Health Plan Performance Improvement Project (PIP)

Health Plan: UnitedHealthcare

PIP Title: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

PIP Implementation Period: January 1, 2020 - December 31, 2020

Submission Dates:

	Proposal/Baseline	Interim/Final
Version 1	02/23/2020	12/10/2020
Version 2	03/11/2020	12/28/2020

MCO Contact Information

1. Principal MCO Contact Person

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

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2. Additional Contact(s)

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

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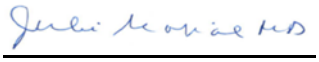
3. External Collaborators (if applicable):

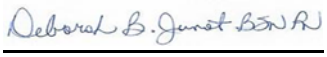
Attestation

Plan Name: UnitedHealthcare
Title of Project: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation:

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

Medical Director signature: 
First and last name: Julie Morial, MD
Date: 01/29/2020

CEO signature: 
First and last name: Karl Lirette
Date: 01/29/2020

Quality Director signature: 
First and last name: Deborah Junot BSN RN
Date: 01/29/2020

IS Director signature (if applicable): _____N/A_____
First and last name:
Date:

Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.
[EXAMPLES INCLUDE: ADDED NEW INTERVENTIONS, ADDED A NEW SURVEY, CHANGE IN INDICATOR DEFINITION OR DATA COLLECTION, DEVIATED FROM HEDIS® SPECIFICATIONS, REDUCED SAMPLE SIZE(S)]

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1	July 2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	Once the HCV PIP resumed after the 3-month hold due to COVID-19 crisis, focus on provider education adapted to a methodology of multiple modalities such as virtual web-case conferencing when possible.
Change 2	July 2020	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	Provider input indicated that strategic partnerships with FQHCs would be beneficial to treating members with complex issues such as HCV and SUD/SMI. CM focused on developing with partnerships with FQHCs and assisting with any confounding factors while conducting CM outreach.
Change 3		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	
Change 4		☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☐ Other	

Abstract

For Final Report submission only. Do not exceed 1 page.

Provide a high-level summary of the PIP, including the project topic and rationale (include baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

Title of Project: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

Rationale for Project: The hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). HCV infection can lead to serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death. HCV prevalence in Louisiana is estimated at 1.6% to 1.8%. There is a marked higher rate among men and women aged 45-54 years of age, urban residents, and African American males aged 45-54 (LA OPH, 2015). Louisiana ranks fifth in the U.S. for HCV/HIV co-infection; an estimated 18% of individuals with HIV as a result of intravenous drug use are also diagnosed with HCV co-infection (LA OPH, 2015).

As of summer, 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. The authorized generic (AG) to which they have access is Epclusa®, which has proven effective in curing 95% of persons living with HCV (LDH, 2019a). Epclusa is the preferred direct-acting antiviral (DAA) and does not require prior authorization unlike other available treatment regimens (LA Medicaid, 2019).

Aim: Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives

Objectives:

1. **Member Intervention Objective**: Outreach and educate eligible members, and facilitate referrals to/schedule appointments with (I) PCPs for screening and (II) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to high risk subpopulations (which are not mutually exclusive, as enrollees may have multiple high risk characteristics)::

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment.

Methodology:

The performance indicators for the study align with the guidance from the HCV PIP IPRO Guidance Document. For the indicators described, the eligible population includes members who have suspected or confirmed cases of HCV. The cases were identified via the listings from OPH as well as those that fall into high risk cohort categories identified through stratified claims data. Pharmacy utilization data was also utilized as well as purposeful tracking of provider education.

Interventions:

- Enhanced provider education through provider engagement activities, free continuing education credits, HCV clinician support line and engagement through provider facing staff with physicians regarding HCV treatment algorithms, generic Epclusa as the DAA drug of choice and supportive additional resources such as BH regional resource providers and toolkits for HCV and members with confounding issues such as SUD or SMI. This will increase knowledge for front line providers and treatment options for members with HCV.

- Providers educated on appropriate coding for high risk groups. This will provide a more in-depth accurate picture of the various confounding conditions of the HCV member and will assist the health plan on intervening accordingly and to proactively address the social determinants of health.
- Developed enhanced materials for case management to increase member engagement and knowledge around HCV diagnosis and treatment.
- Increase member outreach and advocacy for members with HCV or with a history of non-compliance with medication adherence and care through focused case management and outreach initiatives to increase member engagement for treatment.
- Provided education to providers, case management, quality management and utilization management to increase knowledge of generic Epclusa as the DAA drug of choice and has no prior authorization requirement.

Results:

All Performance indicators demonstrated some noted improvement from baseline to final measurement year including, 1a) (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}, 1b) (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}. 2a) Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}, 2b) (Non-Birth Cohort/Risk Factor Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}, 3a) (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}, 3b) (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}, 3c)(HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}. Table 5 shows the measurements between the baseline and final year for each performance indicator.

Conclusions:

Although education around HCV appropriate screening and interventions led to some noted improvements, most of the performance indicators did not meet the target ranges of 10 percent above the 2019 baseline. While some interventions may have made traction, several are still in progress and have not had enough time to successfully impact rates. The target rates for this project was based on a baseline of a full calendar year of 2019. There were only eleven months of data available for the final measurement period of this project. It is also important to note that most interventions of this project started with an effective date of 2/1/2020 and due to the COVID-19 crisis this project was put on hold for three months of the year from March 2020 to June of 2020. The use of indicators as an accurate determination of effectiveness is also complicated by reporting and claims lag. There is limited provider knowledge in a PCP setting around appropriate screening and treatment of members with HCV and referral of members with BH issues or substance abuse disorders. Members are often diagnosed with little knowledge of resources available to assist with confounding factors. In order to increase member and provider engagement, next steps include continuing close strategic partnerships with FQHC's who are equipped to address members with complex comorbidities as well as provider supportive CM supplementation. The health plan will also work closely with providers to ensure they have access to the HCV clinician support line, regional resource information for substance abuse disorders. Member and provider educational materials approved by LDH will continue to be disseminated and telehealth will continue to be promoted due to the complex burden the COVID-19 crisis has presented.

Project Topic

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:** The hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). HCV infection can lead to serious health problems, including liver damage, cirrhosis (scarring of the liver), liver cancer, and even death HCV prevalence in Louisiana is estimated at 1.6% to 1.8%. There is a marked higher rate among men and women aged 45-54 years of age, urban residents, and African American males aged 45-54 (LA OPH, 2015). Louisiana ranks fifth in the U.S. for HCV/HIV co-infection; an estimated 18% of individuals with HIV as a result of intravenous drug use are also diagnosed with HCV co-infection (LA OPH, 2015).

  As of summer, 2019, Healthy Louisiana enrollees have access to safe and effective treatment for hepatitis C. The authorized generic (AG) to which they have access is Epclusa ®, which has proven effective in curing 95% of persons living with HCV (LDH, 2019a). Epclusa is the preferred direct-acting antiviral (DAA) and does not require prior authorization unlike other available treatment regimens (LA Medicaid, 2019).

  Many asymptomatic people are unaware that they are chronically infected with HCV, including those born between 1945 and 1965 (USPSTF, 2013). This contributes to significant delays in initiation of treatment and, as a result, can lead to serious clinical consequences. Which in turn lead to costly financial expenditures for both the member and the State. Increasing quality of life and driving down cost is our main focus for our members. The United States Preventive Services Task Force (USPSTF) recommends one-time Hepatitis C screening for all adults in this birth cohort (USPSTF, 2013). The USPSTF recommends HCV screening for persons at high risk of chronic Hepatitis C infection, with past or current injection drug use as the most important risk factor (USPSTF, 2013). Professional society guidelines also recommend one-time testing for persons with risk exposures, including persons who were ever on long-term hemodialysis; persons with a history of incarceration; and persons with HIV (AASLD/IDSA, 2018).

- **Describe high-volume or high-risk conditions addressed:**
  According the CDC (2020), high risk associated factors of HCV are as follows;
  - Adults born from 1945 through 1965 should be tested once (without prior ascertainment of HCV risk factors)
  - HCV testing is recommended for those who:
  - Currently injecting drugs
  - Ever injected drugs, including those who injected once or a few times many years ago
  - Have certain medical conditions, including persons:
  - who received clotting factor concentrates produced before 1987
  - who were ever on long-term hemodialysis
  - with persistently abnormal alanine aminotransferase levels (ALT)
  - who have HIV infection
  - Were prior recipients of transfusions or organ transplants, including persons who:
  - were notified that they received blood from a donor who later tested positive for HCV infection received a transfusion of blood, blood components, or an organ transplant before July 1992

  HCV- testing based on a recognized exposure is recommended for:
  - Healthcare, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-positive blood
  - Children born to HCV-positive women

- **Describe current research support for topic (e.g., clinical guidelines/standards):**
  According to the World Health Organization (2020), the generalized use of safe and highly effective direct-acting antiviral (DAA) medicine regimens for all persons improves the balance of benefits to harms of treating persons with little or no fibrosis, supporting a strategy of treating all persons with chronic HCV infection, rather than reserving treatment for persons with more advanced disease. Prior to 2014, HCV treatment involved the use of interferon-based regimens with generally low rates of cure, long duration of therapy and substantial toxicities. The introduction of highly effective and well tolerated short-course oral DAA therapy that can cure HCV infection with high rates of sustained virological response (SVR) within weeks transformed the treatment landscape for persons with chronic HCV infection.

  Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):
  UnitedHealthcare's mission is to help people live healthier lives and to help make the health system work better for everyone. We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities. Hepatitis C is a national problem effecting 3.5 million collectively. Of those, 39,000 people in Louisiana either on Medicaid or in the prison system have hepatitis C according the Louisiana Department of Health. We feel, while on the right path, there is still a journey to improvement in front of us for increasing education and awareness to our Providers and Members as we work towards the goal of eradication of this destructive virus.

Aims, Objectives and Goals

Aim: Improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives:

1. **Member Intervention Objective**: Outreach and educate eligible members, and facilitate referrals to/schedule appointments with (I) PCPs for screening and (II) HCV providers (priority; per OPH database) or PCPs (per member preference) for treatment, with tailored interventions targeted to each of the following high risk subpopulations (which are not mutually exclusive, as enrollees may have multiple high risk characteristics):
   a. Beneficiaries born between the years 1945 and 1965
   b. Current or past injection drug use
   c. Persons ever on long term hemodialysis
   d. Persons who were ever incarcerated
   e. Persons with HIV infection

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations and availability of HCV specialty providers (USPSTF, 2013; AASLD/IDSA, 2018), and coordinate referrals for screening and treatment.

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): ***The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.***	N:42,240 D:297,778 R:14%	R:24	Set by the aim of the LDH HCV PIP
Performance Indicator #1b (Birth Cohort Screening): ***The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N:11,006 D:61,971 R:18%	R:28%	Set by the aim of the LDH HCV PIP
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N:7,355 D:32,948 R:22%	R:32%	Set by the aim of the LDH HCV PIP
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.***	N:1,466 D:32,948 R:4%	R:14%	Set by the aim of the LDH HCV PIP
Performance Indicator #3a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated***	N:789 D:5,351 R:5%	R:25%	Set by the aim of the LDH HCV PIP

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
{numerator}.			
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): ***The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N:255 D:2,253 R:11%	R:21%	Set by the aim of the LDH HCV PIP
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N:28 D:206 R:14%	R:24%	Set by the aim of the LDH HCV PIP

[1] Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.
[2] Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.
[3] Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1a (Universal Screening)	**Performance Indicator #1a (Universal Screening)**: ***The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.***	Administrative/ Claims/ Encounter data	All Healthy Louisiana enrollees ages 18-79 years	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members
Performance Indicator #1b (Birth Cohort Screening).	***The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were screened for HCV {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana enrollees born between 1945 and 1965	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening-ever screened)	***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were ever screened for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening)	***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults aged 18 and older who were NOT born between 1945 and 1965, and who meet one or more of the following criteria: a. Current or past injection drug use (ICD-9 or ICD-10 codes in Table A); OR b. Persons ever on long term hemodialysis (ICD-9 or ICD-10 codes in Table B); OR c. Persons who were ever incarcerated (ICD-9 or ICD-10 codes in Table C); OR d. Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table d)	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	Number of Healthy Louisiana enrollees who were screened during the measurement year for HCV: CPT code 86803 OR CPT code 86804 OR CPT code 87520 OR CPT code 87521 OR CPT code 87522 OR HCPCS code G0472	Number of members in the eligible population less number of excluded members

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3a (HCV Treatment Initiation-Overall)	***The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3a
Performance Indicator #3b (HCV Treatment Initiation-Drug Users)	***The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults with current or past drug use (ICD-9 or ICD-10 codes in Appendix A) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3b

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #3c (HCV Treatment Initiation- Persons with HIV)	***The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults ever diagnosed with HIV (ICD-9 or ICD-10 codes in Appendix D) AND with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing	None	Number of adults with a pharmaceutical claim for sofosbuvir/velpatisvir (the authorized generic (AG) of Epclusa ®) or other LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA}	Number of members in the eligible population for Performance Indicator #3c

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?

Sampling Procedures

If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:** N/A

Data Collection

Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:** Edward Coleman III MS, MBA, Medical Clinical Operations Manager & Stephanie Spivey, Senior Claims Business Process Consultant researched and pulled claims data from United Healthcare SAP Orbit, SMART Analytics, and CSP Facets claims extraction platform in regards to listed ICD-10 codes provided by Office of Public Health for the Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation Performance Improvement Project. The numbers reported for each performance indicator was extracted within the respective claim's platform to the specifications of each corresponding Performance Indicator definition.

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

- **Describe validity and reliability:** The UnitedHealthcare Community & State of Louisiana Analytics Team validated data submitted for the Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation Performance Improvement Project by verifying that the data from SMART Analytics, SAP Orbit, and CSP Facets coincided with data that had been entered in ICUE or Community Care (Clinical Documentation Systems); moreover, random sampling and cross reference checks from the claims data extracts ensures validity of what has been entered in either systems. SMART Analytics, SAP Orbit, and CSP Facets are the three databases where all of UHCLA Member and Provider data is stored and where the claims data is extracted accordingly. ICUE and Community Care are Clinical Documentation interfaces where our Clinical/Non-Clinical Staff documents a Member's Utilization and Case Management information. As a result of the UHCLA Analytics Team data validation procedures, the UHCLA Analytics Team produced accurate and concise data for the Hepatitis C baseline data extracts, adhered to Performance Indicators definition as well as continued to monitor the Intervention Tracking Measures.

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*
Describe how plan will interpret improvement relative to goal.
Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

- **Describe data analysis procedures:** Data is pulled from the reporting system using internal and state specific requirements. The data is then analyzed and reported accordingly via usage of CSP Facets, SMART Analytics and Orbit.

- **Describe how plan will interpret improvement relative to goal:** Continuous monitoring of performance indicators and trends relative to statewide set goal.

- **Describe how plan will monitor ITMs for ongoing QI:** Collaborations with the Analytics Team with regards to continuous monitoring of performance indicator benchmarks on a quarterly basis.

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2019
End date: 12/31/2019

Submission of Proposal/Baseline Report Due: 2/3/2020

Interim/Final Measurement Period:
Start date: 1/1/2020
End date: 12/31/2020

PIP Interventions (New or Enhanced) Initiated: 2/1/2020

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/20-3/31/20 Due: 4/30/2020
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/20-6/30/20 Due: 7/31/2020
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/20-9/30/20 Due: 10/31/2020

Submission of Draft Final Report Due: 12/10/2020
Submission of Final Report Due: 12/31/2020

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification: IPRO HCV PIP guidance document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4[1]**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation [2] **Planned Start Date:02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #1a tracking measure:** **N:** # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # members with confirmed or probable HCV per OPH listing not receiving treatment	N: 48 D:1727 R:3%	N:102 D:4718 R:2%	N:265 D:5334 R:5%	N:340 D:6155 R:6%
Intervention #1b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #1b tracking measure :** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 2: Asymptomatic enrollees may not know they are infected with HCV. **Method of barrier identification: IPRO HCV PIP guidance document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Enhanced Case Management Outreach for HCV Screening [3] **Planned Start Date:**	**Intervention #2a tracking measure:** **N:** # members with appointment scheduled with PCP for HCV screening **D:** # members at risk for HCV per MCO claims/encounter data	N:0 D:9,009 R:0%:	N:0 D:9,288 R:0%	N:0 D:12,984 R:0%	N:0 D:14,121 R:0%

[1] All Quarter Four data is noted as partial at this time and is reflective of October, November and Partial December 2020.

[2] Preliminary analysis of members on the OPH listing indicate that 20 percent of the members on the OPH listing of HCV Confirmed or suspected cases had a cofounding substance abuse disorder. CM developed close strategic partnerships with regional FQHCs to better assist in meeting the needs of the member with multiple comorbidities such SUD/SMI. Member input also indicates that some members were apprehensive about attending appointments due to the COVID-19 pandemic. The health plan worked with the regional FQHCs to assist in facemask distribution to help ameliorate member reported apprehension to attending appointments and seeking treatment.

[3] The team ran a report of all members who were born between 1945-1965 and removed those members who were already listed on the OPH list. This report was identified for another CM outreach attempt to educate and schedule members for HCV screening per the CDC guidelines. The script for this additional outreach was submitted to LDH but was placed on hold due to the COVID pandemic. In light of our review of Q1 and Q2 the CM department is proposing a modified HARC outreach, when the script is approved from LDH, to just those members born between 1945-1965 AND who have comorbid conditions of SUD. In Quarter 4, the team began the Hepatitis C screening outreach with CM using the HARC team: to just those members born between 1945-1965 and who have comorbid conditions of SUD. HARC team made 900 calls to 300 members with zero successful contact with a member to educated them on Hep C screening. Of the 300 members there were 135 voicemails. In Quarter 4, the team has submitted plans for a texting campaign directed toward members related to Hepatitis C screening and treatment.

02/01/2020 **Actual Start Date:07/01/2020**					
Intervention #2b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #2b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 3: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback**		**2020** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #3a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. [4] **Planned Start Date:02/01/2020** **Actual Start Date**:02/01/2020	**Intervention #3a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N:897 D:902 R:99%	N:576 D:584 R:99%	N:562 D:576 R:98%	N:547 D:565 R:97%
Intervention #3b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #3b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 4: Primary Care Providers may not be aware of members with HCV have comorbid conditions such as substance use disorders and IVDA. **Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback**		**2020** **Q1**	**Q2**	**Q3**	**Q4**

[4] Provider feedback indicated that providers were satisfied with the removal of the prior authorization requirement and if providers had any concerns regarding treating members with HCV on a PCP basis, the providers were subsequently provided materials from the health plan as well as presented with information regarding OPH's clinician support line.
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Intervention #4a to address barrier: PCP education regarding HCV members assigned to them and associated high-risk cohorts and comorbid conditions **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #4a tracking measure:** **N:** # providers who were educated regarding members assigned to them with probable or confirmed HCV diagnosis per OPH listing. **D:** # providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	N:2 D:1082 R: 0.2%	N: 166 D: 1082 R: 15%	N: 207 D: 1082 R: 19%	N:274 D:1082 R:25%
Intervention #4b to address barrier: **Planned Start Date:** **Actual Start Date**:	**Intervention #4b tracking measure:** **N:** **D:**	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 5: Providers may not be aware of the HCV program the HCV clinician support line and additional resources available **Method of barrier identification: IPRO HCV PIP guidance document/Provider Feedback**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #5a to address barrier: ITM for provider education regarding HCV program including HCV clinician support line and additional resources available. **Planned Start Date: 02/01/2020** **Actual Start Date:02/01/2020**	**Intervention #5a tracking measure:** **N:** # Number of providers educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available **D:** # providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%	N: 1082 D: 1082 R: 100%

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Results

To be completed upon Baseline, Interim and Final Report submissions. The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

Table 5: Results

Indicator	**Baseline Period** Measure period: **1/1/19-12/31/19**	**Final Period** Measure period: **1/1/20-12/31/20**	**Target Rate[1]**
Performance Indicator #1a (Universal Screening): ***The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.***	N: 42,240 D: 297,778 R: 14%	N: 44,906 D: 288,581 R: 15%	Rate: 24%
Performance Indicator #1b (Birth Cohort Screening): ***The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 11,006 D: 61,971 R: 18%	N: 11,759 D: 60,244 R: 20%	Rate: 28%
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 7,355 D: 32,948 R: 22%	N: 9,169 D: 39,478 R: 23%	Rate:32%
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening- Annual Screening): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.***	N: 1,466 D: 32,948 R: 4%	N: 7,143 D: 39,961 R: 17%	Rate:14%
Performance Indicator #3a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N: 789 D: 5,351 R: 15%	N: 1,489 D: 6,770 R: 22%	Rate:25%
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): ***The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for***	N: 255 D: 2,253 R: 11%	N: 315 D: 1,492 R: 21%	Rate:21%

Indicator	Baseline Period Measure period: 1/1/19-12/31/19	Final Period Measure period: 1/1/20-12/31/20	Target Rate[1]
whom pharmaceutical treatment for HCV was initiated {numerator}.			
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.*	N: 28 D: 206 R: 14%	N: 61 D: 219 R: 28%	Rate:24%

[1] Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

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

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in terms of performance improvement in this section.

Discussion

To be completed upon Interim/Final Report submission. The discussion section is for explanation and interpretation of the results.

Discussion of Results

- **Interpret the performance indicator rates for each measurement period,** *i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.*

All performance indicators had noted improvement over the year and three of the seven performance indicators either met or exceeded the baseline target rate. Going forward the target rates will be adjusted accordingly as we monitor for continuous improvement. Sustained improvement cannot be determined however due to not having adequate date to determine trends at this time, as interventions were in place for a short period of time and full data is not available. It is also worth noting that due to the COVID-19 crisis that the HCV PIP was placed on hold for a duration of three months from March of 2020 to June 2020.

The overall goal of the project was to improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions to address the following key intervention objectives. Key performance indicator strategies for this project were implemented by guidance from the HCV PIP IPRO document as well as input from our internal multi-disciplinary team. The team took feedback from providers as well as members to focus and strategize on optimal ways to achieve our goals and navigate through any challenges or barriers presented.

The baseline rate for Performance Indicator #1a (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator} was 14%. The goal for this measure was set at 24% The final rate for this measure was 15%. While the year is not complete, we did have a notable increase in our rate for this measure.

The baseline rate for Performance Indicator #1b (Birth Cohort Screening): The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator} was 18%. The goal for this measure was set at 28%. The final rate for this measure was 20%. While the year is not complete, we did have a notable increase in our rate for this measure.

The baseline rate for Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator} was 22%. The goal for this measure was set at 32%. The final rate for this measure was 23%. While the year is not complete, we did have a notable increase in our rate for this measure.

The baseline rate for Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening- Annual Screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator} was 4%. The goal for this measure was set at 14%. The final rate for this measure was 17%. While this year is not complete, we did meet our goal for this measure and will continuously adjust our target rate in subsequent reporting going forward accordingly as we strive for continuous improvement.

The baseline rate for Performance Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 15%. The goal for this measure was set at 25%. The final rate for this measure was 22%. While the year is not complete, we did have a notable increase in our rate for this measure.

The baseline rate for Performance Indicator #3b (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 11%. The goal for this measure was set at 21%. The final rate for this measure was 21%. While this year is not complete, we did meet our goal for this measure and will continuously adjust our target rate in subsequent reporting going forward accordingly as we strive for continuous improvement.

The baseline rate Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} was 14%. The goal for this measure was set at 24%. The final rate for this measure was 27%. While this year is not complete, we did meet our goal for this measure and will continuously adjust our target rate in subsequent reporting going forward accordingly as we strive for continuous improvement.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** *Use your ITM data to support your interpretations***.**

Intervention tracking measures were identified that were thought to be feasible ways to target key areas that may improve outcomes with member engagement and follow up with HCV screening and treatment. Although some interventions experienced notable limitations due to COVID-19 and other natural disasters throughout the study period, there were some preliminary improvements in rates (pending Q4 complete data). Barriers were identified through direct feedback from providers and members, as well as from internal staff direct interactions and guidance from The Louisiana Department of Health.

For ITM #1 one specific area that we identified through barrier analysis was that the New Healthy Louisiana HCV treatment benefit may be unknown to enrollee and this analysis was derived from IPRO HCV PIP guidance document/member feedback. Focused ITM Enhanced Case Management Outreach was conducted for HCV Treatment Initiation to members identified on the OPH listing. Preliminary analysis of members on the OPH listing indicated that 20 percent of the members on the OPH listing of HCV Confirmed or suspected cases had a cofounding substance abuse disorder. CM developed close strategic partnerships with regional FQHCs to better assist in meeting the needs of the member with multiple comorbidities such SUD/SMI. Member input also indicates that some members were apprehensive about attending appointments due to the COVID-19 pandemic. The health plan worked with the regional FQHCs to assist in facemask distribution to help ameliorate member reported apprehension to attending appointments and seeking treatment. The ITM rate for this measure increased from 3% to 5% throughout the year. The data for the end of the year is not complete however it is important to note that the denominator for this ITM continuously and subsequently increased with each subsequent OPH listing through additional identified cases. COVID-19 also placed a hold on CM outreach for three months out of the year. As of the time of this report the CM department has successful schedule appointments for 327 member for year to date and it is noteworthy that the CM department conducted a year to date total of 24,606 CM interventional activities around identifying and outreach members through a variety of methods including claims analysis and review of pharmacy utilization as well as contacting members PCP and retail pharmacy for updated contact information.

The next area that we identified through barrier analysis as it related to ITM #2 was that asymptomatic enrollees may not know they are infected with HCV. The method of barrier identification

of this ITM was derived from the IPRO HCV PIP guidance document. Enhanced Case Management Outreach for HCV Screening was conducted for members who may be at risk for HCV due to falling into one of the high-risk cohort groups. During a year of an abundance of challenges, UHC focused most of the CM action and efforts toward reaching members that were identified by OPH as having a positive or probable diagnosis of Hepatitis C and educating providers about Hepatitis C treatment and screening. (Year to date, UHC has had 24,606 CM activities in attempts to reach UHC members identified on the OPH Hep C list as positive or probable). UHC focused on this population because we believed there could be more success with partnering with the member's providers and FQHCs to link these members to treatment. Still, UHC planned and prepared for a CM screening outreach. In quarter 1, UHC submitted a script for state approval (HARC outreach for CM outreach for screening) but was understandably directed that the Hep C PIP would be placed on hold temporarily in order for everyone to direct and prioritize activities related to fighting COVID. Once the PIP was resumed and the state approved the script, UHC was able to implement the CM screening outreach for a targeted member screening in October/early Quarter 4. UHC made 900 telephone calls to attempt to reach the targeted 300 members but there were zero successful member contacts (135 voicemails only). In Quarter 4, the team has submitted plans for a texting campaign directed toward members related to Hepatitis C screening and treatment. The team will continue to look and evaluate potential methods of outreach and capturing date for members who need HCV screening.

With regards to ITM #3, Our third ITM tracked the rate of the number of members who were prescribed generic Epclusa as a preferred drug of choice for DAA therapy. This measure was based on both pharmacy and encounter claims data. We provided targeted education to all PCPs and HCV specialist which included a variety of methodologies such as fax blast, web-based conferencing and in person when available. The physicians were also provided with the OPH clinician support line for additional educational opportunities and support as needed. Providers were also provided with LDH approved education on evidence-based screening and treatment for HCV and generic Epclusa. The rate for this ITM stayed consistent for throughout the duration of the PIP and ranged from 97% to 99%. Provider feedback indicated that providers were satisfied with the removal of the prior authorization requirement and if providers had any concerns regarding treating members with HCV on a PCP basis, the providers were subsequently provided materials from the health plan as well as presented with information regarding OPH's clinician support line. The health plan also utilized two SME HCV nurses to track and review pharmacy utilization claims and any physicians who did not utilize generic Epclusa were individually reached out to for further education regarding generic Epclusa as a preferred drug of choice. The team will continue to work closely with our providers and provide education and support as needed as all as monitor pharmacy utilization claims.

For the purposes of ITM #4, One specific area we identified through our barrier analysis was to conduct provider education on the assessment, treatment protocols for HCV and appropriate coding of high risk cohort groups as well as educate providers on additional resources such as the HCV clinician support line that is provided by the Louisiana Office of Public Health. This education included information on HCV in the form of concise toolkits and LDH approved provider education fliers which included appropriate billing codes for high risk cohorts. The provider facing flier also included information regarding generic Epclusa as the preferred drug of choice with no prior authorization requirement. The intervention included a resource packet that was delivered by a Population Health Care Consultant Nurse and SME or a transformation consultant from the quality department. This information was presented in several ways, including via web-based conferencing, breakout sessions with several federally qualified health clinics, in person meetings when available and through virtual provider expos. Additionally, provider facing resource flyers and toolkits regarding SUD/SMI were disseminated to assist providers with treatment and referral resources for members with complex comorbidities. Strong partnerships were established with regional FQHCs and referrals were encouraged to FQHCs when possible to assist the needs of the member who may potentially have multiple social determinant of health adversely affecting potential outcomes. Target member list from OPH regarding members who have confirmed or suspected HCV diagnosis and were shared with the assigned provider. The Clinical transformation consultant provider facing team-engaged and provided education regarding the HCV elimination program and disseminated targeted OPH member list with 74 PCP practices across the state that include large scale practices. The engagement with these

large scale practices occur monthly and throughout the year which included FQHCs-Access Health Louisiana, Baptist Community Health Services, Care South, Case Community Health Institute, David Raines Community Health Center, DePaul Community Health Centers, EXCELth, Iberia Comprehensive Community Health Center, Primary Care Providers for a Healthy Feliciana (RKM Primary Care) Health Systems-FMOL, LCMC, Willis Knighton. The health plan is also utilizing two designated SME Nurses to educate PCP's regarding the HCV elimination program. One covers the north region of the state and one covers the southern region. To date these two SME nurses along with the clinical transformation consultants and population health team have collectively educated 262 of the 1082 identified providers on the OPH listing producing a rate of 24% of PCPs educated via WebEx and in person when available as well as maintained relationships with the PCPs as support and direct to the HCV clinician support line from OPH as needed.

As it relates to ITM #5, The last area we identified through barrier analysis provider feedback and IPRO HCV PIP guidance document. was that providers may not be aware of the HCV program the HCV clinician support line and additional resources available. This intervention began in QTR1 of 2020 via fax blast to our entire provider directory. This was halted due to COVID-19 and interventions resumed after the June 2020 meeting with LDH and will occur via fax blast on a monthly basis to our entire provider directory for the duration of the PIP. Through input from our providers and multi-disciplinary team it was determined that sending out our HCV informational educational materials increased provider awareness regarding the HCV elimination program and allowed providers to reach out to the health plan for any additional questions they may have. The providers also indicated that having this information available also supplemented the in person and web-based conference meetings our provider facing staff had with our providers therefore enhancing understanding of the program. The fax blast method approach remained at 100% as it was the most effective and tangible way to reach all our providers given the challenges of the COVID-19 crisis as well as the multiple natural disasters that occurred throughout the year. The health plan will continue to send out HCV information on a recurring bases to ensure the providers are up to on all resource information available.

- **What factors were associated with success or failure?** *For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.*

Interventions were in place for a limited amount of time, which could have contributed to their lack of efficacy over the course of the project. Additionally, some interventions could not be fully implemented due to both internal and external delays and are still in process. Results of intervention tracking measures and interventions were reviewed in at least bi-weekly multi-disciplinary work group meetings to address any stagnation or declining rates. Some factors associated with limited success included restrictions around communication and interactions with providers and members, as well as the flood of information that members and providers had to absorb during the pandemic.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., 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?**
Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

Typical claims lag can be up to 90 calendar days. Claims continue to be submitted for the 2020 calendar year, which impact the final measurement rates, the key indicators for this study. A full evaluation of the impact of interventions cannot be determined until final measurement rates are completed.

- **Were there any threats to the external validity the findings?**
  Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

  Lower rates in the final quarterly measurement could be attributed to claims only being available through November 2020. This does not consider claims that may be submitted later or are still processing. Lower rates are based on a full calendar year of data, which is not available at this time.

- **Describe any data collection challenges.**
  Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

  The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to several factors including; the short timeframe for the study, the data lags around claims and the key indicators used to determine efficacy being reliant on an entire year's worth of data. The ability to draw true conclusions around the data cannot be determined to be final.

  2020 has proven to be a challenging year for our Hep C PIP; the COVID pandemic has caused many people to choose to stay home or were hesitant to go to a provider's office or even out into the community. Hurricanes Marco, Laura, Zeta, Delta and Sally caused destruction throughout the state of Louisiana and increased barriers to care that were already in place due to COVID. CM continued to outreach members using a new program and job aid/process and new reporting was created just for this PIP. When more members were identified by OPH, these new members would need to be added to reporting and the process. The team continued to be flexible, adapt, re-evaluate and implement continued CM outreach with each new change and/or barrier.

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.

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Intervention 1: Enhanced Case Management Outreach for HCV Treatment Initiation Target Members on the OPH list of confirmed or suspected HCV cases for case management outreach to schedule and assist with appointments PCPs or HCV specialist Intervention Tracking Measure is the percentage of the number of members with appointments scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation by a Case Manager over the number of members with confirmed or probable HCV per OPH listing not receiving treatment	Due to limitations in face to face contact during the COVID-19 crisis, Case Management and community health workers outreach was done primarily by phone during part of the study and may not have been as effective Members were difficult to reach during natural disasters, such as hurricanes, and had more immediate case management needs (i.e. housing support, financial resources, food) which was addressed first. Member apprehension to attending appointments was reported due to concerns surrounding the COVID-19 crisis members who are confirmed HCV or at risk.	The team began strong collaborations with local FQHCs and the health plan provided CM outreach supplementation. Pharmacy claims reviewed and PCPs contacted for up to date member contact information and telehealth promoted as needed, Quality and CM staff collaborated and developed LDH approved member education material to disseminate to members who are confirmed HCV or at risk. Quality Department disseminated facemasks to local FQHCs to distribute to at risk members and confirmed/suspected HCV members to help ameliorate concern for attending appointments due to the COVID-19 crisis.	Continue to supplement CM outreach and support external FQHC organizations with strong collaborations. FQHCs are equipped to address the multiple needs of the HCV member as well as address and BH or SUD and refer to services as needed. MCO to continue to follow the Project Echo model and evaluate best practices and approach for CM member outreach. MCO to continue to work with large group providers to ensure HCV screening is part of the standard order set for members ages 18 and above. Continue to distribute LDH approved member education material as well as face mask to targeted members who are confirmed or high risk. The team has begun a targeted CM outreach to those members who have been identified as having filled oral hepatitis C medication 1 or 2 times and did not fill a

			3rd month of medication. CM will attempt to successfully outreach these members and/or their providers to help overcome barriers in fulfilling the full medication therapy. Evaluate additional tools/materials that can be used to engage members In treatment through direct CM feedback/input and address the complexity of any confounding issues such BH/SUD. Regional referral resources to be continued to be shared with the member as well as the treating provider.
Intervention 2: Enhanced Case Management Outreach for HCV Screening Target Members who are at risk for HCV based on claims data and need case management outreach to schedule and assist with appointments PCPs or HCV specialist for appropriate screenings. Intervention tracking measure is percentage of the number members with appointments scheduled with a PCP for HCV screening over the number of members at risk for HCV per MCO claims/encounter data	The team ran a report of all members who were born between 1945-1965 and removed those members who were already listed on the OPH list. This report was identified for another CM outreach attempt to educate and schedule members for HCV screening per the CDC guidelines. The script for this additional outreach was submitted to LDH but was placed on hold due to the COVID pandemic. Once the PIP was no longer on hold, the script was approved with LDH for the additional CM outreach to the specific UHC population born between 1945-1965.	The CM department will continue to investigate innovative ways to target at risk members to schedule HCV screening. The health plan will continue to work closely with local FQHCs and outreach at risk members to schedule appointments for at risk members for HCV screenings. Pharmacy claims reviewed and PCPs contacted for up to date member contact information and telehealth promoted as needed,	Enhanced Case Management Outreach for HCV screening as well as screening for SUD, IVDA and other associated comorbid conditions. The health plan will continue to follow the project echo model for best practices for member outreach and engagement. Identify providers who are high utilizers of Generic Epclusa through a review of pharmacy claims and refer members who may not be linked to a PCP. Will advocate referrals to FQHCs when available. Once approved, the health plan will utilize

	Considering our review of Q1 and Q2 the CM department is proposed a modified HARC outreach to just those members born between 1945-1965 AND who have comorbid conditions of SUD. In Quarter 4, the team began the Hepatitis C screening outreach with CM using the HARC team: to just those members born between 1945-1965 and who have comorbid conditions of SUD. HARC team made 900 calls to 300 members with zero successful contact with a member to educated them on Hep C screening. Of the 300 members there were 135 voicemails. This notes the challenges of outreach to at risk members and the team will need to look for alternative and innovative methods for screening and outreach to at risk members.	LDH approved member educational material will continue to be disseminated to at risk members. The team has submitted plans for a texting campaign directed toward members related to Hepatitis C screening and treatment	the text campaign to reach many members notifying them of the importance of HCV screening and encouraging members who are at risk to be tested. Multi-disciplinary team of case management, quality, pharmacy, analytics, behavioral health and leadership to continue to meet in weekly workgroups to collaborate on ways to increase and monitor HCV screenings.
Intervention 3: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. Target Provider Education to PCPs and HCV specialist who whom prescribes DAA and reinforce education that Generic Epclusa is the preferred drug of choice with no prior authorization requirement Intervention tracking	The entire provider directory was sent via fax blast on a monthly basis information from LDH including HCV clinical support line and OPH continuing education. Information was also provided indicating that generic Epclusa was the preferred drug of choice for treating HCV. Information included the removal of the prior authorization requirement as well as supplemental Epclusa pharmacological information.	Continue monthly fax blast to entire provider directory which would include HCV clinician support line and LDH approved provider education regarding generic Epclusa and the removal of the prior authorization requirements. Provider facing staff including population health nurses and clinical transformation consultants to	Multi-disciplinary team of case management, quality, pharmacy, analytics, behavioral health and leadership to continue to meet in weekly workgroups to collaborate on ways to continue to reinforce the messaging that generic Epclusa is the preferred DAA drug of choice with no prior authorization requirement. Provider facing staff monthly meetings will continue with key large-scale providers

measure is the percentage of the number members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed over the number of members with any DAA dispensed	Additionally, the provider facing staff would also reinforce generic Epclusa through web conference meetings and emails and highlight the removal of the prior authorization requirement. A small number of providers verbalized some apprehension regarding treating HCV on a primary care basis. The providers were given information for OPH HCV support line as well as CME opportunities provided by OPH on how to become HCV champion providers.	reinforce education to providers via multiple modalities such as web-based conferencing, fax, email and face to face when possible given the constraints of the COVID-19 crisis. Two SME HCV Population Health nurses review monthly DAA pharmacy utilization claims and Identify the small number of providers who prescribe DAA meds other than generic Epclusa. The SME nurses outreach these outlier providers and provide necessary education and reinforcement regarding generic Epclusa being the drug of choice.	and FQHCs with HCV as a monthly agenda item. Two SME HCV Population Health nurses will continue to review DAA pharmacy utilization claims and identify any providers who require additional education regarding generic Epclusa and will provide education and resource materials accordingly. Two SME HCV Population Health nurses will also participate in virtual UHC provider expo trainings as an additional method or increasing awareness and education regarding generic Epclusa being the preferred DAA for HCV with no prior authorization requirement. Multi-disciplinary team will continue to work closely with OPH and distribute information regarding additional educational opportunities and HCV clinician support accordingly.
Intervention 4: Primary Care provider education regarding members assigned to them from the OPH listing with HCV as well as associated comorbid conditions and high-risk cohorts such as SUD, IVDA, and HIV Target Providers to include PCPs and HCV	Provider engagement for new material was limited at time due to high volume of new material being released around COVID-19. Dissemination of available information to providers was difficult due to multiple avenues for distribution.	Clinical transformation consultant provider facing team-engaged, provided education regarding the HCV elimination program and disseminated targeted OPH member list with 74 PCP practices across the state that	Continue to provide HCV training to both medical and HCV specialist providers through various avenues. Collaborate with other MCOs to reduce provider abrasion and duplicative trainings Health Plan to

specialist on the OPH listing who have members assigned to them with confirmed or suspected HCV diagnosis. Intervention tracking measure is the percentage of providers educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available D: Number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	Providers are not utilizing appropriate billing codes, which led to low reported data for the for various high-risk cohort groups. COVID-19 Crisis presented a burden of limiting in person interaction with providers for face to face meetings and education. Multiple Hurricanes and natural disasters and the COVID-19 presented challenges in terms of prioritization of provider focus.	include: FQHCs-Access Health Louisiana, Baptist Community Health Services, Care South, Casse Community Health Institute, David Raines Community Health Center, DePaul Community Health Centers, EXCELth, Iberia Comprehensive Community Health Center, Primary Care Providers for a Healthy Feliciana (RKM Primary Care) Health Systems-FMOL, LCMC, Willis Knighton. The health plan is also utilizing two designated SME Nurses to educate PCP's regarding the HCV elimination program. One covers the north region of the state and one covers the southern region. To date these two SME nurses along with the transformation consultants have collectively educated 226 providers and disseminated targeted OPH listing of suspected/confirmed members cases as of the end of the third quarter of PCPs via WebEx and in person when available as well as maintained relationships with the PCPs as support and direct to the HCV clinician	continue provider outreach and dissemination of member list to providers. Clinical transformation consultants and population health nurse consultants and HCV SME expert nurses to continue reinforcement of education, providing updated member list, clinical pathways and treatment algorithms, LDH provider approved informational fliers, SUD toolkits and regional specific information for resources and referrals sources for complex members with confounding issues such as SUD/SMI or housing instability issues that affect the members SDOH.

		support line from OPH as needed. treatment compliance and medication adherence.	
Intervention 5: Provider Education regarding the HCV program including the HCV clinician support line and additional resources available. Target Providers to include PCPs and HCV specialist on the OPH listing who have members assigned to them with confirmed or suspected HCV diagnosis. Intervention tracking measure is the percentage providers who have members assigned to the them from the OPH listing of suspected or confirmed cases educated regarding the HCV program including HCV clinician support line, waiver of PA requirements for generic Epclusa and additional resources available D: Number providers who have members assigned to them with probable or confirmed HCV diagnosis per OPH listing	The entire provider directory was sent fax blast on a monthly basis information from LDH including HCV clinical support line and OPH continuing education. Information was also provided indicating that generic Epclusa was the preferred drug of choice for treating HCV. Information included the removal of the prior authorization requirement as well as supplemental Epclusa pharmacological information. COVID-19 Crisis presented a burden of shifting prioritization of treatment focus for providers Multiple Hurricanes also presented challenges in terms of prioritization of provider focus.	HCV educational information, HCV clinical support line and supporting materials such as BH resources sent to entire provider directory via monthly recurring fax blast. Provider advocates and Network account managers work with multi-disciplinary team to update provider directory and contact and fax information accordingly.	Multi-disciplinary team of case management, quality, pharmacy, analytics, behavioral health and leadership to continue to meet in weekly workgroups to collaborate on ways to increase and strategize provider education and reinforcement of program. Multi-disciplinary team to continue to work closely with provider advocates and network account managers to ensure providers contact information is up to date. Two HCV SME nurses to also continue to work as a resource guide for providers who have additional inquiries regarding the HCV elimination program, HCV clinician support line and continuing medical education opportunities provided by OPH.

References

American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. May 24, 2018.

Louisiana Department of Health (LDH). Letter from Jen Steel, Medicaid Director, to All Louisiana Medicaid Providers with Subject: Louisiana Fee For Service (FFS) Medicaid and Managed Care Organizations (MCOs) Hepatitis C Virus (HCV) Direct-Acting Antiviral (DAA) Agents Clinical Prior and Pre-Authorization Criteria Revision, April 24, 2018.

Louisiana Department of Health (LDH). Hepatitis C. http://ldh.la.gov/index.cfm/page/1012 [4 November 2019a].

Louisiana Department of Health (LDH). Direct-Acting Antiviral Agents (DAA) Used To Treat Hepatitis C Virus (HCV) Medication Therapy Worksheet For Louisiana Medicaid Recipients. Revised May 2019b.

Louisiana Medicaid. Authorization Criteria for Hepatitis C DAA Agents for Medicaid July 2019.

Louisiana Office of Public Health (LA OPH). Epidemiologic Profile of Hepatitis C Virus Infection in Louisiana – 2015. Louisiana Office of Public Health – Infectious Disease Epidemiology Section- Hepatitis C Infection Epidemiologic Profile. http://ldh.la.gov/assets/oph/Center-PHCH/Center-CH/infectious-epi/Hepatitis/HepC/HepCEpiProfile.pdf [4 November 2019].

United States Preventive Services Task Force. Screening for Hepatitis C Virus Infection in Adults: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2013; 159:349-357.

Table A: **Current or past injection drug use** (any one or more of diagnosis codes or diagnosis code combinations in this table, not restricted to place of service and not restricted to principal or primary diagnosis; note: a limitation of this measure is that ICD-9 and 10 codes do not specify injection vs. other route)

ICD-9 code or code combination	ICD-10 code or code combination	Description
	F11-	Opioid related disorders (Hyphen indicates that all codes within F11 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
304.0-		Opioid dependence
304.7-		Opioid combined with other drug dependence
	F14-	Cocaine related disorders
304.2-		Cocaine dependence
	F15-	Other stimulant related disorders
304.4-		Amphetamine and other psychostimulant dependence
V69.8 AND 304.91		(other problems related to lifestyle) AND (unspecified drug dependence continuous)
	Z72.89 AND F19.20	(other problems related to lifestyle) AND (other psychoactive substance abuse, uncomplicated)

Table B. Persons ever on long term hemodialysis (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z49-	Encounter for care involving renal dialysis (Hyphen indicates that all codes within Z49 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)

ICD-9 code	ICD-10 code	Description
	Z99.2	Dependence on renal dialysis
V4511		Dependence on renal dialysis
V560 or V561 or V562 or V5631 or V5632 or V568		Encounter for care involving renal dialysis

Table C. Persons who were ever incarcerated (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison

Table D. Persons ever diagnosed with HIV infection. (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	B20	Human immunodeficiency virus (HIV) disease
042		Human immunodeficiency virus (HIV) disease
	Z21	Asymptomatic human immunodeficiency virus (HIV) infection status
V08		Asymptomatic human immunodeficiency virus (HIV) infection status

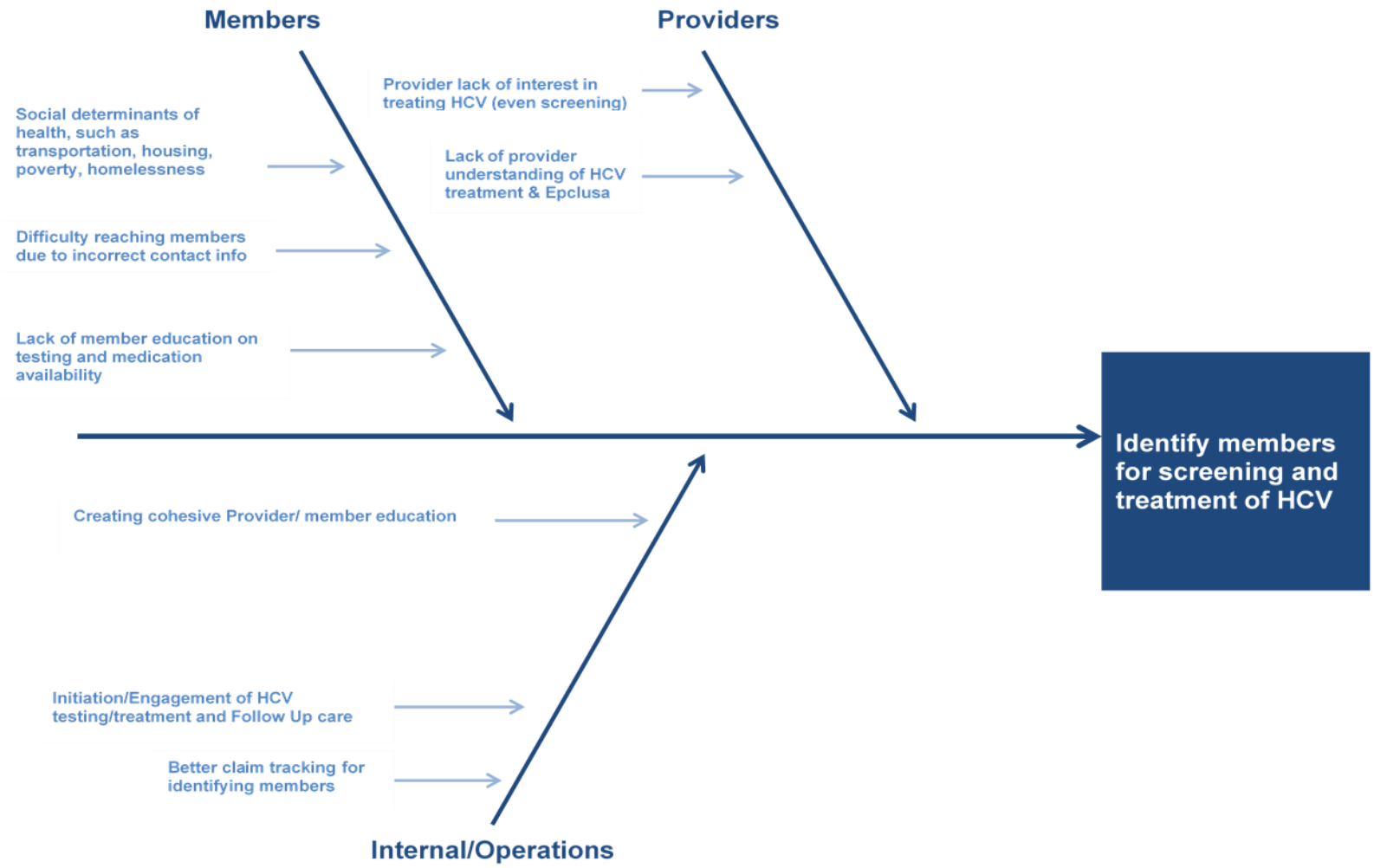
Glossary of PIP Terms

Table 7: PIP Terms

PIP Term	Also Known as…	Purpose	Definition
Aim	• Purpose	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions "How much improvement, to what, for whom, and by when?"
Barrier	• Obstacle • Hurdle • Road block	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	• Starting point	To evaluate the MCO's performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	• Standard • Gauge	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	• Target • Aspiration	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.
Intervention tracking measure	• Process Measure	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP

PIP Term	Also Known as…	Purpose	Definition
			interventions might be necessary to improve success rates on an ongoing basis.
Limitation	• Challenges • Constraints • Problems	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/ analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	• Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	• Intention	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

Appendix A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	Members Providers MCO/Internal	
Less Feasible to Address	Regulated data issues	

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** Increased access and availability of HCV treatment. Historical data confirms members who are actively engaged with CM have higher rates of successful treatment Provider educational materials have been effective in raising awareness and knowledge around appropriate assessment, triage and referral of HCV treatment	***minimize*** **WEAKNESSES** ***Examples:*** Communication between UM/CM Data limitations around ADT feeds
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** Provider education Member engagement with case management Provider engagement with case management	***protect from*** **THREATS** ***Examples:*** Difficulties engaging with rural facilities ITMs/performance indicators are based on administrative data and will be lagged, making it difficult to reassess the impact of interventions throughout a study with a brief measurement period COVID-19 Crisis and multiple hurricanes and natural disasters.

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 1. Increase the HCV screening rates among Healthy Louisiana adults at risk for HCV by 10 percentage points from CY 2019 to CY 2020.	PCPs screen the following high-risk Healthy Louisiana adults for HCV antibody: a. Beneficiaries born between the years 1945 and 1965 b. Beneficiaries with Current or past injection drug use c. Beneficiaries ever on long term hemodialysis d. Persons who were ever incarcerated e. Beneficiaries with HIV infection	Educate PCPs about evidence-based guidelines (EBGs) for HCV screening: -U.S. Preventive Service Task Force Guidelines -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA). -Office of Public Health streamlined test and treat strategy (forthcoming) -Medicaid reimbursable CPT/HCPCS codes	-Notify providers regarding Provider Portal access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate USPSTF and AASLD/IDSA HCV screening guidelines into Clinical Practice Guideline repository -Disseminate Office of Public Health streamlined test and treatment strategy (forthcoming) -Develop and disseminate billing guidelines for HCV screening and Medicaid reimbursement - Encourage providers to participate in OPH-provided HCV treatment training [this covers screening as well]
		Identify adult members at risk for HCV	-Utilize HCV PIP specifications to identify at risk members using historical and current claims -Develop PCP lists of members eligible for screening -Develop Care Coordinator lists of members eligible for HCV screening
		Inform PCPs of their patients who are at risk/ eligible for screening	-Distribute to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening
		Educate at risk members about HCV screening	-Care Coordinators Outreach, educate and council members at risk who are eligible for HCV screening
		Refer at risk members to PCPs and facilitate appointment scheduling for HCV screening	-Care Coordinators refer and schedule appointments with PCPs for HCV screening

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 2. Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2019 to CY 2020.	HCV Providers identified in the OPH database (e.g., gastroenterologists, infectious disease specialists) and/or PCPs prescribe LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA} for beneficiaries diagnosed with HCV	Educate PCPs about evidence-based guidelines (EBGs) for HCV diagnosis and treatment: -Office of Public Health streamlined test and treat guideline -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA).	-Provider Portal notification regarding access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate the Office of Public Health streamlined test and treat guideline into Clinical Practice Guideline repository -Educate providers that prior authorization is not required for Epclusa generic for any Medicaid member -Develop and disseminate billing guidelines for HCV DAA agents and Medicaid reimbursement -Disseminate existing LDH resources to providers; including (1) the DAA Agent Medication Therapy Worksheet, (2) the HCV Treatment Agreement for Louisiana Medicaid Recipients, and (3) the Louisiana Medicaid Hepatitis C Direct-Acting Antiviral (DAA) Agents criteria, and (4) Office of Public Health (OPH) streamlined test and treatment guideline. - Encourage providers to participate in OPH-provided HCV treatment training
		Foster collaboration between PCPs, behavioral health and HCV specialists	-Develop and implement new processes to facilitate communication and coordinate care between PCPs, behavioral health and HCV providers listed in the OPH database (e.g., gastroenterologists, infectious disease specialists)
		Identify all members diagnosed with HCV	-Utilize the Office of Public Health listing of members with probable or confirmed HCV PIP to identify members with HCV diagnosis -Collaborate with OPH to develop PCP-specific listings of their patients who are potential candidates for HCV treatment -Develop Care Coordinator lists of members with HCV diagnosis for referral to PCPs for treatment
		Inform PCPs of their patients with HCV	-Distribute to each PCP their listing of members with HCV for medical assessment of appropriate treatment and/or referral to/ coordination with HCV specialist for treatment
		Educate and refer members with HCV for treatment assessment	-Care Coordinators Outreach, educate, refer and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.

Appendix E: Plan-Do-Study-Act Worksheet

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1: Provide enhanced case management services through strong collaborations with FQHCs and identify barriers that impede them from engaging in treatment.			
Plan: Document the plan for conducting the intervention.	CM software was used to determine if the number of Members were outreached with completed contact (telephonic or face-to-face) to provide education regarding risk for HCV and HCV treatment and to facilitate provider appointments. Our Case managers and CHWs along with outside vendors document face-to-face visits, outreach and telephone calls. Plan report utilized as an additional data source.	CM ITM rates increased from 0.44% (denominator "d"=5,042) in June to 1.30% (d=4,936) in August	Screening rates showed between 1 and 3 percentage point increases from QTR 1 to QTR 3. From QTR 1 to October, the Non-Birth Cohort/Risk Factor Annual Screening rate showed a 5-percentage point increase.
Do: Document implementation of the intervention.	The health plan met with the leadership teams of select FQHCs and developed a collaborative outreach approach to their associated targeted member list of the OPH listing of members assigned to them with confirmed or suspected HCV cases. It is the intent of the health plan that with close strategic partnerships with our providers and dissemination of targeted member list as well as supplementation of CM outreach that we will see an increase in members treated for Hepatitis and on generic Epclusa. Data for the small-scale test were restricted to members on the OPH listing with confirmed or suspected HCV diagnosis.	□	□

Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	Our encounter claims are comparable to the data in our internal systems. Using the information gained from our internal systems, the data was adequate to begin achieving our intended goals of viewing our members. We were able to determine the need to consider alternative processes. We predicted we would see an increase in numbers of members reached based on additional contact information received from the provider. This supports the secondary drivers of informing PCPs of members with HCV and referrals to treatment.	□	□
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	Adapt process. Would like to add members who have been identified, engaged with their PCP/Specialist, and that have completed the HCV appointment. We will also need to adapt our strategies for outreach given the barriers that the present COVID-19 burden has placed on the healthcare system. We will modify our outreach strategies as necessary as well as promote telehealth for our members. Our small-scale test demonstrates that with strategic partnerships with providers as well as education and dissemination of targeted OPH listing and supplementation of CM outreach more members will engage in treatment for HCV thus improving outcomes. Plans to continue close strategic partnerships with FQHCs. CM streamlined approach to referring members to providers who are high utilizers of EPCLUSA and are HCV champions following the project ECHO model. CM strategies also include outreach to member's provider for current contact information. CMs will continue to assess members willingness to participate in treatment given the barrier that COVID-19 pandemic continues to present. Continue the current process and make modifications if necessary, will advocate for telehealth. Continue to engage with our Population Health team, CM team, Pharmacy team, and Analytics team to assist with any	□	□

	confounding factors. Continue provider education regarding available therapies. Purposeful activity tracking related to scheduling, CM scheduling provider appointments and monitoring of appointment compliance. CM department is working closely with OPH linkage to care supervisor and collaborations are ongoing for effective partnerships with outreach to members.	□	□
Intervention #2: Provide education to providers, case management, and utilization management to increase knowledge of generic Epclusa as the preferred DAA with no prior authorization.			
Plan: Document the plan for conducting the intervention.	Targeted education was provided to entire physician directory of PCP and HCV specialist regarding generic EPCLUSA as the DAA drug of choice with no prior authorization requirement. We predicted an increase in members who were prescribed generic Epclusa as a DAA drug of choice. Data for the small-scale test were inclusive of all UHC members for had been prescribed a DAA through an extensive review of pharmacy utilization claims.	The AG Epclusa ITM increased from 96% in June to 99% in September.	Treatment rates showed between 4 and 6 percentage point increases from QTR 1 to QTR 3. From QTR 1 to October, the HCV Treatment Initiation-Overall rate showed a 5-percentage point increase.
Do: Document implementation of the intervention.	Training was offered to staff our entire provider directory via fax blast. Additionally, provider facing staff reinforced education with key target providers and large FQHCs through multiple modalities given the COVID-19 crisis such as web-based conferencing and when available in person.	□	□

Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	The education of member and provider facing staff appeared to have a positive effect on the percentage rate of generic Epclusa utilization as the rate remained 96% to 99% all three quarters. Staff also responded positively to the training. This directly impacted the secondary drive related to barriers for educating providers on evidence-based HCV treatment guidelines. We predicted that we would see an increase in the number of members who would engage in care or engage with a provider regarding HCV treatment once Epclusa was made available without a PA requirement. Additionally, we would see in increase in members treated as targeted provider education is conducted and collaborations with providers are ongoing with dissemination of member specific lists and supplementation of case management resources.	☐	☐
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	Going forward, the generic Epclusa utilization rate will continue to be monitored to ensure rates do not decrease. Additional trainings will be offered if needed, to account for new providers who require any additional education and any changes in authorization processes.	☐	☐