Health Plan Performance Improvement Project (PIP)

Health Plan: UnitedHealthcare Community Plan LA

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: Final

Submission Dates:

	Proposal / Baseline	Interim/ Final
Version 1	01/29/2021	12/28/2021
Version 2		

MCO Contact Information

1. Principal MCO Contact Person

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

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

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Attestation

Plan Name: UnitedHealthcare Community Plan LA
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: _____
First and last name: Julie Morial, MD
Date: 1/28/21; 12/9/21

CEO signature: _____
First and last name: Karl Lirette
Date: 1/28/21; 12/9/21

Quality Director signature: _____
First and last name: Deborah Junot, BSN, RN
Date: 1/28/21; 12/9/21

IS Director signature (if applicable): N/A
First and last name:
Date:

Updates to the PIP

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

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1	3/18/21	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	Focused provider education in Region 8, based on Disproportionate Index (DI) results. Notified care management team of educated providers, so they could begin member outreach to promote and assist with scheduling of well visits that include developmental screenings. ITM 6a was created to track outreach efforts.
Change 2	5/1/21	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	The care gap report was revised to include a monetary incentive available for FQHCs/RHCs and non-FQHC/RHC providers when they bill 96110 on a linked patient.
Change 3	5/10/21	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	Provide EIP referral information to parents/guardians of children with ICD-10 codes F80-F89, not already engaged evaluations and/or therapeutic activities.
Change 4	6/10/21	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	Created a developmental screening tool overview to educate both staff and PCPs. EPSDT coordinator available for those PCPs requiring further assistance.
Change 5	9/1/21	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	Transferred tailored member outreach to Region 7 based on DI results, recent weather impacts, and opportunity for greater improvement. ITM 6b created to track progress.

Abstract

Project Topic and Rationale
Developmental screens identify early childhood developmental delays, which can be improved with early intervention. The longer assessment and treatment are delayed, poor outcomes increase. According to a pre- COVID-19 national survey, Louisiana (LA) children received fewer developmental screenings than children nationwide. The University of LA Monroe (ULM) chart review revealed less than 25% of charts for children under 1 year of age, less than 19% between 1 and 2 years, and less than 12% between 2 and 3 years included developmental screens. LDH Bureau of Family Health indicated that around 1 in 4 children in LA have special health care needs. ULM's findings suggest many intervention missed opportunities, particularly for vulnerable populations. Compounding the problem, the COVID-19 pandemic enveloped the state, causing widespread reduction in screening services due to, but not limited to mandatory lockdowns, loss of facility access, and parental fear of taking children to doctors' offices where viral exposure would seem likely.

Objectives
Implement member and provider outreach and education tools along with a gap in care report with incentives for providers to improve the percent of global developmental screenings for LA Medicaid members, three years and younger from baseline to final measurement. Performance indicators (PI) include 3 cohorts of children: less than 1 year; between 1 and 2 years; and between 2 and 3 years.

Interventions
Member interventions included education and appointment scheduling outreach, an article for the member newsletter, text messages on developmental screening for members who allow texts and tailored telephonic outreach for populations identified by the Disproportionate Index. Provider interventions included collaboration with LDH and all Healthy LA Managed Care Organizations (MCOs) to sponsor an American Academy of Pediatrics (AAP) provider survey, and a series of developmental webinars. UHC created CPT code 96110 gap reports, educated pediatric providers about LDH Informational Bulletins 20-23 and 21-3, the Early Steps referral process, and the LDH Bureau of Family Health Developmental Screening Toolkit Home. Developmental screening and screening tool reference toolkits, a 30-month EPSDT/Developmental Screen flyer, a rebilling tip sheet, and an incentive program for both FQHC/RHC and non-FQHC/RHC providers were created to promote 96110 gap closure and the use of appropriate tools.

Results
The PI goal for all 3 cohorts of 35.8% was not met. Improvement was evidenced by a 9.67 percentage point increase for PI:<1st year, a 7.67 percentage point increase for PI:1< 2nd year, and 3.47 percentage point increase for PI: 2< 3rd year.

Major Conclusions
Progress has been slow due to the barriers created by the member and provider impacts from the COVID-19 pandemic and hurricane IDA. Additional barriers included lack of valid member contact information, and inconsistent provider knowledge of appropriate developmental screening tools and the current EPSDT periodicity schedule recommendations.

Next Steps
Members will continue to be contacted for well visit/developmental screening and early intervention education and appointment assistance. Providers will continue to be educated on the developmental screen process and the gap report. Provider incentives will remain in place to promote the use of appropriate developmental tools and increase gap closure.

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, 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:**
  Developmental screening is a major component of the EPSDT screen for children less than three years of age and helps to identify children who may be at risk for developmental difficulties. Screening programs assure timely identification and remediation of potential developmental issues. As the Bright Futures® periodicity schedule on developmental screening indicates objective screening at 9 months 18 months and 30 months, but developmental surveillance listed for all other visits, providers could easily miss the need for an objective screen. Medical record review requires the practitioner attest that the developmental screen was done but does not require inclusion of the actual screen. Many electronical health records include milestones. Some providers may believe that assessing these milestones is sufficient, and unknowingly surpass conducting an objective screen. Adding a claim for an AAP approved global developmental screening tool will assure that the members are appropriately assessed at the required intervals. Beyond the screening process, children must be referred for evaluation and appropriate interventions to improve developmental outcomes. Therefore, having a proper developmental screening tool in place, will benefit our members because directions for failed tests will lead to referral of the child and family to early intervention for delayed components. In addition, providers will benefit from ongoing education of developmental screening components, as well as early intervention resources to assist them in appropriately identifying and referring children for early intervention.

- **Describe high-volume or high-risk conditions addressed:**
  According to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), the National Survey of Children's Health (NSCH) identifies children with special health care needs (CSHCN) based on the health consequences a child experiences due to an ongoing health condition, regardless of diagnosis. These are categorized as: 1) need or use of prescription medications, 2) need or use of services, 3) need or use of specialized therapies, 4) functional difficulties, and 5) emotional, developmental, or behavioral problems for which treatment or counseling is needed. In 2017-2018, one in four households in the U.S. had one or more CSHCN. NSCH, as noted by the LDH Bureau of Family Health indicated around 1 in 4 children in Louisiana have special health care needs. As noted under Project Topic and Rationale, only approximately 20% of Louisiana children are being screened. This would indicate missed opportunities for early intervention for the most vulnerable. United identifies children with pervasive developmental disorders as having special health care needs and would prioritize this group for outreach and care coordination needs.

- **Describe current research support for topic (e.g., clinical guidelines/standards):**
  Monitoring for developmental disorders is especially important for children enrolled in government sponsored programs, who have a nearly two-fold higher prevalence of developmental delay compared to children who are privately insured.[1] Formal developmental screening facilitates the timely identification of risk for developmental delay and referral for Early Intervention (EI) services, which is associated with improved long-term outcomes.[2] There is evidence in published reports that developmental delays are often not identified in a timely manner, with some children not identified with developmental problems until school entry, past the point at which early intervention is most effective.[3] Developmental screenings are an essential element in identifying children's needs early in life when intervention can produce the best results. Due to the value that screenings can provide to both the child and family, the American Academy of Pediatrics (AAP) recommends developmental surveillance at each pediatric well-child visit with periodic formal developmental screening using a standardized tool at the 9-, 18- and 30-month visits and whenever concerns arise.[4] Despite these recommendations, developmental assessment gaps remain. Provider-identified barriers to formal screening such as time, cost, reimbursement uncertainty, insufficient training, concern for over-identification, and limited knowledge or availability of referral options continue to contribute to these gaps.[5] Screenings, which the AAP defines as the use of standardized tools to identify and refine recognized risk, are administered as a series of questions that cover physical, social, intellectual, and emotional areas of a child's development. There are two components of developmental assessment that are critical to track performance over time. The first is a developmental surveillance at every visit, which the AAP defines surveillance as the process of recognizing children who may be at risk for developmental delays. This elicits parental concerns to augment formal screening, collects parental and clinician observations, and tracks developmental trajectory of the child over time. The second is a periodic routine formal screening of all four domains of development. This includes identifying and refining recognized risk, as well as administering standardized tools at 9, 18, and 30 months, when surveillance yields concerns.[6]

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**
  Historically, developmental screens were a considered part of the bundled services for the EPSDT screen. The CPT code 96110 recommended by the AAP for global developmental screens had also not been available for use if a developmental screen was conducted outside of the EPSDT screen or well child visit. Therefore, there is a dearth of claims data on the number of global developmental screens that have been conducted in Louisiana. The only way to determine if an appropriate screen was used would be to conduct a medical record review. To create a baseline for this project, University of Louisiana Monroe (ULM) conducted a medical record review to determine the current rate of standardized global developmental screening tool use. ULM's data indicated that less than 25% of charts reviewed for children less than one year of age included a standardized tool. Less than 19% of charts for children between the ages of one and two years included a standardized tool, and less than 12% of the charts for children between the ages of two and three years included a standardized tool. Considering the estimates that about 1 in 4 Louisiana children may experience a delay in one or more aspects of development, there is a great opportunity for improvement in this area. The new policy implemented January 1, 2021, to allow for billing of standardized global developmental screening tools will allow for improved surveillance of screening tool use.

1 Boyle CA, Boulet S, Schieve LA et al. "Trends in the prevalence of developmental disabilities in U.S. children, 1997-2008." Pediatrics 2011; 127: 1034-1042.
2 Talmi A, Maya Bunik, Asherin R et al. "Improving developmental screening documentation and referral completion." Pediatrics 2014; 134(4): e1181-e1188.
3 Sices, L. "Developmental Screening in Primary Care: The Effectiveness of Current Practice and Recommendations for Improvement." The Commonwealth Fund, December 2007.
4 American Academy of Pediatrics. "Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening." Pediatrics 2006; 405-420.
5 Rice, Catherine E, et al., et al. Screening for Developmental Delays Among Young Children - National Survey of Children's Health, United States, 2007. Morbidity and Mortality Report. 2014, Vol. 63, 2.
6 Pediatrics Jul 2006, 118 (1) 405-420; DOI: 10.1542/peds.2006-1231

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. Implement provider education using the LDH developmental resources by region, the current AAP/Bright Futures® periodicity schedule, and other documents as they become available, such as a resource tip sheet on the developmental screens noted in table 4a to improve 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, from baseline to final measurement.

  2. Develop member gap reports, stratify by provider and distribute to providers. Implement a process to create member gap reports based on the HEDIS® performance measure of DEVSCR, stratify by provider and distribute to providers as a tool to determine which children less than three years of age are in need of a developmental screening, to improve 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, 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.

  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 ***<u>with</u>*** 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.
     c. Implement a process to create a chart review tool that would be used to discern whether the tools in Table 4a, or similar standardized developmental screening tools approved by AAP, were utilized for global developmental screening at the child's 9-month, 18-month or 30-month visit. Devise a claims request for a sufficient random pull of charts generated from Q1 2021 to Q3 2021 to provide 30 eligible population charts with and without CPT Code 96110. Train staff on the use of the chart review tool and proper storage of results on a secure share point site. Aggregate results to determine improvement of 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, from baseline to final measurement.
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. Implement a process to collaborate with early intervention programs by outreaching to the Early Steps Community Outreach Specialists on the LDH Developmental Disabilities website. Acquire the Early Steps referral form, instructions of how to complete, and information on how best to coordinate with the specialists. Share this information, as well as the LDH developmental resources by region guide, to providers to increase the number of members referred via coordination with primary care provider (PCP) for further evaluation with early intervention program from baseline to final measurement.

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%	R: 35.8%	10 percentage points above baseline
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%	R:35.8%	Healthy People 2030 recommended target for increasing the proportion of children who receive a developmental screening.
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%	R: 35.8%	Healthy People 2030 recommended target for increasing the proportion of children who receive a developmental screening.

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

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 would be targeted by PIP interventions.

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:** N/A

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:** Edward Coleman III, Medical Clinical Operations Manager, and Shnay Wright Richardson, Senior Business Analyst will be researching and pulling claims data from within our internal Orbit and Facets data base system with regards to pertinent ICD-10 codes.

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: The United Healthcare Community & State of Louisiana Analytics Team validates data submitted for the Improving Receipt of Global Developmental Screening in the First Three Years of Life Performance Improvement Project by verifying that the data from SMART Analytics and CSP Facets coincides with data that has been entered in ICUE or Community Care; moreover, random sampling and cross reference checks from data extracts ensures validity of what has been entered in either system. SMART Analytics and CSP Facets are the two databases where all UHCLA Member and Provider data is stored and where data is extracted. ICUE and Community Care are documentation interfaces where our Clinical/Non-Clinical Staff documents a Member's Utilization and Case Management information. As a result of the UHCLA Analytics Team data validation procedures, the UHCLA Analytics Team produced accurate and concise data for the Developmental Screening data extracts as well as the continued monitoring of the Intervention Tracking Measures.

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

- **Describe data analysis procedures:** Data is pulled from the reporting system using internal and state specific requirements. The data is then analyzed and reported accordingly via usage of CSP Facets and Orbit data warehouses.

- **Describe how plan will interpret improvement relative to goal:** Continuous monitoring of performance indicators and trends relative to statewide set goals.

- **Describe how plan will monitor ITMs for ongoing QI:** Collaborations with analytics with regards to continuous monitoring of performance indicator benchmarks on a quarterly basis.

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 member subpopulations.
Susceptible subpopulations are those subpopulations for which the Disproportionate Index > 100%: The subpopulation's share of the total member population eligible for global developmental screening (denominator) is greater than the subpopulation's share of members with global developmental screening (numerator). Thus, the susceptible subpopulations are under-represented in terms of global developmental screening receipt.

Analysis of Disproportionate Under-Representation- 6+ Well-Child Visits first 15 months of life
(HEDIS W15performance indicator for children)

Susceptible subpopulations are those subpopulations for which the Disproportionate Index > 100%: The subpopulation's share of the total member population who turned 15 months old during the measurement year (denominator) is greater than the subpopulation's share of members with six or more well-child visits (numerator). Thus, the susceptible subpopulations are under-represented in terms of access to and continuity of well-childcare.

Initial Analysis of Disproportionate Under-Representation (March 2021)

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	10203	100%	5711	100%	56.0%
Race					
American Indian or Alaska Native	13	.13%	5	<.001	130%
Asian	53	.52%	35	.61%	85%
Black or African American	1458	14.3%	720	13%	110%
Native Hawaiian or Pacific Islander	7	<.001	5	<.001	100%
White	994	9.7%	531	9.3%	104%
Other	0		0		0%
Unknown	7678	75.3%	4415	77.3%	97%
Ethnicity					
Hispanic	25	.25%	17	.3%	83.3%
Non-Hispanic	10178	99.8%	5694	99.7%	100.1%
Unknown					
English as primary language of parent					
Yes	10177	99.7%	5694	99.7%	100%
No	26	.26%	17	.29%	89.7%
LA MCO Region of Residence					
Region 1: Greater New Orleans	1985	19.5%	1122	19.6%	99.5%
Region 2: Capital Area	1979	19.4%	1162	20.4%	95.1%
Region 3: South Central LA	1225	12%	789	13.8%	87%
Region 4: Acadiana	1433	14%	854	15%	93.3%
Region 5: Southwest LA	196	1.9%	81	1.4%	136%
Region 6: Central LA	471	4.6%	246	4.3%	107%
Region 7: Northwest LA	1226	12%	611	10.7%	112%
Region 8: Northeast LA	686	6.7%	274	4.8%	140%
Region 9: Northshore Area	868	8.5%	508	8.9%	96%

Second Analysis of Disproportionate Under-Representation (September 2021)

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	10837	100%	5616	100%	51.8%
Race					
American Indian or Alaska Native	18	.17%	7	.13%	131%
Asian	98	.90%	65	1.16%	77.6%
Black or African American	3484	32.2%	1676	30%	107%
Native Hawaiian or Pacific Islander	15	.14%	8	.14%	100%
White	2279	21%	1244	22.2%	95%
Other	0		0		0%
Unknown	4943	46%	2616	47%	98%
Ethnicity					
Hispanic	27	.25%	17	.30%	83%
Non-Hispanic	10810	98%	5599	99.7%	98%
Unknown					
English as primary language of parent					
Yes	10810	99.8%	5599	99.7%	100%
No	27	.25%	17	.30%	83%
LA MCO Region of Residence					
Region 1: Greater New Orleans	2013	18.6%	1083	19.3%	96.4%
Region 2: Capital Area	2049	19%	1081	19.3%	99%
Region 3: South Central LA	1330	12.3%	732	13%	95%
Region 4: Acadiana	1544	14.3%	822	15%	95%
Region 5: Southwest LA	198	1.8%	64	1.4%	128%
Region 6: Central LA	539	5%	278	5%	100%
Region 7: Northwest LA	1334	12.3%	668	12%	103%
Region 8: Northeast LA	763	7%	320	6%	117%
Region 9: Northshore Area	934	9%	529	9.4%	96%

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:		**2021**				**Year 2**			
Method of barrier identification:		**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: 2/1/21 Actual Start Date: 3/2/21	Intervention tracking measure 1: N: # PCPs who received global developmental screening guideline + coding + referral education D: # PCPs who see children	N: 126 D:1,193 R:10.6%	N: 729 D: 1,193 R: 61.1%	N: 821 D: 1,193 R: 69%	N: 1190 D: 1190 R: 100% (Net loss of 3 PCPs)	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2:		**2021**				**Year 2**			
Method of barrier identification:		**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: 2/28/21 Actual Start Date: 4/15/21	Intervention tracking measure 2: N: # Members whose PCPs were distributed care gap report D: # Members with developmental screening care gap	N: N/A D: R:	N: 23,727 D: 26,725 R: 88.8%	N: 24,952 D: 25,620 R: 97%	N:25,272 D:25,272 R: 100%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 3:		**2021**				**Year 2**			
Method of barrier identification:		**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: 3/1/21 Actual Start Date: 5/10/21	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: N/A D: R:	N: 12 D: 26,725 R: < 0.1%	N: 321 D: 25,620 R: 1.3%	N:283 D:25,272 R:1.1%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 4:		**2021**				**Year 2**			
Method of barrier identification:		**Q1-Q3**				**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 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% N: 16 D: 30 R: 53%				N: D: R: N: D: R:			
Barrier 5:		**2021**				**Year 2**			
Method of barrier identification:		**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: 1/19/21 Actual Start Date: 1/27/21	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 Intervention tracking measure 5a: N: # Members with diagnosis of suspected or documented developmental delay ICD-10 codes F80-F89 receiving early intervention therapy. D: # Members with diagnosis of suspected or documented developmental delay ICD-10 codes F80-F89 Intervention tracking measure 5b: N: # Members with diagnosis of suspected or documented developmental delay ICD-10 codes F80-F89 receiving evaluations and or early intervention therapy.	N: N/A D: R: N: 190 D: 297 R: 64% N: N/A D: R:	N: N/A D: R: N: 232 D: 413 R: 56.2% N: 337 D: 413 R: 81.6%	N: N/A D: R: N: 192 D: 308 R: 62% N: 267 D: 308 R: 87%	N: N/A D: R: N:189 D: 404 R: 47% N: 328 D: 404 R: 81%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

	D: # Members with diagnosis of suspected or documented developmental delay ICD-10 codes F80-F89								
Barrier 6: Susceptible Subpopulations		**2021**				**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 Planned Start Date: 3/18/21 Actual Start Date: 3/18/21	N: # of Region 8 members who received outreach for developmental screening. D: # of Region 8 members with developmental screening care gap:	N: N/A D: R:	N: 203 D: 438 R: 46.3%	N: 325 D: 438 R: 74.2%	N: N/A D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
6b. Tailored and targeted intervention for susceptible subpopulation 6b Planned Start Date: 9/1/21 Actual Start Date: 10/1/21	N: # of Region 7 members who received outreach for developmental screening. D: # of Region 7 members with developmental screening care gap:	N: N/A D: R:	N: N/A D: R:	N: N/A D: R:	N:360 D:631 R: 57%	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 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
	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)

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 (if Interim data available) Measure period: 1/1/21-6/27/21	Final Period Measure period: 1/1/21-12/10/21	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: 2,019 D: 10,838 R: 18.63%	N: 2,654 D: 10,776 R: 24.63%	Rate: 35.8%
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: 2,146 D: 11,170 R: 19.21%	N: 2,579 D: 11,096 R: 23.24%	Rate: 35.8%
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: 1,559 D: 10,441 R: 14.93%	N: 1,768 D: 10,401 R: 17.00%	Rate: 35.8%

1. *Calculated by ULM using the CMS Child Core Set Hybrid Measure (medical record reviews).*
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.
  The UHC Performance Indicator (PI) final rate as of 12/10/21 decreased from the ULM baseline rate of 24.82% by 0.19 percentage points. The UHC interim rate as of 6/27/21 for PI1 improved by 3.45 percentage points from the UHC baseline rate of 15.18%. The UHC final rate improved by 6 percentage points from the interim rate and improved by 9.45 percentage points from the UHC baseline.
  The UHC interim rate as of 6/27/21 for PI2 improved by 0.96 percentage points from the ULM baseline of 18.25%, and by 3.55 percentage points from the UHC baseline of 15.66%. The UHC final rate improved by 4.99 percentage points from the ULM baseline, and 7.58 percentage points from the UHC baseline.
  The UHC interim rate as of 6/27/21 for PI3 improved by 3.25 percentage points from the ULM baseline of 11.68% and 1.34 percentage points from the UHC baseline of 13.59%. The UHC final rate improved by 5.32 percentage points from the ULM baseline, and 3.41 percentage points from the UHC baseline.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**
  All three Performance Indicator results improved due to dissemination of global developmental screening guideline, coding, and referral education to all identified providers who see children. These same providers were also given access to a gap in care report which addressed most children with screening care gaps for the developmental screen. Overall improvement could not be attributed to member education and appointment acquisition as UHC's best quarter outreach only touched 1.3% of the eligible population. However, a targeted outreach to Region 8 members did lead to a 23-percentage point improvement in the Disproportionate Index (DI) for this region. The initial Index for Region 8 in March was 140%, and the subsequent Index in September was 117%. The Disproportionate Index was concerned with the number of children that received all six EPSDT visits for the first 15 months. The more visits the child had, the better chance of the provider conducting an appropriate developmental screen. The chart review conducted to determine if providers were appropriately using and billing for an approved global developmental screening tool revealed 63% of those billing the 96110 code were using an appropriate tool. Charts reviewed for providers not billing the 96110-code revealed 53% were using an appropriate tool.

- **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.
  The main factor associated with the slow progress of this project was the COVID-19 pandemic. Parents/guardians were afraid to bring their children to the doctor's office for well visits. Doctor's office hours were modified, particularly for preventive health due to staffing shortages. The first quarter of 2021 saw a 10-percentage point drop in EPSDT screenings from the same quarter in 2020. The EPSDT visit is when the developmental screen is normally conducted. Doctor's offices were preoccupied with sick patients. One provider told one of our population health nurses that their office now spends their day either treating sick patients or conducting COVID testing. They had no time for preventive health issues. The next disruptive factor was hurricane IDA. Once again, provider access was negatively impacted. Many regions were affected, and numerous offices were closed for various periods of time. Preventive health outreach was halted to focus on member critical needs. Many families were displaced. UHC staff was displaced. With both the pandemic and the hurricane, once member safety was established, alternate methods of communication had to be devised. Virtual visits with providers became the standard. Most

provider education had to be conducted electronically using WebEx® type formats. The COVID issue was tackled by promoting COVID testing and vaccinations. UHC participated in numerous events in collaboration with health care providers to hand out food, masks, and hand sanitizer to any attendees regardless of insurance, to help reduce the general population infection rate.

- **PIP Highlights** Highlight 1-2 most effective member interventions and 1-2 most effective provider interventions, and support with both quantitative ITM data and qualitative member/provider feedback data.
  The most effective member intervention was the tailored and targeted outreach for susceptible subpopulations of Region 8. This was evidenced by the 23-percentage point decrease in the Disproportionate Index, an inverse measure, from 140% in March 2021 to 117% in September 2021. Many members reached did thank the outreach staff for providing information on the importance of developmental screens, and the offer of scheduling assistance.
  The most effective provider intervention was the creation of the developmental screens gap report along with financial incentives for both FQHC/RHC and Non-FQHC/RHC providers. The gap report provided a readily accessible list for providers to check when an eligible child presented to the office or was being scheduled for a visit. The incentive encouraged the providers to take the time to link eligible children to their practice, to use the appropriate tool, and to bill the 96110 code to receive compensation. Though the target rate was not met in any of the 3 cohorts, steady progress was noted despite the ongoing challenge of the pandemic. In all contacts, providers expressed gratitude for the gap report and incentives.

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.
  There numerous claims noted in the data pull for chart reviews, that included ICD-10 code Z1342 (Encounter for screening for global developmental delays (milestones) but did not include the 96110 CPT code. These claims insinuate that a global developmental screen had been conducted, but they would not be captured in the performance indicators due to the lack of the CPT code.

- **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).
  Due to the COVID situation limiting the staff's ability to acquire charts for the ITMs 4a and b, a convenience sample had to be pulled for the providers that the staff could access. Charts were pulled from around the state as much as possible to avoid a skewed outcome.

- **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.
  A way to determine via claims whether a referral to Early Steps had occurred was never found. Early Steps does not bill as such. Providers involved with Early Steps use their own provider identification. There was also not a list found of Early Steps affiliated providers that could have been used to crosswalk claims. Evidence of Early Steps referrals were noted in chart reviews but using a chart review process was not possible to support the response for ITM5.

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
1.Conduct provider education on standardized global development screening tools, Healthy Louisiana billing & coding guideline, and early intervention programs.	1. The AAP provider survey results were not as useful as we had anticipated. The Initial AAP provider survey results was not available until May, had few responses, and there was no follow-up survey. PCP awareness of the new guidelines had to be determined one PCP at a time. The lack of responses also delayed member outreach, as we could not schedule appointments with uneducated PCPs. 2. The disproportionate Index revealed Region 8 as the least compliant for 6 EPSDT visits by 15 months. 3. FQHCs/RHCs aren't reimbursed for CPT 96110 4. Staff and PCPs were not familiar with all appropriate tool options.	1. A Power Point® was created to provide uniform talking points on the coding and billing guidelines, as well as resources for Early Steps and the LDH Bureau of Family Health developmental toolkit home. The presentation was included in the quarterly web-based meetings with large provider groups and reviewed with individual providers during the exit conference of medical record reviews. PCPs not scheduled or available for visits are emailed or faxed the new information. 2. New intervention (#6). 3. New intervention (#7) 4. New intervention (#9)	We will continue to educate new staff and new providers with the developmental screening tool information to assure proper global tool usage, billing and referrals for early intervention when indicated.
2. Develop member gap reports, stratify by provider, and distribute to providers.	PCPS wanted to know why the developmental screen measures on the gap report had no targets like the rest of the measures.	Research revealed no Quality Compass benchmarks for DEV SCR, so we adopted the EPSDT targets for this age group.	Dev screen gaps will continue in 2022 with targets based on HEDIS® W30 rates.
3.Conduct parent education on importance of global developmental screening. Conduct enhanced care coordination outreach/education to parents of members on gap report.	Parents/guardians of members are difficult to reach with wrong numbers, disconnected numbers, no voice mail, and frequent changes of address.	Live calling outreach occurs for members birth to 15 months of age with appointment scheduling support; IVR appointment reminder calls. Letter promoting the scheduling of preventative screening mailed one month prior to members' birthday starting at age 2.	A texting campaign was started in October to promote participation in developmental screenings. (Texting can only be used with member approval.)
4.Conduct a Quarter 1 through Quarter 3 2021 PCP chart review of:	Review findings included: -the use of Denver II and PDQ, which have been out of print since 2015,	PCP education on these and any issues pertaining to the developmental screen is conducted using the	We will continue to educate or reinforce earlier education when developmental

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 the Indicators 1, 2 & 3 aggregate denominator without CPT Code 96110 discern whether the tools 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.	-EHR embedded developmental checklists used in lieu of an approved tool for objective screens, - the 30-month screen and other aspects of the Bright Futures® periodicity schedule not being followed, -claims found with ICD10 code Z1342, but not the CPT code 96110, -office staff unclear on how to rebill.	developmental toolkit, the EPSDT toolkit, the 30-month screen tip sheet and the rebilling tip sheet, depending upon the deficiencies noted.	screening or referral deficiencies are noted in chart reviews.
5.Collaborate with early intervention programs (EIP) and coordinate with providers to facilitate referrals from providers to EIP.	Level of willingness to collaborate varies with different Early Steps regions Provider feedback included comments that the Early Steps process is too slow, many use their own referral resources. Members don't need a provider referral to seek Early Steps services.	Staff education regarding the Early Steps program and referral process was conducted by the Region 8 Early Steps coordinator. Staff now shares this information with providers along with the link for Early Steps Community Outreach Specialists on the LDH Developmental Disabilities website. New intervention (#8)	We will continue to seek opportunities to collaborate with Early Steps teams. Staff are encouraged to attend Early Steps meetings to collect, and then share regional updates and potentially useful information to the local providers, to build a relationship between the 2 groups.
6. Assess Region 8 PCPs whose members did not meet the HEDIS® W15 performance indicator. Educate those PCPs not following the appropriate EPSDT periodicity schedule, with a focus on appropriate global developmental screening tools. Notify Case Management team of prepared providers so they may contact their members, promote, and facilitate scheduling of	The disproportionate Index was created in March. By August, most members that we could reach, that were willing to go to the PCP's office, indicated that they had already had a visit. A new Disproportionate Index revealed that Region 5 was now the most underrepresented.	Due to the low volume of members in Region 5, and challenges with both Regions 5 and 8 due to weather related issues, we chose to focus on Region 7. It was the third highest on the DI scale but was not affected by Hurricane Ida. New ITM (6b)	We will continue our member outreach to promote wellness visits and participation in developmental screens

well visits that include developmental screenings			
7. Determine billing opportunities for FQHC/ RHC billing of CPT code 96110. Research possibility of providing incentive for FQHCs/ RHCs to promote billing of 96110 code when conducting global developmental screens.	Clarified with LDH that FQHCs/RHCs can bill the 96110 code but will not be reimbursed. Provider feedback indicated little interest in billing for no compensation.	UHC's Patient Care Opportunity Report (PCOR) now includes the developmental screening information in the same format as this PIP's performance indicators 1,2, & 3. When the FQHC/RHC PCP bills the 96110 code on a linked child, that gap will close on the PCOR. A $20 per gap closure incentive became available for FQHC/RHCs as well as non-FQHC/RHC PCPs.	The PCOR will continue to include the developmental screening measures along with targets for 2022.
8. Provide EIP referral information to parents/guardians of children with diagnoses of suspected or documented developmental delay ICD-10 codes F80-F89, that are not already engaged evaluations and/or therapeutic activities related to the F80-F89 diagnoses.	Members with special health care needs share the same difficulty to contact as the general population, such as disconnected number, wrong number, no set-up voicemail, and/or incorrect address. Those that can be reached are usually already engaged in evaluations or treatment not yet showing up in claims.	Pull a quarterly report to determine members with ICD-10 codes F80-F89, that do not show claims for early intervention services. Need to revise the process of identifying those in need of EIP information as the time lag is too long.	We will continue to seek ways to assure that parents /guardians of children with special needs are getting the information they need for early intervention opportunities.
9. Create a developmental screening tool overview presentation that can be used to educate both staff and providers. Deploy EPSDT Coordinator for follow-up education on the screening tool options to those providers requiring a more in-depth education on the value of using an appropriate tool.	Providers are preoccupied with the COVID pandemic and are reluctant to meet on preventive health issues.	Provider toolkits were updated to include the developmental and EIP referral information. Providers can review the toolkit at their convenience and request a meeting with the coordinator as needed. Virtual meetings are available to accommodate provider availability.	We will continue to provide this information as a standard part of our EPSDT provider education.
10. Create a new Analysis of Disproportionate Under Representation Chart for comparison with initial chart, and to use to determine next area of outreach focus.	Region 5 now has the highest Disproportionate Index, but it has the least number of members. Region 8 was impacted by hurricane Ida.	We chose Region 7, the 3rd highest DI Region to focus our current attention with outreach.	We will continue our member outreach to promote wellness visits, and participation in developmental screens.

References

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

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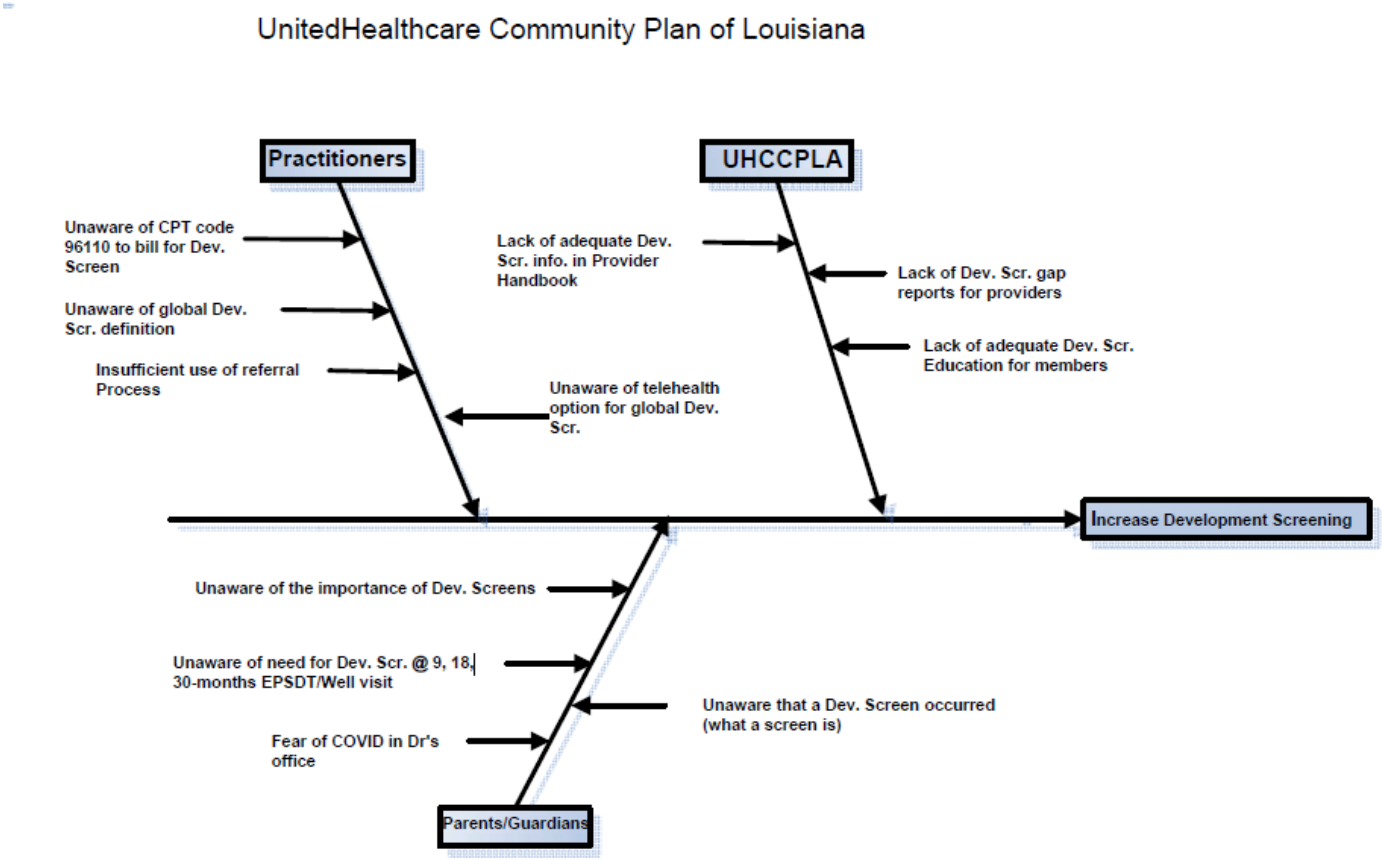
Glossary of PIP Terms

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 • 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

PIP Term	Also Known as…	Purpose	Definition
			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.
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	1. Insufficient knowledge among providers of validated screening tools, appropriate referrals and/or follow-up, and local resources. 2. Insufficient knowledge regarding use of 96610 CPT billing code, reimbursement, and incentives. 3. Insufficient knowledge among parents/guardians regarding importance of preventative care/EPSDT visits and developmental screening. 4. Difficulty contacting parents/guardians of members and when contact made often declined assistance in scheduling appointment.	1. Time Constraints of Providers, too little time to conduct additional screenings during appointments. 2. Efficient provider contact, point of contact. 3. Collaboration with other coalitions and willing partners to enhance public knowledge of importance of developmental screening during early childhood. 4. Training activities and events, particularly during COVID pandemic.
Less Feasible to Address	1. Decreased access to care Covid-19, Severe weather, limited provider hours and/or other issues took priority over preventative care. 2. Difficulty contacting parents/guardians. 3. Coordination among providers and early intervention resources. 4. Data collection-Universal Electronic Health record (EHR) and/or Enhanced access to member medical record for review.	1. Statewide participation in distributing educational materials.

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

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** IHI certification of Quality staff. An understanding of the importance of quality improvement and the triple aim. Stable leadership with a strong quality background facilitates collaboration of a multidepartment approach to achieve improvement goals	***minimize*** **WEAKNESSES** ***Examples:*** Slow process for member education communication approval. Lack of staff knowledge of approved global developmental screening tools. Lack of effective barrier/root cause analysis to decrease disparities in care and improve outcomes
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** Enhancement of communication and messaging to members and providers regarding the developmental screen and early intervention Build relationships with Early Steps staff to act as a bridge between providers and early intervention resources	***protect from*** **THREATS** ***Examples:*** Impacts from COVID pandemic: • Member (parent/guardian) fear of bringing children to practitioners' offices • Diminished practitioner staff and office hours due to illness and addressing COVID in patients • Decreased plan bandwidth for PIP due to higher priorities for COVID testing/vaccination promotion

Appendix D: Driver Diagram

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	INTERVENTIONS
Increase Dev Scr rates of LA children < 3 years to 35.8% by 12/21	Providers perform objective global developmental screens and bill them	Providers know what obj global Dev Screens are, and when they are required (9,18, & 30 months)	Determine providers' understanding about developmental screening requirements via AAP survey, and during individual provider contact
		Staff knows what obj global Dev Screens are and when required, in order to teach providers	Educate staff, then providers on the types of Dev Screens that meet the global definition, and when they are required using the current EPSDT periodicity schedule
		Providers know that they can now bill the 96110 code when a global Dev Scr tool is used for children < 3 yrs of age	Educate providers that they can now bill the 96110 code (FQHCs/RHCs will not get reimbursed)
	Members attend visits that would include the Dev Screen	Members are aware that EPSDT/ Well visits are available and advisable	Educate members of the availability of EPSDT/Well visits
		Members are aware that Dev milestones should be assessed to determine the need for early intervention	Educate members on the importance of Dev Screens
		Members access providers to acquire screens	Educate members on availability of transportation &/or PCP options
	Continuous improvement is driven by data	Data is available for review by plan and providers	Create a gap in care report for Dev Screens- make available to providers

	Data is usable to assess health equity	Create a disparity index based on W15 results- prioritize outreach based on findings