Health Plan Performance Improvement Project (PIP)

MCO Name: AmeriHealth Caritas

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

PIP Implementation Period: January 1, 2021 – December 31, 2021

Project Phase: Final Draft

Submission Dates:

	Proposal / Baseline	Interim	Final
Version 1	1/29/2021	6/30/2021	12/10/2021
Version 2			12/30/2021

MCO Contact Information

1. Principal MCO Contact Person

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

American Academy of Pediatrics

Attestation

Plan Name: AmeriHealth Caritas Louisiana
Title of Project: Improving Receipt of Global Developmental Screening in the First Three Years of Life

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

Medical Director Signature: Rodney Wise, MD.
First and Last Name: **Rodney Wise, MD**
Date: 12/30/2021

Medical Director Signature:
First and Last Name: **Betty Muller, MD**
Date: 12/30/2021

CEO Signature:
First and Last Name: **Kyle Viator**
Date: 12/30/2021

Quality Director Signature: Rhonda Baird
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Date: 12/30/2021

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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	**February 2021**	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	**Conduct Provider Education on Standardized Global Developmental Screening Tools, Healthy Louisiana Billing & Coding Guideline, and Early Intervention Programs**: **a)** AAP / MCO Collaborative Provider Survey (April Through May 2021) – **AAP / Bureau of Family Health Webinars Offered; AAP / Bureau of Family Health Office Hour Webinar Trainings (May – December 2021)** **b) Creation of AmeriHealth Caritas Louisiana EPSDT Provider Toolkit – Published to ACLA Provider Webpage and Distributed to Providers via Provider Alert** c) Ongoing Quality Management Provider Visits **d) LPCA Breakout Session – Educating Providers on Developmental Screening Initiative, CPT 96110 Use, and Approved Tools Use (November 2021)**
Change 2	**January 2021**	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	**Conduct Parent Education on Importance of Developmental Screening. Conduct Enhanced Care Coordination Outreach/Education to Parents of Members on Gap Report**: • Implement Parent Education initiatives via Texting Campaign • Social Media Awareness / Spring 2021 Newsletter – Increasing Education

			• Well-Child Visit Mailings • Planned Gap in Care Member Calls – for Well-Child Visits / Developmental Screening
Change 3	**May 2021**	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	**<u>Develop Member Gap Reports, Stratify by Provider and Distribute to Providers</u>:** • Develop member care gaps, using code **96110**, to notify providers of their members' care gaps to increase the percent of members aged 0 – 3 who receive global developmental surveillance from baseline to final measurement.
Change 4	**February 2021**	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	**<u>Enhanced Provider Outreach</u>:** • Member Spring Newsletter Submitted to Communications • MCO / AAP Collaborative Survey via SurveyMonkey – Completed • Provider Outreach via Quality Zoom Visits

Abstract

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

Project Topic and Rationale
The Developmental Screening Performance Improvement Project (PIP) aimed to improve the receipt of Global Developmental Screening in the First Three Years of Life by ten percentage points from baseline rates.

- **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. Baseline rate was set from MY2018 at 24.82% with a target rate 10 points higher for MY2021 at 34.82%.
- **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. Baseline rate was set from MY2018 at 18.25% with a target rate 10 points higher for MY2021 at 28.25%.
- **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. Baseline rate was set from MY2018 at 11.68% with a target rate 10 points higher for MY2021 at 21.68%.

Objectives
Through various interventions, AmeriHealth Caritas Louisiana (ACLA) set out to increase member and provider knowledge of the developmental screening initiative.

Methodology
ACLA's baseline data was determined using statewide 2018 data provided by the Louisiana Department of Health (LDH). Over the course of 2021, several internal departments and various Managed Care Organizations (MCOs) worked collaboratively to increase provider and member knowledge of the screening initiative. These collaborations ultimately assisted in improving ACLA's developmental screening rates by the recommended ten percentage point increase from baseline.

Interventions
In order to achieve increased screening rates, internal departments including Quality Management, Care Management, Enterprise Analytics (Informatics), Provider Network Management, and Plan Communications collaborated to initiate several member and provider focused interventions. Along with these internal departments, ACLA collaborated with the other Healthy Louisiana MCOs (Aetna, Healthy Blue, LHCC, and United) and the Louisiana AAP Chapter to gather provider feedback through a SurveyMonkey administered provider survey. Direct outreach was made to providers through ACLA's Provider Alert email system, as well as several virtual provider visits hosted by Quality and Provider Network Management teams. In addition, ACLA developed an ESPDT Toolkit that was distributed to providers to increase developmental screening knowledge. In regards to member interventions, ACLA continues to outreach members utilizing texting campaigns, increased social media awareness posts, member newsletter publications, and member gap in care telephonic outreach.

Results
Despite experiencing rate improvement each quarter for all three indicators, ACLA did not meet the target rates for 2021. In addition, final reported rates for 2021 decreased from the baseline rate for all indicators. It is important to note the indicator data is based on claims data, which is dependent on the provider office's billing practices, and may not be a true representation of the developmental screenings that were conducted. In addition, baseline rates for 2018 were based on a sample population.

Major Conclusions
Considering the extraordinary issues faced in 2021, e.g. the ongoing COVID-19 pandemic and various severe weather episodes, ACLA did experience increase in the Developmental Screening rates for our 0-3 year old population.

Next Steps
In 2022, ACLA will continue building on current interventions and continuing to increase rates for all 3 indicators. Internal department collaboration and virtual/face-to-face provider visits will be prioritized to further increase screening rates and improve on the overall use of global developmental screening tools by Louisiana Medicaid providers.

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 (AAP) recommends developmental surveillance at most pediatric well-child visits at a minimum once during each of the 1st, 2nd, and 3rd years of life, using a standardized screening tool, 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 these recommendations, findings from the 2017-2018 National Survey of Children's Health showed that only 20.8% of parents of children ages 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 concerning given a recent analysis conducted by the Centers for Medicare & Medicaid (CMS) which reported 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:**

  The importance of developmental surveillance cannot be overstated. According to the Louisiana Developmental Screening Guidelines, "quality early intervention services can change a child's developmental trajectory and improve life-long outcomes for children, families, and communities" (Bureau of Family Health, 2018). Furthermore, developmental surveillance is paramount considering approximately 15% of U.S. children have a developmental disability, but only 2-3% of U.S. children receiving public early intervention services by age 3 (Bureau of Family Health, 2018). With just under 15,000 members within this birth to 3 years of age cohort, the opportunity to improve on the previous 20.8% rate, the current 24.8% rate, or to the nationwide 33.5% rate would allow us to have an impact on roughly 2,000 additional AmeriHealth Caritas Louisiana members.

- **Describe high-volume or high-risk conditions addressed:**

  According to the Center for Disease Control and Prevention (CDC), about 1 in 6 children aged 3 to 17 years have one or more developmental or behavioral disabilities, such as autism, a learning disorder, or attention-deficit/hyperactivity disorder (CDC, 2020). However, many children with developmental disabilities are not identified until they are in school, by which time significant delays might have occurred and opportunities for treatment might have been missed (CDC, 2020). As a managed care organization, ACLA will pursue ways to increase developmental surveillance at a young age (prior to 3 years) in an attempt to discover any developmental or behavioral disabilities before our members reach the age at which they begin school.

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

  As stated above, the AAP recommends developmental surveillance at most pediatric well-child visits, and formal developmental screening using a standardized screening tool at a minimum of once during each of the 1st, 2nd, or 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). Similarly, Louisiana developmental screening guidelines (LDH, 2018) follow the AAP recommended screening periodicity schedule (AAP, 2020).

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

  There is an opportunity for improvement of developmental surveillance of ACLA members. Given the statewide baseline data, the percentage of children screened for the risk of developmental, behavioral and social delays using a standardized global developmental screening tool in the 12 months preceding or on their first birthday was 24.82%. Sequentially, for children preceding or on their 2nd and 3rd birthday, baseline rates were 18.25% and 11.68%. ACLA plans to give a more in depth discussion of those parameters as this performance improvement project progresses. When combining all subpopulations, members birth to 3 years old, a ten percentage point increase from the baseline rate of 20.8% to 30.8% would result in roughly an additional 2,000 ACLA members receiving developmental surveillance from their respective providers.

Aims, Objectives and Goals

Aim: 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(s)

- **Describe the major interventions that the health plan will implement, in order to positively affect member health outcomes or experiences of care.**
  Implement virtual provider visits, telephonic member outreach, and care gap reporting to improve the percentage of children screening 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 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
     a. ***Provide educational information to providers and their respective staff members to improve the percent of members aged 0–3 years who receive global developmental surveillance from baseline to final measurement.***

  2. Develop member gap reports, stratify by provider and distribute to providers.
     a. ***Develop member care gaps, using code 96110, to notify providers of their members' care gaps to increase the percent of members aged 0-3 who receive global developmental surveillance from baseline to final measurement.***

  3. Conduct parent education on importance of developmental screening. Conduct enhanced care coordination outreach/education to parents of members on gap report.
     a. ***Implement parent education initiatives via texting campaign, member newsletters, and Care Management Outreach to inform and educate caregivers of the developmental screening initiative and ultimately increase the percentage of members aged 0–3 who receive global developmental surveillance from baseline to final measurement.***

  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 without 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.
    a. ***Utilize AmeriHealth Caritas Louisiana's Care Management and Rapid Response Departments to develop or coordinate a process to facilitate referrals from AmeriHealth providers to Early Intervention Programs when indicated by the results of the screening instrument to increase the rate of members aged 0 – 3 who receive global developmental surveillance from baseline to final measurement.***

Table 2: Goals

Indicators	Baseline Rate STATEWIDE RATE[1] 1/1/2018-12/31/2018	Quarter 1 1/1/21–3/31/21	Quarter 2 4/1/21 – 6/30/21	Quarter 3 7/1/21 – 9/30/21	Final Rate 1/1/21 – 11/30/21	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%**	**N:** 452 **D:** 5,001 **R: 9.04%**	**N:** 693 **D:** 5,003 **R: 13.85%**	**N:** 859 **D:** 5,006 **R: 17.16%**	**N:** 890 **D:** 5,007 **R: 17.78%**	**R: 34.82%**	10 Percentage Points or Higher Improvement (Overall National Rate is Approximately 33.5%)
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%**	**N:** 336 **D:** 5,201 **R: 6.46%***	**N:** 660 **D:** 5,203 **R: 12.68%**	**N:** 784 **D:** 5,205 **R: 15.06%**	**N:** 796 **D:** 5,205 **R: 15.29%**	**R: 28.25%**	10 Percentage Points or Higher Improvement (Overall National Rate is Approximately 33.5%)
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%**	**N:** 144 **D:** 4,865 **R: 2.96%***	**N:** 281 **D:** 4,866 **R: 5.77%**	**N:** 342 **D:** 4,874 **R: 7.02%**	**N:** 356 **D:** 4,874 **R: 7.30%**	**R: 21.68%**	10 Percentage Points or Higher Improvement (Overall National Rate is Approximately 33.5%)

1. Calculated by ULM using the CMS Child Core Set Hybrid Measure (medical record reviews). To be updated in December 2020.

Rates Reflect Overall Use of CPT 96110 – Provided by Claims Data through November 2021
As PIP Progresses – ACLA Intends to Perform Sample Chart Reviews to Better Reflect Global Screening Tool Use

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?
The entire eligible population is being targeted by PIP interventions. We plan to educate providers on the importance of developmental surveillance, as well as informing provider staff of the screening initiative and the utilization of CPT 96110 and its reimbursement. Broad outreach will be utilized to educate and inform caregivers of eligible ACLA members of the developmental screening initiative, and a more focused approach towards those members who are present on the newly established gap in care reports.

Sampling Procedures

- **Describe sampling methodology:**
    - In Q2, ACLA pulled a random sample of eligible members with and without CPT code 96110 for medical record review with a goal of receiving 60 charts. 45 records were received.
    - Due to difficulties in receiving records from practices, the plan was short 15 records from the original random sample. ACLA utilized a network facility EMR system to meet the collection goal in Q4. A random sample was collected from a report of eligible members with and without CPT code 96110 and filtered by the unique network facility to obtain the records.
    - ACLA feels confident with the results of the medical record collection project accomplishing its purpose of identifying the utilization of standard developmental screening tools.

Data Collection

- **Describe data collection:**
    - ACLA's Enterprise Analytics (Informatics) Department will collect data from claims/encounter for all eligible members. Data sources may include: claims/encounter data (administrative data). Administrative data will be collected as needed, quarterly, and annually.
    - For Intervention Tracking Measures (ITMs), data will be collected monthly utilizing claims/encounter data, clinical documentation software, and departmental tracking tools.
    - Through the partnership the AAP utilizing SurveyMonkey, ACLA received provider data on best practices, barriers, and barrier interventions in regards to developmental screening. Of the 345 distributed surveys, 98 were completed.

Validity and Reliability

- **Describe validity and reliability:**
    - Administrative data is collected by the Enterprise Analytics (Informatics) team. The process for verifying ITM data validity and reliability is conducted by quality associates within each department. Through the PDSA cycle, analysis will be conducted to determine process improvements, strengths and opportunities. For the hybrid portion of the medical record abstraction, the appropriate training and IRR testing will be done within ACLA's Quality Department.

Data Analysis

Describe data analysis procedures:

- Analysis will address the comparability of baseline and re-measurement data, including factors that impact validity. Results will present numerical data that is accurate, clear, and easily understood. Interpretation will involve looking at all possible explanations for results and factors that may have affected them. Historical circumstances will be considered. Visual displays of data will facilitate analysis and communicate results.
- Quarterly monitoring of ITMs will be conducted to determine improvements or barriers of measure and if interventions should be modified.

- **Describe how plan will interpret improvement relative to goal:**
    - Data analysis will guide how well interventions are influencing performance indicator rates and outcomes. This data will be assessed against established goals and will drive decisions on effectiveness of change.

- **Describe how plan will monitor ITMs for ongoing QI:**
    - ITMs will be validated and monitored weekly and monthly as appropriate through trending, PDSA cycles, run charts, and other QI tools to analyze impact and effectiveness. The process for verifying ITM data validity and reliability will be conducted by quality associates with each department.

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)

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	Children Who Turned 15 Months During the Measurement Year		Children With Six or More Well-Child Visits		Disproportionate Index of Well-child Visit 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	4,225	100%	2,320	100%	
Race					
American Indian or Alaska Native	9	0.21%	5	0.22%	**0.95**
Asian or Pacific Islander	28	0.66%	20	0.86%	**0.77**
Black or African American	1,849	43.76%	945	40.73%	**1.07**
Native Hawaiian or Pacific Islander	*NA*	*NA*	*NA*	*NA*	***NA***
White	1,012	23.95%	619	26.68%	**0.90**
Other	9	0.21%	6	0.26%	**0.81**
Unknown	1,318	31.20%	725	31.25%	**0.99**
LA MCO Region of Residence					
Region 1: Greater New Orleans (1)	927	21.94%	539	23.23%	**0.94**
Region 2: Capital Area (3)	652	15.43%	362	15.6%	**0.99**
Region 3: South Central LA (4)	304	7.2%	168	7.24%	**0.99**
Region 4: Acadiana (5)	512	12.12%	313	13.49%	**0.90**
Region 5: Southwest LA (6)	132	3.12%	64	2.76%	**1.13**
Region 6: Central LA (7)	457	10.82%	256	11.03%	**0.98**
Region 7: Northwest LA (8)	529	12.52%	278	11.98%	**1.05**
Region 8: Northeast LA (9)	280	6.63%	131	5.65%	**1.17**

Subpopulation	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	**13636**	**100%**	**2339**	**100%**	
Age Group					
Children who turned 1	4549	**33.36%**	863	**36.90%**	**90.41%**
Children who turned 2	4726	**34.66%**	868	**37.11%**	**93.40%**
Children who turned 3	4361	**31.98%**	608	**25.99%**	**123.05%**
Sex					
Male	6920	**50.75%**	1155	**49.38%**	**102.77%**
Female	6716	**49.25%**	1184	**50.62%**	**97.30%**
Race					
American Indian or Alaska Native	33	**0.24%**	3	**0.13%**	**188.68%**
Asian	89	**0.65%**	23	**0.99%**	**66.38%**
Black or African American	5296	**38.84%**	826	**35.31%**	**109.98%**
Native Hawaiian or Pacific Islander	0	**0.00%**	0	**0.00%**	**0.00%**
White	2971	**21.79%**	579	**24.75%**	**88.02%**
Other	13	**0.10%**	1	**0.04%**	**222.99%**
Unknown	5234	**38.38%**	907	**38.78%**	**98.99%**
Ethnicity					
Hispanic	802	**5.88%**	136	**5.81%**	**101.20%**
Non-Hispanic	3853	**28.26%**	677	**28.94%**	**97.65%**
Unknown	8981	**65.86%**	1526	**65.24%**	**100.95%**
MCO Region of Residence					
Region 1: Greater New Orleans	3044	**22.32%**	276	**11.80%**	**189.18%**
Region 2: Capital Area	2146	**15.74%**	433	**18.51%**	**85.01%**
Region 3: South Central LA	909	**6.67%**	138	**5.90%**	**112.99%**
Region 4: Acadiana	1695	**12.43%**	613	**26.21%**	**47.43%**
Region 5: Southwest LA	439	**3.22%**	88	**3.76%**	**85.57%**
Region 6: Central LA	1113	**8.16%**	163	**6.97%**	**117.13%**
Region 7: Northwest LA	2065	**15.14%**	211	**9.02%**	**167.87%**
Region 8: Northeast LA	1037	**7.60%**	131	**5.60%**	**135.78%**
Region 9: Northshore Area	1188	**8.71%**	286	**12.23%**	**71.25%**

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 Knowledge Deficit **Method of barrier identification: QM / Provider Network Management Analysis**		**2021**				**2022**			
		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 2021 **Actual Start Date**: February 2021	**Intervention tracking measure 1:** **N:** # PCPs who received global developmental screening guideline + coding + referral education **D:** # PCPs who see children	**N:** 446 **D:** 940 **R: 47.45%**	**N:** 631 **D:** 1,317 **R: 47.91%**	**N:** 631 **D:** 1,317 **R: 47.91%**	**N**: 622 **D**: 1,299 **R: 47.88%**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2: Provider Knowledge Deficit **Method of barrier identification: QM / Provider Network Management Analysis**		**2021**				**2022**			
		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:** Q2 2021 **Actual Start Date**: July 2021	**Intervention tracking measure 2:** **N:** # Members whose PCPs were distributed care gap report **D:** # Members with developmental screening care gap ***# of Providers Who Have Access to Provider Portal / NaviNet***	**N:** **D:** **R**: **N/A**	**N:** 1,300 **D:** 1,317 **R: 98.71%**	**N:** 1,300 **D:** 1,317 **R: 98.71%**	**N**: 1,283 **D**: 1,299 **R: 98.77%**	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Barrier 3: Member Knowledge Deficit **Method of barrier identification: QM / CM Outreach Feedback / Analysis**		**2021**				**2022**			
		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:** February 2021 **Actual Start Date**: February 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 gap	**N:** **D:** **R: N/A**	**N:** **D:** **R: N/A**	**N:** 27 **D:** 98 **R: 27.55%**	**N:** 20 **D:** 130 **R: 15.38%**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 4: Provider Knowledge Deficit of CPT Code Use **Method of barrier identification: QM Analysis**		**2021** **Q1-Q3**				**2022** **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.*** **Planned Start Date:** October 2021 **Actual Start Date**: July 2021	**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 **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 96110	**N:** 19 **D**: 30 **R: 63.33%** **N:** 15 **D:** 30 **R: 50.00%**				N: D: R: N: D: R:			
Barrier 5: Identification of members with a referral for follow-up due to a suspected developmental delay		**2021**				**2022**			

Method of barrier identification: Administrative claims data		**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 when indicated by instrument results. **Planned Start Date:** Q2 2021 **Actual Start Date**: June 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	**N:** 204 **D:** 230 **R**: **88.70%**	**N:** 432 **D:** 474 **R: 91.14%**	**N:** 178 **D:** 243 **R: 73.25%**	**N:** 14 **D:** 48 **R: 29.17%** **Claims through 10/31**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 6: Susceptible Subpopulations		**2021**				**2022**			
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 **Planned Start Date:** TBD **Actual Start Date:** June 2021	**N:** Number of Pediatric Providers who received Developmental Screening Education **D:** Number of Pediatric Providers in Southwest LA and Northeast LA	**N:** 119 **D:** 186 **R 63.98%**	**N:** 160 **D:** 249 **R: 64.26%**	**N:** 160 **D:** 249 **R: 64.26%**	N: 155 D: 245 **R: 63.27%**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
6b. Tailored and targeted intervention for susceptible subpopulation 6b **Planned Start Date:** TBD **Actual Start Date:** June 2021	**N:** Number of Pediatric Providers in High Black or AA Regions who received Developmental Screening Education **D:** Number of Pediatric Providers in Regions of High Black or AA Enrollment	**N:** 164 **D:** 281 **R**: **58.36%**	**N:** 231 **D:** 410 **R: 56.34%**	**N:** 231 **D:** 410 **R: 56.34%**	**N:** 226 **D**: 404 **R: 55.94%**	N: D: R:	N: D: R:	N: D: R:	N: D: R:

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 tool 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	Quarter 1 1/1/21 - 3/31/21	Quarter 2 4/1/21 – 6/30/21	Quarter 3 7/1/21 – 9/30/21	Final Rate 1/1/21 – 12/31/21	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%**	**N:** 452 **D:** 5,001 **R: 9.04%**	**N:** 693 **D:** 5,003 **R: 13.85%**	**N:** 859 **D:** 5,006 **R: 17.16%**	**N:** 890 **D:** 5,007 **R: 17.78%**	**R: 34.82%**
Indicator 2: The percentage of children screened for risk of developmental, behavioral and social delays using a Standardized global developmental screening too l in the 12 months preceding or on their second birthday.	**N:** 25 **D:** 137 **R: 18.25%**	**N:** 336 **D:** 5,201 **R: 6.46%**	**N:** 660 **D:** 5,203 **R: 12.68%**	**N:** 784 **D:** 5,205 **R: 15.06%**	**N:** 796 **D:** 5,205 **R: 15.29%**	**R: 28.25%**
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%**	**N:** 144 **D:** 4,865 **R: 2.96%**	**N:** 281 **D:** 4,866 **R: 5.77%**	**N:** 342 **D:** 4,874 **R: 7.02%**	**N:** 356 **D:** 4,874 **R: 7.30%**	**R: 21.68%**

1. Calculated by ULM using the CMS Child Core Set Hybrid Measure (medical record reviews). To be updated in December 2020.
2. 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.

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.

  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.
  Performance Indicator Final Rate from MY2021 is 7.04 percentage points lower than 2018 baseline data. It is important to note, results indicate total number of eligible population and overall CPT 96110 use. As this PIP continues, ACLA will perform additional chart reviews. Utilizing the 2021 quarterly trend, ACLA predicts numerators and denominators in following years. In addition, developmental screening rates will improve because of current provider and member initiatives and interventions.

  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.
  Performance Indicator Final Rate from MY2021 is 2.96 percentage points lower than 2018 baseline data. It is important to note, results indicate total number of eligible population and overall CPT 96110 use. As this PIP continues, ACLA will perform additional chart reviews. Utilizing the 2021 quarterly trend, ACLA predicts numerators and denominators in following years. In addition, developmental screening rates will improve because of current provider and member initiatives and interventions.

  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.
  Performance Indicator Final Rate from MY2021 is 4.37 percentage points lower than 2018 baseline data. It is important to note, results indicate total number of eligible population and overall CPT 96110 use. As this PIP continues, ACLA will perform additional chart reviews. Utilizing the 2021 quarterly trend, ACLA predicts numerators and denominators in following years. In addition, developmental screening rates will improve because of current provider and member initiatives and interventions.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.**
  Although the PIP is relatively new, ACLA believes the member and provider education initiatives may be contributing to quarter to quarter increases in rates. ACLA's focus is educating both members and providers on the importance of Developmental Screenings and completing well-child visits. ACLA's performance indicator rates have steadily improved throughout 2021.

- **What factors were associated with success or failure?**
  Competing priorities for member and provider outreach, due to other Performance Improvement Projects (COVID-19, HCV, IET, etc.) may be affecting the overall success of ACLA's Developmental Screening

Performance. Other contributing factors include nationwide decreases in immunizations and well-child visit attendance due to the COVID-19 pandemic and local severe weather which led to provider office closures.

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.

- *Utilization of CPT code 96110 use without documentation of the developmental screening tool was noted while conducting ACLA's medical record review.*
- *Inaccurate ICD-10 coding may be contributing to an underrepresentation of developmental screenings that are represented in performance indicator rates.*

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).

- *ACLA pulled a random sample for medical record review and received 45 of the required 60. The remaining records were pulled from a facility EMR resulting in a less randomized sample.*

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.

- *Results from the AAP Provider Survey concluded a 28.41% response rate. Some regions were under-represented.*

PIP Highlights

Member Intervention

Conduct enhanced care coordination outreach/education to parents of members on gap report.

Quantitative Analysis
A total of 91 attempted contacts were made to members with a developmental screening care gap. Out of 91 attempts, 20 members were successfully contacted with at least 3 attempts. Care Management outreach attained a 21.98% success rate educating parents on the importance of scheduling a well visit with their child's PCP.

Qualitative Analysis
ACLA continues to address members' needs through education and coordination of care. Also, access to care, provider collaboration, and care gap alerts are addressed with members.

Barriers

- Fear of COVID-19
- Recovering from Hurricane Ida
- Incorrect contact numbers, Unable to Contact
- Parent unaware of recommended screenings
- Parent unaware of member incentives

Opportunities for Improvement

- Provide member education through the member portal/mobile App, quarterly newsletter, wellness events and postcard mailers
- Inform members of upcoming recommended screenings through texting campaign
- Outreach members with gaps in care for education and assistance with scheduling if requested

Re-measurement

Analysis of the 3 indicators on a quarterly basis to determine improvement of children screened for risk of developmental, behavioral, and social delays using a standardized global screening tool.

Conclusion

Member education will continue throughout 2022 to produce positive Quality outcomes.

Provider Intervention

Conduct provider education quarterly through email and gap in care portal alert notifications.

Quantitative Analysis

For Q1 2021, a total of 941 pediatric providers received an alert with educational material covering the following: Guidelines for utilization of approved global developmental screening tools, coding education, and referral education.

Qualitative Analysis

ACLA was highly effective when developing processes for provider education. Some additional initiatives include: Quality virtual visits and newsletter educational material. Rate improvement was noted on all 3 indicators from Q1 – Q4 in 2021.

Barriers

- Provider groups not registered in provider portal
- No access to care gap reporting due to lack of knowledge
- Providers unaware of registering for email alerts through website

Opportunities for Improvement

- Increase provider awareness of portal registration to obtain gap in care reporting and wellness visit alerts
- Increase provider awareness of email registration utilizing ACLA website for educational material updates
- Utilize provider network team for distribution purposes

Re-measurement

Analysis of the 3 indicators on a quarterly basis to determine improvement of children screened for risk of developmental, behavioral, and social delays using a standardized global screening tool.

Conclusion

Provider education will continue throughout 2022 to produce positive Quality outcomes.

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
Conduct provider education on standardized global developmental screening tools, new billing guidelines for coding developmental screening, and early intervention programs.	Providers are unaware of approved developmental screening tools and utilization of CPT 96110	Provider virtual visits and collaboration with Provider Network Management team for distributing educational materials	Continue Intervention • Education via provider newsletter, portal, virtual visits, and email alerts • EPSDT Toolkit available on provider portal
Develop member gap reports, stratify by provider and distribute to providers.	Member and provider awareness of developmental screening importance	Collaborated with Data Analytics team to assure member/provider gap in care alerts and reporting could be readily accessed	Continue Intervention • Refresh data monthly via provider/member portal • Improve portal access for pediatric providers by sending email alerts
Collaborate with early intervention programs (EIP) and coordinate with providers to facilitate referrals from providers to EIP when indicated by instrument results.	Lack of follow-up after a referral is given	Developed process to utilize LA Medicaid Early Intervention Services Fee Schedule to determine if members scheduled follow-up treatment when a referral was given for a a suspected delay	Contact members without a follow up visit with EarlySteps
Member Education	Awareness of developmental screening age recommendations	Developed materials	Continue Intervention • EPSDT/Developmental Screening wellness postcard mailers. • Wellness event education • Text messaging reminder campaign

References

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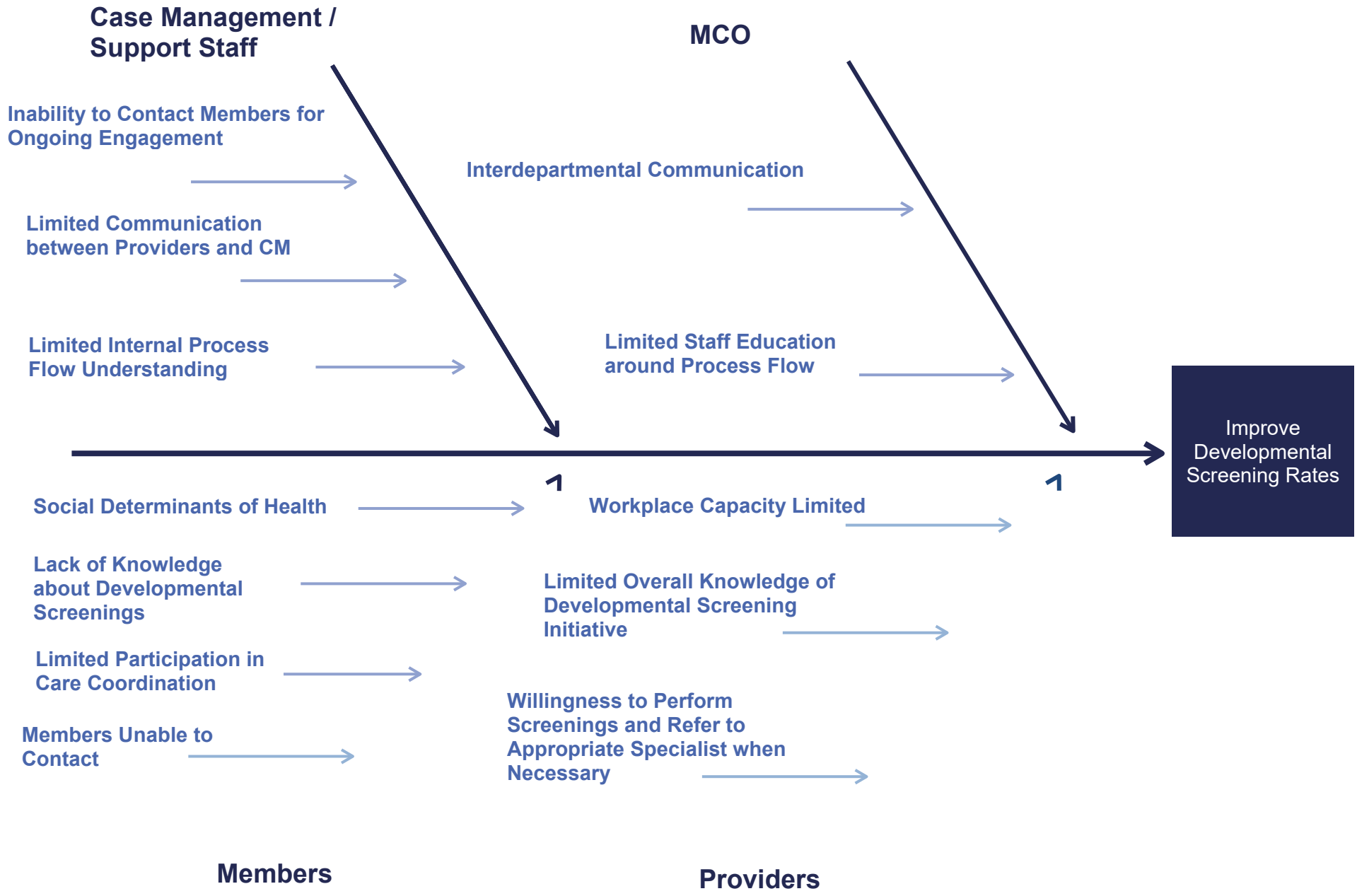
Glossary of PIP Terms

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 • Road block	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 A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Internal Staff Education • Provider Education / Trainings via Newsletter / Bureau of Family Health Webinar • Developmental Screening Guideline Knowledge • Member Education and Awareness of Developmental Screening Importance • Gap in Care Report Access to Providers via Provider Portal	• Face to Face Provider Trainings
Less Feasible to Address	• Members Unable to Contact • Providers Unwilling to Perform Developmental Screening • Fee Schedule Discrepancies Regarding CPT 96110 Being Published	• Locating Transient Members

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** • Provider Education via Newsletter and Provider • Medical Economics (Informatics) Reports Accessibility • Ability to Outreach Gap in Care Members on Large Scale Communication Basis via Care Management and Quality	***minimize*** **WEAKNESSES** ***Examples:*** • Enterprise-Wide Restrictions on In-Office Provider Visits or Face-to-Face Meetings with Providers • System Configurations re: **96110** Reimbursement • Approval Process of ACLA-Based Provider Outreach Materials
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** • Member Outreach Opportunities via Community Health Center Screening Events • Provider Education Through Provider Network Management with Appropriate Guidelines	***protect from*** **THREATS** ***Examples:*** • Provider Participation • Limited Workforce Capacity • Members Unable to Contact

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Interventions to Test / Implement
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 1st, 2nd, or 3rd Birthday	Providers are knowledgeable about AAP/Bright Futures recommended global developmental screening tools, the Bright Futures periodicity schedule for screening tools, the Bright Futures periodicity schedule for screening, Developmental Screening Guidelines, and Early Intervention Program (EIP) Resources.	Conduct Provider Education on Standardized Global Developmental Screening Tools, Healthy Louisiana Billing and Coding Guidelines, and Early Intervention Programs	• Collaborative AAP / MCO Survey • Unified MCO Messaging • 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), and Hand Delivery
	• Parents are knowledgeable about the timing and the benefits of developmental screening. • Parents of children with screening gaps are informed by care coordinators about their child'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 Care 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.	•	•	•