Health Plan Performance Improvement Project (PIP)

Health Plan:

PIP Title: Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and (3) Pharmacotherapy for Opioid Use Disorder (POD)

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

Submission Dates:

	Report Year 2021
Version 1	12/10/2021
Version 2	12/31/2021

MCO Contact Information

1. Principal MCO Contact Person

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3. External Collaborators (if applicable):

Attestation

Plan Name:
Title of Project:

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

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First and last name: Madelyn M. Meyn, MD
Date: 3/13/2020

CEO signature: Richard C Born
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Quality Director signature: ___Arlene Goldsmith_____
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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 Intervention #1) Level of Care Referral	10/3/2020	☐ Project Topic ☐ Methodology ☒ Barrier Analysis/Intervention ☐ Other	We are moving to a Referral Education Process. **Numerator:** ED Providers received Referral Resource list **Denominator:** Total ED Providers
Change 2 Intervention #9 & 10	11/2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis/Intervention ☐ Other	Recovery Coaches were not realized and therefore follow-up remained with Care Management
Change 3 Intervention #7	11/2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis/Intervention ☐ Other	We were able to get Elli access and get some inmate/member history going forward. Video conference with CM still happens, but not dependent on it for history
Change 4 Intervention #1 Level of Care Referral	1/31/2021	☐ Project Topic ☐ Methodology ☐ Barrier Analysis/Intervention ☒ Other	Given the change to other metrics we removed this ITM in 2021
Change 5 Previous Intervention 9 involving Recovery Coaches 1-7 days post discharge	1/31/2021	☐ Project Topic ☐ Methodology ☒ Barrier Analysis/Intervention ☐ Other	This ITM was redefined since funding for the Recovery Coaches was not realized, but we were renewing our efforts for follow-up within the current resource network
Change 6 Previous Intervention 10 involving Recovery Coaches 1-30 days post discharge	1/31/2021	☐ Project Topic ☐ Methodology ☐ Barrier Analysis/Intervention ☒ Other	This ITM was removed since funding for the Recovery Coaches was not realized
Change 7 Intervention #9 and #11	9/2021	☐ Project Topic ☐ Methodology ☐ Barrier Analysis/Intervention ☒ Other	September meeting with LDH we realized how the current ITMs were defined was not representative of how it was being calculated so modifications to metric definitions were made

Abstract

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

Project Topic/Rationale: The Project Rationale is to improve the rate of (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and (3) Pharmacotherapy for Opioid Use Disorder (POD) among Aetna Members.

Objective of the PIP: Improve these rates by implementing interventions 1) Conduct provider training to expand assessments done on members; improve initiation and engagement in treatment and provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between MCO UM and CM for earlier notification of hospitalization, improved discharge planning practices and support, such as recovery coaches). Other interventions as indicated by our findings and barrier analyses conducted as part of the PIP process.

Methodology: Eligible Population: ABHLA Medicaid members, 13 years and older. The percentage of adolescent and adult members with episodes defined within the HEDIS metrics. We analyze results in workgroups with key leaders and PIP committee members, comparing target goals and conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers to success. In addition, ABHLA may use Quality Improvement process items from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluations using both quantitative and qualitative (when applicable) methods. All measures are continuously monitored to evaluate the plan's path to attaining the target rates established in each PIP.

Interventions: All ABH-LA interventions were designed to remove barriers to treatment by improving our detection, monitoring, treatment, and follow-up care of our members with a SUD. We found many of the ITM's needed slight changes to reflect the actions and data currently available given the addition of POD, the removal of MAT Certification by HHS, and the request to LDH for additional SBIRT codes to support the PIP's objective.

Results: Overall, our Performance Indicators did well and showed quarter over quarter improvement. Engagement PI's 4 and 6 were in a lower percentile and while showing improvement it does illustrate that the Alcohol abuse treatment had a very low number which affected the total number. National reports mid-year highlighted that alcohol consumption were on the rise as observed in increased ED cases. It was primarily due to the stress of the Pandemic. Like most MCO's Aetna has been very focused on OUD and will make sure Alcohol gets the attention our current cultural impact requires. Our overall BH focused education should also help support those in Alcohol dependence since overall mental wellbeing is communicated along with resources that are available. Resource information is communicated to providers and members.

Conclusions: In 2021 we knew that provider education and continuity of care for those in treatment would be a 'must' for improvement and were able to add a Behavioral Health Regional Outcomes Director (BH ROD) who has made a big impact in reaching our providers. In addition to this methodology, the PIP teams began using Provider Newsletters and blasts to make sure education of resources was done regularly in conjunction with the quarterly live meetings. The ITM's around education have greatly improved. In addition to education to providers, Aetna realized that focusing just on providers was only half the equation and therefore began educating members via a Members Newsletter as well as outreach efforts via third party vendors for those with a BH diagnosis to highlight available resources within Medicaid. ABHLA understands that members have a large impact on some PI's such as FUA and therefore mid-year, announced a new method of contacting members via Nanosite secure text with resources available for follow-up and this campaign will begin to go out the first week of 2022. This new effort should also support any ITM, like 5c, for transitions of care even if they don't elect CM enrollment.

Next Steps:
Almost all ITM's were focused on 'step' down programs and the continuity of care with continued treatment. The continued focus on long term treatment will help support the BH PIP in 2022 which focuses on follow up after certain BH claims. For overall SUD efforts, our Population Health and Behavioral Quality Teams will continue to implement programs for continued support in all areas needed by members. ABHLA's goal is to keep our SUD HEDIS metrics in the top percentiles and improve in the areas needed.

Project Topic

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

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

Our population assessment showed a membership of 120,037 individuals within all Medicaid product categories. There were 84,5631 (70%) adult members and 35,474 (30%) members under the age of 19. In addition, there are 1548 (1.29%) Justice Involved member, SMI 24216 (20.17%) of membership, 2828 (2.36%) pregnancies, 1429 (1.19%) members with HIV, 2419 (2.02) HCV, and 18455 (15.37%) members with a diagnosis of SUD. When looking at the SUD population only, of the 18455 SUD members, 9730 have a co-occurring SMI (52.72%), 590 pregnancies (3.20%), 603 HIV (3.27%), 128 incarnated (0.70%) and 1551 HCV (8.40%).)

In a recent analysis of ABH-LA data, it was identified that members with a SUD diagnosis, have a higher rate of incident in White, Non-Hispanic members verses African American members. There are significantly higher rates of SUD within White, Non-Hispanic (51.86%) females than African American females (38.91%). The population of African American males (44.75%) and White, Non-Hispanic male (55.25%) is more evenly distributed among those identified with SUD. About 22% of members with a diagnosis of SUD are located in Region 1 – Greater New Orleans Area (n=4,088 which equals 22.15%) followed by Region 7 – Northwest Louisiana (n=2,469 which equals 13.38%), and Region 4 – Acadiana (n=2,348 which equals 12.72%).

According to the Louisiana Department of Health's IET performance improvement project background,

"Louisiana's drug-poisoning death rate showed a statistically significant increase of 14.7% from 2015 to 2016 (DCD, 2017). Prescription and illicit opioids are the prime drivers of drug overdose deaths in the U.S. (CDD, 2017). The opioid-related overdose death rate in Louisiana has more than doubled over the past five years, from 3.7 per 100,000 persons in 2012 to 7.7 in 2016 (NIH, 2018). Prior to 2012, the prime driver of opioid-related overdose deaths was prescription opioids. Since 2012, the number of heroin-related deaths trended sharply upward to exceed that of prescription opioid-related deaths in 2016 (149 vs. 124, respectively; NIH, 2018). The overdose crisis has been interpreted as "an epidemic of poor access care" (Wakeman and Barnett, 2018), with close to 80% of Americans with opioid use disorder lacking treatment (Saloner and Karthikeyan, 2015)."

"Family, friends, and local communities are the first line of defense in preventing substance abuse, and positive adult involvement in children's lives reduces the likelihood of drug use." (ONDCP, 2019) ABH-LA is committed to its community and members. Based on the prevalence of alcohol, opioid, or other drug abuse or dependence in our current member population, ABH-LA has identified opportunities for improvement in member outcomes. The data shows a growing epidemic that is caused by substance misuse, resulting in higher inpatient admission and emergency room visit rates, which can have a direct correlation to the escalating cost of care and mortality. When Louisiana's Opioid Response Plan 2019 was announced, it was identified that "between 2014 and 2018, Louisiana experienced a 49% increase in drug-involved deaths. The number of opioid-involved deaths in Louisiana was 184% times higher in 2018 than in 2012. Additionally, in Louisiana the opioid prescription rate reached a high of 123 per 100 people in 2013." (LDH, 2019).

By improving in our detection, monitoring, treatment, and follow-up care of our members with alcohol, opioid, or other drug abuse or dependence, we will be able to improve our members' health outcomes and lessen their barriers to receiving the treatment and services they need. In addition, ABH-LA is driven to bring awareness to its members and providers by providing information through community events, provider workshops, and other methodologies of communication.

- **Describe high-volume or high-risk conditions addressed: Intensive Care Management Admission Considerations**

Members may be identified as candidates for Intensive CM during one of the following events:

- Appear on [health plan]'s CORE analysis that indicates high risk or complexity.
- Score at or above [health plan]'s high risk HRQ threshold.
- Members who are Pregnant will automatically be identified as candidates for Intensive CM
- High risk pregnancy as indicated by member having at least one of the ICM Program- identified high risk prenatal conditions

Note: High risk pregnancy refers to condition factors that evidence suggests can lead to pre-term labor and/or NICU admissions). Refer to the Perinatal Condition List with High Risk Factors job aid for more information.

In addition to the identification for Intensive candidacy, a member must also meet a few of the following criteria:

- IP > three in six months
- ER > three in six months
- Multiple specialists such as > three types of specialists who services require coordination
- Five plus medications from different therapeutic classes
- PCP predicts life expectancy < six months
- Inadequate medical home such as lack of coordination, member does not have PCP or OB (if pregnant)
- Complex social factors such as lack of support, inadequate housing, financial concerns
- Co-morbidity such as PH and BH diagnosis

State mandates that specific populations or diagnoses be outreached, or case managed
Less intensive services have proven ineffective to improve the member's health outcomes (must be staffed with supervisor and rationale documented)

Supportive Care Management Admission Considerations
To meet the standards for Supportive CM, members must not meet Intensive CM guidelines and should also align with at least one of the following:

- Admissions to inpatient/ED that are not related to preventable disease states (for example, ambulatory care sensitive conditions).
- If the Plan-specific CORE analysis indicates the need for Supportive CM (per a review by a case manager and clinical judgment)
- Members identified as having an Ambulatory Care Sensitive Condition (ACSC) or a disease management condition, e.g. Asthma, CHF, COPD, Diabetes, Depression
- State mandates that specific populations or diagnoses be outreached, or case managed
- Referrals from within the Plan or a provider that indicates care coordination or service needs and/or readmission risks.

Population Health Services Admission Considerations
All members are eligible to receive Population Health services. Characteristics of members that align with admission to Population Health include members who:

- Can self-manage but may benefit from mailed materials.
- Do not meet criteria for any higher level of CM services.
- Are pregnant but have do not high-risk prenatal factors and thus require trimester screenings to see if new risks have developed.
- All Duals members who are unable to be contacted or have been contacted and either have no CM needs or refuse CM services.

Population Health services may include:

- DM Newsletter - Low risk, condition specific mailings for member's with chronic conditions (Asthma, Diabetes, COPD, CAD, HF and Depression)
- Prevention and wellness mailings (HEDIS)
- Well baby and perinatal mailings

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

Over 700,000 people died in the United States from drug overdoses between 1999 and 2017, with 70,237 deaths in 2017 alone. Of these 70,237 deaths, 67.8% involved an opioid. The age-adjusted drug overdose death rate has significantly increased from 6.0 (1999) to 21.7 (2017) deaths per 100,000 population. However, as of September 2019, provisional mortality estimates through February 2019 suggest slight decreases in drug overdose deaths since 2017 in the United States.(CDC, 2019) States with statistically significant increases in drug overdose death rates from 2016 to 2017 included Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, West Virginia, and Wisconsin.(CDC, 2019)

The age-adjusted rate of drug overdose deaths increased significantly in Louisiana by 12.4 percent from 2016 (21.8 per 100,000) to 2017 (24.5 per 100,000). (NIH, 2019) Extensive research has been undertaken over the last several years on the significant increase in opioid related overdose deaths, and opioid use disorders among pregnant women in Louisiana. The number of Neonatal Abstinence Syndrome (NAS/NOWS) cases in Louisiana rose by 50% from 243 cases 2012 to 360 in 2017. St. Tammany, Jefferson and East Baton Rouge Parishes reported the highest number of NAS/NOWS cases, with 45, 32 and 30 cases, respectively NIH, 2019) The Centers for Disease Control and Prevention (CDC, 2019) report identified Louisiana as one of the states that has shown a statistically significant increases in drug overdose death rates from 2016 to 2017, which assisted ABH-LA in understanding the importance of this PIP and the significance of our role in helping increase initiation, engagement and follow-up in treatment options. Upon further research, with assistance from research completed by National Institutes of Health (NIH) and Saloner & Karthikeyan (2015), ABH-LA determined that prescription opioid dependency had increased into epidemic levels casting it on a national stage in our country; while the CDC (2017) provided findings that prescription and illicit opioids are the prime drivers of drug overdose deaths in the U.S. Wakeman and Barnett (2018) extended their research by offering cause to the overdose crisis as "an epidemic of poor access to care".

All utilized data sources were consulted to gain a better understanding of the current climate for members living with alcohol and other drug use or dependence and/or substance abuse disorders. The various sources consistently discussed the stigma associate with diagnosed with having an alcohol and/or drug abuse disorder, and how that stigma can lead to decreased initiation or engagement in treatment and an increased movement in the follow-up process. Many of the articles discussed the lack of patient knowledge of the available treatment options, while also bring attention to the fact that PCPs also lack the knowledge in this same area due to material oversight inefficiencies on the part of the insurance plans. These extensive research resources assisted ABH-LA in determining the barriers that are not only faced by our members and our providers, but also ABH-LA. In addition, to the lack of knowledge related to treatment it was crucial that ABH-LA address the issues identified with follow-up care and the appropriate transitions of care. In reviewing information from AHA it helped to shed some light on the resources available to safeguard against diversion; collaborate with community; becoming an advocate for your member; and more. All the information compiled all pointed to lack of knowledge, training, educational materials, treatment options, and resources. The information gained allowed ABH-LA to create appropriate and effective inventions to meet the needs of our members, providers, and our plan to successfully assist members in the initiation, engagement and follow-up care in the treatment options for alcohol, substance, and/or drug dependency disorders.

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

Measure Initiation and Engagement Abuse or Dependence Treatment	2018 ABH-LA Better Health	2018 Statewide Average	2018 Quality Compass South Central - All LOBs (Excluding PPOs): 50th	2018 Quality Compass National - All LOBs (Excluding PPOs): 50th	% Difference State Average	% Difference 2018 QC South Central	% Difference 2018 QC National
Alcohol abuse or dependence: Initiation	48.63%	45.33%	43.38%	40.69%	3.30%	5.25%	7.94%
Alcohol abuse or dependence: Engagement	13.26%	11.57%	10.00%	10.79%	1.69%	3.26%	2.47%
Opioid abuse or dependence: Initiation	62.07%	60.56%	49.17%	50.73%	1.51%	12.90%	11.34%
Opioid abuse or dependence: Engagement	27.27%	25.92%	19.54%	21.12%	1.35%	7.73%	6.15%
Other drug abuse or dependence: Initiation	51.96%	50.25%	43.37%	41.93%	1.71%	8.59%	10.03%
Other drug abuse or dependence: Engagement	15.13%	15.36%	11.29%	11.28%	-0.23%	3.84%	3.85%
Total: Initiation	50.66%	48.51%	42.60%	42.12%	2.15%	8.06%	8.54%
Total: Engagement	16.14%	15.30%	13.50%	13.66%	0.84%	2.64%	2.48%
Follow-up After ED Visit – 7 Days Total	9.25%						
Follow-up After ED Visit – 30 Days Total	13.78%						

Quantitative Analysis:

- Alcohol abuse or dependence: Initiation rating score 48.63%, ABH-LA met State average, 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Alcohol abuse or dependence: Engagement rating score of 13.26%, ABH-LA met State average, 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Opioid abuse or dependence: Initiation rating score of 62.07%, ABH-LA met State average, 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Opioid abuse or dependence: Engagement rating score of 27.27% ABH-LA met State average. ABH-LA met 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Other drug abuse or dependence: Initiation rating score 51.96% ABH-LA met State average, 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Other drug abuse or dependence: Engagement rating score 15.13%, ABH-LA did not meet State average with a difference of -0.23 percentage points. ABH-LA met 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Total: Initiation: rating score 50.66%, ABH-LA met State average, 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.
- Total: Engagement: rating score 16.14% ABH-LA met State average. ABH-LA met 2018 Quality Compass South Central and Quality Compass National 50th percentile goal.

Qualitative Analysis:
ABH-LA met the 50th percentile for 2018 Quality Compass South Central rates and 2018 Quality Compass National rates for all performance indicators. ABH-LA did meet the State of Louisiana State average for Initiation and Engagement Alcohol, Initiation Opioid, and Total Initiation. ABH-LA did not meet the state average for Opioid Engagement, Other drug abuse Engagement, and Total Engagement.

There may be many causative factors for not meeting the State average. The causative factors have been differentiated into three main categories: 1) Member 2) Provider 3) Health Plan.

ABH-LA is in the process of conducting analysis on the challenges faced and key drivers for improving healthcare outcomes as we continue to review our data ABH-LA will include documentation in this report for items such as:

- Member Challenges/ Opportunities for Improvement.
- Member Cause and Effect Diagram
- Member Key Drivers
- Provider Challenges/ Opportunities for Improvement
- Provider Cause and Effect Diagram
- Provider Key Drivers
- Health Plan Challenges/ Opportunities for Improvement
- Health Plan Key Drivers

Aims, Objectives and Goals

Healthy Louisiana PIP Aim: The overall aim is to improve the rate of Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET; HEDIS 2020) and to improve the rates for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA; HEDIS 2020), as well as Pharmacotherapy for Opioid Use Disorder (POD) by implementing enhanced interventions to test the change concepts indicated in the Driver Diagram (Appendix D) to achieve the following **objectives**:

1. Conduct provider training to expand the workforce for treatment initiation, follow-up, and continuity of pharmacotherapy for Opioid Use Disorder (POD), and encourage provider enrollment in the following training programs:
    - The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder, 2020 Focused Update (hard copy + web-based learning)
    - Treatment of Opioid Use Disorder Course (includes training for the waiver to prescribe buprenorphine) - American Society of Addiction Medicine (ASAM); Targeted providers to include: PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers.
    - Fundamentals of Addiction Medicine (ASAM); Targeted providers to include psychiatrists, pediatricians, LMHPs, PCPs, obstetricians, ER physicians, FQHC and urgent care providers.
    - The ASAM Criteria Course for appropriate levels of care; Targeted providers to include LMHPs, PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers
    - ASAM Motivational Interviewing Workshop; Targeted providers to include LMHPs, PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers
2. Link primary care providers for youth and adults to resources from the Substance Abuse and Mental Health Services Administration (SAMHSA) Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT) (https://www.samhsa.gov/sbirt/resources), and encourage primary care conduct of SBIRT for youth and adults; Targeted providers to include pediatricians, LMHPs, PCPs, obstetricians, ER physicians, FQHC and urgent care providers.
3. Partner with hospitals/EDs to improve timely initiation and engagement in treatment (e.g., MCO liaisons, hospital initiatives, ED protocols); and
4. Provide MCO enhanced care coordination (e.g., behavioral health integration, case management, improved communication between MCO UM and CM for earlier notification of hospitalization, improved discharge planning practices and support, such as recovery coaches, and coordinate with pharmacists).
5. Other interventions as informed by the MCOs' barrier analyses they will conduct as part of the PIP process.

Table 2: Goals

Indicators	Baseline Rate Measurement Period: 1/1/18-12/31/18	Interim I Rate Measurement Period: 1/1/19-12/31/19	Interim II Rate Measurement Period: 1/1/20-12/31/20	Baseline with 2021Target Rate[2]/Stretch	2021 Rationale for Target Rate[3]
Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N: 869 D:1787 R: 48.63%	N: 990 D: 1912 R: 51.78%	N: 917 D: 1728 R: 53.07%	Baseline R: 46.99% R: *52.4% / 56%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 95th Percentile
Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N: 540 D: 870 R: 62.07%	N: 633 D: 977 R:64.79%	N: 642 D: 949 R: 67.65%	Baseline R: 63.31% R: *69.62% / 73%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 90th/95thPercentile
Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort	N: 2357 D: 4653 R: 50.66%	N: 2711 D: 5089 R: 53.27%	N: 2697 D: 4977 R: 54.19%	Baseline R: 50.65% R: *55.49% / 59%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 95th Percentile
Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N: 237 D: 1787 R: 13.26%	N: 300 D:1912 R: 15.69%	N: 274 D: 1728 R: 15.86%	Baseline R: 12.99% R: *16.56% / 20%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 90th / 95th Percentile
Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N: 237 D: 870 R: 27.24%	N: 296 D: 977 R:30.30%	N: 330 D: 949 R: 34.77%	Baseline R:27.73% R: *35.95% / 39%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 66th Percentile. 75th = 39.21%
Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort	N: 751 D: 4653 R: 16.14%	N: 899 D: 5089 R: 17.67%	N: 909 D: 4977 R: 18.26%	Baseline R:16.22% R: *18.57% / 22%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 75th Percentile

Indicators	Baseline Rate Measurement Period: 1/1/18-12/31/18	Interim I Rate Measurement Period: 1/1/19-12/31/19	Interim II Rate Measurement Period: 1/1/20-12/31/20	Baseline with 2021Target Rate[2]/Stretch	2021 Rationale for Target Rate[3]
Indicator #7. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	N: 96 D: 1038 R: 9.25%	N: 90 D: 988 R: 9.11%	N: 87 D: 983 R: 8.85%	Baseline R: 11.41% R: *12.73% / 16%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 50th Percentile. 66th Percentile is 15.54%
Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	N: 143 D: 1038 R: 13.78%	N: 130 D: 988 R: 13.16%	N: 159 D: 983 R: 16.18%	Baseline R:17.75% R: *19.4% / 23.6%*	Based on the 2020 National – HMO: Average NCQA Quality Compass 50th Percentile. 66th Percentile if 23.6%
Indicator #9: The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.	N: D: R:	N: 243 D: 732 R: 33.20%	N: 505 D: 1175 R: 42.98%	Baseline R: R:52.98%	Based on the actual 2020 rate plus 10%

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators[1]

The performance indicators will follow the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) HEDIS Specifications 2020, Volume 2

Indicator #1 **Data Source(s):** Administrative Claims Data
Initiation Treatment (HEDIS IET), stratified by age (a. 13-17; b. 18+ years; c. Total) and, for each age stratification, the rates for the following diagnosis cohorts: I. Alcohol abuse or dependence; ii. Opioid abuse or dependence; iii. Other drug abuse or dependence; iv. Total, the annual time from represented by the data from the start date of the measurement year 2020 of 01/01/2020 to the end of the measurement year 11/13/2020, which is considered the intake period. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

- *For an inpatient IESD,* use the admission date to determine the 60-day Negative Diagnosis History period
- *For an ED or observation visit that results in an inpatient stay*, use the ED/ observation date of service to determine the 60-day Negative Diagnosis History period

Members must be continuously enrolled for 60 days (2 months) before the IESD through 48 days after the IESD (109 total days), with no gaps.

Indicator #2 **Data Source(s):** Administrative Claims Data
Engagement Treatment (HEDIS IET), stratified by age (a. 13-17; b. 18+ years; c. Total) and, for each age stratification, the rates for the following diagnosis cohorts: i. Alcohol abuse or dependence; ii. Opioid abuse or dependence; iii. Other drug abuse or dependence; iv. Total, the annual time from represented by the data from the start date of the measurement year 2020 of 01/01/2020 to the end of the measurement year 11/13/2020. *For members who initiated treatment via an inpatient admission,* the 34-day period for the two engagement visits begins the day after discharge. Once those members are identified whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set). The se members are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days). Identify the remaining members whose initiation of AOD treatment was *not* a medication treatment event (members not identified in step 2).

These members are numerator compliant if they meet *either* of the following:

- At least one engagement medication treatment event
- At least two engagement visits

Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers). Refer to the descriptions below to identify engagement visits and engagement medication treatment events. Exclude the member from the denominator for both indicators *(Initiation of AOD Treatment* and *Engagement of AOD Treatment)* if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Indicator #3 **Data Source(s):** Administrative Claims Data
Follow-Up After Emergency Department Visit (HEDIS IET), stratified by age (a. 13-17; b. 18+ years; c. Total) and, for each age stratification, the rates for the following diagnosis cohorts: i. Alcohol abuse or dependence; ii. Opioid abuse or dependence; iii. Other drug abuse or dependence; iv. Total, the annual time from represented by the data from the start date of the measurement year 2020 of 01/01/2020 to the end of the measurement year 11/13/2020. The denominator for this measure is based on ED visits, not on members. There should only be one ED visit included per 31-day period and if there are multiple visits in a 31-day period only count the first eligible ED visit. Exclusion should include ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission.

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Member with detoxification-only chemical dependency benefits do not meet these criteria	Initiation of AOD treatment: Alcohol abuse or dependence diagnosis with 14 days of the IESD (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Member with detoxification-only chemical dependency benefits do not meet these criteria	Initiation of AOD treatment: Opioid Abuse or dependence diagnosis with 14 days of the IESD (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Total diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Member with detoxification-only chemical dependency benefits do not meet these criteria	Initiation of AOD treatment: Total diagnosis cohort with 14 days of the IESD (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #4 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Members in hospice	Step 1 - Identify all members compliant for the initiation of AOD treatment numerator Step 2 – Identify members whose initiation of AOD treatment was a medication treatment (Alcohol Use Disorder Treatment Medication List) Step 3 – Identify the remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2) Members are numerator compliant if they meet either of the following: • At least on engagement medication treatment event • At least two engagement visits (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #5 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Members in hospice	Step 1 - Identify all members compliant for the initiation of AOD treatment numerator Step 2 – Identify members whose initiation of AOD treatment was a medication treatment (Opioid Use Disorder Treatment Medication List) Step 3 – Identify the remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2) Members are numerator compliant if they meet either of the following: • At least on engagement medication treatment event • At least two engagement visits (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #6 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Total diagnosis cohort**	QSI - HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 13-17 years 18+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date	Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. Members in hospice	Step 1 - Identify all members compliant for the initiation of AOD treatment numerator Step 2 – Identify members whose initiation of AOD treatment was a medication treatment (AOD Medication Treatment Value Set) Step 3 – Identify the remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2) Members are numerator compliant if they meet either of the following: • At least on engagement medication treatment event • At least two engagement visits (See HEDIS Specs)	New episode of AOD abuse or dependence during the Intake Period: Step 1 – Identify the Index Episode. Identify all member in the specified age range who during the intake period had one of the following (see specs) Step 2 – Select the Index Episode and stratify based on age and AOD diagnosis cohort (see specs) Step 3 – Test the Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication during the 60 days before the IESD (see specs) Step 4 – Calculate continuous enrollment. Members must be continuously enrolled for 60 days before IESD through 48 days after the IESD, with no gaps

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #7 (HEDIS FUA)	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit**	QSI – HEDIS 2020, Volume 2	13 years and older as of the ED visit. Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members with detoxification-only chemical dependency benefits do not meet these criteria	The follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit (See HEDIS Specs)	ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of visit. **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.
Indicator #8 (HEDIS FUA)	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit**	QSI – HEDIS 2020, Volume 2	13 years and older as of the ED visit. Continuous enrollment from date of the ED visit through 30 days after the ED visit (31 days) No Gaps in enrollment No anchor date	ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. Members with detoxification-only chemical dependency benefits do not meet these criteria	The follow-up visits with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit (See HEDIS Specs)	ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of visit. **Note:** Do not include more than one ED visit per 31- day period as described in the Multiple visit documentation of spec.

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #9 (HEDIS POD)	**The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.**	QSI – HEDIS 2020, Volume 2	**The total is the sum of the age stratification** 16+ years Continuous Enrollment 60 Days (2 months) prior to the IESD through 48 days after the IESD (109 total days.) No allowable Gaps No Anchor Date		At least 173 days of treatment with OUD pharmacotherapy, beginning on the New Episode of OUD Pharmacotherapy date through 179 days after the New Episode of OUD Pharmacotherapy date (180 total days). This allows a gap in medication treatment up to a total of 7 days during the 180-day period.	The eligible population

1. **HEDIS Indicators: If using a HEDIS measure, specify the HEDIS reporting year used and reference the HEDIS Volume 2 Technical Specifications (e.g., measure name(s)). It is not necessary to provide the entire specification. A summary of the indicator statement, and criteria for the eligible population, denominator, numerator, and any exclusions are sufficient. Describe any modifications being made to the HEDIS specification, e.g., change in age range.**

Data Collection and Analysis Procedures

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

The total population of members 13 years and older are being targeted for this initiative. However, a barrier analysis was completed on the following sub-populations. The justice involved makes up less than 1% of ABH-LA substance and alcohol use disorder population, however early identification of these members can prove difficult to identify through claims data, due to reluctance to seek treatment. In addition, many of these members may not see themselves as having a substance use disorder or may fear seeking treatment due to concerns surrounding probation. The justice involved may had additional barriers including stigma related to have a legal history or criminal justice agencies' preferent to provider "drug-free treatment" that exclude pharmacotherapies for SUD.

ABH-LA pregnancy population makes up approximately 3.20% of the SUD population and these members face barriers to care due to motherhood concerns that are public health and criminal justice related. Negative health consequences associated with substance use impact both the mother and the developing fetus, and there are ongoing attempts to criminalize substance use during pregnancy that put pregnant substance-using women at risk of detection, arrest, and punishment. With this said pregnant moms may be reluctant to getting prenatal care, which result in low birth rates, prematurity, fetal demise and more.

The HIV population makes up approximation 3.27% of the SUD population, some strategies to increase addressing barriers would be to look at location and cost of treatments. Evidence-based SUD treatment is effective for primary and secondary HIV prevention, directly reducing injection- and non-injection-related risk-taking behaviors associated with HIV transmission. Moreover, effective drug treatment improves downstream HIV treatment outcomes, including enhanced access to and retention in HIV care, and increased access and adherence to antiretroviral therapy. Most importantly for achieving lifelong retention in care, drug treatment is stabilizing, improving health-related quality of life, socioeconomic status, employment, and social functioning.

Eligible Population:

- Annual population assessment: Total members enrolled in ABH-LA, ages birth and older.
- HEDIS rates: IET eligible members, 13-17 years of age, 18 years and older, and total.
- CM utilization rates: ABH-LA members 13-17 years of age, 18 years and older.
- Utilization patterns: ABH-LA members 13-17 years of age, 18 years and older.

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:**

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.

Data collection will be performed by the Quality department's Analyst as well as members of the IT department. Data collection will be setup weekly utilizing the below software and methods.

- **TOAD Data Point:** Software will be utilized to generate automated custom reporting specifically around this PIP by combining multiple data sources listed below.
- **Annual population assessment**: Annual report generated integrating member enrollment demographic data, Elli data software linked to State claims received with diagnoses codes, ABH-LA QNXT claims data base.

- **HEDIS rates:** Monthly rolling trend report, quarterly progress report, and final annual rates. QNXT 5.4, Cotiviti and Mckesson Claims check, Change Health care, Inovalon, NCQA accredited software for IET HEDIS data collection.
- **CM Utilization rates:** Report generated utilizing CM Dynamo data platform monthly, quarterly, and final annual rate of enrollment patterns, use of ASAM 6 screening tools, and outreach patterns. Member successful transitions to appropriate level of care by file review.
- **Utilization Management Rates**: QNXT data base system generated quarterly and annual report of member utilization patterns for telemedicine, tele-therapy, outpatient services, and treatment centers.
- **Pharmacy Rates:** Use of Elli software program of prescribing patterns by member/prescribing physician. CVS pharmacy reports of claims received for opioid and controlled substances with member enrollment patterns into the medication restriction program.
- **Member Surveys**: Use of data received from Interactive Telephone Calls to the members' ages 18 years of age and older, who have been identified as non-compliant for initiation of treatment, continuing engagement of treatment and follow-up after hospitalization.
- **Vendor Reports:** Received monthly, quarterly, and final annual rates of text messages and IVR calls to members.

Validity and Reliability

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

Describe validity and reliability:

- **Annual Population Assessment**: member demographic and claims information validated by ABH-LA IT informatics and Health Care Equities Director. We utilize Elli data software program, which is linked to State claims received, ABH-LA QNXT claims received, and member enrollment data to produce reliable data over time.
- **HEDIS**: In accordance with NCQA's protocols, validity audits are conducted by Advent Advisory Group, an NCQA-licensed organization, and led by a Certified HEDIS Compliance Auditor (CHCA). The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability.

Product Line	Product	NCQA Org ID	NCQA Sub ID
Medicaid	HMO	234984	12408

Audits are conducted in accordance with NCQA*HEDIS Compliance Audit: Standards, Policies and Procedures*. NCQA's Information Systems (IS) and HEDIS Measure Determination (HD) standards were the foundation on which auditors assessed the organization's ability to report HEDIS data accurately and

- **Member Survey**: Vendor data file validated by QI Director, IET Project Manager and/or designee. Discrepancies discussed with vendor during monthly meetings. Utilizing interactive phone surveys with State approved scripts. Same method utilized for each survey conducted
- **Pharmacy Rates**: Data file validation by CVS pharmacy and ABH-LA Pharmacy Director
- **Vendor Reports**: Vendor data file reports of text messages, mailers, and IVR calls generated validated by QI Director, IET Project Manager and/or designee. ABH-LA IT generation of member lists utilizing same logic. Discrepancies discussed with vendor during monthly meetings.

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*
Describe how plan will interpret improvement relative to goal.

Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

Describe data analysis procedures:

- Our data collection for identifying, measuring, and reporting gaps in service delivery includes information from our member survey, HEDIS IET performance metrics, Care Management dynamo platform of enrollment patterns, participation, and interventions conducted, utilization management of services used, medical record and CM file audits to ensure provider and health plan adherence to evidence based guidelines. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP IET committee members, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABH-LA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABH-LA of LA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the IET PIP and its corresponding goals.

Describe how plan will interpret improvement relative to goal:

- In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional and provider demographic variations, to identify variation in care. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in active treatment

Describe how plan will monitor ITMs for ongoing QI:

- The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is being observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

PIP Timeline

Report the measurement data collections periods below.

Baseline Measurement Period (IET):
Start date: 1/1/2018
End date: 12/31/2018

Interim I Measurement Period (IET and FUA)
Start date: 1/1/2019
End date: 12/31/2019

Interim II Measurement Period (IET, FUA and POD)
Start date: 1/1/2020
End date: 12/31/2020

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

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 Due: 10/31/2021

First Year PIP Interventions (New or Enhanced) Initiated: 1/1/2019
Second Year PIP Interventions (New or Enhanced) Initiated: 1/1/2020
Third Year PIP Interventions (New or Enhanced) Initiated: 1/1/2021

Submission of IET/FUA/POD Draft Report with CY 2021 data due: 12/10/2021
Submission of IET/FUA/POD Final Report with CY 2021 data due: 12/31/2021

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: Provider: First line medical providers lack of knowledge/training in engaging SUD patients, screening, triage and referral procedures, and SUD treatment continuum of care. **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: **First-line medical provider education supporting screening, brief intervention, and referral for the following Providers:** • OB/GYN • EDs • Pain Management • PCP (Family Practice, Internal Medicine) • Pediatricians • Urgent Care **(Stage of Change, Motivational interviewing knowledge of available treatment/services/providers)** **Planned Start Date: 01/01/2020** **Actual Start Date: 01/01/2020**	**Intervention #2a tracking measure:** **N:** # of first line medical providers receiving education **D:** # of PAR first line providers	N: 12 D: 4260 R: 0.28%	N: 0 D: 4319 R: N/A	N: 332 D:4293 R: 7.73%	N: 0 D: 4424 R: N/A	N: 4454 D: 4454 R: 100%	N: 4462 D: 4462 R:100%	N: 959 D: 4470 R: 21.4%	N:4494 D:4505 R:99.8%
Intervention #2b to address barrier: Educate providers about evidence based SBIRT screening best practices (Stages of Change, motivational interviewing, knowledge of available treatment/services/providers) and	**Intervention #2b** **N**: Number of Claims received with an SBIRT related billing of H0049 and/or H0050 for members	N: 168 D: 4224 R: 3.98%	N: 104 D: 4281 R: 2.43%	N: 447 D: 4232 R: 10.6%	N: 356 D: 4355 R: 8.17%	N: 359 D: 4387 R: 8.18%	N: 280 D: 4407 R: 6.35%	N: 224 D: 4425 R: 5.06%	N:177 D:4463 R:4.0%

billing procedures **ITM Rate: percentage of specific provider types billing SBIRT:** • **OB/GYN** • **EDs** • **Pain Management** • **PCP (Family practice, Internal Medicine)** • **Urgent care** • **Pediatricians** **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	13 years of age or older by provider type **D:** # of providers billing SBIRT by Identified Provider Type								
Barrier 2: <u>Provider:</u> Statewide lack of MAT prescribers and prescriber knowledge of local psychosocial treatment resources. **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #3 to address barrier: **Increasing number of MAT prescriber's in rural areas of regions 5, 6, and 7 outside of Lake Charles, Alexandria, and Shreveport.** **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**Intervention #3 tracking measure:** **N:** # of prescribers that became MAT certified in regions 5, 6, and 7 **D:** # of prescribers in regions 5, 6, and 7	N: 13 D: 2277 R: 0.57%	N: 17 D: 2277 R: 0.74%	N: 15 D: 2376 R: 0.63%	N: 19 D: 2406 R: 0.79%	N: 19 D: 2451 R: 0.78%	N: 22 D: 2540 R: 0.87%	N: 33 D: 2562 R: 1.29%	N 23 D: 2648 R: 0.87%
Intervention #4 to address barrier: Increasing outreach to educate providers of local SUD treatment and concurrent psychosocial treatment and referral procedures for higher levels of care with a focus in rural areas of regions 5, 6, and 7 outside of Lake Charles, Alexandria, and Shreveport	**Intervention #4 tracking measure:** **N:** # of prescribers receiving education of psychosocial treatment resources **D:** # of prescribers in regions 5, 6, and 7	N: N/A D: 2277 R: N/A	N: N/A D: 2277 R: N/A	N: N/A D: 2376 R: N/A	N: N/A D: 2406 R: N/A	N: 957 D: 2451 R: 39.05%	N: 41 D: 2540 R: 1.61%	N: 35 D: 2562 R: 1.37%	N: 965 D: 2648 R: 36.44%

Planned Start Date: 01/01/2020 **Actual Start Date**: **1/1/2021**									
Barrier 3: <u>Provider:</u> Address the knowledge deficit for providers regarding the 7- and 30-days Follow-up after hospitalization (FUA) for members hospitalized for a SUD. **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #5a to address barrier: Educate ED providers and follow-up practitioners on the appropriate care and provision of a resource list **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2021**	**Intervention #5a tracking measure:** **N:** # of ED providers and follow-up practitioners who receive education on 7- and 30-day follow-ups **D:** ED and Follow-up Practitioners	N: N/A D: 5168 R: N/A	N: N/A D: 5278 R: N/A	N: N/A D: 5419 R: N/A	N: N/A D: 5472 R: N/A	N: 9 D: 5573 R: 0.16%	N: 31 D: 5627 R: 0.55%	N: 45 D: 5673 R: 0.79%	N: 5893 D: 5950 R: 99%
Intervention #5b to address barrier: Monitor education of outpatient providers who would follow-up for AOD after ED about evidence-based follow-up care **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2021**	**Intervention #5b tracking measure:** **N**: # of ED providers who were given a list of qualified AOD providers **D:** ED Providers	N: N/A D: 904 R: N/A	N: N/A D: 912 R: N/A	N: N/A D: 935 R: N/A	N: N/A D: 942 R: N/A	N: 945 D: 945 R: 100%	N: 41 D: 950 R: 4.32%	N: 35 D: 956 R: 3.66%	N:975 D:989 R:98.6%
Intervention #5c to address barrier: Monitor MCO CM referral and appointment scheduling of transitions in care from ED to community (Recovery Coach) **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**Intervention #5c tracking measure:** **N:** Members outreached who opt into CM and are actively engaged in ongoing care coordination to address SUD diagnosis and comorbidity	N: 141 D: 926 R: 15.23%	N: 121 D: 729 R: 16.60%	N: 111 D: 745 R: 14.90%	N: 131 D: 823 R: 15.92%	N: 185 D: 1191 R: 15.53%	N: 179 D: 1213 R: 14.76%	N: 210 D: 1323 R: 15.87%	N: 182 D: 1217 R: 15%

	D: Utilizing the ADT data to identify members with 3 plus ED visit within a rolling 6-month time frame that also have a SUD Diagnosis in their claims history.								
Barrier 4: <u>Member</u>: Special Health Care Needs (SHCN) eligible subpopulations pose unique communication/mode of outreach challenges to engagement in case management **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #6 to address barrier: Enhance case management for the SUD involved SHCN populations, including increased face to face contact, and care coordination for members to ensure appropriate continuity of care. **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**Intervention #6 tracking measure:** **N:** # of SHCN members enrolled in CM **D:** # of SHCN members with a SUD diagnosis	N: 269 D: 1945 R: 13.83%	N: 268 D: 1941 R: 13.81%	N: 258 D: 1926 R: 13.40%	N: 289 D: 1827 R: 15.82%	N: 603 D: 4412 R: 13.67%	N: 591 D: 4562 R: 12.95%	N: 624 D: 4662 R: 13.38%	N: 887 D: 6668 R: 13.3%
Barrier 5: Member: Justice involved – Lack of ability to identify justice-involved members appropriate for SUD services prior to release and connect them with services at release **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #7 to address barrier: Enhanced case management for the SUD involved Justice Involved populations, including increased face to face contact, and care coordination for members to	**Intervention #7 tracking measure:** **N:** # of Justice Involved Members enrolled in CM	N: 1 D: 22 R: 4.55%	N: 1 D: 24 R: 4.17%	N: 1 D: 28 R: 3.57%	N: 2 D:36 R: 5.56%	N: 1 D: 31 R: 3.23%	N: 0 D: 30 R: 0.00%	N: 4 D: 36 R: 11.11%	N: 3 D: 33 R: 9.09%

ensure appropriate continuity of care **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**D:** # of Justice Involved Members identified with a SUD								
Barrier 6: <u>Member</u>: Lack of use and referral to programs that instruct on the use of motivational interviewing techniques and parental/family involvement when clinically indicated **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #8 to address barrier: Enhance case management for the involved Adolescent population, including referrals to Breakthrough and care coordination for members to ensure appropriate continuity of care **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**Intervention #8 tracking measure:** **N:** # of members ages 13-17 enrolled in case management **D:** # of members ages 13-17 with a SUD diagnosis	N: 1 D: 34 R: 2.94%	N: 2 D: 50 R: 4.00%	N: 3 D: 62 R: 4.84%	N: 4 D: 69 R: 5.80%	N: 2 D: 25 R: 8.0%	N: 1 D: 39 R: 2.56%	N: 2 D: 23 R: 8.70%	N: 1 D: 30 R: 3.3%
Barrier 7: <u>Member:</u> – Lack of follow-up with members 7 days after hospitalization. **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #9 to address barrier: Utilization of *TeleMed* to assist in the management for the involved members within this population who have had a hospitalization 7 Days prior to ensure appropriate follow-up visit occur after hospitalization **Planned Start Date: 01/01/2020**	**Intervention #9 tracking measure:** **N**: Number of members engaged w/Follow-up 30 days after an ASAM facility visit **D:** Number of Members previously admitted to any	N: N/A D: 162 R: N/A	N: N/A D: 145 R: N/A	N: N/A D: 136 R: N/A	N: N/A D:130 R: N/A	N: 479 D: 523 R: 91.59%	N: 591 D: 672 R: 87.95%	N: 210 D: 239 R: 87.87%	N: 261 D: 287 R: 91%

Actual Start Date: **01/01/2021**	ASAM level for opioid use disorder								
Barrier 8: <u>Member:</u> Lack of follow-up with members 30 days after hospitalization. **Method of barrier identification: IPRO IET PIP Guidance Document, Internal PIP IET Committee barriers brainstorm, 2019 ABH-LA IET PIP Documentation, LDH/IPRO Suggestions for ongoing analysis of barriers**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #11 to address barrier: **Reduce 30-day readmission rates for members that have been in a residential or inpatient setting receiving services specifically for detox (medical) and/or residential services. <u>*Through increased continuity of care to treatment*</u> (ASAM 3.7, 3.5, 3.3 or perhaps 2.1 as indicated) following discharge from 4-WM (medically managed detox in the hospital** **Planned Start Date: 01/01/2020** **Actual Start Date**: **01/01/2020**	**Intervention #11 tracking measure:** **N:** Members admitted to a lower-level Treatment for continuity of care within 30 days of discharge **D:** Members discharged from Inpatient Detox treatment (Not ED)	N: 45 D: 131 R: 34.55%	N: 24 D: 105 R: 22.86%	N: 33 D: 122 R: 27.05%	N: 37 D: 110 R: 33.64%	N: 66 D: 157 R: 42.03%	N: 42 D: 102 R: 41.18%	N: 51 D: 122 R: 41.80%	N: 47 D: 104 R: 45.2%
Intervention #12 to address recidivism of OUD: Proposal ITMS (NEW OTP Patients enrolled in CM). This requested ITM helps to support not only the POD metric, but the network of OTP's that administer Methadone. **Planned Start Date: 01/01/2021** **Actual Start Date**: **01/01/2021**	**Intervention #12 tracking measure:** **N:** # of these members enrolled in Aetna CM **D:** # of members with a first time serv code of H0020 this time period					N: 3 D: 62 R:4.84%	N: 4 D:37 R:10.81%	N: 3 D: 37 R: 8.11%	N: 0 D: 35 R:0.00%

Results

To be completed upon Proposal/Baseline 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** Measure period: 1/1/18-12/31/18	**Interim I** Measure period: 1/1/19-12/31/19	**Interim II** Measure period: 1/1/20-12/31/20	**Final Measure period:** 1/1/2021-12/31/2021	**2021 Target Rate[1]**
Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N: 869 D: 1787 R: 48.63%	N: 990 D: 1912 R: 51.78%	N: 917 D: 1728 R: 53.07%	N: 1017 D: 1977 R: 51.44%	R: *52.4% / 56%*
Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N: 540 D: 870 R: 62.07%	N: 663 D: 977 R: 64.79%	N: 642 D: 949 R: 67.65%	N: 683 D: 998 R: 68.44%	R: *69.62% / 73%*
Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort	N: 2357 D: 4653 R: 50.66%	N: 2711 D: 5089 R: 53.27%	N: 2697 D: 4977 R: 54.19%	N: 2940 D: 5471 R: 53.74%	R: *55.49% / 59%*
Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N: 237 D: 1787 R: 13.26%	N: 300 D: 1912 R: 15.69%	N: 274 D: 1728 R: 15.86%	N: 344 D: 1977 R: 17.40%	R: *16.56% / 20%*
Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N: 237 D: 870 R: 27.24%	N: 296 D: 977 R: 30.30%	N: 330 D: 949 R: 34.77%	N: 346 D: 998 R: 34.67%	R: *35.95% / 39%*
Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort	N: 751 D: 4653 R: 16.14%	N: 899 D: 5089 R: 17.67%	N: 909 D: 4977 R: 18.26%	N: 1101 D: 5471 R: 20.12%	R: *18.57% / 22%*
Indicator #7. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	N: 96 D: 1038 R: 9.25%	N: 90 D: 988 R: 9.11%	N: 87 D: 983 R: 8.85%	N: 102 D: 1053 R: 9.69%	R: *12.73% / 16%*
Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	N: 143 D: 1038 R: 13.78%	N: 130 D: 988 R: 13.16%	N: 159 D: 983 R: 16.18%	N: 166 D: 1053 R: 15.76%	R: *19.44%/23.6%*

Indicator	**Baseline** Measure period: 1/1/18-12/31/18	**Interim I** Measure period: 1/1/19-12/31/19	**Interim II** Measure period: 1/1/20-12/31/20	**Final Measure period:** 1/1/2021-12/31/2021	**2021 Target Rate**[1]
Indicator #9: The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.	N: D: R:	N: D: R:	N: 505 D: 1175 R: 42.98%	N: 516 D: 1228 R: 42.02%	R: 52.98%

[1] Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

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.

Please see table on the next page.

Performance Indicator	Rate Measurement Period: CY 2020	2020 Target Rate / Stretch Goal	1/1/21-3/31/21	4/1/21-6/30/21	7/1/21-9/30/21	10/1/21-12/31/21	Rate Measurement Period: CY 2021	2021 Target Rate / Stretch Goal
Indicator #1.	N: 917		N: 314	N: 668	N: 912	N: 986	N: 986	
Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	D: 1728	Rate: 53.28% / 57%	D: 636	D: 1285	D: 1732	D: 1847	D: 1847	Rate: 52.4% / 56%
	R: 53.07%		R: 49.37%	R: 51.98%	R: 52.66%	R: 53.38%	R: 53.38%	
Indicator #2.	N: 642		N: 202	N: 425	N: 606	N: 645	N: 645	
Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	D: 949	Rate: 68.33% / 72%	D: 328	D: 629	D: 879	D: 935	D: 935	Rate: 69.62% / 73%
	R: 67.65%		R: 61.59%	R: 67.57%	R: 68.94%	R: 68.98%	R: 68.98%	
Indicator #3.	N: 2697		N: 812	N: 1805	N: 2558	N: 2756	N: 2756	
Initiation of AOD Treatment: Total age groups, Total diagnosis cohort	D: 4977	Rate: 53.89% / 57%	D: 1684	D: 3436	D: 4719	D: 5068	D: 5068	Rate: 55.49% / 59%
	R: 54.19%		R: 48.22%	R: 52.53%	R: 54.21%	R: 54.38%	R: 54.38%	
Indicator #4.	N: 274		N: 88	N: 195	N: 283	N: 312	N: 312	
Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	D: 1728	Rate: 16.39% / 20%	D: 636	D: 1285	D: 1732	D: 1847	D: 1847	Rate: 16.56% / 20%
	R: 15.86%		R: 13.84%	R: 15.18%	R: 16.34%	R: 16.89%	R: 16.89%	
Indicator #5.	N: 330		N: 102	N: 208	N: 299	N: 320	N: 320	
Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	D: 949	Rate: 32.41% / 36%	D: 328	D: 629	D: 879	D: 935	D: 935	Rate: 35.95% / 39%
	R: 34.77%		R: 31.1%	R: 33.07%	R: 34.02%	R: 34.22%	R: 34.22%	
Indicator #6.	N: 909		N: 274	N: 639	N: 917	N: 992	N: 992	
Engagement of AOD Treatment: Total age groups, Total diagnosis cohort	D: 4977	Rate: 18.12% / 22%	D: 1684	D: 3436	D: 4719	D: 5068	D: 5068	Rate: 18.57% / 22%
	R: 18.26%		R: 16.27%	R: 18.6%	R: 19.43%	R: 19.57%	R: 19.57%	
Indicator #7.	N: 87		N: 18	N: 55	N: 79	N: 87	N: 87	
The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	D: 983	Rate: 11.41%	D: 255	D: 571	D: 847	D: 926	D: 926	Rate: 12.73% / 16%
	R: 8.85%		R: 7.06%	R: 9.63%	R: 9.33%	R: 9.4%	R: 9.4%	
Indicator #8.	N: 159		N: 31	N: 80	N: 124	N: 139	N: 139	
The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	D: 983	Rate: 17.75%	D: 255	D: 571	D: 846	D: 926	D: 926	Rate: 19.44% / 23.6%
	R: 16.18%		R: 12.16%	R: 14.01%	R: 14.66%	R: 15.01%	R: 15.01%	
Indicator #9.	N: 505		N: 180	N: 299	N: 450	N: 487	N: 487	
The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD.	D: 1175		D: 862	D: 1212	D: 1299	D: 1291	D: 1291	Rate: 52.98%
	R: 42.98%		R: 20.88%	R: 24.67%	R: 34.64%	R: 37.72%	R: 37.72%	

A PI table to show the 2020 Annual numbers and how things went for each through 2021. On many numerators you can see the number does increase but so does the denominator leaving some increases but its also interesting to note we used the same NCQA Compass Quartiles for 2021, ie 95th percentile or 55th percentile, to try and compare progress over time.

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.

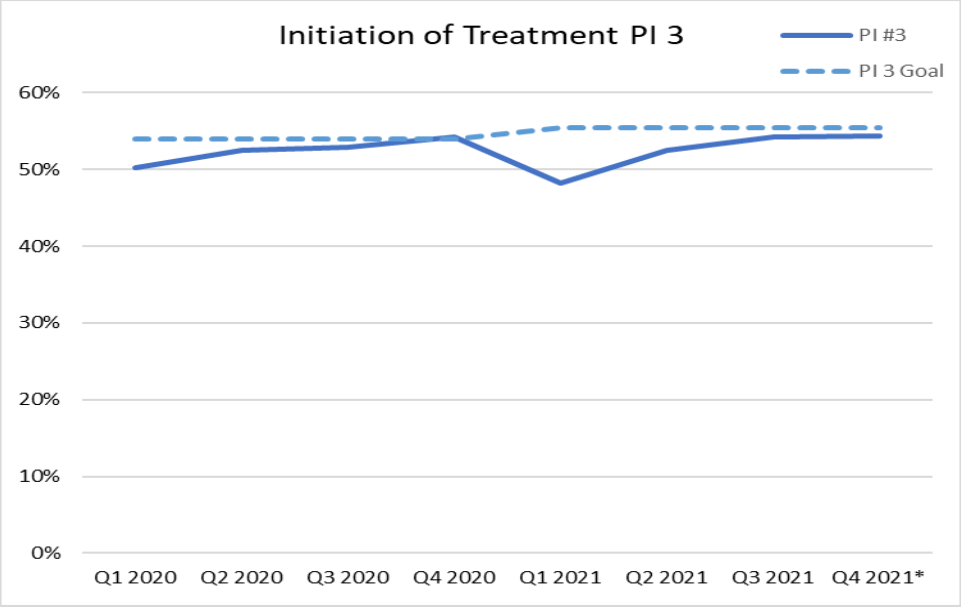
Discussion

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

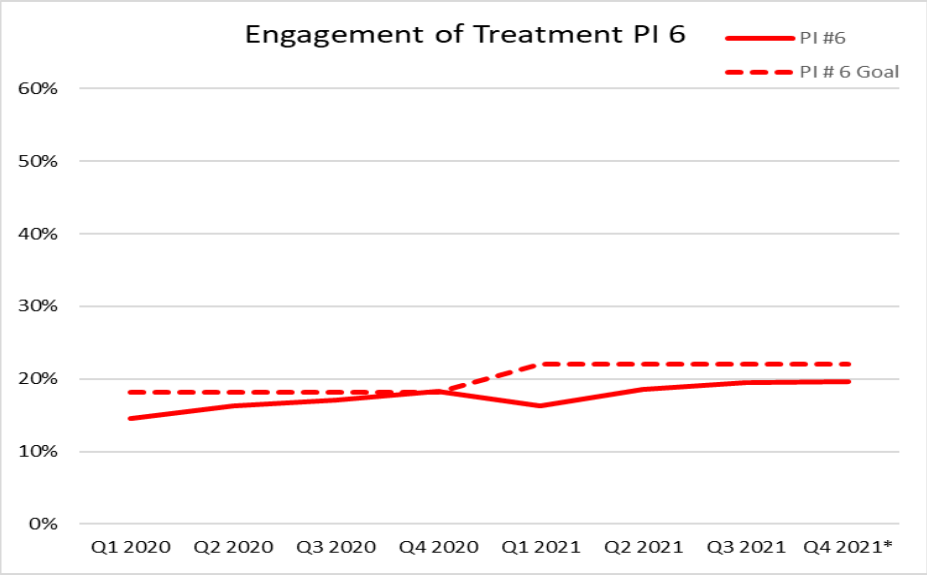
Discussion of Results

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

The PI's for Initiation (PI 1-3) performed steadily in 2021 although we did see a small decline in the Alcohol specific one (PI-1) earlier in 2021 but it has rebounded. We are pleased that our 95 and 90th percentile goals with stretch were maintained and improved upon from interim into the final results of 2021. In reviewing the Baseline target rates for these 3 Indicators the overall improvement is clear as noted in Table 2, but all 3 Target rates were increased by around 10% points from the baseline in 2019 to Final Results in 2021 but the increase in each ones performance year over year supported this ever increasing target rate. The best indication of repeated improvement of their performance was the request to include 'stretch goal's' for all of them since we were so close to the top Percentile via the NCQA Medicaid Quality Compass. All three PI's around Initiation have increases of on average 2% from Baseline to Interim 1, Interim 1 to Interim II, and Interim II to the Final results which in spite of a Pandemic we were able to improve upon per the benefit of our members.



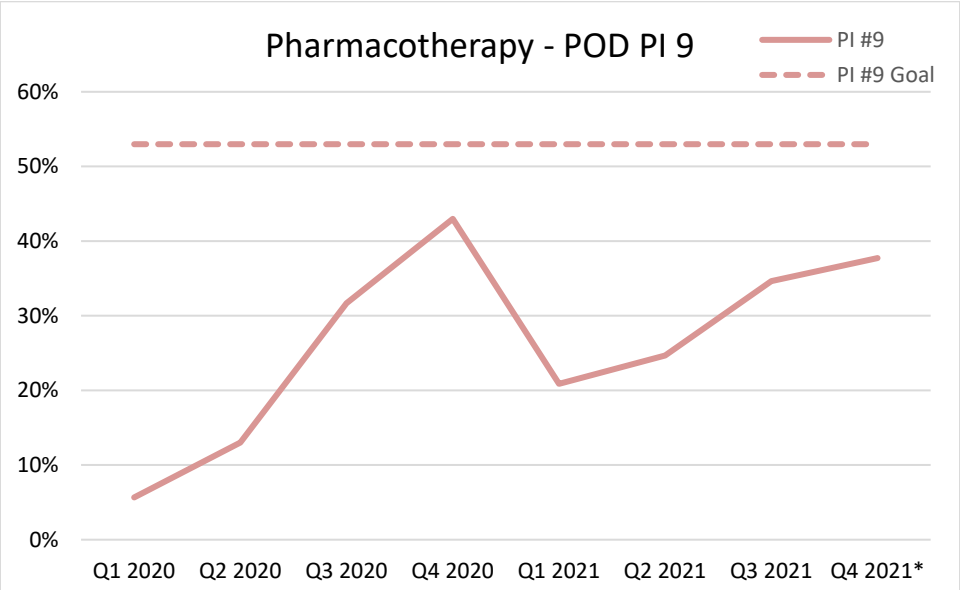
Although the Initiation PI's performed well, we had relatively flat performance around the Engagement PI (PI 4-6) numbers. PI 4 and 6 had only a few, around 4%, point increases on the Target rates from Baseline to the Final report and very incremental increases from Baseline to Interim I, Interim I to Interim II, and Interim II to the Final Results. It did increase year over year but by only 1 or 2% points but PI 5 which is Opioid engagement did show the largest Target increase of almost 10% points (using 2021 stretch goal rate) and although the increase was small year over year, this one area is driving some of the worst drug epidemic issues. The stretch goal for this rate is aligned to the 75th NCQA Quality Compass but in reality, that number of 39% from a population standpoint is low. ABHLA will continue to drive education of both assessments and proper referrals given the results to all Providers. These SUD HEDIS metrics and related programs will transfer to our POP Health team to continue the efforts established.



It is worth noting that in all 6 PI's (PI 1-6) Alcohol was the area that showed the least improvement in both Initiation and Treatment from Interim II to the final results. There are national stories and studies which show an increase in alcohol use during the pandemic so we will need to make sure this one specific area does not get overlooked given so much attention is on opioids. Even though the alcohol specific population was the main driver for slow improvement it is better than 2020 but not at a level we feel reflects the work the Behavioral Health ABHLA teams are doing for SUD. We hope these efforts will show at the end of the year giving ABHLA some comfort these programs will help get members to the right resources. Obviously, the pandemic was a contributor to members finding treatment – given some forms of treatment had social distancing limits, but we also find many PCP's and members themselves are unaware of all the SUD services that Medicaid offers. This realization is why we are continuing to educate providers in the monthly meetings, newsletters, email, and fax blasts as well as adding new outreach education tools for members with things like IVR's, text campaigns, and Member Newsletters. We had hoped allowing members the ability to connect virtuality to providers and treatment professionals that overall rates would reflect that but again members aren't aware of all the resources and rely mostly on providers to educate them during interactions and even providers are not aware of all the benefits that Medicaid offers. Our Provider Network team has already reached out with IET items from the inception of the PIP and told us they want to include them in all 'new' provider onboarding training. The provider education along with our success in having 37 attendees to SBIRT classes in 2021 and HHS rolling back MAT certification requirements and the expansion of OTP sites sets up 2022 and beyond to keep improving on the work done to date.

The two Follow-up PI's (PI 7-8) were added in 2020 and therefore as a part of this PIP only had 2 years in which to implement and follow interventions designed to improve these two PI's. The Baseline Targets for both were set at the 50th Quality Compass and only showed minor improvement of around 1% year over year but we are noticing that the 30-day item for some reason shows quarter over quarter improvement through both the baseline and Interim I year but fall in January. We are not sure of this one trend, but it follows the same pattern in both years so 2022 will hopefully help us understand this better and design new ITM's to help not only improve these month/quarter over quarter but eliminate the January drop. The Baseline Rate was set at 11.4% and 17.75% respectively and the new rates following the same quartile of 50% in 2021 were 12.73% and 19.44% and both are performing below those Target Rates. Traditionally this metric allows members to seek follow-up from a multitude of provider options and therefore given the unique aspect of the FUA PI's ABHLA is looking at all new things in addition to the traditional. We realized that the member makes this metric since they are the ones who choose to do next steps and with whom. Therefore, only notifying one provider of the need to follow-up might be limiting ourselves on improvement. In 2021, the ABHLA PIP team designed an FUA Nanosite to try and drive this performance up for the 30 day as there is more time for action in that PI. Unfortunately, the approval process pushed the launch out to January of 2022 (January 5th is target) so improvements on this metric will be reviewed in 2022 with the monthly results. The FUA is the only portion of the PIP going into 2022, so we are glad to see this new tool still has the potential to really impact this metric.

The last item for PI's was the new POD PI (PI 9), which we weren't sure what to expect as it was the first year NCQA had it as a HEDIS metric. This new HEDIS metric supports many new research papers on reducing recidivism by lengthening MAT timeline to 6 months as a general practice. Although it's the first year of reporting this metric, we are seeing that in using 2020 data as a baseline and actual 2021 data, the quarterly numbers tend to rise through the year and drop in Q1. As more data comes in from NCQA and we can assess this trend we should be able to understand if these Q1 drops are normal or something else given the timeline requirement of the metric. Our baseline rate of 42.98% in 2020 related to a Target Rate of 52.98% in 2021 which was not realized. The ABHLA also thought that HHS rolling back MAT requirements for POD would help to improve this metric performance but so far, it's about the same level as last year.



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

To support an increase in the IET PI's ABHLA developed 5 ITM's around Providers via education and tools for assessment and referrals to the appropriate treatment places. Although many of these metrics showed good coverage (ITM2a at 100%) for outreach, it did not translate to the same increase in the PI's. It is crucial that Providers play a role in member's overall health and well being so ABHLA will continue to educate, review BH goals in Value Base contracts, continue to work with vendors to identify barriers, and most importantly share performance on HEDIS metrics with providers in areas that are not meeting target. As an MCO, we can only influence Providers to do the right thing and therefore continuing to find the pulse points that get action will continue with the new PIP.

Another area we outlined in ITM's was CM support around specific populations. We are finding that many are not receptive to CM and once they turn us down, we cannot contact them again for an extended period. Therefore, we are working to develop other means, like IVR and text campaigns, to get the information to the member in less direct ways allowing them to determine when and how contact is made for next steps. We had 4 ITM's around CM outreaching DOJ members, Special Health Care Needs Members, and minors to get them enrolled in CM with a treatment plan and the rates were consistently below 20%. ABHLA knows CM is an important part of treatment for our members but we need to find the right method of this resource in outreach along with all the others we've outlined. The 2022 year will help us identify ways to steer members into CM as part of an overall outreach model that helps us gain success and we believe Social Determinants of Health will help us identify which members will respond to which methods the best.

- **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.

By far our largest obstacles for continued treatment had to do with the members and providers.

For members whom CM reached out to, less than 20% opted in and therefore continued outreach could not be done via that avenue. This is where direct education to the member on resources available becomes key and that effort is currently being done through Member newsletters, IVR's (Interactive Voice Recordings) and text campaigns. All these highlight that Medicaid offers a full suite of BH resources including SUD. We will continue to educate members in many forms to help empower them towards individual goals by making sure tools and resources are available to them like our Member Services being available 24/7/365. Members can access this resource via phone, web, or our app to get the help they need.

The second barrier to success has to do with providers. Regardless of the pandemic, we find that ED's often take the quickest route for care to the member and don't do a full evaluation either using internal or external resources. ABHLA has a BH Vendor who spotlighted that Providers tend to use a 72 hour hold to get them help not understanding the impact towards treatment. The lack of assessments than hinders the ability to transition the member into the right care and here is another barrier as many providers are given the information but often, we find the individuals interacting with members face/face in the ED – are not getting the full list of resources. ABHLA is committed to pushing providers to do assessments with the right tools, such as using our SBIRT training, and to then understand where the member needs to go for follow-up. ABHLA is glad to see the BH TIC PIP for 2022 as this will highlight the role and importance providers have in getting members to the right treatment. This also means our focus in 2022 will continue to be on educating providers on our resource tool which includes community resources like ATLAS, UniteUs and OTP's. ABHLA is hoping to add this file to a provider portal location so it's easy to access and always up to date. Our value base providers were educated on it and all thought it was great – we hope to continue this trend with all our providers in 2022.

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).

Some of the largest limitations was related to 'receipt' of information to providers. Although we communicated educational information, SBIRT and ASAM with fee codes, we saw little change in the ITM metrics related to results of screenings using these assessment tools. We have been communicating educational items to <u>all providers</u> in multiple methods (email, fax, newsletters) but the core group for understanding usage of this information would be our Value Base Providers who have contractual obligations on certain metrics as well as attending quarterly meetings for both performance and educational items from Aetna. This core group was very appreciative of the information shared, i.e. the SUD Referral Resource List, but since BH metrics were not part of the contracts for all value based groups - it was more informative. Still a good exchange of information was had but in 2022 we are looking at making sure BH is part of provider contracts not <u>just</u> our value based BH providers.

There were also limitations on some intervention categories as far as outreach but for completely different reasons. The first notable limitation was around minors and outreach for SUD by CM, since they are minors outreach has to be done to parent/guardian's and that interaction did not get a high reception for opting in for support and care. There are many potential reasons for this but at the end of the day, without parent/guardian consent we can not move forward with that minor member. The other group was the DOJ members being released. Coordinating of release data was difficult, as it often changes internal to the DOJ without notifying Medicaid but its also difficult because 'new' members being released must self-identify as having a SUD in order for CM to set up a care program. Self-identifying is the limitation here since research and statistics note that well over 80% of inmates had or have a SUD but we are not able to assume and therefore release care programs are built around what is disclosed and health records we receive after enrollment. It's a shame we can't make it mandatory for those exiting the DOJ since well over 90% of members from this population who opt into CM are still active in it a year later.

- **Were there any factors that may pose a threat to the internal validity of 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 were no internal validity issues for this PIP.

- **Were there any threats to the external validity of 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).

  There were no threats to validity for this PIP.

- **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.

  There were no collection challenges for this PIP.

PIP Highlights

- **Highlight 1-2 Member Interventions and support with quantitative ITM data and qualitative member feedback data**

ABHLA members had 4 ITMs (5c, 6, 7, 8) which were related to members being outreached by Care Management (CM). These ITMs highlighted specific populations CM outreached to such as inmates being released, minors (13-17 yo) and those members with special health care needs and co-morbidities. These ITMs were developed to show that members with additional healthcare needs were included when being outreached for treatment support. Unfortunately, the acceptance of CM was low and, in most cases, less than15% but acceptance by members is voluntary. We understand that some members, although not accepting of ABHLA CM are in treatment and the best point for that is the new OTP ITM (12) added this year. Although our CM annual rate for this ITM was just over 7%, these are individuals receiving methadone via a state licensed facility and these facilities have onsite CM and programs to support members. Our other two opioid ITMs that support ongoing treatment (9, 11) both showed steady performance for members still in treatment beyond first 30 days and those who were admitted into a step-down program. Both ITMs were to follow members and understand recidivism even before POD was added.

Our 2021 CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey showed improvement in many areas as noted by members around their personal providers went up 2.5% from last year and the rating around specialist went up almost 18% while the rating of healthcare members got also went up over 4.7%. Two areas where ABHLA need to continue work with Providers as it relates to members is around Coordination of Care and How Well Doctors Communicate. Both of these qualitative results showed small single digit decreases (less than 4%) but can impact members getting to and receiving the right next level of treatment. This shows we need to continue with both educational avenues as well as in person education to make sure Providers know what resources are available and when they should be used or accessed for Medicaid members.

- **Highlight 1-2 Provider Interventions and support with quantitative ITM data and qualitative provider feedback data**

ABHLA focused a lot of attention on education for Providers on tools needed to support members being assessed for SUD as well as appropriate treatment which included quarterly newsletters along with

email/fax blasts, quarterly meetings with our Value Base Providers where our Referral network list was distributed as well as formal training such as SBIRT and ASAM along with MAT requirements and changes to any of these items. We had 4 ITMs (2a, 4, 5a, 5b) which measured the different educational material being delivered to Providers. This also included our co-distribution and education effort around the linkage between SUD and HCV which went to all providers but also a separate and specific distribution to all BH Providers which included the OTP's. ABHLA holds regular meetings with Providers (Provider Advisory Council -PAC) to assess barriers on different items and methods to address those barriers. The constant feedback we get is that they were unaware of specific information which is one reason we began and will continue to find all methods for delivery. Although the educational effort has its 'receipt' barriers, our efforts can be reflected in the increase of claims received with an SBIRT (ITM 2b) related billing code from barely 10% in 2020 to over 28% in 2021which is more than a 100% improvement and reflects more members being properly assessed. All efforts around the Provider Referral list was to support members going to the right treatment and our ITMs around those, as outlined in the above section, were improved this year.

One other barrier Providers mention in PAC are conflicting priorities. Obviously COVID vaccinations and spikes in cases was a priority from a public health perspective, but also conflicting priorities between Providers practices and Medicaid requests. We can only educate providers on Medicaid items; their internal management will continue to focus on things that impact their overall performance.

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
#2a) to address barrier: First-line medical provider education supporting screening, brief intervention, and referral (Stage of Change, Motivational interviewing knowledge of available treatment/services/providers)	Using our ROD's to do specialized and focused training was beneficial and well received. All 'passive' methods for education were utilized.	This ITM will be modified to cover the new BH focus for FUA/FUH/FUM while the SUD portion will transfer to POP Health to be managed within a broader strategy.	The educational aspect to providers will continue on the BH PIP but will be renumbered once the new PIP details are received
#2b) to address barrier: Educate providers about evidence based SBIRT screening best practices (Stages of Change, motivational interviewing, knowledge of available treatment/services/providers) and billing procedures	There is no SBIRT fee code for providers outside of the two listed. Providers focus in 2021 was getting members vaccinated for COVID. We continued to link and educate providers on the importance of screening for all pregnant members	As requested, Aetna did submit a request for an additional SBIRT Fee Code on March 11th which would have given a payment for any 15-minute assessment regardless of gender. We never received follow-up on this request which could have greatly increased the use of SBIRT codes among providers.	This ITM will transfer to POP Health as SUD screening and assessment will not be in the 2022 BH PIP.
#3) to address barrier: Increasing number of MAT prescriber's in rural areas of regions 5, 6, and 7 outside of Lake Charles, Alexandria, and Shreveport.	In researching these regions, there seems to be adequate coverage from a prescriber perspective, but many are affiliated with but not always physically located at treatment locations.	The HHS rolled back educational and Attestation requirements in April allowing any prescriber the ability to do this and Aetna did send out multiple messages to providers on the changes the link to SAMSHA for next steps.	This ITM will transfer to POP Health as SUD screening and assessment will not be in the 2022 BH PIP.
#4) to address barrier: Increasing outreach to educate providers of local SUD treatment and concurrent psychosocial treatment and referral procedures for higher levels of care with a focus in rural areas of regions 5, 6, and 7 outside of Lake Charles, Alexandria, and Shreveport	The majority of treatment options in these regions is outpatient only and therefore members wanting inpatient will be impacted. Although there are facilities in these regions, they don't take Medicaid.	Aetna hopes that as large national names continue to come into the state and add smaller facilities to their network that more options for inpatient will become available. The only option now is	The educational aspect to providers will continue on the BH PIP but will be renumbered once the new PIP details are received

		getting treatment outside of where they live or outpatient.	
#5a) to address barrier: Educate ED providers and follow-up practitioners on the appropriate care and provision of a resource list	This metric continues to be a challenge even with education of the resources the members ultimately have to keep the appointment. The very SUD for their ED visit is often keeping them from continued help.	Aetna is using a Nanosite to contact members within 30 days of an ED visit with all of the resources available to them right in the message in hopes this unavoidable reach coupled with instant connection will allow more members to make those 'follow-up' appointments.	This metric will either in entirety or slight modifications continue in the 2022 BH PIP and will allow us to monitor FUA improvement with the Nanosite.
#5b) to address barrier: Monitor education of outpatient providers who would follow-up for AOD after ED about evidence-base follow-up care	The challenge is getting the information needed into the hands doing the referral. We are sharing these lists with providers in both SBIRT and quarterly provider meetings.	We continue to look for better ways to get this information to providers and although it's in an excel file, we are looking for ways to always have it accessible like in the provider portal. Therefore, emailing and keeping with updates won't be burdensome to recipients.	The referral aspect to providers will continue on the BH PIP but will need to be reviewed for alignment once the new PIP details are received
#5c) to address barrier: Monitor MCO CM referral and appointment scheduling of transitions in care from ED to community	Reaching members and getting them into CM was difficult. For those who opted into CM, they generally account for about 30% so we need broader outreach methods and continuum of care beyond CM	Our CHW team was fully staffed by October and we hope they can outreach members who use the ED often and help guide them through local/community resources. We hope a local focus will be impactful for change.	The outreach aspects in efforts to provide continuum of care in the 2022 BH PIP will be reviewed for alignment once the new PIP details are received
#6) to address barrier: Enhance case management for the SUD involved SHCN populations, including increased face to face contact, and care coordination for members to ensure appropriate continuity of care.	SUD population is hard to connect with and phone calls by CM will need to be subsidized by alternate methods.	Working with all areas to connect resources for a 'total' plan will help this unique group of members find the right resources. With Pyx and other virtual resources, we can help find what works and get support delivered.	This ITM will transfer to POP Health as SUD screening and assessment will not be in the 2022 BH PIP. A robust full BH plan is being developed.
#7) to address barrier: Enhanced case management for the SUD involved Justice Involved populations, including increased face to face contact,	SWOT showed lack of DOC to LDH coordination around member history and release dates.	There will be a very dedicated CM focus on DOC members in 2022 for support and therefore would expect	This ITM will transfer to POP Health as SUD screening and assessment will

and care coordination for members to ensure appropriate continuity of care. * Due to COVID-19 virtual meetings and Telehealth are being utilized more concerning direct contact.	Coordination prior to release is still a barrier and at this time not one that Aetna can resolve.	better follow-up once released regardless of DOC communication.	not be in the 2022 BH PIP. A robust full BH plan is being developed.
#8) to address barrier: Enhance case management for the involved Adolescent population, including referrals to Breakthrough and care coordination for members to ensure appropriate continuity of care	This population must be accessed through a guardian/parent and many are already working via other services, like Social Services, on getting help for this young age group.	Aetna's BH team is looking at working with schools and community centers around BH needs for this group so services can be referred and used by a trusted source.	This ITM will transfer to POP Health as SUD screening and assessment will not be in the 2022 BH PIP. A robust full BH plan is being developed.
#9) to address barrier: Lack of follow-up with members 30 days after Opioid Overdose: Utilization of Follow-Up recovery resource to assist in the ongoing opioid treatment for the involved members within this population who had a previous ASAM Opioid admittance, as long as it is an ongoing and lower level.	This metric was put into place to show the early step-down coverage or adherence of members. Although it has been performing quite high, it is to help focus efforts in early days when recidivism is tenuous.	This metric for Opioid treatment is good but research is showing long term, POD days, is key to long term success.	This metric will roll into the BH PIP for 2022 as it helps support efforts to have effective FUA continuum of care for all SUD diagnoses.
#11) Reduce 30-day readmission rates for members that have been in a residential or inpatient setting receiving services specifically for detox (medical) and/or residential services. Through increased continuity of care to treatment (ASAM 3.7, 3.5, 3.3 or perhaps 2.1 as indicated) following discharge from 4-WM (medically managed detox in the hospital	This metric was defined to understand how many members are admitted to lower levels of care once discharged from a detox treatment, IP, facility. We did not include ED admissions. The hope was to see a large portion of members continue care but less than 50% have.	This metric shows how difficult it is to get and keep members in the level of treatment they need for a true step-down approach. There will be a review to understand is it lack of knowledge/resources/or approval that keeps the numbers low.	This metric will be redefined to align to FUA, the only SUD piece, to understand what portion of members in the ED go to the right next step. This will be changed once detailed PIP's are released from LDH.
#12) Intervention to address recidivism of OUD: Proposal ITMS (NEW OTP Patients enrolled in CM). This requested ITM helps to support not only the POD metric, but the network of OTP's that administer Methadone.	This ITM was requested by LDH. It was noted that the OTP's provide CM which is built into the code H0020. The CM portion is for those members also enrolled in Aetna CM.	There was a potential for conflicting treatment plans so although those with more than one CM qualifying issue were contacted, the main focus was on other health needs to support the overall welfare of the member.	This ITM will transfer to POP Health as SUD screening and assessment will not be in the 2022 BH PIP. A robust full BH plan is being developed

References

List any references that you cite.

CDC (2019) Annual Surveillance Report of Drug-Related Risks and Outcomes
https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf

CDC (2019, June 27) Centers for Disease Control and Prevention
https://www.cdc.gov/drugoverdose/data/statedeaths.html

National Institute on Drug Abuse -NIH (2019, May) Louisiana Opioid Summary
https://www.drugabuse.gov/opioid-summaries-by-state/louisiana-opioid-summary

American Hospital Association (2020) Treatment Options for Opioid Use Disorders
https://www.aha.org/bibliographylink-page/2018-09-28-treatment-options-opioid-use-disorders

LDH (2019) Louisiana's Opioid Response Plan
http://ldh.la.gov/assets/opioid/LaOpioidResponsePlan2019.pdf

Office of National Drug Control Policy (2019, January) National Drug Control Strategy
https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf

State of Louisiana (2017, October 19) The Louisiana Substance Abuse Prevention Strategic Plan
https://gov.louisiana.gov/assets/Programs/drugpolicy/20172021LASubstanceAbusePreventionStrategicPlan.pdf

Glossary of PIP Terms

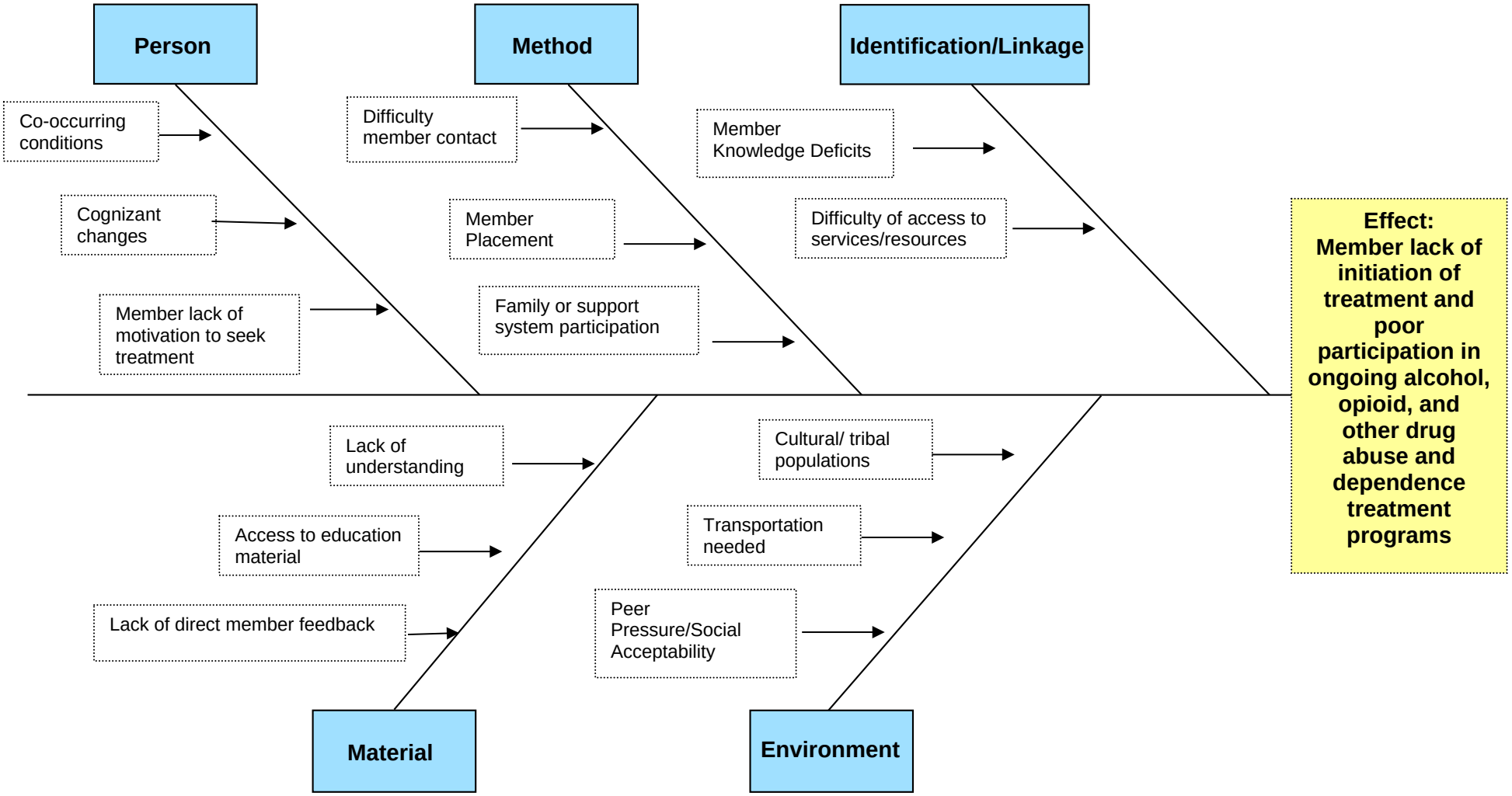
Table 7: PIP Terms

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

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

Appendix A: Fishbone (Cause and Effect) Diagram

Appendix A: Member Cause and Effect ("Fishbone") Diagram



Appendix A:

Member Challenges/Opportunities for Improvement
For the member, there are significant causative factors for their reluctance to receive services necessary for sobriety. They are:

Person:

- Members lack of motivation to seek treatment
    - A members' negative experience with a prior treatment center, and/or with self-treatment.
    - Stigmas associated with alcohol or drug use may prevent an individual from seeking treatment.
    - Members' may have participated in treatment in the past and have a belief that the treatment was not beneficial or helpful to them.
    - Injection drug users or person's alcohol dependent may fear treatment due to withdrawal symptoms.
    - Cognitive changes, clear thinking may be a challenge for heavily drinking/using SUD members
- Co-occurring conditions, nicotine abuse
- Cultural, race, ethnic variances and social determinants to care
- Development of questionnaires/survey to allow direct member feedback on services received through the MAC events

Method:

- Member knowledge deficit of available treatment options, to include web-based telemedicine or tele-therapy alternatives for treatment
- Member placed at incorrect level of care
- Lack of family and/or other support system engagement in therapy

Linkage/Support:

- Members' knowledge deficit of services and treatment options available to them
- Members' knowledge deficit of available case management services available to assist them in obtaining referrals to treatment and coordination of their care with specialized providers

Material:

- Member knowledge deficit of disease processes, treatment types, and available resources
- Difficulty accessing educational material and/or understanding of available material

Environment:

- Lack of transportation to and from appointments
- Social acceptability of alcohol and prescription drug use and peer pressure to drink and attend social drinking functions, and member use of family and/or availability of support system
- Tribal populations, cultural variances

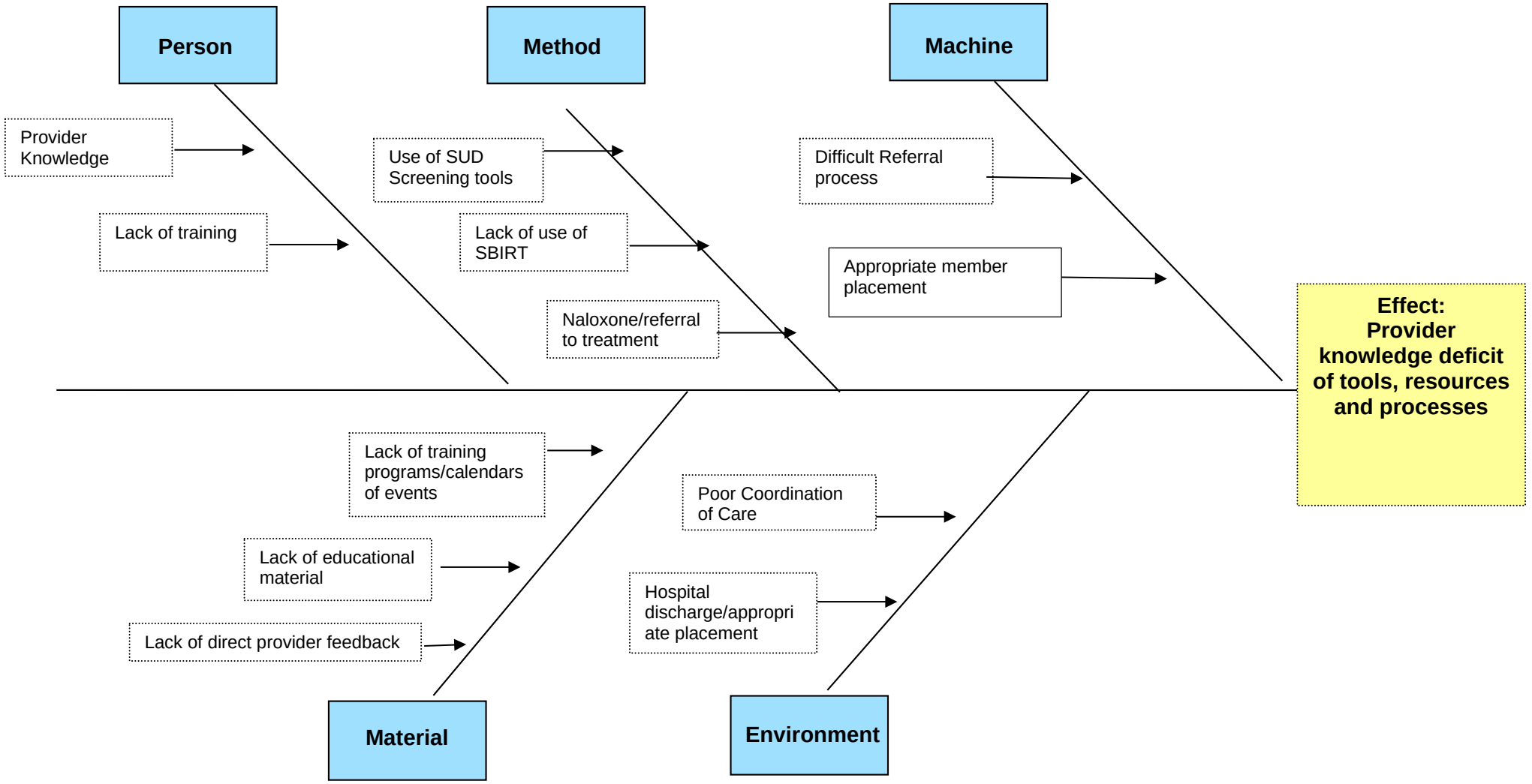
Opportunities for Improvement:

- By analyzing the causative factors, ABH-LA can implement actions to improve our members' participation and continuing treatment. This can be completed by:
- Increasing member participation in treatment by addressing the reasons for lack of participation in therapy and/or for not continuing treatment.

- Improved member utilization of health plan resources and services available to them, including member services, case management, and provision of resource materials in clear, easy to read language, including those for our tribal populations
- Improve member usage of telemedicine and tele-therapy options, especially for tribal populations in rural communities
- Ease of access to member educational material in an easy to understand language
- Member education regarding transportation services available
- Inclusion of the family and/or member support system by case management and the provider in the care planning process when appropriate and permitted by the member

Appendix B: Fishbone (Cause and Effect) Diagram

Appendix B: Provider Cause and Effect ("Fishbone") Diagram



Appendix B: Provider Challenges/Opportunities for Improvement

The provider faces other challenges in meeting the needs of their patient(s). The significant causative factors facing them include:

Person:

- First line provider (primary care, urgent care, OB/GYN, pain management, and ED settings) knowledge deficit of treatment options available to the member
- Insufficient First Line providers trained to provide evidence-based Medication Assisted Treatment (MAT) of opioid use disorders, specifically buprenorphine
- Lack of providers trained to initiate ED-initiated buprenorphine treatment and assurance of member appropriate inpatient and outpatient services for engagement in treatment for drug abuse
- Lack of provider awareness of Tribal variances in the prevention of abuse or misuse of drugs or alcohol
- Lack of provider promotion and engagement of members with nicotine co-dependency in tobacco cessation programs
- Develop process to obtain direct provider feedback, through PAC events for services and information provided by plan.

Method:

- Lack of use of Universal SUD screening tools by all first line providers (primary care, urgent care, OB/GYN, pain management, and ED settings),
- Lack of First Line provider use and endorsement of SBIRT (Screening, Brief Intervention, Referral to Treatment).
- First line providers lack of understanding of reasons for patient resistance and ambivalence and use of motivational interviewing techniques
- Lack of soft transfer of members to a substance abuse treatment center, MAT or 12 step-programs after a response to an overdose and Naloxone use.
- First line provider and/or treating provider engagement with member's family and/or support system
- Lack of promotion of available benefits and services available for all members, tribal action plans for their populations (TAP), and our members with nicotine dependency

Machine:

- Completion of comprehensive evaluations to the appropriate type/level of care and connection to that determined type/level of care
- Difficult processes for ease of referral of members to treatment
- Prescribing practices of opioid and controlled substances

Material:

- Lack of provider education of Universal SUD screening tools, MAT, SBIRT, TAP
- Lack of educational programs or material for ED departments, regarding protocols for ED-initiated buprenorphine treatment and lists of resources available post treatment.

Environment:

- Lack of coordination of care between the primary care physician, hospital, and care management/discharge planner results and treatment providers.
- Inadequate discharge planning and care coordination by Emergency Room staff has a significant role in member not receiving treatment post discharge.

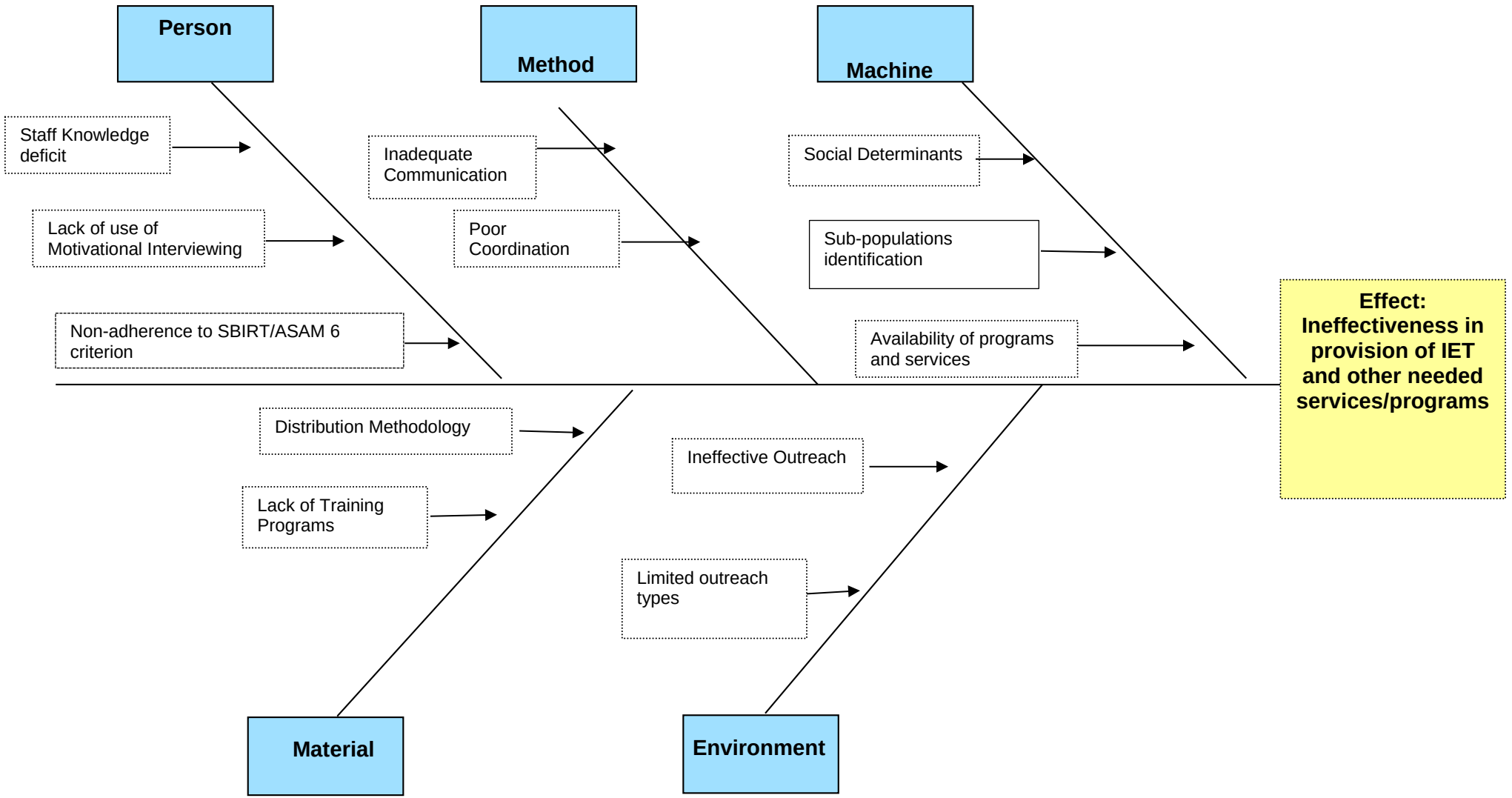
- Inadequate hospital discharge planning and care coordination has a significant role in the success of treatment and relapse.

Opportunities for Improvement:

By analyzing the causative factors, ABH-LA can implement actions to improve availability of services and quality of services provided to our members. This can be done by:

- First line provider SBIRT/TAPS training and/or certification (primary care, urgent care, OB/GYN, pain management, and ED settings) to ensure correct type/level of care placement.
- MAT Training of First Line and ED providers. MAT training allows the primary care team to be able to adequately identify those in need of services and dispense the appropriate information to members.
- ED Settings: ABH-LA collaboration with hospital for MAT education/certification of ED providers regarding protocols for ED-initiated buprenorphine treatment.
- Provider educational handouts of available tobacco cessation programs for members with nicotine dependency
- First line provider education including treatment options available and member referral process for members who screen positive
- Inpatient Settings: Development of communication flowchart to map existing and developed enhanced communication processes between the hospital, MCO Utilization Management (UM) staff and MCO Care Management (CM) staff.
- Track and trend proportion of members discharged who received evidence-based comprehensive discharge planning
- Track and trend prescribing practices for opioid and controlled substances, with Health Plan medical director intervention for identified variances in practice

Appendix C: Health Plan Cause and Effect ("Fishbone") Diagram



Appendix C: Health Plan Challenges/Opportunities for Improvement
The Health Plan faces other challenges in meeting the needs of provider and member. The significant causative factors facing them include:

Person:

- Care Management staff knowledge deficit of evidence-based practice, treatment options, and available services
- Care Management utilization of motivational interviewing skills
- Care Management staff knowledge deficit of SBIRT/TAPS, and ASAM 6 Dimension and patient placement criterion
- Care Management knowledge deficit of available substance abuse providers within our network
- Lack of Peer Support resources within the plan to work with impacted members, given that peer support is an evidence-based intervention at present under-utilized by the plan.

Method

- Inadequate communication between UM/CM/Discharge planners and outpatient providers
- Inadequate communication between CM with the primary care physician, member, the member's family or support system with member approval for communication

Machine:

- Identification of population of risk and sub-populations
- Claims lag of three months for early identification of members with alcohol and/or substance abuse disorders
- Availability of services for treatment of alcohol and substance abuse disorders, and those for tribal members
- Availability of tobacco cessation programs for members with nicotine co-dependency

Material:

- Lack of provider and member educational material
- Lack of training programs for PCPs, Hospitalists, ED department physicians, and OB/GYNs
- Distribution methodology

Environment:

- Ineffective CM telephonic outreach, limited face-to-face interactions
- Limited member outreach i.e. IVR telephone post hospital discharge to the provider and/or to the member (adults only), text messages to the adult member

Opportunities for Improvement:

- By analyzing the causative factors, ABH-LA can implement actions to improve availability of services and quality of services provided to our members. This can be done by:
- Annually assess the characteristics and needs, including social determinants of health, of its member population, and needs of our sub-population
- Improved Care Manager utilization of motivational interviewing when conducting their comprehensive assessment, including substance abuse and pain management
- Improving member participation in alcohol and substance abuse programs, including those with nicotine dependency
- Improved care planning for members with uncontrolled pain, including alternative treatment options/ monitoring for misuse and abuse
- Ensuring improved communication/ service provision through annual training and ongoing education of Care Managers representatives of alcohol and substance abuse disorders, treatment options, and available resources
- Communication flowchart to map utilization patterns between UM/CM/hospital discharge planners and outpatient providers to improve coordination of care.

- Improving care coordination between ABH-LA Utilization Management and Care Management departments with hospitals and emergency rooms, and outpatient treatment

Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	Access to appropriate/inconsistent data Low provider engagement Limited number of providers Member awareness (educational opportunity) Staffing stretched thin, filling multiple hats – in process	
Less Feasible to Address	Narrow capacity and focus within the team Stigma from members/providers SBIRT training for providers	Limitations to number of members who can receive MAT per provider

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

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Dedicated Analyst for Reporting • Multidisciplinary team to work on PIP • Good grasp of what's needed to be done to provide support for PIP • National Opioid Task Force within ABH-LA • National Opioid CM Project -Champion • BH MD who is double board-certified in Psychiatry & Addiction Medicine • Consistent, timely & scheduled workgroup activities • Increased & complete documentation of activities • Active tracking of interventions	***minimize*** **WEAKNESSES** • Access to appropriate/inconsistent data • Staffing: stretched thin; filling multiple hats • Narrow capacity and focus within the team • Member and provider feedback – need to create
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** • Community Outreach • Access to MAT in rural communities • Possible CEUs for education and training • Partnership with external entities such as providers & affect community/population • Participation of providers to drive PIP • OTP Clinics now in Network - methadone • Suboxone now available without a PA • Member Awareness and Education – collaboration with providers	***protect from*** **THREATS** • Low Provider/member engagement; survey responses • Stigma from members and providers of SUD and MAT • Limitations to number of members that can be treated by any practitioner's federal law which creates a barrier to access • Targeted & focuses conversations with appropriate providers • Limited number of appropriate providers in the state

4a. Barrier analysis/susceptible subpopulations: Not Met. Conduct a barrier analysis for the justice involved subpopulation.

Justice Involved Subpopulation SWOT Analysis:

Strength	Weakness

• CM completed two video conference w/member prior to release from correctional facilities
  o Complete Health Risk questionnaire
  o Coordinate PH and BH appointment
  o Assist with Transportation Needs as required
• Above average appointment adherence (Members Contacted)
• Coordinate with external facilities (Permanent Supportive Housing)
• Only MCO with agreement w/Urban League for member referral
	• Limited Internal Resources
	•

Opportunities	**Threat**
• Better reporting on member release locations • Limitation to Medical Record History • Need to have the ability to assist in the prioritization of how members are being accessed as high risk to ensure appropriateness of scale. • Additional visibility into DOC release process for member being released would allow the MCO to assist in the capturing of Member Demographic Information (when member completes Medicaid Application, they do not always have their physical address information, so DOC address is used.)	• Staffing limitation at DOC facilities can impact the video conferencing. • Overall program concern – members release date modification w/o notification to the MCO's (does not allow MCO's to make the initial contact or complete video conference) • Would like to have all these members in a warm hand-off to ensure that MCO's can positively effect engagement rates

DOC LDH Liaison/Coordinator is aware of these issues

Appendix D: Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
1. Improve the rates for Initiation of and Engagement in Alcohol and Other Drug Abuse or Dependence Treatment to the next highest Quality Compass percentile (or by 10 percentage points)	First-line medical provider knowledge: PCPs: youth, adult, OB/Gyn ED providers	- Understanding Stages of Change and motivational interviewing for SUD -SBIRT training: adult, youth -ASAM criteria for level of care/transitions in care training - MAT waiver-training and local SUD treatment resources - Staff and providers may not be aware of the IET timeline specifications	Implement innovative approaches for training providers in (SBIRT) Adult and Adolescent specific screening, brief intervention, triage and referral to ASAM evaluations in first-line medical settings. - Prompt ASAM level of care evaluations/referral to treatment for those members presenting at the ED/inpatient with SUD overdoses. - First-line medical provider education supporting screening, brief intervention and referral (Stages of Change, motivational interviewing, knowledge of available treatment/services/providers)	Partnered with ASAM to provide free training for both ASAM Level of Care and MAT for all Providers, throughout the year. We also had a BH webinar where we did a demonstration of the ASAM tool for reference. In addition, we contracted with a private resource to deliver SBIRT training, free of charge, to all providers and Aetna areas aligned to the PIP.
			Waiver training to increase MAT prescribers statewide	Offered free training to help Providers expand their treatment options.
			Implement innovative statewide intervention to increase MAT prescriber knowledge of local evidence-based psychosocial treatment resources and referral procedures to higher levels of care	In October of 2020, the MCO's began meeting to discuss some of the challenges in delivering this type of training to providers. Its not determined if the lack of training is due to the Pandemic demands on Providers or some other reason. 2021's approach will be to align MCO's efforts and partner with other public health resources like LSU.

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
2. Improve the rates for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence to the next highest Quality compass percentile (or by 10 percentage points)				
	Member Engagement: Youth, adult, all SUD involved SHCN subpopulations eligible for CM: First-line medical provider knowledge: PCPs: youth, adult, OB/Gyn ED providers	-Members in Pre-Contemplation Stage of Change Vulnerability of SHCN sub-populations -SDOH impeding service delivery - Understanding Stages of Change and motivational interviewing for SUD -SBIRT training: adult, youth -ASAM criteria for level of care/transitions in care training - MAT waiver-training and local SUD treatment resources - Staff and providers may not be aware of the IET timeline specifications	SHCN Case Management: Implement innovative approaches to conduct motivational interviewing techniques, with increased face-to-face engagement with members (Recovery coaches, Life coaches BH advocates, etc.) – Establishment and Utilization of Peer Support resources to function as recovery coach resources and provide needed interventions for the members. The structure for this already exists within the plan, as there is a Recovery and Resiliency Administrator within the System of Care team, whose function is intended to be to supervise and direct member-facing peer support staff, i.e., in this instance, recovery coach staff and related resources.	We designed a program around Recovery Coaches to help with those admitted, for all ages, in the follow-up and continuity of care given the diagnosis. Unfortunately, due to COVID and 5 named storms hitting the state of LA we were not able to successfully launch this effort. However, we did send our CM's through SBIRT training to assist with the motivational interviewing techniques to help assess the members for proper ongoing care. The face to face expectation for this assessment was restricted due to the Pandemic. The CM's still did the interviewing but through telephonic outreach.
			Implement innovative approaches for training providers in (SBIRT) Adult and Adolescent specific screening, brief intervention, triage and referral to ASAM evaluations in first-line medical settings. - Prompt ASAM level of care evaluations/referral to treatment for those members presenting at the ED/inpatient with SUD overdoses. - First-line medical provider education supporting screening, brief intervention and referral (Stages of Change, motivational interviewing, knowledge of available treatment/services/providers)	SDoH program was launched in September 2020 and was applied to our entire member base with the help of the CM's and MS. We also enlisted online tools like Unite US and Aunt Bertha to help provide resources as will for members as needed. The SDoH campaigns go to all new members as a part of our Welcome process.

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
3. Improve the rates for the percentage of new opioid use disorder (OUD) pharmaco-therapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD to the next highest Quality compass percentile (or by 10 percentage points)	Increasing access to Pharmacotherapy options for those members diagnosed with OUD Increasing POD treatment to ≥ 6 months	Reducing recidivism for OUD members Reducing overdoses or fatalities of OUD members Improving long term success rates with OUD members Increasing community tenure with prolonged outpatient treatment Reduction of ED events as an outcome of OUD	SDoH to help identify those members who are most at risk for OUD and define specific types of treatment Provider education on the allowance on any provider to write a prescription for certain MAT drugs that previously required specific training and waiver Member education on increased access of drugs that will help replace opioid addiction for long term abstinence Build a model for members who need long term treatment which will include facilities that allow MAT prescriptions	Linkage of members to community resources that are available via their location, like Aunt Bertha and Atlas CM actively doing motivational interviewing with members who may have been recently diagnosed with an SUD CM following members, who opt in, to make sure they stay in treatment, and have access to all the resources needed such as prescriptions and therapy Working with preferred vendors to find the best process for long term support and care for successful abstinence

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.	•	•	•