

# Healthy Louisiana Performance Improvement Project (PIP)

**MCO Name: UnitedHealthcare**

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

**2016- 2018**

**Project Phase:** Final

**Original Submission Date:** 6/28/2019

**Revised Submission Date:**

**Project Phase:** Interim

**Submission Date:** 6/28/2018

**Revised Submission Date:** 9/28/2018

**Project Phase:** Baseline

**Submission Date:** 6/30/2017

**Revised Submission Date:** 7/4/2017

**Project Phase:** Proposal

**Submission Date:** 12/23/2016

**Revised Submission Date:** [Click here to enter a date](#)

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Submission to: IPRO

**State: Louisiana Department of Health**

## MCO Contact Information

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### 1. Principal MCO Contact Person

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

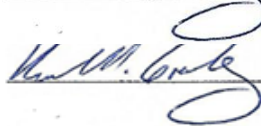
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**Interim Report:** Principal MCO Contact Signature



6/28/2018

**Final Report:** Principal MCO Contact Signature



6/24/2019

### 2. Additional Contact(s)

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

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Quality Director  
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Enter Title

Enter Phone Number (direct line or indicate extension)

Enter email address

### 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 CarePlan Name:** UnitedHealthcare

**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.

Ann Kay Logarbo MD 12/28/2016  
Medical Director (print, sign and date)

Angela Olden 12/28/2016  
Quality Director (print, sign and date)

Sharon Hoffman, MD 12/28/2016  
Behavioral Health Medical Director (print, sign and date)

Allison Young 12/28/2016  
CEO (print, sign and date)

## Attestation Addendum

Kevin Stephens MD 8/24/2017  
Medical Director (print, sign and date)

Angela Olden 8/24/2017  
Quality Director (print, sign and date)

Michael Sievert, MD 8/24/2017  
Behavioral Health Medical Director (print, sign and date)

## Attestation Addendum 2:

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

UnitedHealthcare Community Plan  
Health Plan Name

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

Julie Morial, MD 06/27/2018  
Medical Director (print, sign and date)

Deborah Junot 06/27/2018  
Quality Director (print, sign and date)

Jose CalderonAbbo, MD 06/27/2018  
Behavioral Health Medical Director (print, sign and date)

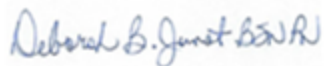
The undersigned approve this FINAL PIP Report:

Medical Director Signature  
Julie Morial, MD



6/24/2019

Quality Director Signature  
Deborah B. Junot



6/24/2019

IS Director Signature (when applicable)  
Printed Name

Date

CEO Signature  
Scott D. Waulters



6/24/2019

### 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:** The prevalence of parent-reported ADHD among publicly insured youth aged 2-17 in Louisiana during 2009 and 2010 was 45.0%, significantly higher than that of publicly insured youth nationwide at 35.5% (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 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. 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 recommended by 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% received effective care coordination, compared to 66.7% of privately insured children.

**Project Aims:** Increase the use of validated ADHD screening instruments across multiple settings. Increase Primary Care Provider (PCP) assessment of alternative causes for ADHD-like presenting symptoms. Increase the referral for evaluation and/or treatment for those children with positive screenings, or documented concerns regarding presenting symptoms. Increase PCP care coordination. Increase MCO outreach and engagement of members newly prescribed medication for ADHD. Increase the percentage of children < 6 years, diagnosed with ADHD, who receive behavioral therapy as first line of treatment for their ADHD symptoms. Meet or exceed the State’s target for the HEDIS® ADD measures. Increase the use of behavioral therapy when appropriate, for children diagnosed with ADHD whether taking ADHD medication, or not.

### Methodology

**Eligible Population:** Less than 20 years old as of the Index Event that had a PCP visit in the initial measurement period (February 1, 2015 - February 29, 2016), the interim measurement period (October 1, 2016 - October 31, 2017), and the final measurement period (April 1, 2017- April 31, 2018). Continuously enrolled for 120 days prior to the Index Start Date.

**Description of Annual Performance Indicators:** Percentages of PCP charts of eligible members that included: validated screening instruments, and if used in multiple settings; assessment of other behavioral health conditions/symptoms; for those with positive findings, referral for evaluation, and/or treatment; evidence of PCP care coordination; evidence of MCO care coordination, outreach, and member engagement; and children < 6 years old receiving behavioral therapy as first line of treatment. HEDIS® ADD measures are used as performance indicators for baseline (2016), for interim (2017), and for the final report (2018). Non-HEDIS® measures indicating the percentage of the eligible population receiving behavioral health (BH) medication along with BH therapy, and the percentage of the eligible population receiving BH medication without BH therapy.

**Sampling Method:** Charts were systematically pulled from the eligible population universe. The primary pull was random, but once 3 charts occurred from the same PCP, subsequent pulls for that PCP would be replaced with alternates. No more than 2 providers from a given office site were included.

**Baseline and Re-measurement Periods:** Hybrid Measurement Baseline: 2/1/15-2/29/16, Interim: 10/1/16-10/31/17; Final: 4/1/17- 4/31/18. HEDIS® and NON-HEDIS® Baseline: 1/1/16-12/31/16; Interim: 1/1/17-12/31/17; Final: 1/1/18-12/31/18.

**Data Collection Procedures:** PCP offices were called, and then sent patient lists via fax following HIPAA guidelines. Staff nurses documented PCPs’ evidence on EXCEL® spreadsheets and uploaded same to a secure UHC SharePoint site. HEDIS® and NON-HEDIS® data was acquired via UHC Business Intelligence reports.

### Interventions

**Member Barriers Identified:** Insufficient PCP knowledge of guidelines, and BH therapy resources.

**Interventions to address member barriers:** Build workforce capacity; Deliver Provider Education; Enhance Care Coordination

**Provider Barriers Identified:** Insufficient PCP knowledge of assessment, and intervention resources.

**Interventions to address provider barriers:** Deliver Provider Education; Facilitate Access to, and Provision of Behavioral Health Consultation for PCPs; Enhance Care Coordination

## Results

**Report Data for Annual Performance Indicators:** Validated ADHD tool baseline (B):43.44%, Interim (I): 63.33%; Final (F): 83.33%. In multiple settings B: 31.67%, I: 50%; F: 65%. Assessment of other B: 58.33%, I: 98.3%; F: 100%. Positive findings B: 41.67%, I: 75%; F: 55%. Evaluation referral B: 80%, I: 95.6%; F: 87.87%. Treatment referral B: 72%, I: 77.8%; F: 63.63%. PCP care coordination (cc) B: 43.33%, I: 80%; F: 63.33%. MCO cc B: 0 %, I: 3.3%; F: 6.67%. MCO member contact B: 0%, I: 1.7%; F: 3.33%. MCO member engagement B: 0%, I: 0%; F: 3.33%. 1<sup>st</sup> line BH therapy B: 3.33%, I: 43.3%; F: 24.13%. HEDIS® ADD initiation B: 52.85%, I: 55.26%; F: 55.42%. Continuation B: 64.49%, I: 70.36%; F: 67.05%. BH drug with BH therapy B: 33.1%, I: 33.8%; F: 32.3%. Without therapy B: 48.5%, I: 47.6%; F: 49.2%.

## Conclusions

**Interpret improvement in terms of whether or not Target Rates were met for annual performance indicators:** Validated tool, and tool in multiple settings, and Assessment of other, met or exceeded final targets. Referral for Evaluation, Treatment, PCP care coordination, MCO outreach, both HEDIS®, BH drug with, and without BH therapy did not meet or exceed final targets.

**Indicate interventions that did and did not work in terms of quarterly intervention tracking measure trends:** The percent of providers educated improved quarterly. Other interventions were not trendable.

**Study Design Limitations:** Most quarterly measures were percentages of actions completed, as opposed to outcomes of interventions.

**Lessons Learned and Next Steps:** A system to track utilization of Evidence Based Practices (EBPs) is needed in order to identify EBP providers. Due to collaboration with LDH, and the other MCOs, the process is underway to be able to accept and track the new EBP codes. Individual providers have varying levels of DSM5/AAP ADHD guideline knowledge and understanding. Collecting and verifying individual provider contact information will facilitate information dissemination to all providers caring for our members. Telehealth may be one answer to provide behavioral health consultation for members and providers. UHC is actively working with providers and designing pilots to bring telehealth to members. Members need options to receive care coordination. Internal trainings, along with provider outreach and education will increase coordination opportunities.

# 1. Project Topic/ Rationale and 2. Aim

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## 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):** The ADHD PIP topic addresses our member needs due to the prevalence of ADHD in our pediatric population. The 2016 National Survey of Children's Health, as cited by the Center for Disease Control and Prevention (CDC, 2018), indicated 9.4% of U.S children ages 2-17 years have ever been diagnosed with ADHD. The percent of this same cohort taking ADHD medications was 5.2. Twenty percent of all of UHC members under the age of 20 years in 2016, either had received an ADHD diagnosis, or were receiving ADHD medications (per HEDIS® definition). Thirty-three percent of children ages 13-17 were diagnosed with, or prescribed medication designated for ADHD. Though these are not direct comparisons, there is an inference of much greater prevalence in Louisiana than nationwide. The 2016 National Survey of Children's Health also noted among 2-17 year olds, 64% or nearly 2 out of 3 children with current ADHD had at least one other mental, emotional, or behavioral disorder. The top 4 disorders are behavioral or conduct disorder such as Oppositional Defiant Disorder (ODD), or Conduct Disorder (CD); anxiety, depression, or Autism Spectrum Disorder (ASD). A Healthy Louisiana Provider Survey for 2016 indicated that 77% of pediatricians and 95% of family practitioners managed ADHD in their practices. However, 29% of both groups on average managed ODD, 35% managed CD, and 57% managed anxiety and depression. As the percentages of Louisiana children that have ADHD are higher than the national average, it would be reasonable to infer that a fair percentage of these children would also be likely to have one or more behavioral comorbidities. This begs the question; would providers manage one disorder and refer the other out? Are they even looking for anything else? This potential disparity of care could negatively affect UHC members. The ADHD PIP topic's importance is that it may reveal and reduce the incidence of insufficient or inappropriate treatment for members who have been diagnosed with ADHD.
- **Describe current research support for topic (e.g., clinical guidelines/standards):** Attention Deficit/Hyperactivity Disorder (ADHD) is the most prevalent neurodevelopmental disorder among children (Feldman and Reiff, 2014). According to a recent article published in the New England Journal of Medicine, high prevalence rates suggest over-diagnosis (Feldman and Reiff, 2014). American Academy of Pediatrics (AAP) guidelines advise that physicians assess the severity of the preschool child's ADHD prior to prescribing medication, and that pharmaceutical interventions be reserved for those preschoolers with moderate to severe dysfunction, i.e.: symptoms that have persisted for at least 9 months, dysfunction that is manifested in both the home and other settings such as preschool or child care, and dysfunction that has not responded adequately to behavior therapy (Subcommittee on ADHD, 2011). The AAP guidelines recommend behavior therapy as the first line of treatment for preschool-aged children (four to five years of age) and advise primary care clinicians to assess for coexisting emotional or behavioral conditions (Subcommittee on ADHD, 2011). The AAP guidelines do not address ADHD diagnosis or treatment in children younger than four years of age, yet it has been reported that very young children are diagnosed with ADHD and prescribed psychotropic medications, particularly children with comorbid mental health and chronic health conditions (Rappley et al., 2002). A multi-state study of preschool children enrolled in Medicaid found that psychotropic drugs were most commonly prescribed for ADHD, followed by depression or anxiety and psychosis or bipolar disorder (Garfield et al., 2015). Yet, the majority of psychotropic drugs prescribed for preschoolers are off-label, i.e., neither tested or approved by the Food and Drug Administration (FDA) for use in this age group (Garfield et al., 2015). Further, inappropriate prescribing of antipsychotic medications among children for non-FDA-approved indications, such as ADHD, has been reported (Matone et al., 2012; Penfold et al., 2013). A national study revealed that among U.S. Medicaid-enrolled children aged 3-18 years, those with ADHD comprised 50% of antipsychotic users, and 15% of antipsychotic use was among youth diagnosed exclusively with ADHD (Matone et al., 2012). Therefore, the prescription of both ADHD and antipsychotic drugs for children with ADHD merits closer monitoring for appropriateness, safety and effectiveness.
- **Explain why there is opportunity for MCO improvement in this area:** The prevalence of parent-reported ADHD among publicly insured youth aged 2-17 in Louisiana during 2009 and 2010 was 45.0% (95% CI = 37.4, 52.6), significantly higher than that of publicly insured youth nationwide (35.5%; 95% CI =

33.9, 37.2%; NS-CSHCN, 2012). Corresponding ADHD medication rates for youth with ADHD were also higher (83.1% versus 74.2%); however, this difference was not statistically significant (NS-CSHCN, 2012). The American Academy of Pediatrics' (AAP) clinical practice guideline for the diagnosis and treatment of ADHD in children aged 4-18 years provides guidelines that can increase the accuracy of diagnosis, and reduce problems of over diagnosis. For example, the AAP guidelines note that for the diagnostic process to be accurate, physicians must rule out alternate causes of the presenting symptoms. Children with ADHD generally gain the attention of healthcare providers as a result of behavioral dysregulation. However, behavioral dysregulation is not unique to ADHD, but rather is a common symptom presentation in children that can result from any of numerous behavioral health concerns including depression, anxiety, trauma, or family stress (including parental behavioral health concerns). When evaluating a child for ADHD, the primary care clinician should assess whether the following alternate causes, instead of, or in addition to ADHD, may actually underlie the child's behavior: Emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct) disorders Developmental (e.g., autism spectrum) disorders Learning and language disorders While not specifically referenced in the 2011 ADHD guidelines, the role of trauma and toxic stress in contributing to behavioral dysregulation – which can also co-occur with or be mistaken for ADHD – was detailed by the AAP in 2012 when they released a policy statement (Garner et al., 2012) and technical report (Shonkoff et. al., 2012) for physicians to aid in understanding the impact of trauma and toxic stress on children's health. The AAP guidelines also provide recommendations for both pharmacologic and non-pharmacologic management (Subcommittee on ADHD, 2011). Recommendations for pharmacologic management entail a face-to-face follow-up visit by the fourth week of medication, with monthly visits until a consistent optimal response is reached, and then every three months during the first treatment year (Subcommittee on ADHD, 2011). The HEDIS measure, "Follow-Up Care for Children Prescribed ADHD Medication" quantifies the percentage of children aged 6-12 years who were newly prescribed ADHD medication who had one follow-up visit during the 30-Day Initiation Phase, as well as the percentage with two additional visits during the continuation and maintenance phase (nine months after the Initiation Phase ended). Of the four Bayou Health Plans reporting these measures for HEDIS reporting year 2014, all of the plans' rates fell below the 95th percentile for both measures, two of the four plans' rates fell below the 50th percentile for the Initiation Phase measure, and one of the plan's rates fell below the 50th percentile for the Continuation & Maintenance Phase measure. Care coordination is another recommendation of the AAP guidelines (Subcommittee on ADHD, 2011) and is a priority of the Louisiana Bureau of Family Health (DHHD-LA, 2014). Yet, among publicly insured children with special health care needs in Louisiana, only 48.6% (95% CI = 40.3, 57.0) received effective care coordination (i.e., help with coordination of care and satisfaction with communication among providers and with schools if needed), compared to 66.7% (95% CI = 59.0, 74.3) of privately insured children.

## 2. Aim Statement, Objectives and Goals

### **Aim Statement:**

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

### **Objective(s):**

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

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

### **Goal(s):**

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



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

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

**Baseline to final measurement goal:** Increase the percent of members of the eligible population sample whose PCP used a validated ADHD screening instrument by 25.1 percentage points (from 43.3% to 68.4%) to meet a meaningful improvement goal by December 2018.

**A2. ADHD Screening in Multiple Settings:** The percentage of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, i.e., home and school.

**Baseline to final measurement goal:** Increase the percent of members of the eligible population sample whose PCP used a validated ADHD screening instrument completed by reporters across multiple settings, by 31 percentage points (from 31.7% to 62.7% ) to meet a meaningful improvement goal by December 2018.

**A3. Assessment of other behavioral health conditions/symptoms:** The percentage of the eligible population sample whose PCP conducted a screening, evaluation, or utilized behavioral health consultation for at least one alternate cause of presenting symptoms and/or co-occurring conditions (e.g., oppositional-defiant disorder, conduct disorder, anxiety, depression, autism, learning/language disorders, substance use disorder, trauma exposure/toxic stress).

**Baseline to final measurement goal:** Increase the percent of members 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, by 41.7 percentage points (from 58.3% to 100%) to meet a meaningful improvement goal by December 2018.

**A4. Positive findings of other behavioral health conditions:** The percentage of the eligible subpopulation sample with screening, evaluation or utilization of behavioral health consultation whose PCP documented positive findings, i.e. positive screens or documented concerns for alternate causes of presenting symptoms and/or co-occurring conditions. (*goal setting not applicable*)

**A5a. Referral for EVALUATION of other behavioral health conditions:** The percentage of the eligible subpopulation sample with positive findings regarding alternate causes/co-occurring conditions whose PCP documented a referral to a specialist behavioral health provider for evaluation and/or treatment of alternate causes of presenting symptoms and/or co-occurring conditions.

**Baseline to final measurement goal:** Increase the percent of members 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 20 percentage points (from 80% to 100%) to meet a meaningful improvement goal by December 2018.

**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 percent 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 to treat alternate causes of presenting symptoms and/or co-occurring conditions, by 21.7 percentage points (from 72% to 93.7%) to meet a meaningful improvement goal by December 2018.

**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 percent 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 46.8 percentage points (from 43.3% to 90.1%) to meet a meaningful improvement goal by December 2018.

**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 percent of the eligible population sample who received care coordination services from the health plan care coordinator, by 68.4 percentage points (from 0% to 68.4%) to meet a meaningful improvement goal by December 2018.**

8. *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 percent of the eligible population sample that were outreached by the health plan care coordinator, by 68.4 percentage points (from 0% to 68.4%) to meet a meaningful improvement goal by December 2018.**

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 percent of the members outreached who were engaged in care management, by 68.4 percentage points (from 0% to 68.4%) to meet a meaningful improvement goal by December 2018.**

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 percent of the eligible population sample aged <6 years who received evidence-based behavior therapy as first-line treatment for ADHD, by 65.1 percentage points (from 3.3% to 68.4%) to meet a meaningful improvement goal by December 2018.**

## **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 IPSP with an ambulatory prescription dispensed for ADHD medication, which had one follow-up visit with practitioner with prescribing authority during the 30-Day Initiation Phase.

**Baseline to final measurement goal: Increase the percent of members aged 6-12 years as of the IPSP 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 5.79 percentage points (from 52.85% to 58.64%) to reach the 95<sup>th</sup> Quality Compass (QC) percentile.**

**Measure B1b. Continuation and Maintenance (C&M) Phase.** The percentage of members aged 6-12 years as of the IPSP with an ambulatory prescription dispensed for ADHD medication, which remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

**Baseline to final measurement goal: Increase the percent of members aged 6-12 years as of the IPSP 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 8.67 percentage points (from 64.49% to 73.16%) to surpass the 95<sup>th</sup> Quality Compass (QC) percentile.**

### ***Non-HEDIS Administrative Measures:***

**Measure B2a. BH Drugs WITH Behavioral Therapy.** Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITH behavioral therapy.

**Baseline to final measurement goal: Increase the percent 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 2.7 percentage points (from 33.1% to 35.8%) to meet a meaningful improvement goal by December 2018.**

**Measure B2b. BH Drugs WITHOUT Behavioral Therapy.** Percentage of any ADHD cases, aged 0-20 years, stratified by age and foster care status, with documentation of behavioral health pharmacotherapy (ADHD medication, antipsychotics, and/or other psychotropics), WITHOUT behavioral therapy.

**Baseline to final measurement goal: Decrease the percent of 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 3.5 percentage points (from 48.5% to 45%) to meet a meaningful improvement goal by December 2018.

## 3. Methodology

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### 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:

An electronic report in spreadsheet format was requested from United's business intelligence department, which included a random pull of claims for children that met the following criteria:

Eligible member description for medical record review:

- Less than 20 years old as of the Index Event
- Had a PCP visit in the measurement period (February 1, 2015 - February 29, 2016).
- Continuously enrolled for 120 days prior to the Index Start Date

Index Event:

- Earliest diagnosis of ADHD, or dispensing of ADHD medication during the Intake Period, with no prior ADHD diagnosis for a period of 120 days (4 months) prior to the Index Diagnosis date.
- Diagnosis codes used for visit identification.
- HEDIS® ADHD medication table used for prescription identifications.

The request for new prescriptions ties in with Healthcare Effectiveness Data and Information Set (HEDIS) measures for ADHD. HEDIS® as described by its creator the National Committee for Quality Assurance, also known as NCQA® (2018) is a set of performance measures that healthcare plans use to gage their effectiveness for specific healthcare issues, relative to plans in other states. The HEDIS® measure for ADHD is two-fold. First, when the provider first prescribes an ADHD medication to a child aged 6-12, in an outpatient office setting, he or she must see the child within 30 days. This is to assure there are no issues with the child taking the medication. The second part of the measure is the assurance that the child was seen at least two more times after the initial prescription within 210 days. This is to assure the medication is working as anticipated, as the initial follow up visit may not have been enough time for the medication to reach a therapeutic level. As these HEDIS® measures are already designed for query to the data bases, there was no need to design a new query. This list was then cross walked against another claims list indicating a new ADHD diagnosis for the same age group, and same time frame. The reports also included the provider's name, address and contact information. To assure as broad a reach of providers across the State for the 60 chart audit, a systemized chart pull was designed for a universe of 12,805 members for the baseline review, 4,699 members for the interim review, and 6,134 members for the final review. The pull was initially random, but once 3 charts occurred from the same provider, subsequent pulls for the provider would be substituted with alternates. Also, no more than two providers from a given group would be used. The exceptions to this rule were large multi-office practices, where providers generally stayed in a particular office. Due to time constraints an abbreviated time line was used all three years. Adjustments that occurred at some of the provider organizations in 2018, allowed for charts housed in electronic systems to be reviewed on line for Interim and Final reviews. Each year, providers that were visited on site, were contacted for review date and time appointments. The charts were determined. The patient lists were then faxed when the contact was available to receive it, a requirement for HIPAA compliance. The audit tool was a modified EXCEL®

spreadsheet, fashioned after the medical record review tool that the Quality team uses for PCP documentation compliance audits. Registered nurses reviewed the chosen records, and recorded their findings in laptop computers. Each year, a number of charts pulled based on claims, had to be excluded after documentation review revealed previous ADHD diagnosis or treatment for children both under and over the age of six. The findings were recorded on the ADHD PIP audit tools. Once back at their respective homes, the nurses transferred the records over a secure virtual private network to a password protected Share Point site. The project lead aggregated the data each year for the baseline, interim, and final reports.

### **Validity and Reliability**

A Power Point® presentation was created for the baseline year, using the information taken from the Louisiana External Quality Review ADHD Collaborative Performance Improvement Project Medical Record Review Data Abstraction Instructions. Each question and the instructions related to that question were addressed. This presentation was updated and used for the interim and final year. Each year the Power Point® was used to train the nursing staff who were to participate in the chart reviews. Examples were given for each situation. Each nurse was also supplied with the original instructions to use as a reference while reviewing charts in the field. The EXCEL spreadsheet included a comment section for nurses to use if there were any issues that they encountered that might influence how a given question was answered. The project lead spoke with each nurse individually to assure understanding of how to score the tool. The project lead was available by phone to answer questions encountered in the field. All completed tools were reviewed by the project lead. Any questions or comments were discussed with the reviewing nurse before the scores were counted.

Administrative data was requested from the business intelligence department using the ADHD PIP document and LDH provided spreadsheets as references to assure the appropriate data was being requested. If there appeared to be a discrepancy between the data results from one year to the next, the Business Intelligence team would be asked to rerun the data for both years. This would assure the query was the same in both cases. The HEDIS® data process affects not only the HEDIS ADD measure, but also those children taking ADHD medication for the record review. The process is audited by specific NCQA certified auditors. The auditors perform a review of UHC's transaction systems and data analysis procedures, examine computer programs to confirm adherence to NCQA specifications, interview key process representatives, examine select transactions including claims, and benchmark the performance rates for each measure against normative data.

### **Data Analysis:**

Methods to analyze data include a review of baseline results, as well as comparison with the results of the collaborating MCOs, as aggregated for the project. The chart review was designed to sample the entire state, making regional comparison not possible. Regional comparison was also not possible for the Performance Indicators for HEDIS®, and NON-HEDIS® total counts. They were compared to the baseline data, and will be compared with the collaborating MCO results. HEDIS® rates were also compared to the national Quality Compass® benchmarks. The NON-HEDIS® measures were also stratified by age and OPH region, which allowed for analysis of not only baseline, interim, and final years, but also age group and geographic area. The ability to view data by age and region allowed for consideration of hot spots, at least for the UHC population. Confidence intervals were calculated at 95% on the performance indicators in order to verify significant change from baseline to final results. Intervals were also calculated to determine increases in goals for most of the measures.

## **3. Project Timeline**

<b>Event</b>	<b>Timeframe</b>
<b>PIP Proposal Submission Date</b>	<b>Target Date: December 30, 2016</b>
<b>Baseline Measurement Periods</b>	<b>Hybrid Measurement:</b> 2/1/15-2/29/16 (+ 4 months preceding 6/1/15 and 3 months following 11/31/15) <b>HEDIS Measure:</b> HEDIS Measurement Year 2016 <b>NON-HEDIS Administrative Measure:</b> 1/1/16-12/31/16
<b>Initiate Interventions After Baseline</b>	<b>Target 1/1/17 for initiation of interventions</b>

Event	Timeframe
Measurement Period	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 <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention Timeframe <sup>5</sup>
Insufficient PCP knowledge of assessment and intervention resources.  Perceived limited access to prescribers within the network and to Child/Adolescent specialists. The Healthy LA Provider ADHD survey results included: #1 Barrier: Lack of qualified behavioral specialists. 16% of pediatric, 15% of	Healthy LA Provider ADHD 2016 survey;  The Optum clinician search engine filters for ADHD, age groups such as children's therapy (0-5).	A 1	A) Workforce capacity: MCOs and LA DH collaborate with BH to build a network of providers in all parishes of the state trained in evidence-based treatments for children including 0-6, e.g., Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT). A1 Track current available BH professionals, who attest that they have an appropriate background to treat children < 6 years of age, by OPH region. Acquire and research which practitioners have CPP, PCIT, or similar evidenced-based skillsets for treatment of children 0-6 year of age, and serve the Medicaid population. Research how best to use the BH provider application form to meet the needs of PCPs and members to find the right type of BH provider. For example, should a specific field for CPP (recommended for PTSD) be included in the OPTUM BH application form, or should more broadly defined fields such as EBP be included, in order to cover not	<i>Planned Start:</i> 1/1/2017 <i>Actual Start:</i> 7/1/2017


Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention on Timeframe <sup>5</sup>
<p>family practice respondents indicated no access to BH providers.</p> <p>Names of providers with specific certifications for evidence-based treatments for children &lt; six years of age, such as CPP, or PCIT is unknown.</p>			<p>only CPP, but similar treatments such as PPT, a CBT for PTSD? Once a determination has been made regarding the best way to differentiate providers specifically using EBPs for ADHD, a request to OPTUM for inclusion of these new fields can occur. Upon OPTUM's approval for new fields, providers can then add these more specific indicators when registering or updating information with OPTUM.</p>	
<p>Insufficient PCP knowledge of assessment and intervention resources.</p> <p>Perceived limited access to prescribers within the network and to Child/Adolescent specialists. The Healthy LA Provider ADHD survey results included: #1Barrier: Lack of qualified behavioral specialists. 16% of pediatric, 15% of family practice respondents indicated no access to BH providers.</p>	<p>Healthy LA Provider ADHD 2016 survey</p>	<p>A2</p>	<p>A2 Educate pediatric PCPs that use the internet, on using the UHC Community Plan's BH Information Center, the Optum Provider Express, and the Live and Work Well (LAWW) Clinician Center that houses a BH provider search engine. A specific presentation on how to search for appropriate BH providers on the LAWW search engine has been created for this purpose. Providers will also be educated on the availability of BH resources and the search engine via the provider manual.</p> <p>Pediatric PCPs that do not use the internet will be educated on the Community Plan's "One Call" Resource Line (866) 675-1607 from which they can acquire information on BH providers in their area. The respondents to the ADHD survey will be targeted first, starting 9/1/17. The rest of the providers will be educated during CPC visits and outreach events, such as the Provider Expos.</p>	<p><i>Planned Start:</i> 2/1/2017 <i>Actual Start:</i> 4/1/2017</p>
<p>There is no mandatory registry for EBP therapists. The PCIT registry for example, only contains those names of providers who choose to share their information. There is currently no way to monitor EBP therapy for children under the age of six via claims history</p>	<p>Review of national PCIT registry; a web-search for EBP therapists; a review of the Optum clinician search engine</p>	<p>A3</p>	<p>A3 Research options to identify evidence of EBP therapy through current source of data. The Louisiana Department of Health (LDH) requires UHC to identify providers who offer specific Evidenced-Based Practices (EBPs). UHC plans to validate that the provider is eligible to offer the EBP at the time of credentialing and through routine roster updates the provider completes. For each EBP, the provider must submit all required documentation in order to be identified in provider systems, including the directory, as eligible to offer the EBP service. These EBPs include Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), Youth PTSD Treatment (YPT) and Preschool PTSD Treatment (PPT). UHC submitted on 1/24/19, its new credentialing plan for Evidence Based Practices (EBP) to LDH. After LDH review, a revised plan was</p>	<p><i>Planned Start:</i> 10/1/2018 <i>Actual Start:</i> 10/1/2018</p>

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			resubmitted on 3/20/19.	
The number of children needing BH therapy for ADHD may be overstated due to issues such as coding issues in EPIC EHR systems. In the course of the interim chart review, it was found in the EPIC system; "hyperactive" is coded as ADHD unspecified F90.9.	Medical record reviews for Interim report	A4	A4 Workforce capacity is considered relative to the population in need of services. As it is important to have sufficient practitioners available to treat the patients, it is also important to have an accurate picture of how many patients are in need of treatment. Examining the prevalence of the ADHD unspecified code (F90.9) being recorded. Added a process measure to acquire a baseline of the percentage of ADHD diagnosis F90.9 relative to all the ADHD codes. Will analyze the extent of unspecified ADHD, and then if warranted; plan an intervention to reduce the number of unspecified diagnoses.	<i>Planned Start:</i> 7/1/2018 <i>Actual Start:</i> 7/1/2018
Lack of known trained practitioners in evidence-based treatments for children including 0-6, e.g., Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).	Optum clinician search engine filters for ADHD, age groups such as children's therapy (0-5).	A5	Though there are sufficient providers who attest to treat children under the age of six for BH issues, the number of practitioners in each region that can conduct specific EBTs such as PCIT is unknown. All of the MCOs have planned to train eligible individuals in one of the recommended therapies. United has chosen PCIT, and has sponsored a PCIT certification training in New Orleans by PCIT International to conduct. Following a pre-training assessment of candidate agencies for suitability, twelve therapists attended the first session on January 28-31, 2019. Eleven attended the second session that ran from April 29 <sup>th</sup> to May 1 <sup>st</sup> . An ITM for PDSA testing is planned once the PCIT initial training is completed. The ITM will address what percentage of individuals who enroll in the UHC sponsored training for PCIT will complete the training.	<i>Planned Start:</i> 1/1/2019 <i>Actual Start:</i> 1/1/2019
Insufficient provider knowledge of managed care and change in carrier/BH carve in, understanding of EPSDT screening as a comprehensive checklist for ruling out alternate causes of ADHD-like behavioral symptoms, and knowledge of assessment and intervention resources  Insufficient PCP	Healthy LA Provider ADHD 2016 survey;  Baseline onsite chart review	B1	B: Provider Education: MCOs and LA DH collaborate to produce and distribute a PCP Toolkit (e.g., AAP guidelines, screening tools and guidelines, resources for referrals) B1 An ADHD Toolkit has been created for presentation to those providers who treat pediatric ADHD patients. The UHC ADHD Toolkit, contains statistics, definitions, HEDIS® requirements, and numerous resources for screening and follow-up. The toolkit was developed as a Power Point presentation for easy dissemination via electronic transmission to enable access to the embedded resource links. Dissemination of the ADHD toolkit was tracked via a manual count when disseminated by Quality team staff. As MCO collaboration continues to enhance the toolkit, revised versions will replace the originals. 100% of the pediatric PCPs who responded to the ADHD survey received the toolkit. 100% of the SBHCs	<i>Planned Start:</i> 1/1/2017 <i>Actual Start:</i> 4/1/2017

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<p>awareness of the requirements of the HEDIS ADHD measure</p> <p>The Healthy LA Provider ADHD survey results included: Healthy LA Provider ADHD 2016 survey- 30% of pediatric, and 19% of family practice respondents indicated lack of comfort to diagnose ADHD for &lt; 6 yrs. of age; 20% of both pediatric and family practice respondents indicated lack of comfort to diagnose ADHD for &gt; 6 yrs. of age. The Baseline Chart review revealed only 43% of 60 charts included documentation of a validated ADHD screening instrument</p>			<p>that treat ADHD received the toolkit. 100% of pediatric PCPs that receive scorecards that include ADHD received the toolkit. Revised UHC ADHD toolkits continue to be distributed to PCPs who treat children, by CPCs during office visits, or electronic contact.</p>	
<p>The ADHD survey indicated less than 20% of respondents had an ADHD registry.</p>	<p>Healthy LA Provider ADHD 2016 survey</p>	<p>B2</p>	<p>B2 Pediatric PCPs have access to Gaps in Care (GIC) reports for ADD and Well Child visits, and EPSDT visits. The ADD list identifies 6 -12 year olds on ADHD medication. The EPSDT/Well visit reports identify 0 - 20 year olds in need of a comprehensive health screen, which includes developmental and behavioral screening components. Pediatric PCPs are educated on, or reminded of the availability of these GICs, and their usefulness as a registry. Education includes the importance of reviewing reports to identify, and outreach to members who are not seen in the practice. The respondents to the ADHD survey were targeted first, starting 9/1/17. The rest of the providers with more than 50 linked pediatric members were educated during CPC visits and outreach events, such as the Provider Expos. The education for pediatricians or family practice providers will be the same, as their members have the same needs.</p>	<p><i>Planned Start: 1/12017</i> <i>Actual Start: 9/1/2017</i></p>
<p>Lack of provider knowledge of assessment and intervention resources</p>	<p>Healthy LA Provider ADHD 2016; Baseline onsite chart review</p>	<p>B3</p>	<p>B3 Educational segments on ADHD, BH provider search engine, and supporting issues were created, and approved by UHC National /the State.</p>	<p><i>Planned Start: 6/9/2017</i> <i>Actual Start: 9/1/2018</i></p>



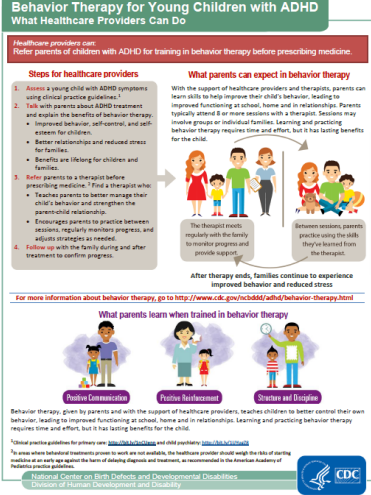
Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention Timeframe <sup>5</sup>
<p>Insufficient PCP awareness of the requirements of the HEDIS ADHD measure</p> <p>The Healthy LA Provider ADHD survey results included: survey-30% of pediatric, and 19% of family practice respondents indicated lack of comfort to diagnose ADHD for &lt; 6 yrs. of age; 20% of both pediatric and family practice respondents indicated lack of comfort to diagnose ADHD for &gt; 6 yrs. of age.</p> <p>The Baseline Chart review revealed only 43% of 60 charts included documentation of a validated ADHD screening instrument. UHC on Air tracking was planned as a resource before all processes of the new system were in place. The ability to track practitioner views did not occur as originally forecast.</p>			 <p>Optum, United's behavioral health partner, has created the Behavioral Health Toolkit for Medical Providers. This resides on the Optum Provider Express website in the clinical resources section. Tools include assessments, guidelines, resources, such as the Vanderbilt scale, and a 24/7 substance use disorder helpline, available for providers or patients. PCPs, who participate in the Accountable Care Organization (ACO) program, were educated in 2018 by Clinical Transformation Consultants (CTCs) on the use of this toolkit, and the importance of integration of healthcare. This resource has also been added to the UHC ADHD toolkit for both CPC and CTC distribution. New for Q1 2019 is the PsychHub™ Video Resources section. The PsychHub™ Video Library includes videos on disorders such as ADHD, OCD, and PTSD. It also includes videos with interaction tips, such as: Key Elements of Effective Listening, Building Empathy with Patients, and the Importance of Cultural Awareness. These videos are available at any time, for the provider's convenience.</p> <p>UHC on Air representatives are available at Provider Expos to show providers how to access UHC on Air, and the variety of content, which includes ADHD, behavioral health and other pertinent subjects. Information on UHC on Air, including instructions on how to access is also on the provider website: <a href="https://www.uhcprovider.com/en/resource-library/link-provider-self-service/uhc-on-air.html">https://www.uhcprovider.com/en/resource-library/link-provider-self-service/uhc-on-air.html</a></p>	
Lack of provider knowledge of assessment and intervention resources	<p>Healthy LA Provider ADHD 2016;</p> <p>Baseline onsite chart review</p>	B4	<p>B4 Educate PCPs on case management. An explanation of case manager services is included in the provider handbook. An article discussing what a case manager provides to members was included in the Winter 2017, and Summer 2018 Practice Matters newsletter. The importance of communication between PCPs and specialists was included in the Spring 2017, and Summer 2018 Practice Matters newsletter. A slide describing services provided by case management is included in the 2018 ADHD toolkit.</p>	<p><i>Planned Start:</i> 7/1/2018 <i>Actual Start:</i> 7/1/2018</p>

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			 <p>In collaboration with the Optum behavior health quality team, an educational flyer was created that addressed the importance of coordination of care, NCQA's recommendations when prescribing ADHD medications, and resources to facilitate coordination of care. This flyer is designed to be handed out to providers, as well as emailed to providers as part of outreach initiatives. This will be disseminated at the upcoming provider 2019 Expositions and in PCP offices by CPCs and CTCs. It will also be included in the ADHD outreach for PCPs who are high prescribers of ADHD medications.</p>	
Lack of provider knowledge of assessment and intervention resources	Healthy LA Provider ADHD 2016;  Baseline onsite chart review	B5	<p>B5 Educate PCPs on new AAP toolkit. All MCOs collaborated to provide the AAP ADHD toolkit online, at no cost to providers. The AAP web administrators track the toolkit, housed on the AAP website. The AAP toolkit flyer was shared with the CPCs for dissemination, and was added to UHC's ADHD toolkit. The MCOs started a collaborative intervention regarding outreach for the AAP toolkit information, but were then advised to track their own version of the intervention.</p> <p>An ITM for PDSA testing was developed based on the original collaborative effort, and was presented at the October Medicaid PIP meeting. The top 10 PCP prescribers of ADHD medications for children less than six years in the last six months were compared to the lists of enrolled providers submitted to the MCOs by the AAP team. One provider had already enrolled for access to the AAP ADHD toolkit website, and was replaced with the next highest prescriber. A letter was created to introduce the AAP ADHD toolkit and encourage providers to take advantage of its resources. The PCPs were called to verify their email addresses. The letter, along with the AAP flyer, was then emailed to nine, and faxed to one of the top 10 prescribing providers that have yet to sign up to use the toolkit. In Q1 2019, twelve weeks of UHCCS ADHD medication New Start reports (Jan 1-March 25) were sorted to determine the top PCPs who: a) wrote the most ADHD medication prescriptions for children ages 0-12 in Q1, b) were not enrolled on the website, or c) had already received outreach correspondence.</p>	<i>Planned Start:</i> 06/25/2018 <i>Actual Start:</i> 07/01/2018 <i>Date Revised:</i> 10/01/2018

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			<p>The AAP toolkit reports showed 3 physicians from the original 10 emails sent in Q4 2018 had enrolled on the AAP toolkit website. A total of 23 emails were sent to 25 pediatric providers that had written 6 or more prescriptions for children ages 6-12 in Q1, and/or 1 or more prescriptions for children &lt; 6 years of age. Four of the emails returned undeliverable. One was already resent with a revised email address. An email review and update has been requested of the CPCs and CTCs when they contact their providers. The AAP report lists names and the titles: physician, BH provider, nurse, other. Only physicians could be identified for the PDSA. To determine if more of the offices outreached had actually signed up for the AAP toolkit, the following actions were taken. The AAP ADHD toolkit Report, Dr. Calderon's introduction letter to the AAP toolkit flyer, and an explanation of the provider outreach PDSA were reviewed with the CPCs. A list of all the "nurses" and "other" enrollees for the toolkit website were shared with the CPCs for review and possible identification. The situation was also discussed with Ashley Politz, executive director LA AAP chapter. Ms. Politz stated she should be able to add an office and address field on the enrollment form. This would allow a connection between staff and PCPs, leading to a more accurate account of future outreach efforts.</p>	
<p>The Healthy LA Provider ADHD survey results indicated: 4% of pediatric and 3% of family practice respondents indicated an arrangement with a telephonic consultation service. Baseline chart review revealed little documentation of referral for evaluation and or treatment of children with suspected BH conditions. The 2016 Integrated Practice Assessment Tool (IPAT) revealed 23% of medical and BH providers indicated they had little or no standard communication regarding shared</p>	<p>Healthy LA Provider ADHD 2016</p> <p>Baseline onsite chart review</p> <p>2016 and 2017 IPAT</p>	C1	<p>C: Behavioral health consultation to PCPs-MCOs and LA DH collaboratively develop strategy to expand access to in-person or telephonic case consultation to PCPs.</p> <p>C1 Educate providers on the Community Plan's "One Call" Resource Line (866) 675-1607. Care Advocates can assist providers with BH referrals. Care BH care managers are available for more challenging cases. The Medical Director is also available if the situation warrants. Those children with complex needs as well as ADHD can be referred for case management to the Whole Person Care (WPC) team. As the name suggests, the WPC team case manages both medical and behavioral issues for patients with complex needs. The integrated care team which includes a Community Health Advocate (CHA), Registered Nurse (RN), Behavioral Health Advocate (BHA), works with the extended care team, including the PCP, pharmacist, Medical Director, and Peer Specialist. Comprehensive health care information from the assessment and plan of care (POC) is shared with both the PCP and the BH provider with the member's consent. The hierarchical disease state determines either a medical or behavioral health primary case manager to support the member, using a primary point of contact to ensure all health care needs are addressed through collaboration with the member's interdisciplinary care team. The primary</p>	<p><i>Planned Start:</i> 1/12017 <i>Actual Start:</i> 4/12017</p>


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patients. 2017 IPAT revealed 20% of medical and BH providers indicated they had little or no standard communication regarding shared patients.			case manager ensures the POC comprehensively addresses the physical, behavioral health, and social/environmental health care concerns. In all cases, interdisciplinary case conferences and joint clinical rounds are conducted, internally and/or externally to establish collaborative goals. The medical director provides clinical leadership and expertise to address member needs. The director's responsibilities include, but are not limited to, contacting the attending physician and/or primary care physician and obtaining specialty physician consultation when appropriate.	
<p>The Healthy LA Provider ADHD survey results indicated:</p> <p>Lack of provider knowledge on how to access BH case consultation that is currently available, such as Project Launch, a national initiative aimed at children less than 8 years of age, currently being piloted in Acadia, Lafayette, and Vermillion parishes. The Healthy LA Provider ADHD survey results indicated: 4% of pediatric and 3% of family practice respondents indicated an arrangement with a telephonic consultation service. Baseline chart review revealed little documentation of referral for evaluation and or treatment of children with suspected BH conditions. The 2016 Integrated Practice Assessment Tool (IPAT) revealed 23% of providers indicated they had</p>	<p>Discussion with Project Launch staff regarding reach and engagement of local providers. Discussion with local providers who were unaware of the program. The Healthy LA Provider ADHD survey; Baseline onsite chart review; 2016 IPAT</p>	C2	<p>C2 Educate pediatric PCPs in a 3 parish area of the Louisiana Project Launch program which, among other services, includes telephonic case consultation. Project Launch (PL) is a national initiative to ensure all children ages 0-8 reach social, emotional, behavioral, physical, and cognitive milestones. The LA PL activities included implementing a clinical consultation model to integrate BH into primary care settings, embedding mental health consultation and parenting education in early care settings, promoting Early Steps, and enhancing access to EBPs. The LA PL pilot team had not reached all of the area's PCPs. The PL coordinator (Ms. Domingue) indicated that some PCPs though informed of the pilot, have yet to participate. A list of PCPs seeing 0-7 was cross-walked with the PL team to determine outreach needs. Of UHC providers in the area that see children 7 years and younger, 17 of 56 (30%) pediatricians, 2 of 68 (3%) FPs. and 1 of 75 (1%) NPs, interacted with PL. Those in need of initial education were contacted first. The PL program flyer was used as the educational tool. The PL program overview was presented at the Oct. 4<sup>th</sup> 2017 Lafayette Expo, and was made available for viewing on UHC on Air June 19, 2018.</p> <div data-bbox="755 1430 1149 1528"> <p>Helping Children Soar- Project Launch-Louisiana</p> <p>AIRIED ON 10/04/2017 3:05 PM</p> <p>WATCH ON DEMAND</p> </div> <div data-bbox="1187 1423 1369 1560"> <p>PROVIDER INFORMATION EXPO</p> <p>WATCH NOW</p> </div>	<p><i>Planned Start: 6/1/2017</i>  <i>Actual Start: 7/1/2017</i>  <i>Date Revised: 6/19/2018</i></p>

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no relationship with a BH provider				
Many pediatric practitioners in the 3 Project Launch (PL) parishes have misleading age panels. Limited engagement of PCPs with few pediatric patients, with Project Launch noted in Interim chart review.	Found in the course of contacting alleged pediatric practitioners in the 3 parish area serviced by Project Launch. Interim onsite chart review;	C3	C3 Follow up on and reinforce education regarding Project Launch. A new list of practitioners in Acadia, Vermillion, & Lafayette parishes will be created using the list of PCPs with ADD on their performance measure value based scorecards, to assure only PCPs that see children 0-7 will be contacted.	<i>Planned Start: 8/1/2018</i> <i>Date Revised: N/A –prog no longer available</i>
<p>Lack of PCP knowledge regarding use of BH therapy as first line of treatment for children &lt; 6 years of age.</p> <p>Lack of SBHCs' knowledge regarding coordination of care with student's PCP.</p> <p>Lack of PCP knowledge regarding the BH programs available at the SBHC that they could tap into for their patients, who are also students/patients at the SBHC. The Healthy LA Provider ADHD survey results indicated only half of practitioners have a consultative-referral relationship with an offsite provider.</p> <p>Lack of member knowledge to inform PCPs of care received from other providers indicated in PCP charts reviewed due to member claims of BH treatment.</p> <p>Lack of member understanding of the importance of being</p>	<p>Informal survey by Quality department staff with SBHC sites to determine level of involvement with students exhibiting ADHD-like symptoms.</p> <p>2016 IPAT, and Healthy LA Provider ADHD surveys;</p> <p>Baseline, and Interim Chart reviews</p> <p>2017 IPAT</p>	D1	<p>D: Enhanced Care Management:</p> <ul style="list-style-type: none"> <li>o Facilitate Behavioral Health referrals/consultation</li> <li>o Care Coordination among CM (when child is high risk), PCP, BH therapist, teacher, parent and child</li> </ul> <p>Increase PCP practice utilization of on-site care coordinator.</p> <p>D1 Educate pediatric PCPs on CDC's recommendation for BH therapy as first line of treatment for children &lt;6 years of age. BH therapy as first line of treatment for children &lt;6 is recommended by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, as well as the CDC. The CDC however, created an eye-catching flyer in 2016, which spells out what parents can expect, what they can learn, and the steps the provider should take regarding the process of referring a child for therapy before prescribing ADHD medication. This colorful, easy to read flyer is more likely to be read by the busy provider. The CDC brand assures the provider that the federal government, not just UHC, backs this recommendation or local BH providers, so the provider could follow this regardless of which MCO the provider is affiliated. This should facilitate evidence-based behavioral health treatment prior to/ in place of ADHD medication, for children &lt; 6</p>	<p><i>Planned Start: 1/1/2017</i> <i>Actual Start: 6/1/2017</i></p> <p><i>Planned Start: 4/1/2017 for SBHC educ.</i> <i>Actual Start: 4/1/2017</i></p> <p><i>Planned Start: 2/1/2017 for notification of trx forms.</i> <i>Date Revised: 3/31/2018</i> <i>School BH program brochure on hold</i></p>

Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention Timeframe <sup>5</sup>
<p>linked to the PCP that provides the member's care. This negatively impacts the ability of the serving provider to participate in coordination of care.</p> <p>Lack of PCP knowledge of availability of Gaps in Care reports for ADD and well visits.</p> <p>2016 IPAT revealed 23% of medical and BH providers indicated they had little or no standard communication regarding shared patients.</p> <p>2017 IPAT revealed 20% of medical and BH providers indicated they had little or no standard communication regarding shared patients.</p>			 <p>years.</p> <p>Engage OPH SBHCs to collaborate with PCPs and MCO for children of school age. Work with OPH SBHC lead (Faith Boudreaux) to assure SBHC staff understands the importance of COC by on-site coordinator with PCP, particularly if medication initiation is involved. Ms. Boudreaux will promote the use of a communication form available for provider notification of care provided with school affiliated BH provider. Determine which SBHCs if any, have a flyer/brochure regarding their clinic's BH programs, available for dissemination to local PCPs. If none, work with SBHC staff to create same. If available, disseminate flyer/brochure to PCPs whose offices are near the SBHC. Educate SBHCs on the importance of determining the student's medical home outside of the SBHC. Ms. Boudreaux, was invited to, and presented "Partner with Your School Based Health Center" at the Baton Rouge provider Expo May of 2018. Ms. Boudreaux's presentation focused on value of medical practitioners collaborating with their neighboring SBHCs to increase care plan collaboration. Ms Boudreaux was unable to attend the fall Expos, but expressed a willingness to present again in 2019, schedule permitting. She has been notified of the Expo opportunities for this year.</p>	
<p>Names of providers with specific certifications for evidence-based treatments for children &lt; six years of age, such as CPP, or PCIT are unknown.</p> <p>There is no specific registry for EBP therapists. The</p>	<p>Review of Optum BH provider database filters.</p> <p>Review of national PCIT website &amp; registry.</p>	<p>D2</p>	<p>D2 Participated in discussions with collaborating MCOs regarding opportunities to share costs of trainings for therapies appropriate for pre-school aged children, and cost sharing of the AAP toolkit, housed on the AAP website. These discussions led to the ongoing collaboration with the other MCOs to pay training costs for EBP therapies, particularly for children &lt; 6 years. This will increase the number of practitioners available for PCP referral. MCOs also continue to provide the AAP toolkit, housed on the AAP website. Prior to the availability of the AAP toolkit, the CDC tip sheet: <i>Behavioral Therapy for</i></p>	<p><i>Planned Start:</i> 6/1/2017 <i>Actual Start:</i> 7/1/2017</p>



Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention Timeframe <sup>5</sup>
national PCIT registry for example, only contains those names of providers who choose to share their information.			<i>Young Children with ADHD</i> was used to educate providers who had linked pre-school age children that received ADHD medication, but were not in therapy. The tip sheet was also handed out at Provider Expos and in PCP offices.	
<p>22.9% of general population members' parents/guardians indicated their child's PCP did not always take enough time with them. 25.32% of Children with Chronic Conditions parent/guardians indicated their child's PCP did not always take enough time with them.</p> <p>PCPs have no control over where their patients go.</p>	<p>2017 Child Medicaid with CCC CAHPS Report</p> <p>Discussions with PCPs regarding their linkage lists when trying to find documentation on their linked patients.</p>	D3	D3 Educate members on the importance of being linked to the provider that they see for care. The importance of having a trusted PCP and how to change PCPs is noted in the Member Handbook. The ability to change PCPs was noted in the Spring 2017 member Health Talk newsletter. In October 2017, talking points were created for customer service agents to speak with members about having the right PCP listed on their membership card. The points were written at a Flesch-Kincaid reading level of 6.6.	<p><i>Planned Start:</i> 1/12017 <i>Actual Start:</i> 4/12017</p>
<p>Insufficient documentation of outreach to members with ADHD per ADHD PIP chart review instructions.</p> <p>Lack of ADHD information provided to caregivers of children who are not referred to case management.</p> <p>The 2018 Child Behavioral Health Survey noted 29.2% of caregivers responded "No" to Question 11: in the last 6 months if your child was prescribed medicine, were you told what side effects to watch for? 21.3% of caregivers responded "No" to Question 15: in the last 6 months, were you given as much information as you wanted about what</p>	<p>Baseline and Interim Chart reviews.</p> <p>2018 Child Behavioral Health Survey</p> <p>Flowchart of current process whereby a child is identified as a candidate for ADHD care management</p>	D4	D4 Develop an internal registry with the aim to improve outreach, contact and engagement. The new pediatric Health Risk Assessment (HRA) tool now includes ADHD as one of the conditions parent/guardians can choose. The HRA, which is set at a 4 <sup>th</sup> grade reading level, is designed to determine children's special health care needs via a scoring system. For example, the question regarding need or use of medication would score 3 points. Conditions expected to last more than 12 months would be scored another 3 points. A score of 9 points will generate a referral to case management (CM) for follow-up. However, a parent/guardian who states he/she needs assistance with her child's care would be referred to CM. The CM creates an Integrated Plan of Care (IPOC). When informed consent is obtained, results from the Health Risk Assessment and the plan of care (IPOC) are shared with both the PCP, and the behavioral health (BH) provider. Interdisciplinary integrated case conferences and joint clinical rounds are conducted, internally and/or externally to establish collaborative goals for all children with IPOCs. If the child has an ADHD diagnosis, and no completed HRA, research is ongoing to create a process of parent/guardian outreach regarding the importance of completing the HRA. Currently, members are made aware of the HRA by way of their member handbook, during the welcome call, and with member newsletter articles	<p><i>Planned Start:</i> 7/12018 <i>Actual Start:</i> 7/12018</p>

Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention Timeframe <sup>5</sup>
you could do to help your child?			 <p>such as:</p>	
2017 IPAT revealed 20% of medical and BH providers indicated they had little or no standard communication regarding shared patients.	2017 IPAT	D5	Work to bring a psychiatric consultation line to Louisiana occurred in the 4 <sup>th</sup> Quarter. The Behavioral Health Integration Optum Pediatric Consultation Program involves psychiatric and social work staff being available during office hours for PCPs to consult with. The two providers from north Louisiana that were originally engaged for the pilot decided not to participate. UHC is now meeting with a psychiatric telehealth provider to explore pilot opportunities to increase access to child and adolescent psychiatrists by provider practices for peer to peer consultation, which is not covered by Medicaid. UHC/Optum also continues to work on how telehealth can be used in other types of primary care settings where behavior health providers are not co-located.	
Insufficient information to determine if BH medication was for ADHD, or other indications. Administrative data suggests the only populations that are not susceptible subpopulations (diagnosed with ADHD, taking BH drugs, but no claim for therapy) are children 4-5 years old. This group requires a Prior Authorization (PA) for most ADHD medications. The PA requires attestation of BH therapy as 1 <sup>st</sup> line of care. It is unclear why children < 48 months would not have similar	Claims history review	E1	<p>E: Susceptible Subpopulations:</p> <ul style="list-style-type: none"> <li>Examine the accuracy of administrative data to evaluate BH medications and indications.</li> </ul> <p>E1 Determine if BH meds for children &lt; 48 months, are for other conditions such as seizures, as opposed to ADHD.</p>	<p><i>Planned Start:</i> 9/1/2017 <i>Actual Start:</i> 9/1/2017 <i>Date Revised:</i> 7/1/2018</p>



Description of Barrier <sup>2</sup>	Method and Source of Barrier Identification <sup>3</sup>	Number of Intervention	Description of Intervention Designed to Overcome Barrier <sup>4</sup>	Intervention on Timeframe <sup>5</sup>
percentages as the 4-5 year olds.				
Numerous charts were excluded during Interim chart review as patients without an ADHD diagnosis were taking "ADHD" medications. Having an ADHD diagnosis on either side of the measure is not producing anything representative of what was seen in the charts. Labeling a child as having ADHD due to taking "ADHD" medications impacts HEDIS® scores for 6-12 year olds. Practitioners may not recognize that it is the drug, not the diagnosis that drives the measure.	Interim Chart review	E2	E2 Determine if ADHD meds for children <48 months, as well as 6-12 year olds are for other conditions, as opposed to ADHD.	<i>Planned Start:</i> 7/1/2018 <i>Actual Start:</i> 7/1/2018

2,3,4,5: See PIP HEALTHY\_LOUISIANA\_PIP\_TEMPLATE\_w\_examples for examples and additional guidance.

**Monitoring Table YEAR 1: Quarterly Reporting of Rates for Intervention Tracking Measures, with corresponding intervention numbers.**

Number of Intervention	Description of Intervention Tracking Measures <sup>6</sup>	Q1 08/31/17	Q2 12/31/17	Q3 03/31/18	Q4 06/30/18
A1	Track availability of BH providers available to treat children 0-5 with ADHD diagnosis, by OPH region. Num: # BH providers available to treat children 0-5 age group by region Denom: # members aged 0-5 years with an ADHD diagnosis by region*EBP Therapy is not specified by current credentialing  R=Region Num= Numerator	R1 Num: 213 R1 Denom: 142 R1 Ratio: 1.5:1  R2 Num: 73 R2 Denom: 177 R2 Ratio: .41:1  R3 Num: 37 R3 Denom: 76 R3 Ratio: .49:1  R4 Num: 53 R4 Denom: 116 R4 Ratio: .46:1  R5 Num: 30	R1 Num: 213 R1 Denom: 72 R1 Ratio: 3:1  R2 Num: 68 R2 Denom: 89 R2 Ratio: .76:1  R3 Num: 38 R3 Denom: 39 R3 Ratio: .97:1  R4 Num: 53 R4 Denom: 59 R4 Ratio: .9:1  R5 Num: 24	R1 Num: 215 R1 Denom: 45 R1 Ratio: 4.8:1  R2 Num: 67 R2 Denom: 51 R2 Ratio: 1.3:1  R3 Num: 34 R3 Denom: 29 R3 Ratio: 1.2:1  R4 Num: 50 R4 Denom: 48 R4 Ratio: 1:1  R5 Num: 25	R1 Num: 217 R1 Denom: 55 R1 Ratio: 3.9:1  R2 Num: 65 R2 Denom: 58 R2 Ratio: 1.1:1  R3 Num: 33 R3 Denom: 34 R3 Ratio: .97:1  R4 Num: 53 R4 Denom: 58 R4 Ratio: .91:1  R5 Num: 25

Number of Intervention	Description of Intervention Tracking Measures <sup>6</sup>	Q1 08/31/17	Q2 12/31/17	Q3 03/31/18	Q4 06/30/18
	Denom=Denominator	R5 Denom: 13 R5 Ratio: 2.3:1  R6 Num: 26 R6 Denom: 52 R6 Ratio: .5:1  R7 Num: 53 R7 Denom: 141 R7 Ratio: .38:1  R8 Num: 64 R8 Denom: 113 R8 Ratio: .57:1  R9 Num: 73 R9 Denom: 69 R9 Ratio: 1.1:1	R5 Denom: 12 R5 Ratio: 2:1  R6 Num: 25 R6 Denom: 20 R6 Ratio: 1.3:1  R7 Num: 46 R7 Denom: 57 R7 Ratio: .81:1  R8 Num: 64 R8 Denom: 65 R8 Ratio: .99:1  R9 Num: 72 R9 Denom: 66 R9 Ratio: 1.1:1	R5 Denom: 3 R5 Ratio: 8.3:1  R6 Num: 30 R6 Denom: 17 R6 Ratio: 1.8:1  R7 Num: 46 R7 Denom: 34 R7 Ratio: 1.4:1  R8 Num: 63 R8 Denom: 44 R8 Ratio: 1.4:1  R9 Num: 72 R9 Denom: 35 R9 Ratio: 2.1:1	Denom: 5 R5 Ratio: 5:1  R6: Num: 28 Denom: 17 R6 Ratio: 1.7:1  R7: Num: 46 Denom: 45 R7 Ratio: 1:1  R8: Num: 62 Denom: 55 R8 Ratio: 1.1:1  R9: Num: 70 Denom: 42 R9 Ratio: 1.7:1
B1	Track # of ADHD survey respondents that received ADHD toolkit Num: # PCP ADHD survey respondents provided with ADHD toolkit Denom: total # PCP ADHD survey respondents	Num: 22 Denom: 87* Rate: 25% (*Original # recalculated due to age range, specialty, or duplication)	Num: 63 Denom: 87 Rate: 72%	Num: 73 Denom: 86* Rate: 85% (*1 office closed)	Num: 85 Denom: 85* Rate: 100% (*1 provider no longer at listed address)
B1	Track # of PCPs with ADD scorecards that received ADHD toolkit  Num: # PCPs with ADHD scorecards provided with ADHD toolkit Denom: total # PCPs with ADHD scorecards	Num: 80 Denom: 233 Rate: 34%	Num: 165 Denom: 232* Rate: 71% (*1 PCP deceased)	Num: 178 Denom: 231* Rate: 77% (*1 PCP not participating)	Num: 212 Denom: 229* Rate: 93% (* 2 offices not participating)
B1 & D1	Track # of pertinent SBHCs that received ADHD toolkit Num: # SBHCs that treat ADHD, and are contracted with UHC, provided with ADHD toolkit Denom: total # SBHCs that treat ADHD, and are contracted with UHC	Num: 30 Denom: 31 Rate 97%	Num: 30 Denom: 31 Rate 97%	Num: 31 Denom: 31 Rate 100%	
C2	Track # of targeted providers in 3 parish area, which received Project Launch information. Num: # targeted pediatric providers in Lafayette, Vermillion, and Acadia parishes that treat children	Num: 40 Denom: 167* Rate 24% (*Original # recalculated due to age range, specialty, and address discrepancies or changes.)	Num: 102 Denom: 167 Rate 61%	Num: 113 Denom: 167 Rate 68%	Num: 167 Denom: 167 Rate 100%

Number of Intervention	Description of Intervention Tracking Measures <sup>6</sup>	Q1 08/31/17	Q2 12/31/17	Q3 03/31/18	Q4 06/30/18
	0-7 years of age educated about Project Launch Denom: Total # targeted pediatric providers in Lafayette, Vermillion, and Acadia parishes that treat children 0-7 years of age.				
D1	Track # of pertinent SBHCs equipped with provider notification forms for BH treatment  Num: # SBHCs that treat students with ADHD, equipped with a form to notify PCPs of BH treatments Denom: /# SBHCs that treat students with ADHD	Num: 30 Denom: 31 Rate 97%	Num: 31 Denom: 31 Rate 100%		
D1	Track # of pertinent PCPs that received CDC's BH as 1 <sup>st</sup> line of therapy recommendation Num: # pediatric PCPs with linked children < 6 years old with ADHD Dx, receiving meds, but who have not been referred for therapy, that have received CDC 2016 BH therapy flyer Denom: # pediatric PCPs with linked children < 6 years old with ADHD Dx, receiving meds, but who have not been referred for therapy	Num: 11 Denom: 178 Rate: 6%	Num: 103 Denom: 178 Rate: 58%	Num: 144 Denom: 178 Rate: 81%	Num: 178 Denom: 178 Rate: 100%
E1	Determine if BH meds for children < 48 months, are for other conditions such as seizures, as opposed to ADHD Denominator:  Num: # of children < 48 months of age with ADHD diagnosis, taking BH medication for condition other than ADHD Denom: # of children < 48 months of age with ADHD diagnosis, taking BH medication	N/A	Num: 4 Denom: 4 Rate: 100%	Num: 4 Denom: 4 Rate: 100%	N/A

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.**

Number of Intervention	Description of Intervention Tracking Measures <sup>6</sup>	Q1 09/30/18	Q2 12/31/18	Q3 03/31/19	Q4 Enter year
A1	Track availability of BH providers available to treat children 0-5 with ADHD diagnosis, by OPH region. Num: # BH providers available to treat children 0-5 age group by region Denom: # members aged 0-5 years with an ADHD diagnosis by region*EBP Therapy is not specified by current credentialing	R1 Num: 219 R1 Denom: 78 R1 Ratio: 2.8:1  R2 Num: 64 R2 Denom: 117 R2 Ratio: .6:1  R3 Num: 34 R3 Denom: 75 R3 Ratio: .5:1  R4 Num: 51 R4 Denom: 95 R4 Ratio: .5:1  R5 Num: 26 R5 Denom: 17 R5 Ratio: 1.5:1  R6 Num: 38 R6 Denom: 42 R6 Ratio: .9:1  R7 Num: 42 R7 Denom: 78 R7 Ratio: .5:1  R8 Num: 65 R8 Denom: 85 R8 Ratio: .8:1  R9 Num: 67 R9 Denom: 90 R9 Ratio: .74:1	R1 Num: 205 R1 Denom: 93 R1 Ratio: 2.2:1  R2 Num: 65 R2 Denom: 127 R2 Ratio: .5:1  R3 Num: 36 R3 Denom: 78 R3 Ratio: .5:1  R4 Num: 52 R4 Denom: 96 R4 Ratio: .54:1  R5 Num: 25 R5 Denom: 24 R5 Ratio: 1:1  R6 Num: 39 R6 Denom: 41 R6 Ratio: 1:1  R7 Num: 48 R7 Denom: 79 R7 Ratio: .6:1  R8 Num: 64 R8 Denom: 80 R8 Ratio: .8:1  R9 Num: 66 R9 Denom: 92 R9 Ratio: .74:1	R1 Num: 192 R1 Denom: 80 R1 Ratio: 2.4:1  R2 Num: 59 R2 Denom: 129 R2 Ratio: .5:1  R3 Num: 36 R3 Denom: 79 R3 Ratio: .5:1  R4 Num: 48 R4 Denom: 102 R4 Ratio: .5:1  R5 Num: 22 R5 Denom: 19 R5 Ratio: 1.2:1  R6 Num: 39 R6 Denom: 41 R6 Ratio: 1:1  R7 Num: 49 R7 Denom: 76 R7 Ratio: .65:1  R8 Num: 75 R8 Denom: 67 R8 Ratio: 1.1:1  R9 Num: 63 R9 Denom: 83 R9 Ratio: .8:1	
A4	Evaluate the percentage of ADHD diagnosis F90.9s relative to all the ADHD codes to determine the extent of, and ultimately reduce the number of unspecified diagnoses Num: # of children < 6 years with an F90.9 ADHD Dx code Denom: # children <6 with any ADHD Dx code (F90.0, F90.1, F90.2, & F90.9)	Num: 92 Denom: 296 Rate: 31.08%	Num: 72 Denom: 238 Rate: 30.25%	Num: 72 Denom: 231 Rate: 31.17%	
B1	Track # of PCPs with ADD scorecards that received ADHD toolkit  Num: # PCPs with ADHD scorecards provided with ADHD toolkit Denom: total # PCPs with ADHD scorecards	Num: 229 Denom: 229 Rate: 100%			
C1	Track outcome of BH education	Num: 91 Denom: 296	Num: 80 Denom: 238	Num: 81 Denom: 231	

Number of Intervention	Description of Intervention Tracking Measures <sup>6</sup>	Q1 09/30/18	Q2 12/31/18	Q3 03/31/19	Q4 Enter year
	Num: # children <6 years with an ADHD Dx with a BH therapy claim Denom: # children < 6 years with an ADHD Dx	Rate: 31.08%	Rate: 34.87%	Rate: 35.06%	
C1	Track outcome of Project Launch education  Num: # children <6 years in Lafayette, Vermillion & Acadia parishes with an ADHD Dx, & a claim for BH consultation Denom: # children < 6 years in Lafayette, Vermillion & Acadia parishes with an ADHD Dx	Num: 2 Denom: 20 Rate: 10%	Num: 0 Denom: 0 Rate: 0%	Num: 1 Denom: 1 Rate: 100%	
E2	Evaluate the % of children <48 months, without an ADHD Dx taking "ADHD" medication. Num: # of children < 48 months without an ADHD diagnosis taking "ADHD" medication (as described by HEDIS) Denom: # of children < 48 months taking ADHD medications	Num: 38 Denom: 40 Rate: 95%	Num: 28 Denom: 29 Rate: 96.55%	Num: 18 Denom: 28 Rate: 64.29%	
E2	Evaluate the % of children 6-12 years, without an ADHD Dx taking "ADHD" medication. Num: # of children 6-12 years without an ADHD diagnosis taking ADHD medication Denom: # of children 6-12 years taking "ADHD" medication	Num: 660 Denom: 9911 Rate: 6.7%	Num: 1915 Denom: 9891 Rate: 19.4%	Num: 2425 Denom: 9891 Rate: 24.52%	

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.

### 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 = 12,804 If "H", Sample size = 60 Numerator = 26 Denominator = 60  Rate = 43.33%	Eligible Population = 4,699 If "H", Sample size = 60 Numerator = 38 Denominator = 60  Rate = 63.33%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 50 Denominator = 60  Rate = 83.33%	Target Rate: 68.4% Rationale: Initial Aim goal
Indicator #2 A2. ADHD Screening in Multiple Settings	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 19 Denominator = 60  Rate = 31.67%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 30 Denominator = 60  Rate = 50%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 39 Denominator = 60  Rate = 65%	Target Rate: 62.7% Rationale Upper CI for 50%
Indicator #3 A3. Assessment of other behavioral health conditions/ symptoms	H	Eligible Population = 12804 If "H", Sample size = 60 Numerator = 35 Denominator = 60  Rate = 58.33%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 59 Denominator = 60  Rate = 98.3%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 60 Denominator = 60  Rate = 100%	Target Rate: 100% Rationale Upper CI for 98.3%
Indicator #4 A4. Positive findings of other behavioral health conditions	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 25 Denominator = 60  Rate = 41.67%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 45 Denominator = 60  Rate = 75%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 33 Denominator = 60  Rate = 55%	
Indicator #5 A5a. Referral for EVALUATION of other behavioral health conditions	H	Eligible Population = 12,804 If "H", Sample size = 25 Numerator = 20 Denominator = 25  Rate = 80%	Eligible Population = 4699 If "H", Sample size = 45 Numerator = 43 Denominator = 45  Rate = 95.6%	Eligible Population = 6134 If "H", Sample size = 33 Numerator = 29 Denominator = 33  Rate = 87.87%	Target Rate: 100% Rationale Upper CI for 95.6%
Indicator #6 A5b. Referral to TREAT other behavioral health conditions	H	Eligible Population = 12,804 If "H", Sample size = 25 Numerator = 18 Denominator = 25  Rate = 72%	Eligible Population = 4699 If "H", Sample size = 45 Numerator = 35 Denominator = 45  Rate = 77.8%	Eligible Population = 6134 If "H", Sample size = 33 Numerator = 21 Denominator = 33  Rate = 63.63%	Target Rate: 93.7% Rationale Surpasses upper CI for 77.8% (89.9)
Indicator #7 A6. PCP Care Coordination	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 26 Denominator = 60  Rate = 43.33%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 48 Denominator = 60  Rate = 80%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 38 Denominator = 60  Rate = 63.33%	Target Rate: 90.1% Rationale Upper CI for 80%

Indicator #8 A7. MCO Care Coordination	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 0 Denominator = 60  Rate = 0%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 2 Denominator = 60  Rate = 3.3%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 4 Denominator = 60  Rate = 6.67%	Target Rate: 68.4% Rationale Suggested as a bold aim instead of the upper CI of 7.9%
Indicator #9 A8. MCO Outreach with Member Contact	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 0 Denominator = 60  Rate = 0%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 1 Denominator = 60  Rate = 1.7%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 2 Denominator = 60  Rate = 3.33%	Target Rate: 68.4% Rationale Suggested as a bold aim instead of the upper CI of 4.9%
Indicator #10 A9. MCO Outreach with Member ENGAGEMENT	H	Eligible Population = 12,804 If "H", Sample size = 60 Numerator = 0 Denominator = 60  Rate = 0%	Eligible Population = 4699 If "H", Sample size = 60 Numerator = 0 Denominator = 60  Rate = 0%	Eligible Population = 6134 If "H", Sample size = 60 Numerator = 2 Denominator = 60  Rate = 3.33%	Target Rate: 68.4% Rationale Suggested as a bold aim due to a continued rate of 0.
Indicator #11 A10. First Line Behavior Therapy for Children < 6 years	H	Eligible Population = 365 If "H", Sample size = 30 Numerator = 1 Denominator = 30  Rate = 3.33%	Eligible Population = 397 If "H", Sample size = 30 Numerator = 13 Denominator = 30  Rate = 43.3%	Eligible Population = 758 If "H", Sample size = 29 Numerator = 7 Denominator = 29  Rate = 24.13%	Target Rate: 68.4% Rationale Surpasses upper CI for 43.3% (61.1)
Indicator #11 A10a. Clinical Exclusions <sup>1,2</sup>	H	Eligible Population = 365 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 397 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 758 Exclusions= 1 If "H", Sample size = 29 Numerator = 0 Denominator = 29  Rate = 0%	
Indicator #11 A10b. Exclusions- No qualified providers in area <sup>1</sup>	H	Eligible Population = 365 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 397 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 758 Exclusions= 1 If "H", Sample size = 29 Numerator = 0 Denominator = 29  Rate = 0%	

Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients <sup>1</sup>	H	Eligible Population = 365 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 397 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 758 Exclusions= 1 If "H", Sample size = 29 Numerator = 0 Denominator = 29  Rate = 0%	
Indicator #11 A10c. Exclusions- Qualified providers in area are not accepting new clients <sup>1</sup>	H	Eligible Population = 365 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 397 Exclusions= 0 If "H", Sample size = 30 Numerator = 0 Denominator = 30  Rate = 0%	Eligible Population = 758 Exclusions= 1 If "H", Sample size = 29 Numerator = 0 Denominator = 29  Rate = 0%	
Indicator #12 B1a. HEDIS ADD Measure: Initiation Phase	A	Eligible Population = 5260 Numerator = 2780 Denominator = 5260  Rate = 52.85%	Eligible Population = 5519 Numerator = 3050 Denominator = 5519  Rate = 55.26%	Eligible Population = 5832 Numerator = 3232 Denominator = 5832  Rate = 55.42%	Target Rate: 58.64% Rationale 95 <sup>th</sup> Quality Compass (QC) percentile
Indicator #13 B1b. HEDIS ADD Measure: Continuation Phase	A	Eligible Population = 994 Numerator = 641 Denominator = 994  Rate = 64.49%	Eligible Population = 1056 Numerator = 743 Denominator = 1056  Rate = 70.36%	Eligible Population = 1053 Numerator = 706 Denominator = 1053  Rate = 67.05%	Target Rate: 73.16% Rationale Surpasses 95 <sup>th</sup> Quality Compass (QC) percentile
Indicator #14 B2a. BH Drug with Behavioral therapy <sup>3</sup>	A	Eligible Population = 34538 Numerator = 11435 Denominator = 34538  Rate = 33.1%	Eligible Population = 33921 Numerator = 11467 Denominator = 33921  Rate = 33.8%	Eligible Population = 32407 Numerator = 10452 Denominator = 32407  Rate = 32.3%	Target Rate: 35.8% Rationale Surpasses upper CI for 33.8% (34.3)
Indicator #15 B2b. BH Drug WITHOUT Behavioral therapy <sup>3</sup>	A	Eligible Population = 34538 Numerator = 16745 Denominator = 34538  Rate = 48.5%	Eligible Population = 33921 Numerator = 16151 Denominator = 33921  Rate = 47.6%	Eligible Population = 32407 Numerator = 15940 Denominator = 32407  Rate = 49.2%	Target Rate: 45% Rationale Below lower CI for 47.6% (47.1)

<sup>1</sup>The denominator for each exclusion is the chart review eligible population aged <6 years.

<sup>2</sup>Illustrative examples of clinical exclusions include multiple psychiatric conditions, risk of harm to self or others.

<sup>3</sup> 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

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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.

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## 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:** The quality of care received by children with ADHD has improved overall from 2016 to 2018. The percentage use of a validated screening instrument increased by 20 points, from baseline to interim. The rate increased 20 points from interim to final, and 40 points from baseline to final. The final target rate of 68.4% was surpassed by 14.93 percentage points. The percentage use of the instrument in multiple settings increased 18.33 points from baseline to interim. The rate increased 15 points from interim to final, and 33.33 points from baseline to final, surpassing the final target rate of 62.7% by 2.3 percentage points. Assessment of other behavioral health conditions/symptoms increased 40 percentage points from baseline to interim. The rate increased 1.7 points from interim to final, and 41.67 points from baseline to final, meeting the final target rate of 100%. Referral percentage for evaluation increased 15.6 points from baseline to interim. The rate decreased 7.73 points from interim to final, but increased 7.87 points from baseline to final. The 100% final target rate was not met by 12.13 percentage points. Referral percentage for treatment increased 5.8 points from baseline to interim. The rate decreased 14.17 percentage points from interim to final, and 8.37 points from baseline to final. The 93.7% final target rate was not met by 30.07 percentage points. PCP percentage of care coordination increased 36.67 points from baseline to interim. The rate fell 16.67 points from interim to final, but increased 20 points from baseline to final. The 90.1% final target was not met by 26.77 percentage points. The percentage of MCO care coordination increased 3.3 points from baseline to interim. The rate increased 3.37 points from interim to baseline, and 3.33 points from baseline to final. The final target rate of 68.4% was not met by 61.73 percentage points. The percentage of MCO outreach and engagement increased by 1.7 points, and 0 points respectively from baseline to interim. Both rates increased by 3.33 points from interim to final, and baseline to final. The final target rate of 68.4% was not met by 65.07 percentage points. The percentage of first line behavior therapy increased 40 points from baseline to interim. The rate decreased 19.17 points from interim to final, but increased 20.8 points from baseline to final. The final target of 68.4% was not met by 44.27 percentage points. HEDIS® ADD initiation rate percentage increased by 2.68 points from baseline to interim. The rate increased 0.16 points from interim to final, and 2.57 points from baseline to final. The final target of 58.64% was not met by 3.22 percentage points. The continuation rate percentage increased 5.87 points from baseline to interim. The rate decreased 3.31 points from interim to final, but increased 2.56 points from baseline to final. The final target of 73.16% was not met by 6.11 percentage points. B2a, the percentage of BH Drug with Behavioral therapy increased by 0.7 points from baseline to interim. The rate decreased 1.5 points from interim to final, and 0.8 points from baseline to final. The final target was not met by 3.5 percentage points. B2b, the percentage of BH Drug WITHOUT Behavioral therapy decreased 0.9 points from baseline to interim. The rate increased 1.6 points from interim to final, and 0.7 points from baseline to final. The final target of 45% was not met by 4.2 percentage points.

**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:** Despite the modest final improvement of indicators, there has been a great deal of work done, both internally and at the practice level to increase practitioner knowledge of ADHD symptoms, HEDIS expectations, and resources for behavioral health. The indicators of B2 BH drug with and without therapy imply that all children with and ADHD diagnosis have ADHD, and all children taking an ADHD medication have ADHD. The BH drugs involved in the count, and the “ADHD” labeled drugs in particular, are used for other purposes than ADHD. To evaluate this, a tracking measure was initiated to evaluate the % of children less than 48 months, as well as children 6-12 years of age without an ADHD diagnosis, taking ADHD medication. The numbers for the less than 48 month olds were small, but the majority of the children taking “ADHD” medications, did not have an ADHD diagnosis. The 6-12 year old cohort was a much larger population. The trend for this group was a sharp increase in percentage of those without an ADHD diagnosis taking “ADHD medication”. The percentages

first tracked Year 2, Q1 showed 6.7%. The Year 2 Q2 rate increased 12.7 percentage points to 19.4%. The Year 2 Q3 rate increased an additional 5.12 percentage points to 24.52%. The 6-12 age group is the largest cohort in the B2 BH drug with and without therapy population. The count of children that do not have ADHD but are being counted as such, due to the medication they are on, may negatively skew the total score. There is also the issue that hyperactivity is coded as F90.9 (ADHD unspecified) in at least one major EHR system. It is unclear at this point, how many children have been inappropriately labeled, and not by the doctor's hand, but the coding system. To evaluate this, a tracking measure was initiated to evaluate the % of children less than 6 years of age with an ADHD diagnosis code of F90.9 (ADHD unspecified). During the last three quarters, at least 30% of children less than 6 years of age with an ADHD diagnosis were coded with the F90.9 code. The count of children that do not have ADHD but are being coded as such may negatively skew the total score.

**What factors were associated with success or failure?** One of the factors causing less than target percentages was the unknown. Most indicators are based on PCP chart review. As members can go wherever they want to, the PCP does not necessarily have all the information that pertains to the child. During one chart review for the final report, a provider was informed that the chart being reviewed belonged to a child who had a claims history for not only a psychiatric evaluation, but also numerous therapy sessions. The child and her mother happened to be in the office at the time of the chart review. The office manager asked the mother if the child was receiving behavioral health care. The mother responded yes, that her child was referred for evaluation and treatment by her school, because she had low self-esteem. The chart had to be marked as if the child had received no care, because there was no documentation of the evaluation and treatment in the PCP's chart. This was not the only member that had a claims history with evaluations and treatment. For the interim report, it was noted that 78% of the PCPs that did not have documentation of a screening tool, had referred the child offsite for evaluation. Had the referred to provider submitted documentation to the PCP, the percentage of screening tools may have been higher. Another factor was timeframe. The MCO outreach and engagement indicator looks at a 3-month window subsequent to the index date. Removing that 3-month window for the interim report gives a 48.3% improvement, though still short of the 68.4% target. For the final chart review, there were a number of charts indicating children erroneously coded with ADHD due to the coding of F90.9. The child may have ultimately been correctly diagnosed at a later date, but the outreach would have been outside of the 3 month window. A third factor is the way our system is set up. There has been a system in place for outreach to children ages 6-12 years of age, identified as new recipients of an ADHD prescription, not an ADHD diagnosis. The percentage of children under the age of six receiving behavioral therapy as first line of treatment, is tied to provider knowledge, availability of BH professionals, and a way to bill the therapies. During the time frame for this review, there was still no tracking system in place. In the course of the chart review, it was realized that children taking ADHD medications as determined by HEDIS, are included in the ADD measure, regardless if they have an ADHD diagnosis or not. This point is being brought to the practitioners' attention so that all children taking ADHD medications will be re-assessed on the same timeline to assure drug efficacy and safety.

## Limitations

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

- **Were there any factors that may pose a threat to the internal validity the findings?** The Optum behavioral health provider enrollment form did not include fields to indicate whether the provider had a specific EBP certification during the time frame of this study. Consequently the number of actual available EBP providers was unknown.  
**Were there any threats to the external validity the findings?** PCP documentation does not include all services provided based on administrative claims. Some electronic systems code the word "hyperactive" as ADHD unspecified. At least one provider indicated ADHD unspecified meant that the child does not have ADHD. The PCIT.org site lists only 7 individuals in the State of Louisiana as PCIT certified. There was no way to track these via EBP claims at the time of the chart reviews.
- **Describe any data collection challenges.** Documentation in many charts revealed that once a child has been diagnosed with ADHD, re-assessment does not occur, regardless of the gap in time between the parent/guardian requests for medication. Consequently, many children have been intermittently treated with ADHD medication for periods of time much longer than the chart review criteria cut off. Because of this, many charts were excluded only after a review of the chart has occurred. This made chart reviews of older children very difficult, even when extra charts were requested to assure at least one usable chart for the review.

## Member Participation

There was no member participation from the MCO standpoint, regarding topic selection. Members have been involved in interventions by way of outreach efforts for those with newly prescribed ADHD medications. Outreach occurs by phone to the parents or guardians. Those reached are educated on the importance of a follow-up visit with the prescribing provider within 30 days, the availability of transportation services if needed, and the value of completing a Health Risk Assessment (HRA). If an HRA is completed and indicates a need for case management, then the member is referred to Whole Person Care, UnitedHealthcare's model to address both medical and behavioral health needs.

Describe methods utilized to solicit or encourage membership participation: Methods utilized to solicit or encourage membership participation include the member handbook, member newsletters, mailers, member focused outreach events such as UHC participation in back to school fairs, PCP and Health Unit open houses. Welcome calls are made to new members to share benefit information, location of resources, and to offer assistance to complete a Health Risk Assessment (HRA). Members' levels of satisfaction are solicited by a request to fill out the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The survey along with a cover letter explaining the importance of completing the survey was mailed to members using first class postage. A return business reply envelope addressed to DSS was included with each booklet. DSS staffed a toll-free phone line for members to call if they had any questions. To reduce possible confusion and respondent burden, the sample was processed to remove duplicates so that only one child per household was included in the sample. Respondents were given the option of completing the survey in Spanish. A telephone number was provided on the survey cover letter for members to call if they would like to complete the survey in Spanish. Members aged 17 or younger with a behavioral health diagnosis, that have been enrolled with the health plan for 6 consecutive months or longer with no more than one 30-day break in enrollment are a focus of the Child Behavioral Health survey. This satisfaction survey, based on the Louisiana Department of Health survey instrument, follows a mail-only methodology comprised of three mailings. Each mailing includes a survey package of one cover letter, a four-page survey, a language services disclosure, and a business reply envelope. The language services disclosure provides access to translation services, making the survey available in alternate languages to non-English speaking members.

## Dissemination of Findings

- **Describe the methods used to make the findings available to members, providers, or other interested parties:** During the course of the project, finding updates were shared with internal staff during committee and staff meetings. Monthly updates were submitted to the clinical and behavioral health medical directors. Quarterly updates were presented during Provider Advisory Committee meetings, which include external practitioners. The final report is submitted to the Louisiana Department of Health.

## 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	Tracking utilization of evidenced-based practices (EBPs) required a systems change.	The Medicaid Specialized Behavioral Health Fee Schedule previously covered claims for only 4 EBP programs (FFT, MST, Homebuilders, and ACT). The system now is set up to	Continue with training and setting up of systems to accommodate the capture of EBP utilization.

		<p>accommodate the original four, and also includes CPP, PCIT, YPT, and PPT.</p> <p>To make this happen, UHC collaborated with LDH, the Center for Practice, and other MCOs to develop consistent definitions of the EBPs and the needed education / certification to be a provider in these areas. UHC redesigned their system to accept EBP tracking codes provided by LDH.</p> <p>Additionally, a credentialing process was developed that ensures all EBP services are provided by appropriately trained and certified providers</p>	
Deliver Provider Education Outreach	All providers in a given office do not have the same understanding of DSM-5/AAP guidelines for ADHD	Work towards a better identification report of individual provider email addresses, to assure education reaches all practitioners.	Continue to capture all providers contact information as well as the office manager.
Facilitate access to and provision of behavioral health consultation for PCPs	<p>Telehealth may be a way to facilitate access to behavioral health consultations, particularly in non-urban areas.</p> <p>The Tulane Early Childhood Collaborative (TECC) is available for consultation to pediatric primary care providers to promote mental health in children under 6 years.</p>	Identification of potential partner to address direct member consultation as well as offering peer to peer consultation designed to enhance BH related engagement and knowledge of the primary care practice.	<p>Currently negotiating solutions to identified barriers related to tracking of services.</p> <p>Working on a process to bill for hosting services.</p> <p>Educate pediatric providers, in the greater N.O. area, that care for children under 6 years about the availability of TECC as a resource.</p>
Enhanced Care Coordination	The more options a member has to receive care coordination, either by his/her provider or UHC staff, the better outcomes the member will have.	New training courses, such as Adverse Childhood Experiences, were developed the C&S Hotspotting Collaborative Team and delivered to the WPC CM teams in 2018. The goal of this training curriculum was to build CM's capacity to engage members with complex psychosocial situations including the experience of trauma.	The BH/clinical team is currently involved in face to face provider outreach across the state, as part of the medical - behavioral health integration initiative. Increasing integration of care between medical and behavioral practitioners should improve care management & coordination.

## 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).