Healthy Louisiana Performance Improvement Project ADHD (PIP)

Please use this template to complete your PIP Interim Report and Final Report.
For detailed instructions, examples, PDSA worksheet and glossary of terms, refer to version: HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples.

MCO Name: Amerihealth Caritas Louisiana

Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD

2016- 2018

Project Phase: Baseline
Original Submission Date: 6/30/2017
Revised Submission Date: 10/12/17
Project Phase: Interim
Submission Date: 6/30/2018
Revised Submission Date:
Project Phase: Final
Submission Date: 6/28/2019
Revised Submission Date: Click here to enter a date
Project Phase: Choose an item
Submission Date: Click here to enter a date
Revised Submission Date: Click here to enter a date

Submission to: IPRO
State: Louisiana Department of Health

MCO Contact Information

1. Principal MCO Contact Person

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

Cindy Leatherwood
Quality Performance Specialist
843-452-0763
cleatherwood@amerihealthcaritasla.com

Interim Report: *Cindy Leatherwood* 6/28/2018
Final Report: *Cindy Leatherwood* 6/28/2019

2. Additional Contact(s)

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

Mary Scorsone
Director of Quality Management
225-300-9115
mscorsone@amerihealthcaritasla.com

Rhonda Baird
Manager of Quality Management
225-300-9111
rbaird@amerihealthcaritasla.com

3. External Collaborators (if applicable): NA

4. <u>For Final Reports Only</u>: If Applicable, Summarize and Report All Changes in Methodology and/or Data Collection from Initial Proposal Submission:

NA

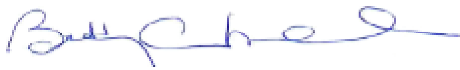
5. Attestation

Managed Care Plan Name: AmeriHealth Caritas
Title of Project: Improving the Quality of Diagnosis, Management, and Care Coordination of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD)

Required Attestation signatures for PIP <u>Proposal</u> and PIP <u>Final</u> Report:

(1) Medical Director or Chief Medical Officer; (2) Quality Director or Vice President for Quality

The undersigned approve this <u>PIP Proposal</u> and assure involvement in the PIP throughout the course of the project.


Betty Muller, M.D.

12/30/2016

Mary Scorsone, RN

12/30/2016

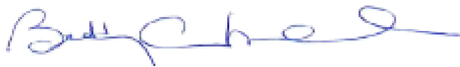
IS Director Signature (when applicable)
Printed Name

Date

Kyle Viator

12/30/2016

The undersigned approve this <u>FINAL</u> PIP Report:


Betty Muller, M.D.

6/26/2019

Mary Scorsone, RN

6/26/2019

IS Director Signature (when applicable)
Printed Name

6/26/2019

Kyle Viator

6/26/2019

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Abstract

The Abstract should be drafted for the Interim Report and finalized for the Final Report submission. Should not exceed 2 pages.

Provide an abstract of the PIP highlighting the project topic, rationale and aims, briefly describe the methodology and interventions, and summarize results and major conclusions of the project (refer to instructions in full report template or appendix).

Project Topic/Rationale/Aims

Title of Project: Improving the Quality of Diagnosis, Management, and Care Coordination of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD)

Rationale for Project: Attention Deficit/Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children (Feldman and Reiff, 2014). According to a recent article published in the New England Journal of Medicine, high prevalence rates suggest over-diagnosis (Feldman and Reiff, 2014). American Academy of Pediatrics (AAP) guidelines advise that physicians assess the severity of the preschool child's ADHD prior to prescribing medication, and that pharmaceutical interventions be reserved for those preschoolers with moderate to severe dysfunction, i.e.: symptoms that have persisted for at least 9 months, dysfunction that is manifested in both the home and other settings such as preschool or child care, and dysfunction that has not responded adequately to behavior therapy (Subcommittee on ADHD, 2011). The AAP guidelines recommend behavior therapy as the first line of treatment for preschool-aged children (four to five years of age) and advise primary care clinicians to assess for coexisting emotional or behavioral conditions (Subcommittee on ADHD, 2011). A national study revealed that among U.S. Medicaid-enrolled children aged 3-18 years, those with ADHD comprised 50% of antipsychotic users, and 15% of antipsychotic use was among youth diagnosed exclusively with ADHD (Matone et al., 2012). Therefore, the prescription of both ADHD and antipsychotic drugs for children with ADHD merits closer monitoring for appropriateness, safety and effectiveness.

Project Aims: The Collaborative PIP aims to improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, community, and provider interventions to improve rates of each performance indicator and process measures located in the PIP below.

Methodology

Eligible Population: See below

Hybrid Analysis of Overall Quality of Care for ADHD Population

The majority of the performance indicator data for this PIP will be obtained via the Hybrid Method on an annual analysis of medical record review based on specifications set forth by IPRO and LDH. The Eligible population is identified as members less than or equal to 20 years of age who had a PCP visit during the measurement period and were continuously enrolled for 240 days (8 months) prior to the Index Start Date and 90 days (3 months) after the Index Start Date. The Index Start Date is identified by the date of earliest Index Event (Diagnosis of ADHD or Dispensing of ADHD Medication, whichever occurs first) during the specified Intake Period (120 days (4 months) prior to diagnosis or dispense).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

The specifications for Follow-Up Care for Children Prescribed ADHD Medication (ADD) are located in the HEDIS® 2017/2018 Technical Specifications for health plans. HEDIS® certified codes are utilized. Chart reviews are used to supplement administrative claims for the ADD HEDIS® population. Extraction procedures are based on the IPRO/LDH specifications noted above. Children with newly prescribed ADHD medication are identified by using an Index Prescription Start Date (IPSD) that includes a negative medication history timeframe of 120 days (4 months) prior to the new prescription or refill. Additional specifications require reported rates of at least 3 follow-up care visits within a 10 month period following the IPSD; the first within 30 days post prescription (Initiation) and the following two within the remaining 270 days (9 months) post prescription (Continuation and Maintenance). The number of medication treatment days during the 10 month follow-up period must be greater than or equal to 210 days (300 days with allowable 90 day gap).

Modified HEDIS® Follow-Up Care for Children Prescribed ADHD Medication (ADD)
A modified administrative data collection for the ADD HEDIS® measure will be included in the analysis of the overall quality of care for the ADD population. The modification will include the addition of data collection regarding the percentage of any ADHD cases less than or equal to 20 years of age, stratified by age, with documentation of pharmacotherapy with or without behavior therapy. The eligible population is identified as any ADHD case identified by either a diagnosis or medication claim during the Administrative measurement period (age determined as of the last day of the measurement period).

Description of Annual Performance Indicators: See below

- Indicator: A1: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument.
- Indicator : A2: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple (two or more) settings (i.e., home and school). (Note: children not yet in a daycare/school setting may be a denominator exclusion.)
- Indicator: A3: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress).
- Indicator: A4: The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation whose PCP documented positive findings (i.e. positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions).
- Indicator: A5: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes whose PCP documented a referral to a specialist behavioral health provider for treatment of alternate causes of presenting symptoms and/or co-occurring conditions.
- Indicator: A6: The percentage of the eligible population sample who received PCP care coordination (e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination).
- Indicator: A7: The percentage of the eligible population sample who received care coordination services from the Healthy Louisiana Plan care coordinator.
- Indicator: A8: The percentage of the eligible population sample who were outreached by the Healthy Louisiana Plan care coordinator.
- Indicator: A9: The percentage of the members outreached who were engaged in care management.
- Indicator: A10: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD.

- Indicator : B1: HEDIS ADD measure (Follow-up Care for Children Prescribed ADHD Medication), expanded to younger children and adolescents: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication with at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported for the eligible subpopulation who were prescribed ADHD mediation:

- Indicator: B2: Non-HEDIS Administrative Measure - Children With and Without Behavioral Therapy. Description: Percentage of any ADHD cases aged 0-20 years, stratified by age (as of end of Measurement Period) and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics) and with/without behavioral therapy.

Sampling Method: AmeriHealth Caritas Louisiana's Medical Economics (Informatics) Department will collect data from claims/encounter files of all eligible members. Data sources may include: claims/encounter data (administrative data) and hybrid (medical/treatment records and administrative). Administrative data collection will occur on a quarterly basis with hybrid collection and analysis included on an annual basis.

Baseline and Re-measurement Periods: Baseline: Hybrid Measurement-2/1/15-2/29/16 (+ 4 months preceding 6/1/15 and 3 months following 11/31/15). HEDIS Measurement Year 2016 and Non-HEDIS Admin Measure 1/1/16-12/31/16. Interim: Hybrid Measurement-10/1/16-10/31/17. HEDIS Measurement Year 2017

and Non-HEDIS Admin Measure 1/1/17-12/31/17. Final: Hybrid Measurement-10/1/17-10/31/18. HEDIS Measurement Year 2018 and Non-HEDIS Admin Measure 1/1/18-12/31/18.

Data Collection Procedures: Data is collected by Administrative Claims and Hybrid Medical Record Review.

Interventions

Member Barriers Identified: Lack of member adherence to recommended guidelines for follow up; Lack of keeping follow up appointments; Lack of member knowledge of ADHD diagnosis, treatment, and available resources as well as the need for behavioral therapy; Lack of member engagement in plan sponsored care coordination; Lack of member knowledge of ADHD diagnosis, treatment, and available resources as well as the need for behavioral therapy for the < 6 and 13-17 year old age groups; Lack of compliance and/or documentation of recommended behavior therapy as first line treatment for diagnosis; Lack of compliance and/or documentation of recommended behavior therapy as first line treatment for diagnosis.

Interventions to address member barriers: The plan continues to work with members to increase recommended ADHD care. The Plan's IHCM team outreaches to members 6-12 and <6 to encourage appropriate follow-up with their provider and BH therapy if ordered. The plan also distributes gift cards to the 6-12 age group for follow-up visits. Educational letter to the 13-17 yo ADHD population. Outreach to the 13-17 year old population diagnosed with ADHD, on BH drugs W/OUT BH Therapy and who have a comorbidity. The goal of the outreach is to identify why members are not receiving BH therapy (identify barriers), also to identify their functional status as the member may not need therapy and also to identify if "Lack of BH Providers" is a barrier.

Provider Barriers Identified: Lack of available BH specialized providers for member referral, evaluation and treatment, and PCP collaboration; lack of PCP knowledge of available BH providers within network. Lack of PCP member referral to BH specialists; Lack of available provider BH resources; Lack of provider/specialist collaboration; Lack of reimbursement (incentive) for host provider requesting tele-consultation; Inconsistent provider use of recommended and thorough screening tools for evaluation to ensure appropriate diagnosis of ADHD; Insufficient use of available resources. Lack of user-friendly, easily accessible BH toolkit; Lack of provider adherence to ADHD recommendations;

Interventions to address provider barriers: The plan continues to work with providers to build a network of providers in all parishes of the state trained in evidence-based treatments for children 0-6, e.g., Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT) and also provide behavior therapy training to providers. (may include Positive Parenting Program (Triple P), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent Management Training (PMT). The plan has sponsored Triple P Training as well as hosted Preschool PTSD Training for providers. The plan is working with providers to promote the AAP and PCP BH ADHD Toolkit. Provider Network Management is currently outreaching to the high prescribing PCP providers to promote/educate the AAP ADHD toolkit. The "Medical Neighborhood" Initiative is evolving into "Project Echo". "ACLA is currently working on marketing this project to providers. The "Medical Neighborhood" initiative will be retired at this time and once "Project Echo" is fully implemented, we will develop a process measure to support this initiative. The plan is also working to improve/enhance provider education for ADHD and also information on the PHQ 9 initiative. ACLA has developed an "Integrated Health Care Screening Tool" Flyer. This flyer explains what the Patient Health Questionnaire, (PHQ) is and where it can be found on the Plan's website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The Plan's Account Executives will distribute the flyer when they make their provider visits.

Results

Report Data for Annual Performance Indicators: See below

A1. *Validated ADHD Screening Instrument*:

This measure decreased from baseline 18.33% to 16.67% at Interim and increased to 22.22% at Final.

A2. *ADHD Screening in Multiple Settings*:

This measure decreased from baseline 16.67% to 12.12% at Interim and increased to 12.70% at Final.

A3. *Assessment of other behavioral health conditions/symptoms*:

This measure increased for Interim and then had a decrease at Final, Baseline 26.67%, Interim 27.27% and Final 14.29%.

A4. *Positive findings of other behavioral health conditions*:
This measure trended upward for the three year measurement periods; Baseline 93.75%, Interim 94.44% and 100% Final.
A5a. *Referral for EVALUATION of other behavioral health conditions*:
This measure increased for Interim and then had a decrease at Final, Baseline 46.67%, Interim 52.94% and Final 33.33%.
A5b. *Referral to TREAT other behavioral health conditions*:
This measure demonstrated a decrease during the three measurement years; Baseline 40.0%, Interim 11.76% and Final 11.11%.
A6. *PCP Care Coordination*:
This measure increased for Interim and then had a decrease at Final, Baseline 5%, Interim 36.36% and Final 12.70%.
A7. *MCO Care Coordination*:
This measure increased for Interim and then had a decrease at Final, Baseline 3.39%, Interim 9.09% and Final 22.22%.
A8. *MCO Outreach with Member CONTACT*:
This measure trended upward for the three year measurement periods; Baseline 16.67%, Interim 18.18% and Final 46.03%.
A9. *MCO Outreach with Member ENGAGEMENT*:
This measure increased for Interim and then had a decrease at Final, Baseline 22.22%, Interim 33.33% and Final 8%.
A10. *First Line Behavior Therapy for Children <6 years*:
This measure decreased from Baseline to the Interim MY, 3.33% to 0%, there were no members out of the identified 30 members that received evidence-based behavior therapy as a first-line treatment for ADHD. The rate increased to 6.90% for the Final.

B. ADMINISTRATIVE Measures (utilizing encounter/pharmacy files):
HEDIS Administrative Measures:
Measure B1a. Initiation Phase.
This measure increased from Baseline to the Interim MY, 34.73% to 53.19% and decreased for the Final MY, 49.17%.
Measure B1b. Continuation and Maintenance (C&M) Phase.
This measure trended upward for the three year measurement periods; Baseline 45.15%, Interim 64.98% and 65.53% Final.

Non-HEDIS Administrative Measures:
Measure B2a. BH Drugs WITH Behavioral Therapy.
This measure trended upward for the three year measurement periods; Baseline 22.6%, Interim 28.0% and 29.3% Final.
Measure B2b. BH Drugs WITHOUT Behavioral Therapy.
Baseline to Interim: This measure trended downward for the three year measurement periods; Baseline 57.6%, Interim 48.8% and 48.6% Final.

Conclusions

Interpret improvement in terms of whether or not Target Rates were met for annual performance indicators: Although aggressive target rates for the Hybrid chart reviews were not met for all measures, the plan did see a positive trend across all three measurement years in measures A7 and A8; MCO Care Coordination and MCO Outreach with Member Contact. Additionally, the plan met the target goal for A8, MCO Outreach with Member Contact. A9, MCO Outreach with Member Engagement, revealed a noteworthy decline from interim to final demonstrating the challenges associated with engaging members in case management. Furthermore, the denominator for this measure doubled in size from interim to final due to the improvement in member outreach success (A8). The plan also demonstrated positive trending across all three measurement years in the Non-HEDIS Administrative Measures; B2a – Behavioral Health Drugs with Behavioral Therapy and B2b – Behavioral Health Drugs without Behavioral Therapy. The plan met both HEDIS Administrative Measure goals for Follow-Up Care for Children Prescribed ADHD Medication; Initiation and Continuation and

Maintenance. The plan acknowledges the need for improvement in PCP specific performance indicators as the additional performance indicator target goals were not met. AmeriHealth Caritas Louisiana has initiated a robust set of interventions that include: provider outreach and education; member outreach and education; and network expansion. The plan will continue to execute current interventions and expand initiatives to improve member health outcomes.

Administrative Measures:
HEDIS Administrative Measures:
Measure B1a. Initiation Phase. The target goal continued to be met for this measure.
Measure B1b. Continuation and Maintenance (C&M) Phase. - The target goal continued to be met for this measure.
Non-HEDIS Administrative Measures:
Measure B2a. BH Drugs WITH Behavioral Therapy. The target goal continued to be met for this measure.
Measure B2b. BH Drugs WITHOUT Behavioral Therapy. The target goal continued to be met for this measure.

Indicate interventions that did and did not work in terms of quarterly intervention tracking measure trends: See below

- Total number of PCP's requesting training for the "Behavioral Health" PCP ADHD toolkit-Measure, Retired.
- The number of Evidenced Based Providers that offer specialized behavior therapy. Measure updated. Numerator/Denominator updated to capture the number of BH Providers that received training.

Study Design Limitations: The prescribing physician of the ADHD medication is at times not the members PCP, resulting in lack of care coordination services for the member. Providers do not schedule follow-up appointments during the current appointment. On-going-Lack of member adherence to recommended guidelines for follow up; lack of keeping follow up appointments.
Lessons Learned and Next Steps: See Below:
Lessons Learned/Next Steps:

- There continues to be a shortage of Evidence-Based Practice (EBP) providers statewide. There is also a need for services for the 0-5 population. **/** ACLA will continue to identify and sponsor Evidence-Based Practice (EBP) Trainings for the 0-5 age group. ACLA is also working on developing a partnership with the LSU Center Practice to address training needs.

- The plan acknowledges the need for improving provider participation rates at provider trainings. **/** Continue to promote the Plan's regional provider trainings to increase participation rates.

- Providers are unaware of the toolkits availability and how to access them. **/** Continue to promote the Behavioral Health and AAP ADHD Toolkit to providers. Continue to encourage providers to sign up and utilize the AAP ADHD Toolkit.

- "Unable to Contact" members continues to be a barrier as well as "Lack of the member keeping their follow-up appointments". / Continue member outreach via telephone and educational letters. Continue educating parents on the importance of timely ADHD follow-up.

- The newly identified < 6 year old ADHD population is difficult to contact and their caregiver/parent often feel as if they don't need any additional support. / Continue to outreach to this population and evaluate any needs/barriers to care.

- There continues to be a barrier with Providers completing the PHQ-9 form. / ACLA has developed an "Integrated Health Care Screening Tool" Flyer. This flyer explains what the Patient Health Questionnaire, (PHQ) is and where it can be found on the Plan's website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The Plan's Account Executives will distribute the flyer when they make their provider visits. The flyer is also in the Provider Newsletter.

- <u>Medical Neighborhood and Integrated Healthcare initiative</u> - While providers agree with the need for integrated care, many barriers, such as lack of physical space, continue to be a problem for providers to fully implement full integration. / The “Medical Neighborhood” Initiative is evolving into “Project Echo”. .ACLA is currently working on marketing this project to providers.

1. Project Topic/ Rationale and 2. Aim

Suggested length: 2 pages

1. Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members (e.g., disease prevalence stratified by demographic subgroups):** Click here to enter text.
- **Describe current research support for topic (e.g., clinical guidelines/standards):** Attention Deficit/Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children (Feldman and Reiff, 2014). According to a recent article published in the New England Journal of Medicine, high prevalence rates suggest over-diagnosis (Feldman and Reiff, 2014). American Academy of Pediatrics (AAP) guidelines advise that physicians assess the severity of the preschool child's ADHD prior to prescribing medication, and that pharmaceutical interventions be reserved for those preschoolers with moderate to severe dysfunction, i.e.: symptoms that have persisted for at least 9 months, dysfunction that is manifested in both the home and other settings such as preschool or child care, and dysfunction that has not responded adequately to behavior therapy (Subcommittee on ADHD, 2011). The AAP guidelines recommend behavior therapy as the first line of treatment for preschool-aged children (four to five years of age) and advise primary care clinicians to assess for coexisting emotional or behavioral conditions (Subcommittee on ADHD, 2011). The AAP guidelines do not address ADHD diagnosis or treatment in children younger than four years of age, yet it has been reported that very young children are diagnosed with ADHD and prescribed psychotropic medications, particularly children with comorbid mental health and chronic health conditions (Rappley et al., 2002). A multi-state study of preschool children enrolled in Medicaid found that psychotropic drugs were most commonly prescribed for ADHD, followed by depression or anxiety and psychosis or bipolar disorder (Garfield et al., 2015). Yet, the majority of psychotropic drugs prescribed for preschoolers are off-label, i.e., neither tested or approved by the Food and Drug Administration (FDA) for use in this age group (Garfield et al., 2015). Further, inappropriate prescribing of antipsychotic medications among children for non-FDA-approved indications, such as ADHD, has been reported (Matone et al., 2012; Penfold et al., 2013). A national study revealed that among U.S. Medicaid-enrolled children aged 3-18 years, those with ADHD comprised 50% of antipsychotic users, and 15% of antipsychotic use was among youth diagnosed exclusively with ADHD (Matone et al., 2012). Therefore, the prescription of both ADHD and antipsychotic drugs for children with ADHD merits closer monitoring for appropriateness, safety and effectiveness.
- **Explain why there is opportunity for MCO improvement in this area:** The prevalence of parent-reported ADHD among publicly insured youth aged 2-17 in Louisiana during 2009 and 2010 was 45.0% (95% CI = 37.4, 52.6), significantly higher than that of publicly insured youth nationwide (35.5%; 95% CI = 33.9, 37.2%; NS-CSHCN, 2012). Corresponding ADHD medication rates for youth with ADHD were also higher (83.1% versus 74.2%); however, this difference was not statistically significant (NS-CSHCN, 2012). The American Academy of Pediatrics' (AAP) clinical practice guideline for the diagnosis and treatment of ADHD in children aged 4-18 years provides guidelines that can increase the accuracy of diagnosis, and reduce problems of over diagnosis. For example, the AAP guidelines note that for the diagnostic process to be accurate, physicians must rule out alternate causes of the presenting symptoms. Children with ADHD generally gain the attention of healthcare providers as a result of behavioral dysregulation. However, behavioral dysregulation is not unique to ADHD, but rather is a common symptom presentation in children that can result from any of numerous behavioral health concerns including depression, anxiety, trauma, or family stress (including parental behavioral health concerns). When evaluating a child for ADHD, the primary care clinician should assess whether the following alternate causes, instead of, or in addition to ADHD, may actually underlie the child's behavior: Emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct) disorders Developmental (e.g., autism spectrum) disorders Learning and language disorders While not specifically referenced in the 2011 ADHD guidelines, the role of trauma and toxic stress in contributing to behavioral dysregulation – which can also co-occur with or be mistaken for ADHD – was detailed by the AAP in 2012 when they released a policy statement (Garner et al., 2012) and technical report (Shonkoff et. al., 2012) for physicians to aid in understanding the impact of trauma and toxic stress on

children's health. The AAP guidelines also provide recommendations for both pharmacologic and non-pharmacologic management (Subcommittee on ADHD, 2011). Recommendations for pharmacologic management entail a face-to-face follow-up visit by the fourth week of medication, with monthly visits until a consistent optimal response is reached, and then every three months during the first treatment year (Subcommittee on ADHD, 2011). The HEDIS measure, "Follow-Up Care for Children Prescribed ADHD Medication" quantifies the percentage of children aged 6-12 years who were newly prescribed ADHD medication who had one follow-up visit during the 30-Day Initiation Phase, as well as the percentage with two additional visits during the continuation and maintenance phase (nine months after the Initiation Phase ended). Of the four Bayou Health Plans reporting these measures for HEDIS reporting year 2014, all of the plans' rates fell below the 95th percentile for both measures, two of the four plans' rates fell below the 50th percentile for the Initiation Phase measure, and one of the plan's rates fell below the 50th percentile for the Continuation & Maintenance Phase measure. Care coordination is another recommendation of the AAP guidelines (Subcommittee on ADHD, 2011) and is a priority of the Louisiana Bureau of Family Health (DHHD-LA, 2014). Yet, among publicly insured children with special health care needs in Louisiana, only 48.6% (95% CI = 40.3, 57.0) received effective care coordination (i.e., help with coordination of care and satisfaction with communication among providers and with schools if needed), compared to 66.7% (95% CI = 59.0, 74.3) of privately insured children. Healthy Louisiana Plans have the opportunity to participate in a statewide collaborative Performance Improvement Project (PIP) to facilitate performance improvements consistent with evidence-based recommendations for (1) diagnosis/evaluation, (2) pharmacologic management and follow-up, (3) non-pharmacologic management and follow-up, and (4) care coordination. AmeriHealth Caritas Louisiana (ACLA) identifies the disparities between treatment interventions among the statewide diagnosed ADHD population and is committed to increasing the quality of diagnoses, the overall management and care coordination of their members by developing targeted interventions tailored to address our own unique barriers.

2. Aim Statement, Objectives and Goals

Aim Statement:

The Collaborative PIP aims to improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, community, and provider interventions to improve rates of each performance indicator specified in the below goal statements:

Objective(s):

To improve the quality of care received by children with ADHD by implementing a robust set of health plan, member, community and provider interventions designed to activate the following strategies:

A. Build workforce capacity;
B. Deliver Provider Education;
C. Facilitate Access to and Provision of Behavioral Health Consultation for PCPs;
D. Enhance Care Coordination (e.g., Facilitate behavioral health referrals/ consultation; Care plan collaboration among CM, PCP, BH therapist, teacher, parent and child; Increase PCP practice utilization of on-site care coordinator)

Goal(s):

Each performance indicator should have its own unique goal. Enter a goal statement for each performance indicator, below:

A. HYBRID Measures (utilizing a random, stratified sample of new ADHD cases for chart review):

A1. ***Validated ADHD Screening Instrument***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument.

Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument will increase 19.57%, from 18.33% at baseline to 37.9% at final re-

measurement. The goal was set over the 95th Confidence Interval as the plan wants to encourage PCP's to utilize a validated ADHD screening instrument.
A2. ***ADHD Screening in Multiple Settings***: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, i.e., home and school.
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, i.e., home and school, will increase 18.83 %, from 16.67% at baseline to 35.5% at final re-measurement. The goal was set over the 95th Confidence Interval
A3. ***Assessment of other behavioral health conditions/symptoms***: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress).
Baseline to final measurement goal: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress) will increase 22.33% from 26.67% at baseline to 49.00% at final re-measurement. The goal was set over the 95th Confidence Interval.
A4. ***Positive findings of other behavioral health conditions***: The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation whose PCP documented positive findings, i.e. positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions. (*Goal setting not applicable*)
A5a. ***Referral for EVALUATION of other behavioral health conditions***: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions will increase 28.33% from 46.67% at baseline to 75.00% at final re-measurement. The goal represents a bold aim given the wide 95th Confidence Interval, which is attributable to a small sample size.
A5b. ***Referral to TREAT other behavioral health conditions***: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CsOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CsOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions will increase 29% from 40.00% at baseline to 69.00% at final re-measurement. The goal represents a bold aim given the wide 95th Confidence Interval, which is attributable to a small sample size.
A6. ***PCP Care Coordination***: The percentage of the eligible population sample who received PCP care coordination, e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination.
Baseline to final measurement goal: The percentage of the eligible population sample who received PCP care coordination, e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination will increase 11% from 5.00% at baseline to 16.00% at final re-measurement. The goal was set over the 95th Confidence Interval.
A7. ***MCO Care Coordination***: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator will increase 36.61% from 3.39% at baseline to 40.00% at final re-measurement. The goal is aligned with our outreach target goal due to the plan's outreach interventions.

A8. ***MCO Outreach with Member CONTACT***: The percentage of the eligible population sample who were outreached by the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who were outreached by the health plan care coordinator will increase 23.33% from 16.67% at baseline to 40.00% at final re-measurement. The goal is based on a statistical and member population health perspective.
A9. ***MCO Outreach with Member ENGAGEMENT***: The percentage of the members outreached who were engaged in care management.
Baseline to final measurement goal: The percentage of the members outreached who were engaged in care management will increase 37.78% from 22.22% at baseline to 60.00% at final re-measurement. The goal is aligned with the plan's enhanced care management interventions.
A10. ***First Line Behavior Therapy for Children <6 years***: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD.
Baseline to final measurement goal: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD will increase 39.67% from 3.33% at baseline to 43.00% at final re-measurement. Once interventions are initiated, the plan hopes to see significant changes and can possibly raise goal even higher.

B. ADMINISTRATIVE Measures (utilizing encounter/pharmacy files):
HEDIS Administrative Measures:

Measure B1a. Initiation Phase. The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-Day Initiation Phase.
Baseline to final measurement goal: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-Day Initiation Phase will increase 7.46% from 34.73% at baseline to 42.19% at final re-measurement. This target rate is from the 25th to the 50th Quality Compass Percentile.
Measure B1b. Continuation and Maintenance (C&M) Phase. The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.
Baseline to final measurement goal: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended will increase 7.32% from 45.15% at baseline to 52.47% at final re-measurement. This target rate is the 66.67th Quality Compass Percentile.

Non-HEDIS Administrative Measures:

Measure B2a. BH Drugs WITH Behavioral Therapy. Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITH behavioral therapy.
Baseline to final measurement goal: BH Drugs WITH Behavioral Therapy. Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITH behavioral therapy will increase 2.4%, from 22.6% at baseline to 25% at final re-measurement. This target rate is above the upper 95% confidence interval.
Measure B2b. BH Drugs WITHOUT Behavioral Therapy. Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITHOUT behavioral therapy.
Baseline to final measurement goal: Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITHOUT behavioral therapy will decrease 2.6%, from 57.6% at baseline to 55% at final re-measurement. This target rate is below the lower 95% confidence interval.

3. Methodology

Performance Indicators

HYBRID Measures A1 through A10: Follow measure specifications per instructions in the Chart Abstraction Tool, dated 8.10.16.

HEDIS ADMINISTRATIVE Measures B1a and B1b: Follow HEDIS specifications.

NON-HEDIS ADMINISTRATIVE Measures B2a and B2b: Follow measure specifications in Appendix A.

Data Collection and Analysis Procedures

Data Collection:

AmeriHealth Caritas Louisiana's Medical Economics (Informatics) Department will collect data from claims/encounter files of all eligible members. Data sources may include: claims/encounter data (administrative data) and hybrid (medical/treatment records and administrative). Administrative data collection will occur on a quarterly basis with hybrid collection and analysis included on an annual basis.

Unless otherwise specified, medical claims that are paid, adjusted or denied are included. For pharmacy claims, only paid or adjusted claims are included. These rates are calculated using administrative claims data found in the Data Warehouse unless otherwise specified. All measures are calculated with a 3-month lag time to allow adequate time for the claim submission and payment process.

Hybrid Analysis of Overall Quality of Care for ADHD Population

The majority of the performance indicator data for this PIP will be obtained via the Hybrid Method on an annual analysis of medical record review based on specifications set forth by IPRO and LDH. The Eligible population is identified as members less than or equal to 20 years of age who had a PCP visit during the measurement period and were continuously enrolled for 240 days (8 months) prior to the Index Start Date and 90 days (3 months) after the Index Start Date. The Index Start Date is identified by the date of earliest Index Event (Diagnosis of ADHD or Dispensing of ADHD Medication, whichever occurs first) during the specified Intake Period (120 days (4 months) prior to diagnosis or dispense).

Performance indicators are centered around overall quality of care for children and adolescents diagnosed with ADHD including such factors as pre-screening evaluations utilizing recommended tools and guidelines, proper referral to specialized practitioners for validation of diagnosis and treatment, utilization of recommended guidelines for treatment of children less than or equal to 6 years of age, and care coordination efforts by PCPs as well as the Health Plan itself.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

The specifications for Follow-Up Care for Children Prescribed ADHD Medication (ADD) are located in the HEDIS® 2017 Technical Specifications for health plans. HEDIS® certified codes are utilized. Chart reviews are used to supplement administrative claims for the ADD HEDIS® population. Extraction procedures are based on the IPRO/LDH specifications noted above. Children with newly prescribed ADHD medication are identified by using an Index Prescription Start Date (IPSD) that includes a negative medication history timeframe of 120 days (4 months) prior to the new prescription or refill. Additional specifications require reported rates of at least 3 follow-up care visits within a 10 month period following the IPSD; the first within 30 days post prescription (Initiation) and the following two within the remaining 270 days (9 months) post prescription (Continuation and Maintenance). The number of medication treatment days during the 10 month follow-up period must be greater than or equal to 210 days (300 days with allowable 90 day gap).

Modified HEDIS® Follow-Up Care for Children Prescribed ADHD Medication (ADD)

A modified administrative data collection for the ADD HEDIS® measure will be included in the analysis of the overall quality of care for the ADD population. The modification will include the addition of data collection regarding the percentage of any ADHD cases less than or equal to 20 years of age, stratified by age, with documentation of pharmacotherapy with or without behavior therapy. The eligible population is identified as any ADHD case identified by either a diagnosis or medication claim during the Administrative measurement period (age determined as of the last day of the measurement period).

Validity and Reliability
(For definitions, refer to Glossary of PIP Terms in HEALTHY_LOUISIANA_PIP_TEMPLATE_w_example)**:**

Medical Record abstraction data was performed by Registered Nurses proficient in medical record reviews. The nurses have experience in statutory medical record reviews and HEDIS® medical record reviews with required IRR testing. The nurses were trained on the ADHD tool and specifications set forth by IPRO and LDH and the same nurses review the records for each hybrid project to ensure validity and reliability.

Administrative data is collected by the Medical Informatics team. All HEDIS® measures are reviewed and audited via the Plan's NCQA accredited auditor. The audit also includes review of the plan's HEDIS Medical Record Review Process. Non-HEDIS measures are validated through an internal quality audit process.

Data Analysis:
ADHD administrative data for baseline to Interim to the final year were reviewed and analyzed for tracking and trending purposes.

Goals are set above/and or below the 95th confidence interval and rates are evaluated to determine if goals are met. T-Test are applied.

HEDIS data is trended monthly as well as reviewed annually and rates are compared to Quality Compass Benchmarks.

Provider Dashboards are utilized to identify rates for individual providers as well as demographics and Race, Ethnicity and Language.

3. Project Timeline

Event	Timeframe
PIP Proposal Submission Date	**Target Date: December 30, 2016**
Baseline Measurement Periods	**Hybrid Measurement**: 2/1/15-2/29/16 (+ 4 months preceding 6/1/15 and 3 months following 11/31/15) **HEDIS Measure: HEDIS Measurement Year 2016** **NON-HEDIS Administrative Measure**: 1/1/16-12/31/16
Initiate Interventions After Baseline Measurement Period	**Target 1/1/17 for initiation of interventions developed in response to provider survey findings and parent-child behavior therapy presentations.**
Baseline PIP Report Submission Date	**June, 2017**
Interim Measurement Periods	**Hybrid Measurement**: 10/1/16-10/31/17 **HEDIS Measure: HEDIS Measurement**

Event	Timeframe
	Year 2017 **NON-HEDIS Administrative Measure:** 1/1/17-12/31/17
Interim PIP Report Submission Date	**June, 2018, Updated 9/28/18**
Final Re-measurement Periods	**Hybrid Measurement**: 4/1/17-4/31/18 **HEDIS Measure: HEDIS Measurement Year 2018** **NON-HEDIS Administrative Measure:** 1/1/18-12/31/18
Final PIP Report Submission Date	**June 30, 2019**

4. Barriers and 5. Interventions

This section describes the barriers identified and the related interventions planned to overcome those barriers in order to achieve improvement.

Populate the tables below with relevant information, based upon instructions in the footnotes.
Add rows as needed.

Table of Barriers Identified and the Interventions Designed to Overcome Each Barrier. Interventions should address the each of the following intervention categories: A.Workforce capacity; B. Provider Education; C. Behavioral Health Consultation to PCPs; D. Enhanced Care Coordination (e.g., Facilitate behavioral health referrals/ consultation; Care plan collaboration among CM, PCP, BH therapist, teacher, parent and child; Increase PCP practice utilization of on-site care coordinator)

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
Lack of available BH specialized providers for member referral, evaluation and treatment, and PCP collaboration; Lack of PCP knowledge of available BH providers within network. Lack of PCP member referral to BH specialists; Lack of available provider BH resources; Lack of	Members Providers IHCM/Provider Mgt Departments	1	**Workforce capacity:** MCOs and LA DH collaborate with BH to build a network of providers in all parishes of the state trained in evidence-based treatments for children 0-6, e.g., Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT). Provide behavior therapy training to providers.(may include Positive Parenting Program (Triple P), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent Management Training (PMT) 7/2018-Up-date-. As an update, ACLA sponsored Preschool PTSD training in Shreveport at our Wellness Center on July 17, 2018, (27 Providers attended but they are not yet certified to offer this Evidenced Based	Planned Start:9/2017-ongoing

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
provider/specialist collaboration; Lack of reimbursement (incentive) for host provider requesting tele-consultation			Practice.). Intervention Tracking Measure (Numerator/Denominator updated to capture the numbers of BH Providers that received training. 9/2018 Update- ACLA is continuing to work with Healthy Blue to sponsor PTSD training through Tulane. This collaborative effort is still pending at this time. ACLA is also working with Aetna to sponsor Triple P Training for the 0-5 age group, this series of training will begin in January 2019. 10/2018 Update- ACLA is continuing to work with Healthy Blue to sponsor PTSD training through Tulane. This collaborative effort is still pending at this time. ACLA is also working with Aetna to sponsor Triple P Training for the 0-5 age group, this series of training will begin in January 2019. 1/2019 Update- o Triple P Training- Aetna and ACLA are co-sponsoring this training. The training has been postponed and is tentatively scheduled for March/April of 2019. o Preschool PTSD Training – ACLA held this training in July 2018 with 26 providers in attendance. We currently have 3 providers getting ready to complete the 6 month supervision requirement to become certified to offer this evidence-based practice. ACLA also plans to hold another training in April or May 2019. o The PTSD Training is scheduled for April 2nd, 2019 in New Orleans. 4/2019 Update- o Triple P Training- Aetna and ACLA sponsored this training on April 15th to April 18th, and certification will conclude on May 29th. 18 of the 20 Providers invited attended. o Preschool PTSD Training – ACLA hosted a Preschool PTSD Training on April 2nd at the New Orleans Wellness Center. 26 of the 50 Providers invited attended. Dr. Murphy stated that since the first training in July, 2 Providers have completed the supervision portion and become fully credentialed to offer the	

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
			EBP.	
Inconsistent provider use of recommended and thorough screening tools for evaluation to ensure appropriate diagnosis of ADHD; insufficient use of available resources. Lack of user-friendly, easily accessible BH toolkit	Providers IHCM/Provider Mgt Departments	2	**Provider Education / Outreach:** MCOs and LA DH collaborated to produce and distribute an AAP ADHD Toolkit (e.g., AAP guidelines, screening tools and guidelines, resources for referrals). Toolkit can be promoted during the Plan's Provider Trainings which include Pediatricians and Family Practice Providers. Update-The toolkit went live in 3/2018 and is available online. Providers were notified via fax blast and email. All MCO's will be meeting on 6/25/18 to discuss how to outreach to the provider community with the AAP toolkit for ADHD and how MCO's can track usage. *Behavioral Health* PCP Toolkit (Toolkit placed on the plan's website 10/17) Providers were notified of this new information and training will be offered if requested. (Process measure retired) 9/2018-Information regarding the Behavioral Health PCP toolkit as well as the AAP ADHD Toolkit will be included in the plan's regional provider training. 10/2018-Update. See PDSA worksheet for new ITM related to the ADHD Toolkit. PCP's (high prescribers) who treat children with ADHD will receive education on the ADHD Toolkit. 1/2019-Update- Provider Network Management is currently making educational visits to the high prescribing PCP's to promote/educate the AAP ADHD Toolkit. 4/2019 Update-AAP ADHD Toolkit Provider Network Management (PNM) are continuing their educational visits to promote the ADHD Toolkit. They have completed the educational visits to the first batch of providers and are currently making visits to the next group of 40 providers. Quality continues to work with PNM on ensuring that they are capturing the person who is actually signing into (representing the office) the toolkit as the AAP Toolkit Report only captures the person that signs in to the toolkit.	Planned Start: 1/2017 Actual Start: 3/2018 Planned Start:1/2017 Actual Start10/2017

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
			6/2019 Update AAP ADHD Toolkit- As of June 25th, 2019, Provider Network Management has completed 51 educational visits to the providers on the assigned list. As of the May AAP ADHD Toolkit Report, 30 of the 51 Providers have accessed the ADHD Toolkit.	
Lack of access to ADHD user friendly information and resources for providers; lack of provider use of approved screening tools to facilitate appropriateness of treatment and management Lack of provider adherence to ADHD recommendations	Providers IHCM/Provider Mgt Departments	2	**Provider Education / Outreach:** Provider participation in plan sponsored Provider Regional Training's. ADHD information was added to the training information. Training to include Family Practice providers. AAP ADHD focused provider toolkit, Toolkit can be promoted during the Plan's Provider Trainings. ADHD Medication Prescriber Letter, this letter is sent out to the ADHD medication prescriber for any child ages 6-12. The letter explains the recommended follow-up as well as tips to increase medication compliance. 9/2018-PCP ADHD Notification Letter- This letter is currently in review and pending. This will be a letter that is sent to the members PCP when ADHD medication is prescribed by another physician. This letter will act as notification to the members PCP and also explain the recommended guidelines for ADHD follow-up. Update 1/2019- The letter has been approved and will begin distribution 2/01/19. Attention Deficit Hyperactivity Disorder (ADHD) eLearning Module is now available for AmeriHealth Caritas Louisiana providers as of June 10th, 2019. This information was distributed to Providers via the Plan's "PROVIDERALERT" notification system.	Planned Start: 1/2017, ongoing Actual Start: 1/2017, ongoing Date Revised: 10/2017 3/2018 Planned Start: 1/2017, ongoing Actual Start: 1/2017
Lack of member adherence to recommended guidelines for follow up; lack of keeping follow up appointments Lack of member	Members IHCM Department Providers	3	**Enhanced Case Management and/or collaboration, Member Education / Outreach, Behavioral Health Consultation to PCP** o Telephonic outreach to members 6-12 years of age starting ADHD medication, (Successful contact made with mbr or legal guardian, Rapid Response encourages visit within 30 days and explains their timeframe and assist with	Planned Start:1/2017 Actual Start:1/2017

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
knowledge of ADHD diagnosis, treatment, and available resources as well as the need for behavioral therapy. Lack of member engagement in plan sponsored care coordination. Lack of member knowledge of ADHD diagnosis, treatment, and available resources as well as the need for behavioral therapy for the< 6 and 13-17 year old age groups. Lack of compliance and/or documentation of recommended behavior therapy as first line treatment for diagnosis Lack of Care Coordination services from Providers			scheduling appointment if needed) o Member Initiation Phase gift card incentives for adherence to initial 30 day follow-up appt. (For Members ages 6-12, includes foster kids) o Enhanced Care Coordination to members (caregivers), 6 years of age or younger diagnosed with ADHD and/or prescribed ADHD medication. BH Care Connectors make outreach calls to encourage follow-up with their provider, Behavioral Therapy, assistance with finding a BH therapist if needed and also offer Case Management Services. These members also receive an educational letter. o Enhanced Case Management and/or collaboration for the 13-17 year old ADHD population. Educational Letter approved 3/2018 and began distribution in 4/2018. o Develop/look into opportunities for implementation of on-site care coordinators. The plan will need to assess data, review ADHD population sizes and compare to CPC+ and VBC participating providers. Review of Members with ADHD, on BH drugs W/OUT BH Therapy Who have a comorbidity (Denominator) Drill down this data by age group. < 6, 7-17. Successful outreach to the parent/guardian to identify barriers to receiving BH therapy (Numerator) o Update 1/2019-Quality is continuing to work on the data for this ITM. Data is currently pending for the 2018 MY, once received, Quality will analyze the data to identify members who have a comorbidity and outreach to them to identify barriers to receiving any BH Therapy. o Update 5/2019- Quality has received the data and reviewed it with the plan's Behavioral Health Medical Director, she has provided Quality with a list of Comorbidity/Diagnoses that we should start	Planned Start:1/2017 Actual Start:1/2017 Planned Start:7/2017 Actual Start:8/2017 Planned Start:9/2017 Actual Start:3/2018 Planned Start: 12/2017 Actual Start: Still in planning phase Planned Start:9/2018 Actual Start: 05/2019

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
			outreach efforts on. Outreach will start with the 13-17 year old population. The goal of the outreach will be to identify why members are not receiving BH therapy (identify barriers), also to identify their functional status as the member may not need therapy and also to identify if "Lack of BH Providers" is a barrier. As of 6/20/19, there have been 22 successful contacts made to members on the identified list.	
Lack of compliance and/or documentation of recommended behavior therapy as first line treatment for diagnosis	Providers Members	4	**Behavioral Health Consultation to PCP:** Pilot Medical Neighborhood and Integrated Healthcare initiative (This is a clinical-community partnership that includes the medical and social supports necessary to enhance health. It will focus on meeting the needs of the individual patient, but also incorporate aspects of population health and overall community health needs.) 7/2018-Update- Medical Neighborhood and Integrated Healthcare initiative; we continue to reimburse providers for completing screenings (PHQ-9 & Health Wellness Questionnaire). We are continuing to evaluate other initiatives which may help to further Integrate Healthcare statewide. The plan is also looking to drill down data/evaluate how the Pilot Medical Neighborhood and Integrated Healthcare initiative is leading to a positive impact on ADHD care (Reviewing ADHD rates of the providers that are currently participating in the "Medical Neighborhood"). Update 1/2019- The "Medical Neighborhood" Initiative is evolving into "Project Echo". "Project Echo (Extension for Community Healthcare Outcomes) is a movement to demonopolize knowledge and amplify local capacity to provide best practice care for underserved people all over the world. ACLA is currently working on marketing this project to providers. The "Medical Neighborhood" initiative will be retired at this time and once "Project Echo" is fully implemented, we will develop a process measure to support this initiative.	Planned Start:1/2017 Actual Start:3/2017

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
			5/2019-Project Echo is pending approval.	
Lack of reimbursement (incentive) for providers completing depression screening	Providers	5	**Provider Education / Outreach:** Provider incentive offered for completion of PHQ9 and Healthy Living evaluation Update 1/2019- There continues to be a barrier with Providers completing the PHQ-9 form. The PHQ-9 initiative continues to be promoted at the CALOCUS/LOCUS Trainings as well as the Regional Provider Trainings. An "Educational Flyer" is currently being developed to educate Providers on this initiative. Also there is a plan to begin collecting PHQ-9 scores to analyze for trends beginning in April 2019. Update 4/2019- ACLA has developed an "Integrated Health Care Screening Tool" Flyer. This flyer explains what the Patient Health Questionnaire, (PHQ) is and where it can be found on the Plan's website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The Plan's Account Executives will distribute the flyer when they make their provider visits. The flyer will also be placed in the Provider Newsletter.	Planned Start:1/2017 Actual Start:1/2017

2,3,4,5: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

Monitoring Table YEAR 1: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.
Add rows as needed.

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
1	Describe intervention tracking measure that corresponds to intervention #1 Num: The number of Evidenced Based Providers that offer specialized behavior therapy Denom:The number of Evidence Based Providers	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: **Pending-** The plan is currently working on contract negotiations with Tulane and Healthy Blue.
2	Describe intervention tracking measure that corresponds to intervention #2 Num: Total number of PCP's requesting training for the "Behavioral Health" PCP ADHD	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: Toolkit placed on the

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	toolkit Denom:Total number of PCP providers				plans website10/01/17, notification to providers via the Plan's "Provider post" on the Website 12/17. No request for trainings thus far RETIRED..
2	Describe intervention tracking measure that corresponds to intervention #2 Num: Total number of Participating providers in plan sponsored regional training (ADHD information added to the trainings 3rd Qtr) Denom: Total number providers invited to regional training	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: 225 Providers attended training for the 3rd Qtr	Numerator: Enter # Denominator: Enter # Rate: No trainings were held in the 4th Qtr
3	Describe intervention tracking measure that corresponds to intervention #3 Num: Successful number of Rapid Response outreach calls made to ADHD members (ages 6-12) Denom: total number of members identified as having a new ADHD medication claim	Numerator: 128 Denominator: 609 Rate: 21%	Numerator: 95 Denominator: 366 Rate: 25.9%	Numerator: 276 Denominator: 967 (increased d/t back to school) Rate: 28.5%	Numerator: 309 Denominator: 784 Rate:39%
3	Describe intervention tracking measure that corresponds to intervention #3 Num: Sub-category-The numbers of members receiving follow-up visit within 30 days Denom: Successful (speaks to member or legal guardian) Rapid Response outreach calls made to ADHD members	Numerator: 101 Denominator: 164 Rate: 62%	Numerator: 64 Denominator: 96 Rate: 66.7%	Numerator: 160 Denominator: 276 Rate: 57.97%	Numerator: 153 Denominator: 309 Rate: 50%
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of newly identified (< 6 year) ADHD members with a successful Care Connector contact Denom: The number of newly identified (< 6 year) ADHD members	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: 6 Denominator: 21 Rate: 28.6%-Sept	Numerator: 18 Denominator: 86 Rate: 20.9% Oct 9/4, Nov 3/4, Dec 6/78. (Den includes members identified in the global lookback that was completed in Dec, additional outreaches may be reported in the next Qtr).
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of members compliant for 30 day follow up	Numerator: 410 Denominator: 609 Rate: 67.3%	Numerator: 394 Denominator: 366 Rate: 100.7%	Numerator: 506 Denominator: 967 Rate: 52.3%	Numerator: 674 Denominator: 784 Rate: 85.9%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	visit (receiving gift card) Denom: The total number members Mailed ADHD outreach letter (HEDIS Initiation)		(rate is higher d/t claim lag (additional claims came in)		
4	Describe intervention tracking measure that corresponds to intervention #4 Num: The total number of Participating Medical Neighborhood Providers Denom: The total number of targeted Medical Neighborhood Providers	Numerator: 3 Denominator: 6 Rate: 50%	Numerator: 7 (participated this Qtr) Denominator: 4 Rate: 175%	Numerator: 2 Denominator: 7 Rate: 29%	Numerator: 7 Denominator: 7 Rate: 100%
5	Describe intervention tracking measure that corresponds to intervention #5 Num: Total number of PCP's billing PHQ 9 Denom: Total number of PCP's	Numerator: Enter # Denominator: Enter # Rate: 0	Numerator: 4 Denominator: 5629 Rate: .07%	Numerator: 10 Denominator: 4597 Rate. 02%	Numerator: 6 Denominator: 4545 Rate: 0.1%

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

Monitoring Table YEAR 2: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.
Add rows as needed.

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
1 *Process Measure Updated.	Describe intervention tracking measure that corresponds to intervention #1 Num: Number of targeted providers that received specialized behavioral training Denom: Number of Behavioral Health Providers targeted for specialized behavioral training	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate:NA, Training was held in 3rd Qtr	Numerator: 27 Denominator: 50 Rate: 54% (PTSD Training)	Numerator: Enter # Denominator: Enter # Rate: NA
2	Describe intervention tracking measure that corresponds to intervention #2 Num: : Total number of Participating providers that registered for the plan sponsored regional training (Trainings will be held in the 4th Qtr 2018) Denom: Total number providers invited to regional training. *Measure updated to capture the number of providers that registered for the training.	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: Enter # Denominator: Enter # Rate: NA	Numerator: 73 Denominator: 100 Rate:73%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
3	Describe intervention tracking measure that corresponds to intervention #3 Num: Successful number of Rapid Response outreach calls made to ADHD members (ages 6-12) Denom:Total number of members identified as having a new ADHD medication claim	Numerator: 306 Denominator: 661 Rate: 46.2%	Numerator: 227 Denominator: 538 Rate: 42.19%	Numerator: 361 Denominator: 911 Rate: 39.6% Increase in Denominator is due to school starting back	Numerator: 309 Denominator: 759 Rate: 39.7%
3	Describe intervention tracking measure that corresponds to intervention #3 Num: Sub-category-The numbers of members receiving follow-up visit within 30 days Denom: Successful (speaks to member or legal guardian) Rapid Response outreach calls made to ADHD members	Numerator: 237 Denominator: 306 Rate: 77%	Numerator: 117 Denominator: 227 Rate: 51.5%	Numerator: 159 Denominator: 361 Rate: 44.0%	Numerator: 123 Denominator: 302 Rate:40.7%
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of members compliant for 30 day follow up visit (receiving gift card) Denom: The total number members Mailed ADHD outreach letter (HEDIS Initiation)	Numerator: 237 Denominator: 661 Rate: 36%	Numerator: 359 Denominator: 538 Rate: 66.7%	Numerator: 317 Denominator: 911 Rate: 34.7% (increase in Den is due to school starting back)	Numerator: 486 Denominator: 759 Rate: 64%
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of newly identified (< 6 year) ADHD members with a successful Care Connector contact Denom: The number of newly identified (< 6 year) ADHD members	Numerator: 4 Denominator: 8 Rate: 50% Jan ½ Feb 2/5 March 1/1	Numerator: 5 Denominator: 6 Rate: 83.3% April 3/3 May 2/1 June 1/1	Numerator: 2 Denominator: 9 Rate: 22.2% July 2/0 Aug 2/1 Sept 5/1	Numerator: 1 Denominator: 8 Rate: 12.5% Oct 0/0 Nov 2/0 Dec 6/1
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of non-HEDIS population members	Numerator: 9 Denominator: 9 Rate: 100%	Numerator: 6 Denominator: 6 Rate: 100%	Numerator: 10 Denominator: 10 Rate: 100%	Numerator: 4 Denominator: 4 Rate: 100%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
	< 6, outreached via an educational letter Denom: The number of newly identified (< 6 year) ADHD members				
3	Describe intervention tracking measure that corresponds to intervention #3 Num: The number of non-HEDIS population members 13-17, outreached via an educational letter Denom: The number of newly identified (13-17 year old) ADHD members	Numerator: 0 Denominator: 0 Rate: NA	Numerator: 9 Denominator: 9 Rate: 100%	Numerator: 20 Denominator: 20 Rate: 100%	Numerator: 23 Denominator: 23 Rate: 100%
4 *Cumulative Rate *Measure retired 1/2019.	Describe intervention tracking measure that corresponds to intervention #4 Num: The total number of Participating Medical Neighborhood Providers Denom: The total number of targeted Medical Neighborhood Providers (Cumulative Rate)	Numerator: 6 Denominator: 10 Rate: 60%	Numerator: 6 Denominator: 10 Rate: 60%	Numerator: 6 Denominator: 10 Rate: 60%	Numerator: 6 Denominator: 10 Rate: 60%
5	Describe intervention tracking measure that corresponds to intervention #5 Num: The number of PCP's billing PHQ 9 Denom: Total number of PCP's	Numerator: 2 Denominator: 4523 Rate: .04%	Numerator: 14 Denominator: 4535 Rate: 0.3%	Numerator: 1 Denominator: 4535 Rate: 0.02% This intervention is currently being evaluated to determine the impact/barriers to providers completing the PHQ form.	Numerator: 9 Denominator: 4535 Rate: 0.1%

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

6. Results

The results section should present project findings related to performance indicators. Indicate target rates and rationale, e.g., next Quality Compass percentile. Accompanying narrative should describe, but ***not*** interpret the results in this section.

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.

Results Table.

Performance Indicator	Administrative (A) or Hybrid (H) Measure?	Baseline Period Hybrid Measurement: 2/1/15-2/29/16 (+ 4 months preceding 6/1/15 and 3 months following 11/30/15) HEDIS-1/1/16-12/31/16	Interim Period Hybrid Measurement: 2/1/16-2/28/17 (+ 4 months preceding 6/1/16 and 3 months following 11/30/16) HEDIS-1/1/17-12/31/17	Final Period Hybrid Measurement: 2/1/17-2/28/18 (+ 4 months preceding 6/1/17 and 3 months following 11/30/17) HEDIS-1/1/18-12/31/18	Final Goal/Target Rate
Indicator #1 A1. Validated ADHD Screening Instrument	H	Eligible Population = 60 Exclusions= NA If "H", Sample size = 60 Numerator = 11 Denominator = 60 Rate = 18.33%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 11 Denominator = 66 Rate = 16.67%	Eligible Population =63 Enter # Exclusions= NA If "H", Sample size = 63 Numerator = 14 Denominator = 63 Rate = 22.22%	Target Rate: 37.9% Rationale: The goal was set over the 95th Confidence Interval
Indicator #2 A2. ADHD Screening in Multiple Settings	H	Eligible Population = 60 Exclusions= NA If "H", Sample size = 60 Numerator = 10 Denominator = 60 Rate = 16.67%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 8 Denominator = 66 Rate = 12.12%	Eligible Population = 63 Exclusions= NA If "H", Sample size = 63 Numerator = 8 Denominator = 63 Rate = 12.70%	Target Rate: 35.5% Rationale: The goal was set over the 95th Confidence Interval
Indicator #3 A3. Assessment of other behavioral health conditions/ symptoms	H	Eligible Population = 60 Exclusions= NA If "H", Sample size = 60 Numerator = 16 Denominator = 60 Rate = 26.67%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 18 Denominator = 66 Rate = 27.27%	Eligible Population = 63 Exclusions= NA If "H", Sample size = 63 Numerator = 9 Denominator = 63 Rate = 14.29%	Target Rate:49% Rationale: The goal was set over the 95th Confidence Interval
Indicator #4 A4. Positive findings of other behavioral health conditions	H	Eligible Population = 16 Exclusions= NA If "H", Sample size = 16 Numerator = 15 Denominator = 16 Rate = 93.75%	Eligible Population = 18 Exclusions= NA If "H", Sample size = 18 Numerator = 17 Denominator = 18 Rate = 94.44%	Eligible Population = 9 Exclusions= NA If "H", Sample size = 9 Numerator = 9 Denominator = 9 Rate = 100%	NA
Indicator #5 A5a. Referral for EVALUATION of other	H	Eligible Population = 15 Exclusions= NA If "H", Sample	Eligible Population = 17 Exclusions= NA If "H", Sample	Eligible Population = 9 Exclusions= NA If "H", Sample	Target Rate: 75% Rationale: The goal represents a

behavioral health conditions		size = 15 Numerator = 7 Denominator = 15 Rate = 46.67%	size = 17 Numerator = 9 Denominator = 17 Rate = 52.94%	size = 9 Numerator = 3 Denominator = 9 Rate = 33.33%	bold aim given the wide 95th Confidence Interval, which is attributable to a small sample size.
Indicator #6 A5b. Referral to TREAT other behavioral health conditions	H	Eligible Population = 15 Exclusions= NA If "H", Sample size = 15 Numerator = 6 Denominator = 15 Rate = 40.0%	Eligible Population = 17 Exclusions= NA If "H", Sample size = 17 Numerator = 2 Denominator = 17 Rate = 11.76%	Eligible Population = 9 Exclusions= NA If "H", Sample size = 9 Numerator = 1 Denominator = 9 Rate = 11.11%	Target Rate: 69% Rationale: The goal was set over the 95th Confidence Interval
Indicator #7 A6. PCP Care Coordination	H	Eligible Population = 60 Exclusions= NA If "H", Sample size = 60 Numerator = 3 Denominator = 60 Rate = 5%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 24 Denominator = 66 Rate = 36.36%	Eligible Population = 63 Exclusions= NA If "H", Sample size = 63 Numerator = 8 Denominator = 63 Rate = 12.70%	Target Rate: 16.0% Rationale: The goal was set over the 95th Confidence Interval
Indicator #8 A7. MCO Care Coordination	H	Eligible Population = 59 Exclusions= NA If "H", Sample size = 59 Numerator = 2 Denominator = 59 Rate = 3.39%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 6 Denominator = 66 Rate = 9.09%	Eligible Population = 63 Exclusions= NA If "H", Sample size = 63 Numerator = 14 Denominator = 63 Rate = 22.22%	Target Rate:40% Rationale: The goal is aligned with our outreach target goal due to the plan's outreach interventions.
Indicator #9 A8. MCO Outreach with Member Contact	H	Eligible Population = 60 Exclusions= NA If "H", Sample size = 60 Numerator = 10 Denominator = 60 Rate = 16.67%	Eligible Population = 66 Exclusions= NA If "H", Sample size = 66 Numerator = 12 Denominator = 66 Rate = 18.18%	Eligible Population = 63 Exclusions= NA If "H", Sample size = 63 Numerator = 29 Denominator = 63 Rate = 46.03%	Target Rate:40% Rationale: The goal is based on a statistical and member population health perspective.
Indicator #10 A9. MCO Outreach with Member ENGAGEMENT	H	Eligible Population = 9 Exclusions= NA If "H", Sample size = 9 Numerator = 2 Denominator = 9 Rate = 22.22%	Eligible Population = 12 Exclusions= NA If "H", Sample size = 12 Numerator = 4 Denominator = 12 Rate = 33.33%	Eligible Population = 29 Exclusions= NA If "H", Sample size = 29 Numerator = 2 Denominator = 29 Rate = 6.89%	Target Rate: 60% Rationale: The goal is aligned with the plan's enhanced care management interventions.

Indicator #11 A10. First Line Behavior Therapy for Children < 6 years	H	Eligible Population = 30 Exclusions= NA If "H", Sample size = 30 Numerator = 1 Denominator = 30 Rate = 3.33%	Eligible Population = 30 Exclusions= NA If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0%	Eligible Population = 29 Exclusions= NA If "H", Sample size = 29 Numerator = 2 Denominator = 29 Rate = 6.90%	Target Rate:43% Rationale: Once interventions are initiated, the plan hopes to see significant changes and can possibly raise goal even higher.
Indicator #11 A10a. Clinical Exclusions[1,2]	H	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = <u>NO Exclusions</u>	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = <u>NO Exclusions</u>	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = <u>NO Exclusions</u>	Target Rate: Rationale
Indicator #11 A10b. Exclusions- No qualified providers in area[1]	H	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Target Rate: Rationale
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients[1]	H	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator = Enter # Denominator = Enter # Rate = NA	Target Rate: Rationale
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new	H	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator =	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator =	Eligible Population = Enter # Exclusions= Enter # If "H", Sample size = Enter # Numerator =	Target Rate: Rationale

clients[1]		Enter # Denominator = Enter # Rate = NA	Enter # Denominator = Enter # Rate = NA	Enter # Denominator = Enter # Rate = NA	
Indicator #12 B1a. HEDIS ADD Measure: Initiation Phase	A	Eligible Population = 2439 Exclusions= 1 If "H", Sample size = 2439 Numerator = 847 Denominator = 2439 Rate = 34.73%	Eligible Population = 2397 Exclusions= 0 If "H", Sample size = 2397 Numerator = 1275 Denominator = 2397 Rate = 53.19%	Eligible Population = 2225 Exclusions= 0 If "H", Sample size = 2225 Numerator = 1094 Denominator = 2225 Rate = 49.17%	Target Rate:42.19% Rationale This target rate is from the 25th to the 50th Quality Compass Percentile. :
Indicator #13 B1b. HEDIS ADD Measure: Continuation Phase	A	Eligible Population = 505 Exclusions= 0 If "H", Sample size = 505 Numerator = 228 Denominator = 505 Rate = 45.15%	Eligible Population = 454 Exclusions= 0 If "H", Sample size = 454 Numerator = 295 Denominator = 454 Rate = 64.98%	Eligible Population = 351 Exclusions= 0 If "H", Sample size = 351 Numerator = 230 Denominator = 351 Rate = 65.53%	Target Rate:52.47% Rationale: This target rate is the 66.67th Quality Compass Percentile
Indicator #14 B2a. BH Drug with Behavioral therapy[3]	A	Eligible Population = 15,299 Exclusions= NA If "H", Sample size = 15,299 Numerator = 3465 Denominator = 15,299 Rate = 22.6%	Eligible Population = 14,645 Exclusions= NA If "H", Sample size = 14,645 Numerator = 4104 Denominator = 14,645 Rate = 28.0%	Eligible Population = 14,704 Exclusions= NA If "H", Sample size = 14,704 Numerator = 4315 Denominator = 14,704 Rate = 29.3%	Target Rate:25% Rationale: The goal was set over the 95th Confidence Interval
Indicator #15 B2b. BH Drug WITHOUT Behavioral therapy[3]	A	Eligible Population = 15,299 Exclusions= NA If "H", Sample size = 15,299 Numerator = 8813 Denominator = 15,299 Rate = 57.6%	Eligible Population = 14,645 Exclusions= NA If "H", Sample size = 14,645 Numerator = 7145 Denominator = 14,645 Rate = 48.8%	Eligible Population = 14,704 Exclusions= NA If "H", Sample size = 14,704 Numerator = 7144 Denominator = 14,704 Rate = 48.6%	Target Rate:55% Rationale: The goal was set below the 95th Confidence Interval

[1]The denominator for each exclusion is the chart review eligible population aged <6 years.
[2]Illustrative examples of clinical exclusions include multiple psychiatric conditions, risk of harm to self or others.

[3] Report total sin this table, and report stratified data for each subpopulation using the Excel reporting template for the administrative measures. Use stratified data to inform re-charting of PIP course, i.e., modifications to interventions.

7. Discussion

The discussion section is for explanation and interpretation of the results. Please draft a preliminary explanation and interpretation of results, limitations and member participation for the Interim Report, then update, integrate and comprehensively interpret all findings for the Final Report. Address dissemination of findings in the Final Report.

Discussion of Results

Interpret the performance indicator rates for each measurement period, i.e., indicate whether or not target rates were met, describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods: See Below

A. HYBRID Measures (utilizing a random, stratified sample of new ADHD cases for chart review):
A1. ***Validated ADHD Screening Instrument***:
Baseline to Final: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument decreased 1.66% from baseline to the interim MY, (18.33% to 16.67%), and increased 5.55% from the interim MY to the final MY, (16.67 % to 22.22%). There was a 3.89 % increase from the baseline to the final MY, (18.33% to 22.22%). The target goal was not met for this measurement period.
A2. ***ADHD Screening in Multiple Settings***:
Baseline to Final: The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, i.e., home and school, decreased 4.55% from baseline to the interim MY, (16.67% to 12.12%) and increased 0.58% from the interim MY to the final MY, (12.12 % to 12.70%). There was a 3.97 % decrease from the baseline to the final MY, (16.67% to 12.70%). . The target goal was not met for this measurement period.
A3. ***Assessment of other behavioral health conditions/symptoms***:
Baseline to Final: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress) increased 0.6% from baseline to the interim MY, (26.67% to 27.27%), and decreased 12.98% from the interim MY to the final MY, (27.27 % to 14.29%). There was a 12.38 % decrease from the baseline to the final MY, (26.67% to 14.29%). The target goal was not met for this measurement period.
A4. ***Positive findings of other behavioral health conditions***:
Baseline to Final: The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation whose PCP documented positive findings, i.e. positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions increased 0.69% from baseline to the interim MY, (93.75% to 94.44%), and increased 5.56% from the interim MY to the final MY, (94.44 % to 100%). There was a 6.25 % increase from the baseline to the final MY, (93.75% to 100%).
A5a. ***Referral for EVALUATION of other behavioral health conditions***:
Baseline to Final: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions increased 6.27% from baseline to the interim MY, (46.67% to 52.94%), and decreased 19.61% from the interim MY to the final MY, (52.94 % to 33.33%). There was a 13.34 % decrease from the baseline to the final MY, (46.67% to 33.33%). The target goal was not met for this measurement period.
A5b. ***Referral to TREAT other behavioral health conditions***:
Baseline to Final: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CsOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions decreased 28.24% from baseline to the interim MY, (40.0% to 11.76%), and decreased 0.65% from the interim MY to the final MY, (11.76 % to 11.11%). There was a 28.89 % decrease

from the baseline to the final MY, (40.00% to 11.11%). The target goal was not met for this measurement period.

A6. ***PCP Care Coordination***:

Baseline to Final: The percentage of the eligible population sample who received PCP care coordination, e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination increased 31.36% from baseline to interim MY, (5% to 36.36%), and decreased 23.66% from the interim MY to the final MY, (36.36 % to 12.70%). There was a 7.7 % increase from the baseline to the final MY, (5% to 12.70%). The target goal was not met for this measurement period.

A7. ***MCO Care Coordination***:

Baseline to Final: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator increased 5.7% from baseline to interim MY, (3.39% to 9.09%), and increase 13.13% from the interim MYto the final MY, (9.09 % to 22.22%). There was an 18.83 % increase from the baseline to the final MY, (3.39% to 22.22%). Although there was significant Improvement from baseline to final measurement, the target goal was not met for this measurement period.

A8. ***MCO Outreach with Member CONTACT***:

Baseline to Final: The percentage of the eligible population sample who were outreached by the health plan care coordinator increased 1.50% from baseline to interim MY, (16.67% to 18.18%), and increased 27.85% from the interim MY to the final MY, (18.18 % to 46.03%). There was a 29.36% increase from the baseline to the final MY, (16.67% to 46.03%). The target goal was met and exceeded for this measurement period.

A9. ***MCO Outreach with Member ENGAGEMENT***:

Baseline to Final: The percentage of the members outreached who were engaged in care management increased 11.11% from baseline to interim MY, (22.22% to 33.33%), and decreased 25.33% from the interim MY to the final MY, (33.33 % to 6.89%). There was a 15.33% decrease from the baseline to the final MY, (22.22% to 6.89%). The target goal was not met for this measurement period.

A10. ***First Line Behavior Therapy for Children <6 years***:

Baseline to Final: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD showed an decrease from baseline to the interim MY, (3.33% to 0%), there were no members out of the identified 30 members that received evidence-based behavior therapy as a first-line treatment for ADHD. From interim to final, the measure increased 6.90%, (0% to 6.90%) and from baseline to final, the measure increased 3.57%, (3.33% to 6.90%). The target goal was not met for this measurement period.

B. ADMINISTRATIVE Measures (utilizing encounter/pharmacy files):

HEDIS Administrative Measures:

Measure B1a. Initiation Phase.

Baseline to Final: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-Day Initiation Phase increased 18.46% from baseline to the interim MY, (34.73% to 53.19%), and decreased 4.02% from the interim MY to the final MY, (53.19 % to 49.17%). There was a 14.44 % increase from the baseline to the final MY, (34.73% to 49.17%). The target goal was met.

Measure B1b. Continuation and Maintenance (C&M) Phase.

Baseline to Final: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended increased 19.83% from baseline to the interim MY, (45.15% to 64.98%), and increased 0.55% from the interim MY to the final MY, (64.98 % to 65.53%). There was a 20.38 % increase from the baseline to the final MY, (45.15% to 65.53%). The target goal was met.

Non-HEDIS Administrative Measures:

Measure B2a. **BH Drugs WITH Behavioral Therapy.**

Baseline to Final: BH Drugs WITH Behavioral Therapy. Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITH behavioral therapy increased 5.4% from baseline to the interim MY, (22.6% to 28.0%),and increased 1.3% from the interim MY to the final MY, (28.0 %

to 29.3%). There was a 6.7 % increase from the baseline to the final MY, (22.6% to 29.3%). The target goal was met.

Measure B2b. **BH Drugs WITHOUT Behavioral Therapy.**

Baseline to Final: BH Drugs WITHOUT Behavioral Therapy Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITHOUT behavioral therapy decreased 8.8% from the baseline MY to the interim MY, (57.6% to 48.8%), and decreased 0.2% from the interim MY to the final MY, (48.8 % to 48.6%). There was a 9 % decrease from the baseline to the final MY, (57.6% to 48.6%). The target goal was met.

Explain and interpret the extent to which improvement was or was not attributable to the interventions, by interpreting quarterly or monthly intervention tracking measure trends: See Below

- Behavior therapy training to providers. The plan continues to work on this intervention and has currently sponsored trainings. The plan is currently reevaluating this process measure to possibly evaluate the providers who have already received/and or will be receiving training. As an update, ACLA is sponsoring Preschool PTSD training in Shreveport at our Wellness Center on July 17, 2018. The class will train 50 providers in the EBP and these providers will then undergo 6 months of weekly supervision.
  Update-
  - ACLA sponsored Preschool PTSD training in Shreveport at our Wellness Center on July 17, 2018, (27 Providers attended but they are not yet certified to offer this Evidenced Based Practice).
  - Preschool PTSD Training – ACLA hosted a Preschool PTSD Training on April 2nd, 2019 at the New Orleans Wellness Center. 26 of the 50 Providers invited attended. Dr. Murphy stated that since the first training in July, 2 Providers have completed the supervision portion and become fully credentialed to offer the EBP.
  - Triple P Training- Aetna and ACLA sponsored this training on April 15th, 2019 to April 18th, 2019 and certification concluded on May 29th. 18 of the 20 Providers invited attended.

- "Behavioral Health" PCP ADHD Toolkit/Reference guide. The BH toolkit is a reference guide regarding common Behavioral Health conditions. The Behavioral Health PCP ADHD Toolkit was placed on the plan's website in October 2017 and providers (PCP's) were notified in December 2017. No providers have requested training thus far. The goal is to increase awareness to PCP's that the toolkit is available, the plan will work on this goal. (Process measure retired)

- AAP ADHD Toolkit. MCOs and LA DH collaborated to produce and distribute an AAP ADHD Toolkit (e.g., AAP guidelines, screening tools and guidelines, resources for referrals). The toolkit is promoted during the Plan's Provider Trainings which include Pediatricians and Family Practice Providers. The toolkit went live in 3/2018 and is available online. Providers were notified via fax blast and email. The AAP is currently providing all MCO's with a monthly report that tracks the usage/log in of the ADHD Toolkit. ACLA has developed an Intervention Tracking Measure related to the ADHD Toolkit. PCP's who treat children with ADHD will receive education on the ADHD Toolkit. Provider Network Management (PNM) are conducting educational visits to promote the ADHD Toolkit to the high prescribing PCP's.

- Participating providers in plan sponsored regional training (ADHD information added to the training in the 3rd Qtr 2017). There were 225 providers that attended training during the 3rd Qtr of 2017 and there were no trainings held during the 4th Qtr. The plan acknowledges that there is room for improvement and will work on increased trainings to providers.
  Update- *Measure Updated to capture the number of providers that registered for the training. In the 4th Qtr of 2018, 73 out of 100 Providers attended training.

- Educational outreach to ADHD members; the plan currently outreaches via direct member contact (phone) and educational mailings to members identified as having a new ADHD medication claim. These rates for successful contact fluctuated in 2017. The plan also seen an increase in the number of new ADHD medication claims in the third Qtr of 2017, this can be contributed to members starting back on ADHD

medication for the school year. The plan acknowledges there is room for improvement in successfully contacting the member/guardian and will continue to work on identifying barriers/interventions to improve successful contact rates.

- **Update-** These rates continued to fluctuate in 2018, but did show an improvement.

- Member receiving follow-up visit within 30 days after a successful contact by Rapid Response; the plan seen a slight decrease in the number of follow-up visits within 30 days in 2017. The rate for 1st Qtr was 62% and 4th Qtr was 50%. The decrease for the last two Qtrs of 2017 could be attributed to an increase in the number of members starting back on the ADHD medication for the new school year. The plan will continue to evaluate this measure.
  Update- This measure showed an increase for the 1st Qtr of 2018 and then showed a decrease. The plan acknowledges this decrease and is continuing to work on identifying barriers/interventions to improve follow-up rates. The plan has also developed a PCP ADHD notification letter. This letter is sent to the members PCP when ADHD medication is prescribed by another physician. This letter acts as notification to the members PCP and also explains the recommended guidelines for ADHD follow-up.

- The number of members compliant for 30 day follow up visit (receiving gift card); these rates for members that were compliant for their 30 day f/u visit fluctuated in 2017, and indicates that members are for the most part receiving their follow-up visit. The decrease in the third Qtr can be attributed to the increase in the number of members starting back on ADHD drugs for the school year. The plan will continue to monitor this measure as well as the outreach efforts.
  Update- This measure continued to fluctuate in 2018 but did show an increase in the 4th Qtr. The plan will continue to work on improving the rates for the 30 day follow-up visit.

- Medical Neighborhood and Integrated Healthcare initiative; we continue to reimburse providers for completing screenings. We are continuing to evaluate other initiatives which may help to further Integrate Healthcare statewide. The plan is also looking to drill down data/evaluate how the Pilot Medical Neighborhood and Integrated Healthcare initiative is leading to a positive impact on ADHD care.
  Update- ACLA has developed an “Integrated Health Care Screening Tool” Flyer. This flyer explains what the Patient Health Questionnaire, (PHQ) is and where it can be found on the Plan’s website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The Plan’s Account Executives will distribute the flyer when they make their provider visits. The flyer will also be placed in the Provider Newsletter.
  The “Medical Neighborhood” Initiative is evolving into “Project Echo” and is in the approval process at this time.

- The number of newly identified (< 6 year) ADHD members; ACLA continues outreach efforts in order to provide education on ADHD as well as medication compliance. The intervention for the < 6 ADHD population has been updated as the plan acknowledged that the < 6 report was identifying a relatively low number of members so the lookback period was changed from 6 months to 4 months. The plan also completed a global lookback period back to January 2017. The new list was reviewed and all new members not previously identified were pulled out. This group of members was outreached to via the < 6 educational letter as well as Integrated Health Care Management outreach.
  Update- Outreach efforts continue for the < 6 year old ADHD Population.

- The number of newly identified (13-17 yo) ADHD members; Members ages 13-17 yo identified as having ADHD either via diagnosis and/or a medication claim. The plan is using the same methodology to identify this population as the < 6 year old population. Meetings were held to discuss barriers/outreach interventions for this age group. The plan developed an educational letter that is sent to identified members/guardian. This letter provides information on ADHD as well as encourages follow-up with a Behavioral Health Specialist if ordered by their PCP.
  Update- Outreach efforts continue for the 13-17 year old ADHD Population.

Listed below are a few identified barriers that the plan is continuing to work on in order to achieve or exceed our target goals for 2018;

- The prescribing physician of the ADHD medication is at times not the members PCP, resulting in lack of care coordination services for the member, (*lack of provider/specialist collaboration).* The plan is working on ways to improve communication between the two physicians to improve coordination of care for the member. **Update-** The plan has developed a PCP ADHD notification letter. This letter is sent to the members PCP when ADHD medication is prescribed by another physician. This letter acts as notification to the members PCP and also explains the recommended guidelines for ADHD follow-up.

- On-going-Lack of member adherence to recommended guidelines for follow up; lack of keeping follow up appointments. The plan recognizes the need to improve successful contact with the member's parent/guardian to improve follow-up visits. Another common barrier is that the provider does not schedule follow-up appointments during the current appointment. The plan will continue to work with providers on scheduling the follow-up appointment as well as notifying the plan through Case Management engagement. The plan will also continue to work on identifying interventions to improve successful contact, resulting in improved follow-up rates. **Update**- See above for newly developed letter. Case Management continues to work on successful contact to members to provide ADHD education. The plan continues to work on this barrier.

- Lack of provider adherence to ADHD recommendations. There continues to be opportunities for improvement in the plans rates for the following measures; HEDIS ADD Measure: Initiation and continuation Phase and BH Drug with and without Behavioral therapy. The plan will be reviewing data from these measures to identify any barriers/opportunities and interventions to improve rates as well as identify any low-performing providers and target them for educational outreach. **Update-** These measures showed an increase in the 2018 measurement year. The plan is continuing to promote the AAP ADHD Toolkit to providers and outreach was initiated to the high prescribing providers. The plan developed two Intervention Tracking Measures to support the AAP ADHD Toolkit as well as evaluation of members not receiving Behavioral Therapy. The plan continues to work on identifying barriers/interventions to improve rates.

- ADHD Medical Record Review- Due to the timeframe of the review for the interim period, there were minimal interventions completed. The plan acknowledges that there is still room for improvement in many of the MRR performance indicators, the plan will continue to work on identifying barriers/opportunities to improve the rates for ADHD medical record review.
  Update- The Plan acknowledges that there is still room for improvement in the MRR rates, The plan will continue to work on identifying barriers/interventions to improve the MRR rates.

What factors were associated with success or failure? The prescribing physician of the ADHD medication is at times not the members PCP, resulting in lack of care coordination services for the member. Providers do not schedule follow-up appointments during the current appointment. On-going-Lack of member adherence to recommended guidelines for follow up; lack of keeping follow up appointments.

Limitations (For definitions and examples, refer to HEALTHY_LOUISIANA_PIP_TEMPLATE_w_example)

As in any population health study, there are study design limitations for a PIP. Examples of study limitations include: Accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; Accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided.

- **Were there any factors that may pose a threat to the internal validity the findings?** Threats to the internal validity of the findings include care management/ case management process measure data accuracy due to the limitations of episodic documentation and data abstractions from the plan's integrated care management software.

- **Were there any threats to the external validity the findings?** Threats to the external validity of the findings include administrative measure accuracy that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes and the accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided.
- **Describe any data collection challenges.** The plan faced challenges with data collection for process measures focused on case management / care management outreach. Limitations relative to the episodic documentation and data abstraction from the plan's integrated care management software resulted in under-represented Case Management / Care Management member interactions. Additionally, data collection challenges include locating and obtaining requested medical records for the annual hybrid portion of the ADHD medical record review.

Member Participation

Members are outreached to via phone (Case Management and/or Care Coordination) outreach as well as educational mailings.

Describe methods utilized to solicit or encourage membership participation: Members are outreached to through several methods including, Case Management/Care Coordination Outreach (telephonic and member mailings), Community Education also outreaches to members.

9/2018-Update from PIP Feedback: Member feedback is received from the parent/guardian during direct member outreach. IHCM and Rapid Response conducts telephonic outreach and identifies/discusses barriers to ADHD care. Member feedback is also received in the form of the Plan's annual Member Satisfaction Survey and Behavioral Health Member Satisfaction Survey. Results from these surveys are analyzed to identify barriers/opportunities and interventions to improve any areas in need of improvement. Opportunities from the Behavioral Health Member Survey exists to improve outcomes when members call the Plan for help as well as measures related to informing members (patient rights, information about managing their condition and different kinds of treatment options available). Interdepartmental meetings are held on a monthly basis in order to continue to identify Action Plans on specific Key Finding Measures.
The plan also has a Member Advisory Council (MAC), members are asked to contribute to the development of health education programs to improve the member's quality of care. Feedback is received from members as well.
Currently the plan is working on a report to drill down the Non-HEDIS Measure, "Behavioral Health Drugs with and without BH Therapy". This report will be stratified by age groups to include the < 6 age group. The report will look at members in this denominator who have co-morbidities and outreach to determine if there are any barriers to the member receiving BH Therapy.

Provider Participation:

Provider Input is received by the plan via various methods, i.e.; ADHD Provider Survey, Quality Committee Meetings (ADHD PIP as well as ADHD Rates are reviewed and input is received from both internal and external providers. One example of an ADHD topic/Best Practice that was discussed in the committee meeting due to Provider feedback, was information on the "Negative Medication History" for the HEDIS ADHD Measure. The HEDIS measure was reviewed/explained due to Providers lack of understanding). The Quality Department is also making educational outreach visits to Provider offices. The Provider's QEP report as well as other educational topics (ADHD information) are reviewed with the Provider/office staff.
The plan is also reevaluating the ADHD education that is provided during the Plan's regional training to providers. Information on ADHD (Toolkit, Clinical Guidelines, etc will be provided).

Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** Updates from the ADHD PIP are provided quarterly at the plan's Quality of Clinical

Care Committee meetings. The plan also has a Quarterly workgroup meeting to review/discuss the ADHD PIP.

8. 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.

Description of Intervention	Lessons Learned	System-level changes made and/or planned	Next Steps
Specialized behavioral training to targeted providers. o ACLA sponsored Preschool PTSD training in Shreveport at our Wellness Center on July 17, 2018 o Preschool PTSD Training ACLA hosted a Preschool PTSD Training on April 2nd, 2019 at the New Orleans Wellness Center. 26 of the 50 Providers invited attended. o Triple P Training- Aetna and ACLA sponsored this training on April 15th, 2019 to April 18th, 2019 and certification concluded on May 29th. 18 of the 20 Providers invited attended.	There continues to be a shortage of Evidence-Based Practice (EBP) providers statewide. There is also a need for services for the 0-5 population.	ACLA continues to expand its provider network thought the offering of these Evidence-Based Practice (EBP) Trainings	ACLA will continue to identify and sponsor Evidence-Based Practice (EBP) Trainings for the 0-5 age group. ACLA is also working on developing a partnership with the LSU Center to Practice to address training needs.
Regional provider trainings	The plan acknowledges the need for improving provider participation rates at provider trainings.	Identify barriers as to why providers don't attend training.	Continue to promote the Plan's regional provider trainings to increase participation rates.
"Behavioral Health" PCP ADHD Toolkit/Reference guide. AAP ADHD Toolkit. MCOs and LA DH collaborated to produce and distribute an AAP ADHD Toolkit.	Providers are unaware of the toolkits availability and how to access them.	The plan continues to work on identifying barriers/opportunities to increase provider awareness of these toolkits.	Continue to promote the Behavioral Health and AAP ADHD Toolkit to providers. Continue to encourage providers to sign up and utilize the AAP ADHD Toolkit.
Successful number of Rapid Response outreach calls made to ADHD members (ages 6-12) and how many receive a visit within 30 days	"Unable to Contact" members continues to be a barrier as well as "Lack of the member keeping their follow-up appointments".	The plan continues to work on identifying barriers/opportunities to increase member contact as well as increasing follow-up	Continue member outreach via telephone and educational letters. Continue educating parents on the importance of timely ADHD

		visits to providers in the recommended time frame.	follow-up and identify any barriers to receiving care.
Educational contact made to the newly identified < 6 year old ADHD Population.	This age group is difficult to contact and their caregiver/parent often feel as if they don't need any additional support.	A report was developed to capture this age group to evaluate and assess their diagnosis of ADHD and their needs.	Continue to outreach to this population and evaluate any needs/barriers to care.
Review/outreach of Members (13-17) with ADHD, on BH drugs W/OUT BH Therapy who have a comorbidity.	Intervention is new and is still currently being evaluated.	Intervention is new and is still currently being evaluated.	Continue to educate parents/member on the importance of Behavioral Therapy if indicated
Providers that bill for the PHQ	There continues to be a barrier with Providers completing the PHQ-9 form.	The PHQ-9 initiative continues to be promoted at the CALOCUS/LOCUS Trainings as well as the Regional Provider Trainings.	ACLA has developed an "Integrated Health Care Screening Tool" Flyer. This flyer explains what the Patient Health Questionnaire, (PHQ) is and where it can be found on the Plan's website. The flyer also explains that providers will be reimbursed for completing the screening and also how the screening should be billed. The Plan's Account Executives will distribute the flyer when they make their provider visits. The flyer is also in the Provider Newsletter.
Medical Neighborhood and Integrated Healthcare Initiative	While providers agree with the need for integrated care many barriers, such as lack of physical plant space, continue to be a problem for providers to fully implement full integration.	The "Medical Neighborhood" initiative will be retired at this time and once "Project Echo" is fully implemented, we will develop a process measure to support this initiative.	The "Medical Neighborhood" Initiative is evolving into "Project Echo". .ACLA is currently working on marketing this project to providers.

APPENDIX A

Healthy Louisiana ADHD PIP: B2 Administrative Measure Specifications

Report Total and Stratified data for each ADHD Administrative Measure by the following age and foster care subpopulations:

- All Members <48 months of age
- Foster children <48 months of age
- All Members age 4-5
- Foster children age 4-5
- All Members ages 6-12
- Foster children ages 6-12
- All Members ages 13-17
- Foster children ages 13-17
- All Members ages 18-20
- TOTAL of All Members

B2. NON-HEDIS ADMINISTRATIVE MEASURE- Children With and Without Behavioral Therapy:

Eligible population- Any ADHD Cases, as identified by either an ADHD diagnosis or and ADHD medication claim, during the Measurement Period, with age determined as of the last day of the Measurement Period (there is no intake period)

- **Baseline Measurement Period: 1/1/16-12/31/16**
- **Interim Measurement Period: 1/1/17-12/31/17**
- **Final Measurement Period: 1/1/18-12/31/18**

Measure B2. Children With and Without Behavioral Therapy. Description: Percentage of any ADHD cases aged 0-20 years, stratified by age (as of end of Measurement Period) and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics) and with/without behavioral therapy.

- Denominator B2: Children with either a diagnosis of ADHD or a prescription for ADHD medication, at any time during the Administrative Measurement Period for Any Cases.
- Numerator B2a: **BH DRUG WITH behavioral therapy**: Children with a claim for any BH drug (in the BH Drug List) AND a claim for any counseling type (in the Specialized BH Tx tab).
- Numerator B2b**: BH DRUG WITHOUT behavioral therapy**: Children with a claim for any BH drug (in the BH Drug List) BUT WITHOUT a claim for any counseling type (in the Specialized BH Tx tab).