Bayou Health Plan
Performance Improvement Project (PIP)

Aetna Better Health

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

2016-2018

Final Report: 06/30/2019

Submission to: LA Department of Health and Hospitals
IPRO

Health Plan and Project Identifiers

Please complete all fields as accurately and as completely as possible.

1. Name of Health Plan: AETNA BETTER HEALTH

2. Select the Report Submission: [If any change from initial submission, please complete section 7 below.]

☐ PIP Part I: Project Proposal Date submitted: 12 / 30 / 2016
☐ PIP Part II: Interim Report Date submitted: 06 / 29 / 2018
☒ PIP Part III: Final Report Date submitted: 06 / 30 / 2019

3. Contract Year: 2018

4. Principal Contact Person:
[person responsible for completing this report]

4a. Title: Melder Burton

4b. Phone: (504) 667 - 4480 ext.

4c. Email Address: BurtonM1@aetna.com

5. Title of Project: ADHD Diagnosis and Treatment in Children (Ages 0-20)

6. External Collaborators (if any): N/A

7. For Interim and Final Reports Only: If Applicable, Report All Changes from Initial Proposal Submission: [Examples include: added a new survey, added new interventions, changed interventions, deviated from HEDIS® specifications, reduced sample sizes]

- Streamline an outreach program in 2018
- Start IVR Program in 2018
- Started Member Toolkit 2018

8. Attestation

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

Aetna Better Health
Health Plan Name

ADHD Diagnosis and Treatment in Children (Ages 0-20)
Title of Project

Madhavi Rajulapalli, M.D.
Medical Director (print, sign and date)

Arlene Goldsmith, MA, CPHQ
Quality Director (print, sign and date)

N/A
IS Director (when applicable) (print, sign and date)

Richard Born, CEO
CEO (print, sign and date)

Project Topic

Provide a general description of the project topic that is clearly stated and relevant to the enrolled population.

1. Describe Project Topic

The Performance Improvement Plan for Aetna Better Health was created to improve the diagnosis and care of children with ADHD by facilitating performance improvements consistent with evidence-based recommendations. This is important to the health and well-being of our members to assure evaluation, treatment, and monitoring is consistent with clinical practice guidelines. When evaluating a child for ADHD, the primary care clinician should assess whether other conditions are present that might coexist with ADHD. The primary care clinician should monitor and alter, as needed, the dose of medication given to the child for ADHD in order to achieve the maximum benefit while minimizing any problems from taking the medication.

2. Rationale for Topic Selection

ABHLA completed an analysis of the prevalence of ADHD by subgroup. Against our total population, we had a higher incidence of ADHD amongst out members' ages 6 – 12 years of age, member 13-17 years of age, and member ages 18-20 years of age. Cases per total population, the highest incidence is for foster children ages 6-12 years of age at 37.2%, and foster children ages 13-17 years of age at 38.8%. Refer to table below.

Disease prevalence by Sub-Groups	ADHD Cases (1)	Total Member Population Count	ADHD Cases as percent of total population
For all members < 48 months of age:	15	12266	0.1%
For foster children < 48 months of age:	1	105	1.0%
For all members age 4-5:	82	3372	2.4%
For foster children age 4-5:	0	28	0.0%
For all members ages 6-12:	1586	11151	14.2%
For foster children ages 6-12:	42	113	37.2%
For all members ages 13-17:	1164	7383	15.8%
For foster children ages 13-17:	31	80	38.8%
For all members ages 18-20:	679	4996	13.6%
TOTAL	3526	39168	9.0%

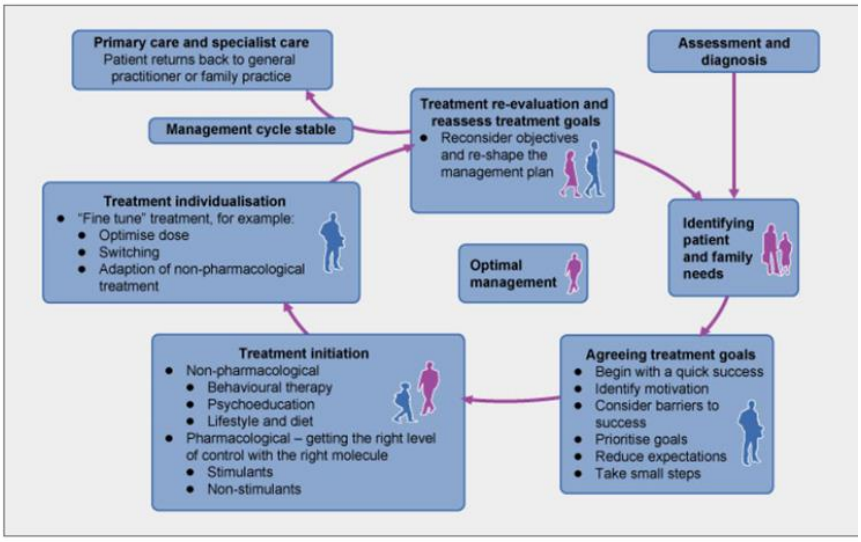
3. Aim Statement

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):
The aim of this project is optimizing management of members with a diagnosis of ADHD, which can be obtained through supportive care management. Supportive Care Management aim is to reduce members' functional impairments and provide a better quality of life through improved symptom management. This will be done through care management outreach and member monitoring, which will assist the plan in effective medication management and treatment success. Optimal care management of ADHD processes should be inclusive of input from the patient, family/caregivers and school to assist in establishing the appropriate therapy (non-

pharmacological and pharmacological), goals and assessment/follow-up, resulting in a tailored multimodal treatment plan centered on the patient.

The optimal management of ADHD process[1-3,18-22]



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.

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 overdiagnosis. 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.

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: Increase the percentage of validated ADHD screening instruments used from 45.45% at baseline to 59% target goal at final re-measurement. The target goal is set to match the NCQA HEDIS 50th percentile for ADD – Initiation and Continuation Phase by June 2019.
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: Increase the percentage of ADHD screenings in multiple settings from 27.27% at baseline to 59% target goal at final re-measurement. The target goal is set to match the NCQA HEDIS 50th percentile for ADD – Initiation and Continuation Phase by June 2019.
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: Increase the percentage of assessments of other behavioral health conditions from 45.45% at baseline to 59% target goal at final re-re-measurement. The target goal is set to match the NCQA HEDIS 50th percentile for ADD – Initiation and Continuation Phase by June 2019.
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: Increase the referrals for evaluation of other behavioral health conditions from 0.00% as baseline to 59% target goal at re-measurement. The target goal is set to match the NCQA HEDIS 50th percentile for ADD – Initiation and Continuation Phase by June 2019
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: Increase the percentage of referrals to treat other behavioral conditions from 0.00% as baseline to 59% target goal at re-measurement. The target goal is set to match the NCQA HEDIS 50th percentile for ADD – Initiation and Continuation Phase by June 2019.
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: Increase the percentage of PCP Care Coordination from 9.09% at baseline to 59% target goal at final re-measurement by June 2019.
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: Increase the percentage of members under 21 receiving care coordination services from 0.00% at baseline to 75% target goal at final re-measurement by June 2019.
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: Increase the percentage of members under 21 receiving case management outreaches from 0.00% at baseline to 75% target goal at final re-measurement by June 2019.
A9. ***MCO Outreach with Member ENGAGEMENT***: The percentage of the members outreached who were engaged in care management.
Baseline to final measurement goal: Increase the percentage of members under 21 with engagement in Case Management. The measure did not apply to any members at baseline. The target goal is set at 45% at final re-measurement June 2019.
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: Increase the percentage of members <6 who received first-line behavioral therapy from 0.00% at baseline to 45 target goal by final re-measurement. For this measure, also report the counts for each of the 3 exclusion reasons.

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: Increase the percent of members aged 6-12 who had one follow-up visit with the practitioner during the 30-day Initiation Phase from 45.3% at baseline to 47.6% at final re-measurement. Target goal is set to match the NCQA HEDIS 50th percentile annually, and at the final re-measurement of 2019.
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: **Increase the percent of members aged 6-12 who had two follow-up visits with a practitioner within nine months after the Initiation Phase ended from 51.2% at baseline to 55.9% at final re-measurement. Target goal is set to match the NCQA HEDIS 50th percentile annually, and at the final re-measurement of 2019.**

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: Increase the percent of members aged 0-20 with documentation of behavioral health pharmacotherapy with therapy from 30.0% at baseline to 40.0% at final re-measurement.
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: Decrease the percent of members aged 0-20 with documentation of behavioral health pharmacotherapy without therapy from 56.3% at baseline to 47.0% at final re-measurement. The target goal is set to match the HEDIS national percentiles.

Methodology

The methodology section describes how the data for the project are obtained.

1. 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.

2. Procedures

Data Collection:
ABHLA's on-going collection and monitoring of data covers several variables including quality indicators, systematic interventions, and initiating activities to sustain improvement to ensure complete and accurate data was collected. HEDIS and Non-HEDIS measures are being monitored, analyzed, and reported per State PIP requirements. All eligible members are included in the metric reporting for process measures. The Plan's Data Analyst collects pharmacy data from an ADHD first fill prescription report and then is utilized by Case

Management for outreach purposes. The Case Management Supervisor of Clinical Health utilizes an Aetna Case Management software (Dynamo) for tracking and trending individualized care planning, member outreach, education, community resources, and care coordination specific to the needs addressed.

Validity and Reliability
The Plan utilizes QSI (Quality Spectrum Insight) software system for reporting HEDIS performance indicators. Non-HEDIS metrics are reported from the Plan's QNEXT administrative claims software system. Pharmacy real-time data is provided to ABHLA from a CVS ADHD prescription first fill report, validated by Data Analytics, and utilized by Case Management for outreach purposes. Case Management member outreach, attempts, and outcomes are validated by monthly audits of member files by the Supervisor of Clinical Health. Outcomes are reported at the Quality Management/ Utilization Management (QMUM) committee meeting, and the Quality Management Operations committee (QMOC) meeting. Medical record reviews are conducted by both the PIP Project Manager and contracted abstractors trained by Quality Management on ADD HEDIS, Non-HEDIS, and hybrid measure specifications.

Data Analysis:
Data collection will be used to track and trend process and outcome measures for each measurement period. Data will be analyzed and validated by both Informatics and Quality Management.

Data will be contrasted internally over time to address any intervention modifications. If trends vary considerably, an analysis of data will take place to determine potential changes. The identification of barriers through barrier analysis and the selection of appropriate intrusions to address those barriers are necessary steps to improve outcomes. ABHLA will identify opportunities for improvement, and take actions based on our findings.

3. Project Timeline

[The timeline should include all important dates regarding the conduct of the study, including baseline measurement period, interventions, remeasurement period, analysis, final report. Complete the table below. For each event, provide a date or date range (start and end dates), as applicable.]

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 Year 2017** **NON-HEDIS Administrative Measure:** 1/1/17-12/31/17
Interim PIP Report Submission Date	**June, 2018**
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, 2019**

Interventions/Changes for Improvement

Interventions should be targeted to the study aim and should be reasonable and practical to implement considering plan population and resources.

1. Interventions Planned and Implemented

ABHLA outreached a total of 209 members with an ADHD diagnosis in CY 2017. The Plan identified a low rate for Case Management outreach and enrollment into the program. Case Management did not outreach members under 6 years of age. Causes for not reaching our process goals include:

- Undefined process
- Lack of internal resources
- Flagging system for specific subpopulations
- Lack of certified PCIT's
- Lack of available material

Refer to Appendix A (Cause and Effect Diagram - Member Outreach)

ABHLA's aim was to improve the follow-up care of members diagnosed with ADHD by December 31, 2017. The primary drivers of the intervention included:

- Improving member education
- Increasing Case Management outreach and enrollment
- Improving Case Management training module

Refer to Appendix B (Driver Diagram - Member Outreach)

ABHLA will provide on-site provider education after findings from the 2018 chart review concluded a knowledge deficit in the metrics reported. Also, education will include information to assist providers with accessing and utilizing the provider toolkit provided by AAP. Causes of the knowledge deficit include:

- Lack of departmental coordination and collaboration
- Lack of educational resources
- Breakdown of PCP education
- Delayed toolkit readiness
- Lack of care coordination

Refer to Appendix C (Cause and Effect Diagram - Provider Outreach)

ABHLA's aim is to improve the follow-up care of members diagnosed with ADHD by 2% by December 31, 2018 by conducting on-site education to 10 ADHD treating PCPs per month starting September 2018. The primary drivers of the intervention include:

- Collaboration with Provider Relations
- Improved educational materials
- Targeting PCP high prescribers

Refer to Appendix D (Driver Diagram – Provider Outreach)

ABHLA will begin providing outreach and care coordination for 70 foster care members with an ADHD diagnosis starting October 2018. Causes for the delayed outreach include:

- Lack of Plan understanding of State recommendations
- Lack of departmental collaboration
- Lack of internal resources
- Flagging system for foster care population
- Report generation

Refer to Appendix E (Cause and Effect Diagram – Foster Care Population)

ABHLA's aim is to conduct outreach on the 70 foster care members identified by December 31, 2018. The Case Management team will engage members to enroll in the program to provide the highest level of care coordination to assure member needs are met. The primary drivers of the intervention include:

- Accurate reporting tools
- Clinical team support
- Care Coordination

Refer to Appendix F (Foster Care Population Driver Diagram)

ABHLA formulated a PDSA for identifying and developing interventions for members under 6 years of age. This includes 56 members identified for on-going outreach through 2018 and care coordination to assure PCPs are following the recommended clinical care guidelines established by AAP.
Refer to Appendix G (PDSA – Members under 6)

Complete the sections in the table below and add more rows as needed. For each intervention, provide date ranges (start and end dates) in the first column of the table. Interventions that began post-remeasurement should not be listed as interventions since they could not impact the rates. They should be highlighted in the Next Steps section.

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]
Unable to aggregate geo-access report based on parameters given	Workforce Capacity	1	Intervention #1 – Collaborate with LDH to build a network of providers throughout the State trained in evidence-based treatments (CPP, PCIT, and, PMT) for children under 6. Intervention #1a - Expand the ADHD referral capacity across the state.	*Planned Start: October 2017* *Actual Start: Plan to perform additional research for capturing PMT services*

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]
			Intervention #1b - Analyze network adequacy. Determine geo access to address gaps in specific regions/parishes. Measure ongoing access to services. Intervention #1c - Collaborate with LDH and MCOs to establish accessible training programs for providers. Intervention #1d – Outreach to Behavioral Health clinicians to determine their Specialty and recruit for training program Intervention #1e - Collaborate with LDH and MCOs to create a marketing strategy for advertising the training program and disseminating to appropriate associations and university programs.	*Date Revised: No Revisions*
Unable to aggregate geo-access report based on parameters given	Workforce Capacity	2	Intervention #2 – Work with Informatics to determine proper coding to determine network certified CPP, PCIT, and PMT for quarterly reporting.	*Start: June 2018* *Actual Start: June 2018* *Date Revised:* *Currently, working with Case Management, Provider Relations and other team members in the development of the educational tools required to bring members and provider into compliance with appropriate educational methodologies.*
Provider knowledge deficit regarding ADHD clinical guidelines and inconsistent use of validated screening tools	Provider Education	3	Intervention #3 – ABHLA performs provider and office staff outreach and education interventions Intervention #3a – Target education efforts towards ADHD treating providers and providers with gaps in care as identified	*Planned Start: April 2017* *Actual Start: June 2018* *Date Revised: No Revisions*

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]
			through the provider survey and medical record review. Intervention #3b - Support providers and office staff within person training on accessing the AAP provider toolkit and tracking and trending education efforts Intervention #3c - Utilize Provider Relation Liaisons to bring materials to provider offices that list resources in the providers' region/parish where referrals can be actively made Intervention #3d - Develop a Provider Relations checklist for provider visits. The checklist will include materials for provider visits (billing guides, resources, etc.) and cover topics that should be discussed with the Provider such as HEDIS guidelines, Gaps in Care reports, and value based contracting solutions. Intervention #3e - Edit existing provider site visit survey to include quality topics which will include options for providers to ask for training and receive materials regarding ADHD. Intervention #3f - Conduct provider webinars Intervention #3g - Utilize Provider Relations liaisons to coordinate resources between physicians and Behavioral Health resources in the region. Reps will work with providers to bridge relationships between physicians and behavioral health staff in their area to increase referral resources for these physicians.	
Lack of qualified BH specialists for member referrals Lack of knowledge diagnosing/ treating ADHD and co-occurring conditions	Behavioral Health consultation to PCPs	4	Intervention #4 – Distribute an updated list of BH therapist/Counselors per region during on-site provider education Intervention #4a - Improve the PCP's ability to access consultations from behavioral specialists by providing information	*Planned Start: June 2017* *Actual Start: May 2018* *Date Revised: No Revisions*

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]
			on AAP guidelines specific to ADHD Intervention #4b - Increase members referrals to tele-therapy vendor (i.e. Breakthrough Services)	
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	5	Intervention #5 - ABHLA will enhance CM case finding procedures. Case managers' goals: establish BH provider, discuss medications and their effectiveness, PCP appointment in 30 days from fill date and 2 more visits within 9 months. Intervention #5a - ADHD Medication First Fill Report: Four times per month (when Rx claims are refreshed), members who have received a first fill of ADHD medication are reviewed for CM history with the plan. Case managers' goals: establish BH provider, discuss medications and their effectiveness, PCP appointment in 30 days from fill date and 2 more visits within 9 months. Intervention #5b – Direct member outreach will be conducted based from referrals from the first fill prescription report with the purpose of enrollment into the Care Management Program Intervention #5c – Unreachable members will be mailed a letter explaining the benefits of enrollment into the program along with the member toolkit. Initial PDSA worksheet 8/24/2018  CollaborativeADHD PIP_PDSA_WORKSHE	*Planned Start: March 2017* *Actual Start: March 2017* *Date Revised: May 2018*
Lack of a streamlined process for capturing and accurately reporting member outreach, BH	Enhanced Case Management	6	Intervention #7 – Bi-weekly reports generated for newly diagnosed ADHD members utilized for 100%-member outreach, education,	*Planned Start: May 2018* *Actual Start: May 2018*

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]
referrals, and care coordination for all newly diagnosed members			scheduling assistance, case management enrollments, care coordination, BH referrals, and tele-therapy coordination. Intervention #7a - Care managers will provide educational materials and community resources to help them better manage their ADHD and associated symptoms. They will utilize the same resource guides that provider relations will be delivering to providers that list BH therapy services in their region/parish. (B2.2.1)	
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	7	Intervention #8 - There are 3 identifying questions on the new member welcome call that identify members potentially diagnosed with ADHD. The welcome call will prompt the member to speak with a case manager if desired or a call back is generated.	*Planned Start: Dec. 2017* *Actual Start: Sept. 2018*
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	9	Intervention #9 - CM initiates a Care Plan for members meeting criteria and/or requested by PCP, member/parent. The Care Plan will reflect collaboration by PCP with CM, BH therapist and caregiver/ child. Intervention #9a - Design a process to confirm consent from caregiver/child to share care plan with the care team. The consent is documented as a note in CM Activity Tracking and must be standardized for appropriate reporting.	*Planned Start: April 2017* *Actual Start: April 2017*
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	10	Intervention #10 – Utilization of the ABHLA's Case Management team to support the PCPs' internal capacity to effectively coordinate the individual members care. Make referrals to BH therapy, case management, community resources and communicate with teachers (in lieu of onsite coordinator).	*Planned Start: April 2017* *Actual Start: April 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]
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	11	Intervention #11 - Provide parents the Bright Futures teacher rating scale that can be completed by the teacher and brought to the physician. This would be sent regardless of whether member agrees to case speaking with us and remind them we are here if needed management. Letter can thank them for.	*Planned Start: Dec. 2017* *Actual Start: June 2018*
Lack of a streamlined process for capturing and accurately reporting member outreach, BH referrals, and care coordination for all newly diagnosed members	Enhanced Case Management	12	Intervention #12 - Refer guardians to breakthrough for parental training under 6 years old that meet criteria to PCIT, Triple P, or Child-Parent Psychotherapy (CPP). Care Management will educate member's parent(s)/guardian(s) to breakthrough.	*Planned Start: Oct. 2017* *Actual Start: May 2018*
Lack of health literacy available for all members diagnosed and member awareness of the diagnosis and benefits of care coordination	Enhanced Case Management	13	Intervention #13 - Provide parents who are unable to reach after 2 attempts with a member toolkit via mail-out to address symptoms, treatment, follow-up care, and parental resources.	*Planned Start: May 2018* *Actual Start: May 2018*
Members under 48 ordered psychotropic medication without physiological symptoms / health reasons to quantify usage	Enhanced Case Management	14	Intervention #14 – Data analysis to be conducted regarding the correlation between psychotropic medications prescribed to members with a diagnosis of ADHD and other medical conditions, example seizure disorders. For CY 2017, 9 members under 48 months were identified with an ADHD drug without BH. 7 of those members were found to have a physical disorder leading to the prescription order. 4 diagnosed with seizure disorder. The Plan with conduct provider education for the two members without a physical condition to determine cause of drug. Intervention #14a – Generate a report of members ages 48 months	*Planned start: Sept. 2018* *Actual Start: Sept. 2018*

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]
			and younger with a confirmed ADHD diagnosis Intervention #14b – Review medical records of same members for rationale behind ordering by MD based upon physiological symptoms For CY 2018, 13 members under 48 months were identified with an ADHD drug w/o BH. All 13 of these members had at least one diagnosis for a seizure disorder during the 2018 dates of service.	
Foster care members for children ages 6-12 prescribed an ADHD drug without behavioral therapy, and identified an increased rate from baseline to interim from 38.3% to 50%	Enhanced Case Management	15	Intervention #15 – Case Management clinical team to begin outreach. Goal: 70 members, under the age of 21 years, to phone members and/or legal guardian who receive foster care services with care coordination services arranged #15a – Care coordination to include contacting State case worker to assure behavioral therapy is integrated into the care #15b – Case Management to document physical conditions/symptomology that requires the use of an ADHD drug, and reasons why no behavioral health therapy has been prescribed All 139 members identified in the ADHD 2018 final report were outreached by Case Management and appropriate documentation made. The breakdown for outreach is as follows: • Under 6 – 65 • 6 and Up – 74	*Planned start: Sept. 2018* *Actual Start Date: Sept. 2018*

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 Reporting	Enhanced Case Management	16	Intervention #16 Excel reporting spreadsheet designed for manual data entry of member specific information, including: ○ Care Coordination activities, such as scheduling doctor's appointments ○ Member enrollment totals, including member opt in and opt out ○ Total number behavioral health referrals ○ Tracking of member educational mailers ○ Tool kit distribution tracking	*Planned Start: April 2018* *Actual Start: May 2018*

2,3,4,5: 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]	Q2 Final 2018	Q3 Final 2018	Q4 Final 2018
1	# Certified PCIT/PMT/CPP Therapists / # Members (0-5 years) x 1000 (Measured by parish)	Unable to run report by provider specialty, currently updating our provider registry	Unable to run report by provider specialty, currently updating our provider registry	Unable to run report by provider specialty, currently updating our provider registry

Number of Intervention	Description of Intervention Tracking Measures[6]	Q2 Final 2018	Q3 Final 2018	Q4 Final 2018
2	# Providers participating in continuing education / Total # Pediatricians	Num: 23 Den: 465 Rate: 4.95%	Num: 20 Den: 435 Rate: 4.60%	Num: 14 Den: 482 Rate: 2.90%
3	# Provider Education Events Completed / # Provider Events Planned (minimum of 10)	Num: 6 Den: 10 Rate: 60%	Num: 5 Den: 10 Rate: 50%	Num: 13 Den: 13 Rate: 100%
4	# Completed Telemedicine visit (1) / # ADHD Members	Num: 0 Den: 209 Rate: <1%	Num: 0 Den: 421 Rate: <1%	Num: 2 Den: 382 Rate: <1%
5	# Members outreached by plan care coordinators / # Members referred based on new ADHD diagnoses by region	Num: 138 Den: 209 Rate: 66.03%	Num: 191 Den: 366 Rate: 52.19%	Num: 168 Den: 261 Rate: 64.37%
6	# of ADHD members with a successful contact (live communication) / # of ADHD members contacted	Num: 24 Den: 138 Rate: 17.39%	Num: 30 Den: 191 Rate: 15.71%	Num: 27 Den: 168 Rate: 16.07%
7	# ADHD members enrolled in CM / # ADHD members with successful contacts	Num: 12 Den: 24 Rate: 50%	Num: 4 Den: 30 Rate: 13.33%	Num: 13 Den: 33 Rate: 39.39%
8	# ADHD Referrals to CCP, PCIT, PMT, BH Therapists / # Eligible ADHD referrals (0-5)	Num: 0 Den: 26 Rate:0.00%	Num: 1 Den: 3 Rate: 33.33%	Num: 6 Den: 10 Rate: 60%
9	# ADHD Referrals to CCP, PCIT, PMT, BH Therapists / # Eligible ADHD referrals (6-20)	Num: 0 Den: 22 Rate:0.00%	Num: 23 Den: 27 Rate: 85.19%	Num: 20 Den: 23 Rate: 86.96%
10	# Member received educational material / ADHD population	Num: 160 Den: 209 Rate: 76.56%	Num: 365 Den: 375 Rate: 97.33%	Num: 167 Den: 261 Rate: 63.98%

6: 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	Q1 2018
1	Workforce capacity Num: # Certified PCIT/PMT/CPP therapists Denom:# Members under 6	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den:0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%
2	Provider Education Num: # Providers participating in continuing education Denom: Total # Pediatricians (provider attendance credit is awarded with office staff representation)	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num:140 Den:1859 Rate: 7.53%	Num: 21 Den:1859 Rate: 1.13%
3	Provider Education Num: # Provider toolkit education events completed Denom:# Provider events planned	Num: 1 Den: 10 Rate: 10%	Num: 1 Den: 10 Rate: 10%	Num: 1 Den: 10 Rate: 10%	Num: 4 Den: 10 Rate: 40%	Num: 1 Den: 10 Rate: 10%
		Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 1 Den:1 Rate: 100%	Num: 1 Den: 1 Rate: 100%	Toolkit has been ordered, approved, and paid for by ABHLA. Toolkit is now available on website of American Academy of Pediatrics
5	Behavioral Health Consultation to PCPs Num: # Completed telemedicine visits	Num: 0 Den: 301 Rate: 0.00%	Num: 0 Den: 195 Rate: 0.00%	Num: 0 Den: 235 Rate: 0.00%	Num: 1 Den 411 Rate: <1%	Num: 0 Den 256 Rate: 0.00%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
	Denom:# ADHD members					
6	Enhanced Case Management Num: # ADHD referrals to CM Denom:# ADHD members	Num: 119 Den: 301 Rate: 39.53%	Num: 48 Den: 195 Rate: 24.62%	Num: 93 Den: 235 Rate: 39.57%	Num: 169 Den: 411 Rate: 41.12%	Num: 71 Den: 256 Rate: 27.73%
7	Enhanced Case Management Num: # Member received educational material Denom:# ADHD population	Num: 301 Den: 301 Rate: 100%	Num: 195 Den: 195 Rate: 100%	Num: 235 Den: 235 Rate: 100%	Num: 411 Den: 411 Rate: 100%	Num: 256 Den: 256 Rate: 100%
8	Enhanced Case Management Num: # ADHD Care Plans Denom:# ADHD Members	Num: 31 Den: 301 Rate: 10.30%	Num: 14 Den: 195 Rate: 7.18%	Num: 19 Den: 235 Rate: 8.09%	Num: 26 Den: 411 Rate: 6.33%	Num: 0 Den: 13 Rate: <1%
9	Enhanced Case Management Num: # ADHD referrals to CCP, PCIT, PMT Denom:# Eligible ADHD referrals	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 0 Rate: 0.00%	Num: 0 Den: 13 Rate: 0.00%
10	Enhanced Case Management Num: # ADHD members outreached by plan care coordinators Denom:# ADHD members by region	Num: 51 Den: 301 Rate: 16.94%	Num: 30 Den: 195 Rate: 15.38%	Num: 26 Den: 235 Rate: 11.06%	Num: 102 Den: 411 Rate:24.81%	Num:159 Den: 256 Rate: 62.11%
11	Enhanced Case Management Num: # ADHD members in CM Denom:# ADHD members, by ICM level by region	Num: 31 Den: 301 Rate: 10.30%	Num: 14 Den: 195 Rate: 7.18%	Num: 19 Den: 235 Rate: 8.09%	Num: 26 Den: 411 Rate: 6.33%	Num: 4 Den: 256 Rate: 1.56%

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

2. Barrier Analyses

[Barrier analysis should be conducted as part of the project design. Describe the barriers that your interventions are designed to overcome, e.g., lack of member or provider knowledge, lack of transportation, lack of standardized tools, lack of adequate discharge planning. Barrier analyses should include analyses of data, both quantitative and qualitative (such as focus groups or interviews) and published literature where appropriate. Barriers are distinguished from challenges you confronted in conducting the study. Those challenges should be described in the Limitations section.]

- Member Outreach (live contacts)
- Therapy for assistance with parental training
- Medical record review on-site with survey/interview real-time of providers to determine ways to assist them to improve their means of managing their ADHD patients conducted monthly
- Lack of qualified behavioral specialists (PCIT, PMT, BH Therapists)
- Access to large provider groups
- Clarity of state regulations to ensure same quality of care
- Collaborations with Provider Relations team to provide report for ADHD treating providers
- Underutilization of vendor
- Ability to partner with school-based facilities for ongoing monitoring and collaboration
- Actionable Gap Analysis

Family School Success (FSS) is an intervention program that links the family and school systems to address the needs of elementary school children with ADHD (Power, Soffer, Clarke, & Mautone, 2006). In addition, the health system may be included in the process of intervention planning for cases in which the parents elect to have their children take medication to treat ADHD as part of the intervention package. The purpose of this article is to describe key components of the program and the theoretical foundation upon which they were developed.

FSS was originally designed as a clinic-based, family–school intervention for elementary-aged children with ADHD. The FSS program is grounded in attachment theory, social learning theory, and ecological systems theory. In addition, research related to family involvement in education strongly influences the FSS model. FSS consists of 12 weekly sessions, including six group sessions for parents with concurrent child groups, four individual family behavior therapy sessions, and two conjoint behavioral consultation sessions held at the school (Power et al., 2006). Program goals include (a) strengthening the parent-child relationship; (b) improving parents' behavior management skills (i.e., through the use of positive attending and token economy systems); (c) increasing family involvement in education at home (i.e., through homework support and parent tutoring); and (d) promoting family–school collaboration to address educational difficulties. Program clinicians have been doctoral-level providers in clinical or school psychology.

Strengthening the Parent–Child Relationship

As is the case for several parent training programs for children with attention and behavior disorders (e.g., Barkley et al., 2001; Bell & Eyberg, 2002; McMahon & Forehand, 2003; Webster-Stratton, 2005a), the FSS program draws from attachment theory and places a strong emphasis on the development and maintenance of strong parent–child relationships.

Through positive interactions with their parents, children learn self-regulation skills that provide the foundation for relationships with adults and peers outside of the home. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3195402/

Results

The results section should quantify project findings related to each study question and project indicators. **Do not** interpret the results in this section.

Performance Indicator	**Administrative (A) or Hybrid (H) Measure?**	**Baseline Period** MY 2016	**Interim Period** MY 2017	**Final Period** Insert final measurement year	**Final Goal/Target Rate**
Indicator #1 A1. Validated ADHD Screening Instrument	H	Eligible Population = 40 Exclusions= 29 If "H", Sample size = 11 Num: = 5 Den = 11 Rate = 45.45%	Eligible Population = 94 Exclusions= 34 If "H", Sample size = 60 Num: = 12 Den = 60 Rate = 20.00%	Eligible Population = 60 Exclusions= 17 If "H", Sample size = 60 Num: = 16 Den = 43 Rate = 37.21%	Target Rate: 59% Rationale: The rate increased from interim rate of 20% to 37.21% in the Final Period. Rate increase of 17.21%
Indicator #2 A2. ADHD Screening in Multiple Settings	H	Eligible Population = 40 Exclusions= 29 If "H", Sample size = 11 Num: = 3 Den = 11 Rate = 27.27%	Eligible Population = 94 Exclusions= 34 If "H", Sample size = 60 Num: = 12 Den = 60 Rate = 20.00%	Eligible Population = 60 Exclusions= 17 If "H", Sample size = 60 Num: = 21 Den = 43 Rate = 48.84%	Target Rate: 59% Rationale: The rate increase from interim rate of 20% to 48.84% in the Final Period. Rate increase of 28.84%
Indicator #3 A3. Assessment of other behavioral health conditions/ symptoms	H	Eligible Population = 40 Exclusions= 29 If "H", Sample size = 11 Num: = 5 Den = 11	Eligible Population = 94 Exclusions= 34 If "H", Sample size = 60 Num: = 26 Den = 60	Eligible Population = 60 Exclusions= 17 If "H", Sample size = 60 Num: = 17 Den = 43	Target Rate: 59% Rationale: The rate decreased from interim rate of 43.33% to 39.53% in the Final Period. Rate decrease of 3.8%

		Rate = 45.45%	Rate = 43.33%	Rate = 39.53%	
Indicator #4 A4. Positive findings of other behavioral health conditions	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 11 Num: = 1 Den = 11 Rate = 9.09%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 28 Den = 60 Rate = 46.67%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = 60 Num: = 14 Den = 43 Rate = 32.56%	Target rate to be established in collaboration with LDH. No target rate established upon baseline.
Indicator #5 A5a. Referral for EVALUATION of other behavioral health conditions	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 1 Num: = 0 Den = 1 Rate = 0.00%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 9 Den = 28 Rate = 32.14%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = 60 Num: = 7 Den = 14 Rate = 50.00%	Target Rate: 59% Rationale: The rate increased from interim rate of 32.14% to 50.00% in the Final Period. Rate increase of 17.86%
Indicator #6 A5b. Referral to TREAT other behavioral health conditions	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 1 Num: = 0 Den = 1 Rate = 0.00%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 10 Den = 28 Rate = 35.71%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = 60 Num: = 6 Den = 14 Rate = 42.86%	Target Rate: 59% Rationale: The rate increase from interim rate of 35.71% to 42.86% in the Final Period. Rate increase of 7.15%
Indicator #7 A6. PCP Care Coordination	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 11 Num: = 1 Den = 11 Rate = 9.09%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 9 Den = 60 Rate = 15%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = 60 Num: = 2 Den = 43 Rate = 4.65%	Target Rate: 59% Rationale: The rate decreased from interim rate of 15% to 4.65% in the Final Period. Rate decrease of 10.35%

Indicator #8 A7. MCO Care Coordination	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 11 Num: = 0 Den = 11 Rate = 0.00%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 7 Den = 60 Rate = 11.67%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = 60 Num: = 3 Den = 43 Rate = 6.98%	Target Rate: 75% Rationale: The rate decreased from interim rate of 11.67% to 6.98% in the Final Period. Rate decrease of 4.69%
Indicator #9 A8. MCO Outreach with Member Contact	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 11 Num: = 0 Den = 11 Rate = 0.00%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = 60 Num: = 13 Den = 60 Rate = 21.67%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = N/A Num: = 7 Den = 43 Rate = 16.28%	Target Rate: 75% Rationale: The rate increased by 21.67% from a baseline rate of 0.00% to interim rate of 21.67% and decreased by 5.39% to a Final Rate of 16.28%
Indicator #10 A9. MCO Outreach with Member ENGAGEMENT	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 11 Num: = 0 Den = 11 Rate = 0.00%	Eligible Population = 94 Exclusions= 34 If “H”, Sample size = N/A Num: = 4 Den = 60 Rate = 6.67%	Eligible Population = 60 Exclusions= 17 If “H”, Sample size = N/A Num: = 2 Den = Enter # 43 Rate = 4.65%	Target Rate: 45% Rationale: The rate increased by 6.67% from a baseline rate of 0.00% to interim rate of 6.67% and decreased by 2.02% to a Final Rate of 4.65%
Indicator #11 A10. First Line Behavior Therapy for Children < 6 years	H	Eligible Population = 40 Exclusions= 29 If “H”, Sample size = 1 Num: = 0 Den = 1 Rate = 0.00%	Eligible Population = 42 Exclusions= 12 If “H”, Sample size = 30 Num: = 3 Den = 30 Rate = 10%	Eligible Population = 30 Exclusions= 10 If “H”, Sample size = 30 Num: = 2 Den = 20 Rate = 10%	Target Rate: 45% Rationale: No change in rate from Interim to Final.

Indicator #11 A10a. Clinical Exclusions[1,2]	H	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = NA Exclusions= NA If "H", Sample size = NA Num: = NA Den = NA Rate = NA	Target Rate: N/A Rationale: Not identified during medical record review
Indicator #11 A10b. Exclusions- No qualified providers in area[1]	H	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = NA Exclusions= NA If "H", Sample size = NA Num: = NA Den = NA Rate = NA	Target Rate: N/A Rationale Not identified during medical record review
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients[1]	H	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = NA Exclusions= NA If "H", Sample size = NA Num: = NA Den = NA Rate = NA	Target Rate: N/A Rationale Not identified during medical record review
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients[1]	H	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = N/A Exclusions= N/A If "H", Sample size = N/A Num: = N/A Den = N/A Rate = N/A	Eligible Population = NA Exclusions= NA If "H", Sample size = NA Num: = NA Den = NA Rate = NA	Target Rate: N/A Rationale Not identified during medical record review

Indicator #12 B1a. HEDIS ADD Measure: Initiation Phase	A	Eligible Population = 181 Exclusions= 0 If "H", Sample size = N/A Num: = 82 Den = 181 Rate = 45.30%	Eligible Population = 366 Exclusions= 0 If "H", Sample size = N/A Num: = 166 Den = 366 Rate = 45.36%	Eligible Population = 428 Exclusions= 0 If "H", Sample size = N/A Num: = 186 Den = 457 Rate = 40.07%	Target Rate: 47.60% Rationale: ABHLA did not meet NCQA benchmark of 47.60% for the Initiation Phase, with a rating score of 40.07% with a difference of -7.53% of the Targeted NCQA rate.
Indicator #13 B1b. HEDIS ADD Measure: Continuation Phase	A	Eligible Population = 43 Exclusions= 0 If "H", Sample size = N/A Num: = 22 Den = 43 Rate = 51.2%	Eligible Population = 58 Exclusions= 0 If "H", Sample size = N/A Num: = 35 Den = 58 Rate = 60.34%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = N/A Num: = 31 Den = 54 Rate = 57.40%	Target Rate: 55.9% Rationale: ABHLA did met NCQA benchmark of 55.9% for the Continuation Phase of Treatment with a rating score of 57.40%, with difference of +1.5% of the Targeted NCQA Rate
Indicator #14 B2a. BH Drug with Behavioral therapy[3]	A	Eligible Population = 3101 Exclusions= 0 If "H", Sample size = N/A Num: = 913 Den = 3101 Rate = 29.4%	Eligible Population = 3526 Exclusions= 0 If "H", Sample size = N/A Num: = 1213 Den = 3526 Rate = 34.40%	Eligible Population = 4155 Exclusions= 0 If "H", Sample size = N/A Num: = 1430 Den = 4155 Rate = 34.42%	Target Rate: 40% Rationale: ABHLA did not meet the target benchmark of 40% for Behavioral Health drugs with therapy with a rate of 34.42%, with difference of -5.58% for the final rate.
Indicator #15 B2b. BH Drug WITHOUT Behavioral therapy[3]	A	Eligible Population = 3101 Exclusions= 0 If "H", Sample size = N/A Num: = 1766	Eligible Population = 3526 Exclusions= 0 If "H", Sample size = N/A Num: = 1946 Den = 3526	Eligible Population = 4155 Exclusions= N/A If "H", Sample size = N/A Num: = 2180 Den = 4155	Target Rate: 47% Rationale: ABHLA did not meet the target benchmark of 47% for Behavioral Health drugs without

		Den = 3101 Rate = 56.9%	Rate = 55.19%	Rate = 52.47%	therapy with a rate of 52.47%, with difference of -5.47%. Measure did decrease from interim by 2.72% for Final.

[1]The Den 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.

Discussion

The discussion section is for explanation and interpretation of the results.

1. Discussion of Results

The MY 2018 HEDIS rating scores did not demonstrate improvement from MY 2017. For ADD initiation phase, MY 2018 final rating score of 40.07%, decreased of 7.53 percentage points for the NCQA targeted rate. ABHLA did not meet the goal of 47.6% NCQA 50th percentile for the initiation phase of treatment. ADD continuation and maintenance phase MY 2018 rating score of 57.40%, increased by 1.5 percentage points for the NCQA targeted rate. Although there was a decrease identified in the continuation and maintenance phase from interim to final period. The rate decreased from 60.34% to 57.40%, however ABHLA did meet goal of 55.9% NCQA 50th percentile for continuation phase of treatment.

When measuring Non-HEDIS metrics, behavioral health drugs with therapy showed inconsistency across the board and therefore we did not meet the target rate of 40% for the final re-measurement period. Behavioral health drugs without therapy exhibited a slight improvement with a decreased rate from 55.2% to 52.47%. ABHLA did not meet the target benchmark of 47% for behavioral health drugs without therapy. The Plan has developed new strategies for assisting members without behavioral health therapy. New interventions have been developed and implemented in 2018 to sustain improvement including new referrals to tele-therapy utilizing our vendor, Breakthrough, as well as the utilization of an updated list of Behavioral Health providers stratified by region. Case Management behavioral health referrals will properly assist the member with identifying any common co-existing conditions. ABHLA will classify members with co-existing conditions in a higher risk status by adding a flag to the member outreach data and work towards implementing an action plan to assure the proper services and resources are offered for members with the specified conditions. With all the changes implemented in 2018 we did see a decrease of 2.72%, which was significant, however, not enough to meet the benchmark target.

We identified opportunities for improvement for NCQA HEDIS rates and will continue with our intervention of enhance case management and expect to have positive impacts on metrics moving forward:

- Certified CPP, PCIT, and PMT continuing to work with case management, provider relations, Medical Directors to identify educational tool to ensure that the plan is providing appropriate

educational materials through email fax blast to provider, face to face visits, information posted to provider portal.

Provider_Onsite_Handout.docx

- Due to low referral rates for behavioral health therapy, education regarding the Plan's vendor, Breakthrough, has been provided. Breakthrough offers tele-behavioral health, also called tele-therapy, as a new way to get mental health and substance use care. In addition, Case Management has identified a designated CM staff member, who is dedicated to reaching out to members that have been identified with an ADHD Diagnosis. Those members are offered the following assistance:
    - Parental/Caregiver Training
    - Referral to Breakthrough (Breakthrough offers tele-behavioral health, also called tele-therapy, as a new way to get mental health and substance use care.)
    - Mailed a Member Toolkit, which is inclusive of the patient guide and appointment tracker.

adhdtoolkitpatientguideandappointme

    - Given the opportunity to opt into CM
    - Offered Transportation services
    - Assistance with appointments

  As well as utilizing tele-therapy as a referral source for members. All Case Management processes will continue pass the final stage
- The Case Management team solicits member feedback regarding barriers to BH and PCP appointment scheduling through member surveys, individualized care planning (discusses barriers), as well as member outreach following a reported grievance.
- Case Management increased member calls in 2019 from 3-5 to reach more member via live contact.
- Outreach efforts were successfully improved via IVR program and member appointment reminder mailers, which allowed for 100% outreach efforts for members who were prescribed an ADHD drug. ABHLA is continuing the IVR Campaign with a focus on initiation and continuation for members to identify any gaps in care as it relates to:
    - PCP Appointment Availability
    - Transportation
    - Medication Adherence
- Due to low participation in provider webinars and not meeting the ADHD HEDIS Initial Phase NCQA benchmark, ABHLA will expand HEDIS webinar training and begin targeting high volume providers for on-site education opportunities.
- Due to low case management outreach rates, a pharmacy first time fill report was created that flags first time ADHD prescription to assist the plan in addressing all newly diagnosed members. Information from this report is reviewed weekly through case management. The goal is direct member outreach, which is expected to continue to have a positive impact on our HEDIS initiation phase metric.
- ABHLA identified 70 Foster Care members to be included in the program based on appendix F for review in 2018 and based on the findings, 54 of those members remained at the end of reporting period in 2018. Fifty-one (51) remained at the end of reporting in

2019. These members were assigned to a single staff member in case management, who responsibilities include the following:

- Engaging the members in CM
- Assisting with provider referrals
- Medication adherence
- Assisting with behavioral therapy, etc.

The outcome from this interaction identified that many of the foster care population was either termed or aged out of foster care. The plan between November and December of 2018 received 2 new Foster Care members and 4 new members in the timeline of March through June 2019. ABHLA decided to take a holistic approach to the ADHD population for corroboration in providing the same level of care to all members based on these findings.

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:
Improvement of the HEDIS measure continuation and maintenance phase is reflected from the member and provider outreach interventions throughout the PIP. Both provider and member letters were mailed based from an ADHD first fill report informing providers/members of the recommended appointments for monitoring of medication.
Improvement of behavioral health drugs with therapy from administrative claims was not attributable by the Plan's Case Management team due to the provider telephonic outreach project initiated in fall of 2017 and completed in 2018. The behavioral health provider directory was updated and is now being utilized by Case Management for member referrals.

What factors were associated with success or failure? HEDIS scores increased significantly for both initiation phase and continuation phase due to new initiative in 2018 and ongoing activities in 2019, which included the Case Management Outreach, IVR campaign, Reminder Letters, On-site Provider visit, Provider tool-kit education, Member tool-kit education and the initiation of a dedicated CM staff member who was used to engage members participation in the available program within the plan. These activities allotted ABHLA to continue to see improvement in the HEDIS metrics and are expected to continue the positive trend.
Minimal improvement was noted for behavioral health drugs with and without therapy. This is an area noted for improvement throughout the calendar year. The case manager will continue to outreach members and give three referrals for BH therapy.

Limitations

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?** Limitations include appropriate documentation of the hybrid measures for chart review. If care coordination is limited between providers, proper documentation of assessments and screenings may not be available for reporting. In addition, incorrect procedure/diagnosis codes may pose a threat by compromising data validity.
- **Were there any threats to the external validity the findings?** Claims coding could pose as a threat to our findings when incorrect filing of diagnosis/procedure codes for both follow-up appointments and behavioral health therapy take place

- **Describe any data collection challenges.** Proper coding and appropriate documentation of codes for administrative capture of data.

Member Participation

Members under 21 began receiving appointment reminder letters in 2016 to schedule a follow-up appointment with their doctor before the first 30 days of the ADHD prescription fill and then again to remind them of two additional needed follow-up visits to assure the medication was working properly. In addition, Case Management outreach began utilizing the same pharmacy data to ensure consistency across the board with data, which would allow them the ability in 2017 to help with care coordination and case management services.

After reviewing member compliance, interventions proved to be successful for the 30-day follow-up visits from the date of prescription and post 30-day visit for a period, however continuous review or processes are ongoing to identify best practices for the plan to meet this metric.

Describe methods utilized to solicit or encourage membership participation: Case Management Outreach, IVR campaign, Reminder Letters, and Member tool-kit distribution assisted with the significant increase in our HEDIS initiation and continuation phases.

Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** Distribution of member newsletters, member follow-up appointment letters, provider toolkit and provider letters informing of HEDIS measure specifications for compliance once a prescription was issued.

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

1. Lessons Learned

- When making referral to Breakthrough – members are not utilizing the referral process appropriately (Methodology: Use live contact data with members to gauge participation)
- Unsuccessful Contact - Increase call attempts from 3 to 5
- Rate low for Hybrid Chart Review – Increase onsite education highlighting the areas of low performance
- BH Drugs w/o Therapy – Improve BH therapy when ADHD drugs are prescribed through better education of provider; collaboration with PR team to provide report on provider by region/parish.
- Tool-Kit Education: Implement better tracking mechanism; increase number of provider visits to improve use AAP toolkit.
- Engagement of plan resources to ensure communication and collaboration in moving the needle on metrics

- Develop internal educational program and resources to assist and encourage mental health providers to engage parents to ensure that programs recommendations that allow the family unit to have desired outcomes from treatments are achieved. This would encompass programs such as: Certified Parent – Child Interaction (PCIT), Parent Management Training (PMT), and Child Parent Psychotherapy (CPP) certification
- Partner with Case Management, Provider Relations, and other departments to provide educational services
- Develop tracking methodology for certification program
- Formalization of committees with clarity of state regulations to ensure same quality of care
- Continue member activities such as (i.e. Member Website, Member Mailers, Member Newsletter, IVR Calls, and Member Toolkits)
- Designated CM staff member will continue activities to increase member engagement in to Case Management.
- ABHLA is currently working with Wellpass (Welltok) in the development stages for member surveys to gauge members concerns with:
    - Barriers to BH
    - Childcare Needs

2. System-level Changes Made and/or Planned

[Describe how findings will be used, actions that will be taken to sustain improvement, and plans to spread successful interventions to other applicable processes in your organization.]

- Assess organization for readiness for change, to include estimation of impact to staffing, front line staff and critical data integration and availability
- Work with permanent PIP task force in developing a work group infrastructure that utilizes clinical, claims and operational data to facilitate review of member outreach/education and provider outreach/education with continuous quality improvement based on baseline data, using SMART to increase metric overtime
- Design a workforce team with different levels of responsibilities such as guidance team, clinical team and work group team for sustainable results
- Align Behavioral health surveys to ascertain and analyze member engagement
- Integration of the marketing department to schedule townhalls with members as an educational event
- Implementation of member incentive for achieving compliance with completion of PMT
- Partner with provider to ensure the ability to perform medical record review on-site with survey/interview real-time of providers to determine ways to assist them to improve their means of managing their ADHD patients conducted monthly
- Identify new outcome measure to track the number of toolkit access/provider education events
- Identify ways to increase Case Management successes in outreach and the referral processes

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:

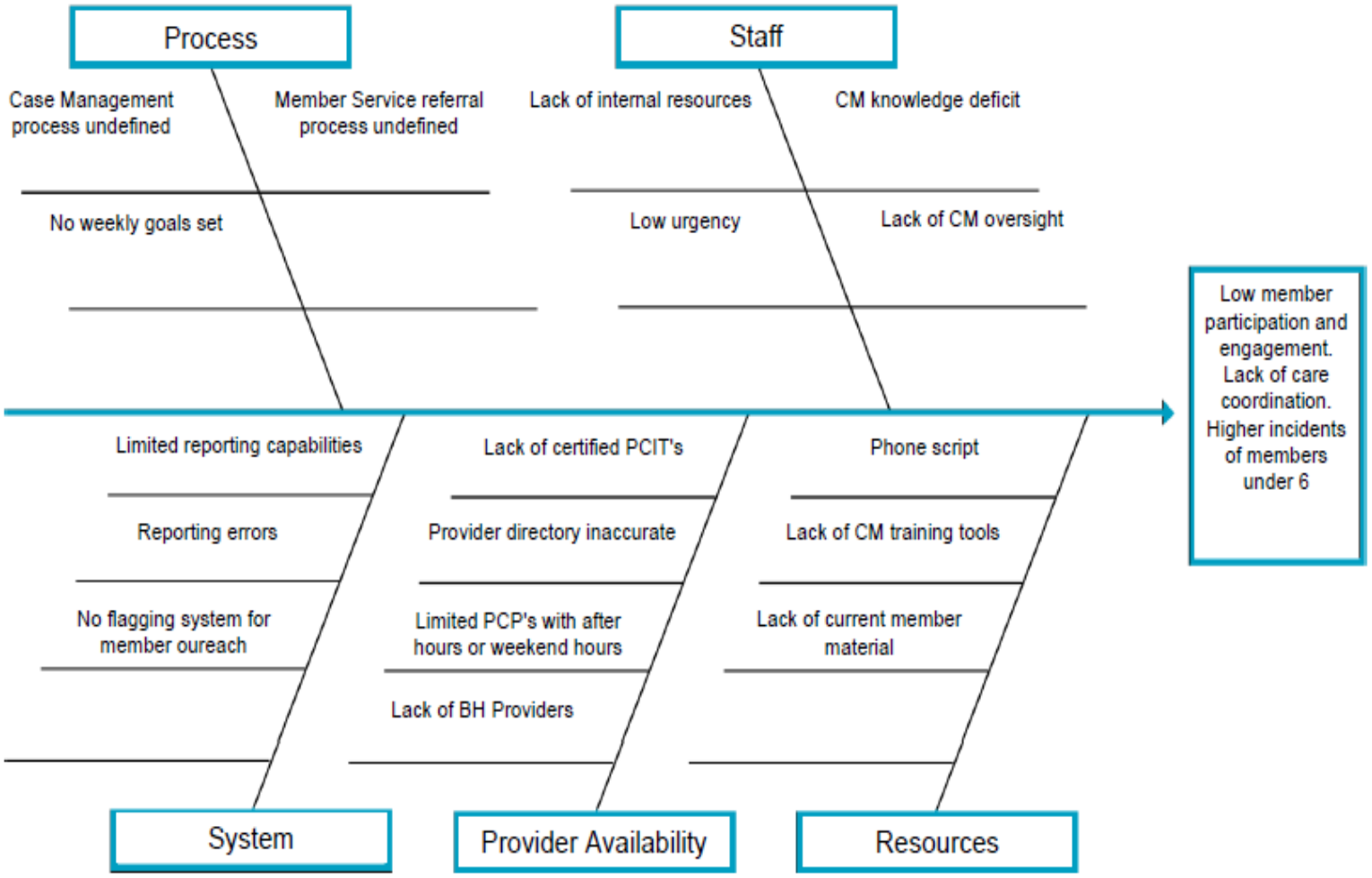
Eligible population- Any ADHD Cases, as identified by either an ADHD diagnosis or and ADHD medication claim, during the Measurement Period, with age determined as of the last day of the Measurement Period (there is no intake period)

- **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**

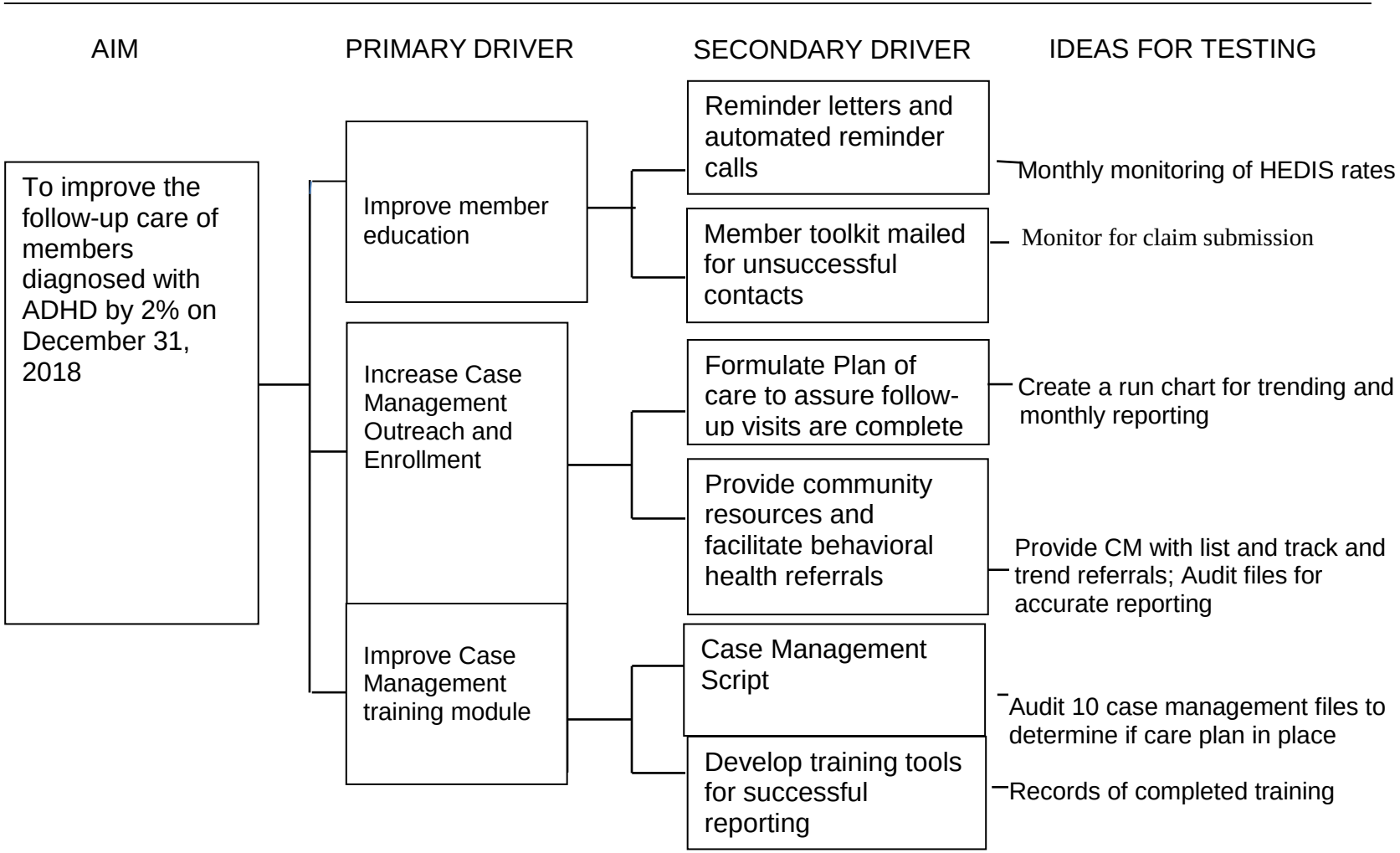
Measure B2. Children With and Without Behavioral Therapy. Description: Percentage of any ADHD cases aged 0-20 years, stratified by age (as of end of Measurement Period) and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics)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

- Den 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.
- Num: 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).
- Num: 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).

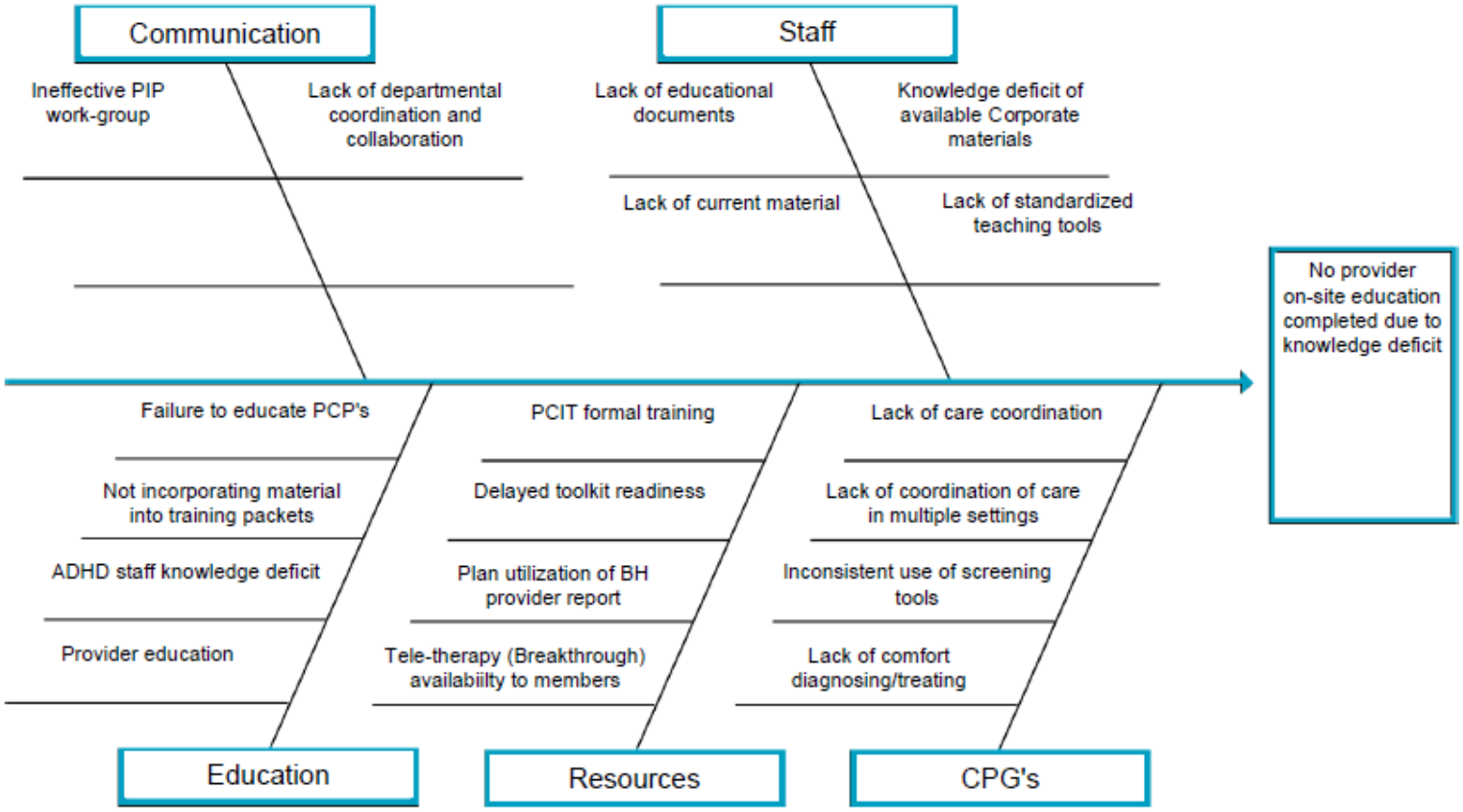
Appendix A
Cause and Effect Diagram (Member Outreach)



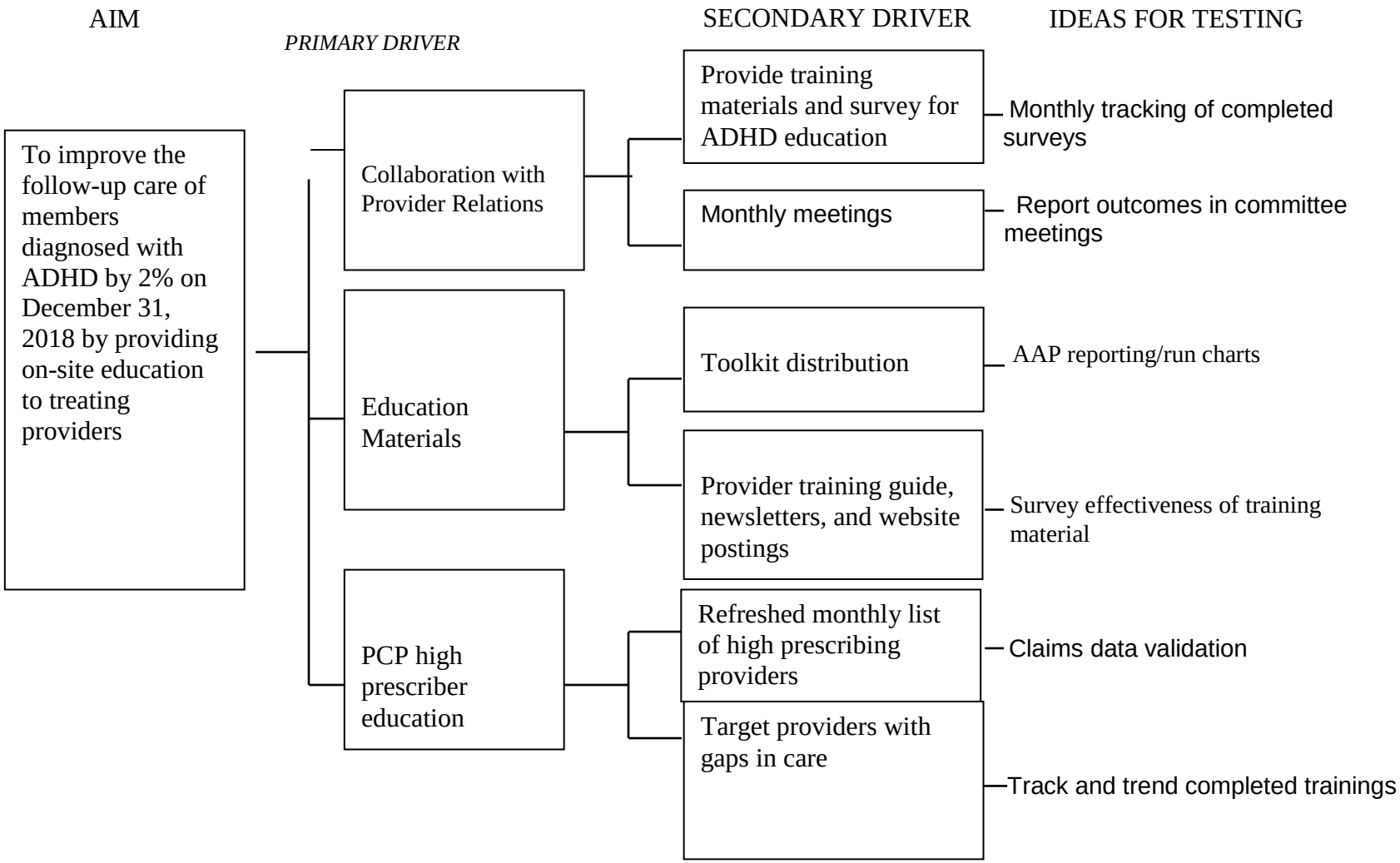
Appendix B
Member Driver Diagram



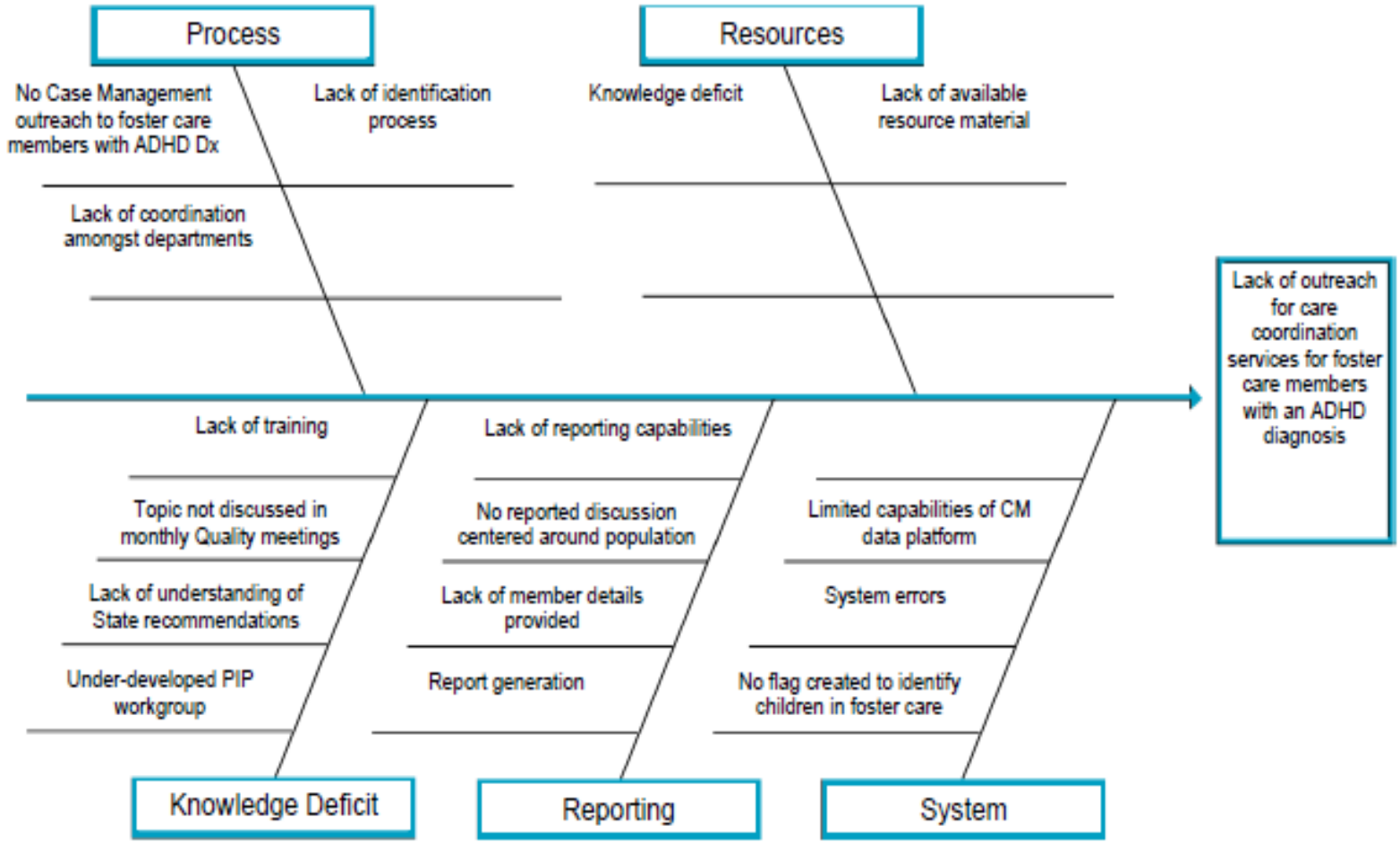
Appendix C
Cause and Effect Diagram (Provider Outreach)



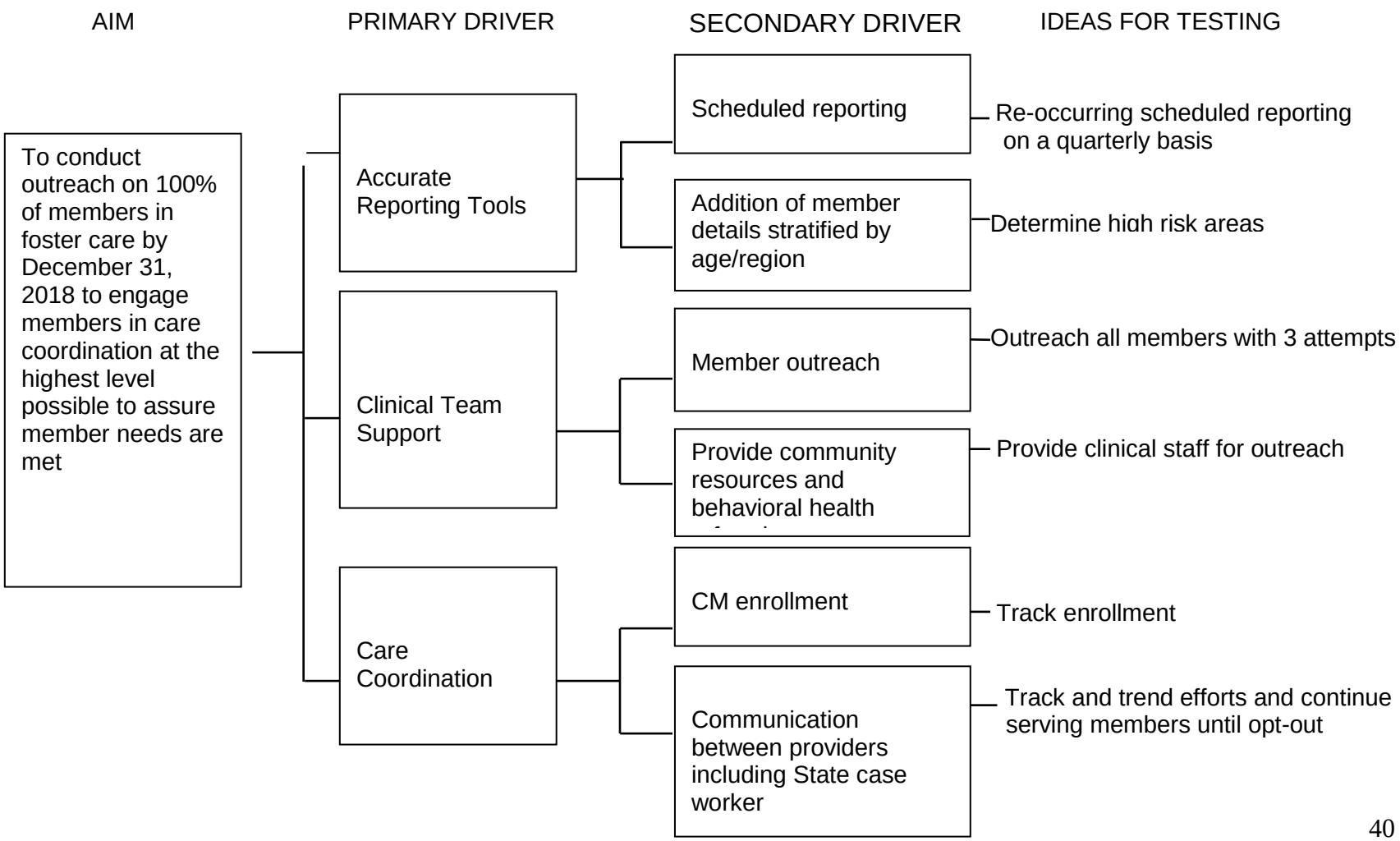
Appendix D
Driver Diagram (Provider Outreach)



Appendix E
Cause and Effect Diagram (Foster Care Population)



Appendix F
Foster Care Population Driver Diagram



Appendix G
PDSA – Members Under 6

ITM #1: Identifying and developing interventions for members under 6	Questions and Predictions: How many members under 6 are receiving CM services? Who, what, where, when: The number of ADHD members under 6 being outreached on a monthly basis and engaging in the case management program. Plan for collecting the data: Internal collaboration for the generation of weekly reports identifying newly diagnosis members under 6 for outreach, tracking, and trending	Describe what happened. What data did you collect? What observations did you make? 56 members have been identified for 2018. 0 have enrolled in our Case Management program	Summarize and reflect on what you learned: Small Dens and unsuccessful attempts and contacts are made. The few live contacts that were made refused care coordination services.	Determine what modification you should make – adapt, adopt, or abandon: The Plan should abandon the current outreach from a non-clinician and begin utilizing a clinical staff member for outreaching this population to assure care coordination needs are met including parental training and therapy.