Health Plan Performance Improvement Project (PIP)

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Health Plan: Healthy Blue Louisiana

PIP Title: Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

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

Submission Dates:

	Interim	Final
Version 1	2/4/2020	12/10/2020
Version 2	3/20/2020	

MCO Contact Information

1. Principal MCO Contact Person

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

Robin Landry, RN/MSN
Clinical Quality Program Manager
225-316-3344
Robin.landry@healthybluela.com

2. Additional Contact(s)

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

Shana Hunter
GBD Quality Manager
504-220-2881
Shana.hunter@healthybluela.com

Christin Cantavespri, MSHCM, CPHQ
Director I, GBD Quality Management
225.819.4893
Christin.Cantavespri@healthybluela.com

3. External Collaborators (if applicable):

Attestation –(Signed version in PDF)

Plan Name: Healthy Blue
Title of Project: IET/FUA

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

Medical Director signature: _____
Cheryll Bowers-Stephens, Provider Performance Medical Director
Date:

CEO signature: _____
Aaron Lambert, Plan President
Date:

Quality Director signature: _____
Christin Cantavespri, Quality Director /Shana Hunter, Quality Manager
Date:

IS Director signature (if applicable): _____
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	3/19/2020	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	Due to Covid-19, the PIP was placed on hold
Change 2	6/19/2020	☐ Project Topic ☒ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Added PIs (7a & 8a) for tracking subsets of population based on HIV/SUD/SMI diagnosis for FUA
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.

Healthy Blue continued the performance improvement project of Improving rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence in 2020. The goal was to implement enhanced interventions to enact change for this population and compare the baseline encounter/claims data to determine target rates for each measure.
Healthy Blues objective was to increase the number of referrals to follow-up care and treatment post emergency and hospital admits by:

- Conducting provider training for treatment initiation and follow-up, and encourage provider enrollment in training programs
- Link primary care providers for youth and adults to resources from the Substance Abuse and Mental Health Services Administration (SAMHSA) Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Partner with hospitals/EDs to improve timely initiation and engagement in treatment
- Provide enhanced member care coordination

Healthy Blue identified members who had a claims/encounter related to alcohol for SUD, along with specific subsets, e.g. pregnant members with SUD, members with three (3) or more ED visits for SUD, members with high readmits for SUD, dual diagnosis for Sever Mental Illness (SMI) and those justice involved. Once the populations were stratified for outreach, case management engaged members for care coordination and referrals to treatment based upon the appropriate ASAM level of care. Provider education on SBIRT and motivational interviewing techniques was provided via various routes, e.g. CME educational virtual programs and opioid use disorder (OUD) treatment standards.

The results for the Performance Indicators (PI) are as follows:

- Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort: Increased by 4.91 percentage points from 55.15% to 60.06%
- Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort: Increased by 8.98 percentage points from 64.19% to 73.17%
- Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort: Increased by 6.25 percentage points from 55.52% to 61.77%
- Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort: Increased by 8.82 percentage points from 10.80 to 19.62
- Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort: Increased 10.94 percentage points from 26.79% to 37.73%
- Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort: Increased 7.09 percentage points from 14.14% to 21.23%
- Indicator #7. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit: Increased 5.33 percentage points from 10.66 to 15.99
- Indicator #7a **(subset measure)** The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit: Increased 11.11 percentage points from 0 to 11.11

- Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit: Increased 2.64 percentage points from 8.46 to 11.10
- Indicator #8a **(subset measure)** The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit: Increased 11.11 percentage points from 0 to 11.11

The plan identified many barriers during the project. The greatest barrier was related to Covid-19 pandemic, which essentially halted the project for three (3) months and increased the challenge of engaging members with IET and FUA for SUD/Alcohol. Another barrier identified was the challenge of three (3) hurricane storms within two (2) months affecting the Gulf Coast region. Other barriers included reduction in provider office staff and high emergency usage, resulting in decreased access to care. Healthy Blue was able to successfully engage members in case management resulting in an increase with referrals to the appropriate ASAM level of care for follow-up care. Ultimately, positive outcomes were obtained despite barriers in measurement year 2020.

Looking into 2021, the Health Plan will continue initiatives to include the identification of disparities in screenings and treatments among demographics and clinical subsets, develop strategies with Case Management for enhanced member engagement in CM services and work closely with providers to elicit feedback to address member interventions and strategies for improved progress and outcomes. Additionally, improved care coordination with providers and hospitals for better discharge planning practices, are key initiatives for the plan to successfully refer members for follow-up care and reducing SUD readmissions. The plan will collaborate with pharmacists, UM and CM for enhanced discharge planning and care coordination efforts to identify barriers for continuity of care.

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:**
  Addressing substance use disorders among our health plan members, in the community, and for members who are the support system for others dealing with substance use disorders, is a priority and a key strategy for Healthy Blue as we continue to improve health outcomes. The widespread impact of SUD's extends across all delivery points within the healthcare system, with no single entity capable of implementing a complete solution. As a health plan, we have the opportunity to leverage data and technology, further build provider relationship and provide best practices to providers in an effort to improve screening, evaluation and treatment (initiation and engagement) for our members. Healthy Blue supports the development of evidence-based standards and quality metrics that define and encourage successful treatment for our members and support for their caregivers.

  A deep dive was conducted to evaluate high volume and high-risk conditions within the health plan. This evaluation encompassed a population review of Healthy Blue member claims, which included all members with a Substance Use Disorder diagnosis and sub stratified members by age, race, location, top diagnosis by age and race, and top disease cohorts (including SMI and prenatal SUD). A barrier analysis was conducted with members and providers.

  The results of Healthy Blue Louisiana's analyses will be used to drive meaningful interventions for this performance improvement project and monitor any declining trends that would trigger additional barrier analyses, continue to obtain provider and member input through reviews, and adjust modifications as indicated.

- **Describe high-volume or high-risk conditions addressed:**
  Health Blue identifies members who with high-risk conditions through review of claims data, pharmacy data, utilization management and case management. Once identified and risk stratified, Healthy Blue uses our CM Recovery Coaches to drive member support for initiation and engagement. The Recovery Coaches maintain case guidelines for members identified with SUDs. Opioid Use disorder identified during pregnancy is outreached within 72 hours of assignment. Co-occurring PH and BH conditions are actively managed with SUD as indicated in our analysis, as is the screening and management of communicable disease. Medication Assisted Treatment for SUD (Methadone, Buprenorphine maintenance for opioids and Naltrexone and Acamprosate for Alcohol SUD) as appropriate and concurrent with behavioral health screening and treatment. Relapse is considered a part of recovery and SUD treatment continues in these cases. A review of member statistics on pertinent member characteristics, such as the prevalence of co-occurring severe mental illness (SMI), pregnancy, and SHCN, revealed a need for continued monitoring and outreach. While the PIP eligible population with SMI had a 40% engagement rate at the end of 2019 where SUD pregnant members only had an engagement rate of 1.60%.
- **Describe current research support for topic (e.g., clinical guidelines/standards):**
  Healthy Blue is focused on improving models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other comparable

nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. Healthy Blue is utilizing a regional model to review quality best practices within Anthem and drive those opportunities to the local health plans and is utilizing a Medicaid Risk Team to assist with SBIRT best practices and training to support the local market.

- **Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):**
  Opportunities to improve performance and barriers as identified in the Barrier Analyses conducted and review of Healthy Blue Plan Data, are a priority. Identifying, Screening and Connecting members with initiation and follow up for SUD and effective case management, as well as coordination with Behavioral Health and the members Primary Care providers, is essential to the success of the overall health of our members. Healthy Blue will conduct a barrier analysis for the subpopulation of ED and inpatient high utilizers to increase FUA metrics. Our other disparity population focus will be to continue the rate of engagement with CM for our SUD pregnant members. This opportunity aligns us comparatively with the NCQA Quality Compass Benchmark Scores for our Market, and higher in all areas than the state average, in which Healthy Blue currently leads regarding these metrics as indicated in the table below. Improvement beyond the expected NCQA guidelines is continually the focus for Healthy Blue Louisiana. Healthy Blue will focus on improving our baseline HEDIS IET data using Quality Compass measures and where indicated, by at least 3 percentage points.

Aims, Objectives and Goals

Healthy Louisiana PIP Aim: The overall aim is to improve the rate of Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET; HEDIS 2020) and to improve the rates for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA; HEDIS 2020) by implementing enhanced interventions to test the change concepts indicated in the Driver Diagram (Appendix D) to achieve the following **objectives**:

1. Conduct provider training to expand the workforce for treatment initiation and follow-up, and encourage provider enrollment in the following training programs:
   - Treatment of Opioid Use Disorder Course (includes training for the waiver to prescribe buprenorphine) - American Society of Addiction Medicine (ASAM); Targeted providers to include PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers.
   - Fundamentals of Addiction Medicine (ASAM); Targeted providers to include psychiatrists, pediatricians, LMHPs, PCPs, obstetricians, ER physicians, FQHC and urgent care providers.
   - The ASAM Criteria Course for appropriate levels of care; Targeted providers to include LMHPs, PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers
   - ASAM Motivational Interviewing Workshop; Targeted providers to include LMHPs, PCPs, pediatricians, obstetricians, ER physicians, FQHC and urgent care providers
2. Link primary care providers for youth and adults to resources from the Substance Abuse and Mental Health Services Administration (SAMHSA) Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT) (https://www.samhsa.gov/sbirt/resources), and encourage primary care conduct of SBIRT for youth and adults; Targeted providers to include pediatricians, LMHPs, PCPs, obstetricians, ER physicians, FQHC and urgent care providers.
3. Partner with hospitals/EDs to improve timely initiation and engagement in treatment (e.g., MCO liaisons, hospital initiatives, ED protocols); and
4. Provide enhanced member care coordination (e.g., behavioral health integration, case management, improved communication between MCO UM and CM for earlier notification of hospitalization, improved discharge planning practices and support, such as recovery coaches).

5. Other interventions as informed by the MCOs' barrier analyses they will conduct as part of the PIP process.

Table 2: Goals

Indicators	Baseline Rate Measurement Period: 1/1/18-12/31/18	Interim Rate Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N:1553 D:2703 R: 57.45%	N: 1782 D: 2977 R: 59.86%	R: 62.86%	NCQA Quality Compass benchmarks for 95th percentile exceeded; 3% increase to baseline
Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N:932 D:1342 R: 69.45%	N: 1136 D: 1624 R: 69.95%	R: 79.95%	NCQA Quality Compass benchmarks for 95th percentile exceeded; 3% increase to baseline
Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort	N:4715 D:8089 R: 58.29%	N: 5512 D: 9092 R: 60.62%	R: 63.62%	NCQA Quality Compass benchmarks for 95th percentile exceeded; 3% increase to baseline
Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N:445 D:2703 R: 16.46%	N: 516 D: 2977 R: 17.33%	R:19.34%	NCQA Quality Compass benchmarks for 95th percentile.
Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N:412 D:1342 R: 30.70%	N: 550 D: 1624 R: 33.87%	R:36.87%	NCQA Quality Compass benchmarks for 95th percentile exceeded; 3% increase to baseline
Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort	N:1604 D:8089 R: 19.83%	N: 1877 D: 9092 R: 20.64%	R:24.82%	NCQA Quality Compass benchmarks for 95th percentile.
Indicator #7. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	N:178 D:1627 R: 10.94%	N: 10 D: 108 R: 9.26%	R: 13.78%	NCQA Quality Compass benchmarks for 25th percentile.

Indicators	Baseline Rate Measurement Period: 1/1/18-12/31/18	Interim Rate Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Indicator #7a The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	N: 2 D: 22 R: 9.09%	N: 9 D: 36 R: 25%	R:28%	3% increase to baseline
Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	N:103 D:1627 R: 6.33%	N: 9 D: 108 R: 8.33%	R: 11.56%	NCQA Quality Compass benchmarks for 50th percentile.
Indicator #8a The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	N: 2 D: 22 R: 9.09%	N: 6 D: 36 R: 16.67%	R:19.67%	3% increase to baseline

[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[1]

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #1 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; alcohol abuse or dependence, (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #2 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; opioid abuse or dependence, etc. (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #3 (HEDIS IET)	**Initiation of AOD Treatment: Total age groups, Total diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; alcohol abuse or dependence, Opioid abuse or dependence. Other drug abuse or dependence. (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #4 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; alcohol abuse or dependence, (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #5 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; opioid abuse or dependence, etc. (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #6 (HEDIS IET)	**Engagement of AOD Treatment: Total age groups, Total diagnosis cohort**	Administrative Claims Data	=/> 13 years as of the MY; AOD dx cohorts; alcohol abuse or dependence, Opioid abuse or dependence. Other drug abuse or dependence. (IET specs)	Members in Hospice; Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.	Initiation of AOD treatment within 14 days of the index episode start date	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #7 (HEDIS FUA)	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit**	HEDIS Administrative NCQA 2020 Measures and Guidelines	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence,	Members in Hospice; Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission	A follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.	Eligible population
Indicator #7a (HEDIS FUA)-HIV/AIDS	**The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit**	HEDIS Administrative NCQA 2020 Measures and Guidelines	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence,	Members in Hospice; Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.	Eligible population

Indicator	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator #8 (HEDIS FUA)	**The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit**	HEDIS Administrative NCQA 2020 Measures and Guidelines	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence,	Members in Hospice; Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.	Eligible population
Indicator #8a (HEDIS FUA) – HIV/AIDS	**The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit**	HEDIS Administrative NCQA 2020 Measures and Guidelines	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence,	Members in Hospice; Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission	A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.	Eligible population

1. **HEDIS Indicators: If using a HEDIS measure, specify the HEDIS reporting year used and reference the HEDIS Volume 2 Technical Specifications (e.g., measure name(s)). It is not necessary to provide the entire specification. A summary of the indicator statement, and criteria for the eligible population, denominator, numerator, and any exclusions are sufficient. Describe any modifications being made to the HEDIS specification, e.g., change in age range.**

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why? Yes, Using HEDIS Administrative NCQA 2017-2018 Measures and Guidelines

Sampling Procedures

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

Data Collection

- **Describe data collection:**

HEDIS Data will be provided by validated corporate data specific to Healthy Blue Louisiana. Data collection for Pharmacy Intervention strategy will be provided by Healthy Blue Louisiana Administrative data collection through Plan Pharmacy Data. Data collection for CM and UM initiatives will be collected through respective departments and claims data.

Validity and Reliability

- **Describe validity and reliability:**

Validity: All HEDIS data submitted by Healthy Blue is produced by Invovalon which is an NCQA certified vendor. Additionally, Healthy Blue uses an over-read process for all Hybrid measure data. Prior to any data being finalized, Healthy Blue also sends all data to a third-party auditor for review. Any additional administrative claims data information not HEDIS related is validated by ensuring that data pulled is for members who had a prior diagnosis via the claims system. Data collection is done in conjunction with the specifications set forth by the measures. The HEDIS manager performs an audit of data pulled and addresses any gaps in missing data by conducting a deep dive of data collection method.

Data Analysis

- **Describe data analysis procedures:**

Once the HEDIS data is obtained, it is analyzed and compared to the goals set forth for each performance measure. Additionally, the data is trended and compared to prior results for identification of opportunities of improvement. The data is stratified by region and member demographics to identify opportunities for targeted interventions to address specific performance measures. Additional administrative claims data, not HEDIS related, is validated by ensuring that data pulled is for those members who had a prior diagnosis via the claims system.

- **Describe how plan will interpret improvement relative to goal:**

Goals will be developed based upon the initial data set for members with substance use disorders. Data is continuously monitored, at minimum, on a quarterly basis to determine if metrics are on target or at risk to meeting goals. Data is benchmarked using similar studies and compared to previous results each quarter. Additionally, data deep dives may be required to determine a subset of population trends as related to regional prevalence, member disparities and/or access to care barriers.

- **Describe how plan will monitor ITMs for ongoing QI:**

Healthy Blue will complete monthly PDSA and run charts for oversight of measuring interventions to impact overall goals. Additionally, barrier analysis and member/provider focus groups if needed, will be used to identify additional barriers with obtaining goals will be conducted as needed. These exercises will assist in the monitoring of interventions, developing new interventions or the realignment of existing interventions as needed.

PIP Timeline

Report the measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2018
End date: 12/31/2018

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

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/20-3/31/30 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

Interim Measurement Period:
Start date: 1/1/2019
End date: 12/31/2019

First Year PIP Interventions (New or Enhanced) Initiated: 12/1/2018
Second Year PIP Interventions (New or Enhanced) Initiated: 1/1/2020

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

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: Decreased follow up post Hospitalization and ED DC for alcohol/SUD **Method of barrier identification: DC planning and Care Coordination**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #1 to address barrier: Targeted CM outreach post ED visit related to alcohol/SUD. **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #1 tracking measure:** **N:** # of those >3 ED visits members enrolled/outreached/ engaged in CM **D:** # of members with 3 or more ED visits identified with an alcohol or SUD DX	Num:1 Denom: 12 Rate: 8.33	Num:2 Denom: 23 Rate: 8.70	Num: 8 Denom: 17 Rate: 47.05	Num: 10 Denom: 21 Rate 47.62
Intervention #2 to address barrier: Targeted CM outreach post Hospitalization related to alcohol/SUD **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #2 tracking measure:** **N:** # of members enrolled/outreached/engaged in CM post hospitalizations for alcohol/SUD **D:** # of members identified with hospitalization for alcohol and SUD	Num:112 Denom: 289 Rate: 38.75	Num:95 Denom: 166 Rate: 57.23	Num: 37 Denom: 228 Rate: 16.23	Num: 1 Denom 9 Rate: 11.11
Barrier 2: Lack of information for providers and members regarding treatment initiation and follow up for alcohol/SUD **Method of barrier identification: Provider feedback**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #3 to address barrier: Provider education about evidence based SBIRT screening best practices (Stages of Change, Motivational interviewing techniques, knowledge of available treatment/services/providers) and billing practices. **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #3 tracking measure:** **N:** # of SBIRT screenings for members 13 years of age and older billed/paid, by ED provider type **D:** # of providers billing SBIRT, by provider type in network A. Primary care (Family practice, Internal medicine) B. Urgent care C. Pediatricians D. OBs E. Other	A.Num: 7 Denom:2876 Rate: .24 B. Num: 0 Denom: 59 Rate: 0 C. Num: 0 Denom: 681 Rate: 0 D. Num: 0	Num: 7 Denom: 2876 Rate: .24 Num: 0 Denom: 59 Rate: 0 Num: 0 Denom: 681 Rate: 0	Num: 12 Denom: 2876 Rate: .42 Num: 0 Denom: 59 Rate: 0 Num: 0 Denom: 681 Rate: 0	Num: 35 Denom: 2876 Rate: 1.22 Num: 0 Denom: 59 Rate: 0.00 Num: 0 Denom: 681

		Denom: 646 Rate: 0 E. Num: 2 Denom: 1151 Rate: .17	Num: 9 Denom: 646 Rate: 1.39 Num: 1 Denom: 1151 Rate: .09	Num: 0 Denom: 646 Rate: 0 Num: 6 Denom: 1151 Rate: .52	Rate: 0.00 Num: 22 Denom: 646 Rate: 3.41 Num: 3 Denom: 1151 Rate: .27
Barrier 3: Access to care for Outpatient SUD TX resulting in increased hospitalizations and Overdoses **Method of barrier identification: Utilization and diagnostic data**		**2020** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #4 to address barrier: Inpatient Readmission Outreach Case management and Discharge Planning Program- **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #4 tracking measure:** **N:** # of members connected with a Case Manager for discharge planning and had a follow-up visit completed by member with SUD diagnosis following hospital discharge **D:** Members identified as having re-admissions with SUD diagnosis	Num: 94 Denom: 1267 Rate: 7.41	Num: 79 Denom: 751 Rate: 10.51	Num: 107 Denom: 972 Rate: 11.01	Num: 2 Denom: 33 Rate: 6.06
Intervention #4a to address barrier: Targeted CM for members that have a dual diagnosis of SUD and SMI diagnosis discharged from an ED with referral to treatment and follow-up. **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #4a tracking measure:** **N:** # of SUD Members with SMI outreached by CM for follow up care **D:** # of members with 3 or more ED visits identified as special health care need members with SUD and SMI diagnosis	Num:0 Denom: 9 Rate:0	Num:0 Denom: 18 Rate:0	Num: 7 Denom: 13 Rate: 53.85	Num: 9 Denom: 18 Rate: 50.00
Intervention #5 to address barrier: Targeted CM for members that have a dual diagnosis of SUD and SMI diagnosis discharged from an inpatient admission with referral to treatment and follow-up.	**Intervention #5 tracking measure:** **N**: # of SUD Members with SMI outreached by CM for follow up care post inpatient admission **D**: # of inpatient admissions of members with SUD and SMI diagnosis	Num: 74 Denom: 1111 Rate: 6.66	Num: 62 Denom: 616 Rate: 10.06	Num: 80 Denom: 792 Rate: 10.10	Num: 1 Denom: 25 Rate: .04

Planned Start Date: 2/2020 **Actual Start Date**:					
Barrier 4: Members not aware of SUD support and follow up options **Method of barrier identification: Claims and encounter data**		**2020** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #6 to address barrier: Enroll members text educational campaigns to educate members on resource tools available through Common Ground Library targeting Behavioral Health needs **Planned Start Date**: **2/2020** **Actual Start Date**	**Intervention #6 tracking measure:** **N:** # of members actively enrolled in receiving educational tools and accessing resource library **D:** # of members outreached and educated	***Intervention to resume in Q3 due to Covid-19*** Num: Denom: Rate:	***Intervention to resume in Q3 due to Covid-19*** Num: Denom: Rate:	Num: 383 Denom: 419 Rate: 91.4	Num:81 Denom: 118 Rate:69
Intervention #7 to address barrier: Educate Heathy Blue members on the telehealth platform for provider visits **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #7 tracking measure: CLAIMS** **N:** # of SUD members who are utilizing the telemedicine platform for BH visits **D:** # of members identified with SUD	Num: 4054 Denom: 6253 Rate: 64.283	Num: 2900 Denom: 4607 Rate: 62.95	Num: 3919 Denom: 5674 Rate: 69.07	Num: 910 Denom: 1300 Rate: 70.00
Intervention #8 to address barrier: CM to use stratified population health reporting to identify all new and current pregnant mothers with SUD's with goal to engage in CM services **Planned Start Date: 2/2020** **Actual Start Date**:	**Intervention #8 tracking measure:** **N:** Members engaged in CM who are pregnant and have a SUD Diagnosis **D:** Pregnant Members identified with SUD	Num: 2 Denom: 237 Rate: 0.84	Num: 11 Denom: 151 Rate: 7.28	Num: 29 Denom: 469 Rate: 6.18	Num: 18 Denom: 416 Rate: 4.33
Barrier 5: Justice involved Members not engaged in AOD Treatment or without follo **Method of barrier identification: Claims and encounter data**		**Q1**	**Q2**	**Q3**	**Q4**
Intervention #9 to address barrier:	**Intervention #9 tracking measure:**	Num:0 Denom: 0	Num: 5 Denom: 5	Num: 16 Denom: 16	Num: 8 Denom: 8

CM to use stratified population health reporting to identify all Justice involved members and have a SUD diagnosis with goal to engage in CM services	**N:** Members engaged in CM who were recently incarcerated and have a SUD Diagnosis **D:** Justice involved members who have a SUD diagnosis	Rate: 0	Rate: 100%	Rate: 100%	Rate: 100%

Results

To be completed upon Proposal/Baseline 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 Measure period: 1/1/18-12/31/18	Interim Measure period: 1/1/19-12/31/19	Final Measure period: 1/1/20-12/31/20	Target Rate[1]
Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N:1553 D:2703 R: 57.45%	N: 1782 D: 2977 R: 59.86%	N: 1753 D: 2939 R: 59.65%	R: 62.86%
Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N:932 D:1342 R: 69.45%	N: 1136 D: 1624 R: 69.95%	N: 1146 D: 1588 R: 72.17%	R: 79.95%
Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort	N:4715 D:8089 R: 58.29%	N: 5512 D: 9092 R: 60.62%	N: 5470 D: 9004 R: 60.75%	R: 63.62%
Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort	N:445 D:2703 R: 16.46%	N: 516 D: 2977 R: 17.33%	N: 551 D: 2939 R: 18.75%	R:19.34%
Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort	N:412 D:1342 R: 30.70%	N: 550 D: 1624 R: 33.87%	N: 577 D: 1588 R: 36.34%	R: 36.87%
Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort	N:1604 D:8089 R: 19.83%	N: 1877 D: 9092 R: 20.64%	N: 1865 D: 9004 R: 20.71%	R:24.82%
Indicator #7. The percentage of emergency	N:178 D:1627 R: 10.94%	N: 10 D: 108 R: 9.26%	N: 247 D: 1628 R: 15.17%	R: 13.78%

Indicator	Baseline Measure period: 1/1/18-12/31/18	Interim Measure period: 1/1/19-12/31/19	Final Measure period: 1/1/20-12/31/20	Target Rate[1]
department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit				
Indicator #7a (HEDIS FUA)-HIV/AIDS The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit	N: 2 D: 22 R: 9.09%	N: 9 D: 36 R: 25%	N: 3 D: 37 R: 8.11%	R: 28%
Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit	N:103 D:1627 R: 6.33%	N: 9 D: 108 R: 8.33%	N: 173 D: 1628 R: 10.63%	R: 11.56%
Indicator #8a. The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and a principal diagnosis	N: 2 D: 22 R: 9.09%	N: 6 D: 36 R: 16.67%	N: 3 D: 37 R: 8.11%	R: 19.67%

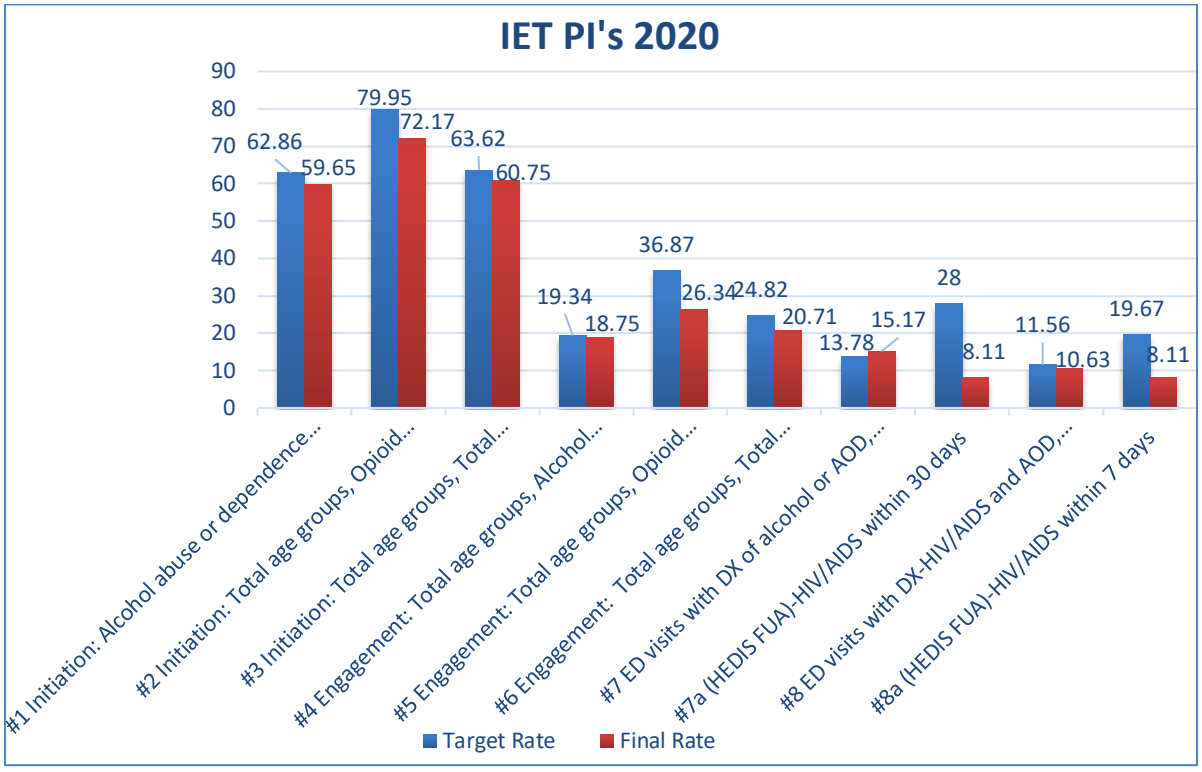
Indicator	Baseline Measure period: 1/1/18-12/31/18	Interim Measure period: 1/1/19-12/31/19	Final Measure period: 1/1/20-12/31/20	Target Rate[1]
of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit				

[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.

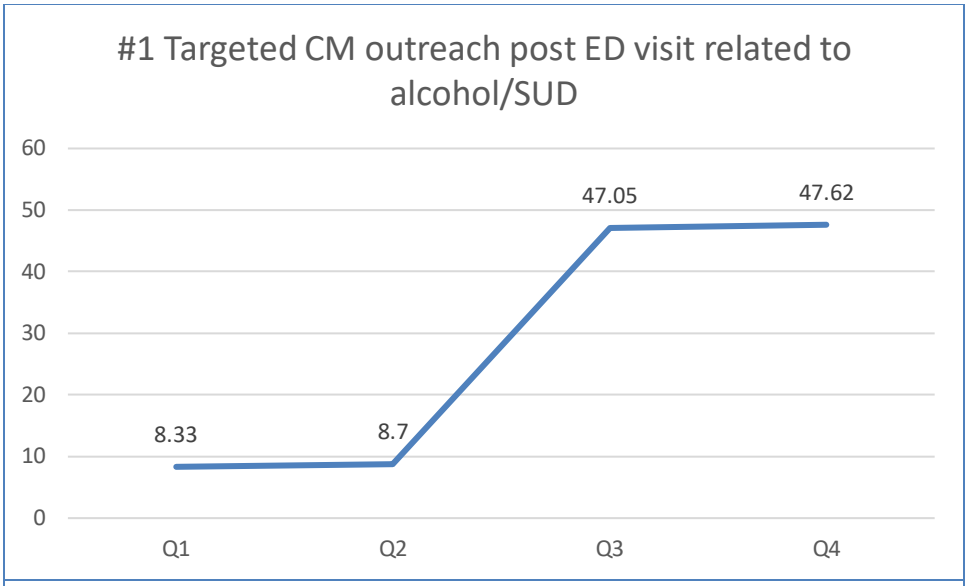
OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development and refinement of interventions,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

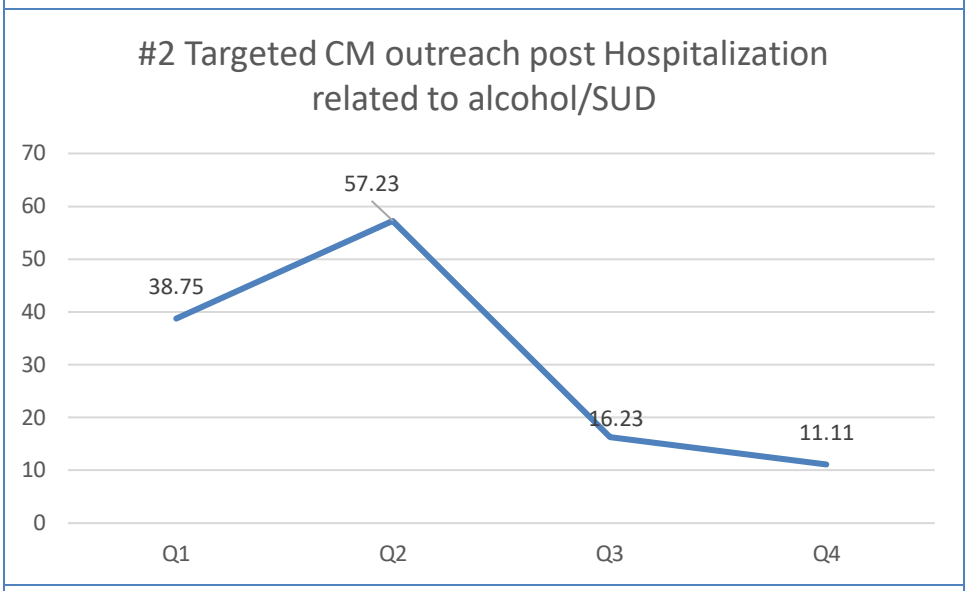
In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. ***Do not*** interpret the results in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

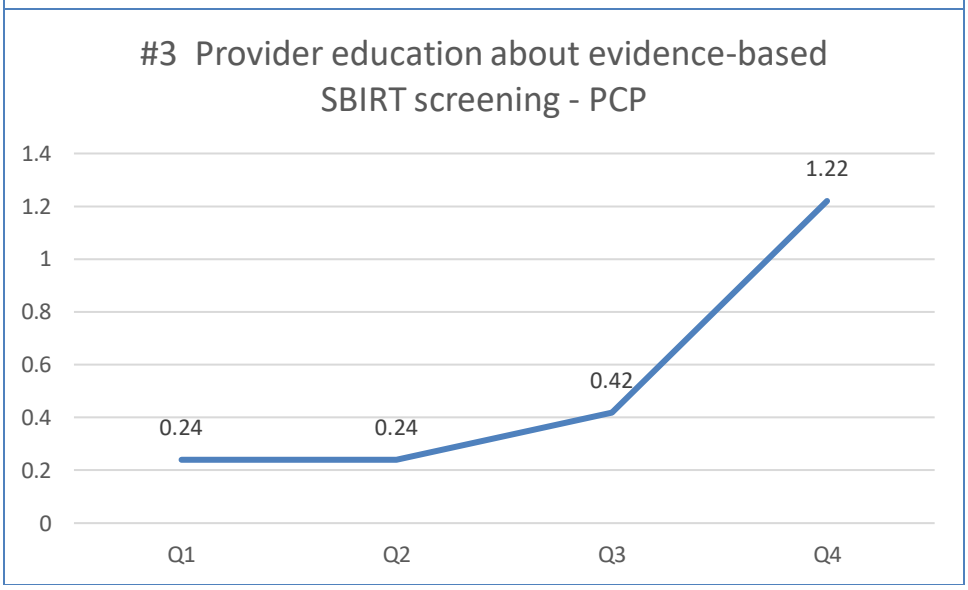
Performance Indicator Trends:

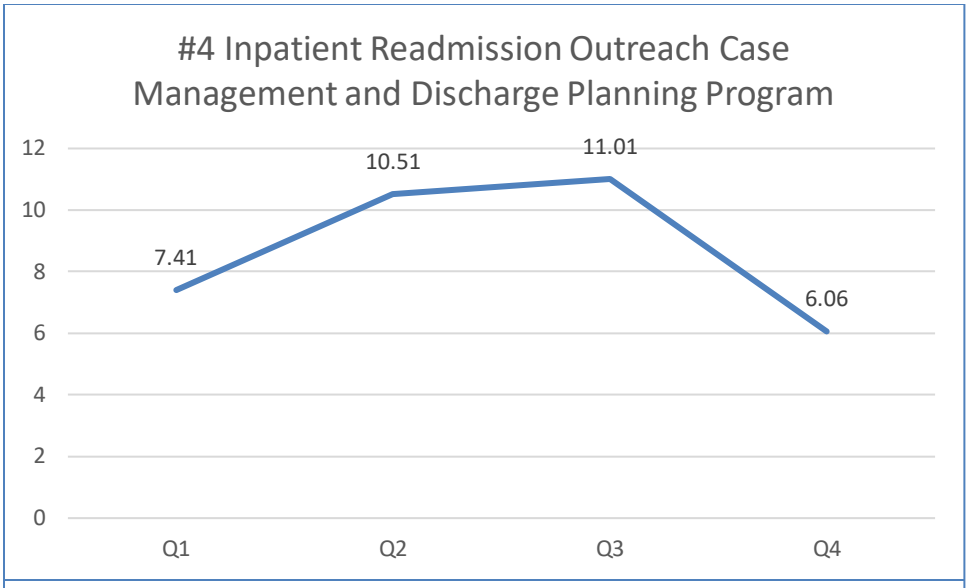


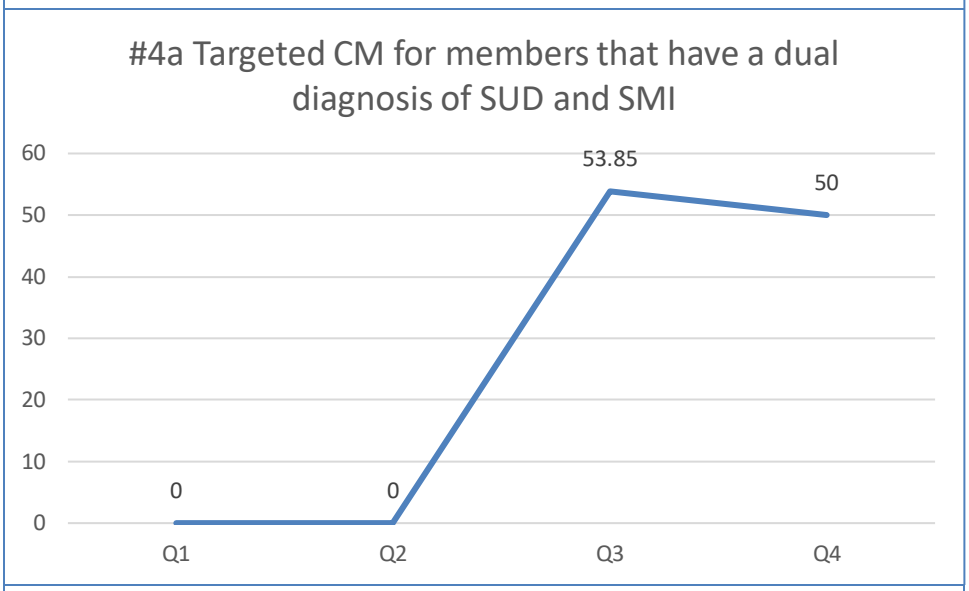
ITM Trends:

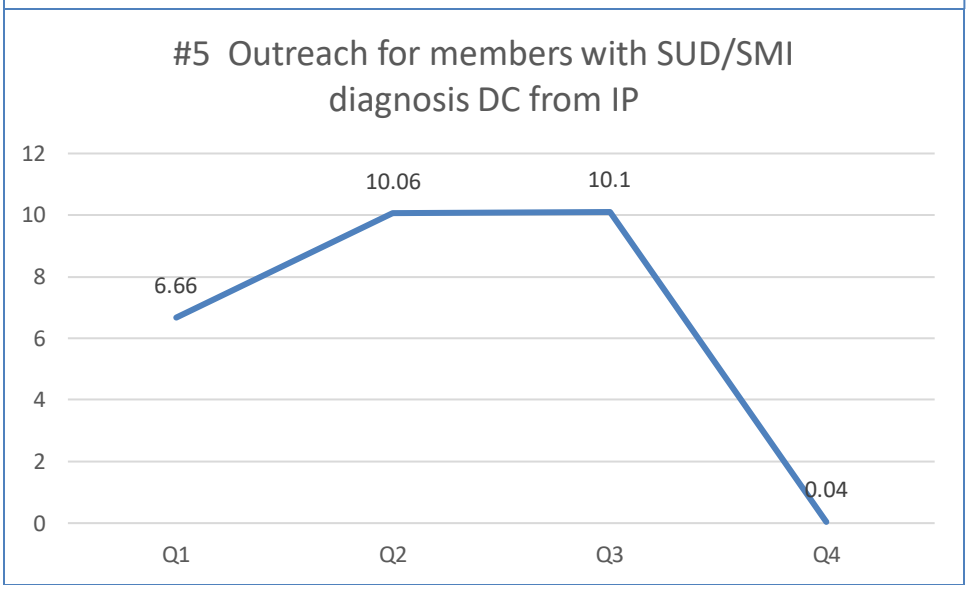

#1 Targeted CM outreach post ED visit related to alcohol/SUD
60
50
40
30
20
10
0
8.33
8.7
47.05
47.62
Q1
Q2
Q3
Q4

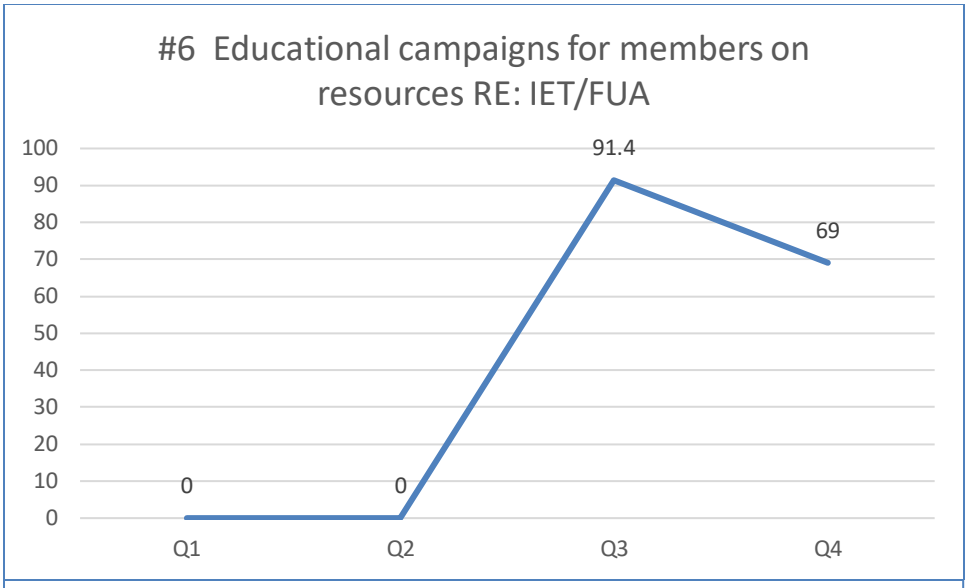

#2 Targeted CM outreach post Hospitalization related to alcohol/SUD
70
60
50
40
30
20
10
0
38.75
57.23
16.23
11.11
Q1
Q2
Q3
Q4

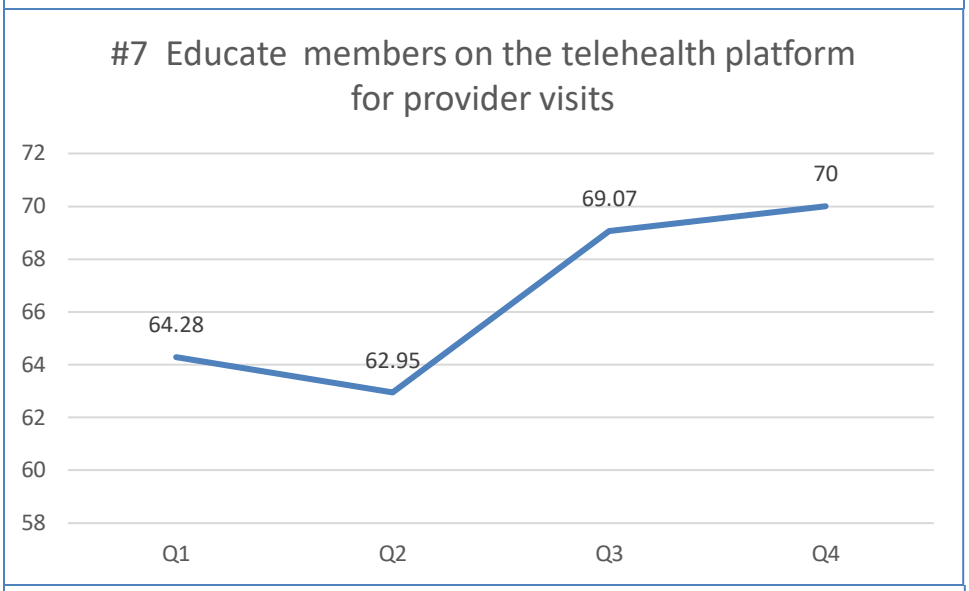

#3 Provider education about evidence-based SBIRT screening - PCP
1.4
1.2
1
0.8
0.6
0.4
0.2
0
0.24
0.24
0.42
1.22
Q1
Q2
Q3
Q4

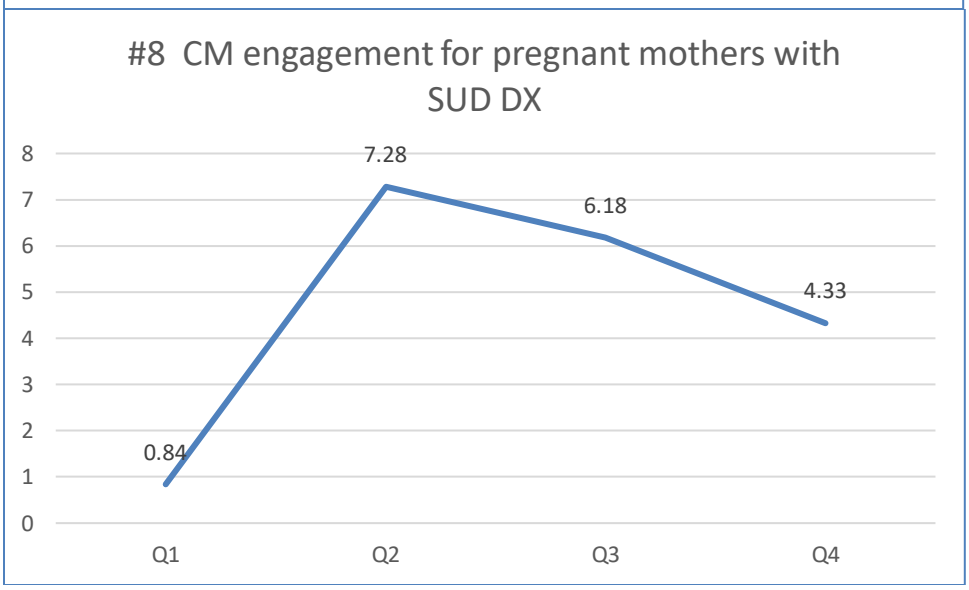

#4 Inpatient Readmission Outreach Case Management and Discharge Planning Program
12
10
8
6
4
2
0
7.41
10.51
11.01
6.06
Q1
Q2
Q3
Q4

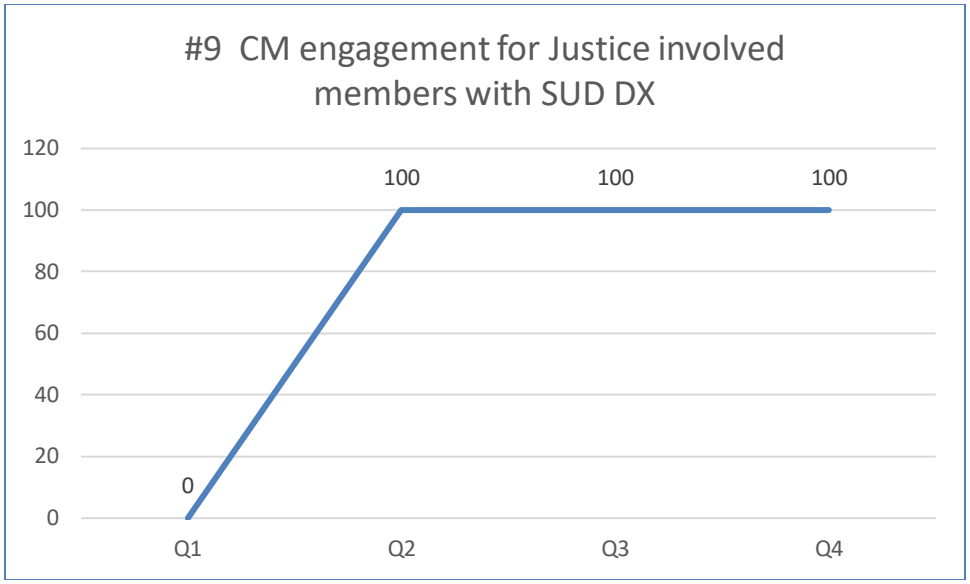

#4a Targeted CM for members that have a dual diagnosis of SUD and SMI
60
50
40
30
20
10
0
0
0
53.85
50
Q1
Q2
Q3
Q4


#5 Outreach for members with SUD/SMI diagnosis DC from IP
12
10
8
6
4
2
0
6.66
10.06
10.1
0.04
Q1
Q2
Q3
Q4


#6 Educational campaigns for members on resources RE: IET/FUA
100
90
80
70
60
50
40
30
20
10
0
0
0
91.4
69
Q1
Q2
Q3
Q4


#7 Educate members on the telehealth platform for provider visits
72
70
68
66
64
62
60
58
64.28
62.95
69.07
70
Q1
Q2
Q3
Q4


#8 CM engagement for pregnant mothers with SUD DX
8
7
6
5
4
3
2
1
0
0.84
7.28
6.18
4.33
Q1
Q2
Q3
Q4


#9 CM engagement for Justice involved members with SUD DX
120
100
80
60
40
20
0
100
100
100
0
Q1
Q2
Q3
Q4

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**

The results for the Performance Indicators (PI) are as follows:

- Indicator #1. Initiation of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort: Increased by 4.91 percentage points from 55.15% to 60.06%. Target rate of 62.86 was not met
- Indicator #2. Initiation of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort: Increased by 8.98 percentage points from 64.19% to 73.17%. Target rate of 79.95 was not met
- Indicator #3. Initiation of AOD Treatment: Total age groups, Total diagnosis cohort: Increased by 6.25 percentage points from 55.52% to 61.77%. Target rate of 63.62 was not met
- Indicator #4. Engagement of AOD Treatment: Total age groups, Alcohol abuse or dependence diagnosis cohort: Increased by 8.82 percentage points from 10.80 to 19.62. Target rate of 19.34 was not met
- Indicator #5. Engagement of AOD Treatment: Total age groups, Opioid abuse or dependence diagnosis cohort: Increased 10.94 percentage points from 26.79% to 37.73%. Target rate of 36.87 was not met
- Indicator #6. Engagement of AOD Treatment: Total age groups, Total diagnosis cohort: Increased 7.09 percentage points from 14.14% to 21.23%. Target rate of 24.82 was not met
- Indicator #7. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit: Increased 5.33 percentage points from 10.66 to 15.99. Target rate of 13.78 was met and exceeded by 1.39%
- Indicator #7a **(subset measure)** The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days of the ED visit: Increased 11.11 percentage points from 0 to 11.11. Target rate of 28 was not met
- Indicator #8. The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit: Increased 2.64 percentage points from 8.46 to 11.10. Target rate of 11.56 was not met
- Indicator #8a **(subset measure)** The percentage of emergency department (ED) visits for members 13 years of age and older with a diagnosis of HIV/AIDS and a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 7 days of the ED visit: Increased 11.11 percentage points from 0 to 11.11. Target rate of 19.67 was not met

The interpretation and analysis of the performance indicator rates for 2020 showed a quarter over quarter improvement in most measures, except for Q4, mostly due to partial data not inclusive of December claims. Healthy Blue exceeded the final measure target rate of Indicator #7 (follow up post ED within 30 days) by 1.39 percentage points and almost met target rate for 7-day FUA by 0.93 percentage points. Engagement in AOD

treatment, total age groups, was just shy of the target rate by 0.59 percentage points. The indicator rates also had increases from the baseline measure of 2018 by an average of 3%.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.**

Healthy Blue's interventions implemented in 2020 helped meet the objectives and goals for this PIP. The intervention of increasing provider awareness and coding for Screening, Brief, Intervention and Referral to Treatment (SBIRT) showed an increase from Q3 to Q4 by 0.8% for primary care practitioners. The obstetric practitioner group also showed an increase in SBIRT screenings in Q4 by 3.41%. Q4 ITM related to telehealth provider visits as well as a few others, only had partial data included in the report and Healthy Blue still showed an increase in most ITM measures.

- **What factors were associated with success or failure?**

Healthy Blues ITMs #4a, for dual diagnosis of SUD and SMI referrals to treatment post ED and Hospitalization were successful and engagement in case management was noted for 50% of the population from Q1 to Q4. The plan determined that members with a dual diagnosis (ITM 5) are more difficult to engage in case management due to SMI members are typically engaged in intensive outpatient programs and the SUD issue is not the priority of treatment. Evaluating the SMI and SUD population separately will help the plan focus on CM engagement and treatment for SUD. The plans engagement of justice involved members is a successful program with engaging 100% of SUD members into case management post discharge from the facility. The plan determined that the ITM #1 had the greatest impact on improving the PI 7 and FUA where ITM #2 had less of an impact. ITM #3 assisted in increasing the PIs overall with providing education to providers on SBIRT screenings. ITM #8 subpopulation of pregnant members assisted with improving PIs for this population but improved engagement rate is a goal for 2021.

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?**

Healthy Blue provided many educational opportunities for the providers on motivational interviewing and SBIRT coding. A monthly refresh on data versus obtaining the data the following month, would enhance our outreach efforts due to not having a timely member lists available for case management.

- **Were there any threats to the external validity the findings?**
  External threat noted as receiving timely ED data collection related to FUA.

- **Describe any data collection challenges.**
  Pharmacy data presented a delay for timely analysis as well as other claims/encounter data delays.

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
#1) Targeted CM outreach post ED visit related to alcohol/SUD.	Tracking and engaging hig ED utilizers improved outcomes	Identifying high ED utilizers	Identifying high ED utilizers will continue in 2021
#2) Targeted CM outreach post Hospitalization related to alcohol/SUD	Increased access to appropriate ASAM level of care for follow-up care and treatment assisted with improving outcomes	Referring members to the appropriate level of care based upon ASAM levels	Continue referring members to the appropriate level of care based upon ASAM level
#3) Provider education about evidence based SBIRT screening best practices (Stages of Change, Motivational interviewing techniques, knowledge of available treatment/services/providers) and billing practices	Provider educational sessions continued throughout the project. Increased education and provider follow up would he improve the plans outcome	Provide provider awareness and appropriate coding for SBIRT and use of motivational interviewir techniques	Increase provider awareness and appropriate coding for SBIRT and use of motivational interviewing
#4) Inpatient Readmission Outreach Case management and Discharge Planning Program-	Telemedicine services use has assisted in follow-up a outreach for members; identified as high readmits has assisted with inpatient admissions	Promote telehealth services for follow up care	Continue to promote telehealth services for follow up care
#4a) Targeted CM for members that have a dual diagnosis of SUI and SMI diagnosis discharged fro an ED with referral to treatment and follow-up	Targeted CM outreach and engagement to members who are high ED utilizers with a SUD and SMI diagnosis improved outcomes as well as initiati post DC programs	Identifying high ED utilizers	Continue targeted CM outreach and engageme of the high ED utilizers
#5 Targeted CM for members that have a dual diagnosis of SUD and SMI diagnosis discharged from an inpatient admission with referral to treatment and follow-up	Targeted CM outreach and engagement to members who have frequent hospital readmits with a SUD and SMI diagnosis improved outcomes	Identifying members wi frequent hospital readmits for referral to treatment based upon ASAM level of care	Continue identifying members with frequent hospital readmits for referral to treatment based upon ASAM level of care
#6) Enroll members text educational campaigns to educate members on resource tools available through	Text campaign for member with SUD diagnosis and offering CM engagement a	Initiated member text and IVR call campaign for all members on	Continue to enroll members in text/IVR campaigns

Common Ground Library targeting Behavioral Health needs	resources for SUD/alcohol treatment improved results	SUD/Alcohol treatment resources	
#7) Educate Heathy Blue members on the telehealth platform for provider visits	Increased use of telemedicine and awarenes campaign for members wit SUD diagnosis through phone call and text campaigns assisted with improved outcomes	Initiated member text and IVR call campaign related to use of telehealth options for care	Continue to enroll members in text/IVR campaigns
#8) CM to use stratified population health reporting to identify all new and current pregnant mothers with SUD's with goal to engage in CM services	Identify high risk pregnant members through the population health platform analytics and predictive modeling assisted improvir outcomes with this population	Using population healt platform and use predictive modeling to identify this population	Continue Using population health platfor and use predictive modeling to identify this population
#9. CM to use stratified population health reporting to identify all Justice involved members and have a SUD diagnosis with goal to engage in CM services	Recently incarcerated members with high risk diagnoses are identified an outreached for CM engagement; this initiative has yielded positive results	Identify all justice involved members with SUD diagnosis and engaging them in CM services	Continue to Identify all justice involved membe with SUD diagnosis and engaging them in CM services

References

List any references that you cite.

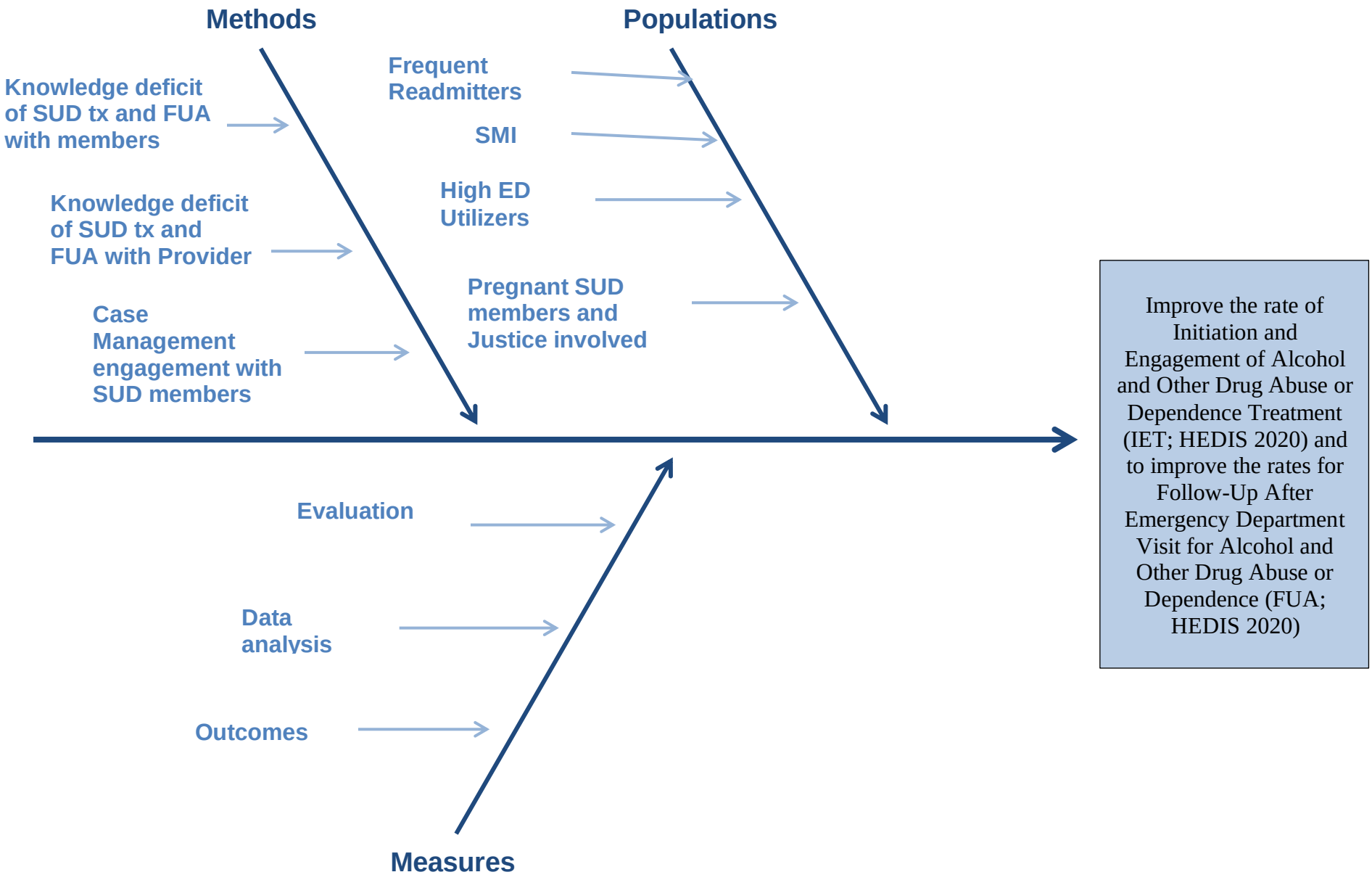
Glossary of PIP Terms

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 • Roadblock	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 interventions might be necessary to improve success rates on an ongoing basis.

PIP Term	Also Known as…	Purpose	Definition
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 – identifying target populations and subpopulations to educate on SUD	Pregnancy and SUD Dx identification and engagement High re-admits and ED Utilization identification and engagement SMI members with dual SUD Dx identification and engagement	Use of IOP services
Less Feasible to Address – decreasing member readmits	Actual CM engagement with the SUD/Alcohol identified member Member completes follow up visits with provider within 30 days	Data analysis/identification Actual engagement with follow up services

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

	Positives	**Negatives**
INTERNAL ***under your control***	***build on*** **STRENGTHS** Data analysis Case management structure Member resources/Education Provider Relationships Community Partner Partnerships	***minimize*** **WEAKNESSES** Claims/encounter data analysis delay Lack of centralized ED data
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** Provider education and knowledge of member resources Improved collaboration with Hospitals and ED's Provider education on SBIRT and Motivational interviewing techniques	***protect from*** **THREATS** member engagement in services Inaccurate Member demographics Claims delays Lack of provider knowledge of methods for motivational interviewing Member fears

Appendix D: Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
1. Improve the rates for Initiation of and Engagement in Alcohol and Other Drug Abuse or Dependence Treatment to the next highest Quality Compass percentile (or by 10 percentage points) 2. Improve the rates for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence to the next highest	First-line medical provider knowledge: PCPs: youth, adult, OB/Gyn ED providers	- Understanding Stages of Change and motivational interviewing for SUD -SBIRT training: adult, youth -ASAM criteria for level of care/transitions in care training - MAT waiver-training and local SUD treatment resources - Staff and providers may not be aware of the IET timeline specifications	Implement innovative approaches for training providers in (SBIRT) Adult and Adolescent specific screening, brief intervention, triage and referral to ASAM evaluations in first-line medical settings. - Prompt ASAM level of care evaluations/referral to treatment for those members presenting at the ED/inpatient with SUD overdoses. - First-line medical provider education supporting screening, brief intervention and referral (Stages of Change, motivational interviewing, knowledge of available treatment/services/providers)	
			Waiver training to increase MAT prescribers statewide	
			Implement innovative statewide intervention to increase MAT prescriber knowledge of local evidence-based psychosocial treatment resources and referral procedures to higher levels of care	
	Member Engagement: Youth, adult, all SUD involved SHCN subpopulations eligible for CM:	-Members in Pre-Contemplation Stage of Change Vulnerability of SHCN sub-populations -SDOH impeding service delivery	SHCN Case Management: Implement innovative approaches to conduct motivational interviewing techniques, with increased face-to-face engagement with members (Recovery coaches, Life coaches BH advocates, etc.)	

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
Quality compass percentile (or by 10 percentage points)				

Appendix E: Plan-Do-Study-Act Worksheet

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•