Health Plan Performance Improvement Project (PIP)

Health Plan: Louisiana Healthcare Connections (LHCC)

PIP Title: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

PIP Implementation Period: January 1, 2020-December 31, 2021

Submission Dates:

	Proposal/Baseline	Interim	Final
Version 1	2/3/2020	12/10/2020	12/10/2021
Version 2	3/11/2020	12/31/2020	12/31/2021

MCO Contact Information

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1. Principal MCO Contact Person

[PERSON RESPONSIBLE FOR COMPLETING THIS REPORT AND WHO CAN BE CONTACTED FOR QUESTIONS]

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2. Additional Contact(s)

[PERSON(S) RESPONSIBLE IN THE EVENT THAT THE PRINCIPAL CONTACT PERSON IS UNAVAILABLE]

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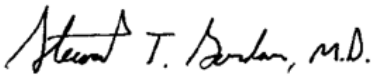
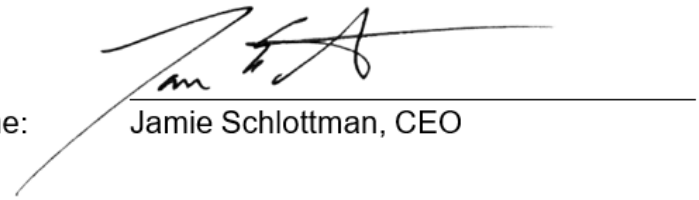
3. External Collaborators (if applicable):

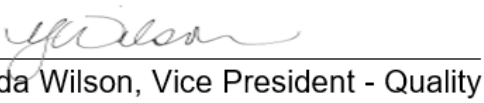
Attestation

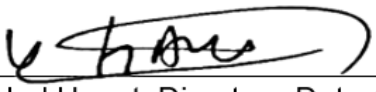
Plan Name: **Louisiana Healthcare Connections**
Title of Project: **Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation**

The undersigned approve this PIP and assure involvement in the PIP throughout the course of the project.

Medical Director signature: 
First and last name: Stewart Gordon, MD
Date: 12/10/2021

CEO signature: 
First and last name: Jamie Schlottman, CEO
Date: 12/10/2021

Quality Director signature: 
First and last name: Yolanda Wilson, Vice President - Quality
Date: 12/10/2021

IS Director signature: 
First and last name: Michel Hanet, Director - Data Analytics & Reporting
Date: 12/10/2021

Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.
[EXAMPLES INCLUDE: ADDED NEW INTERVENTIONS, ADDED A NEW SURVEY, CHANGE IN INDICATOR DEFINITION OR DATA COLLECTION, DEVIATED FROM HEDIS® SPECIFICATIONS, REDUCED SAMPLE SIZE(S)]

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1	3/10/2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☒ Other	Revised data calculations per LDH/IPRO guidance; updated baselines provided. Clarification on data integrity process.
Change 2	7/31/2020	☐ Project Topic ☒ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Incorporated updated OPH data into analysis as new lists were released; intervention modifications to expand outreach, disseminate updated resource materials received, and mitigate identified barriers (i.e., transition to virtual provider outreach).
Change 3	10/31/2020	☐ Project Topic ☒ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Incorporated updated OPH data into analysis as new lists were released; expanded member outreach modalities; intervention modifications to expand outreach and mitigate identified barriers; retired ITM 2b as directed by LDH/IPRO.
Change 4	1/31/2021	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Revised 2a to capture all organizational outreach and education efforts to increase member screenings.
Change 5	11/30/2021	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Revised description of intervention tracking measure 2b to include screening and treatment care gaps

Abstract

For Final Report submission only. Do not exceed 1 page.

Project Topic/Rationale/Objectives

Topic: Improved Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

Rationale: The Hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019). HCV prevalence in Louisiana is estimated at 1.6 to 1.8 percent, with higher rates among urban residents, men and women aged 45-54 years, with highest rates among males in all age groups and among African American males aged 45-54 years (LA OPH, 2015). As of summer 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. Many asymptomatic people are unaware that they are chronically infected with HCV; therefore, screening for HCV in accordance with evidence-based recommendations is indicated for Healthy Louisiana enrollees who are at risk for HCV infection.

Objectives: Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

- **Member Intervention Objective**: outreach and educate eligible members, and facilitate referrals to schedule appointments with (i) PCPs for screening and (ii) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to each of the following high risk sub-populations
- **Provider Intervention Objective**: educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment

Methodology

Eligible population: Louisiana residents ages 18 years of age and older who are enrolled in the Louisiana Medicaid program.

Description of Annual Performance Indicators: Annual Performance Indicators collected through administrative claims data measured the percentage of members receiving screening for HCV based on several categories, including age and risk factor cohorts. Treatment related performance indicators included the percentage of members for whom treatment for HCV was initiated based on several additional categories including members with a confirmed or probably diagnosis of Chronic Viral Hepatitis C per OPH listings provided, current or past drug use, and HIV subcategories.

Sampling Method: No sampling is being used; the entire eligible population is being targeted by PIP interventions.

Baseline and Re-measurement Periods: Baseline period: 1/1/2019 to 12/31/2019; Interim measurement period: 1/1/2020 to 12/10/2020; Final Measurement Period: 1/12021 to 12/31/2021.

Data Collection Procedures: Data was collected through administrative claims data using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. Data was also utilized from Centene's Enterprise Data Warehouse and additional programs such as Microstrategy, TruCare, and Sharepoint. Additional data for ITMs was collected through our internal Data Analytics team, Case Management, and Pharmacy reporting. Although some data elements were collected monthly for consistency in process and workflows, PIP data was aggregated and reported on a quarterly basis. Supplemental data from OPH resources provided by LDH have also been utilized for indicators as instructed. Those who collected the data include Data Analysts, Quality Improvement team members, and Case Management and/or Pharmacy staff who tracked and trended their department's data.

Interventions

Interventions developed to address the member needs and barriers include:

- Member outreach campaigns with targeted outreach communications including telephonic, direct mail, and automated dialing technologies to broaden scope of member contact efforts for the larger group of age cohort members; expansion and incorporation of HCV education, assessment, and appointment assistance into each member touchpoint in order to facilitate member education, treatment and screening appointment scheduling
- CM outreach was initially launched to a targeted subpopulation of HCV members on OPH list that were active in CM; following this pilot group, CM outreach strategies were expanded to broader CM population for HCV/OPH members.
- Utilization of region-driven, disparity-focused messaging was updated to enhance member engagement opportunities to promote education on the prevalence of HCV to members in specific regions and facilitate treatment appointments in regions with highest disparities
- Health Check Coordinators were engaged for supplemental outreach promoting HCV screening through IVR campaigns to reach the larger group of universal age cohort members, prioritizing those without annual wellness visits
- Efforts to increase member awareness of HCV screening recommendations and treatment options through member-facing audio, digital, and visual advertisements in major markets and distribution of member-facing HCV educational flyers to Community Based Organizations throughout the State
- Stratification of the OPH member list based on internal risk tools for prioritization of outreach to members at highest risk, with subsequent incorporation of expanded HCV status indicators provided by LDH
- Monitoring list of OPH members not receiving treatment monthly for targeted outreach/intervention opportunities.
- Expanded assessment tool to facilitate more intentional inquiry into member treatment history and lend more consistency in documentation, data collection surrounding member responses and feedback.

Interventions developed to address provider needs and barriers include:

- Distribution of member care gap reports identifying screening and treatment status were incorporated into the Secure Provider Portal and updated monthly
- Promotion of LDH resources and collaterals including screening guidelines and treatment algorithms, incorporating these into provider visit agendas for distribution/presentation during virtual visits as well as digital and mail distribution when indicated
- Implementation of Provider incentive to further engage providers in HCV awareness and increasing member screenings through enhanced reimbursement for gap closures
- Online distribution of collaterals including screening and treatment algorithms (website, blogs, social media) and on-demand resources for providers via LHCC's online portal for direct access
- Collaborative efforts with LDH and other MCOs to align resources and standardize messaging directed to providers

Results

Although annual rates are pending year-end aggregation and review; all available performance indicator data through 12/10/2021 may be found beginning on page 23. HCV screening and treatment rates improved over baseline, though not meeting the target rates set at the onset of the project. This is an improvement from the previous year when only HCV screening rates improved over prior year baseline and anticipated increases in treatment rates were less notable. YTD rates for the various cohorts are as follows:

- Screening rates: universal cohort group 14.49 percent, 4.18 percentage points higher than baseline; birth cohort group (>18 yrs) 15.91 percent, 2.3 percentage points higher than baseline; non-birth cohort (ever screened) 30.07 percent, 6.91 percentage points higher than baseline; non-birth cohort (annually screened) 16.73 percent, 7.91 percentage points higher than baseline
- Treatment rates: all members on OPH list with treatment initiated 16.53 percent, 4.54 percentage points higher than baseline; OPH subgroup with current or past drug use 18.19 percent, 5.94 percentage points higher than baseline; OPH subgroup diagnosed with HIV 20.36 percent, 6.02 percentage points higher than baseline.

Conclusions and Next Steps

Ongoing analysis of HCV interventions and outcomes has provided valuable insight into member and provider centric challenges and highlighting opportunities for continued improvement. In 2020, significant impacts from the COVID-19 pandemic and multiple hurricane events in Louisiana were recognized as disruptive to both member and provider facing initiatives as well as impacting provider operations and member access patterns. PIP activities were suspended for several months as COVID-19 emerged, with activities resuming in July 2020. Although education and outreach initiatives resumed in Quarter 3 of 2020 with alternative approaches to navigate the pandemic barriers, established targets for the HCV performance indicators were not met. Similar impacts continued throughout 2021 with the COVID-19 pandemic and recent Delta variant surge, as well as significant impacts of Hurricane Ida across many parishes in Southeast Louisiana. Interventions for HCV screening and treatment opportunities are ongoing, with rates through 12/10/2021 indicating positive trends in each measure with improvement over the baseline and interim rates. Overall, treatment indicators are showing more improvement than screening indicators.

Provider education and member outreach initiatives were adversely impacted during 2020-2021 and remain a continued focus as we move into 2022. Provider education and access to HCV resources remains a priority, as well as continued member outreach to facilitate linkage to treatment, follow up support, and resources. Increasing member knowledge of HCV screening and testing recommendations, along with preferred treatment options, is an ongoing effort with promotion through direct communications, online media platforms, and community partners. The additional screening status information included in OPH listings in mid-2021 will be used in continued efforts to tailor messaging and outreach focus and evaluate effectiveness of interventions. Emphasis on innovation will also be carried into 2022 to increase member engagement with care management services that provide support and assistance with resources for HCV treatment. Opportunities include employing new and/or alternative outreach strategies to improve successful contacts and communication with subsets of our population that have historically been difficult to contact; these efforts will also include continued exploration and of member communication preferences that may evolve over time, ensuring alignment of outreach strategies with member preferences when available. Collaboration across MCO’s and state partners have been effective in streamlining providing communications and linkage to resources - strategies that will continue into the coming year.

Project Topic

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**
  Louisiana Healthcare Connections (LHCC) is committed to the mission of improving the health of our community one member at a time. Prevalent infectious disease trends throughout the state and the nation are particularly relevant to our membership and ultimately impact the health and wellbeing of our members. As LDH has emphasized, the Hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States, with Louisiana prevalence estimated at 1.6 percent to 1.8 percent. Of particular relevance to our member population, the increased prevalence of HCV among baby boomers (born between 1945-1965), urban residents, and African American males aged 45-54 years underscores the importance of focused intervention for the benefit of our members (LDH, 2019). In addition to demographic risk stratification, there is a general knowledge deficit in the general public; infected individuals may be asymptomatic and unaware of both the inherent health risks they face, as well as the risk of transmission to others. These realities support the need for improved screening for HCV in accordance with evidence-based recommendations for those members who are identified as at risk for HCV infection.

- **Describe high-volume or high-risk conditions addressed:**
  With enrollment of over 500,000 members, at least half of which may be impacted by this risk, LHCC is pleased to partner with LDH and other participants in this performance improvement project to Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**
  Review of best practices and recommendations from leading healthcare advisory groups, including the Louisiana Hepatitis C Elimination Plan, have been initiated to enable thoughtful and deliberate focus on optimal strategies to increase compliance with the two core initiatives and ultimately improvement of health outcomes for the at-risk populations. In early 2020, the US Preventative Services Task Force updated its 2013 recommendation for HCV screening to include all adults between the ages of 18 and 79 with no known liver disease. Current screening guidelines and treatment algorithms are supported by the American Association for the Study of Liver Diseases. A one-time screening is recommended for individuals 18 years and older and periodic and/or annual screening is recommended for individuals with additional risk factors (AASLD, 2021). Current treatment recommendations support a standard treatment of direct-acting, oral antiviral (DAA) regimens without interferon (AASLD, 2021; USPSTF, 2020).

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**
  Immediate efforts towards initiating this performance improvement project included data aggregation and analysis to determine scope of current membership affected and/or at risk, as well as a review of best practices and recommendations from leading healthcare advisory groups including the Louisiana Hepatitis C Elimination Plan. A review of the membership as of January 25th, 2020 was conducted and preliminary analysis along with OPH data was initiated to determine the current risk stratification volumes within the Plan membership. Preliminary review indicated significant opportunity is evident, consistent with the established risk per birth cohort alone, with over 83,000 members during 2019 baseline year born between 1945-1965; of these members, only 14 percent appear to have screening for HCV – supporting the need for increased routine screening activity. The additional benefit of pharmaceutical treatment options and authorization initiatives further support the ability to impact outcomes for those with positive diagnosis.

Aims, Objectives and Goals

Aim: Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

1. **Member Intervention Objective**: Outreach and educate eligible members, and facilitate referrals to/schedule appointments with (I) PCPs for screening and (II) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to each of the following high-risk subpopulations (which are not mutually exclusive, as enrollees may have multiple high-risk characteristics):
    a. Beneficiaries born between the years 1945 and 1965
    b. Current or past injection drug use
    c. Persons ever on long term hemodialysis
    d. Persons who were ever incarcerated
    e. Persons with HIV infection

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment.

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): *The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	**N:** 41,207 **D:** 399,868 **R:** 10.31%	**R:** 20.31%	Project aim recommendation – improve 10 percentage points from baseline
Performance Indicator #1b (Birth Cohort Screening): *The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	**N:** 9,405 **D:** 69,110 **R:** 13.61%	**R:** 23.61%	Project aim recommendation – improve 10 percentage points from baseline
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening-ever screened): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	**N:** 6,298 **D:** 27,193 **R:** 23.16%	**R:** 33.16%	Project aim recommendation – improve 10 percentage points from baseline

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.
[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	**N:** 2399 **D:** 27,193 **R:** 8.82%	**R:** 18.82%	Project aim recommendation – improve 10 percentage points from baseline
Performance Indicator #3a (HCV Treatment Initiation-Overall): *The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 622 **D:** 5189 **R:** 11.99%	**R:** 21.99%	Project aim recommendation – improve 10 percentage points from baseline
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): *The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 241 **D:** 1967 **R:** 12.25%	**R:** 22.25%	Project aim recommendation – improve 10 percentage points from baseline
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	**N:** 37 **D:** 258 **R:** 14.34%	**R:** 24.34%	Project aim recommendation – improve 10 percentage points from baseline

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1a (Universal Screening)	The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.	Administrative/ Claims/ Encounter data	All Healthy Louisiana enrollees ages 18-79 years	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members
Performance Indicator #1b (Birth Cohort Screening).	The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were screened for HCV {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana enrollees born between 1945 and 1965	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened)	The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR d. Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening)	The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR d. Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were screened during the measurement year for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3a (HCV Treatment Initiation-Overall)	The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3a
Performance Indicator #3b (HCV Treatment Initiation-Drug Users)	The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with current or past drug use (ICD-9 or ICD-10 codes in Appendix A) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3b

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3c (HCV Treatment Initiation- Persons with HIV)	The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	Administrative/ Claims/ Encounter data	Healthy Louisiana adults ever diagnosed with HIV (ICD-9 or ICD-10 codes in Appendix D) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3c

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?

Sampling Procedures

If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:**
  No sampling is being used in this PIP.

Data Collection

Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:**
  Data will be collected through administrative claims data using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. Data may also be utilized from Centene's Enterprise Data Warehouse and additional programs such as Microstrategy, TruCare, and Sharepoint. Additional data for ITMs will be collected through our internal Data Analytics team, Case Management, and Pharmacy reporting. Although some data elements will be collected monthly for consistency in process and workflows, PIP data will be aggregated and reported on a quarterly basis. Supplemental data from OPH resources provided by LDH have also been utilized for indicators as instructed. Those who collect the data include Data Analysts, Quality Improvement team members, and Case Management and/or Pharmacy staff who track and trend their department's data.

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

- **Describe validity and reliability:**
  For data reliability, the screening rates, percentage of diagnosed members per month and treatment initiation rates obtained from QSI-XL (Inovalon) is compared to number of claims in our data warehouse for the same time period, hence a correlation ratio is derived to check data consistency. Data validation is conducted using various methods, including consultation with Medical director, case management team and quality team. Additional validation methods include enrollment checks to ensure timely screening of susceptible HCV population and treatment continuity of diagnosed population. In addition to above methods, statistical methods (experimental design) are used to compare number of HCV related claims received, unique number of Medicaid members.

  Note: Initial proposal baseline data was revised and resubmitted 3/11/2020; data integrity check was performed, and an erroneous encounter code had been included during initial data collection, skewing the initial baseline rates reported. This was corrected to include only the specified CPT and HCPCS codes provided by LDH and updated data validated by Data Analyst.

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.). Describe how plan will interpret improvement relative to goal. Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).*

- **Describe data analysis procedures:**
  Data is compared to previous year's data as available; denominators and numerators will be checked for inclusion of all eligible populations and any identified discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid data possible.

- **Describe how plan will interpret improvement relative to goal:**
  Improvement will be monitored via internal benchmarking against established baseline thresholds. Preliminary analysis (as described above) indicated variation in HCV diagnosed population by age and region, providing a baseline upon which ongoing performance may be compared to benchmark progress towards higher engagement, screening and/or treatment for at-risk and HCV diagnosed enrollees.

- **Describe how plan will monitor ITMs for ongoing QI:**
  ITM's will be monitored at minimum monthly to evaluate positive improvement, plateaus, or identify adverse trends for prompt investigation, analysis and/or action to modify interventions if indicated. Bi-weekly and monthly monitoring of enrollees who are HCV diagnosed will be conducted using Business Intelligent tools to support initiatives promoting increased awareness, screening, and treatment for HCV.

PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2019
End date: 12/31/2019

Submission of Proposal/Baseline Report Due: 2/3/2020

Interim Measurement Period:
Start date: 1/1/2020
End date: 12/31/2020

PIP Interventions (New or Enhanced) Initiated: 2/1/2020

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/21-3/31/21 Due: 4/30/2021
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/21-6/30/21 Due: 7/31/2021
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/21-9/30/21 Due: 10/31/2021

Submission of Draft Interim Report Due: 12/10/2020
Submission of Final Interim Due: 12/31/2020

Final Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Draft Final Report Due: 12/10/2021
Submission of Final Final Report Due: 12/31/2021

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification:** Analysis of treatment rates and member feedback.		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**[4]
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #1a tracking measure:** **N:** # members with appointment scheduled by MCO Case Manager / Care Coordinator for HCV treatment assessment/initiation **D**: # members with confirmed or probable HCV per OPH listing not receiving treatment **Initial outreach began with a smaller subset of population to test on smaller scale – both measures provided for Q1.*	*Denom / Initial subset group - N: 43 D: 121 R: 35.5% Denom / Total on OPH list N: 43 D: 5,223 R: 0.82%	*PIP suspended*	N: 12 D: 3645 R: 0.33%	N: 17 D: 4579 R: 0.37%	N: 13 D: 5413[5] R: 0.24%	N: 6 D: 5564 R: 0.11%	N: 13 D: 5466 R: 0.24%	N: 4 D: 6005 R: 0.07%

[4] Q4 data represent the results of outcomes collected to date; holiday impacts on access, availability, and data collection taken into consideration.
[5] Variation in denominator acknowledged; attributed to growth of membership identified in latest OPH listing. Appointment scheduling outreach is limited to treatment-eligible enrollees.

Barrier 2: Asymptomatic enrollees may not know they are infected with HCV. **Method of barrier identification:** Analysis of screening rates and member feedback.		2020				2021			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**[4]
Intervention #2a to address barrier: CM Outreach: Enhanced Case Management Outreach for HCV Screening **Planned Start Date:** 3/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #2a tracking measure:** **N:** # members with appointment scheduled by MCO Case Manager / Care Coordinator for HCV screening **D:** # members at risk for HCV per MCO claims/encounter data targeted for outreach	**Screening outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 243 D: 31950 R: 0.76%	N: 256 D: 32455 R: 0.79%	N: 0 D: 30047 R: 0.00%	N: 188 D: 26263 R: 0.72%	N: 102 D: 72376[6] R: 0.14%	N: 38 D: 27598 R: 0.14%
ITM 2A Sub-measure: CM Outreach: Enhanced Case Management Outreach or HCV Screening **Planned Start Date:** 2/1/2021 **Actual Start Date**: 2/1/2021	**ITM 2A Sub-measure:** **N:** # members outreached by MCO for HCV education and screening appointment assistance **D**: # members ages 18-79 years eligible for screening	*Initiated Q1-2021*	*Initiated Q1-2021*	*Initiated Q1-2021*	*Initiated Q1-2021*	N: 30047 D: 461719 R: 6.51%	N: 26263[7] D: 468231 R: 5.61%	N: 72376 D: 473138 R: 15.30%	N: 27598 D: 476222 R: 5.80%
***Retired* Intervention #2b to address barrier:** Provider Outreach: Provide PCPs with customized list of members for whom	**Intervention #2b tracking measure:** **N:** # members in birth cohort receiving HCV screening	N: 8,601 D: 66,387 R: 12.96%	N: 9,405 D: 69,110 R: 13.61%	N: 10,574 D: 74,338 R: 14.22%	N: 10,803 D: 75,232 R: 14.36%				

[6] Variation in denominator acknowledged; reflects increase in targeted outreach calculation due to integration with overlapping needs (i.e., HCV included in HEDIS and other PIP outreach encounters) for maximum reach. Appointment scheduling outreach is limited to screening-eligible enrollees with medical coverage.
[7] In response to feedback received in Q1 Quarterly Status Report, this sub-measure is indicative of outreach volume and overall efforts to engage this screening population.

HCV screening is indicated by birth year between 1945 and 1965. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**D:** # members with HCV screening indicated per birth year cohort								
Intervention #2b to address barrier: Provider Outreach: Provide PCPs with customized list of members for whom HCV screening and treatment is indicated. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	***Resumed* ITM 2B:** **Numerator:** # screening-eligible members whose care gap information was distributed to providers **Denominator:** # members ages 18-79 years eligible for screening					Resumed Q2 2021[8]	Delayed to Q3 2021[9]	N: 251290 D: 473138 R: 53.11%	N: 251701 D: 476222 R: 52.85%
Barrier 3: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification:** Plan assessment of provider network prescription patterns.		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4[4]**
Intervention #3a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #3a tracking measure:** **N:** # members who were dispensed SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) **D:** # members with any DAA dispensed	N: 778 D: 790 R: 98.48%	N: 510 D: 526 R: 96.96% *PIP suspended*	N: 527 D: 539 R: 97.77%	N: 490 D: 499 R: 98.20%	N: 432 D: 450 R: 96.00%	N: 442 D: 450 R: 98.22%	N: 387 D: 393 R: 98.47%	N: 120 D: 121 R: 99.17%

[8] Corrected based on final report feedback (previously retired in error).
[9] Incorporation and distribution of screening and treatment member care gap reports integrated into secure provider portal July 2021.

Intervention #3b to address barrier: Provider Outreach: Provide PCP education to include prior authorization is not required for Epclusa generic and applicable billing guidelines for HCV DAA agents and Medicaid reimbursement. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 9/1/2020	**Intervention #3b tracking measure:** **N:** # of providers outreached by Provider Network and provided education/resource materials for generic Epclusa availability without PA, billing/ reimbursement guidelines **D:** # of providers targeted for outreach	**Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 95 D: 636 R: 14.94%	N: 126 D: 636 R: 19.81%	N: 262 D: 795 R: 32.96%	N: 358 D: 795 R: 45.03%	N: 433 D: 793 R: 54.60%	N: 121 D: 793 R: 15.26%
Barrier 4: Members must voluntarily agree to Case Management to benefit from available plan support/resources. **Method of barrier identification: Plan assessment of internal case management barriers and analysis of member feedback**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**[4]
Intervention #4 to address barrier: CM Outreach: Increase members enrolled in CM through targeted CM outreach and strategic care coordination for identified members with HCV. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #4 tracking measure:** **N:** # of HCV members targeted that agreed to CM services **D:** # of HCV members targeted for CM outreach	**Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.*	*PIP suspended*	N: 5 D: 286 R: 1.75%	N: 18 D: 2,210[10] R: 0.81%	N: 7 D: 220 R: 3.18%	N: 78 D: 842 R: 9.26%	N: 60[11] D: 814 R: 7.37%	N: 5 D: 150 R: 3.33%

[10] Variation in denominator acknowledged. Expanded outreach with automated messaging modality initiated to reach remaining treatment population.

[11] Member and health plan staff displacement related to damages and power/internet outages following Hurricane Ida impacted outreach efforts and outcomes.

Barrier 5: Member compliance with course of pharmaceutical treatment (length of treatment, adverse symptoms/side effects, lack of support) Method of barrier identification: Plan assessment of internal case management and pharmacy observed barriers		2020				2021			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4[4]
Intervention #5a to address barrier: Enhanced case management/ongoing outreach to support members through course of therapy. **Planned Start Date:** 7/1/2020 **Actual Start Date**: 7/1/2020	**Intervention #5a tracking measure:** **N:** # of members receiving treatment outreached by CM/provided ongoing support/services **D:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed	*Outreach set to begin 3/1 but was delayed; COVID restrictions mid-March.	*PIP suspended*	N: 72 D: 527 R: 13.66%	N: 71 D: 490 R: 14.49%	N: 17 D: 432 R: 3.94%	N: 78 D: 442 R: 17.65%	N: 60 D: 387 R: 15.50%	N: 5 D: 121 R: 4.13%
Intervention #5b to address barrier: Treatment completion: Member compliance with course of treatment as prescribed. **Planned Start Date:** 3/1/2020 **Actual Start Date**: 3/1/2020	**Intervention #5b tracking measure:** **N:** # Members completing prescribed medication therapy **D:** # Members prescribed treatment	N: 82 D: 201 R: 40.80%	N: 202 D: 294 R: 68.71%	N: 298 D: 412 R: 72.33%	N: 431 D: 592 R: 72.80%	N: 208 D: 235[12] R: 88.51%	N: 241 D: 381 R: 63.25%	N: 294 D: 529 R: 55.58%	N: 439 D: 636 R: 69.03%

[12] Variation in denominator acknowledged. Please note that members may start and end therapy during overlapping time periods.

Results

To be completed upon Baseline, Interim and Final Report submissions. The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

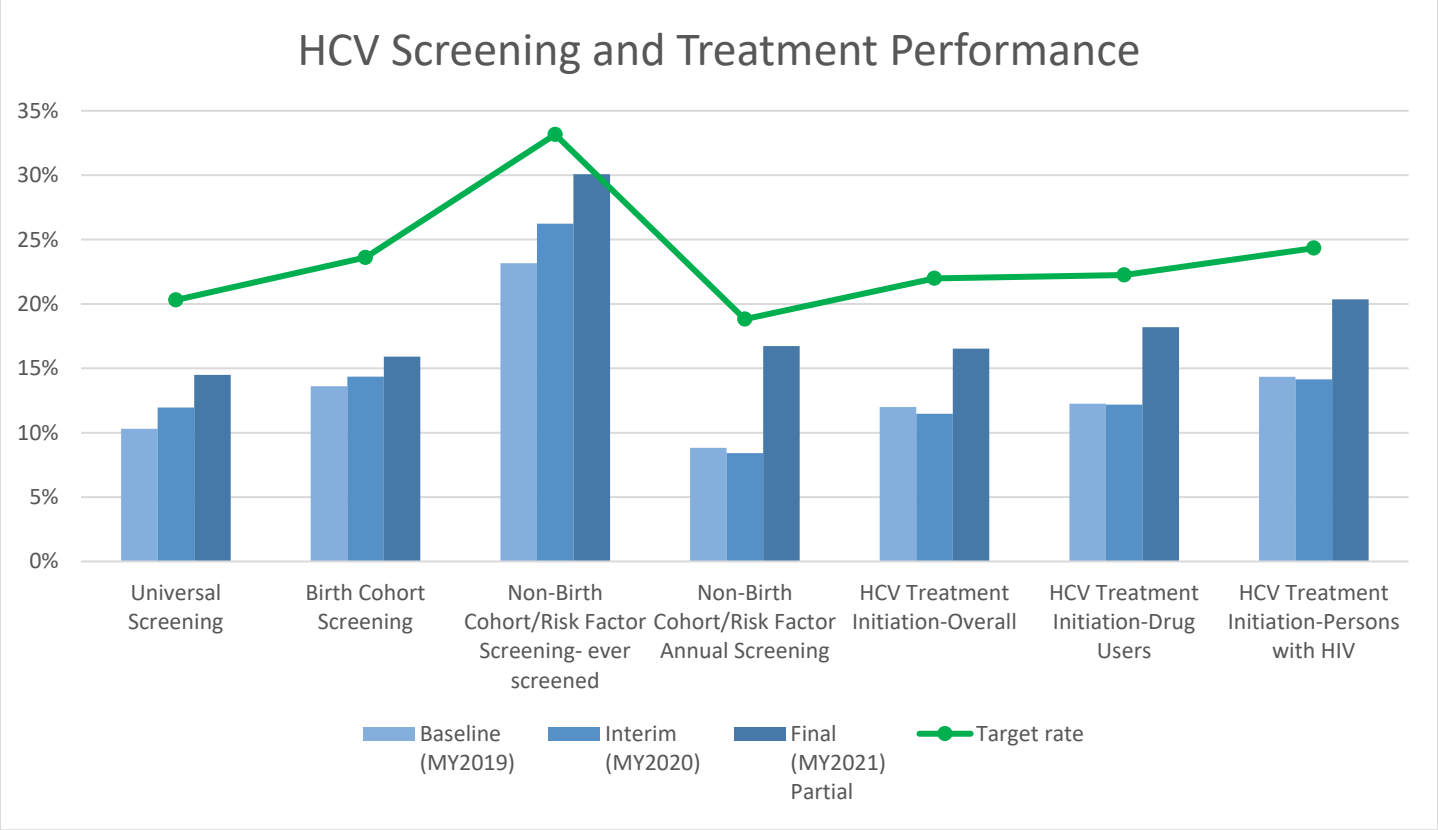
Table 5: Results

Indicator	Baseline Period Measure period: 1/1/2019-12/31/2019	Interim Period Measure period: 1/1/2020-12/31/2020	Final Period[13] Measure period: 1/1/2021-12/31/2021	Target Rate[14]
Performance Indicator #1a (Universal Screening): *The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	N: 41,207 D: 399,868 R: 10.31%	N: 51,556 D: 430,990 R: 11.96%	N: 69,007 D: 476,222 R: 14.49%	Rate: 20.31%
Performance Indicator #1b (Birth Cohort Screening): *The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	N: 9,405 D: 69,110 R: 13.61%	N: 10,803 D: 75,232 R: 14.36%	N: 12,792 D: 80,406 R: 15.91%	Rate: 23.61%
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.*	N: 6,298 D: 27,193 R: 23.16%	N: 8,512 D: 32,455 R: 26.23%	N: 11,505 D: 38,259 R: 30.07%	Rate: 33.16%

[13] Q4 data represent the results of outcomes collected to date; holiday impacts on access, availability, and data collection taken into consideration.
[14] Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

Indicator	Baseline Period Measure period: 1/1/2019-12/31/2019	Interim Period Measure period: 1/1/2020-12/31/2020	Final Period[13] Measure period: 1/1/2021-12/31/2021	Target Rate[14]
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening- Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	N: 2399 D: 27,193 R: 8.82%	N: 2,733 D: 32,455 R: 8.42%	N: 6,401 D: 38,259 R: 16.73%	Rate: 18.82%
Performance Indicator #3a (HCV Treatment Initiation-Overall): *The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 622 D: 5189 R: 11.99%	N: 592 D: 5,161 R: 11.47%	N: 1,189 D: 7,194 R: 16.53%	Rate: 21.99%
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): *The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 241 D: 1967 R: 12.25%	N: 354 D: 2,907 R: 12.18%	N: 758 D: 4,167 R: 18.19%	Rate: 22.25%
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of*	N: 37 D: 258 R: 14.34%	N: 41 D: 290 R: 14.14%	N: 79 D: 388 R: 20.36%	Rate: 24.34%

Indicator	Baseline Period Measure period: 1/1/2019-12/31/2019	Interim Period Measure period: 1/1/2020-12/31/2020	Final Period[13] Measure period: 1/1/2021-12/31/2021	Target Rate[14]
Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.				



Discussion

To be completed upon Interim/Final Report submission. The discussion section is for explanation and interpretation of the results.

Discussion of Results

- **Interpret the performance indicator rates for each measurement period,** *i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.*

  Analysis of screening and treatment indicator performance demonstrated improved screening and treatment for HCV from the baseline and interim year measure outcomes; however, it was noted that initiation of pharmaceutical treatment was below the prior year baseline despite expanded coverage for antiviral therapy and targeted interventions to engage and support members. Notable improvements have been noted in all performance indicator rates over baseline, however the established 10 percentage point improvement targets were not achieved in 2021 YTD. Interruption in PIP activities due to the ongoing COVID-19 pandemic and multiple hurricane-related weather events were recognized as significant factors adversely impacting the plan's progress in these initiatives during 2020 and 2021. A synopsis of performance outcomes is provided below:

  Screening indicators for all subgroups (universal, birth cohort, ever screen, annual screen) increased from the MY2019 baseline and the MY2020 interim measurements, with the risk factor/annual screening subgroup showing the most notable increases.

  Outcomes for screening indicators demonstrating the percentage of Healthy Louisiana enrollees for whom HCV screening is indicated and who were ever screened for HCV are as follows:
  - Indicator #1a: Universal Screening for enrollees 18-79 years increased 4.18 percentage points over baseline and 2.53 percentage points over interim MY2020; YTD screening increased 2.06 percentage points from Q1 of this measurement year.
  - Indicator #1b: Birth Cohort screening for enrollees born between 1945 and 1965 increased 2.30 percentage points over baseline and 1.55 percentage points over interim MY2020; YTD screening increased 1.18 percentage points from Q1 of this measurement year.
  - Indicator #2a: Non-Birth Cohort/Risk Factor Screening for enrollees 18 and older with one or more risk factors other than age cohort (ever screened) increased 6.91 percentage points over baseline and 3.84 percentage points over interim MY2020; YTD screening increased 3.13 percentage points from Q1 of this measurement year.
  - Indicator #2b: Non-Birth Cohort/Risk Factor Screening for enrollees 18 and older for one or more risk factors other than being born between 1945 and 1965 (annual screening) increased 7.91 percentage points over baseline; increased 8.31 percentage points from interim MY2020; YTD screening increased 5.46 percentage points from Q1 of this measurement year.

  Treatment indicators for all subgroups (overall, past/current drug use, HIV) also increased from the MY2019 baseline and the MY2020 interim measurement. Treatment for the subgroup of members with HIV had the most notable increase.

  Outcomes for treatment indicators demonstrating the percentage of LHCC enrolled adults (ages 18 - 79) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing for whom pharmaceutical treatment for HCV are as follows:
  - Indicator #3a: HCV Treatment Initiation-Overall rates (adults 18-79) increased 4.54 percentage points over baseline and 5.06 percentage points over interim MY2020; YTD screening increased 3.11 percentage points from Q1 of this measurement year.

- Indicator #3b: HCV Treatment Initiation-Drug Users: subset of adults with current or past drug use increased 5.94 percentage points over baseline and 6.01 percentage points over interim MY2020; YTD screening increased 3.33 percentage points from Q1 of this measurement year.
- Indicator #3c: HCV Treatment Initiation-Persons with HIV: subset of adults ever diagnosed with HIV increased 6.02 percentage points over baseline and 6.22 percentage points over interim MY2020; YTD screening increased 3.23 percentage points from Q1 of this measurement year.

As indicated in Table 5. above, performance indicators for HCV screening of members in all subgroups have increased consistently year over year. Moreover, HCV treatment performance indicators that lagged below the baseline during the interim measure year have since improved and exhibit a greater average percentage of growth than the screening rates.

Upon further analysis of the screening indicator rates, members with higher identified risk factors in both the annual and 'ever screened' subgroups also saw the most significant rate increases from baseline and interim measurements. Efforts to promote member/provider education as well as facilitate linkage to screening resources did demonstrate a more favorable outcome for this vulnerable population, though falling short of the target rates previously established.

Regarding treatment indicators, members identified with HIV were the most significantly impacted subgroup, with a >6 percentage points increase over baseline and interim rates noted. On average, HCV treatment subgroups showed $\geq$5 percentage point increases from both baseline and interim measure periods. Again, these outcomes indicate more favorable improvement for interventions targeting members with a higher risk of negative health outcomes resulting from chronic liver disease.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** *Use your ITM data to support your interpretations.*

LHCC engaged a multidisciplinary team to support this HCV initiative and collaborate on impactful interventions to improve HCV screening and treatment. In particular, Case Management and Provider Network teams have worked diligently to improve outcomes through member and provider outreach and education, expanding access to information and resources, and modifying interventions and processes as needed. LHCC continues to explore barriers in member contact and engagement as well as provider education and awareness needs, with ongoing collaboration across disciplines to explore alternate mitigation strategies and improvement opportunities.

LHCC's care management team has made diligent efforts to outreach all members in the HCV population to provide education regarding HCV screening recommendations, plan benefits, and available treatments. Case Management outreach efforts included offering support, resources, and assistance with scheduling appointments follow-up on previous positive results and/or prior treatment when indicated. In response to poor ITM rates for screening and treatment, call outcome analysis indicated many outreach attempts with 'unable to contact' barriers due to incorrect contact information. As a result, case management teams focused efforts on researching and updating member contact information for members targeted for outreach and reattempting outreach for those that were unable to be contacted previously. Automated outreach with region-driven disparity-focused messaging was launched, providing tailored scripting to educate members on the prevalence of HCV in specific regions. Despite the intent to facilitate member screening and treatment appointments in regions with highest disparities, a significant increase in targeted IVR outreach campaigns in Q3 of 2021 did not result in the anticipated improvement in rates (as reflected in ITM 2A). Direct mail campaigns supplemented telephonic outreach as part of a multi-modal approach. Case management teams focused on utilizing motivational interviewing techniques to maximize successful outreach and member engagement when offering support, resources, and assistance with screening and treatment appointments. These teams also incorporated HCV education, assessment, and appointment assistance into each member touchpoint to maximize outcomes from each successful outreach. A targeted outreach campaign focused on members with HCV and HIV to assess screening and treatment status for this high-risk subgroup, providing education and information on available treatment options, and assisting with appointment scheduling.

Analysis of case management outreach results early in the project indicated members enrolled in case management were significantly more engaged with outreach activities; alternatively, members on the OPH list who were not enrolled in case management were more difficult to contact and less responsive to efforts to engage them for follow-up and treatment. The data demonstrated that inability to contact members was a common and challenging barrier throughout 2020 and 2021. These member contact barriers were initially impacted with the onset of COVID-19 and further compounded by overlapping outreach needs and local challenges that evolved throughout the project (i.e., surge in COVID infections due to the Delta variant, hurricane preparedness and recovery efforts; interruptions in communications and utility outages due to significant weather events). Analysis of successful contacts were insightful, despite limited encounters. Outreach results consistently indicate that more than 35 percent of OPH listed members contacted reported prior HCV treatment initiation or completion, with an additional 10 percent preferring to schedule follow-up treatment independently, declining health plan assistance for appointment scheduling (limiting impact on related performance indicators dependent on appointment scheduling). The data further indicates that case management teams were able to successfully engage and support approximately 16 percent of members as they completed the treatment process. These supplemental findings were informative when considering the limited progress in outreach and support efforts as noted in the limited case management appointment scheduling rates.

Additional efforts to increase member awareness of HCV screening and treatment recommendations through broader methods (in light of limited successful outreach) included distribution of member facing HCV educational flyers in English, Spanish and Vietnamese to over 200 community-based organizations throughout the State. In addition, member-facing audio, digital, and visual advertisements provided HCV messaging to Louisiana residents in six major markets. These included radio and visual ads, and an additional 200,000 digital ads to increase member awareness of HCV screening and treatment.

Provider facing interventions were similarly impacted by COVID-19 and hurricane activities during 2020-2021, with more notable impact on outcomes in 2020. PIP activities were suspended in March 2020 as the pandemic was emerging in Louisiana, while provider operations and priorities were adapting to the evolving crisis and population impacts. Stay at home orders, restrictions on some health access activities such as elective procedures, and concerns for exposure risks influenced member activity patterns in general, with related impact on HCV efforts surrounding screening and treatment appointment scheduling. As PIPs resumed in Q3 2020, Provider outreach modalities were adapted to navigate the continued COVID limitations and exposure concerns while still promoting HCV initiatives, resources, and provider education needs.

As interventions resumed in Q3 of 2020, LHCC's Provider Consultants shifted to virtual Provider trainings for HCV screening, testing and treatment guidelines, presenting to nearly 15 percent of the provider network in Q3. These efforts continued throughout 2021, increasing to 33-55 percentage points of provider groups receiving HCV information and resources quarterly. In the 3rd Quarter of 2021, HCV member care gap reports were incorporated into the Secure Provider Portal and included both screening and treatment care gap indicators, with monthly updates to support ongoing provider efforts. While ITM 2b measures care gap distribution in comparison to overall eligible members, it is important to note that 100 percent of member care gaps were distributed to providers through the portal each month since July 2021.

Prescriber activity for generic Epclusa has remained consistent over the course of the project, with 98-99 percent of members receiving the approved generic Epclusa over other available antiviral treatments. Monthly monitoring and review of authorization data for direct acting antiviral utilization reflected declines in the volume of Epclusa/all DAA prescriptions from pre-pandemic baselines that aligned with initial coverage and promotion of Epclusa; pharmacy claims averaged 170 per month in 2020 and subsequent decline to an average of 138 monthly prescriptions in 2021. Despite the decline in overall prescriptions, the rate of Epclusa utilization over other non-preferred DAA's remained favorable and indicative of provider adherence to the recommended treatment options for Medicaid members. Member completion of the treatment regimen increased steadily from 40.8 percent to 72.8 percent in 2020, peaking at 88.51 percent in the first quarter of 2021 before declining steadily through to reminder of the year. This downward trend is also attributed to surge in COVID infections related to the Delta variant mid-year, as well as the impacts of Hurricane Ida in Q3 which impacted housing and infrastructure of both members and providers in the southeast Louisiana – the highest geographical density area for our HCV member population.

- **What factors were associated with success or failure?** *For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.*

  Several factors were identified as contributing to the limited progress with performance indicators and intervention outcomes. Significant member population size (as reflected in ITMs 1A and 2A for screening and treatment) required a strategy for prioritizing outreach due to scope/volume. Incorporating HCV outreach through each member touchpoint maximized outreach opportunities in conjunction with expanding targeted outreach efforts; however, a significant number of members indicated treatment was completed prior to outreach. A smaller group indicated a preference to self-schedule appointments; while these encounters allowed outreach teams to provide HCV education, these efforts had limited impact on the outcome rates for measures 1A and 2A. Incorporating automated systems for broader contact opportunity was recognized as positively impacting screening outreach initiatives with notable increase in contacts to the larger group of age cohort members for routine screening.

  Beyond the scope of this HCV initiative, initial impacts from the onset of COVID-19 included member reluctance to schedule and/or attend appointments due to fear of exposure. As the pandemic evolved, these member hesitancy trends were more focused on transportation services and exposure risks related to that particular subset of services. To address or overcome these barriers, LHCC staff offered to assist members with making appointments (3-way calls with member, LHCC and MD office), promoted the option for telehealth visits (if member preferred), and explained the importance of screening as well as benefits of treating/eradicating HCV.

  Ambiguity surrounding member treatment history was recognized due to variation between OPH information and member/provider reported status; the potential for erroneous disclosure to members unaware of HCV diagnosis prompted additional validation measures during member encounters to reduce disclosure risks. In addition, opportunity was noted for deeper inquiry with members reporting historical diagnosis but no record of treatment – or members with treatment years prior but lacking current status or unaware of potential for re-exposure. Feedback from members reporting prior treatment revealed some perceptions that their condition had been managed or resolved, prompting them to decline CM services/support. This resulted in missed opportunities to provide education related to HCV risk factors including potential for reinfection, and the importance of maintaining physician relationships and annual wellness visits. Revised scripting/queries were developed with some success in mitigating these threats and resulted in additional information that brought value to the assessment of member status, history and needs. Unfortunately, the limited response to member outreach attempts hindered sufficient interaction to engage in this level of inquiry on a broad level. The enhanced inquiry scripts were incorporated into outreach efforts and will continue as the HCV initiatives continue on. Additional improvements were achieved through reallocation of staffing resources, aligning case management and health care coordinators as designated HCV outreach staff to allow closer monitoring of process, fluency of outreach, and consistency in scripting.

  Provider awareness of updated screening recommendations by USPSTF, removal of prior authorization requirements for generic Epclusa, and availability of provider toolkits/treatment algorithms were core areas of opportunity for targeted intervention as reflected by ITM 3B. Initial distribution of resource materials and collaterals including screening and treatment algorithms were disseminated online (website, blogs, social media) and posted to the LHCC online portal for direct access. As provider visits transitioned to virtual encounters, review and promotion of these resources were incorporated into Provider Consultant's virtual provider visits as well as mail distribution when indicated. The Provider network team continues to deliver these resources, with 35 percent of provider groups receiving the resources in latter half of 2020, increasing upwards to 55 percent in 2021. Continued monitoring of these interventions will allow better evaluation of impact and opportunity for adaptation as needed to achieve goals.

  Adverse impacts on measure achievement were largely attributed to the challenges with contacting and engaging members as well as providers, as reflected in intervention outcomes including ITMs 1A, 2A, 4A and 5A, In Q1 2020, Case Management outreach to schedule treatment appointments began with a smaller study of members on the OPH list who were already enrolled in Case Management. The response to this initial group was favorable and over 35 percent of these members were assisted to schedule an appointment. There was a significant decrease in successful outreach with expansion of outreach to the broader target

group which included the remainder of members on the OPH list. Rates of appointments scheduled declined to 0.82 percent in members not previously enrolled in case management, further supporting the value of case management engagement and intervention through establishing communications and relationships with members.

There was consideration that the impacts on communications and outreach modalities may contribute to member and provider 'outreach fatigue' secondary to the volume of outreach efforts related to COVID-19 and later vaccine promotion, multiple hurricane preparedness/recovery communications, and routine continuity of care efforts in recent months; these overlapping priorities have been attributed to limited progression of measure outcomes such as the declining rate of appointments scheduled (ITM 1A) from 0.82 percentage points in Q1 2020 to 0.07 percentage points through (partial) Q4 2021. Screening appointments (ITM 2A) also remained below 1 percent. Member and provider safety and wellness remained primary focus in accordance with LDH guidance and automated outreach services and virtual communication methods were employed to facilitate communication with members and providers. Ongoing evaluation of these interventions also revealed potential for provider abrasion, noting that providers may be receiving multiple communications and varied resource materials across all MCO's. An opportunity was recognized to promote consistent resources and unified messaging in alignment with LDH goals. Collaborative discussions with MCO quality liaisons, LDH, and IPRO representatives were initiated in October 2020 to explore shared barriers and identify opportunities for aligned efforts to reduce duplication and minimize provider abrasion (collaboration ongoing).

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided).

- **Were there any factors that may pose a threat to the internal validity the findings?**
  Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

  No internal validity issues were noted; however, there was a revision in the reporting of select performance measure data from quarterly to cumulative to better reflect progress in rates as discussed with IPRO.

  Potential threats to the internal validity of the findings were considered, including case management ITM data accuracy due to variation in staff documentation of member engagement outcomes and the inherent limitations of episodic documentation in free-text fields by case managers.

- **Were there any threats to the external validity the findings?**
  Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

  No external threats were identified; however, potential threats to the external validity of the findings may include provider accuracy in coding/documentation practices and resulting impact on the validity of administrative measure rates.

- **Describe any data collection challenges.**
  Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

  The primary challenge to data collection was the ability the successfully outreach members in order to assess and collect relevant information to guide interventions. Expanding the outreach efforts was a

continual process - engaging the automated dialing system and incorporating multiple outreach methods to increase connection to members.

Member feedback and scheduling barrier information collected during successful outreach was reviewed and analyzed cumulatively to monitor for major themes. A significant number of members that were successfully outreached had refused to engage in discussion with case management or declined offers for linkage to care/resources; predominant factors reported included members previously completing treatment (perceiving no further treatment/follow up necessary), members preferring to schedule their own appointments independently, or members unaware of positive HCV result and unwilling to discuss further with plan staff. Since member enrollment in case management is voluntary and members may also request not to be contacted, these instances limited collection of valuable member information for analysis.

PIP Highlights

Provider feedback and supportive data indicated favorable impacts on the project, particularly the development and distribution of member care gap reports and consistent, recurring educational touchpoints for providers. Delivering member care gaps via the secure portal allowed providers direct access to updated gaps in HCV screening/treatment as reflected in performance indicator growth in all cohort groups. ITM 2b reflected a decline in the number of eligible screening and treatment care gaps, with the rate declining from 53.11 percent to 52.85 percent. Although this reduction in eligible member care gaps appears low, the rate is more impactful when considered in relation to its denominator of over 476,000 members. Provider network teams delivered HCV education regarding USPSTF recommendations for screening, treatment algorithms, Medicaid reimbursement, and recommended therapy in accordance with LDH guidance. ITM 3b supports initial delivery of education to 15 percent of targeted providers and reinforcement of education to 33-55 percent of provider groups each quarter during 2021.

Member-focused interventions impacting project effectiveness included case management engaging members to offer support, resources, and linkage to services for members as they completed the prescribed therapeutic regimen. ITM 5A indicates an average of 16 percent members engaged in case management support and services while receiving the approved HCV therapy (generic Epclusa), contributing to improvement in overall therapy completion rates from 41 percent at inception and peaked at 89 percent. While ITM outcomes and member feedback are limited to successful member contacts, member feedback trends indicated that 30 percent of members in the treatment population reported prior treatment completion or currently in treatment; though these reports limited case management’s opportunity to further impact screening and treatment measure outcomes, the additional insights that more members had received treatment than OPH lists indicated was considered favorable. An additional 15 percent denied knowledge of a previous HCV diagnosis, prompting education and appointment scheduling assistance for screening when permitted, while 25 percent declined case management services, indicating a preference to self-schedule appointments.

Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
CM Outreach: Enhanced Case Management Outreach for HCV Screening	Population size/ volume has proven labor intensive to outreach Limited member response in comparison to volume of outreach attempts.	Expanded routine CM outreach to include automated telephonic support for increased contact potential. Employed alternative methods to outreach populations and better engage members via preferred communication methods. Exploring existing and alternate vendors/ capabilities for expanded SMS/texting modalities. Addition of member HCV screening and treatment care gap reports to secure provider portal. Addition of provider incentive for completion of HCV screening.	Continued case management outreach and supplemental outreach methods. Exploration of additional alternative methods to outreach populations and better engage members via preferred communication methods. Continued monthly updates to HCV screening and treatment care gap reports in secure provider portal. Continue Provider incentive for HCV screening.
CM Outreach: Enhanced Case Management Outreach for HCV Treatment Initiation CM Outreach: Increase members enrolled in CM through targeted CM outreach and strategic care coordination for identified members with HCV. CM Outreach:	Members not previously enrolled in CM services are more difficult to outreach successfully. Member response limited in comparison to volume of outreach attempts. Inconsistent availability of information regarding treatment history; 1/3 of members outreached successfully had	Expanded routine CM outreach to include automated telephonic support for increased contacts. Employed alternative methods to outreach populations and better engage members via preferred communication methods. Exploring existing and alternate vendors/	Continued case management outreach and supplemental outreach methods; exploration of alternative methods to outreach populations and better engage members via preferred communication methods. Continue to promote telehealth options, reinforcing COVID prevention strategies

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Enhanced case management/ ongoing outreach to support members through course of therapy. Treatment completion: Member compliance with course of treatment as prescribed.	reported completing treatment previously. COVID-19 impact on appointment adherence as well as prescription compliance.	capabilities for expanded SMS/texting modalities. Addition of member HCV screening and treatment care gap reports to secure provider portal. CM outreach – additional inclusion of information about alternative resources including telehealth, reinforcing COVID prevention strategies including social distancing/social support. Incorporated alert into clinical documentation software for enhanced member recognition for HCV engagement/ outreach.	including social distancing/ social support. Continue monthly updates to HCV screening and treatment care gap reports in secure provider portal.
Provider Outreach: Provide PCPs with customized list of members for whom HCV screening is indicated by birth year between 1945 and 1965.	Potential for claims lag – delay in member screening status updates. Technological limitations for revision of current provider portal configuration to add HCV to existing logic/reporting system.	Updated HCV collaterals to reflect USPSTF revisions for screening to include members 18-79 years of age. Addition of member HCV screening and treatment care gap reports to secure provider portal.	Continue monthly updates to HCV screening and treatment care gap reports in secure provider portal.
Provider Outreach: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. Provider Outreach: Provide PCP education to include prior authorization is not required for Epclusa generic and applicable billing guidelines for HCV DAA agents and Medicaid reimbursement.	Limited provider awareness of ongoing HCV initiatives and treatment algorithms/ available guidance. PCP comfort level with prescribing medications/HCV– deference to specialty providers. Pandemic and hurricane impacts on Provider availability, prioritization of patient	LHCC provider guidance/resource collaterals including provider toolkit, treatment algorithms, updated and posted to online resource library. Transitioned from traditional in-person provider office visits to virtual encounters to maintain provider relations and support; incorporated review and	Continue to promote HCV screening/ treatment initiatives during virtual provider visits with continued on-demand/live virtual options with convenient scheduling to meet provider needs. HCV screening added to LDH performance monitoring indicators; add to quality scorecard for continued focus and

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
	scheduling needs limiting utilization or availability for education/resource offerings.	promotion of HCV initiative/collaterals.	heightened awareness across organization.

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Table A: **Current or past injection drug use** (any one or more of diagnosis codes or diagnosis code combinations in this table, not restricted to place of service and not restricted to principal or primary diagnosis; note: a limitation of this measure is that ICD-9 and 10 codes do not specify injection vs. other route)

ICD-9 code or code combination	ICD-10 code or code combination	Description
	F11-	Opioid related disorders (Hyphen indicates that all codes within F11 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
304.0-		Opioid dependence
304.7-		Opioid combined with other drug dependence
	F14-	Cocaine related disorders
304.2-		Cocaine dependence
	F15-	Other stimulant related disorders
304.4-		Amphetamine and other psychostimulant dependence
V69.8 AND 304.91		(other problems related to life style) AND (unspecified drug dependence continuous)
	Z72.89 AND F19.20	(other problems related to life style) AND (other psychoactive substance abuse, uncomplicated)

Table B. Persons ever on long term hemodialysis (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z49-	Encounter for care involving renal dialysis (Hyphen indicates that all codes within Z49 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
	Z99.2	Dependence on renal dialysis
V4511		Dependence on renal dialysis
V560 or V561 or V562 or V5631 or V5632 or V568		Encounter for care involving renal dialysis

Table C. Persons who were ever incarcerated (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison

Table D. Persons ever diagnosed with HIV infection. (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	B20	Human immunodeficiency virus (HIV) disease
042		Human immunodeficiency virus (HIV) disease
	Z21	Asymptomatic human immunodeficiency virus (HIV) infection status
V08		Asymptomatic human immunodeficiency virus (HIV) infection status

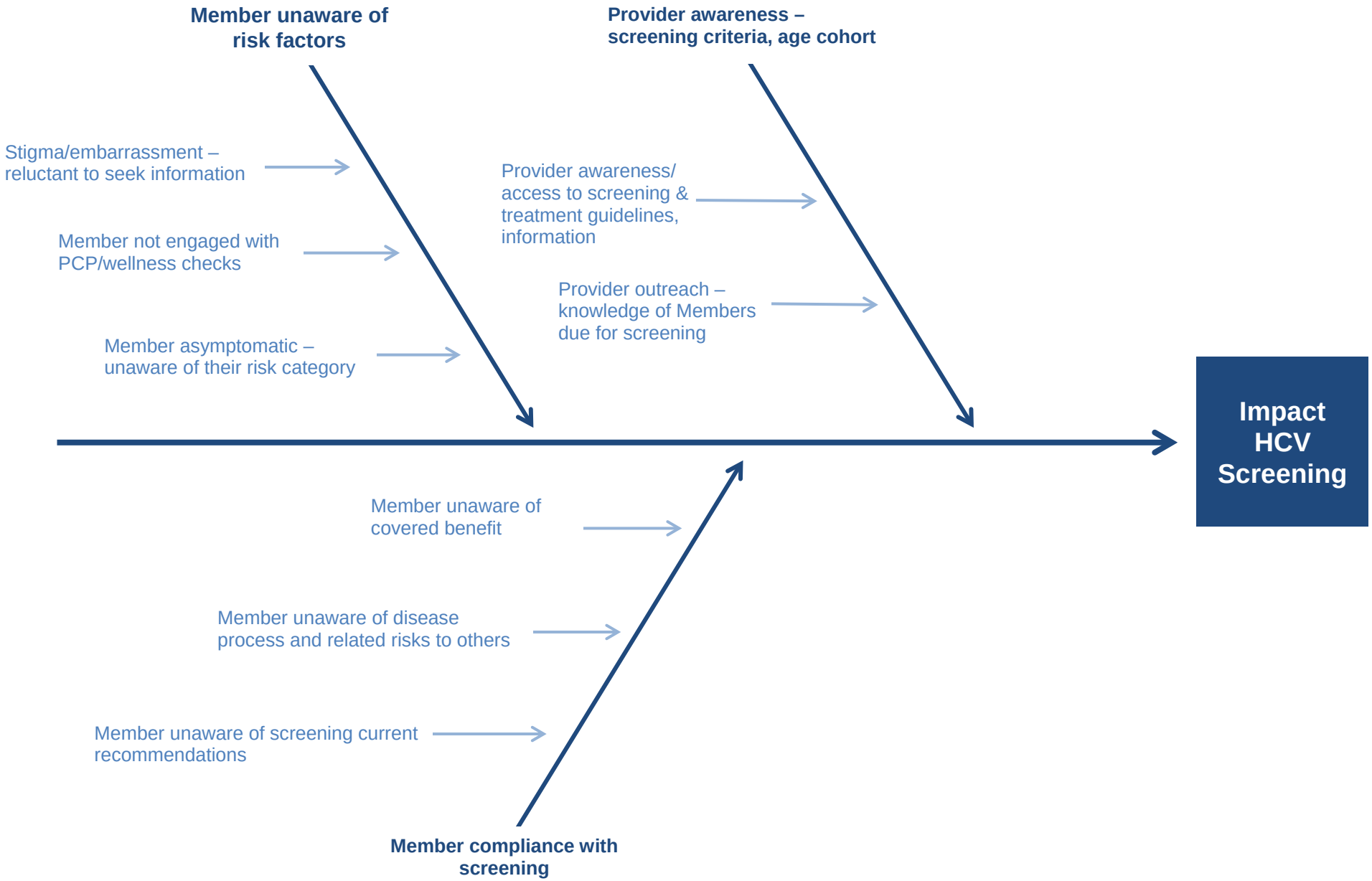
Glossary of PIP Terms

Table 7: PIP Terms

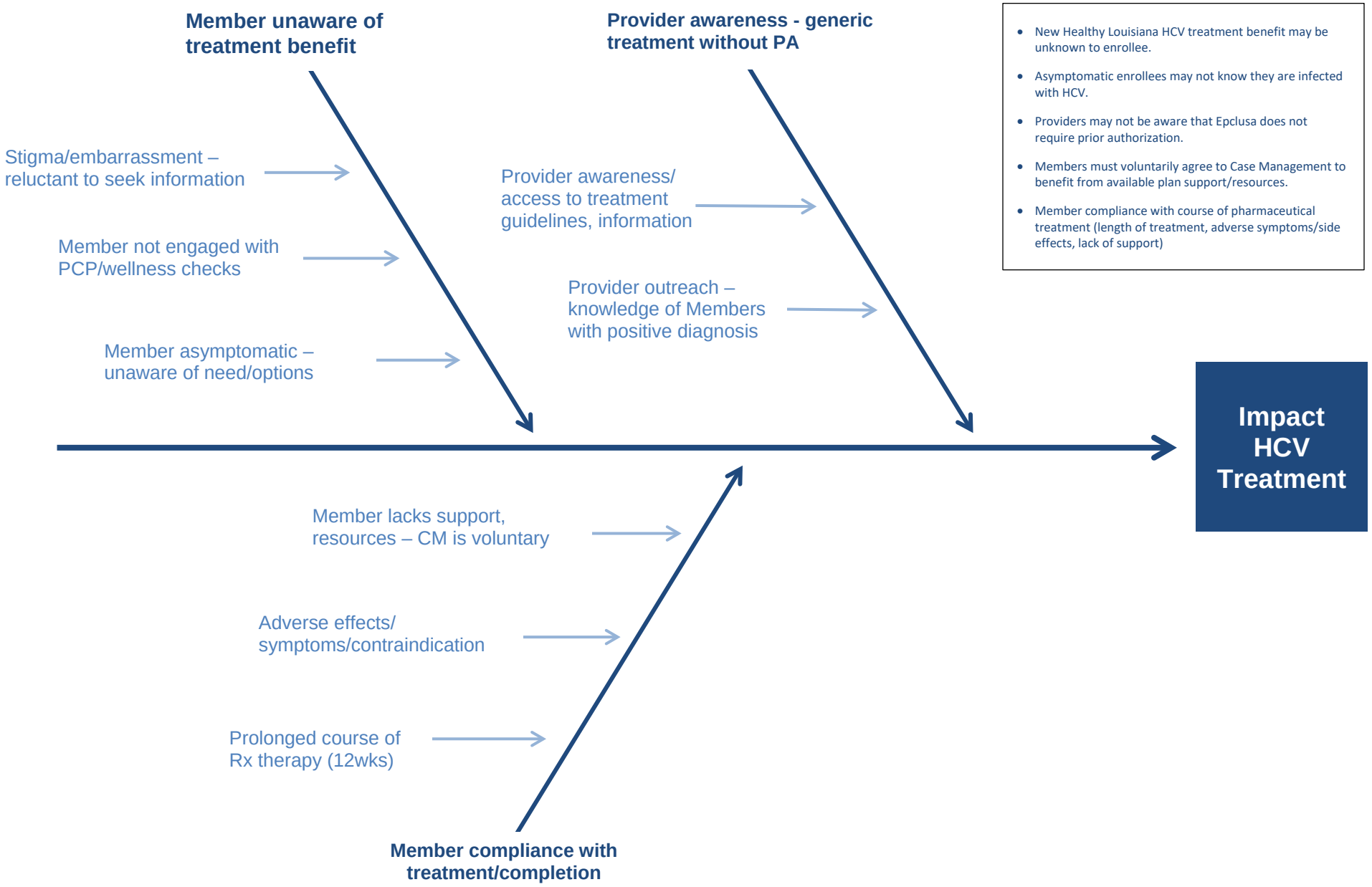
PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Roadblock	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention tracking measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.

PIP Term	Also Known as…	Purpose	Definition
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

Appendix A1: Fishbone (Cause and Effect) Diagram



Appendix A2: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix*

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Awareness of HCV status; (establish data sourcing for identification of members in at risk categories for screening outreach) • Prioritization of members for proactive outreach vs ongoing CM support (review available OPH data for initiation of outreach) • Provider engagement in education and implementation of clinical guidelines	
Less Feasible to Address	• Face to Face engagement of Providers – geographic scope • Stigma limiting member engagement in screening and/or treatment services	

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Pharmacy identification/reporting of members on treatment already in place; partnering with CM to share member lists to initiate outreach. • Community Health Workers in place; have ability to expand their services to support face to face intervention if feasible. • Plan and department leadership engagement and support of PIP initiative • Education/resource availability, online distribution and access platforms	***minimize*** **WEAKNESSES** • CM currently only outreaching to members on medication therapy; additional resource allocation needed to expand outreach • Unknown frequency of OPH data updates • Provider Outreach/dissemination of member lists – HIPAA caution, provider reluctance to access secure portals – seek alternative options to compliantly deliver value added information to providers
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** • Consider ease of access to information resources; currently provider portal is log in access – expand to a HCV focus site to promote LDH/LA program materials • Inquire – is LDH considering a custom measure for any of these risk categories/populations? (would ensure standardization/consistency in data)	***protect from*** **THREATS** • Provider reluctance to log into available portal (access to resources) • Member intolerance/adverse reaction or contraindication to generic approved medication (rebate available) • Regional/geographic scope – ability for face-to-face outreach for both member and providers across all regions

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 1. Increase the HCV screening rates among Healthy Louisiana adults at risk for HCV by 10 percentage points from CY 2019 to CY 2020.	PCPs screen the following high risk Healthy Louisiana adults for HCV antibody: a. Beneficiaries born between the years 1945 and 1965 b. Beneficiaries with Current or past injection drug use c. Beneficiaries ever on long term hemodialysis d. Persons who were ever incarcerated e. Beneficiaries with HIV infection	Educate PCPs about evidence-based guidelines (EBGs) for HCV screening: -U.S. Preventive Service Task Force Guidelines -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA). -Office of Public Health streamlined test and treat strategy (forthcoming) -Medicaid reimbursable CPT/HCPCS codes	-Notify providers regarding Provider Portal access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate USPSTF and AASLD/IDSA HCV screening guidelines into Clinical Practice Guideline repository -Disseminate Office of Public Health streamlined test and treatment strategy (forthcoming) -Develop and disseminate billing guidelines for HCV screening and Medicaid reimbursement - Encourage providers to participate in OPH-provided HCV treatment training [this covers screening as well]
		Identify adult members at risk for HCV	-Utilize HCV PIP specifications to identify at risk members using historical and current claims -Develop PCP lists of members eligible for screening -Develop Care Coordinator lists of members eligible for HCV screening
		Inform PCPs of their patients who are at risk/ eligible for screening	-Distribute to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening
		Educate at risk members about HCV screening	-Care Coordinators Outreach, educate and counsel members at risk who are eligible for HCV screening
		Refer at risk members to PCPs and facilitate appointment scheduling for HCV screening	-Care Coordinators refer and schedule appointments with PCPs for HCV screening

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 2. Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2019 to CY 2020.	HCV Providers identified in the OPH database (e.g., gastroenterologists, infectious disease specialists) and/or PCPs prescribe LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA} for beneficiaries diagnosed with HCV	Educate PCPs about evidence-based guidelines (EBGs) for HCV diagnosis and treatment: -Office of Public Health streamlined test and treat guideline -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA).	-Provider Portal notification regarding access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate the Office of Public Health streamlined test and treat guideline into Clinical Practice Guideline repository -Educate providers that prior authorization is not required for Epclusa generic for any Medicaid member -Develop and disseminate billing guidelines for HCV DAA agents and Medicaid reimbursement -Disseminate existing LDH resources to providers, including (1) the DAA Agent Medication Therapy Worksheet, (2) the HCV Treatment Agreement for Louisiana Medicaid Recipients, and (3) the Louisiana Medicaid Hepatitis C Direct-Acting Antiviral (DAA) Agents criteria, and (4) Office of Public Health (OPH) streamlined test and treatment guideline. - Encourage providers to participate in OPH-provided HCV treatment training
		Foster collaboration between PCPs, behavioral health and HCV specialists	-Develop and implement new processes to facilitate communication and coordinate care between PCPs, behavioral health and HCV providers listed in the OPH database (e.g., gastroenterologists, infectious disease specialists)
		Identify all members diagnosed with HCV	-Utilize the Office of Public Health listing of members with probable or confirmed HCV PIP to identify members with HCV diagnosis -Collaborate with OPH to develop PCP-specific listings of their patients who are potential candidates for HCV treatment -Develop Care Coordinator lists of members with HCV diagnosis for referral to PCPs for treatment
		Inform PCPs of their patients with HCV	-Distribute to each PCP their listing of members with HCV for medical assessment of appropriate treatment and/or referral to/ coordination with HCV specialist for treatment
		Educate and refer members with HCV for treatment assessment	-Care Coordinators Outreach, educate, refer and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.

Appendix E: Plan-Do-Study-Act Worksheet (use power point template)

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	□	□	□
Do: Document implementation of the intervention.	□	□	□
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	□	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	□	□	□
Intervention #2:			
Plan: Document the plan for conducting the intervention.	□	□	□
Do: Document implementation of the intervention.	□	□	□
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	□	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	□	□	□