Healthy Louisiana Performance Improvement Project (PIP)

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

MCO Name: Louisiana Healthcare Connections

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

2016- 2018

Project Phase: Baseline
Original Submission Date: 6/30/2017
Revised Submission Date: Click here to enter a date
Project Phase: Interim
Submission Date: 6/29/2018
Revised Submission Date: 9/28/2018
Project Phase: Final
Submission Date: 6/28/2019
Revised Submission Date: Click here to enter a date
Project Phase: Choose an item
Submission Date: Click here to enter a date
Revised Submission Date: Click here to enter a date

Submission to: IPRO
State: Louisiana Department of Health

MCO Contact Information

1. Principal MCO Contact Person

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

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Interim Report: Carey Hotard Date 6/29/18

Final Report: Carey Hotard Date 6/26/19

2. Additional Contact(s)

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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: Louisiana Healthcare Connections
Title of Project: Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD

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 PIP Proposal and assure involvement in the PIP throughout the course of the project.

Dr. Marcus Wallace, Sr. Vice President, Medical Affairs — Date 6/25/19

Joe Tidwell, Vice President, Quality Improvement — Date

IS Director Signature (when applicable)
Printed Name — Date

CEO Signature
Printed Name — Date

The undersigned approve this FINAL PIP Report:

Dr. Marcus Wallace, Sr. Vice President, Medical Affairs — Date 6/25/19

Joe Tidwell, Vice President, Quality Improvement — Date 6/25/2019

IS Director Signature (when applicable)
Printed Name — Date

Jamie Schlottman, CEO — Date 6/27/19

Abstract

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

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

Project Topic/Rationale/Aims

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

Rationale for Project: Attention Deficit/Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children (Feldman and Reiff, 2014). According to a recent article published in the New England Journal of Medicine, high prevalence rates suggest over-diagnosis (Feldman and Reiff, 2014). Please see page 5 for more detailed information on the rationale for this project.

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

Methodology

Eligible Population: Children between the ages of 0-18 who are enrolled in the Louisiana Medicaid program.

Description of Annual Performance Indicators: A total of 15 performance indicators have been selected. They are a combination of both HEDIS and non-HEDIS measures. Please refer to page 7 for the complete list and a description of each.

Sampling Method: We utilize a random, stratified sample of new ADHD cases for chart review per measurement period.

Baseline and Re-measurement Periods: Please see page 10 for the table of baseline and all subsequent re-measurement periods during this PIP.

Data Collection Procedures: Data is collected through medical record review and claims data.

Interventions

Member Barriers Identified: Lack of care coordination between members, providers and MCOs

Interventions to address member barriers: Enhanced Case Management Program

Provider Barriers Identified: Lack of proper completion of assessment tools prior to diagnosing and prescription dispensing; lack of BH providers in some areas of the state, lack of BH resources available to PCPs

Interventions to address provider barriers: Provider Education, Workforce Capacity Analysis, BH Consultation to PCPs

Results

Report Data for Annual Performance Indicators: Overall, the performance indicators have increased from the baseline to the final measurement periods. There was improvement in the areas of PCPs use of ADHD screening tools, screening across multiple settings, providers screening for other behavioral conditions and referring those patients for further evaluation and treatment to specialists, and increased PCP care

coordination. Additionally, there was improvement from the baseline year to the final year in behavior therapy being offered as a first line treatment option in children younger than 6 years old. Both HEDIS ADD measures improved from the baseline year and surpassed the targets. A decline in the rate was observed for engagement of ADHD members in Disease Management and BH drugs being prescribed in conjunction with behavioral therapy. However, the rate for BH drugs being prescribed without behavioral therapy has also declined. This discrepancy is due to the fact that there may be members in the denominator who have a diagnosis of ADHD but no ADHD medication claims.

Conclusions

Interpret improvement in terms of whether or not Target Rates were met for annual performance indicators: Out of 17 performance indicators with target rates set, 10 were met or exceeded. Seven were not met, however 5 of those showed improvement from the baseline to final measurement period. Three of the rates not met were related to Disease Management outreach and engagement, however a random chart sample of 75 charts would not give an accurate picture of our Disease Management engagement rates as our plan serves a very large pediatric population.

Indicate interventions that did and did not work in terms of quarterly intervention tracking measure trends: The intervention centered on enhancing disease management services has been successful. The process measures developed for that intervention show positive rates for member engagement and referrals to outside behavioral health services and provider collaboration on care plan development. The LCSW program is underway with a social worker hired and working within the three pediatric practices who have partnered with LHCC. Once adequate claims data is available, we will analyze and explore the possibility of expanding the program to other practices.

Study Design Limitations: Some data used in the ADHD PIP is claims based and therefore dependent on providers coding properly.

Lessons Learned and Next Steps: Please see table on pages 26-27.

1. Project Topic/ Rationale and 2. Aim

Suggested length: 2 pages

1. Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members (e.g., disease prevalence stratified by demographic subgroups):** This PIP addresses member needs because of the rise in ADHD prescriptions being written for children between the ages of 0-18. In addition to stratifying foster care children in our chart abstraction, LHCC has also stratified our process measure data by age groups 0-6, 7-12, and 13-18 years of age to help identify any needs that may be more specific to a certain age group.
- **Describe current research support for topic (e.g., clinical guidelines/standards):** Attention Deficit/Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children (Feldman and Reiff, 2014). According to a recent article published in the New England Journal of Medicine, high prevalence rates suggest over-diagnosis (Feldman and Reiff, 2014). American Academy of Pediatrics (AAP) guidelines advise that physicians assess the severity of the preschool child's ADHD prior to prescribing medication, and that pharmaceutical interventions be reserved for those preschoolers with moderate to severe dysfunction, i.e.: symptoms that have persisted for at least 9 months, dysfunction that is manifested in both the home and other settings such as preschool or child care, and dysfunction that has not responded adequately to behavior therapy (Subcommittee on ADHD, 2011). The AAP guidelines recommend behavior therapy as the first line of treatment for preschool-aged children (four to five years of age) and advise primary care clinicians to assess for coexisting emotional or behavioral conditions (Subcommittee on ADHD, 2011). The AAP guidelines do not address ADHD diagnosis or treatment in children younger than four years of age, yet it has been reported that very young children are diagnosed with ADHD and prescribed psychotropic medications, particularly children with comorbid mental health and chronic health conditions (Rappley et al., 2002). A multi-state study of preschool children enrolled in Medicaid found that psychotropic drugs were most

commonly prescribed for ADHD, followed by depression or anxiety and psychosis or bipolar disorder (Garfield et al., 2015). Yet, the majority of psychotropic drugs prescribed for preschoolers are off-label, i.e., neither tested or approved by the Food and Drug Administration (FDA) for use in this age group (Garfield et al., 2015). Further, inappropriate prescribing of antipsychotic medications among children for non-FDA-approved indications, such as ADHD, has been reported (Matone et al., 2012; Penfold et al., 2013). A national study revealed that among U.S. Medicaid-enrolled children aged 3-18 years, those with ADHD comprised 50% of antipsychotic users, and 15% of antipsychotic use was among youth diagnosed exclusively with ADHD (Matone et al., 2012). Therefore, the prescription of both ADHD and antipsychotic drugs for children with ADHD merits closer monitoring for appropriateness, safety and effectiveness.

- **Explain why there is opportunity for MCO improvement in this area:** The prevalence of parent-reported ADHD among publicly insured youth aged 2-17 in Louisiana during 2009 and 2010 was 45.0% (95% CI = 37.4, 52.6), significantly higher than that of publicly insured youth nationwide (35.5%; 95% CI = 33.9, 37.2%; NS-CSHCN, 2012). Corresponding ADHD medication rates for youth with ADHD were also higher (83.1% versus 74.2%); however, this difference was not statistically significant (NS-CSHCN, 2012). The American Academy of Pediatrics' (AAP) clinical practice guideline for the diagnosis and treatment of ADHD in children aged 4-18 years provides guidelines that can increase the accuracy of diagnosis, and reduce problems of 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 who's PCP used a validated ADHJD screening instrument.
Baseline to final measurement goal: The percentage of the eligible population sample who's PCP used a validated ADHD screening instrument will increase from 33.3% at baseline to 78.67% at final re-measurement.
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: 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 will increase from 14.67% to 78.67% at final re-measurement.
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: The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress) will increase from 16% to 32.6% at final re-measurement.
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. (G*oal setting not applicable*)
A5a. ***Referral for EVALUATION of other behavioral health conditions***: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions will increase from 60.0% to 80.0% at final re-measurement.

A5b. ***Referral to TREAT other behavioral health conditions***: The percentage of the eligible subpopulation sample referred to behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CsOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions.
Baseline to final measurement goal: The percentage of the eligible subpopulation sample referred to a behavioral specialist for evaluation/treatment of alternate causes/co-occurring conditions whose PCP documented referral to a mental health rehabilitation provider (e.g., CPST, PSR, CSOC) to treat alternate causes of presenting symptoms and/or co-occurring conditions will increase from 50.0% to 85.0% at final re-measurement.
A6. ***PCP Care Coordination***: The percentage of the eligible population sample who received PCP care coordination, e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination.
Baseline to final measurement goal: The percentage of the eligible population sample who received PCP care coordination, e.g., provider notes regarding communication with a behavioral therapist, other specialist, the child's teacher, or health plan case manager regarding ADHD care coordination will increase from 38.67% to 70.67% at final re-measurement.
A7. ***MCO Care Coordination***: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who received care coordination services from the health plan care coordinator will increase from 5.33% to 60.7% at final re-measurement.
A8. ***MCO Outreach with Member CONTACT***: The percentage of the eligible population sample who were outreached by the health plan care coordinator.
Baseline to final measurement goal: The percentage of the eligible population sample who were outreached by the health plan care coordinator will increase from 4% to 50.0% at final re-measurement.
A9. ***MCO Outreach with Member ENGAGEMENT***: The percentage of the members outreached who were engaged in care management.
Baseline to final measurement goal: The percentage of the members outreached who were engaged in care management will be maintained at 75% at final re-measurement.
A10. ***First Line Behavior Therapy for Children <6 years***: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD.
Baseline to final measurement goal: The percentage of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD will increase from 0% to 50% at 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: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-Day Initiation Phase will increase from 40.44% to 44.80% at final re-measurement.
Measure B1b. Continuation and Maintenance (C&M) Phase. The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.
Baseline to final measurement goal: The percentage of members aged 6-12 years as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended will increase from 53.83% to 55.90% at final re-measurement.

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: Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITH behavioral therapy will increase from 39.9% to 43.89% 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: Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITHOUT behavioral therapy will decrease from 46.2% to 40.0% at final re-measurement.

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:

Various data collection methods are being utilized within this PIP. Chart sampling is used and charts are stratified by age and foster care status. In addition to chart sampling, we are utilizing data from Centene's Enterprise Data Warehouse and then through Microstrategy, TruCare, and SharePoint. Data will be collected using the Centene level corporate Quality Spectrum Insight (QSI-XL) database. Audits of clinical data or medical records will be performed if needed to corroborate the findings from the QSI-XL analysis. Therefore, hybrid methodology may be employed if needed to scrub the data and ensure data reliability and validity. LHCC ensures the validity and reliability of the data through weekly meetings between health plan data analytics and quality departments. Meetings with the Centene-based analytics team occur as needed. In addition, reports go through test run for reliability.

Those who collect the data include Data Analysts, Quality Improvement Abstractors, and Disease Management staff who track and trend their department's data.

Validity and Reliability

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

Data is validated by our Quality Improvement Abstractors, the HEDIS team, and our Analytics Department. All Quality Improvement Abstractors are provided training and must pass subsequent testing. Abstractors are

also audited on a quarterly basis. We validate data by having multiple analysts run same data for a volume check and analyze further if there is a discrepancy.

Data Analysis:
Data is compared to previous year's data when available, denominators and numerators will be checked for inclusion of all eligible populations and any discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid data possible.

3. Project Timeline

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

Populate the tables below with relevant information, based upon instructions in the footnotes.

Add rows as needed.

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

Description of Barrier[2]	Method and Source of Barrier Identification[3]	Number of Intervention	Description of Intervention Designed to Overcome Barrier[4]	Intervention Timeframe[5]
Providers not completing and/or completing incorrectly the appropriate assessment tools prior to diagnosing children with ADHD	Provider Survey	1	Provider Education – academic detailing by Medical Director and ADHD Provider Toolkit	*Planned Start: 1/1/2017* *Actual Start: 7/1/2017* *Date Revised:*
Lack of care coordination between CM, child, parent/guardian, and other appropriate stakeholders. During Interim period, there was a decline in the number of foster care children who received ADHD meds and BH therapy. Develop ITMs that incorporate this susceptible subpopulation.	Provider Survey	2	Enhanced Case Management – increased collaboration of care plan development with provider -Identification of children in foster care newly prescribed ADHD meds to ensure they also receive coordinating BH therapy	*Planned Start: 1/1/2017* *Actual Start: 1/1/2017* *Date Revised:*
Lack of BH providers in some regions of the state	Provider Survey	3	Workforce Capacity	*Planned Start: 1/1/2017* *Actual Start: 1/1/2017* *Date Revised:*
Lack of BH resources available to PCPs for consultation	Provider Survey	4	1. Behavioral Health Consultation to PCPs 2. Physician-to-physician meetings designed to offer resources and gather provider input regarding barriers they face with the ADHD population	*Planned Start: 10/1/2018* *Actual Start: 10/1/2018* *Date Revised:*

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

Barrier Analysis Notes:

LHCC develops all care plans in conjunction with the member and/or member's guardian. We feel we have adequate care coordination between the plan and members. We have developed ITMs to focus on increasing provider collaboration in the development of member care plans. In addition to developing all care plans in

collaboration with our members/members' guardians, we rely on member input to determine a successfully closed case. An ADHD Disease Management case in not considered successfully closed until the member's guardian communicates to the plan that their child has shown a positive increase in behaviors that were previously being exhibited, for example, trouble focusing at school, acting out at home, etc. The plan will continue to provide services until the member's guardian has conveyed that their child has shown an adequate increase in behaviors and states they feel the services are no longer needed. This is when a case is closed as successful.

Regarding the academic detailing program, we are going to focus our efforts on those high prescribers for age range 0-18 initially. Once those meetings are complete, we will focus on age range 0-6, then 7-18 as there is some variance in these lists once broken down.

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	Percentage of new BH providers that join our network that receive training and educational information Num: # of new BH providers who received training during quarter Denom: # new BH providers in LHCC network during the quarter			Numerator: 14 Denominator: 14 Rate: 100%	Numerator: 58 Denominator: 58 Rate: 100%
1	Percentage of high prescribing providers in members 0-6 years of age that LHCC Medical Director has met with to discuss proper diagnosing, treatment options, etc, Num: # of providers provided academic detailing during quarter Denom: # providers targeted for academic detailing				
1	Percentage of high prescribing providers in members 7-18 years of age that LHCC Medical Director has met with to discuss proper diagnosing, treatment options, etc, Num: # of providers provided academic detailing during quarter Denom:# providers targeted for academic detailing				

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
1	EnvolveU.com - ADHD Training Num: # of providers that attended training Denom:# providers in network		*Tracking initiated in Q3 2017*	Numerator: 51 Denominator: 20162 Rate: 0.25%	Numerator: 35 Denominator: 4954 Rate: 0.80% **Denom dropped due to eliminating specialists*
1	EnvolveU.com – Proper Completion of BH Assessment Tools Num: # of providers that attended training Denom:# providers in network		*Tracking initiated in Q3 2017*	Numerator: 17 Denominator: 20162 Rate: 0.055%	Numerator: 14 Denominator: 4954 Rate: 0.28% **Denom dropped due to eliminating specialists*
2	Percentage of 0-6 y/o members engaged with Disease Management that health plan collaborated with provider on plan of care Num: # 0-6 y/o members health plan collaborated with provider on plan of care Denom:# 0-6 y/o total active cases in quarter	Numerator: 1 Denominator: 18 Rate: 5.56%	Numerator: 9 Denominator: 45 Rate: 20.00%	Numerator: 2 Denominator: 10 Rate: 20.00%	Numerator: 1 Denominator: 7 Rate: 14.29%
2	Percentage of 7-12 y/o members engaged with Disease Management that health plan collaborated with provider on plan of care Num: # 7-12 y/o members health plan collaborated with provider on plan of care Denom:# 7-12 y/o total active cases in quarter	Numerator: 4 Denominator: 37 Rate: 10.81%	Numerator: 10 Denominator: 73 Rate: 13.70%	Numerator: 3 Denominator: 13 Rate: 23.08%	Numerator: 2 Denominator: 19 Rate: 10.53%
2	Percentage of 13-18 y/o members engaged with Disease Management that health plan collaborated with provider on plan of care Num: # 13-18 y/o members health plan collaborated with provider on plan of care Denom:# 13-18 y/o total active cases in quarter	Numerator: 3 Denominator: 16 Rate: 18.75%	Numerator: 6 Denominator: 33 Rate: 18.18%	Numerator: 1 Denominator: 4 Rate: 25.00%	Numerator: 1 Denominator: 10 Rate: 10.00%
2	Percentage of 0-6 y/o members engaged in Disease Management that health plan referred for outside BH resources Num: # 0-6 y/o members referred for outside BH resources Denom:# 0-6 y/o total active cases in quarter	Numerator: 6 Denominator: 18 Rate: 33.33%	Numerator: 27 Denominator: 45 Rate: 60.00%	Numerator: 10 Denominator: 10 Rate: 100.00%	Numerator: 7 Denominator: 7 Rate: 100.00%
2	Percentage of 7-12 y/o members engaged in Disease Management that	Numerator: 20 Denominator: 37 Rate: 54.05%	Numerator: 44 Denominator: 73 Rate: 60.27%	Numerator: 12 Denominator: 13 Rate: 92.31%	Numerator: 18 Denominator: 19 Rate: 94.74%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	health plan referred for outside BH resources Num: # 7-12 y/o members referred for outside BH resources Denom:# 7-12 y/o total active cases in quarter				
2	Percentage of 13-18 y/o members engaged in Disease Management that health plan referred for outside BH resources Num: # 13-18 y/o members referred for outside BH resources Denom:# 13-18 y/o total active cases in quarter	Numerator: 10 Denominator: 16 Rate: 62.50%	Numerator: 14 Denominator: 33 Rate: 42.42%	Numerator: 4 Denominator: 4 Rate: 100.00%	Numerator: 9 Denominator: 10 Rate: 90.00%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 0-6 y/o members enrolled in ADHD DM program Denom:# 0-6 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 18 Denominator: 24 Rate: 75.00%	Numerator: 45 Denominator: 51 Rate: 88.24%	Numerator: 2 Denominator: 4 Rate: 50.00%	Numerator: 3 Denominator: 4 Rate: 75.00%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 7-12 y/o members enrolled in ADHD DM program Denom:# 7-12 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 37 Denominator: 49 Rate: 75.51%	Numerator: 73 Denominator: 84 Rate: 86.91%	Numerator: 9 Denominator: 9 Rate: 100.00%	Numerator: 8 Denominator: 8 Rate: 100.00%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 13-18 y/o members enrolled in ADHD DM program Denom:# 13-18 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 16 Denominator: 30 Rate: 53.33%	Numerator: 33 Denominator: 43 Rate: 76.74%	Numerator: 2 Denominator: 2 Rate: 100.00%	Numerator: 4 Denominator: 4 Rate: 100.00%
2	Percentage of ADHD DM cases that were successfully closed during the quarter (A successfully closed case is one where the member's guardian reports child's behaviors have improved and services are no longer needed at this time) Num: # 0-6 y/o successfully closed cases	Numerator: 8 Denominator: 18 Rate: 44.44%	Numerator: 22 Denominator: 45 Rate: 48.89%	Numerator: 0 Denominator: 2 Rate: 0.00%	Numerator: 1 Denominator: 3 Rate: 33.33%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	Denom:# 0-6 y/o active cases in ADHD DM program				
2	Percentage of ADHD DM cases that were successfully closed during the quarter Num: # 7-12 y/o successfully closed cases Denom:# 7-12 y/o active cases in ADHD DM program	Numerator: 17 Denominator: 37 Rate: 45.95%	Numerator: 25 Denominator: 73 Rate: 34.25%	Numerator: 4 Denominator: 9 Rate: 44.44%	Numerator: 1 Denominator: 8 Rate: 12.50%
2	Percentage of ADHD DM cases that were successfully closed during the quarter Num: # 13-18 y/o successfully closed cases Denom:# 13-18 y/o active cases in ADHD DM program	Numerator: 3 Denominator: 16 Rate: 18.75%	Numerator: 9 Denominator: 33 Rate: 27.27%	Numerator: 1 Denominator: 2 Rate: 50.00%	Numerator: 1 Denominator: 4 Rate: 25.00%
2	Social Worker grant program: Num: # LCSWs Denom: # 13-18 y/o active cases in ADHD DM program *Claims data will be analyzed for further process measures when available.*		*Program slated to begin Q3 2017*	Numerator: 2 Denominator: 3 Rate: 66.67%	Numerator: 2 Denominator: 3 Rate: 66.67%
3a	Percentage of members that live in an urban area and are within 15 miles of a BH provider Num: # members within 15 miles of a BH provider Denom:# total members	Numerator: 323401 Denominator: 326960 Rate: 98.91%	Numerator: 322093 Denominator: 325738 Rate: 98.88%	Numerator: 322183 Denominator: 325738 Rate: 98.91%	Numerator: 321436 Denominator: 324952 Rate 98.92%
3b	Percentage of members that live in a rural area and are within 30 miles of a BH provider Num: # members within 30 miles of a BH provider Denom:# total members	Numerator: 150828 Denominator: 150833 Rate: 99.99%	Numerator: 151106 Denominator: 151112 Rate: 99.99%	Numerator: 151624 Denominator: 151630 Rate: 99.99%	Numerator: 152458 Denominator: 152463 Rate: 99.99%
4	Percentage of PCs who received a list of BH providers in their region Num: # of PCPs who received list Denom: Total number of PCPs in network	After further analysis, the process measure was determined to be ineffective. Plan is in development stages of a replacement measure.			

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

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

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
1a	Percentage of new BH providers that join our network that receive training and educational information Num: # of new BH providers who received training during quarter Denom:# new BH providers in LHCC network during the quarter	Numerator: 47 Denominator: 47 Rate: 100%	Numerator: 27 Denominator: 27 Rate: 100.00%	Numerator: 41 Denominator: 41 Rate: 100.00%	Numerator: 43 Denominator: 43 Rate: 100.00%
1b	Percentage of high prescribing providers that LHCC Medical Director has met with to discuss proper diagnosing, treatment options, etc, Num: # of providers provided academic detailing during quarter Denom:# providers targeted for academic detailing				*Program will begin Q1 2019*
1	EnvolveU.com - ADHD Training Num: # of providers that attended training Denom:# providers in network	Numerator: 65 Denominator: 5393 Rate: 1.21%	Numerator: 66 Denominator: 3262 Rate: 2.02%	Process measure ended. Will replace with process measure monitoring provider education on the availability of the AAP Toolkit in Q1 2019.	
1	EnvolveU.com – Proper Completion of BH Assessment Tools Num: # of providers that attended training Denom:# providers in network	Numerator: 17 Denominator: 5393 Rate: 0.32%	Numerator: 49 Denominator: 3262 Rate: 1.50%	Process measure ended. Will replace with process measure monitoring provider education on the availability of the AAP Toolkit in Q1 2019.	
1c	Percentage of PCPs and BH specialists that have been educated about the availability of the AAP ADHD Toolkit				

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
	Num: # providers outreached and educated Denom: # of providers targeted (This will be a cumulative process measure to account for providers as they are educated.)				*Will begin Q1 2019*
1d	Percentage of providers that are in the process of completing LHCC-provided Child-Parent Psychotherapy training. Num: # providers that have attended trainings to date Denom: # providers offered the course		Numerator: 35 Denominator: 35 Rate: 100.00%	Numerator: 35 Denominator: 35 Rate: 100.00%	Numerator: 31 Denominator: 35 Rate: 88.57%
2a	Percentage of newly identified children in foster care with a new ADHD med prescription filled, who had a claim for the ADHD medication AND a claim for any counseling type Num: # members in foster care with a claim for an ADHD med and for any counseling type Denom: #members in foster care with a newly filled ADHD med prescription			*ITM added in Q4 2018.*	Numerator: 124 Denominator: 1326 Rate: 9.35%
2b	Percentage of newly identified children in foster care ages 4-5 years old with a new ADHD med prescription filled, who had a claim for the ADHD medication AND a claim for any counseling type Num: # members in foster care with a claim for an ADHD med and for any counseling type Denom: #members in foster care with a newly filled ADHD med prescription			*ITM added in Q4 2018*	Numerator: 9 Denominator: 76 Rate11.84%
2	Percentage of 0-6 y/o members engaged with Disease Management that health plan collaborated with provider on plan of care Num: # 0-6 y/o members health plan collaborated with provider on plan of care Denom:# 0-6 y/o total active cases in quarter	Numerator: 0 Denominator: 7 Rate: 0.00%	Numerator: 1 Denominator: 2 Rate: 50.00%	Numerator: 2 Denominator: 7 Rate: 28.57%	Numerator: 3 Denominator: 16 Rate: 18.75%
2	Percentage of 7-12 y/o members engaged with	Numerator: 1	Numerator: 4 Denominator: 7	Numerator: 9	Numerator: 11

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
	Disease Management that health plan collaborated with provider on plan of care Num: # 7-12 y/o members health plan collaborated with provider on plan of care Denom:# 7-12 y/o total active cases in quarter	Denominator: 5 Rate: 20.00%	Rate: 57.14%	Denominator: 29 Rate: 31.04%	Denominator: 48 Rate: 22.92%
2	Percentage of 13-18 y/o members engaged with Disease Management that health plan collaborated with provider on plan of care Num: # 13-18 y/o members health plan collaborated with provider on plan of care Denom:# 13-18 y/o total active cases in quarter	Numerator: 0 Denominator: 3 Rate: 0.00%	Numerator: 2 Denominator: 4 Rate: 50.00%	Numerator: 5 Denominator: 14 Rate: 35.71%	Numerator: 5 Denominator: 16 Rate: 31.25%
2	Percentage of 0-6 y/o members engaged in Disease Management that health plan referred for outside BH resources Num: # 0-6 y/o members referred for outside BH resources Denom:# 0-6 y/o total active cases in quarter	Numerator: 7 Denominator: 7 Rate: 100.00%	Numerator: 2 Denominator: 2 Rate: 100.00%	Numerator: 4 Denominator: 7 Rate: 57.14%	Numerator: 7 Denominator: 15 Rate: 46.67%
2	Percentage of 7-12 y/o members engaged in Disease Management that health plan referred for outside BH resources Num: # 7-12 y/o members referred for outside BH resources Denom:# 7-12 y/o total active cases in quarter	Numerator: 5 Denominator: 5 Rate: 100.00%	Numerator: 5 Denominator: 7 Rate: 71.43%	Numerator: 13 Denominator: 29 Rate: 44.83%	Numerator: 14 Denominator: 48 Rate: 29.17%
2	Percentage of 13-18 y/o members engaged in Disease Management that health plan referred for outside BH resources Num: # 13-18 y/o members referred for outside BH resources Denom:# 13-18 y/o total active cases in quarter	Numerator: 3 Denominator: 3 Rate: 100.00%	Numerator: 4 Denominator: 4 Rate: 100.00%	Numerator: 7 Denominator: 14 Rate: 50.00%	Numerator: 7 Denominator: 16 Rate: 43.75%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 0-6 y/o members enrolled in ADHD DM program Denom:# 0-6 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 10 Denominator: 57 Rate: 17.54%	Numerator: 0 Denominator: 3 Rate: 0.00%	Numerator: 6 Denominator: 53 Rate: 11.32%	Numerator: 10 Denominator: 50 Rate: 20.00%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
2	Percentage of ADHD DM referrals that were enrolled in program per quarter (stratified by those members 0-6 y/o and in FC) Num: # 0-6 y/o members enrolled in ADHD DM program or another DM/CM program as needs dictate Denom:# 0-6 y/o members referred and determined to be appropriate for ADHD DM program			Numerator: 1 Denominator: 10 Rate: 10.00%	Numerator: 1 Denominator: 3 Rate: 33.33%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 7-12 y/o members enrolled in ADHD DM program Denom:# 7-12 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 3 Denominator: 6 Rate: 50.00%	Numerator: 15 Denominator: 30 Rate: 50.00%	Numerator: 24 Denominator: 145 Rate: 16.55%	Numerator: 22 Denominator: 146 Rate: 15.07%
2	Percentage of ADHD DM referrals that were enrolled in program per quarter Num: # 13-18 y/o members enrolled in ADHD DM program Denom:# 13-18 y/o members referred and determined to be appropriate for ADHD DM program	Numerator: 0 Denominator: 1 Rate: 0.00%	Numerator: 12 Denominator: 16 Rate: 75.00%	Numerator: 7 Denominator: 62 Rate: 11.29%	Numerator: 5 Denominator: 60 Rate: 8.33%
2	Percentage of ADHD DM cases that were successfully closed during the quarter Num: # 0-6 y/o successfully closed cases Denom:# 0-6 y/o active cases in ADHD DM program	Numerator: 4 Denominator: 11 Rate: 36.36%	Numerator: 0 Denominator: 0 Rate: N/A	Numerator: 0 Denominator: 6 Rate: 0.00%	Numerator: 0 Denominator: 11 Rate: 0.00%
2	Percentage of ADHD DM cases that were successfully closed during the quarter Num: # 7-12 y/o successfully closed cases Denom:# 7-12 y/o active cases in ADHD DM program	Numerator: 0 Denominator: 3 Rate: 0.00%	Numerator: 2 Denominator: 15 Rate: 13.33%	Numerator: 0 Denominator: 25 Rate: 0.00%	Numerator: 0 Denominator: 25 Rate: 0.00%
2	Percentage of ADHD DM cases that were successfully closed during the quarter Num: # 13-18 y/o successfully closed cases Denom:# 13-18 y/o active cases in ADHD DM program	Numerator: 0 Denominator: 0 Rate: N/A	Numerator: 0 Denominator: 0 Rate: N/A	Numerator: 0 Denominator: 0 Rate: N/A	Numerator: 0 Denominator: 0 Rate: N/A
2	Social Worker grant program: Num: # LCSWs hired	Numerator: 2 Denominator: 3 Rate: 66.67%	Numerator: 2 Denominator: 3 Rate: 66.67%	Numerator: 3 Denominator: 3 Rate: 100%	Numerator: 3 Denominator: 3 Rate: 100%

Number of Intervention	Description of Intervention Tracking Measures[6]	Q1 2018	Q2 2018	Q3 2018	Q4 2018
	Denom:# # of clinics in program				
3	Percentage of members that live in an urban area and are within 15 miles of a BH provider Num: # members within 15 miles of a BH provider Denom:# total members	Numerator: 204019 Denominator: 204331 Rate: 99.85% *Numbers lower due to change in state reporting.*	Numerator: 315822 Denominator: 326199 Rate: 96.81% *Numbers higher due to state reporting reverting back.*	Numerator: 312597 Denominator: 322789 Rate: 96.84%	Numerator: 316267 Denominator: 326491 Rate 96.87
3	Percentage of members that live in a rural area and are within 30 miles of a BH provider Num: # members within 30 miles of a BH provider Denom:# total members	Numerator: 88519 Denominator: 88862 Rate: 99.61% *Numbers lower due to change in state reporting.*	Numerator: 142507 Denominator: 143101 Rate: 99.59% *Numbers higher due to state reporting reverting back.*	Numerator: 141197 Denominator: 141752 Rate: 99.61%	Numerator: 142443 Denominator: 143038 Rate: 99.58%

6: See PIP HEALTHY_LOUISIANA_PIP_TEMPLATE_w_examples for examples and additional guidance.

6. Results

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

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development and refinement of interventions, and/or analysis of PIP performance.

Results Table.

Performance Indicator	**Administrative (A) or Hybrid (H) Measure?**	**Baseline Period** 2016	**Interim Period** 2017	**Final Period** 2018	**Final Goal/Target Rate**
Indicator #1 A1. Validated ADHD Screening Instrument	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 25 Denominator = 75 Rate = 33.33%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 54 Denominator = 75 Rate = 72.00%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 47 Denominator = 75 Rate = 62.66%	Target Rate 78.67% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement

Indicator #2 A2. ADHD Screening in Multiple Settings	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 11 Denominator = 75 Rate = 14.67%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 50 Denominator = 75 Rate = 66.67%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 38 Denominator = 75 Rate = 50.66%	Target Rate: 78.67% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #3 A3. Assessment of other behavioral health conditions/ symptoms	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 12 Denominator = 75 Rate = 16.00%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 18 Denominator = 75 Rate = 24.00%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 35 Denominator = 75 Rate = 46.66%	Target Rate: 32.60% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #4 A4. Positive findings of other behavioral health conditions	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 10 Denominator = 75 Rate = 13.33%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 19 Denominator = 75 Rate = 25.33%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 33 Denominator = 75 Rate = 44.00%	
Indicator #5 A5a. Referral for EVALUATION of other behavioral health conditions	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 10 Numerator = 6 Denominator = 10 Rate = 60.00%	Eligible Population = 19 Exclusions= 0 If "H", Sample size = 19 Numerator = 15 Denominator = 19 Rate = 78.94%	Eligible Population = 33 Exclusions= 0 If "H", Sample size = Enter # Numerator = 33 Denominator = 33 Rate = 100.00%	Target Rate: 80.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #6 A5b. Referral to TREAT other behavioral health conditions	H	Eligible Population = 10 Exclusions= 0 If "H", Sample size = 10 Numerator = 5 Denominator = 10 Rate = 50.00%	Eligible Population = 19 Exclusions= 0 If "H", Sample size = 19 Numerator = 17 Denominator = 19 Rate = 89.47%	Eligible Population = 33 Exclusions= 0 If "H", Sample size = 33 Numerator = 33 Denominator = 33 Rate = 100.00%	Target Rate: 85.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #7 A6. PCP Care Coordination	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 29	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 48	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 68	Target Rate: 70.67% Rationale: CMS recommendations for setting bold, feasible goals for

		Denominator = 75 Rate = 38.67%	Denominator = 75 Rate = 64.00%	Denominator = 75 Rate = 90.66%	meaningful improvement
Indicator #8 A7. MCO Care Coordination	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 4 Denominator = 75 Rate = 5.33%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 0 Denominator = 75 Rate = 0.00%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 1 Denominator = 75 Rate = 1.33%	Target Rate: 60.70% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #9 A8. MCO Outreach with Member Contact	H	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 3 Denominator = 75 Rate = 4.00%%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 0 Denominator = 75 Rate = 0.00%	Eligible Population = 75 Exclusions= 0 If "H", Sample size = 75 Numerator = 4 Denominator = 75 Rate = 5.33%	Target Rate: 50.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #10 A9. MCO Outreach with Member ENGAGEMENT	H	Eligible Population = 3 Exclusions= 0 If "H", Sample size = 3 Numerator = 3 Denominator = 3 Rate = 100.00%	Eligible Population = 0 Exclusions= 0 If "H", Sample size = 0 Numerator = 0 Denominator = 0 Rate = 0.00%	Eligible Population = 4 Exclusions= 0 If "H", Sample size = 4 Numerator = 0 Denominator = 4 Rate = 0.00%	Target Rate: 75.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #11 A10. First Line Behavior Therapy for Children < 6 years	H	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 13 Denominator = 30 Rate = 43.33%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 10 Denominator = 30 Rate = 33.33%	Target Rate: 50.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #11 A10a. Clinical Exclusions[1,2]	H	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Target Rate: 0.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement

Indicator #11 A10b. Exclusions- No qualified providers in area[1]	H	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Target Rate:0.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients[1]	H	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Eligible Population = 30 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30 Rate = 0.00%	Target Rate: 0.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement
2627Indicator #12 B1a. HEDIS ADD Measure: Initiation Phase	A	Eligible Population = 6496 Exclusions= 0 If "H", Sample size = N/A Numerator = 2627 Denominator = 6496 Rate = 40.44%	Eligible Population = 7630 Exclusions= 0 If "H", Sample size = N/A Numerator = 4335 Denominator = 7630 Rate = 56.82%	Eligible Population = 7210 Exclusions= 0 If "H", Sample size = N/A Numerator = 3591 Denominator = 7210 Rate = 49.81%	Target Rate: 44.80% Rationale: Quality Compass 50th percentile
Indicator #13 B1b. HEDIS ADD Measure: Continuation Phase	A	Eligible Population = 1278 Exclusions= 0 If "H", Sample size = N/A Numerator = 688 Denominator = 1278 Rate = 53.83%	Eligible Population = 1449 Exclusions= 0 If "H", Sample size = N/A Numerator = 1002 Denominator = 1449 Rate = 69.15%	Eligible Population = 1223 Exclusions= 0 If "H", Sample size = N/A Numerator = 805 Denominator = 1223 Rate = 65.82%	Target Rate: 55.90% Rationale: Quality Compass 50th percentile
Indicator #14 B2a. BH Drug with Behavioral therapy[3]	A	Eligible Population = 40980 Exclusions= 0 If "H", Sample size = N/A Numerator = 82623 Denominator = 40980 Rate = 20.16%	Eligible Population = 48274 Exclusions= 0 If "H", Sample size = N/A Numerator = 7686 Denominator = 48274 Rate = 15.92%	Eligible Population = 45567 Exclusions= 0 If "H", Sample size = N/A Numerator = 6180 Denominator = 45567 Rate = 13.56%	Target Rate: 43.89% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement

Indicator #15 B2b. BH Drug WITHOUT Behavioral therapy[3]	A	Eligible Population = 40980 Exclusions= 0 If "H", Sample size = N/A Numerator = 30399 Denominator = 40980 Rate = 74.18%	Eligible Population = 48274 Exclusions= 0 If "H", Sample size = N/A Numerator = 29567 Denominator = 48274 Rate = 61.25%	Eligible Population = 45567 Exclusions= 0 If "H", Sample size = N/A Numerator = 27149 Denominator = 45567 Rate = 59.58%	Target Rate: 40.00% Rationale: CMS recommendations for setting bold, feasible goals for meaningful improvement

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

7. Discussion

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

Discussion of Results

Interpret the performance indicator rates for each measurement period, i.e., indicate whether or not target rates were met, describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods: Overall, the performance indicators have increased from the baseline to the final measurement periods. There was improvement in the areas of PCPs use of ADHD screening tools (almost a 30% increase from baseline to final), screening across multiple settings (over 35% increase from baseline to final), providers screening for other behavioral conditions (just over 30% from baseline to final) and referring those patients for further evaluation and treatment to specialists (a 40% increase from baseline to final), and increased PCP care coordination (over a 50% increase from baseline to final). Additionally, there was improvement from the baseline year to the final year in behavior therapy being offered as a first line treatment option in children younger than 6 years old. Both HEDIS ADD measures improved from the baseline year and surpassed the targets. One area that the performance indicators showed a decrease in was MCO Care Coordination and Case Management engagement, however some of the intervention tracking measures (ITMs) showed improvement in that area over the last three quarters, particularly with the engagement of children in the 0-6 year old category. The ITMs are looking at all cases concurrently from each quarter, which reflects early member identification of newly diagnosed ADHD cases, whereas the performance indicator rates are only looking at a random sample of 75 charts from the year prior. It should be noted that some cases of newly identified children with ADHD are not enrolled in the ADHD program due to having other behavioral issues that may take precedence over the ADHD behaviors. Those children may be enrolled in a different program but their ADHD needs are still addressed. Another area that showed a decline is the measure around BH drugs being prescribed in conjunction with behavioral therapy. However the rate for BH drugs being prescribed without behavioral therapy has also declined. The discrepancy is due to the fact that there may be members in the denominator who have a diagnosis of ADHD but no ADHD medication claims.

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: After analyzing the intervention process measures, success can be attributed to our Disease Management process measures. Care plan collaboration with providers increased from baseline to final in all three age groups (0-6, 7-12, and 13-18). Since tracking referrals to outside behavioral health resources, this rate improved for age group 0-6. Disease Management enrollment rates for all age groups decreased from baseline to final tracking, however, there was a change in how we identified these denominators, resulting in much larger denominators and therefore lower rates. Because more members are being identified as appropriate for DM services, our DM department has developed prioritization for outreach, including utilizing proactive scoring provided on the first fill report for ADHD medications. This allows our Disease Managers to focus outreach on those members with higher acuity needs. If other co-morbidities are identified during the outreach process, it may result in those members being enrolled in other, more intensive and traditional Case Management services. Despite being enrolled in another program, those members' ADHD needs are also being addressed.

What factors were associated with success or failure? Our Disease Management staff continues to focus on the betterment of our ADHD program. They have dedicated resources and staff to focus on the interventions in this PIP, including care coordination with providers, increasing engagement rates and ensuring members are referred to the appropriate behavioral health services. Network adequacy remains high throughout all areas of the state. The LCSW pilot program is underway and all three participating pediatric clinics have hired a social worker. Once more claims data can be analyzed, LHCC will explore the possibility of expanding the program to additional practices. Academic Detailing is still in development, but once it begins, the plan Medical Director will make

outreach to high prescribing providers across the state and have peer-to-peer discussions about what resources the plan can provide to them in order to better align their patients with the services that they need.

Limitations (For definitions and examples, refer to HEALTHY_LOUISIANA_PIP_TEMPLATE_w_example)

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

- **Were there any factors that may pose a threat to the internal validity the findings?** There were no threats to internal validity identified.
- **Were there any threats to the external validity the findings?** Some data used in the ADHD PIP is claims based and therefore dependent on providers coding properly.
- **Describe any data collection challenges.** Some data used in the ADHD PIP is claims based and therefore dependent on providers coding properly.

Member Participation

There was no direct member participation utilized in the development or implementation of this PIP.

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:** Findings within this PIP have been shared with other interested parties, such as Case Management, Data Analytics and Provider Network. The information is disseminated through meetings.

8. Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

Description of Intervention	Lessons Learned	System-level changes made and/or planned	Next Steps
Build Workforce Capacity	Despite maintaining network adequacy, there are not enough providers who provide these specific services for children with ADHD.	Developed partnership with SLU for NP psychiatric training.	LHCC has partnered with SLU to offer psychiatric certification to any nurse practitioners associated with FQHCs. Will continue to monitor network adequacy and will recruit and contract with

			providers in areas as needs are identified.
Deliver Provider Education/ Outreach	Many providers do not properly use ADHD assessment tools. PCPs need better tools to equip them for proper diagnosing.	Built data analytics reporting to identify high prescribers of ADHD meds. Added ADHD Toolkit as a talking point during all PCP Provider Consultant visits.	LHCC BH Medical Director and CMO will initiate the academic detailing program.
Facilitate access to and provision of behavioral health consultation for PCPs	PCPs do not always make BH referrals once diagnosing a child with ADHD due to lack of knowledge on who to refer them to.	Developed and implemented LCSW program with three pediatric practices. Developed partnership with SLU for NP psychiatric training.	Exploring expanding the LCSW program to other pediatric practices. Rolling out an e-consult platform for PCPs to make direct referrals for BH services. NPs working with FQHCs are being offered training to become specialized in psychiatry.
Enhanced Care Coordination	Identified the need to better stratify our ADHD population to proactively identify those who would benefit from DM services versus those who need more intensive CM services. Need to better partner with our providers on the development of care plans.	Changes made to documentation process within TruCare to identify more members who might be eligible for ADHD DM services.	Eliza – implemented this program and will continue to utilize to help contact parents/guardians at more convenient times.

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).