Health Plan Performance Improvement Project (PIP)

Health Plan: Aetna Better Health of Louisiana

PIP Title: Improving Receipt of Global Developmental Screening in the First Three Years of Life

PIP Implementation Period: 1/1/21-12/31/21

Project Phase: Proposal

Submission Dates:

	Proposal / Baseline	Interim/ Final
Version 1	01/29/2021	12/31/2021
Version 2		

MCO Contact Information

1. Principal MCO Contact Person

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

First and last name: Madelyn Meyn, M. D.
Title: Chief Medical Officer/Medical Director
Phone number: 504-667-4541
Email: MeynM@Aetna.com:

2. Additional Contact(s)

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

First and last name: Arlene Goldsmith
Title: Quality Management Director
Phone number: 504-667-4648
Email: GoldsmithA@Aetna.com

First and last name: Melder Burton
Title: QM Operations Manager
Phone number: 225-316-1127
Email: BurtonM1@Aetna.com

3. External Collaborators (e.g., Early Intervention Programs):

- Head starts (collaborate with other MCOs to co-brand educational documents)
- Daycare facilities, schools
- Nurse Family Partnership/Parents as Teachers (NFP/PAT)
- EPSDT Population
- Children's Coalition
- LA-AAP

Attestation

Plan Name:
Title of Project:

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

Medical Director signature: Madelyn M. Meyn, MD
First and last name: Dr. Madelyn M. Meyn
Date: January 29, 2021

CEO signature: Richard C Born
First and last name: Richard C. Born
Date: January 29, 2021

Quality Director signature: Arlene Goldsmith
First and last name: Arlene Goldsmith
Date: January 29, 2021

IS Director signature (if applicable): Kenneth J Landry
First and last name: Kenneth Landry
Date: January 29, 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 ITM 6a logic was modified	January 26, 2021	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	To look for modifier 95 with CPT code 96110 for members utilizing telemedicine
Change 2 ITM 6b start date due to	July 9, 2021	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	Modification of the ITM start date due to concerns with having access to the provider charts for medical record review and the reallocation of resources is requiring us to remodel 6B, so we will begin chart audits in Q3.
Change 3 Indicators 1, 2, and 3	February 10, 2021	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	Q1 the plan modified the indicators to be inclusive of all providers that see our pediatric population. Prior data was reflective of pediatricians only, which did not capture the entire population. In addition, we reran data due to claims lag to ensure that the current reporting is reflective of the most recent data pulls.
Change 4 ITM 7	October 28, 2021	☐ Methodology ☐ Barrier Analysis ☐ Intervention ☒ ITM	Looking to eliminate this ITM as a viable solution for this PIP.

Abstract

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

Project Topic/Rationale: The Project Rational is to increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday.

Objective of the PIP: ABHLA objective is to assist our members and the Louisiana Department of Health (LDH), by successfully increasing the percentage of children screened for risk of developmental, behavioral, and social delays. ABHLA goal is to increase the knowledge of our members regarding the importance of early detection; working with providers to identify barriers to completion of screenings and partnering with early intervention programs such as head start.

Methodology: We analyze results in workgroups with key leaders and PIP Global Developmental Screening committee members, comparing prior months/years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABHLA may use Quality Improvement process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the Global Developmental Screenings PIP and its corresponding goals.

Interventions: ABHLA integrates educational opportunities in our community outreach activities, virtual baby showers, and HEDIS outreach. We are committed to developing strong relationships with different community partners like Parent as Teacher, Nurse Family Partners, and various other Early Intervention Programs. In reviewing the data from all the activities and educational events ABHLA shows a steady progress in the performance indicators defined by LDH over the past 3 quarters, yielding a percentage point change >2% from Q1 to Q3. In addition, a few of the ITM's yield positive results with noticeable progress in intervention tracking measures 1 and 6a yielding percentage point change of > 5% to date. Other ITM's had forward momentum, however the gain was less significant. These less than significant gains are attributed to the pandemic and hurricane IDA which caused devastation in multiple areas within Louisiana. These events shifted our members' priorities from seeing their providers and accessing care to getting access to other resources such as housing, food, etc.

Results: Although, ABHLA made some progress toward reaching the goal rate there were areas that intervention tracking measures did not fare as well as expected. There were many challenges in our ability to gain access to charts for review pertaining to ITM's 4a, 4b, and 6b. As identified in the recent LDH monthly PIP reporting, in Q3 the plan experienced difficulty obtaining records from ABHLA providers due to Covid-19 and Hurricane Ida. In addition, to those two prominent issues, we found that some providers are just non-compliant with our record requests nor were they communicating to the plan if they need more time. As we are working with our BH Program Coordinators it was stated that during our monthly meeting with LDH it was discussed that every MCO is having the same issues with providers from specific areas of the state. As a result of these findings the behavioral workgroup decided to do the following:

1. Work with LDH to create and implement consequences for non-compliance
2. LDH will be backing a mandatory training that discusses Audit Readiness
3. Internally those who are non-compliant will be referred to SIU

Conclusion: The Developmental Screening PIP was new to the plan in 2021 and due to the pandemic and the limitations with provider and member face to face activities, it was imperative to identify new practices to engage both the member and provider populations. To ensure that we made our providers aware of the changes occurring to the fee schedule effect January 1, 2021 the multidisciplinary internal team met to determine the best methodology to communicate the changes identified by the Louisiana Department of Health (LDH). This team was tasked with ensuring that there were effective and concise communication avenues to ensure providers were aware that CPT code 96110 would now be reimbursable under the updated fee schedule, as well as communications on the American Association of Pediatrics and LDH recommended screening tools. Communications were developed and utilized by our Regional Outcome Directors in the provider newsletter and shared in the provider advisory committee. In addition to our internal efforts ABHLA led the multi-MCO collaboration where we partnered with the American Association of Pediatrics to develop a combined survey for our providers to gauge the level of knowledge around the changes to the fee schedule and recommended developmental screening tools as well as the development and execution of 3 educational webinars that ran through the end of 2021, which offered CEU's to eligible participants

Next Steps: ABHLA is currently starting the effort to collect social determinant of health (SDoH) data, which will complement the current Analysis of Disproportionate Under-Representation grid included in the PIP requirements. The plan has partnerships with community-based organizations like Aunt Bertha (national) and Unite Us (state). Information for either can be loaded onto a member's phone for ease of use and this gives them access to all their needs beyond what Medicaid can offer. In addition, the strategic alliances made with the other MCO's will assist in building continuity of care models by the standardization of screening tools, reimbursement of CPT code 96113, partnering with vendors and external partners.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

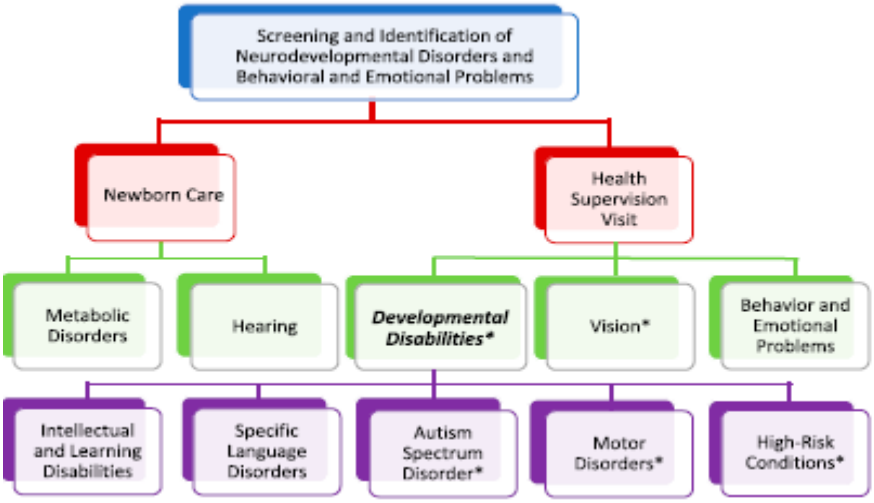
The American Academy of Pediatrics recommends developmental surveillance at most pediatric well-child visits, and formal developmental screening using a standardized screening tool at a minimum once during each of the 1st, 2nd, and 3rd years of life, to occur at pediatric well-child visits with appropriate follow-up for children with concerning screening results (Lipkin et al., 2020). Louisiana developmental screening guidelines (LDH, 2018) follow the AAP recommended screening periodicity schedule (AAP, 2020). Despite this, findings from the 2017-2018 National Survey of Children's Health showed that only 20.8 % of parents of children age 9-35 months in Louisiana reported their child received developmental screening using a parent-completed screening tool in the past 12 months, compared to 33.5% of children nationwide (Child and Adolescent Health Measurement Initiative, 2017-2018). This is particularly concerning given a recent Centers for Medicare & Medicaid (CMS) analysis reporting that during the coronavirus disease public health emergency, there were 44% fewer child screening services compared to 2019.

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**

  In reviewing the data for ABHLA it was found that our total population of 143,489 members is made up of 11,580 members age 0-3 years in 2020, which is 8.07% of ABHLA membership. As we continue to review and evaluate the data by reviewing members who have had claims with the CPT code of 96110 from January1, 2018 – December 31, 2020 we have been able to determine that we are well below the 33.5% reported in the Child and Adolescent Health Measurement Initiative, 2017-2018, showed above.

Indicators	Baseline Rate STATEWIDE RATE[1] Measurement Period: 1/1/2018-12/31/2018	Baseline Rate ABHLA (All qualifying members) Measurement Period: 1/1/2018-12/31/2018	2019 ABHLA (All qualifying members) Measurement Period: 1/1/2019-12/31/2019	2020 ABHLA (All qualifying members) Measurement Period: 1/1/20/20-12/31/2020
Indicator 1: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first birthday	N: 34	N: 274	N: 290	N: 220
	D: 137	D: 5395	D: 5368	D: 4873
	R: 24.82%	R: 19.69%	R: 18.51%	R: 22.15%
Indicator 2: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their second birthday	N: 25	N: 358	N: 381	N: 295
	D: 137	D: 4222	D: 4152	D: 3801
	R: 18.25%	R: 11.79%	R: 10.90%	R: 12.88%
Indicator 3: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their third birthday	N: 16	N: 242	N: 290	N: 168
	D: 137	D: 4099	D: 3659	D: 2906
	R: 11.68%	R: 16.93%	R: 12.62%	R: 17.30%

ABHLA results are lower than the sampling chart review conducted by LDH in 2018 for all indicators except for ABHLA indicator 3. ABHLA 2020 indicator 3 data pulled shows that the plan was performing 5.25% point higher for the same period. However, the plan was –16.57% point under the national survey. This information aids in the need to address the disparity found in members receiving proper screening during the first three years of life. In addition, we have been able to extrapolate that our largest population of members within the 0–36-month age range reside in these four regions:1 (2536), 7 (1258), 4 (1197), and 2(1091), therefore the plan will focus resources and develop strategies to address the need to have prompt developmental screenings.



Based on information found in the American Academy of Pediatrics "Early identification and intervention for developmental disorders are abstract critical to the well-being of children and are the responsibility of pediatric professionals as an integral function of the medical home. This report models a universal system of developmental surveillance and screening for the early identification of conditions that affect children's early and long-term development and achievement, followed by ongoing care. These conditions include autism, deafness/hard-of-hearing, intellectual and motor disabilities, behavioral conditions, and those seen in other medical conditions. Developmental surveillance is supported at every health supervision visit, as is as the administration of standardized screening tests at the 9-, 18-, and 30-month visits." downloaded from www.aappublications.org/news at AETNAMedical Library on January 13, 2021

By working with providers and members to have developmental screenings completed at the appropriate times, ABHLA can aid in early detection for members at risk. "Screening tools do not provide conclusive evidence of developmental delays and do not result in diagnoses. A positive screening result should be followed by a thorough assessment done by a trained provider. A more detailed evaluation will show whether the child needs treatment and early developmental intervention services. Medical examinations can identify whether the problems are related to underlying medical conditions that need to be treated." (CDC). Although, developmental screening tools are not used for diagnosing, they are important tools for early detection.

- **Describe high-volume or high-risk conditions addressed:**
  Members may be identified as candidates for Intensive CM through our claims data. In reviewing the data for 2020, ABHLA has been able to determine that 1.51% of the members in the age group 0-3 has had a claim with a procedure code of F80 – F89. In some cases, members may have multiples of these codes. ABHLA ranked the top three diagnosis within the F-Codes identified below:

  - Developmental Disorder Speech and Language unspecified (F80.9)
  - Autistic Disorder (F84.0)
  - Specific Developmental Disorder Motor Function (F82)

  The goal is work closely with our CM staff and BH staff to ensure that collaboration of care coordination is in place for our members.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**

  Current research assisted ABHLA in understanding that cost and time to complete assessment can be a cause for members not to receive the appropriate screenings in the suggested timelines by the AAP. "Although time and financial barriers are real, it is also likely that some of the residual gaps in guideline-concordant practice reflect variability among pediatricians in their perception of the clinical relevance of certain developmental problems that require formal instruments to identify and, in the availability, and

effectiveness of services targeted to children with these less severe developmental issues." (Mei Elansary and Michael Silverstein, 4/2020)

ABHLA also looked at information to determine if there were clinical information pertaining to members who were screened and if they were referred to the appropriate level of care. One article identified that "although the value of referring children with severe delays that are evident without a formal screen may be clear, there is a far broader population with developmental risk for whom the most appropriate course of action may not be seen as so straightforward. Although evidence has highlighted the first years of life as a critical window for improved long-term outcomes." (Shonkoff JP, Garner AS, 2012). Information from this article supported that time and financial issues areas that should be explored in this PIP.,

Due to the current state of our nation caused by the pandemic, it will be important for ABHLA to partner with our telehealth vendor to increase utilization of these services. "The American Academy of Pediatrics (AAP) strongly supports continued access to health care for children and adolescents during the coronavirus disease 2019 (COVID-19) pandemic, whether it be in person or via telehealth. Among the many dramatic changes seen in clinical pediatric practice during this public health emergency has been the rapid adoption of telehealth. Many patients and families have found telehealth to be a valuable means to access their medical home, pediatric medical subspecialists, or pediatric surgical specialists. Although telehealth is an important mode of health care service delivery, communities lacking access to key infrastructure to support care through telehealth, e.g. internet or home technology, may not have fully realized the potential benefits of access to care through telehealth leading to worsening of existing disparities in access to care." (AAP, 2020)

There are several articles and information supporting the need for appropriate and timely screen of members ages 0-3 years. The tools used for developmental screening are formal questionnaires or checklists based on evidence-based practices that assess a child's development. Developmental screening can be done by a doctor or nurse, but also by other professionals in healthcare, early childhood education, community, or school settings. These screenings are more formal and therefore not recommended to be completed by the parents. The developmental monitoring are not as formal and can be completed more often.

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**

  Based on state rankings from the Data Resource Center for Child & Adolescent Health, Louisiana is ranked 44 out of 51 states (including the District of Columbia) for children who received a developmental screening using a parent-completed screening tool in the past 12 months for age 9-35 months (about 3 years). The estimated population size for this data was 175,529 with a sample size of 143 resulting in only 29% of parents completing the developmental screening. 2018 baseline data of all ABHLA members indicates that in the 12 months preceding or on the member's first, second, and third birthdays; rates of completion of the standardized global developmental screening tool were 19.69%, 11.79%, and 16.94% respectively. Numerators and denominators for these can be found on Table 2: Goals of this document.

Aims, Objectives and Goals

<u>Aim:</u> Increase the percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday.

<u>Objective(s)</u>

- **Describe the major interventions that the health plan will implement, in order to positively affect member health outcomes or experiences of care.**
  The following sentence structure is encouraged:

"Implement [describe major interventions] to improve [cite performance indicator(s)] from baseline to final measurement."
Example: Implement automatic pharmacy refills to improve the percent of members ages 5-11 years with asthma who were dispensed asthma controller medication from baseline to final measurement.

Address each of the following key intervention areas in this section by describing your interventions:

1. Conduct provider education on standardized global developmental screening tools, Healthy Louisiana billing & coding guideline, and early intervention programs. Resources include, but are not limited to LDH developmental screening guidance and resources by region: https://ldh.la.gov/index.cfm/page/3195 and AAP/Bright Futures: (https://screeningtime.org/star-center/#/screening-tools)
2. Develop member gap reports, stratify by provider and distribute to providers.
3. Conduct parent education on importance of developmental screening. Conduct enhanced care coordination outreach/education to parents of members on gap report.
4. Conduct a Quarter 1 through Quarter 3 2021 PCP chart review of:
   a. random sample of 30 eligible population charts in the Indicators 1, 2 & 3 aggregate denominator ***with*** CPT Code 96110 to validate whether the tools in Table 4a were utilized for global developmental screening.
   b. random sample of 30 eligible population charts in the Indicators 1, 2 & 3 aggregate denominator with***out*** CPT Code 96110 to discern whether the tools in Table 4a were utilized for global developmental screening at the child's 9-month, 18-month or 30-month visit.

Note: If random chart selection is not feasible due to COVID-19, then the chart selection method may use charts procured for other purposes.

5. Collaborate with early intervention programs (EIP) and coordinate with providers to facilitate referrals from providers to EIP.
6. Work with our internal Quality Analytics team to develop reporting mechanisms and algorithms to allow for random sampling for our internal abstractor to use in the chart review process.
7. Collaborate with BH and CM team to ensure that members who were diagnosed with autism or other developmental delays are being referred to the appropriate levels of care.
8. Link to Webinar Series offered by Bureau of Family Health on the Recommended Developmental Instruments.
9. Work with vendor to develop a Nano site to collect developmental screening data from members.

Table 2: Goals

Indicators	Baseline Rate STATEWIDE RATE[1] Measurement Period: 1/1/2018-12/31/2018	Target Rate	Rationale for Target Rate
Indicator 1: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first birthday.	N: 34 D: 137 R: 24.82%	Rate: 34.82%	Target rates were identified by the guidance given in the 1/21/2021 collaborative meeting notes. Set a rate that is 10 percentage points higher than the Healthy Louisiana 2018 rates calculated by ULM
Indicator 2: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their second birthday.	N: 25 D: 137 R: 18.25%	Rate: 28.25%	Target rates were identified by the guidance given in the 1/21/2021 collaborative meeting notes. Set a rate that is 10 percentage points higher than the Healthy Louisiana 2018 rates calculated by ULM

Indicator 3: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their third birthday.	N: 16 D: 137 R: 11.68%	Rate: 21.68%	Target rates were identified by the guidance given in the 1/21/2021 collaborative meeting notes. Set a rate that is 10 percentage points higher than the Healthy Louisiana 2018 rates calculated by ULM

1. Calculated by ULM using the CMS Child Core Set Hybrid Measure (medical record reviews).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Continuous Enrollment	Numerator	Denominator
Indicators 1, 2 and 3	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday.	**Administrative claims data**	**Indicator 1:** Children who turned 1 during the performance period (Birth to 1 year of age) **Indicator 2:** Children who turned 2 during the performance period (> 1 year to 2 years of age) **Indicator 3:** Children who turned 3 during the performance period (> 2 years to 3 years of age)	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday. No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).	CPT code 96110 (Global developmental testing, with interpretation and report) is submitted within the 12 months preceding or on the patient's birthday during the age stratified episode of care (e.g., children who turn 12 months of age, 24 months of age and 36 months of age during the performance period). The submission of the CPT 96110 code and documentation of the denominator eligible patient encounter do not need to occur simultaneously. **Numerator Exclusion**: Modified claims to indicate standardized screening only for a specific domain of development, such as social emotional screening via the ASQ-SE, autism screening	The Eligible Population who meet the continuous enrollment criteria.

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:**
- Sampling was initially employed with a random selection of 60 members per group (those with 96110 and those without) to allow for sufficient oversampling to produce the target number of records collected. The related requests met with very low response (2 records total), so the methodology was changed to review applicable records obtained for the MRR audit process and those available through provider EMR systems ABHLA can access like ~~to~~ Ochsner.

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 collection will be performed by the Quality department's Analyst as well as members of the IT department. Data collection will be setup weekly utilizing the below software and methods:
  - **TOAD Data Point:** Software will be utilized to generate automated custom reporting specifically around this PIP by combining multiple data sources listed below.
  - **Annual Population Assessment**: Annual report generated integrating member enrollment demographic data, Elli data software linked to State claims received with diagnoses codes, ABH QNXT claims data base.
  - **CM Utilization rates:** Report generated utilizing CM Dynamo data platform monthly, quarterly, and final annual rate of enrollment patterns.
  - **Utilization Management Rates**: QNXT data base system generated quarterly and annual report of member utilization patterns for telemedicine, tele-therapy, outpatient services, and treatment centers.
  - **Member Surveys**: Use of data received from Interactive Telephone Calls to the members with PIP age-appropriate children, who have been identified as non-compliant.
  - **Vendor Reports:** Received monthly, quarterly, and final annual rates of text messages and IVR calls to members.
  - **Chart Review:** Complete medical record review to capture analysis on developmental screen tools utilized and the use of billing code 96110.

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:**
  - **Annual Population Assessment**: Member demographic and claims information validated by Aetna IT informatics and Health Care Equities Director. We utilize Elli data software program, which is linked to State claims received, ABH QNXT claims received, and member enrollment data to produce reliable data over time.
  - **HEDIS**: In accordance with NCQA's protocols, validity audits are conducted by Advent Advisory Group, an NCQA-licensed organization, and led by a Certified HEDIS Compliance Auditor (CHCA). The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability. Audits are conducted in accordance with NCQA*HEDIS Compliance Audit: Standards, Policies and Procedures*. NCQA's Information Systems (IS) and HEDIS Measure Determination (HD) standards were the foundation on which auditors assessed the organization's ability to report HEDIS data accurately and

- **Member Survey**: Vendor data file validated by QI Director, Developmental Screening Project Manager and/or designee. Discrepancies discussed with vendor during monthly meetings. Utilizing interactive phone surveys with State approved scripts. Same method utilized for each survey conducted.
- **Pharmacy Rates**: Data file validation by CVS pharmacy and Aetna Pharmacy Director
- **Vendor Reports**: Vendor data file reports of text messages, mailers, and IVR calls generated validated by QI Director, Project Manager and/or designee. Aetna IT generation of member lists utilizing same logic. Discrepancies discussed with vendor during monthly meetings.
- **CM Utilization Rates:** Validated by Project Manager and CM project manager for variances in data and/or technical reporting issues within the Dynamo data platform. Aetna IT informatics review of final rates and of discrepancies found and using the same data base system and logic for reliable results.
- **Utilization Management Rates:** Validated by UM Manager and Medical Management Director for validity and accuracy of data with Aetna IT informatics review of final rates, and of discrepancies found for member utilization of treatment services.
- **Chart Review:** Identify methods to ensure validity and reliability, including IRR methods, as well as alternative methods for chart selection and how to ensure sample representative of eligible members:
    - Data Analytics has developed a macro that will allow for random sampling of the population. These samples will be provided quarterly for chart retrieval.
    - To address the chart return being unknown, if the return on sample is low, we will default to utilizing EMR's that we have access to.
    - We will be utilizing the standard AETNA IRR process.
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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:**
    - Our data collection for identifying, measuring, and reporting for needs related to Global Developmental Screenings are generated from claims and chart reviews. In addition, the plan integrates QSI HEDIS performance metrics, Care Management dynamo platform of enrollment patterns and care coordination for screening and treatment, enrollee participation, and intervention tracking measures, as well as any additional process metrics. An analysis of related utilization management services, provider/enrollee claims audits to ensure provider and/or member adherence to screening and linkage to treatment and/or evidence- based guidelines is conducted. Data is stratified by at risk populations identified for Global Developmental Screenings including key clinical factors. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP Global Developmental Screenings committee members, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABH-LA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABH-LA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention

tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the Global Developmental Screenings PIP and its corresponding goals.

- **Describe how plan will interpret improvement relative to goal:**
  - In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional, member, and provider demographic variations, to identify variation in access and health care services. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in screening and active treatment.
- **Describe how plan will monitor ITMs for ongoing QI:**
  - The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is being observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2020
End date: 12/31/2020

Submission of Proposal/Baseline Report Due: 1/29/2021

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

PIP Interventions (New or Enhanced) Initiated: 2/1/2021

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 and Chart Review Findings for the Period from 1/1/21-9/30/21 Due: 10/31/2021

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

Analysis of Disproportionate Under-Representation (to be completed for the Final Report for the period from 1/1/21-11/1/21) Will be updated in Final submission

Aggregated Performance Indicator #s 1, 2 & 3 (The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first, second or third birthday) stratified by enrollee subpopulations.
Susceptible subpopulations are those subpopulations for which the Disproportionate Index > 100%: The subpopulation's share of the total enrollee population eligible for global developmental screening (denominator) is greater than the subpopulation's share of enrollees with global developmental screening (numerator). Thus, the susceptible subpopulations are under-represented in terms of global developmental screening receipt.

Subpopulation – 1/1/21 – 11/1/21	Children Eligible for Global Developmental Screening		Children Who Received Global Developmental Screening Using a Standardized Tool		**Disproportionate Index of Global Developmental Screening Under-representation**
	# of enrollees in the denominator	**% of MCO TOTAL denominator**	# of enrollees in the numerator	**% of MCO TOTAL numerator**	**% of MCO TOTAL denominator ÷ % of MCO TOTAL numerator**
MCO TOTAL	12,219	100%	2,271	100%	1.00
Age Group					
Children who turned 1	5,127	41.96%	863	38.00%	1.10
Children who turned 2	5,030	41.17%	912	40.16%	1.03
Children who turned 3	5,812	47.57%	722	31.79%	1.50
Sex					
Male	6,271	51.32%	1,202	52.93%	0.97
Female	5,948	48.68%	1,069	47.07%	1.03
Race					
American Indian or Alaska Native	27	0.22%	4	0.18%	0.00
Asian	122	1.00%	25	1.10%	0.91
Black or African American	3,877	31.73%	678	29.85%	1.06
Native Hawaiian or Pacific Islander	25	0.20%	4	0.18%	1.16
White	2,996	24.52%	562	24.75%	0.99
Other	78	0.64%	18	0.79%	0.81
Unknown	5,094	41.69%	980	43.15%	0.97
Ethnicity					
Hispanic	32	0.26%	8	0.35%	0.74
Non-Hispanic	2,996	24.52%	562	24.75%	0.99
Unknown	9,191	75.22%	1,701	74.90%	1.00
Primary Language Spoken at Home					
English	12,183	99.71%	2,258	99.43%	1.00
Other	36	0.29%	15	0.66%	0.45
LA Region of Residence					
Region 1: Greater New Orleans	3,496	28.61%	594	26.16%	1.09
Region 2: Capital Area	1,526	12.49%	271	11.93%	1.05
Region 3: South Central LA	780	6.38%	108	4.76%	1.34
Region 4: Acadiana	1,572	12.87%	536	23.60%	0.55
Region 5: Southwest LA	359	2.94%	28	1.23%	2.38
Region 6: Central LA	714	5.84%	106	4.67%	1.25
Region 7: Northwest LA	1,727	14.13%	259	11.40%	1.24
Region 8: Northeast LA	674	5.52%	87	3.83%	1.44
Region 9: Northshore Area	1,371	11.22%	282	12.42%	0.90

Barrier Analysis, Interventions, and Monitoring

To be completed upon Proposal submission (to be updated for baseline, interim and final reports).

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: Provider education on standardized global developmental screening tools, Healthy Louisiana billing & coding guideline, and early intervention programs. **Method of barrier identification:** Based on objective alignment on page 9 of this document and data retrieved from the AAP developmental survey		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 1. Conduct provider education on standardized global developmental screening tools, new billing guidelines for coding developmental screening, and early intervention programs. Planned Start Date: February 1, 2021 Actual Start Date: March 17, 2021	Intervention tracking measure 1: N: # PCPs who received global developmental screening guideline + coding + referral education D: # PCPs who see children	N: 0 D: 596 R: 0.00%	N: 0 D: 596 R:0.00%	N: 0 D: 673 R: 0.00%	N: 0 D :673 R: 0.00%	N: 97 D: 1675 R: 5.72%	N: 180 D: 1675 R: 10.75%	N: 0 D: 1685 R: 0.00% Due to Hurricane IDA and Covid there were no educational sessions performed	N: 1014 D: 1675 R: 60.54%
Barrier 2: Ensure providers have access to gap reports for members requiring developmental screenings **Method of barrier identification:** Based on objective alignment on page 9 of this document		**Year 1**				**Year 2**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 2. Develop member gap reports, stratify by provider, and distribute to providers. Planned Start Date: May 1, 2021 Actual Start Date: May 17, 2021	Intervention tracking measure 2: N: # Members whose PCPs were distributed care gap report D: # Members with developmental screening care gap (Distinct count of members from 0 – 36 months with No claims w/ CPT Code 96110 for 2020 for Q1 – Q4 2020. Members can be counted in multiple quarters)	N: 0 D: 5267 R: 0.00%	N: 0 D: 4171 R: 0.00%	N: 0 D: 4772 R: 0.00%	N: 0 D: 4335 R: 0.00%	N: N/A D: 8508 R: N/A	N: 874 D: 8414 R: 10.38%	N:0 D: 7780 R: 0.00 Due to Hurricane IDA and Covid there were no educational sessions performed	N: 3240 D: 8853 R: 36.60%

Barrier 3: Member Education and Resources **Method of barrier identification:** Based on objective alignment on page 9 in this document		**Year 1**				**Year 2**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention to address barrier: 3. Conduct enhanced care coordination outreach/education to parents of members on gap report. Planned Start Date: March 1, 2021 Actual Start Date: April 10, 2021	Intervention tracking measure 3: N: # Members who received care coordination outreach, education + appointment scheduled with PCP for screening D: # Members with developmental screening care (Distinct count of members from 0 – 36 months with No claims w/ CPT Code 96110 for 2020 for Q1 – Q4 2020. Members can be counted in multiple quarters)	N: 0 D: 5267 R: 0.00%	N: 0 D: 4171 R: 0.00%	N: 0 D: 4772 R: 0.00%	N: 0 D: 4335 R: 0.00%	N: 1 D: 8508 R: 0.01%	N: 5 D: 8414 R: 0.06%	N: 43 D: 7780 R: 0.55%	N: 62 D: 8853 R: 0.70%
Barrier 4: Appropriate developmental screening tool utilization and billing of CPT code 96110 Method of barrier identification: Guidance given during the January 21, 2021 PIP review presentation and internal SWOT analysis performed.		**Year 1** **Q1-Q3**				**Year 2** **Q1-Q3**			
Intervention to address barrier: 4. Conduct a PCP chart review of: a. random sample of 30 eligible population charts ***with*** CPT Code 96110 to validate whether the tools in Table 4a were utilized for global developmental screening. b. random sample of 30 eligible population charts with***out*** CPT Code 96110 to discern whether the tools in Table 4a were utilized for global developmental screening at the child's 9-month, 18 month or 30-month visit. Note: If random chart selection is not feasible due to COVID-19, then the chart selection method may use charts procured for other purposes.	Intervention tracking measure 4a: N: # Members who received global developmental screening using one of the tools in Table 4a D: Eligible population ***with*** CPT Code 96110 (Distinct count of members from 0 – 36 months with a claim for CPT 96110 for Q1 – Q3 2020, regardless of which quarter they are in)) Intervention tracking measure 4b: N: # Members who received developmental screening using one of the tools in Table 4a D: Eligible population with***out*** CPT Code 9611096110 (Distinct count of members from 0 – 36 months with no claim for CPT 96110 for Q1 – Q3 2020. Member will only be counted once, regardless of which quarter they are in)	N: 0 D: 503 R: 0.00% N: 0 D: 7721 R: 0.00%				N: 1 D: 7 R: 14.29% N: 0 D: 19 R: 0.00%			
Barrier 5: Collaborations with early intervention programs and day cares		**Year 1**				**Year 2**			
Method of barrier identification: Review of the maternal health program and community collaboration efforts, and guidance given in the PIP presentation on January 21, 2021		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**

Intervention to address barrier: **5.** Collaborate with early intervention programs (EIP) and coordinate with providers to facilitate referrals from providers to EIP. Planned Start Date: February 1, 2021 Actual Start Date: March 3, 2021	Intervention tracking measure 5: N: # Members referred via coordination with PCP for further evaluation with early intervention program D: # Members with diagnosis of suspected or documented developmental delay ICD-10 codes F80-F89 (Distinct count of members from 0 – 36 months with claim for ICD-10 codes F80-F89 for Q1 – Q4 2020. Members can be counted in multiple quarters)	N: 0 D: 52 R: 0.00%	N: 0 D: 39 R: 0.00%	N: 0 D: 51 R: 0.00%	N: 0 D: 51 R: 0.00%	N: 45 D: 97 R: 46.39%	N: 46 D: 148 R: 31.08%	N: 54 D: 133 R: 40.60%	N: 21 D: 125 R: 16.80%
Barrier 6: Susceptible Subpopulations		**Year 1**				**Year 2**			
Method of barrier identification: Disproportionate Under-representation analysis		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
6a. Tailored and targeted intervention for Susceptible subpopulation 6a Work with community outreach to leverage external partner in regions 1, 4, 7, and 2 to increase education on developmental global screening Planned Start Date: April 1, 2021 Actual Start Date: April 1, 2021	N: # of members in Regions 1, 4, 7, and 2 who has been screened and have a claim with CPT Code 96110(Distinct count of members from 0 – 36 months with a claim for CPT 96110 for Q1 – Q4 2020 for regions 1, 2, 4, and 7. Members can be counted in multiple quarters) D: # Members in Regions 1, 4, 7, and 2 eligible for standard developmental global screening (Distinct count of members from 0 – 36 months with no claim for CPT 96110 for Q1 – Q4 2020 for regions 1, 2, 4, and 7. Members can be counted in multiple quarters)	N:175 D:3879 R:4.51%	N:148 D:3130 R:4.73%	N:180 D:3519 R:5.12%	N:158 D:3247 R:4.87%	N: 825 D: 6560 R: 12.58%	N: 741 D: 6422 R: 11.53%	N: 1151 D: 6398 R: 17.98%	N: 1201 D: 6522 R: 18.41%
6b Tailored and targeted intervention for Susceptible subpopulation 6b Work with behavioral health staff to ensure continuity of care for members identified with Autism Planned Start Date: April 01, 2021 Actual Start Date:	N: # of Members that have been identified as having continuity of care via chart reviews. D: # of Members identified with a diagnosis of Autism (CPT. Code F84) (Distinct count of members from 0 – 36 months with claim for CPT code F84 for Q1 – Q4 2020. Members can be counted in multiple quarters)	N: 0 D:8 R: 0.00%	N: o D:4 R: 0.00%	N: 0 D:3 R: 0.00%	N: 0 D:5 R: 0.00%	N: N/A D: 0 R:N/A	N: N/A D: 18 R: N/A	N: N/A D: 14 R: N/A	N: N/A D: 15 R: N/A Unable to retrieve medical records from providers
Barrier : Telemedicine Visit		**Year 1**				**Year 2**			

Method of barrier identification: Underutilization of Telemedicine services for completion of developmental screening		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
7. Increase the number of members receiving screens through telemedicine Planned Start Date: February 1, 2021 Actual Start Date: March 1, 2021	N: Distinct count of members 36 months or less with a CPT code of 96110 and a modifier of 95 D: Distinct count of members 36 months or less with a CPT code of 96110 (Distinct count of members by quarter for 2020 that had a CPT code of 96110. Members can be counted in multiple quarters)	N:0 D: 227 R: 0.00%	N:1 D: 185 R: 0.54%	N:0 D: 222 R: 0.00%	N:0 D: 192 R: 0.00%	N: 1 D: 1107 R: 0.09%	N: 0 D: 1005 R: 0%	N: 0 D: 1561 R: 0%	N: 3 D: 1708 R: 0.18%

Table 4a. Chart Review to validate developmental screening.

Chart Documentation Requirements	Standardized Global Developmental Tools cited by Bright Futures (and the American Academy of Pediatrics statement on developmental screening)
• A note indicating the date on which the test was performed, evidence of a screening result or screening score, and the standardized too used. • Standardized tools used to screen for specific disorders (e.g., Modified Checklist for Autism in Toddlers M-CHAT) do not meet the numerator requirement for a standardized global developmental screening tool. • Any validated global developmental screening tool supported by AAP/Bright Futures: (https://screeningtime.org/star-center/#/screening-tools) • LDH developmental screening guidance and resources by Region: https://ldh.la.gov/index.cfm/page/3195	Ages and Stages Questionnaire (ASQ) - 2 months to age 5[1]
	Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
	Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
	Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
	Brigance Screens-II - Birth to 90 months
	Child Development Inventory (CDI) - 18 months to age 6
	Infant Development Inventory - Birth to 18 months
	Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
	Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

1. The Ages and Stages Questionnaire-2 (ASQ-3) is recommended for global screening by the Louisiana Bureau of Family Health, Office of Public Health, Louisiana Department of Health, as of 8/2018. The ASQ-3 has an associated on-time nominal fee.

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.

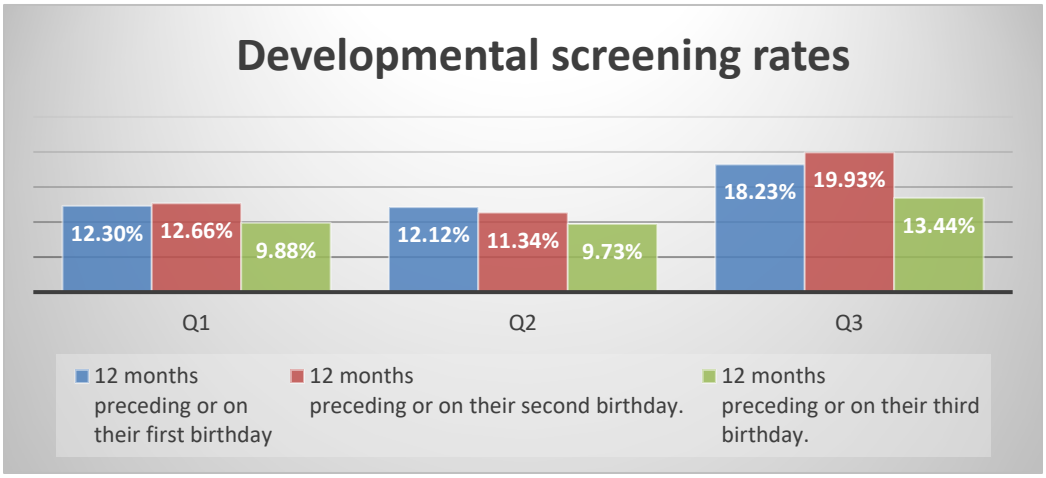
Table 5: Results

Indicator	Baseline Period STATEWIDE measure calculated by ULM[1] Measure period: 1/1/18-12/31/18	Interim Period Measure period: 1/1/20-12/31/20	Final Period Measure period: 1/1/21-11/1/21	Target Rate[2]
Indicator 1: The percentage children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first birthday.	N: 34 D: 137 R: 24.82%	N: 514 D: 5753 R: 8.93%	N: 876 D: 4437 R: 19.74%	Rate: 34.82% Suggested Target rate at kickoff meeting
Indicator 2: The percentage children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their second birthday.	N: 25 D: 137 R: 18.25%	N: 522 D: 5371 R: 9.72%	N: 987 D: 5204 R: 18.97%	Rate: 28.25% Suggested Target rate at kickoff meeting
Indicator 3: The percentage children screened for risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their third birthday.	N: 16 D: 137 R: 11.68%	N: 329 D: 5747 R: 5.72%	N: 782 D: 6007 R: 13.02%	Rate: 21.68% Suggested Target rate at kickoff meeting

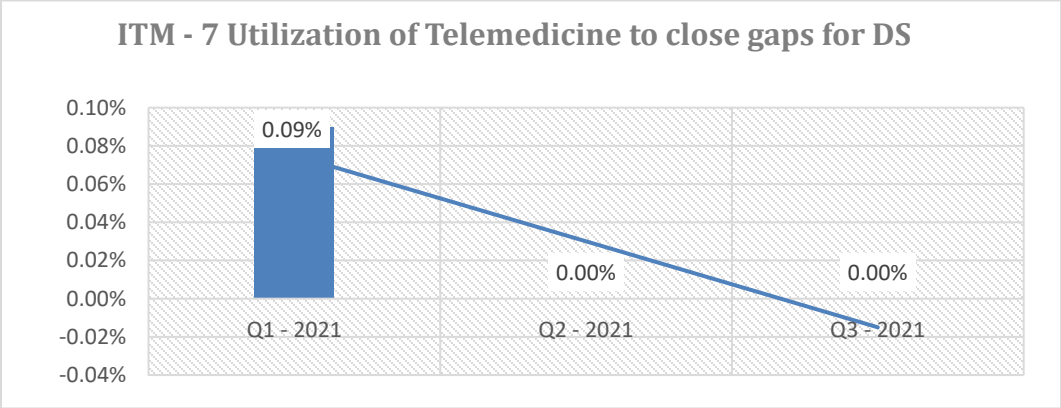
1. Calculated by ULM using the CMS Child Core Set Hybrid Measure (medical record reviews).
2. Suggested target rates based upon improvement beyond margin of error from 2018 rates: Indicator #1: 39%; Indicator #2: 31%; Indicator#3: 22.4%. Another approach would be to target 15 percentage point improvement for each performance indicator. Upon interim evaluation of target rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development, and refinement of interventions, and/or analysis of PIP performance.

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.



As seen in this table above over the past three quarters in 2021 ABHLA saw an increase in indicators except for indicator 2, which dropped in the second quarter, but rebounded in Q3. This data has been reported in the Quality Management Committee and is used to drive the effectiveness of the current interventions developed. Q4 data will be reported in the upcoming meeting and the expectation is that we see the continuous increase in these rates.



ITM 7 table above show that ABHLA was unable to effectively impact the metric in the first 3 quarters, due to this in Q4 ABHLA performed a SWOT analysis to review current communication process effectiveness and to determine what the plan can do additionally to ensure that all available avenues are being sourced for effectively communicating on the importance of early detection through screenings. ABHLA continues to struggle with getting members interested in utilizing the telemedicine vendor in this capacity. Due to this difficulty, ABHLA re-evaluated the effectiveness of this ITM as a viable solution for members and it has been determined to discontinue this ITM in Q4.

Discussion

To be completed upon Interim and Final Report submissions. The discussion section is for explanation and interpretation of the results. In the Final Report Discussion, revise the Interim Discussion so that the Final Discussion Section represents one comprehensive and integrated interpretation of results, rather than a separate add-on to the Interim discussion.

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. In reviewing the data for ABHLA it was found that our total population of 143,489 members is made up of 11,580 members age 0-3 years in 2020, which is 8.07% of ABHLA membership. As we continue to review and evaluate the data by reviewing members who have had claims with the CPT code of 96110 from January1, 2018 – December 31, 2020 we have been able to determine that we are well below the 33.5% reported in the Child and Adolescent Health Measurement Initiative, 2017-2018. ABHLA 2021 analysis noted a >2% increase from Q1 to Q3, in all 3 reporting quarters for indicators 1-3. However, when comparing the indicators to the ULM baseline data; the plan was –16.57% point under the national survey. This information aids in the need to address the disparity found in members receiving proper screening during the first three years of life through many of the interventions implemented, educational efforts, and community partnerships the plan's final rates increased from interim by approximately 7-8% percentage points, which contributed to the significance of the work being done around this this PIP.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**
  Overall, the data showed that ABHLA had forward momentum in ITMs 3, 5, and 6a,which are intervention dealing with member education and resources, assisting with getting members access to early intervention programs and in regions 1, 4, and 7 which were the regions identified in the data analysis requiring the most attention based on our study of the population.

  However, when reviewing 4a, 4b, and 6b metrics associated with medical record retrieval , we did not meet the targets set forth due to several reasons. Most of that information can be found in the summary presented above and in the quarterly reports submitted to LDH. As indicated in the reports, ABHLA discussed the difficulty in chart retrieval for various reasons. In addition, the plan identifies the underutilization of telemedicine in completing developmental screenings which led to re-evaluation of ITM 7 as it relates to its effectiveness.

- **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.
  Factors that contributed to the success and/or failure of the many of programs initiated:

  ABHLA uses QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the Global Developmental Screenings PIP and its corresponding goals.

PIP Highlights:

Successes:

- Internal and External partner collaborations
- Provider survey on current screening tools ***(effective provider intervention)***
- Development of collaborative efforts for all MCO's
- Development of Gaps in Care Reports used to assist providers in closing Gaps ***(effective provider intervention)***
- Education and communication materials to ensure provider knowledge regarding the appropriate billing codes and screening tools
- Integration of member outreach in the HEDIS process
- Integration of member educational material in virtual baby shower ***(effective member intervention)***
- Increased partnership with Parents as Teachers and Nurse Family Partners ***(effective member intervention)***
- Collateral received from the CDC and LDH is being shared at community events currently. Due to restriction surrounding COVID additional plans are moving forward surrounding partnerships with EIP and other partners to share information regarding the importance of developmental screening.

Failures:

- Unable to increase opportunities initiating intervention number 6b
    - Chat retrieval has been a challenge along with provider cooperation has been difficult
- Telehealth-removing the barriers associated with members willingness to use telehealth as a viable option for having their child/children screened.
- As identified in the recent LDH monthly PIP reporting, the ABHLA identified in Q3 the difficulty receiving records from providers due to covid-19 and hurricane Ida

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, there is no threat to the internal validity to the data findings.

- **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, there is no threat to the external validity of the findings

- **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.
  Record retrieval for 2021 remains low due to challenges from COVID and Hurricane Ida. Access to providers remains limited, as does available provider staff and resources to comply with fulfilling record requests. Due to this concern the plan was forced to use claims data as a mechanism for identifying the increase of the CPT code 96110 utilization and although it was difficult to obtain records of those abstracts, the data revealed that the providers were using some sort of developmental screening, however they were not billing the appropriate code.

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
Intervention 1	There is an ongoing need to communicate the significance of the appropriate screening tools identified by the American Association of Pediatrics and LDH and the importance of billing for CPT code 96110	Continue to provide provider communications through newsletter, provider visits and gap reports.	Continue education and communications regarding the appropriate tools and the utilization of CPT code 96110.
Intervention 2	Providing the gaps in care reports to providers assist the plan in closing some of the gaps associated with developmental screening.	Currently, working with the national team to automate the developmental GIC report.	Once the GIC report has been automated, the plan is to incorporate this in the regular HEDIS gaps in care report that providers receive.
Intervention 3	We found that there is a small % of member who qualify for developmental screening in CM and although there is a need for enhanced case management, how could the plan better utilize resources for getting members the education and resources needed.	No additional changes have been made for this intervention,	Continue to use the developed member communications at community events and member portal to share education and available resources. Nurse Family Partners (NFP)/Parents as Teachers (PAT) working with these groups to share information with members receiving services and how to capture the work being completed
Intervention 4a and 4b	Access to provider charts and the ability to identify the types of developmental tools being used by providers	The plan has taken IPRO's guidance in utilizing available charts and continue to work with providers in the request for charts.	Currently working to gain additional access to EMR systems.
Interventions 5, 6a and 6b	The plan has found that some providers are just non-compliant with our records request nor are they communicating if they need more time. As we are working with our BH Program Coordinators it was stated that "During our monthly meeting with LDH it was discussed that every MCO is having the same issues with providers from specific areas of the state	Working with LDH to create and implement consequences for non-compliance LDH will be backing a mandatory training that discusses Audit Readiness Internally those who are non-compliant will be referred to SIU"	The inventions and issues identified during the developmental PIP will be incorporated into the ABA/Autism programs, initiative, and campaigns plan for 2022. ABHLA has begun creating both provider and member education that will coincide with member education on the importance of developmental screening. ABHLA will be creating mailers that are delivered before important milestone PCP visits to educate members on what developmental indicator to look for in their children and when to discuss any concerns and/or setbacks with their PCP.

Intervention 7	During this pandemic we have learned that guardians have various concerns such as connectivity issues, seeking assistance for non-medical concerns, etc.	Due to this difficulty, we are re-evaluating the effectiveness of this ITM as a viable solution for members.	This ITM has been discontinued

References

Include a list of references for any sources of information used to formulate the project.

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Glossary of PIP Terms

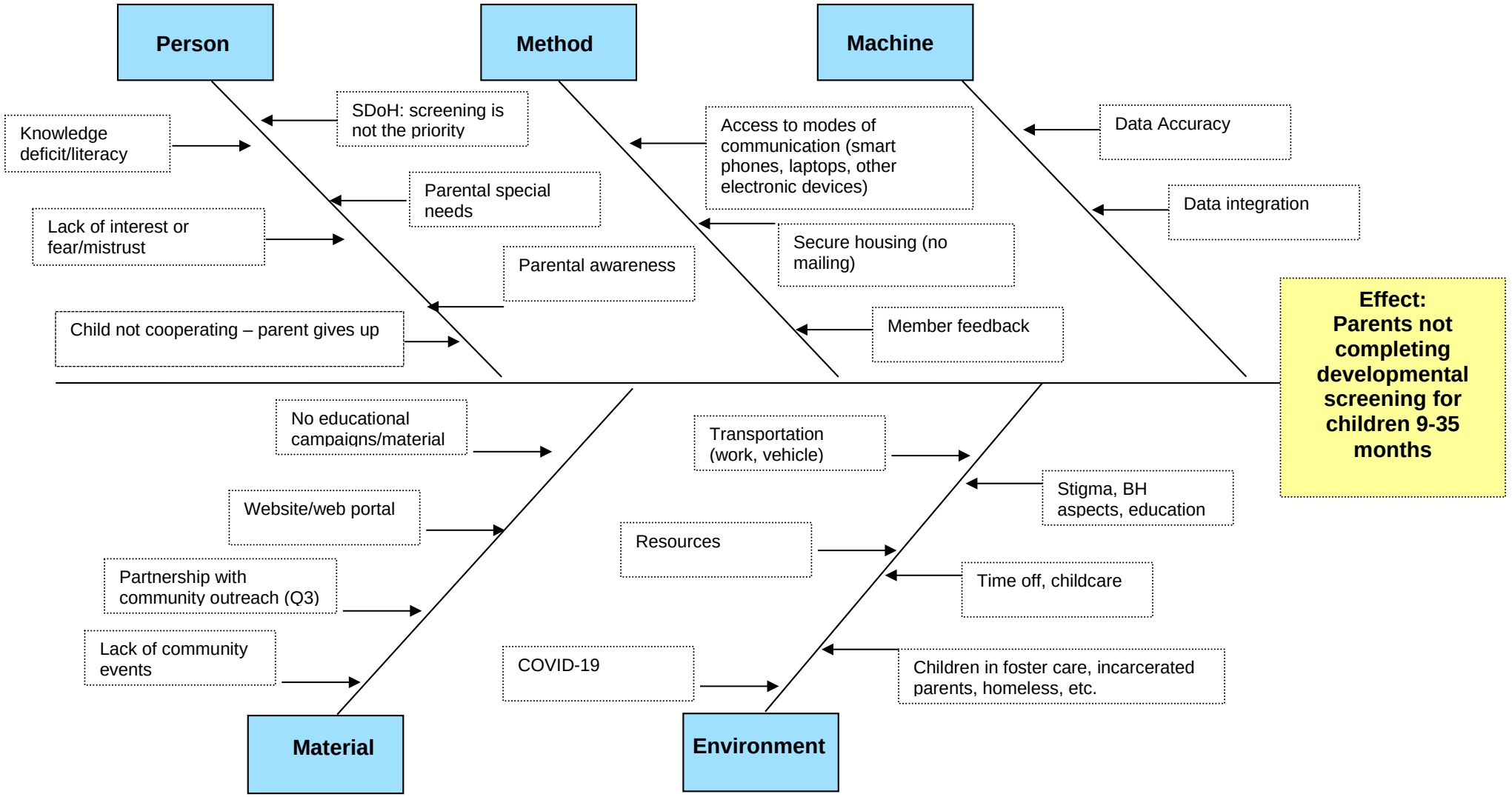
Table 7: PIP Terms

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.

PIP Term	Also Known as…	Purpose	Definition
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.
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).

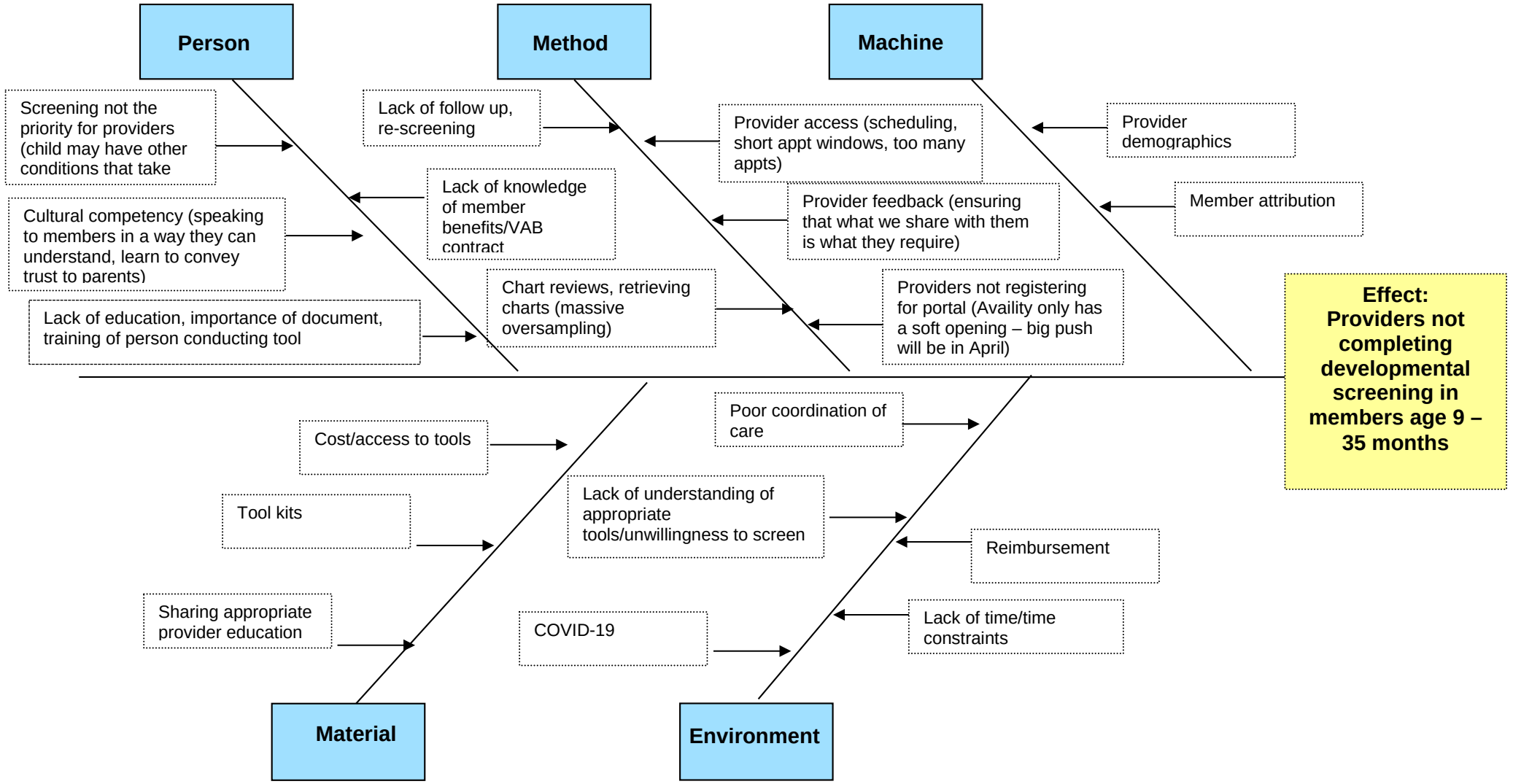
Appendix A: Fishbone (Cause and Effect) Diagram

Member Focused



Appendix A: Fishbone (Cause and Effect) Diagram

Provider Focused



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Educate Providers on the reimbursement opportunities with CPT Code 96110 • Develop Member educational materials about well checks and developmental screenings (What to expect) • Work w/community Outreach team to develop partnerships with EIP's. • Develop Provider Gap Reports for 96110 this will be in conjunction with the W30 • Develop unified/collaborative MCO's provider communications to identify barriers to screenings and tools • Provider Education on Developmental Screening and the Periodicity Schedule	
Less Feasible to Address	• Assisting providers with time and financial resources to complete screenings	

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

For improving AETNA Developmental Screenings by 5%

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** Multidisciplinary Team Pediatrician PIP Champion Reporting Capabilities	***minimize*** **WEAKNESSES** ***Examples:*** Member/Provider Linkage Web Portal readiness
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** Develop relationships with EIP's MCO's Collaborative Sub-Committee Increase utilization of telemedicine Increase provider reimbursement Increase linkage to care for members	***protect from*** **THREATS** ***Examples:*** COVID 19 Providers willingness to use recommended screening tools Getting providers to utilize website/web portal Recycling claims code payment causing provider abrasion Member/Provider utilization of website/web portal

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Increase the percentage of children screened for risk of developmental, behavioral and social delays by 10 percentage points from 2018 to 2020, using a standardized, global developmental screening tool in the 12 months preceding or on their first, second or third birthday.	Providers are knowledgeable about AAP/Bright Futures recommended global developmental screening tools, the Bright Futures periodicity schedule for screening, Developmental Screening Guidelines, and Early Intervention Program (EIP) resources	Conduct provider education on standardized global development screening tools, Healthy Louisiana billing & coding guideline, and early intervention programs.	• Collaborative AAP survey • Unified messaging for all MCOs • Onsite/virtual education
	Providers are informed about their patients who are eligible for global developmental screening and who have an annual screening gap.	Develop member gap reports, stratify by provider and distribute to providers.	• Distribution via provider portal, electronic (email, SFTP), hand-delivery
	• Parents are knowledgeable about the timing and benefits of developmental screening. • Parents of children with screening gaps are informed by care coordinators about their children's' need for annual global developmental screening.	• Conduct parent education on importance of global developmental screening. • Conduct enhanced care coordination outreach/education to parents of members on gap report.	• Distribution via member portal • Developing campaigns • Working with case management to incorporate developmental screening materials • Leveraging community partner messaging • Daycare providers
	• Care coordinators establish relationships with EIP. • Care coordinators facilitate provider referrals to EIP.	Collaborate with early intervention programs (EIP) by developing and implementing processes/procedures to coordinate with providers to facilitate referrals from providers to EIP.	• Provider referral and follow-up for continuity of care

Appendix E: Plan-Do-Study-Act Worksheet

	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.	•	•	•