Healthy Louisiana Performance Improvement Project (PIP)

MCO Name: Healthy Blue

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

2016- 2018

Project Phase: Proposal
Original Submission Date: 12/30/2016
Revised Submission Date: Click here to enter a date
Project Phase: Baseline
Submission Date: 6/30/2017
Revised Submission Date: Click here to enter a date
Project Phase: Interim
Submission Date: 7/13/2018
Revised Submission Date: 9/27/2018
Project Phase: Final
Submission Date: 7/1/2019
Revised Submission Date: 9/5/2019

Submission to: IPRO
State: Louisiana Department of Health

MCO Contact Information

1. Principal MCO Contact Person

Christin Cantavespri
Quality Improvement Director
225-819-4893 ext 106-122-4009
Christin.cantavespri@healthybluela.com

Final Report: 7/1/2019

2. Additional Contact(s)

Shana Hunter
Quality Improvement Manager
504-834-1271 ext 106-122-4097
Shana.hunter@healthybluela.com

3. External Collaborators (if applicable): N/A

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

5. Attestation

Managed Care Plan Name: Healthy Blue
Title of Project: ADHD PIP

Required Attestation signatures for PIP Proposal and PIP Final Report:
(1) Medical Director or Chief Medical Officer; (2) Quality Director or Vice President for Quality

The undersigned approve this FINAL PIP Report:

Cheryll Bowers-Stephens, M.D. 9/5/2019
Medical Director

Christin Cantavespri, MSHCM CPHQ 9/5/2019
Quality Director

Aaron Lambert 9/5/2019
CEO/Plan President

Abstract

1. **Describe Project Topic and Rationale for Topic Selection**
   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).

2. **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.

3. **Explain why there is opportunity for MCO improvement in this area:** 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). The four Bayou Health Plans reported 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):

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 who's PCP used a validated ADHD screening instrument.

- ***Baseline to final measurement goal:*** Increase the percentage of the eligible population sample who's PCP used a validated ADHD screening instrument by 9.9% (from 22.7% to 32.6%) by in order to meet the target goal of 32.6% during final measurement period.

A2. ***ADHD Screening in Multiple Settings***: The percentage of the eligible population sample who's 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 the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, i.e., home and school by 10% (from 28% to 38%) by in order to meet the target goal of 38% during final measurement period.

A3. ***Assessment of other behavioral health conditions/symptoms***: The percentage of the eligible population sample who's 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 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) by 10% (from 57.3% to 67.3%) by in order to meet the target goal of 67.3% during final measurement period.

A4. ***Positive findings of other behavioral health conditions***: The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation who's PCP documented positive findings, i.e. positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions.

- ***Baseline to final measurement goal:*** N/A

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 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 by 13.5% (from 41.9% to 55.4%) by in order to meet the target goal of 55.4% during final measurement period, with a stretch goal of 65.4%.

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 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 by 13.5% (from 41.9% to 55.4%) by in order to meet the target goal of 55.4% during final measurement period.

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 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 by 10.7% (from 29.3% to 40%) by in order to meet the target goal of 40% during final measurement period.

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 the eligible population sample who received care coordination services from the health plan care coordinator by 10.3% (from 62.7% to 73%) by in order to meet the target goal of 73% during final measurement period.

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 the eligible population sample who were outreached by the health plan care coordinator by 10.3% (from 62.7% to 73%) by in order to meet the target goal of 73% during final measurement period.

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 the members outreached who were engaged in care management by 12.4% (from 66% to 78.4%) by in order to meet the target goal of 78.4% during final measurement period.

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 the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD in order to meet the target goal calculated by IPRO during final measurement period.

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

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 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 by 3.98% (from 47.42% to 51.40%) by in order to meet the target goal of 51.40% during final measurement period.

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 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 by 8.79% (from 60.21% to 69.0%) by in order to meet the target goal of 69.0% during final measurement period.

Non-HEDIS Administrative Measures:

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 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 by 9.2% (from 20.8% to 30%) by in order to meet the target goal of 30% during final measurement period.

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 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 by 10.75% (from 35.75% to 25%) by in order to meet the target goal of 30% during final measurement period.

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:

Data will be collected by multiple departments within the Health Plan. Data collection will be completed by Business Data Analysts, Case Management Program Manager, BH Analysts, Quality Improvement Manager and HEDIS Manager. The tools that are used to collect the data include the use of SQL Server Management Studio and Teradata to analyze claims data. Additionally, the Medical Record reviews were performed by BH Analysts and clinical staff.

For Hybrid medical record review, 20158 members were identified for the sample via administrative data collection. A total of 129 members (oversampling) were selected via random sampling for record request. A total of 75 random charts were audited for hybrid measure data collection.

For Administrative data collection, a total of 5739 ADHD cases were identified utilizing the specifications outlined in the Administrative Performance Measures spreadsheet.

Validity and Reliability:

The administrative claims data information is validated by ensuring that data pulled is for members who had a prior diagnosis via the claims system. Data collection is done in conjunction with the specifications set forth by the measures. The Finance Analyst performs an audit of data pulled and addresses any gaps in missing data by conducting a deep dive of data collection method.

For hybrid data, a random sample sort was statistically obtained from the initial data, including an adequate oversampling amount, to arrive at the eligible population of seventy-five members. The data abstractors were trained on identifying the audit elements and collecting the data on the survey tool. The seventy-five eligible member's records were reviewed for appropriate documentation of the elements contained within the PIP. Quality monitoring and validation of the survey tool was completed by two staff over reading the results to ensure data accuracy. Validation and analysis of the results was completed by the quality management team.

Data Analysis:

Once data is obtained it is analyzed and compared to the goals set forth for each performance measure. In addition, the data is trended and compared to prior results for identification of opportunity of improvement. Also, data is stratified by region and member demographics to identify opportunity for targeted interventions to address specific performance measures.

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 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

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.

Description of Barrier	Method and Source of Barrier Identification	Number of Intervention	Description of Intervention Designed to Overcome Barrier	Intervention Timeframe
Provider knowledge of HEDIS criteria and gaps in care	Data obtained through Health Promotions Educational Visits	1	The Health Plan determined the top 124 providers with care gaps to provide outreach and scorecards as well as a missed opportunity report which outlines members who are in need of gap closure. The scorecards and missed opportunity list will identify all newly prescribed members receiving ADHD mediation who have not received follow- up care treatment.	*Planned Start:1/2016 Actual Start:3/2016 Date Revised: 1/2017*
Low Member Engagement	Utilization Pharmacy Data	2	QM outreach specialist assist with scheduling 30 day follow up appointment with members prescribed ADHD medication	*Planned Start: 1/2016 Actual Start:3/2016 Date Revised: Q2 2017 & Q3 2017 Intervention put on hold. Resumed Q4 2017*
Member Education	Utilization Pharmacy Data	2A	Plan will mail letters which indicate the need for initiation and continuation follow-up visit to members PCP's of members who were newly prescribed an ADHD medication	*Planned Start: 4/2017 Actual Start:4/2017 Date Revised: NA*
Member Education	Utilization Pharmacy Data	2B	ADHD New Start Program, which identifies members ages 6-12 who are newly started on ADHD medication. Notes are sent to the parent/guardian of identified member details the importance of taking the ADHD medication as directed and follow- up visits with the prescriber.	*Planned Start: April 2018 Actual Start: 4/2018 Date Revised: NA*
Provider Coordination of Care	Utilization Pharmacy Data	3	Plan will mail letters which indicate the need for initiation and continuation follow-up visit to members PCP's of members wo were newly prescribed an ADHD medication – Outreach calls are also completed for Coordination of Care to connect the member to their PCP (see above)	*Planned Start: 1/2017 Actual Start:1/2017 Date Revised: Only Q1 2017 Intervention*

Description of Barrier	Method and Source of Barrier Identification	Number of Intervention	Description of Intervention Designed to Overcome Barrier	Intervention Timeframe
Provider Education	Utilization Pharmacy Data	3A	Educational Letter fax blast on importance of follow-up appointments sent to top 30 providers	*Planned Start: 4/2017 Actual Start:4/2017 Date Revised: Q1 2019- intervention re-implemented*
Access to Network	Provider Network Data	4	Measure of network availability related to access to care.	Planned Start: 1/2017 Actual Start:12/2018 Revised: Q1 2019- PCIT Training Implemented to expand workforce.
PAR Provider Education	Provider Network Data	4A	Complete educational fax blast to providers to alert them of certified PCIT/PMT/CPP therapists in the state	*Planned Start: 1/2017 Actual Start:1/2017 Date Revised: Q1 2017 & Q1 2018 intervention only*
PAR Provider Education	Provider Network Data	4B	Build the Work Force by facilitating Patient Child Interactive Therapy (PCIT) Training for providers.	*Planned Start: 1/2019 Actual Start:1/2019 Date Revised: NA*
Network Provider Psycho Educational Training and Resource Availability	PCP Care Coordination Data	5	Training of Current Network Providers- Implementation of also training PCP's on available psycho educational and online resources will also be implemented 2018. The psycho educational trainings and online trainings will be specialized for family practitioners to include the use of referral and consultation and importance of obtaining collateral information from school and the home. Cross training between pediatricians and family practitioners will be completed	*Planned Start:4/2018 Actual Start: Q4 2018 Date Revised: NA*
Network Access	Utilization Data	6	Outreach to providers that are not in our network and offer single case agreements on an as need basis for members identified by case manager and utilization management. This has not been initiated for CPP and PCIT	*Planned Start:4/2018 Actual Start: 1/2019 Date Revised: NA*

Description of Barrier	Method and Source of Barrier Identification	Number of Intervention	Description of Intervention Designed to Overcome Barrier	Intervention Timeframe
			providers (initiation planned for Q1 2018) and the outreach will be conducted by a BH liaison.	
Provider Accessibility to ADHD Toolkit	PCP Care Coordination Data	7	Obtain Provider Tool Kit in collaboration with LDH and Roll out Provider training. Perform onsite visits with all PCP's that treat members with ADHD –Provider Tool Kit education. Currently, the focus is offering education and training on psychoeducational and online resources for treatment of ADHD (scheduled for Q1 2018). The Health Plan is currently reviewing the AAP toolkit, trainings will be implemented once the tool kit is finalized. Track progress on MCO specific efforts to build the workforce of therapists trained in BH therapy EBP's for ADHD, toolkit and related concerns. (Collaborative PIP)	*Planned Start:4/2018 Actual Start: 09/10/2018 Date Revised: NA*
Provider Accessibility/Training to ADHD Toolkit	PCP Access Data	8	Contract with Vanderbuilt to build online platform to educate providers on ADHD Tool Kit. Education includes case scenarios, clinical practice guideline education, HEDIS education and direct Tool Kit education. Go Live: 11/2019	Planned Start: 1/2019 Actual Start: 1/2019 Date Revised: NA
Limited Access to Care	Utilization Data	9	Expand access to in-person or telephonic case consultation to PCPs. Telemedicine contract and telemedicine Behavioral Health Network is in place. Consultation to selected Primary care practices will begin in the Orleans Parish region will be implemented during the 4th quarter.	*Planned Start:7/2018 Actual Start: Q4 2019 Date Revised: NA*
SBC Education	Network Data	10	Educate School Base Clinics – Provider Tool Kit. We will identify providers by using Pharmacy data	*Planned Start:2017 Actual Start: Q4 2019 Date Revised: NA*
Care Management	Care Coordination Data	Tabled	The plan will identify children under 6 years old who are prescribed ADHD meds vs not on ADHD medication through utilization management, case management and pharmacy data. We will work to connect the families to non-pharmacologic interventions for at minimum 6 months prior to initiating medication. Individuals identified on	*Planned Start:7/2018 Actual Start: Still being developed Date Revised: Q1 2019- A* subset of

Description of Barrier	Method and Source of Barrier Identification	Number of Intervention	Description of Intervention Designed to Overcome Barrier	Intervention Timeframe
			medications, outreach will be completed to prescribing providers to provide education and support of management to members.	these members will be analyzed, choosing to focus on the Foster Population and analyze this subpopulation for current BH status and engagement in CM and/or therapy (see # 11)
Evidence Based Prescribing of foster population	Utilization Data	In Progress	Baseline analysis of foster population to identify patterns of medication use, diagnosis and prescriber behavior. Based on this analysis we will develop targeted provider outreach to encourage evidence based prescribing. Health plan is currently reviewing data for foster population and looking at trends in this population to identify opportunities to outreach to those prescribers, review our prior authorization documents and modify those as needed. (see #11) Additionally, we will look at a systemic change in process based off of trends that we identify, work with pharmacy to develop a comprehensive clinical profile and build specific protocols with pharmacy, BH Medical Directors and case management to enforce evidenced based prescribing.	*Planned Start:7/2018 Actual Start: 10/01/2018 Date Revised: 09/27/2018*
ADHD Medication & Receiving Counseling	Utilization Data	11	Members with ADHD on medication and receiving counseling for the following ages: • For foster children < 48 months of age • age 4-5 foster children age 4-5 • ages 6-12: • foster children ages 6-12: • ages 13-17: • foster children ages 13-17: members ages 18-20:	*Planned Start: 1/2019 Actual Start:1/2019 Date Revised: NA*

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	On-site Provider Education Num: Providers educated Denom: Top Providers with gaps in care Identified	Numerator: 72 Denominator: 75 Rate: 96%	Numerator: 21 Denominator: 124 Rate: 17%	Numerator: 59 Denominator: 103 Rate: 57%	Numerator: 35 Denominator: 44 Rate: 80%
2	Member Outreach Num: # members outreached by QM specialist Denom: members due for ADHD follow-up	Numerator: 1106 Denominator: 2438 Rate: 45.36%	No Data to Report Outreach not completed in this quarter as resource was allocated elsewhere.	No Data to Report Outreach not completed in this quarter as resource was allocated elsewhere.	Numerator: 1852 Denominator: 2084 Rate89%
2A	ADHD Follow-up Care Letter Num: number of members who received a letter Denom: identified members who are less than 18 years of age and are newly started on a ADHD medication (i.e. no ADHD meds on profile in past 120 days or 4months	Intervention started in Q2 2017	Numerator: 576 Denominator: 576 Rate: 100%	Numerator: 121 Denominator: 121 Rate:100% *Data valid; rebranding occurred and letters were not sent for two months this quarter.	Numerator: 849 Denominator: 849 Rate100%
3	Num: # PCP's outreached via letter who's patient were prescribed a ADHD medication Denom: # members receiving ADHD medication	Numerator: 1106 Denominator: 2438 Rate: 45.36%	No data to report Outreach not completed in this quarter as resource was allocated elsewhere.	No data to report Outreach not completed in this quarter as resource was allocated elsewhere.	No data to report Outreach not completed in this quarter as resource was allocated elsewhere.
3A	Educational Letter fax blast on importance of follow-up appointments sent to top 30 providers Num: number of educational letters sent Denom: total number of providers identified	Q2 2017 intervention	Numerator: 26 Denominator: 30 Rate: 87%	Q2 2017 intervention	Q2 2017 intervention
4	PCIT/PMT/CPP Network Availability	Numerator: 71	Q1 2017 Intervention	Q1 2017 Intervention	Q1 2017 Intervention

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Num:) # certified PCIT/PMT/CPP therapists who are par providers Denom: # certified PCIT/PMT/CPP therapists in the state	Denominator: 102 Rate: 69.60%			

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

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
1	On-site Provider Education Num: Providers educated Denom: Top Providers with gaps in care Identified	Numerator: 43 Denominator: 200 Rate: 22%	Numerator: 105 Denominator: 157 Rate: 66%	Numerator: 56 Denominator: 56 Rate:100%	Numerator: 47 Denominator: 47 Rate: 100%
2	Member Outreach Num: # members outreached by QM specialist Denom: members due for ADHD follow-up	Numerator: 597 Denominator: 2217 Rate: 27%	Numerator: 73 Denominator: 217 Rate: 34%	Numerator: 293 Denominator: 672 Rate: 44%	Numerator: 102 Denominator: 805 Rate:13%
2A	ADHD Follow-up Care Letter Num: number of members who received a letter Denom: identified members who are less than 18 years of age and are newly started on a ADHD medication (i.e. no ADHD meds on profile in past 120 days or 4months	Numerator: 706 Denominator: 706 Rate: 100%	Numerator: 606 Denominator: 606 Rate: 100%	Numerator: 592 Denominator: 592 Rate:100%	Numerator: 1133 Denominator: 1133 Rate: 100%
2B	New ADHD Start Program Num: Member Education Notifications Sent Denom: Members 6-12 identified who are newly started on ADHD Medication	N/A	Num: 484 Denom: 484 Rate: 100%	Num: 793 Denom: 793 Rate: 100%	Num: 810 Denom: 1439* Rate:56%
3	Num: # PCP's outreached via letter who's patient were	No Data to Report	No Data to Report	No Data to Report	No Data to Report

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
	prescribed a ADHD medication Denom: # members receiving ADHD medication				
3A	Educational Letter fax blast on importance of follow-up appointments sent to top 30 providers Num: number of educational letters sent Denom: total number of providers identified	No Data to Report	No Data to Report	No Data to Report	No Data to Report
4	PCIT/PMT/CPP Network Availability Num:) # certified PCIT/PMT/CPP therapists in the state Denom: # certified PCIT/PMT/CPP who are PAR providers	Numerator: 75 Denominator: 102 Rate: 69.60%	Q1 2018 Intervention. Planning Phase for PCIT Training	Q1 2018 Intervention. Planning Phase for PCIT Training	Q1 2018 Intervention. Planning Phase for PCIT Training
5	Number of providers trained to Toolkit and Vanderbilt Assessment (numerator) and Denominator will be providers selected to receive training based on top 10 prescribing, one selected FQHC, and facilities treating a significant number of members by region.	Q4 2018 Intervention	Q4 2018 Intervention	Q4 2018 Intervention	Num: 46 Denom: 290 Rate: 15.8%

Monitoring Table YEAR 3: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2019
1	On-site Provider Education Num: Providers educated Denom: Top Providers with gaps in care Identified	Num: 0 Denom: 0 Rate: 0.0% (Driven by HEDIS Data)
2	Member Outreach Num: # members outreached by QM specialist Denom: members due for ADHD follow-up	Num: 145 Denom: 279 Rate: 51.9%
2A	ADHD Follow-up Care Letter	Num: 1997 Denom: 1997

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2019
	Num: number of members who received a letter Denom: identified members who are less than 18 years of age and are newly started on a ADHD medication (i.e. no ADHD meds on profile in past 120 days or 4months	Rate: 100%
2B	New Start ADHD Program Num: Member Education Notifications Sent Denom: Members 6-12 identified who are newly started on ADHD Medication	Num: 806 Denom: 806 Rate: 100%
3	Num: # PCP's outreached via letter who's patient were prescribed a ADHD medication Denom: # members receiving ADHD medication	Measure Retired and 3A implemented
3A	Educational Letter fax blast on importance of follow-up appointments sent to top 30 providers Num: number of educational letters sent Denom: total number of providers identified	@1 month: 550/550 @3 month: 214/214 @6 month: 1284/1284 Rate: 100%
4	PCIT/PMT/CPP Network Availability Num:) # certified PCIT/PMT/CPP therapists in the state Denom: # certified PCIT/PMT/CPP who are PAR providers	No data to report-Training PCIT Providers Implemented (see 4B)
4B	PCIT Training Num: Number of Providers in PCIT Training Denom: Number of Providers Identified for the training	Num: 11 Denom: 29 Rate: 37.93%
5	Number of providers trained to Toolkit and Vanderbilt Assessment (numerator) and Denominator will be providers selected to receive training based on top 10 prescribing, one selected FQHC, and facilities treating a significant number of members by region.	Q4 2018 Intervention
6	Outreach to providers that are not in our network and offer single case agreements on an as need basis for members identified by case manager and utilization management. This has not been initiated for CPP and PCIT providers (initiation planned for Q1	Num: 2 Denom: 2 Rate: 100%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2019
	2018) and the outreach will be conducted by a BH liaison. (only in state agreements)	
7	Obtain Provider Tool Kit	Completed
8	Online educational platform	Planning Phase: Q1 2019-Q3-2019 Go Live projected: 11/2019
9	Expand access to in-person or telephonic case consultation to PCPs.	Num: 7222 Denom: 9632 Rate: 74.9%
10	School Based Facility Education on ADHD Tool Kit Num: # of school based clinics educated Denom: # of school based clinics identified	Num: 4 Denom: 5 Rate: 80%
11	Members with ADHD on medication and receiving counseling for the following ages: • For foster children < 48 months of age • age 4-5 foster children age 4-5 • ages 6-12: • foster children ages 6-12: • ages 13-17: • foster children ages 13-17: • members ages 18-20 Num: # of members receiving counseling Denom: # of members prescribed ADHD Meds	Foster <48 mos Num: 0 Denom: 1 0% (18.75% 2018) Age 4-5 Num: 7 Denom: 45 15.56% (22.58% 2018) Foster 4-5 Num:2 Denom:3 66.67% (32.26% 2018) Age 6-12 Num:56 Denom: 259 21.62% (28.62% 2018) Foster 6-12 Num:4 Denom: 23.53% (53.79% 2018) Age 13-17 Num: 51 Denom: 211 24.17% (32.28% 2018) Foster 13-17

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2019
		Num: 5 Denom: 16 31.25% (47.52% 2018) Age 18-20 Num: 10 Denom: 79 12.66% (20.67% 2018)

6. Results

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 11/31/15) **HEDIS Measure: HEDIS Measurement Year 2016 NON-HEDIS Administrative Measure:** 1/1/16-12/31/16	Interim Period Hybrid Measurement: 10/1/16-10/31/17 **HEDIS Measure: HEDIS Measurement Year 2017 NON-HEDIS Administrative Measure:** 1/1/17-12/31/17	Final Period 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 Goal/Target Rate
Indicator #1 A1. Validated ADHD Screening Instrument	H	Eligible Population = 17778 Exclusions= UNK If "H", Sample size = 75 Numerator = 17 Denominator = 75 Rate = 22.7%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 35 Denominator = 75 Rate = 46.67%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 23 Denominator = 75 Rate = 30.67%	**Target Rate:** 55% **Rationale:** 10% point increase from Baseline Rate
Indicator #2 A2. ADHD Screening in Multiple Settings	H	Eligible Population = 17778 Exclusions= 0 If "H", Sample size = 75 Numerator = 21 Denominator = 75 Rate = 28%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 13 Denominator = 75 Rate = 17.33%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 16 Denominator = 75 Rate = 21.33%	**Target Rate:** 38.0% **Rationale:** 10% point increase from Baseline Rate
Indicator #3 A3. Assessment of other behavioral	H	Eligible Population = 17778 Exclusions= 0	Eligible Population = 21007 Exclusions= 47	Eligible Population = 20158 Exclusions= 15	**Target Rate:** 67.33% **Rationale:**

health conditions/ symptoms		If "H", Sample size = 75 Numerator = 43 Denominator = 75 Rate = 57.3%	If "H", Sample size = 214 Numerator = 43 Denominator = 75 Rate = 57.33%	If "H", Sample size = 129 Numerator = 56 Denominator = 75 Rate = 74.67%	10% point increase from Baseline Rate
Indicator #4 A4. Positive findings of other behavioral health conditions	H	Eligible Population = 17778 Exclusions= 0 If "H", Sample size = 75 Numerator = 43 Denominator = 75 Rate = 57.3%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 45 Denominator = 75 Rate = 60%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 45 Denominator = 75 Rate = 60%	
Indicator #5 A5a. Referral for EVALUATION of other behavioral health conditions	H	Eligible Population = 17778 Exclusions= 32 If "H", Sample size = 75 Numerator = 18 Denominator = 43 Rate = 41.9%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 26 Denominator = 45 Rate = 57.77 %	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 23 Denominator = 45 Rate = 51.11%	**Target Rate:** 65.4% **Rationale:** 95% CI=26.0, 55.4%
Indicator #6 A5b. Referral to TREAT other behavioral health conditions	H	Eligible Population = 17778 Exclusions= 32 If "H", Sample size = 75 Numerator = 18 Denominator = 43 Rate = 41.9%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator 10 Denominator = 45 Rate = 22.22%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 23 Denominator = 45 Rate = 51.11%	**Target Rate:** 55.4% **Rationale:** 95% CI=26.0, 55.4%
Indicator #7 A6. PCP Care Coordination	H	Eligible Population = 17778 Exclusions= 0 If "H", Sample size = 75	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129	**Target Rate:** 40% **Rationale:** 10% point increase from Baseline Rate

		Numerator = 22 Denominator = 75 Rate = 29.3%	Numerator = 20 Denominator = 75 Rate = 26.67%	Numerator = 29 Denominator = 75 Rate = 38.67%	
Indicator #8 A7. MCO Care Coordination	H	Eligible Population = 17778 Exclusions= 0 If "H", Sample size = 75 Numerator = 47 Denominator = 75 Rate = 62.7%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 2 Denominator = 75 Rate = 2.66%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 17 Denominator = 75 Rate = 22.67%	**Target Rate:** 73% **Rationale:** 10% point increase from Baseline Rate
Indicator #9 A8. MCO Outreach with Member Contact	H	Eligible Population = 17778 Exclusions= 0 If "H", Sample size = 75 Numerator = 47 Denominator = 75 Rate = 62.7%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 1 Denominator = 75 Rate = 1.33%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 11 Denominator = 75 Rate = 14.67%	**Target Rate:** 73% **Rationale:** 10% point increase from Baseline Rate
Indicator #10 A9. MCO Outreach with Member ENGAGEMENT	H	Eligible Population = 17778 Exclusions= 28 If "H", Sample size = 75 Numerator = 31 Denominator = 47 Rate = 66%	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 0 Denominator = 75 Rate = 0%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 10 Denominator = 75 Rate = 13.33%	**Target Rate:** 78.4% **Rationale:** 95% CI=51.3, 78.4%
Indicator #11 A10. First Line Behavior Therapy for Children < 6 years	H	Eligible Population = 17778 Exclusions= 48 If "H", Sample size = 75	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 5	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 8	Target Rate: 86.5%

		Numerator = 22 Denominator = 27 Rate = 81%	Denominator = 44 Rate = 11.36%	Denominator = 30 Rate = 26.67%	
Indicator #11 A10a. Clinical Exclusions[1,2]	H	NA for Baseline	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 0 Denominator = 44 Rate = 0%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 0 Denominator = 30 Rate = 0%	**Target Rate:** N/A
Indicator #11 A10b. Exclusions- No qualified providers in area[1]	H	NA for Baseline	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 0 Denominator = 44 Rate = 0%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 0 Denominator = 30 Rate = 0%	**Target Rate:** NA
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients[1]	H	NA for Baseline	Eligible Population = 21007 Exclusions= 47 If "H", Sample size = 214 Numerator = 0 Denominator = 44 Rate = 0%	Eligible Population = 20158 Exclusions= 15 If "H", Sample size = 129 Numerator = 0 Denominator = 30 Rate = 0%	Target Rate: NA

Indicator #12 B1a. HEDIS ADD Measure: Initiation Phase	A	Eligible Population = 2438 Exclusions= 0 If "H", Sample size NA Numerator = 1156 Denominator = 2438 Rate = 47.42%	Eligible Population = 2586 Exclusions= 3 If "H", Sample size = NA Numerator = 1260 Denominator = 2589 Rate = 48.7%	Eligible Population = 2579 Exclusions= 1 If "H", Sample size = NA Numerator = 1163 Denominator = 2589 Rate = 44.92%	**Target Rate:** 51.40% **Rationale:** The lower 95% CI is considered (47.2-45.4=2 percentage points; and the spread added to the upper 95% CI, e.g., 2+49.4=51.4%.
Indicator #13 B1b. HEDIS ADD Measure: Continuation Phase	A	Eligible Population = 475 Exclusions= 0 If "H", Sample size = NA Numerator = 286 Denominator = 475 Rate = 60.21%	Eligible Population = 475 Exclusions= 1 If "H", Sample size = NA Numerator = 299 Denominator = 475 Rate = 62.95%	Eligible Population = 450 Exclusions= 0 If "H", Sample size = NA Numerator = 268 Denominator = 450 Rate = 59.56%	**Target Rate:** 69.0% **Rationale:** 4.5 points higher than the upper CI, e.g., 64.5+4.5=69.0.
Indicator #14 B2a. BH Drug with Behavioral therapy[3]	A	Eligible Population = 7170 If "H", Sample size = NA Numerator = 1490 Denominator = 7170 Rate = 20.8%	Eligible Population = 5617 Exclusions= 0 If "H", Sample size = NA Numerator = 1606 Denominator = 5617 Rate = 28.6%	Eligible Population = 5739 Exclusions= 0 If "H", Sample size = NA Numerator = 1576 Denominator = 5617 Rate = 28.06%	**Target Rate:** 30% **Rationale:** Goal is 10% points above baseline
Indicator #15 B2b. BH Drug WITHOUT Behavioral therapy[3]	A	Eligible Population = 7170 If "H", Sample size = NA Numerator = 2563 Denominator = 7170 Rate = 35.75%	Eligible Population = 5617 Exclusions= 0 If "H", Sample size = NA Numerator = 2465 Denominator = 5617 Rate = 43.88%	Eligible Population = 5739 Exclusions= 0 If "H", Sample size = NA Numerator = 2584 Denominator = 5739 Rate = 45.0%	**Target Rate:** Decrease to 25% **Rationale:** The target rate is 10% lower than baseline

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

- Measure A1- The use of validated ADHD screening instrument results from baseline to interim improved by 23.97%. The interim rate has missed the goal by 8.33%. From interim to final the results decreased by 16%. The final rate of 30.67% did not meet the goal of 55%.
- Measure A2- The use of ADHD screening in multiple settings decreased. The interim rate is currently 20.67 percentage points below the goal. From interim to final the results increased by 4%. The final rate of 21.33% did not meet the goal of 38.0%.
- Measure A3- The assessment of other behavioral health conditions/symptoms has not changed from baseline to interim. The interim rate is currently 10 percentage points below the goal. From interim to final the rate increased by 17.34%. The final rate of 74.67% exceeded the goal of 67.33%
- Measure A4- Positive findings of other behavioral health conditions has increased from baseline to interim. From interim to final, the rate remained the same at 60%.
- Measure A5a- Referral for evaluation of other behavioral health conditions has increased from baseline to interim. The Interim rate has met the initial goal and is 10 percentage points away from the stretch goal set. From interim to final the rate decreased by 6.66%. The final rate of 51.11% did not meet the goal of 65.4%.
- Measure5b- Referral to treat other behavioral health conditions has decreased from baseline to interim. The interim rate is 33.18 percentage points below the goal. From interim to final the rate increased by 28.89%. The final rate of 51.11% did not meet the goal of 55.4%.
- Measure A6- PCP care coordination has decreased from baseline to interim. The interim rate is 13.33 percentage points below the goal. From interim to final the rate increased by 12%. The final rate of 38.67% did not meet the goal of 40%.
- Measure A7- MCO care coordination has decreased from baseline to interim. The interim rate is 70.34 percentage points below the goal. From interim to final the rate increased by 20.01%. The final rate of 22.67% did not meet the goal of 73%.
- Measure A8- MCO outreach with member contact has decreased from baseline to interim. The interim rate is 71.67 percentage points below the goal. From interim to final the rate increased by 13.34%. The final rate of 14.67% did not meet the goal of 73%.
- Measure A9- MCO outreach with member engagement has decreased from baseline to interim. The interim rate is 78.4 percentage points below the goal. From interim to final the rate increased by 13.33%. The final rate of 13.33% did not meet the goal of 78.4%.
- Measure A10 -First line behavior therapy for children <6 years has decreased from baseline to interim. From interim to final the rate increased by 15.31%. The final rate of 26.67% did not meet the 86.5%.
- Measures A10a-A10C- Rate is 0.0% for interim. The rate remained 0% for final. No goal was applicable to this measure as this applied to exclusions only.
- Measure B1a- HEDIS ADD Measure- Initiation Phase increased from baseline to interim. The interim rate is 2.7 percentage points below the goal. From interim to final the rate decreased by 3.78%. The final rate of 44.92% has not met the goal of 51.4%.
- Measure B1b- HEDIS ADD Measure- Continuation Phase increased from baseline to interim. The interim rate is 6.05 percentage points below the goal. From interim to final the rate decreased by 3.39%. The final rate of 59.56% did not meet the goal of 69.0%.
- Measure B2a- BH Drug with Behavioral Therapy has increased from baseline to interim. The interim rate is 1.4 percentage points below the goal. From interim to final the rate decreased by .54%. The final rate of 28.06% did not meet the goal of 30%.
- Measure B2b- BH Drug without Behavioral Therapy has increased from baseline to interim (inverted measure). The interim rate is 18.88 percentage points above the inverted goal. From interim to final the rate increased by 1.13%. The final rate of 45.0% did not meet the inverted goal of 25%.

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: Based on intervention tracking the extent to which improvement for some measures was attributable to the increase in initiatives from 2017 to present. Healthy Blue increased the number of initiatives from 2017 to 2019. There was a heavy focus on provider education and member outreach. MCO engagement, outreach and care coordination improved from interim to final as well as PCP coordination. This improvement can be attributed to the member outreach efforts made. First line BH therapy for children under 6 and referral of members to treat other BH conditions improved from interim to final. Overall, there was a decrease of screenings done in multiple settings, the ADHD Tool Kit emphasizes that the PCP should submit a rating scale to the schools or the patient. There are however barriers to this in the primary care setting. The most common practice is for specialized behavioral health providers to send the scales to schools; however, this is not a common practice of the PCP office. Healthy Blue is currently working with an education platform vendor to build provider education on the ADHD tool kit which will allow providers to experience case scenarios and additional tools to aid as resources to adhering to the ADHD tool kit. Healthy Blue anticipates with the addition of interventions in 2019 to offer telemedicine, expansion of provider education through use of an evidence based web tool, PCIT training and engagement of school based centers there will be improvement in these measures.

What factors were associated with success or failure? The ability to engage members in case management is an attributing factor to the ability to not meet goals. Additionally, NCQA's specification change in the ADHD Initiation and Continuation Measure negatively impacted the Health Plan's rate.

Limitations

As in any population health study, there are study design limitations for a PIP. 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?** Timely submission of provider claims and correct coding.
- **Were there any threats to the external validity the findings?** None

Describe any data collection challenges. For the quarterly intervention tracking measures, Healthy Blue experienced having to remove one of the interventions related to tracking partial authorizations for providers to connect members to a LMHP. Healthy Blue had all these partial authorizations reviewed by a Medical Director. We were unable to report out on this data as our system did not allow us to manual or auto reporting.
Member Participation: N/A

Describe methods utilized to solicit or encourage membership participation: N/A

Dissemination of Findings

Describe the methods used to make the findings available to members, providers, or other interested parties: Healthy Blue makes Quality Improvement information available to members via Quality Program Up-Date Post Card sent out to members annually. The information is also up-dated on our Web-site.

8. Next Steps

Description of Intervention	Lessons Learned	System-level changes made and/or planned	Next Steps

Top provider HEDIS education and gaps in care outreach	Provider's identified for outreach needed expansion to include more reach in the provider community.	HEDIS provider outreach- would also include providers in rural areas and school based health clinics.	On-going provider outreach on-going, currently expanding on current outreach plan to rural clinics and SBC's
Member outreach	Member outreach is effective as it relates to ADHD Initiation and Continuation rates	Expand member outreach methods to text campaigns	Develop text campaigns for ADHD and implement outreach campaign
ADHD Provider Education	Limited participation from providers for additional training on ADHD Toolkit. Various types of education sessions planned but poorly attended. Ease of accessibility should be explored.	Implementation of WebEx Training and ADHD online platform	Currently planning to implement WebEx training sessions and video training for the ADHD Toolkit/Vanderbilt Assessment. ADHD online Platform buildout began in Q1 2019, Go Live is Q4 2019.

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).