Bayou Health Reporting

Report Information

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Definitions and Instructions:

- Reporting Quarter
  2nd Quarter, June 2021

- Agenda Topics
  – Introductions
  – Health Plan Updates
  – Health Disparities and Interventions
  – Group Discussion

- Introductions
  - All attendees gave their name, title, and organization they were representing
  - Peter Lambousy, Marketing Director for Healthy Blue, stated during this meeting we would be discussing disparities and how we were able to aid different communities and individuals (people) in getting the access to care that they may need
  - Two new team members for the Healthy Blue Marketing Department introduced themselves: Cassandra Sibenaller – Marketing Coordinator Sr., and Robin Bennett – Community Relations Representative III

- Health Plan Updates
  - Current total membership: 336,783
  - This growth is due to the pandemic and is across all Medicaid plans.
  - Healthy Blue has seen a 70,000-member increase over the COVID-19 period.
  - The state and federal government has frozen and locked in membership.
  - No member must show eligibility and renewal information until the emergency is removed.
  - The state is still sending out eligibility letters. If you do not reply to the letter you will not lose coverage.
  - There was an emergency contract issued by the state.

- The emergency contract for Medicaid was in effect from January 1 through December 31, 2021.
- When the RFP was released, there was some protest involved about the way it was scored. The governor issued an emergency contract to make sure the program would not end. That contract was from January 1, 2020 through December 31, 2020.
- We are going back into an RFP. We expect the release of this sometime in spring. We will respond to it and we are confident we will keep this population.
- Under this RFP, the contract would go into effect January 1, 2022.

- Health Disparities and Interventions
  - Christin Cantavespri, Director of Quality Management for Healthy Blue, presented on Health Disparities and Interventions.
  - Christin stated that Healthy Blue uses health disparities to measure its progress toward reaching health equity (fairness).
    - **What are Health Disparities?**
    - **Health disparities are preventable differences to achieve good health linked to social, economic, or environmental disadvantage.**
    - Health disparities can be used to measure progress toward achieving health equity.
      Reducing health disparities shows we are moving toward greater health equity.
      Health is achieved by improving the health of those who are economically/socially disadvantaged, not by worsening the health of those in advantaged groups.
    - Health means everyone could reach their highest level of health. Barriers (hurdles) to doing so must be removed.
      This includes giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
      Barriers can be access to care, quality of care, community resources, personal behaviors, and discrimination.
- Culturally and Linguistically Appropriate Services (CLAS) and Health Disparities Program
    - At Healthy Blue, we have a Culturally and Linguistically Appropriate Services (CLAS) and Health Disparities program. We are certified by the National Committee for Quality Assurance (NCQA). Being a National Accreditation Entity on this program shows the importance of delivering relevant health benefits and making sure the quality of care for our members is equal across the board.
- Overall Disparities – Analysis (Study)

- We noticed in our membership there are disparities for the African American populations (groups of people) versus other populations we serve. In particular, childhood immunizations (vaccinations), controlling high blood pressure, and diabetes measures. We see a high percentage who have diabetes and high blood pressure not having these chronic needs being met. There are some behavioral health measures as well. We noted some disparities around depression and substance use disorder treatment (care).
- The first population we will discuss is the substance use disorder population. The African American population has a much lower compliance rate with following up on initiation, treatment, and engagement for managing substance use disorder compared to the White population.
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2019 Disparities Analysis: All Results for Medicaid Measures													
Catego	Regio	Measu	SubMeasure	LOB	State	Race / Ethnici	Compliant Mbrs	Eligible Mbrs	Compliance Rate	Odds Ratio to Whit	Gaps to White Ra	Statistically significant	NCQA Scored Measure
BH	Central	IET	EN TOTAL	Medicaid	LA	Black	620	3,660	16.95%	0.77	190	Yes	Y
BH	Central	IET	IN TOTAL	Medicaid	LA	Black	1,996	3,660	54.54%	0.89	248	Yes	

- We have a performance improvement plan with the state for this population. There's a lot of work being done by the Managed Care Association (in collaboration) to improve the outcomes for this membership. We have targeted education right now. We have determined those members and who their primary care physicians (PCPs) are. We are doing outreach to let the PCPs know we are seeing this disparity within their member panel. We are alerting

the PCP of the disparity issue in their membership, and then letting them know the members need follow-up, initiation, engagement, and treatment for substance use disorder. We did some outreach Q4 of last year for these PCPs' targeted members. We saw some improvements in the overall rates in terms of data.

- IET Initiation Measure (Opioid DX population targeted, Regions 2 & 8):
- Region 2:
- Q1 2020- 52.38% (AA) vs. 69.7% (White)
- Q2 2020- 60% (AA) vs. 65.0% (White)
- Q3 2020- 62.16% (AA) vs. 66.67% (White)
- Q4 2020- 56.25% (AA) vs. 72.00% (White) * not full data set for Q4 2020
- Region 8:
- Q1 2020- 37.5% (AA) vs. 64.71% (White)
- Q2 2020- 60% (AA) vs. 78.95% (White)
- Q3 2020- 54.55% (AA) vs. 75.0% (White)
- Q4 2020- 60.00% (AA) vs. 77.97% (White) * not full data set for Q4 2020
- IET Cont Measure (Opioid Dx population targeted Regions 3,4,8)
- Region 3:
- Q1 2020- 15.79% (AA) vs. 30.0% (White)
- Q2 2020- 10.53% (AA) vs. 33.33% (White)
- Q3 2020- 18.18% (AA) vs. 34.69% (White)
- Q4 2020- 33.33% (AA) vs. 38.57% (White) * not full data set for Q4 2020
- Region 4:
- Q1 2020- 0% (AA) vs. 28.13% (White)
- Q2 2020- 20% (AA) vs. 40.74% (White)
- Q3 2020- 27.27% (AA) vs. 42.62% (White)
- Q4 2020- 27.78% (AA) vs. 38.46% (White) * not full data set for Q4 2020
- Region 8:
- Q1 2020- 0% (AA) vs. 47.06% (White)
- Q2 2020- 10% (AA) vs. 57.89% (White)
- Q3 2020- 18.18%% (AA) vs. 50% (White)
- Q4 2020- 20% (AA) vs. 52.54% (White) * not full data set for Q4 2020

- Through Q1 and Q4, we identified certain regions. We saw disparities in regions 2 and 8 for initiation of treatment; and regions 3, 4, and 8 for continuing the treatment. During our intervention and outreach to the providers, we saw an increase in the overall compliance rate for African Americans compared to the White population. The compliance rates are still lower than the White population's, but we were able to see improvement, which is our goal.
- We also do provider feedback surveys. It is important for us to get feedback. We were able to survey some of our provider groups around substance use disorder and what barriers they're seeing to treating members. They did identify a few barriers. One being parental reluctance, keeping regular appointments for our members and patients. Patients do not always want to answer the questionnaire at the visit. One of the initiatives we have is making sure our providers know about all the screening tools for substance use disorder. And making sure members are screened so they can be referred to the correct services at the patient's discretion. Other barriers are patients refusing Behavioral Health services and consistency in screening. Providers use Medication-Assisted Therapy (MAT) therapy for substance use disorder. Nearly 67% of providers offer MAT. This is a push from the Louisiana Department of Health (LDH) because it's an evidence-based practice. We are asking more providers to use this therapy for our members because we have seen good results.

- **Survey sent out to 12 provider groups**
- 9 results obtained
- 9 questions on survey responses:
- Barriers identified:
  - Parental reluctance, keeping consistent appointments

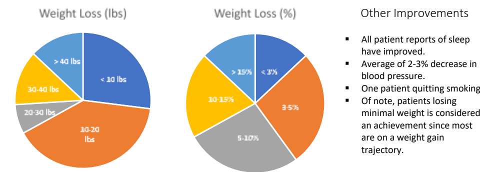
        - Patient does not want to answer questionnaire at visit
        - Patient refusing BH services or consistency in screening
- Provider use of MAT therapy:
- 66.67% stated Yes

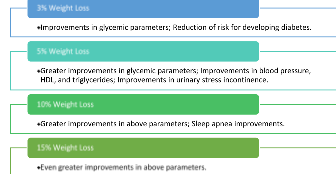
- Colorectal Screenings – Current Interventions
    - The next big area of focus is on colorectal screenings. We have a multi-approach to colorectal screenings.
    - Screening rates for our members were down this past year. Because of COVID-19, a lot of preventive services were put on hold. Now we are trying to catch up.
    - Healthy Blue believes in a multi-approach, to ensure our members are getting care and have access to preventive services such as colorectal services. The multi-approach includes:
        - <u>Robust Provider Engagement</u> – Our Quality and our Clinical Transformation teams work together to provide education and training for providers; on identifying gaps in care within their practice, clinical practice guidelines, coding education, and HEDIS (Healthcare Effectiveness Data Information Set) specifications.
            - Gap in care reporting, identifying members assigned to PCP panels, are given to providers to use for interventions to increase outcomes. Quality metrics by practice/individual provider are sent to providers, as well as real-time access to Healthy Blue's Population Health Platform.
        - <u>Member Engagement</u> – Outreach members by text campaigns, live and Interactive Voice Response (IVR) calls, to connect them with their PCP to close gaps in care.
        - <u>Member Education</u> – Educational materials are shared with members on wellness and preventive services.
        - <u>Community Partnerships</u> – We engage members in the communities they reside in, offering screenings and education.
        - <u>Taking Aim at Cancer in LA Initiative (TACL)</u> – Healthy Blue has also been active in the TACL initiative to align payors and the LDH on policy and strategy, and to improve overall outcomes for the residents of Louisiana.

- Colorectal-Disparity Analysis
    - Healthy Blue currently has 27,000 members who meet eligibility for colorectal screenings.
        - Ages 52-65 were noted to have the highest noncompliance rate.
        - Regions 7 and 8 had the highest noncompliance rate.
        - Healthy Blue works with the Mary Bird Perkins Cancer Center (MBP) to hold screening events in areas with disparities, like Region 8.
    - Since November 2020, MBP and Healthy Blue have hosted four cancer screening events (three colorectal screening events, and one breast and colorectal screening event). These events were held in the Catahoula, Concordia, and Morehouse parishes.
    - To date, 130 screenings have been done. Seven participants had abnormal findings and got support from the MBP patient navigator to reach timely resolve of the findings. At this time, no cancers have been diagnosed.
    - Screening participants also received produce boxes, recipes, and education on the relationship between maintaining a healthy diet and cancer prevention.
    - The next event is scheduled for June 24, 2021, in Jonesville, LA.
    - A future 2021 goal is to hold a provider training symposium with community partners and high performing quality providers. Disparity and inequity training will be included.

Success	Challenges
Community Partnerships- Mary Bird Perkins	COVID Fears- need to bring members back into the office setting
MCO Collaboration via TACL	Member engagement, Medicaid recipient demographic data challenging
Analysis of disparities and incentive program developed tied to SDOH to focus on whole person centered health & improved outcomes	Provider office staffing structures due to COVID & Natural Disasters (office closures)
Provider incentive programs for meeting quality goals tied to wellness checks & COL screenings	Lab Data challenges, receiving timely and accurate data to determine COL rates and opportunities for improvement)
Expansion of telehealth & at-home visit strategy with overall goal to connect the members back to their PCP	

- Diabetes and Controlling Blood Pressure (CBP) Disparities
  - We did deep dives in regions 1, 2, and 9 to identify (find) gaps of disparity in the African American population in CBP and diabetic care.
  - Disparities in the African American population were identified (found) for CBP, blood sugar level (A1c <8), and CDC-CBP 140/90
  - CBP – 154 members identified
  - A1c <8 – 392 members identified
  - CDC-CBP – 397 members identified
  - Intervention: Member gap in care list sent to Nurse Practitioner (NP) who will make home visits to close gaps in care and connect the members with their PCPs.
  - Planned intervention to begin in Q2 2021
  - We are working with a NP who is being sent into the community to outreach these members. The NP is making house calls, giving the members education, taking their A1c, taking their blood pressure, connecting them back to their PCP, and any follow-up as needed.
  - We don't have any outcome data on this yet; we just started it three weeks ago. We hope to get these members access to care and get them more compliant with these conditions overall.
  - Pennington Biomedical Research Center – Diabetes Program
  - For diabetes, we also partner with Pennington Research Center. They have developed a great program.
  - They are enrolling members who are on the cusp of becoming diabetic. It's more of a preventive program. They manage their weight, teach them about healthy eating habits, exercise, sleeping patterns, and how to tackle stress.
  - This program is to help prevent diabetes in people at risk, and to reverse the effects of type 2 diabetes in those already diagnosed.
    To be eligible, members must:
    - Be 21 or older.
    - Struggle with being overweight.
    - Be diagnosed by their doctor with pre-diabetes or diabetes and/or struggle to lose weight.
    - Be ready to change habits related to diet, exercise, sleep, and how they tackle stress.
  - Healthy Blue identified members eligible with the above and added a layer for members with more than two Emergency Department (ED) visits in 2019 and 2020.
    - These members experienced access to care barriers and had up to 13 ED visits during the measurement period.
    - In 2020, Healthy Blue helped to enroll 67 members into the program who met eligibility.





- Well-Child Immunizations
  - This measure also has been hard hit by decline because of COVID-19.
  - Immunization rates across Medicaid have gone down. A lot of children aren't on schedule with their immunizations because they haven't gotten back into the office.
  - We are trying to get these children back on schedule. We want to make sure they have their immunizations, and that they're seeing their pediatricians regularly and getting their well-checks.
  - Provide incentives for meeting performance goals
  - Text campaigns and live call center outreach – connecting members to PCPs
  - Work with LA American Academy of Pediatrics (AAP) on Back to Office Campaign – includes messaging and provider survey deployment on barriers
  - Immunization screening events as COVID-19 allows
  - Healthy Reward member incentives: well-checks
  - Immunization Registry State File
  - Medical Record Audits: NCQA Requirement and action planning related to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements
  - State Performance Improvement Plan (PIP) on childhood developmental screening: Shared efforts of Managed Care Organizations (MCOs) to develop meaningful interventions and data collection to drive performance (monthly Plan-Do-Study-Act (PDSA), quarterly tracking, and annual reporting)
  - EPSDT/provider co-branding initiative – partner with providers to co-brand member education materials
  - Partnership with Pfizer – birthday reminders
  - Provider gap in care and report card distribution
  - Analysis on disparity and targeted interventions is underway
- HEP C Screenings and Treatment
  - HEP C is an area of focus now for the state.
  - We have a performance improvement plan around that for Medicaid members for the entire state.
  - We have noted some disparities:
  - **Disparity Rates:**
  - Age group most affected – 28-54 years (by 54.97%)
  - Gender – Males (by 59.34%)

- Race – Black or African American (by 35.48%) and White (by 31.49%)
- Regions of prevalence – 1, 4, and 9 (with a combined rate of 48.87%)
- Outreach data:
- 3,075 members identified as not receiving hepatitis c virus (HCV) treatment
- 386 attempted member outreaches to date
- 333 members contacted
- 28 appointments made
- Member feedback:
- More than 300 members stated they had completed (finished) treatment for HCV
- Barriers to care identified – none
- Christin Cantavespri asked Barbara Miller of Southwest Louisiana AIDS Council to join her after the meeting (since they are doing screenings for HEP C and HIV).

- COVID-19 Immunizations
  - COVID-19 immunizations are huge right now. Trying to get our state up to par with getting everyone immunized is the battle we have.
  - We have done a disparities analysis:
    - Rates and disparity analysis as of 5/27/2021
  - Members getting one or both vaccine doses from any manufacturer:
    - 22.46% of Healthy Blue eligible members received at least one dose
    - 19.20% of Healthy Blue members completed the vaccine course
  - Race/Ethnicity Breakdown:
    - Black or African American: 22.34% of eligible members received at least one dose; 18.85% completed the vaccine course
    - White: 17.94% of eligible members received at least one dose; 15.32% completed the vaccine course
    - Hispanic/Latino: 18.97% of eligible members received at least one dose; 15.82% completed the vaccine course
    - Other/Unknown: 27.80% of eligible members received at least one dose; 24.19% completed the vaccine course
  - Member outreach for eligible and second dose missed:
    - Community Health Worker (CHW) outreach
    - National call center outreach
    - Text campaign outreach
    - Social media campaigns
    - Mobile unit partnerships with community organizations on giving the vaccination
    - Partnership with Mendoza Medical Clinic – focus on improving vaccinations within the Hispanic/Latino populations
    - Provider gap in care reporting outreach
    - Community education

- Take Away

- Peter told everyone how vital it was to hear from them. That's how Healthy Blue gets ideas, understands obstacles and challenges, and other things you may see on the day-to-day basis. You have more knowledge because you are working closely with the community, our members, and any other Medicaid recipient. Peter also said Healthy Blue wants to improve access and ease any fears or hesitancy with people. The COVID-19 vaccine is the hot topic now. A lot of people have hesitancy and there's a large part of the population that is anti-vaccination. Our goal is always to be respectful of individuals and their choices. At the same time, we want to make sure we are educating them, so they have the full understanding of the need for the COVID-19 vaccination and all the screenings.
- Peter asked if there was anything anyone could think of that would create barriers, obstacles, or concerns. Is there anything Healthy Blue can do better? Or just general information?
  - Barbara put in the comments that she's trying to get members in to get tested in consistent numbers. Many clinics in the area have been affected by the storms and flooding. Christin replied that Healthy Blue has seen this in many settings and has discussed this with the LDH. Just recently around trying to get members in areas that have seen greater impacts. It's affecting prevention and screening rates overall, which is an area of concern.
  - Christin stated that Healthy Blue can't send telehealth kits for the screenings. We are trying to promote using telehealth with the providers, who may not be able to access the clinic themselves. We have an initiative now where we will be sending out telehealth kits to members we have identified. We are working with Case Management to make sure we identify members who really need the kits. These will be sent to members controlling blood pressure and diabetes, and high-risk moms.
  - Patricia Williams with David Raines Community Health Center stated that their colorectal rates have gone up over the past year. They are partnering with LSU AgCenter to start a project for rural communities. We would have preferred it to be in Region 7, but it's for rural. This project is for colorectal screenings. Patients are going to get $25 to sign up. The projected start date is July 2021. Our goal is to enroll 200 people over a 3-month period: that's any patient coming to David Raines. Colorectal and diabetes are our primary focus. David Raines has been very involved in giving COVID-19 vaccines in this part of the state. We have given 11,000 vaccines. Peter replied by assuring Patricia that Healthy Blue is here to help in any way to support their efforts in what they're doing in the community. Patricia said that the Healthy Blue mobile van was coming to her on the day of this meeting. Kathy Victorian, Marketing Manager with Healthy Blue, told Patricia that the van would be available for screenings as well as vaccinations.
  - Monette Kilburn, Community Outreach Representative with Healthy Blue, stated that Kathy opened a can of worms about the mobile van. Kathy replied that she would send photos of the van again to the marketing representatives to distribute to their community partners. Peter stated that use of the van is as our schedule permits. He added that it's open to any organization and that Healthy Blue does not provide medical services. We help administer and provide access to those services. We would need a partnership where there are NPs and/or doctors that can help staff those events. If your organizations don't have those connections to providers, we can help make those connections in the area. There is no place in the state that we would exclude access to the van. It's just more of a scheduling, first-come, first-served basis. The more we can utilize it, the better it is for Healthy Blue members and communities. We have the van on loan for a year.