Health Plan Performance Improvement Project (PIP)

Health Plan: Aetna Better Health of Louisiana

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	02/03/2020	
Version 2		12/31/2020

MCO Contact Information

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Attestation

Plan Name: Aetna Better Health of Louisiana
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: Madelyn M Meyn MD
First and last name: Madelyn Meyn, M.D.
Date: 03/11/2020

CEO signature: Richard C Born
First and last name: Richard C. Born
Date: 03/11/2020

Quality Director signature: Arlene Goldsmith
First and last name: Arlene Goldsmith
Date: 03/11/2020

IS Director signature (if applicable): Kenneth Landry
First and last name: Kenneth Landry
Date: 03/11/2020

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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 CM Linkage to Treatment Rate/PDSA	9/2020	☐ Methodology	MCO outreach denominator changed to OPH population
Change 2 MCO Outreach to at Risk Members enhanced	10/2020	☐ Other	As required in the PIP, all ABH-LA members who are at risk were identified for outreach to get testing/treatment
Change 3 Member Services added for Outreach coverage	10/28/2020	☐ Barrier Analysis / Intervention	Outreach was our primary goal, MS added to help with the extensive outreach need
Change 4 QNXT Flag for HCV	9/2020	☐ Methodology	The HCV Flag allows any pro-active contact with the member to address this health concern and not wait on outreach

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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.

The Year 2020 was filled with multiple obstacles from a worldwide Covid-19 Viral Pandemic that locked the State of Louisiana down for 6 weeks and only allowed limited movement afterwards where personal interaction of any kind was concerned; to Louisiana experiencing a record breaking 5 named storms, 4 of which were Hurricanes, making land fall over 5 months.

ABH-LA took a whole population view of this initiative and based on all risk factors outlined in the PIP, added members who met those criteria's and worked to contact them for either testing or treatment. This commitment to our members took us beyond the OPH list sent periodically which is usually around 3,000 to well over 14,000. Between the Pandemic closing down doctors' offices and hurricanes battering our state, we needed to expand the outreach beyond Care Management to include Member Services (MS) in order to support this effort. Since October 28th, MS had been able to outreach 3832 members who are suspected of having HCV with 328 either having appointments or in treatment noted on the first call, which is a positive 11.68% of the expanded population being affected by these efforts. This remarkable coverage will drive the overall population to treatment going into 2021 and this model will continue to be used going forward.

Although, other forms of outreach planned did not come to fruition, the literature like flyers and mailers were completed and are currently being used in the field at community outreach events or left behind at facilities. The concept of physically mailing information to members had to be revised due to both inefficiencies and other forms being more effective. Unfortunately, this virus does have a negative connotation for risky behavior and some members are not receptive to testing. As we look forward to 2021, our goal for campaigns being developed is to encourage our member population of 18+ to get tested as a standard practice. By implementing this practice, we are hoping to take hold and help identify those who otherwise may not consider themselves at risk. We will also be doing text campaigns to help educate members of the potential effects this disease can cause if untreated, hoping to drive them to want to get tested. Our Community Outreach Team will also be working to implement more HCV testing in Community events to help screen as one pilot event in October yielded 6 HCV tests.

We have also been able, through articles from LDH and our own data, to link SUD behavior and a high-risk factor for HCV. Therefore, we are looking to implement requests that anyone with a SUD diagnosis also be tested for HCV as it is the single highest risk associated with HCV. We will also be working with some key internal areas, like Provider Relations, to outline specific processes around this PIP such as delivery of members HCV status to the appropriate Providers for proper outreach and next steps. Working with Community Outreach for specific events for testing throughout 2021, and Provider Communications/Education for proper testing and treating.

The Performance Indicators for Screening did not reach the goals we had expected however, they did improve from Q1 to Q4 despite the pandemic, but many of the treatment ones (3a-3c) did meet or exceed our goals. Once again supporting the Epclusa (DAA) graph showing high commitment to treatment once a prescription is generated.

We have learned many things that worked, things delivered via virtual, this year and will continue into 2021. The things we have learned and achieved towards the end of the year have shown the focus on all at risk members is correct, and how getting more testing done outside of the Providers office will carry into 2021. This year's Pandemic and Hurricanes have brought us permanent tools and processes, like QNXT flag for HCV, that will continue to serve our members long after the PIP is retired. These efforts to reduce long term issues associated with liver damage and transplants, is a cost and effort that ABH-LA takes seriously for not only our members health, but the state's budget.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

According to the Louisiana Department of health's HCV performance improvement project background,

> "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 prevalence in Louisiana is estimated at 1.6% to 1.8%, with higher rates among urban residents, men and women aged 45-54 years, with highest rates among males in all age groups and among African American males aged 45-54 years (LA OPH, 2015). Louisiana ranks fifth in the U.S. for HCV/HIV co-infection; an estimated 6% of individuals with HCV in Louisiana are co-infected with HIV, and 18% of individuals with HIV as a result of intravenous drug use are also diagnosed with HCV co-infection (LA OPH, 2015)" (Health I. a., 2019).

The Louisiana Health Hub outlines that there are "roughly 40,000 people in our state with a probable or confirmed case of Hepatitis C" (Health L. D., 2019). Aetna Better Health of Louisiana's enrollee population should have a basic understanding and awareness of the health risks of HCV as it is the "most common blood-borne disease" (Health I. a., 2019). Members at higher risk should understand the benefits of screening, rescreening annually and completing a prescribed treatment regimen if a positive diagnosis for HCV is confirmed. As we consider the population we serve and the enrollees that are high-risk, we look to professional society guidelines which "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)" (Health I. a., 2019). Past or current drug users are also at risk for HCV exposure, according to the CDC, as well as the baby boomer population (Prevention, Viral Hepatitis: Testing Recommendations for Hepatitis C Virus Infection, 2020).

For individuals on hemodialysis, HCV infection is a major cause of morbidity and/or mortality (D.C. CARAGEA, 2018). In 2016, the CDC put out a health advisory for patients on hemodialysis due to increased number of HCV infections in persons undergoing dialysis at clinics within the United States (Prevention, Emergency Preparedness and Response: CDC Health Advisory Summary: HCV, 2016). According to the Hepatitis C and Incarceration facts sheet from the CDC, "adults in correctional facilities are at risk for Hepatitis C because many people in jails or prisons already have Hepatitis (Prevention, Hepatitis C & Incarceration, 2013)." The Louisiana's Justice Reinvestment Reforms 2019 Annual Performance Report noted that in 2017, Louisiana "led the nation in imprisonment, with a rate nearly double the national average and significantly higher than the second and third highest states, Oklahoma and Alabama (Corrections L. D., 2019)." In June of 2019, the Louisiana Department of Public Safety and Corrections Demographics Fact Sheet outlined that there were 31,756 adult offenders housed in local and state facilities (Corrections L. D., 2019). For persons living with HIV the CDC states the following for HIV and coinfections of HCV: "Many people who inject drugs (PWID) and have HIV also have hepatitis C…As hepatitis C is a virus transmitted through direct contact with the blood of an infected person, coinfection with HIV and hepatitis C is common (62–80%) among PWID with HIV (Prevention, HIV: HIV and Coinfections, 2019)."

According to the National Institute on Drug Abuse,

> "Because drug use often impairs judgement, PWID repeatedly engage in these unsafe behaviors, which can increase their risk of contracting viral hepatitis. One study reported that each person who injects drugs infected with HCV is likely to infect about 20 others, and that this rapid transmission of the disease occurs within the first 3 years of initial infection. Drug and alcohol use can also directly damage the liver, increasing risk for chronic liver disease and cancer among those infected with hepatitis. This underscores that early detection and treatment of hepatitis infections in PWID and other drug users is paramount to protecting both the health of the person and that of the community…(Abuse, 2018)."

The baby boomers (population born between 1945 and 1965) are also at risk. According to an article in the Harvard Health Publishing, "three out of every 100 baby boomers were infected with HCV…This was at least five times higher than any other group of adults and accounted for about 75% of HCV cases (Raymond Chung, 2019)." The article noted that "risk factor assessments suggest that this group may have been more likely to engage in occasional or ongoing injection drug use during young adulthood… (Raymond Chung, 2019)."

Based on at-risk population served by Aetna Better Health of Louisiana, the data analysis produced the following narrative: Within Aetna Better Health of Louisiana's enrollee population, there are 1,107 individuals with a confirmed/probable diagnosis of HCV. The highest rates of HCV are within the 55-59 years age group at (n=229 which is

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equal to 20.69%). The second most impacted age group is the 60-64 at (n=222 which is equal to 20.05%), and the third most impacted age group is the 50-54 years age group at (n=142 which is equal to 12.83%). These age groups are followed by age group 35-39 years at (n=117 which is equal to 10.57%) and 40-44 years at (n=116 which is equal to 10.48%). There are more males at (n=731 which is equal to 66.03%) compared to females at (n=376 which is equal to 33.97%) with confirmed or probable HCV.

For ethnicity, there are more White (Non-Hispanic) at (n=656 which is equal to 59.26%) than African-American (n=317 which is equal to 28.64%); and all other races at (n=16 which is equal to 1.45%) with confirmed or probable HCV. There are (n=118 which is equal to 10.66%) categorized as Unknown or Not provided. The three regions most impacted by HCV are the Greater New Orleans region at (n=388 which is equal to 35.05%), Capital Area at (n=164 which is equal to 14.81%), and Northshore Area at (n=155 which is equal to 14.00%). For parish, HCV most impacts enrollees in Orleans (n=207 which is equal to 18.70%), Jefferson (n=143 which is equal to 12.92%), East Baton Rouge (n=116 which is equal to 10.48%), Saint Tammany (n=62 which is equal to 5.60%), and Lafayette (n=55 which is equal to 4.97%). For cities, HCV most impacts enrollees in New Orleans (n=206 which is equal to 18.61%), Baton Rouge (n=96 which is equal to 8.67%), Shreveport (n=41 which is equal to 3.70%), Metairie (n=41 which is equal to 3.70%), and Lafayette (n=35 which is equal to 3.16%). For the population at risk, there are 2,826 persons identified with substance use disorder, 1,319 persons living with HIV, 51 persons identified as ever incarcerated, 382 persons on long term hemodialysis, and 24,120 persons within the baby boomer population.

For enrollees with current or past injection drug use, almost 53% (n=1,489 which equals 52.69%) are White (Non-Hispanic) followed by Black enrollees (n=1,126 which equals 39.84%). More males (n=1,509 which equals 53.40%) are impacted by current or past injection drug use than females (n=1,317 which equals 46.60%). For region, the majority of enrollees are located within the following: Northwest Louisiana (n=527 which equals 18.65%), Greater New Orleans Area (n=512 which equals 18.12%), and Capital Area (n=512 which equals 18.12%). For parish, the majority of enrollees located in the following: East Baton Rouge (n=402 which equals 14.23%), Orleans (n=275 which equals 9.73%), Caddo (n=265 which equals 9.38%), and Jefferson (n=200 which equals 7.08%).

For enrollees with HIV, almost 70% (n=918 which equals 69.60%) of members at risk are Black followed by White (Non-Hispanic) (n=290 which equals 21.99%). More males (n=838 which equals 63.53%) are impacted than females (n=481 which equals 36.47%). For region, the majority of enrollees are located within the following: Greater New Orleans Area (n=552 which equals 41.85%), Capital Area (n=235 which equals 17.82%), and Northwest Louisiana (n=150 which equals 11.37%). For parish, the majority of enrollees are located in the following parishes: Orleans (n=430 which equals 32.60%), East Baton Rouge (n=208 which equals 15.77%), and Jefferson (n=106 which equals 8.04%).

For enrollees ever incarcerated, almost 53% (n=27 which equals 52.94%) are Black followed by White (Non-Hispanic) (n=17 which equals 33.33%). More males (n=40 which equals 78.43%) are impacted than females (n=11 which equals 21.57%). For region, the majority of enrollees are located within the following: Greater New Orleans Area (n=11 which equals 21.57%), Capital Area (n=12 which equals 23.53%), and Acadiana (n=8 which equals 15.69%). For parish, the majority of enrollees are located in the following: East Baton Rouge (n=11 which equals 21.57%), Orleans (n=6 which equals 11.760%), Caddo (n=4 which equals 7.84%), and Rapides (n=4 which equals 7.84%).

For enrollees on long term hemodialysis, 60% (n=230 which equals 60.21%) are Black followed by White (Non-Hispanic) enrollees (n=99 which equals 25.92%). More males (n=227 which equals 59.42%) are impacted than females (n=155 which equals 40.58%). For region, the majority of enrollees are located within the following: Greater New Orleans Area (n=122 which equals 31.94%), Capital Area (n=58 which equals 15.18%), and Northwest Louisiana (n=46 which equals 12.04%). For parish, the majority of enrollees are located in the following: Orleans (n=60 which equals 15.71%), Jefferson (n=49 which equals 12.83%), and East Baton Rouge (n=40 which equals 10.47%).

For enrollees within the baby boomer population, almost 50% (n=11,105% which equals 46.04%) are Black followed by White (Non-Hispanic) enrollees (n=9,363 which equals 38.82%). More females (n=13,623 which equals 56.48%) are within this population compared to males (n=10,497 which equals 43.52%). For region, the majority of enrollees are located within the following: Greater New Orleans Area (n=6,084 which equals 25.22%), Northwest Louisiana (n=3349 which equals 13.88%), and Capital Area (n=3,070 which equals 12.73%). For parish, the majority of enrollees are located in the following: Orleans (n=3,291 which equals 13.64%), Jefferson (n=2,452 which equals 10.17%), and East Baton Rouge (n=2,067 which equals 8.57%).

There is opportunity for members to understand the health risks of living with Hepatitis C and the benefits of completing a prescribed treatment regimen; and elicit changes in members' health-related behaviors to increase the potential for attaining positive health outcomes. Our baseline data for performance indicators are as follows: The 1/1/19 to 6/30/19 baseline rate for performance indicator 1 (Birth Cohort Screening) is 16%, performance indicator 2 (Non-Birth Cohort/Risk Factor Screening) is 31%, performance indicator #3a (HCV Treatment Initiation-Overall) is 6%, performance indicator #3b (HCV Treatment Initiation-Persons who use drugs) is 4%, and performance indicator #3c (HCV Treatment Initiation-

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Persons with HIV) is 2%. The 1/1/19 to 12/31/19 baseline rate for performance indicator 1 (Birth Cohort Screening) is 18%, performance indicator 2 (Non-Birth Cohort/Risk Factor Screening) is 35%, performance indicator #3a (HCV Treatment Initiation-Overall) is 16%, performance indicator #3b (HCV Treatment Initiation-Persons who use drugs) is 14%, and performance indicator #3c (HCV Treatment Initiation-Persons with HIV) is 7%. The target is to achieve a rate increase of 10 percentage points for each performance indicator by 12/31/2020, and target rates will be adjusted based on quarterly tracking of improvement.

There are a multitude of barriers that current research outlines and was pointed out in the Louisiana Department of Health's HCV performance improvement project background and training presentation documents that impact HCV screening and linkage to treatment:

> "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. The AASLD/IDSA identifies additional barriers and *corresponding counter- strategies* for providers (AASLD/IDSA, 2018) that MCOs can also facilitate through provider education, care coordination, and case management. First, to address substance abuse, providers are advised to conduct counseling and education and to refer the enrollee for opioid substitution therapy. For patients with psychiatric disorders, counseling and education is also advised, as well as referral for psychiatric services. To minimize loss to follow-up, strategies include engagement of case managers and patient navigators, as in the HIV model, and co-localized services, e.g., primary care, medical homes, and drug treatment. To address the long treatment duration, the AASLD/IDSA recommends conducting appropriate education and monitoring, as well as using directly observed therapy, as in the tuberculosis model. To address lack of practitioner expertise, the AASLD/IDSA recommends collaboration with specialists, as in telemedicine or the Project ECHO-like models (AASLD/IDSA, 2018) (Health I. a., 2019)."

Through identifying barriers and addressing them through specific interventions and/or policy changes, there is room to increase HCV screening and address linkage to treatment in at risk populations. To further address challenges, the Healthy Louisiana program has initiated the following:

For contra-indications to treatment, the Healthy Louisiana program removed the sobriety requirement (IPRO, 2020). Also, the fibrosis and/or cirrhosis diagnosis measures are no longer required for patients with HIV. For further support and opportunity to address HCV within ABH-LA's population is that the Louisiana Department of Health has removed barriers to receive DAA therapy "as of summer 2019" (Health I. a., 2019). Enrollees with chronic HCV diagnosis "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)." Without the need for prior authorization, the process for DAA for prescribing physicians has been streamlined. The Office of Public Health has streamlined the treatment guideline and have made the AASLD/IDSA treatment guideline available for providers (IPRO, 2020). In addition, the prescriber specialty requirement has been eliminated for HCV treatment, and the Office of Public Health has provided a dataset of HCV providers to support access and linkage to evaluation and treatment (Health I. a., 2019).

A posting on the American Academy's Family Physicians' website on HCV screening states, "More than 4 million people in the United States have a past or current hepatitis C virus infection… (Crawford, 2019)." With collaboration and support from the Louisiana Department of Health, the Office of Public Health, ABH-LA, and providers within Louisiana, there is opportunity to decrease HCV in the population; thus, impacting the quality of life for enrollees and Louisiana's citizens. There is the opportunity to address disparities with HCV screening and treatment amongst the confirmed / probable and at-risk populations that we serve. With a coordinated effort, we can achieve the aims, objectives, and goals within the HCV performance improvement project and address barriers related to educating providers and enrollees about HCV and increasing screening and linkage to treatment for enrollees.

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:

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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: 10849 D: 69005 R: 16%	R: 26%	As mandated within the goals and scope of the PIP Hep C
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: 3779 D: 21125 R: 18%	R: 28%	As mandated within the goals and scope of the PIP Hep C
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: 3401 D: 10178 R: 33%	R: 43%	As mandated within the goals and scope of the PIP Hep C
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: 1720 D: 10178 R: 17%	R: 27%	As mandated within the goals and scope of the PIP Hep C
Performance Indicator #3a (HCV Treatment Initiation-Overall): *The*	N: 364 D: 2283 R: 16%	R: 26%	As mandated within the goals and scope of the

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Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
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}.			PIP Hep C
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: 179 D: 1313 R: 14%	R: 24%	As mandated within the goals and scope of the PIP Hep C
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: 9 D: 121 R: 7%	R: 17%	As mandated within the goals and scope of the PIP Hep C

[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).

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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

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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 d) Persons ever diagnosed with HIV infection (ICD-9 or ICD-10 codes in Table	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

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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
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

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Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
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
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

Proprietary

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?
The entire eligible population is being targeted by PIP Interventions.

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:

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:
Data collection will be performed by the Quality department's Analyst as well as members of the IT department. Data collection will be setup weekly utilizing the below software and methods:

- **TOAD Data Point:** Software will be utilized to generate automated custom reporting specifically around this PIP by combining multiple data sources listed below.
- **Annual Population Assessment**: Annual report generated integrating member enrollment demographic data, Elli data software linked to State claims received with diagnoses codes, ABH QNXT claims data base.
- **CM Utilization rates:** Report generated utilizing CM Dynamo data platform monthly, quarterly, and final annual rate of enrollment patterns, use of ASAM 6 screening tools, and outreach patterns. Member successful transitions to appropriate level of care by file review.
- **Utilization Management Rates**: QNXT data base system generated quarterly and annual report of member utilization patterns for inpatient, outpatient services, screenings and treatment.
- **Pharmacy Rates:** Use of Elli software program of prescribing patterns by member/prescribing physician. CVS pharmacy reports of claims received for HCV screening, treatment and/or DAA therapies.
- **Office of Public Health Reports:** OPH HCV Confirmed/Probable list, Prescribing Providers, and HIV list.

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:**
  - **Annual Population Assessment**: Member demographic and claims information validated by Aetna IT informatics and Health Care Equities Director. We utilize Elli data software program, which is linked to State claims received, ABH QNXT claims received, and member enrollment data to produce reliable data over time.
  - **Pharmacy Rates**: Data file validation by CVS pharmacy and Aetna Pharmacy Director
  - **Vendor Reports**: Vendor data file reports of text messages, mailers, and IVR calls generated validated by QI Director, Project Manager and/or designee. Aetna IT generation of member lists utilizing same logic. Discrepancies discussed with vendor during monthly meetings.
  - **CM Utilization Rates:** Validated by Project Manager and CM project manager for variances in data and/or technical reporting issues within the Dynamo data platform. Aetna IT informatics review of final rates and of discrepancies found and using the same data base system and logic for reliable results.

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- **Utilization Management Rates:** Validated by UM Manager and Medical Management Director for validity and accuracy of data with Aetna IT informatics review of final rates, and of discrepancies found for member utilization of treatment services.

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:**
  - Our data collection for identifying, measuring, and reporting for needs related to HCV screening and linkage to treatment information are generated from claims. In addition, the plan integrates OPH data, Hep C performance metrics, Care Management dynamo platform of enrollment patterns and care coordination for screening and treatment, enrollee participation, and intervention tracking measures, as well as any additional process metrics. An analysis is conducted of related utilization management services, and provider/enrollee claims audits to ensure provider and/or member adherence to screening, linkage to treatment and/or evidence-based guidelines. Data is stratified by at risk populations identified for Hep C screening and linkage to treatment, including key clinical factors. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP Hep C committee members, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABH-LA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABH-LA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the HCV PIP and its corresponding goals.
- **Describe how plan will interpret improvement relative to goal:**
  - In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional, member, and provider demographic variations, to identify variation in access and health care services. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in screening and active treatment.
- **Describe how plan will monitor ITMs for ongoing QI:**
  - The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is being observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

Proprietary

(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

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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; lack access to screening and treatment; lack access to transportation for screenings, appointments, and pharmacy for prescription pick-ups (Lack access to benefits/services or they are unknown to enrollee) **Barrier 2: Members who are injectable drug users, members with mental and behavioral health issues, and/or incarceration may prevent adherence to screening and treatment and users may be hard to contact and engage** **Barrier 3: Enrollees concerned about confidentiality and stigma related to HCV screening, especially members living with HIV and have stigmas/trauma, fear screening and follow-up treatment; or other social factors that prevent screening and adherence to treatment (i.e. Members who have cultural and religious beliefs that pose barriers to knowledge acceptance on Hep C screening and treatment)** **Method of barrier identification: IPRO HCV PIP Guidance Document, National Viral Hepatitis Action Plan 2017-2020, DHHS (Services, National Viral Hepatitis Action Plan 2017–2020), Internal PIP Hep C committee barriers brainstorm, Community-based HCV screening: knowledge and attitudes in a high risk urban population (Norton, 2014), Breaking Down the Barriers to Hepatitis C Virus (HCV) Treatment Among Individuals With HCV/HIV Coinfection: Action Required at the System, Provider, and Patient Levels (Grebely, 2013), Mental Health Treatment Considerations for People Who Have Chronic Viral Hepatitis C (Treatment, 2011), Assessment of methadone clinic staff attitudes toward hepatitis C evaluation and treatment (Talal, 2013), Barriers and facilitators to hepatitis C virus screening and treatment- a description of prisoners' perspective (Crowley, 2018), Hepatitis C, stigma and cure, Cultural Insights: Communicating with Hispanics/Latinos (Prevention, Cultural Insights: Hispanics and Latinos)**		**2020**			
		Q1	**Q2**	**Q3**	**Q4-TD**
Intervention #1a to address barriers 1 to 3: Enhanced Case Management Outreach for HCV Treatment Initiation: Utilize OPH listing of members with confirmed or probable HCV to conduct outreach for referral for HCV pharmaceutical treatment and appointment scheduling with (a) an HCV provider in the OPH database (PIP-prioritized provider) or (b) the member's PCP (if the member prefers)	**Intervention #1a tracking measures (1):** **Numerator:** Number of members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV treatment assessment/initiation **Denominator:** Number of members with confirmed or probable HCV per OPH listing for SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred): (Linkage to Treatment)	N: 94 D: 2702 R: 3.5%	N: 202 D: 2541 R: 7.9%	N: 141 D: 2267 R: 6.2%	N: 94 D: 2793 R: 3.4%
Hepatitis C Treatment Care Management Outreach and Referral: **Linkage to treatment:**	**Intervention #1a tracking measures (2):** **Numerator:** Number of members who were dispensed SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred)	N: 470 D: 472 R: 99.6%	N: 296 D: 302 R: 98.0%	N: 281 D: 287 R: 97.9%	N: 186 D: 190 R: 97.9%

• Have members understand the health risks of living with HCV • CM assesses the member's current knowledge regarding the diagnosis • Have members understand the benefits of completing a prescribed treatment regimen; to include linkage to treatment HCV provider • Identify and mitigate potential barriers to treatment success so that members complete the full treatment • Elicit changes in members' health-related behaviors that positively impact their current and future health and wellness • Evaluate and create an integrated plan of care to address PH, BH, and/or SDoH (such as transportation). • Care plan addresses follow-up appointment support **Already in treatment:** • Have members understand the health risks of living with HCV • Have members understand the benefits of completing a prescribed treatment regimen • Identify and mitigate potential barriers to treatment success so that members complete the full treatment; maintain adherence • CM assesses the member's current knowledge regarding the diagnosis, treatment process, understanding of prescribed HCV med (dosage, frequency, expected length of treatment, how medication will be obtained – from local pharmacy or mailed), knowledge of interval follow up appts being scheduled by	**Denominator:** Number of members with any DAA dispensed				

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provider to evaluate the effectiveness of the medication through lab work and interview • Elicit changes in members' health-related behaviors that positively impact their current and future health and wellness • Evaluate and create an integrated plan of care to address PH, BH, and/or SDoH (such as transportation). • Care plan addresses follow-up appointment support **Planned Start Date: 2/17/2020** **Actual Start Date:**					
Intervention #1b to address barriers 1 to 3: Enhanced Case Management Outreach for HCV Screening: Utilize MCO claims/encounter data to identify at-risk members for HCV screening and schedule a screening appointment with the member's PCP Hepatitis C Drug Treatment Care Management Outreach and Referral for HCV Screening is to: • Have members understand their at risk status; HCV education • Have members understand the benefits of completing a screening • Coordinate appointment for screening and support follow-up appointments • Evaluate and create integrated care plan to address PH, BH, and/or SDoH (such as transportation) • Identify and mitigate potential barriers to screening success • At Risk Member Population to be outreached includes the following: – SUD (Current and Past Drug Injection Use)	**Intervention #1b tracking measure:** **Numerator:** Number of members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV screening; **Denominator:** Number of members at risk for HCV per MCO claims/encounter data	N: 16 D: 18315 R: 0.08%	N: 34 D: 19069 R: 0.17%	N: 24 D: 20365 R: 0.12%	N: 64 D: 20630 R: 0.31%

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– Incarceration (All members past incarceration and recent) – Long Term Hemodialysis – HIV – Baby Boomers **Planned Start Date: 2/17/2020** **Actual Start Date:**					
Barrier 4: Asymptomatic enrollees may not know they are infected with HCV; enrollees at risk may lack education and awareness regarding screening, treatment, and management **Method of barrier identification: IPRO HCV PIP guidance document, Internal PIP committee brainstorm/discussion, *Viral Hepatitis: Testing Recommendations for Hepatitis C Virus Infection*** (Prevention, Viral Hepatitis: Testing Recommendations for Hepatitis C Virus Infection, 2020)		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #4a to address barrier: Develop Educational Mailer Campaign to All Enrollees who are at risk, 18 and above with the following: At Risk Information, Symptoms, HCV Screening and Treatment Education, Pharmacy Benefits, Referral and Appointment Scheduling Support **Planned Start Date: 5/15/2020** **Actual Start Date:**	**Intervention #4a tracking measure:** **Numerator:** Number of members 18 and above who are in the at risk identified population and have a claim / encounter for HCV screening after mailer was sent **Denominator:** Number of members 18 and above who are in the at risk identified population	N: NA D: 18315 R: NA	N: NA D: 19069 R: NA	N: NA D: 20365 R: NA	N: NA D: 20630 R: NA
Intervention #4b to address barrier: Enhanced Community Outreach to Community and Faith Based Organizations that specifically serve community members to link and promote HCV Awareness and Education; to promote HCV Screenings at community events (potentially in disproportionately impacted geographic areas/subset populations) **Planned Start Date: 3/31/2020** **Actual Start Date:**	**Intervention #4b tracking measure:** **Numerator:** Number of community collaborators providing HCV education and/or HCV screening at community events (potentially in disproportionately impacted geographic areas/subset populations) **Denominator:** Number of community collaborations with community and faith-based organizations (potentially in disproportionately impacted geographic areas/subset populations)	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA
Barrier 5: Providers may not be aware that Epclusa does not require prior authorization and streamlined algorithm; providers who are uncomfortable screening and/or treating or lack access to screening and referrals for HCV treatment; lack access to training and education **Method of barrier identification: Breaking Down the Barriers to Hepatitis C Virus (HCV) Treatment Among Individuals With HCV/HIV Coinfection: Action Required at the System, Provider, and Patient Levels (Grebely, 2013) , Internal PIP Hep C committee brainstorm/discussion, Understanding and addressing hepatitis C reinfection in the oral direct**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**

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acting antiviral era (Falade-Nwulia, 2018), Chief Medical Officer Peer to Peer conversation with GI Professional, IPRO HCV PIP guidance document, National Viral Hepatitis Action Plan 2017-2020, DHHS (Services, National Viral Hepatitis Action Plan 2017–2020), Expert Consultation on the Evidence for Early Hepatitis C Treatment in the United States, DHHS (Services, Consultation Report: Expert Consultation on the Evidence for Early Hepatitis Treatment in the United States, 2016)					
Intervention #5a to address barrier: Educate Providers on Evidence-based Screening, Treatment, and Pharmacy Benefits for HCV through Provider Relations and/or Medical Director Face to Face Visits (Linkage to Treatment and HCV Screening) **Planned Start Date: 3/1/2020** **Actual Start Date:**	**Intervention #5a tracking measure (1):** **Numerator:** Number of providers educated and are dispensing SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) and have claims / encounters for HCV screening **Denominator:** Number of providers educated on HCV screening and linkage to treatment **Intervention #5a tracking measure (2):** **Numerator:** Number of providers educated and have claims / encounters for HCV screening **Denominator:** Number of providers educated on HCV screening and linkage to treatment	N: NA D: NA R: NA N: NA D: NA R: NA	N: NA D: NA R: NA N: NA D: NA R: NA	N: NA D: NA R: NA N: NA D: NA R: NA	N: NA D: NA R: NA N: NA D: NA R: NA
Intervention #5b to address barrier: Inform PCPs of their patients who are at risk/ eligible for screening by distributing to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening (HCV Screening) **Planned Start Date: 4/15/2020** **Actual Start Date:**	**Intervention #5b tracking measure:** **Numerator:** Number of members on PCP lists with claims/encounter data for HCV screening **Denominator:** Number of members on PCP lists at risk for HCV per enrollment data	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA
Intervention #5c to address barrier: Inform PCPs of their patients who are at risk/eligible for linkage to treatment by distributing to each PCP their listing of eligible and at-risk members with instructions to contact patients to schedule an appointment for HCV Treatment Initiation (Linkage to Treatment) **Planned Start Date: 4/15/2020** **Actual Start Date:**	**Intervention #5c tracking measure:** **Numerator:** Number of members on PCP lists with claims/encounter data for treatment (DAA dispensed) **Denominator:** Number of members on PCP lists with confirmed or probable HCV per OPH listing	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA	N: NA D: NA R: NA

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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: 1/1/2019-6/30/2019	**Updated Baseline (if needed to update with complete claims data)** Measure period: 1/1/2019-12/31/2019	**Final Period-TD** Measure period:1/1/2020-12/15/2020	**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: 11063 D: 81700 R: 14%	N: 10849 D: 69005 R: 16%	N: 14238 D: 79661 R: 18%	Rate: 26%
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: 3818 D: 24212 R: 16%	N: 3779 D: 21125 R: 18%	N: 4507 D: 22531 R: 20%	Rate: 28%

Indicator	**Baseline Period** Measure period: 1/1/2019-6/30/2019	**Updated Baseline (if needed to update with complete claims data)** Measure period: 1/1/2019-12/31/2019	**Final Period-TD** Measure period:1/1/2020-12/15/2020	**Target Rate[1]**
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: 3383 D: 11709 R: 29%	N: 3401 D: 10178 R: 33%	N: 4469 D: 11834 R: 38%	Rate: 43%
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: 1117 D: 11709 R: 10%	N: 1720 D: 10178 R: 17%	N: 1926 D: 11834 R: 16%	Rate:27%
Performance Indicator #3a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed or probable***	N: 139 D: 2316 R: 6%	N: 364 D: 2283 R: 16%	N: 780 D: 2835 R: 28%	Rate: 26%

Indicator	**Baseline Period** Measure period: 1/1/2019-6/30/2019	**Updated Baseline (if needed to update with complete claims data)** Measure period: 1/1/2019-12/31/2019	**Final Period-TD** Measure period:1/1/2020-12/15/2020	**Target Rate[1]**
diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.				
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}.***	N: 51 D: 1221 R: 4%	N:179 D: 1313 R: 14%	N: 446 D: 1717 R: 26%	Rate: 24%
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: 2 D: 109 R: 2%	N: 9 D: 121 R: 7%	N: 56 D: 133 R: 42%	Rate: 17%

[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.

Please note this section was in the original PIP submission and was not deleted for the final. Final Performance Indicators are in the Results Section.

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

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 #1:
For baseline measure period January to June 2019, there are 24,212 enrollees for whom HCV screening is indicated by birth year between 1945 and 1965. Of the 24,212 enrollees, 3,818 enrollees were screened for HCV. The rate is 16%. For baseline measure period January to December 2019, there 21,125 enrollees for whom HCV screening is indicated by birth year between 1945 and 1965. Of the 24,125 enrollees, 3,779 enrollees were screened for HCV, and the rate is 18%.

Performance Indicator #2:
For baseline measure period January to June 2019, there are 9,887 enrollees for whom HCV screening is indicated by risk factors, excluding those born between 1945 and 1965. Of these enrollees, 3,070 enrollees were screened for HCV. The rate is 31%. For baseline measure period January to December 2019, there were 9,373 enrollees for whom HCV screening is indicated by risk factors and were not born between 1945 and 1965. Of these enrollees, 3,237 enrollees were screened for HCV. The rate is 35%.

Performance Indicator #3a:
For baseline measure period January to June 2019, there are 2,316 enrollees 18 and older with a confirmed or probable diagnosis of chronic hepatitis C. Of these enrollees, 139 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 6%. For baseline measure period January to December 2019, there were 2,283 enrollees 18 and older with a confirmed or probable diagnosis of chronic hepatitis C. Of these enrollees, 364 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 16%.

Performance Indicator #3b:
For baseline measure period January to June 2019, there are 1,221 enrollees with current or past drug use and with a confirmed or probable HCV diagnosis. Of these enrollees, 51 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 4%. For baseline measure period January to December 2019, there are1,313 enrollees with current or past drug use and with a confirmed or probable HCV diagnosis. Of these enrollees, 179 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 14%.

Performance Indicator #3c:
For baseline measure period January to June 2019, there are 109 enrollees ever diagnosed with a confirmed or probable diagnosis of chronic hepatitis C. Of these enrollees, 2 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 2%. For baseline measure period January to December 2019, there are 121 enrollees ever diagnosed with a confirmed or probable diagnosis of chronic hepatitis C. Of these enrollees, 9 enrollees had a pharmaceutical treatment for HCV initiated. The rate is 7%. All baseline rates have a target rate of increase of 10 percentage points as described in the goals and scope of the chronic hepatitis C health plan performance improvement project. All target rates will be adjusted quarterly based on improvements.

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.

  From the first baseline of 6 months in 2019 through 2020 performance to date, our areas that fell below the goal were consistently in the screening area. There is a layer of COVID that contributed but even though we didn't meet or exceed the goals set we did quarter over quarter improve slightly so even with challenges of personal interaction needed for testing we were able to see improvement. The areas we did well and exceeded goals were in 'Treatment'. This shows if we can get more people screened with medical supervision, we should be able to get more into treatment as well. The area of opportunity for us was communication to both Providers and Members outside of the outreach efforts. Individual Performance Indicator summaries are below:

  Performance Indicator #1: Both indicators, a & b, showed improvement from the baseline to the Final Period TD Measure. This increase, although small, showed improvement during a pandemic where for months Providers were not doing face/face appointments. Screening via bloodwork was not as widely done as other months due to the restrictions set by the State. The improved numbers for all members was not as significant as those within a specific birth year (Baby Boomers). All members showed a less than 2% increase while Birth Year screening did increase by 2%. This shows that for the time we were able to focus on outreach for screening, it did have a positive impact. The national and state campaigns by different sources also helps to educate all members about screening, especially Baby Boomers. We will look to continue and build off this positive trend with increased communication to providers to test all members over the age of 18 as well as including screening in Community Outreach events which are open to ALL state citizens.

  Performance Indicator #2: Both indicators, a & b, showed improvement although the population outside of Baby Boomers (2a) showed the most significant increase of over 1,000 members. This can be attributed to our enhanced HCV model that incorporates the 5 risk factors as well as member history of previous diagnosis taking in prescription history as well. With the addition of Member Services outreaching to these individuals for testing, ABH-LA expects this number to rise in 2021 now that safe practices for providers and members has been established and regular screening can resume. The non-Baby Boomer population are the ones to benefit the most a key message in 2021 to providers to test all members 18 and over as regular practice.

  Performance Indicator #3a: This metric was one of the success stories for this PIP which actually improved over the Target Rate by almost 2 percentage points. Although we are showing a rate of prescription filling to be over 97% for the whole year for those who get a prescription, getting the those tested on the OPH list into treatment has been a challenge and the barriers follow those in the article IPRO sent out. Substance abuse has been identified as the number one single contributor to HCV among ABH-LA members, so we have incorporated this PIP with our IET in order to drive better screening and treatment. We are hoping to add provider recommendations to our messaging such as, SUD providers screen and begin treatment for members they council.

  Performance Indicator #3b: This metric also saw actual performance exceed the Target Rate by almost 2 percentage points which continues to be part of the Care Management outreach effort. The increase in members entering treatment can also be contributed to the QNXT flag which allows any ABH-LA communication with the member to see and follow protocol for flags. This allows any CM to discuss and set

up the next steps for any member noted with this care gap even if they don't opt into CM. As noted in 3a, SUD and HCV are both a focus of CM so we expect these factors to continue bringing members into focus who need additional services.

Performance Indicator #3c: This metric was vastly improved from the baseline, from 7% to 42% at the end of the first year. Although this population is small, the numerator grew by 6 times. The additional medical condition/diagnosis of HIV is touch point for CM and now with the QNXT flag we can see those that require additional support for both short term treatment and long term as appropriate for each virus.

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

  As noted in the ITM's, screening was our low performing metric which had to do with education activities to both Providers and Members. Our campaigns came together in the second half of the year. Going forward, making regular outbound communications to Providers on screening all members over 18 on a regular basis should help build that portion while Text campaigns and Community Outreaches will help educate members.

- **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.

  Prior to COVID-19, we were accustomed to relating with our providers on a more face to face interaction and interactive connection with our members. In response to the current situation, we had to develop ways to integrate other methods of delivery. The Pandemic gave us the opportunity to use alternate methods which will stay in place through 2021 so the screening population should increase quarter over quarter as we try and find every avenue possible to get the member pool tested/treated.

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.

  There were no factors that posed a threat to internal data validity.

- **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).

  There are no known external threats to the validity of findings.

- **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.

  There were challenges in collecting some of the specific metrics based on definitions, primarily in the ITM section. The barriers highlighted at beginning of the PIP became even more evident with the Pandemic and Hurricanes, but we continued to review internal processes and make the necessary changes to make sure members were always first and barriers are diminishing.

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
1a (1 & 2)Enhanced Case Management Outreach for HCV Treatment Initiation: Utilize OPH listing of members with confirmed or probable HCV to conduct outreach for referral for HCV pharmaceutical treatment and appointment scheduling with (a) an HCV provider in the OPH database (PIP-prioritized provider) or (b) the member's PCP (if the member prefers)	Relying on one method of outreach was a weak point as hurricane season proved. With CM having to do outreach before and after each storm, the OPH list of confirmed members began to really grow and making an effective impact began to be a major focus.	Turning the QNXT flag on helped a lot since even CM outreach for hurricanes allowed conversations to occur around next steps once the members status was made available at the end of September. We see this tool enhancement allowing proactive outreach in transactional settings by both MS and CM.	We will continue to use MS and CM for active HCV outreach into 2021.
#1b) Enhanced Case Management Outreach for HCV Screening: Utilize MCO claims/encounter data to identify members for HCV screening and schedule a screening appointment with the member's PCP	The OPH status list was only a small portion of our member list that was determined to be at risk as outlined by the PIP, so we enhanced our model to include others as noted by all member information available.	This enhanced model allows us to identify those who have never been tested but have a probability for HCV risk, especially incorporating SUD diagnosis claims.	Continue to monitor our member population and make sure they are incorporated into our outreach and education efforts.
4a) Develop Educational Mailer Campaign to All Enrollees who are at risk, 18 and above with the following: At Risk Information, Symptoms, HCV Screening and Treatment Education, Pharmacy Benefits, Referral and Appointment Scheduling Support	The mailer was finalized to be more of a tri-fold educational item which could be mailed.	The tri-fold brochure is now used as educational items for Community Outreach events or as collateral left behind at locations.	Use our digital delivery systems for educational purposes instead of physical items. Multiple campaigns to members on getting tested will be done throughout the year.
4b) Enhanced Community Outreach to Community and Faith Based Organizations that specifically serve community members to link and promote HCV Awareness and Education; to promote HCV Screenings	This endeavor was primarily focused on Flyers that would be used at Community events and left behind where appropriate to help with education.	The Flyer was finalized and ready for distribution in October.	Make sure this form of education is an effective piece of the whole education plan for HCV in 2021.

at community events (potentially in disproportionately impacted geographic areas/subset populations)			
5a) Educate Providers on Evidence-based Screening, Treatment, and Pharmacy Benefits for HCV through Provider Relations and/or Medical Director Face to Face Visits (Linkage to Treatment and HCV Screening)	This endeavor was primarily focused on face/face interaction and training and came to a grinding halt with COVID	COVID restrictions by LDH and CVS/Aetna did not allow face/face meetings after the states initial shut down in March through the end of the Year.	Aligning with Providers Relations on using virtual means like fax blasts, newsletters, and emails should help drive this initiative even after face/face is allowed.
5b) Inform PCPs of their patients who are at risk/ eligible for screening by distributing to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening (HCV Screening)	There were two methods outlined for this delivery, one was hand delivery due to patient information and the other was secure Provider Portal both of which had problems in 2020.	The PIP did not launch in earnest for efforts until February and COVID hit a month later so hand delivery was out, can't mail it, and our secure provider portal was not done until September.	We have the secure portal for providers now up so we can deliver via that method. The Provider Relations team will be putting together a complete delivery plan for 2021 to help make sure these lists get distributed on a regular basis.
5c) Inform PCPs of their patients who are at risk/eligible for linkage to treatment by distributing to each PCP their listing of eligible and at-risk members with instructions to contact patients to schedule an appointment for HCV Treatment Initiation (Linkage to Treatment)	There were two methods outlined for this delivery, one was hand delivery due to patient information and the other was secure Provider Portal both of which had problems in 2020.	The PIP launched in February and COVID hit a month later, and for several months MCO's could not contact providers. This left only a few months for virtual contact	We have the secure portal for providers now up so we can deliver via that method. The Provider Relations team will be putting together a complete delivery plan for 2021 to help make sure these lists get distributed on a regular basis.

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Internal PIP Hep C Committee Meeting 01/27/2020
Internal PIP Hep C Committee Meeting 01/30/2020
IPRO Hep C Guidance Documents

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.)
	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

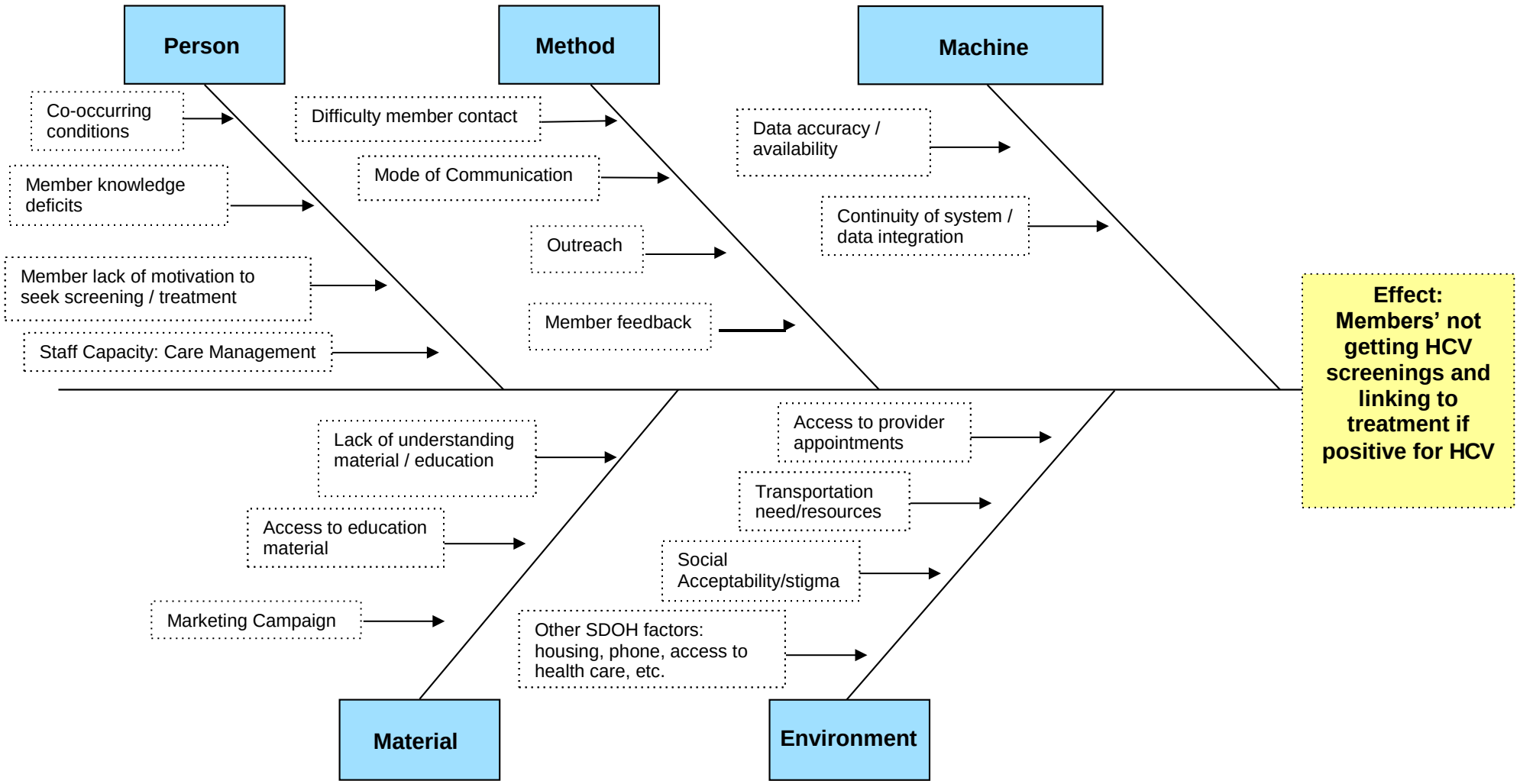
Table 7: PIP Terms

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 • 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.

PIP Term	Also Known as…	Purpose	Definition
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.
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 A: Member Cause and Effect ("Fishbone") Diagram



Appendix A:

Member Challenges/Opportunities for Improvement

For the member, there are significant causative factors for their reluctance to receive services for HCV screening and/or treatment. They are:

Person:

- Members lack of motivation to seek treatment
    - A members' negative experience with a prior treatment center, and/or with self-treatment
    - Stigmas associated with Hep C may prevent an individual from seeking treatment
    - Members' may have assumption that treatment is painful
    - Members' belief that treatment will be denied
    - Members' lack of awareness of risk and/or asymptomatic
    - Injection drug users or person's alcohol dependent may prevent member taking appropriate action to address Hep C
    - Cognitive changes, clear thinking may be a challenge for members with AUD/SUD
- Co-occurring conditions, HIV
- Cultural, race, ethnic variances and social determinants to care (i.e. incarceration)
- Member knowledge deficit of available treatment options; No prior authorization and access to generic Epclusa for treatment

Method:

- Due to the transient population, member contact information such as telephone numbers and addresses may not be up to date
- Identifying the appropriate mode of communication to properly reach our members
- The various outreach tools that are available to the plan; mailers, phone calls, text messaging, outreach events, etc.
- Using CM outreach/discussions to understand member engagement issues and feedback

Machine

- Ensuring that the data for metrics is available and accurate for reporting
- Communication barriers between internal systems

Material:

- Member knowledge deficit of disease processes, treatment types, and available resources
- Difficulty accessing educational material and/or understanding of available material
- Marketing campaigns and collaboration to ensure cohesiveness of member information

Environment:

- Lack of transportation to and from appointments
- Social acceptability of Hep C, and member use of family and/or availability of support system
- Provider appointments; limited availability of times members can access provider based on work schedule
- SDOH factors contributing to members having limited access to care

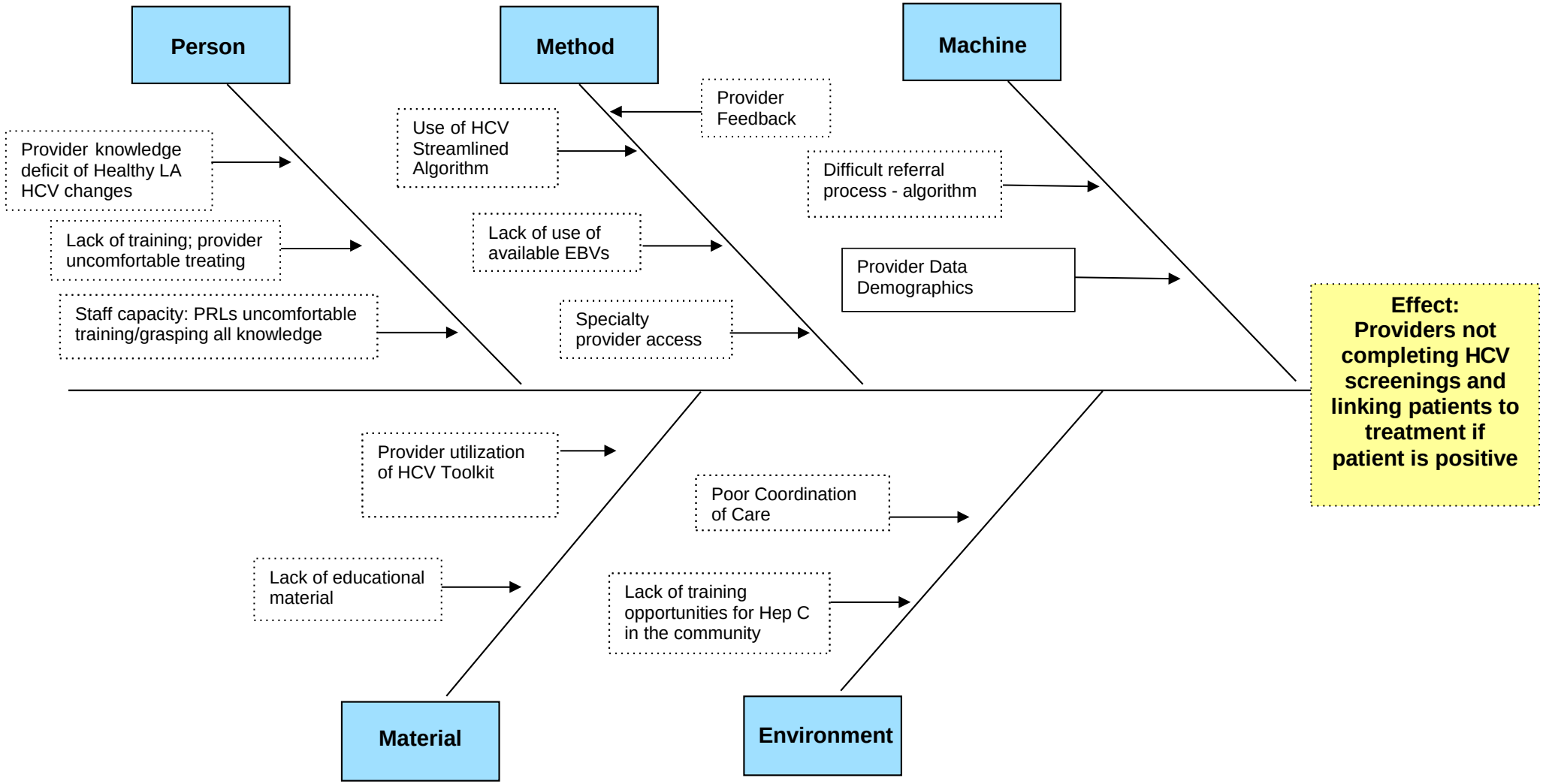
Opportunities for Improvement:

- By analyzing the causative factors, ABHLA can implement actions to improve our members' participation in HCV screening and linkage to treatment. This can be completed by:

- Increasing at risk members' participation in screening and treatment by addressing the reasons for lack of participation in screening and/or for not adhering to prescribed treatment.
- Improved member utilization of health plan resources and services available to them, including member services, case management, and provision of resource materials in clear, easy to read language
- Ease of access to member HCV educational material in an easy to understand language; improve member awareness and risks of HCV
- Member education regarding transportation services available and how to schedule transportation
- Enhanced member outreach through care management for screening and treatment linkage; mitigation of barriers and SDOH factors for members
- Member feedback through CM discussions/outreach; Member Advisory Council
- Addressing the member's support system by case management and the provider in the care planning process when appropriate and permitted by the member; especially those that may have SUD, AUD, HIV, or other co-occurring conditions or physical and/or behavioral health challenges
- Improve member usage of PCPs and OPH providers for access to Hep C screening and linkage to treatment, especially for at-risk population and/or asymptomatic
- Increased awareness and education through community outreach
- Ensuring appropriate CM process and capacity

Appendix A: Fishbone (Cause and Effect) Diagram

Appendix A: Provider Cause and Effect ("Fishbone") Diagram



Appendix A:

Provider Challenges/Opportunities for Improvement

The provider faces other challenges in meeting the needs of their patient(s). The significant causative factors facing them include:

Person:

- PCPs knowledge deficit of changes to HCV screening and treatment restrictions that provide greater access for HCV treatment available to the member
- Lack of primary care providers trained to provide evidence-based HCV screening/treatment
- Lack of providers trained on streamlined algorithm for HCV screenings and treatment
- Provider is uncomfortable with HCV screening and treatment
- Provider lack of willingness to treat if person has AUD/SUD challenges, fear member adherence to treatment and re-infection
- Lack of provider awareness of at-risk populations need for screening
- PRLs comfort level of explaining and providing provider HCV education toolkit

Method:

- Lack of use of streamlined treatment algorithm screening tools by PCPs
- PCPs lack of understanding of reasons for patient resistance and ambivalence to screening and treatment
- Lack of promotion of benefits and changes to HCV screening and treatment procedures
- Limited access to specialty providers
- Using tools to properly gauge provider engagement and feedback

Machine:

- Difficult processes for ease of referral of members to treatment
- Working with our internal IT teams to ensure data demographic information is updated appropriately in all systems

Material:

- Development of and appropriate education for use of provider toolkit for HCV
- Lack of educational material for PCPs; billing guidelines for HCV screening and treatment

Environment:

- Lack of coordination of care between the primary care physician, care management and specialty providers
- Working with PRLs to provide more outreach events and education for providers

Opportunities for Improvement:

By analyzing the causative factors, ABHLA can implement actions to improve availability of services and quality of services provided to our members. This can be done by:

- Training PCPs and providers on the streamlined algorithm for HCV
- Informing PCPs of their patient list for linkage to screening and treatment
- Provider educational handouts developed on HCV algorithm and billing guidelines
- Training provider relations team
- Provider feedback through face to face visits and peer to peer conversations
- Track and trending HCV screening and treatment
- Track and trending prescribing providers and practices for DAAs

Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• Provider awareness of HCV Healthy Louisiana process changes • Provider training and outreach to address knowledge deficits • Provider knowledge of at-risk patients and confirmed / probable patients that are assigned to them • Member knowledge and education for at-risk and need for HCV screening • Member linkage to treatment for positive screenings • Member outreach for HCV screening and linkage to treatment • Staff appropriation - other staff focus / priorities within the team • Staff not clear of their role in in linkage to screening and treatment for members • Access to appropriate/inconsistent data • Increase staff capacity	• Partnership with external entities such as community-based organizations & affect community/population
Less Feasible to Address	• Member adherence to treatment • Provider collaboration and coordination • Member and provider feedback / guidance • Member may not want to share their status with others; disclose to the case manager • Limited appointment times with providers	• Member may feel stigma related to screening

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** • Multidisciplinary team to work on PIP (Highly-skilled clinical CM staff, PRLs, Analysts, Community Outreach etc.) • National Hep C Care Management Program • National Aetna GI Provider tasked for PIP support and guidance • Consistent, timely & scheduled workgroup activities; intervention tracking and documentation of activities • CM staff have commitment to improving members' health • History of successful care management cases • Ability to refer to providers and PCPs (referral resources) • Availability of data indicators via claims • Dedicated data analyst for reporting	***minimize*** **WEAKNESSES** • Staff appropriation - other staff focus / priorities within the team • Staff not clear of their role in in linkage to screening and treatment for members • Access to appropriate/inconsistent data
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** • Partnership with external entities such as community-based organizations & affect community/population • Provider collaboration and coordination • Members who are active in case management • Member and provider feedback / guidance • Increase staff capacity	***protect from*** **THREATS** • Low provider/member engagement • Member lack of awareness and education • Member may not want to share their status with others; disclose to the case manager • Member may feel stigma related to screening • Transient / unstable members (housing, up-to-date contact information) • Members with SUD, AUD, Mental, Behavioral Health issues • PCPs/providers unaware / uncomfortable with screening and treating • Limited appointment times with providers • Stigma from providers - Hep C

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 counsel 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 (use power point template)

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1: Enhanced Case Management Outreach for HCV Treatment Initiation			
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: Enhanced Case Management Outreach for HCV Screening			
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 #3: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription			
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 #4:			
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 #5:			

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 #6:			
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 #7:			
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 #8:			
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.	•	•	•