and non-clinical performance improvement projects may be delegated to the Performance Improvement Team (PIT), a subcommittee of the Quality **Assessment and Performance** Improvement Committee (Q**API**C) due to its clinical and key functional area representation within the organization affecting services.

III. PIP progress and evaluation will be reported at a minimum of annually to the Q**API**C.

IV. The Plan utilizes a ten-step methodology recommended by Department of Health and Human Services Centers for Medicare and Medicaid Services EQR Protocol 7 Implementation of Performance Improvement Projects to implement its quality improvement initiatives. However, there may be opportunities for improvement identified in which a modified version of this process may be used.

Step 1: Selecting the Project or Study Topic

Plan routinely collects and interprets data from all areas of the organization, to identify areas of concern, health delivery system issues, and issues in member and provider services. Plan may also wish to test an innovative strategy for improving the quality of care or services provided. The opportunity must be specific and relevant to Plan programs and/or member population, and must describe an observable, measurable, and manageable issue.

In choosing a study topic, Plan may review the following types of information:

- Population information. Data on member characteristics relevant to health risks or utilization of clinical and non-clinical services, demographics (age, sex, race and ethnicity, language, etc), disability or functional status, and/or geographic location of membership
- Performance measures. Data on the organization's performance as reflected in standardized measures, including when possible local,

state, or national information on performance of comparable organizations.

- Other utilization, diagnostic, and outcome information. Data on utilization of services, procedures, medications and devices; admitting and encounter diagnoses; adverse incidents (such as deaths, avoidable admissions, or readmissions); and patterns of referrals or authorization requests.
- External data sources. Data from outside organizations, including Medicaid fee-for-service data, data from other Plans, and local or national public health reports on conditions or risks for specified populations, data from health information exchange technology including registries.
- Member and provider satisfaction information; data from surveys (such as Consumer Assessment of Health Plans Survey (~~, or~~ CAHPS)-and provider satisfaction surveys), information from the grievance (member and provider) processes, information on disenrollment's and requests to change providers, etc.
- Data in appointment and provider networks (e.g., access, open and closed panel, and provider language spoken).
- Data from certified electronic health record (EHR) technology if available.

To the extent possible, the following elements shall be considered in selection of project topics:

- Align managed care quality efforts with fee-for-service quality activities in order to improve health care outcomes for beneficiaries and reduce provider burden;
- Select projects based on Healthcare Effectiveness Data and Information Set (HEDIS) measures for consistency;
- Seek relevance to all lines of business within the health plan (e.g. Medicaid, SCHIP, ABD, SSI, and Medicare)

Appropriate topics are derived from either clinical areas or service delivery areas. In selecting clinical topics, each committee reviews demographic and utilization data of the enrolled populations to construct a demographic and health profile. The topics chosen reflect high-volume or high-risk conditions for the populations' served, preventative health needs such as EPSDT or quality of care issues and clinical practice

guidelines. Topics selected are those in which improvement in Plan performance will make a difference to the population served, either through better service or improved health outcomes. Input for study topics may also be obtained from Member Advisory Committees and or Specialty Advisory Groups.

Step 2: Define the Study Question

Before proceeding further with a study, it is important for the appropriate committee, clinical or non-clinical to clearly state in writing the question(s) the study is designed to answer. Stating the question(s) is important in order to stay focused on the mission. Writing a clear study question helps the QI team identify priority questions as well as set the frame work for the data collection, analysis and interpretation.

Potential sources of information to help for the study question include:

- State data relevant to the topic being studied
- Plan data relevant to the topic being studied
- Relevant clinical literature

Identifying the Specific Practice Guidelines or Health Service Standards Practice guidelines are systematically developed statements based on accepted medical evidence that assist provider and patient decisions about appropriate health care for specific clinical circumstances. They are used to objectively evaluate clinical and health service delivery issues as well as guide care delivery. Clinical care guidelines are available from a number of sources, including but not limited to:

- The American Medical Association, Directory of Practice Parameters;
- Medical Specialty Societies, such as the American Academy of Pediatrics;
- The National Institutes of Health;
- The Agency for Healthcare Research and Quality formally The Agency for Health Care Policy and Research of the U.S. Department of Health and Human Service's Public Health Service; and
- U.S. Preventive Services Task Force's Guide to Clinical Preventive Services.

Although nationally-developed guidelines can serve as the foundation, the Plan's Q**AP**IC obtains input from network providers to ensure that variations are considered. Plan's committee also ensures that State contract standards are considered where appropriate. These contract standards and input are integrated, as appropriate, into any clinical guidelines accepted and distributed to network providers.
State contractual requirements and Plan internal service standards are used to evaluate non-clinical QI initiatives. Service performance standards related to these initiatives are routinely reviewed and analyzed by the Q**AP**IC.

Step 3: Identify the Study Population
Measurement and improvement efforts must be system wide. The PI must clearly identify the "system" or population, also referred to as the universe. Once the population is identified, the Plan will determine whether to study date for the entire population or a sample of that population. A representative sample of the identified population is acceptable (see Step 5).

Data on the Plan's enrolled population as well as enrollee counts relevant to the study topic and measures. This includes: demographic information from enrollment files, other databases, as needed (e.g., pharmacy clams data to identify patients taking a specific medication(s) during a specific enrollment period), and utilization and outcome information such as:

- Services
- Procedures
- Admitting and encounter diagnoses
- Adverse incidents (e.g., deaths, avoidable admissions, readmissions)
- Patterns of referrals
- Authorization requests

Step 4: Identifying Study Indicators, Criteria and Goals
Study indicators are defined, measurable variables derived from clinical practice/treatment guidelines, State contract, or Plan internal service

standards. The indicators are used to monitor the processes and outcomes of care.

Criteria are the rules established for data collection and are defined prior to data collection to ensure uniformity.
Goals are predetermined, desired levels of performance on indicators. Goals may be reported as "perfection", expressed as 0% or 100%, industry benchmark, or percentage change from baseline measurement.

Each PIP should have one or more measured indicator to track performance and improvement over a specific period of time. All measured indicators should be objective; clearly defined; based on current clinical knowledge or health services research; and enrollee outcomes (e.g., health or functional status, enrollee satisfaction).

The number and complexity of measures may vary depending on the study question(s); the complexity of existing practice guidelines for a clinical condition; and availability of data and resources to gather data.

Potential Sources of goals include clinical and non-clinical practice guidelines along with administrative and medical data.

Step 5: Population and Sample Methodology Identification
Appropriate sampling is necessary to ensure valid and reliable information. Please refer to Appendix II of the EQR Protocols for an overview of sampling methodologies applicable to PIPs. HEDIS ® measures should also use HEDIS® sampling methodology, which is considered valid and reliable. Identifying the target population and determining a sampling plan are the next steps in developing a performance improvement project or focused study. The principle issues are: defining the target population; specifying the minimum enrollment period; and determining how to identify the study population. Once the population is identified, Plan's appropriate quality committee will decide whether to review data for the whole population or draw a sample from the population.

Step 6: Developing the Data Collection and Retrieval Plan

Once the population or sampling plan has been developed, the strategy for data collection will be developed. Data collection procedures must ensure that the data used to measure performance are valid and reliable. Valid data measure what is intended to be measured, while reliable data produces consistent results. To ensure both validity and reliability, the data collection plan should specify:

- the data sources and how data will be collected;
- who will collect the data;
- the instrument(s) that will be used to collect the data or, for automated data systems, specifications for automated collection of the data;

The data retrieval phase includes the following components:

- field-testing the data collection methodology/instrument;
- selection and orientation of data collection staff;
- collection of data and information staff;
- validation

Step 7: Data Analysis and Interpretation of the Study Results

Analysis begins with examining the study data to calculate plan performance on clinical or service indicators. The examination is initiated using the statistical tools defined in the data analysis plan. The VPQI or QI Director compares plan performance with previous performance, selected goals and/or industry benchmarks, depending upon the defined study methodology, and presents the information to the appropriate committee for review and input. Accurate PIP data analysis is critical because changes in treatment and operations are implemented based on the results of a PIP.

Interpretation and analysis of the study data should be based on continuous improvement philosophies and reflect an understanding that most problems result from failures of administrative or delivery system processes. Plan's QI Department will develop hypotheses about the possible causes, and collect data to validate the hypothesis.
Addition resources of information could include:

- Baseline project indicator measurements
- Industry benchmarks

- Analytic reports of PIP results by the Plan
- Repeat project indicator measurements

Step 8: Identify Improvement Strategies

Real sustained improvements result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.

An improvement strategy is defined as an intervention designed to change behavior at an institutional, practitioner, or beneficiary level. The effectiveness of the intervention activity or activities is determined by measuring the Plan's change in performance, according to predefined quality measures.

Interventions are key to a PIP's ability to bring about improved healthcare outcomes. Appropriate interventions are identified and/or developed for each PIP to assure the likelihood of effecting measurable change.

Potential sources of interventions include:

- Current project baseline data
- Previous project data (if available)
- Results of clinical and literature research
- Project evaluation results completed by evaluators

If repeated measures indicate that quality improvement actions were not successful (i.e., did not achieve significant improvement), the problem solving process should begin again with data analysis to identify possible causes and propose and implement solutions. If the quality improvement actions were successful, the new processes are standardized and monitored.

Step 9: Planning and Implementing Improvement Strategies for Real Improvement

This step is the crucial step in improving Plan performance throughout its system and, thereby, the health of the population. Real, sustained improvements in care result from a continuous cycle of measuring

performance, analyzing performance, and developing and implementing system-wide improvements in care or service. Improvements in care or service depend on thorough analysis and implementation of appropriate solutions.

Once the Committee analyzes study results and collects and identifies additional information to explain results, it must develop a quality improvement plan. Depending upon the nature and scope of identified problems, the Q**AP**IC may involve more people or form subgroups to address specific issues. Other issues in implementing the action plan may include: clearly defining specific tasks to be accomplished, identifying persons responsible for the tasks, establishing time lines and determining how and when the quality improvement plan's effectiveness will be measured.

Step 10: Re-evaluation and Monitoring for Sustained Improvement
Re-evaluation assesses whether quality improvement actions were effective. If reevaluation indicates that quality improvement actions were not successful, the problem-solving process begins again with data analysis to identify possible causes, propose and implement solutions, and so forth.

If quality improvement actions were successful, the new processes will be standardized and monitored on a continuous basis to ensure the improvements are sustainable. Improvement must demonstrate repeated improvements or the likelihood of repeated improvements. Potential sources of information include:

- Baseline and first repeated measurements on quality indicators
- Additional measurements on quality indicators made after the first repeated measurement

V. The QI designee shall document the PIP using ~~the HSAG form or other~~ State mandated form.

VI. Summary of progress and outcomes is reported to the PIT. A summary of each PIP is also documented in the Annual Q**AP**I Program Evaluation.

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a. As defined per State contract, submission of PIP documentation to the State or other external agency may also be required

REFERENCES:
Current NCQA Health Plan Standards and Guidelines
42 CFR §438.240
MCO Contract Section 14.1. Quality Assessment and Performance Improvement Program (QAPI)

ATTACHMENTS:
~~Attachment A – HSAG Performance Improvement Project Summary form 2014~~
none

DEFINITIONS:
Demonstrable Improvement – significant improvement sustained over time.
Significant Improvement – those that achieve pre-calculated-effect sizes.

REVISION LOG:	**DATE**
Changed NCQA date	5-2014
NCQA date was changed incorrectly in May, correcting to 2013	7/2014
Updated References: Current NCQA Health Plan Standards and Guidelines	5/2015
Revised references throughout document: from LA CCN-P to MCO	5/2015
Changed Appendix D to Appendix DD	5/2015
Added "Additionally, the plan must be engaged in at least one DHH approved behavioral-health performance improvement project each contract year."	9/2015
Changed Section 1 and 2 to read, "Performance Improvement Projects for the initial three-year term of the contract" as per amended contract language. Changed "provider agreement" to contract as per amended contract language Changed DHH to LDH	8/2016
Updated Policy to mirror Corporate Policy Updated PIP guidelines to reflect CMS EQR Protocol 7 Implementation of Performance Improvement Project	7/17

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Removed Attachment A-NCQA Quality Improvement Activity Form 03/07. Replaced Attachment A with HSAG Performance Improvement Project Summary form 2014 Removed Attachment B-Instructions for NCQ QIA Form 03/07 Minor grammatical edits Removed Quality Improvement Activity (QIA) Changed QIC to PIT Removed reference of the NCQA Quality Improvement Activity Form replaced reference to HSAG form Reference of Appendix DD to Appendix J	
Changed wording to reflect changes reflected in Amendment 11 from the RFP.	7/18
No revisions	6/19
Changed QIC to QAPIC **Removed Appendix DD** **Added Contract Extension Section 14.2.8** **Removed Attachment HSAG as no longer applicable**	**4/20**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

VP Quality Improvement: _____ Electronic Signature_____
~~Sr. VP, Medical Affairs~~**Chief Medical Officer**:_____ Electronic Signature _____