Health Plan Performance Improvement Project (PIP)

MCO Name: Amerihealth Caritas

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	2/30/2020	6/23/2020	12/10/2020
Version 2	3/11/2020		12/31/2020

MCO Contact Information

1. Principal MCO Contact Person

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

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3. External Collaborators (if applicable):

Attestation

Plan Name: AmeriHealth Caritas 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: Rodney Wise, MD
First and Last Name: Rodney Wise, MD
Date: 12/30/2020

CEO signature: _____
First and Last Name: Kyle Viator
Date: 12/30/2020

Mary S Scorsone

Quality Director Signature: _____
First and Last Name: Mary Scorsone
Date: 12/30/2020

IS Director Signature (if applicable): _____
First and Last Name: Trampas Cranford
Date: 12/30/2020

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	June 2020	☒ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	Under the guidance of USPSTF, AASLD, CDC, and LDH, the scope of the PIP changed from Increasing the Screening rates of the 1945-1965 cohort to include all Healthy Louisiana members aged 18-79 years old.
Change 2	June 2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	ITM #1 – CM Outreach focused on utilizing the OPH listing of members with confirmed or probable HCV who are not receiving treatment
Change 3	July 2020	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Provider Education Update – LDH Hepatitis C Screening and Treatment Initiative, New CDC Guidelines, and Epclusa Treatment Option
Change 4	July 2020	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Enhanced Member Outreach – ACLA Newsletter to at-risk members, as well as a monthly texting campaign providing members with Screening and/or Treatment Information
Change 5	September 2020	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Enhanced Provider Outreach – Establish provider awareness of at-risk members associated with Provider Groups; QM virtual provider visits

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 Hepatitis C Virus (HCV) Performance Improvement Project (PIP) aimed to improve the Healthy Louisiana Screening Rate and Initiation of HCV pharmaceutical treatment rate by ten percentage points. In order to do this, AmeriHealth Caritas Louisiana (ACLA) implemented a robust set of interventions to address two key intervention objectives:

1. **Member Intervention Objective** – outreach and educate eligible members, and facilitate referrals to / schedule appointments with PCPs for screening or HCV providers for treatment with tailored interventions.

2. **Provider Intervention Objective** – educate providers on evidence-based recommendations and availability of HCV providers and coordinate referrals for screening and treatment.

AmeriHealth Caritas Louisiana's baseline data was calculated using designated numerators and denominators from the previous year 2019. Over the course of the year 2020, several internal departments worked together to improve our baseline 2019 screening and treatment rates. The target goal outlined by the PIP instructions was to achieve a ten percentage point increase in the seven performance indicators provided. However, ACLA achieved a large increase in performance indicator rates initially, so as a plan, we decided to increase our goal from a ten percentage point increase to a fifteen percentage point increase.

In order to achieve these robust increases, our Quality, Care Management, Medical Informatics, and Provider Network Management Departments collaborated to initiate several member and provider-focused interventions to increase our Hepatitis C Virus Screening and Treatment rates. Direct outreach was performed to members on the OPH Confirmed / Probable HCV List through Care Management and Provider / Provider Groups through Zoom-Initiated Provider Visits with Quality and Provider Network Management. Further member outreach was achieved via member newsletter mailing and texting campaigns, and provider outreach via provider updates and clinical practice guidelines updates on the ACLA website.

Six of the seven performance indicators saw an increase from the baseline percentages. Two performance indicators exceeded the lofty fifteen percentage point increase, and four of the performance indicators ended within five percentage points of the LDH goal of the ten percentage point increase. We did not achieve the ten percentage point increase across all seven performance indicators, but we believe the 2020 PIP results to be a success.

Considering the extraordinary issues faced in 2020, e.g. COVID-19 Pandemic and various severe weather episodes, we were able to make significant advances in our Hepatitis C Virus outreach, member screening rates, and Epclusa treatment initiation. We look forward to having a full year in 2021 to build on several of our interventions, as well as including more departments within AmeriHealth Caritas Louisiana to implement more interventions geared towards increasing the HCV screening and treatment rates of our members.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

Describe how PIP Topic addresses your member needs and why it is important to your members:

The Hepatitis C Virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). The prevalence of the anti-HCV antibody in the United States is approximately 1.6% in noninstitutionalized persons. According to data from 1999 to 2008, about three fourths of patients in the United States living with HCV infection were born between 1945 and 1965, with a peak prevalence of 4.3% in persons aged 40 to 49 from 1999 to 2002 (USPSTF, 2013). 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 (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).

- **Describe high-volume or high-risk conditions addressed:**

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 clinical consequences. Therefore, the United States Preventative Services Task Force (USPSTF) recommends one-time Hepatitis C screening for all adults in this birth cohort (USPSTF, 2013). The USPSTF also recommends HCV screening for persons at high risk of chronic Hepatitis C infection (USPSTF, 2013):

- With Past or Current Injection Drug Use
- Persons Who Were Ever on Long-Term Hemodialysis
- Persons with a History of Incarceration
- Persons with HIV (AASLD/IDSA, 2018)

Persons born between 1945 and 1965 are more likely to be diagnosed with HCV infection, possibly because they received blood transfusions before the introduction of screening in 1992 or have a history of other risk for exposure decades earlier (USPSTF, 2013). A risk-based approach may miss detection of a substantial proportion of HCV-infected persons in the birth cohort because of a lack of patient disclosure or knowledge about prior risk status (USPSTF, 2013).

The most important risk factor for HCV infection is past or current injection drug use, with most studies reporting a prevalence of 50% or more (USPSTF, 2013). In 1998, the highest prevalence rates of the anti-HCV antibody occurred in person with significant direct percutaneous exposure, such as injection drug users and persons with hemophilia (60% to 90%); persons with less significant percutaneous exposures involving smaller amounts of blood, such as patients receiving hemodialysis (10 to 30%), had more moderate prevalence rates (USPSTF, 2013).

Describe current research support for topic (e.g., clinical guidelines/standards):

In February 2020, the American Association for the Study of Liver Diseases – Infectious Diseases Society of America (AASLD-IDSA) chance its recommendations regarding Hepatitis C Virus Screening. These recommendations were updated to include recommended universal HCV screening for all adults aged 18 years or older followed by periodic testing for persons with ongoing risk behaviors and/or exposures (AASLD-IDSA, 2020). Independent studies using different modeling techniques demonstrated that one-time universal screening for adults 18 years or older is more cost-effecting when compared to the birth-cohort screening (AASLD-IDSA, 2020). Along with this change, AASLD-IDSA still

recommends risk-based HCV testing for members 18 years old with behaviors, exposures, or conditions or circumstances associated with an increased risk of HCV infection (AASLD-IDSA, 2020). Also periodic repeat HCV testing for persons with behavior, exposures, or conditions associated with an increased risk of HCV exposure, and annual HCV testing for all persons who inject drugs and for men with HIV infection who have unprotected sex with men (AASLD-IDSA, 2020).

Explain why there is opportunity for MCO improvement in this area (must include baseline and if available, statewide average/benchmarks):

As of summer 2019, Healthy Louisiana enrollees, specifically our AmeriHealth Caritas Louisiana (ACLA) members, have access to safe and effective treatment for Hepatitis C. According to the baseline data for ACLA as of 12/31/2019, roughly 14,000 members fall within the 1945 – 1965 birth cohort. Through June 2019, only 629 of the 14,000 had been screened, and as of December 2019, roughly 1,200 ACLA members had been screened for the Hepatitis C Virus. Given the aim of this Performance Improvement Project (PIP) to improve the Healthy Louisiana HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points from baseline to final re-measurement, there is immense potential for ACLA to improve in our HCV screening numbers when comparing the low number of members screened versus the high number of members who have not been screened.

For ACLA's members who are not within the 1945 to 1965 birth cohort but are at high risk for chronic Hepatitis C virus, e.g. persons with past or current drug use, persons ever on long-term hemodialysis, persons who were ever incarcerated, and persons ever diagnosed with HIV, the opportunity for improved screening rates is attainable. Our reports indicate a screening base of just over 10,000 members for whom HCV screening is indicated by any one or more of the aforementioned risk factors within the measurement year of 2019. Through June of 2019, roughly 600 members did receive a HCV screening, and a totality of nearly 1,200 for the entire year.

Given these raw numbers mentioned above, ACLA members for whom HCV screening is indicated is roughly 25,000. Any improvements in our current screening rates will be beneficial for our at-risk members. Furthermore, with the current availability of pharmaceutical interventions provided by LDH, our Hepatitis C positive members have access to medication that was once not readily accessible. 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)

Aims, Objectives and Goals

Aim

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

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

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

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): *The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.*	**N:** 14,224 **D:** 91,922 **R:** 15.47%	**R:** 30.47%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible
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:** 1,190 **D:** 13,956 **R:** 8.53%	**R:** 23.43%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible
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:** 1,137 **D:** 10,348 **R:** 10.99%	**R:** 25.99%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	**N:** 1,215 **D:** 11,717 **R:** 10.37%	**R:** 25.37%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	Target Rate[2]	Rationale for Target Rate[3]
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}.*	**N:** 495 **D:** 3,558 **R:** 13.91%	**R:** 28.91	**15 Percentage Points** For Maximum Proportion of Members That is Feasible
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:** 256 **D:** 1,981 **R:** 12.92%	**R:** 27.92%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible
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:** 39 **D:** 226 **R:** 17.26%	**R:** 32.26%	**15 Percentage Points** For Maximum Proportion of Members That is Feasible

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

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

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

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

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

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

Data Collection and Analysis Procedures

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

The entire eligible population was targeted by PIP interventions. Care Management Outreach targeted members on the OPH Confirmed / Probable HCV List. Member newsletters / mailing options were distributed to members within the original at-risk 1945 – 1965 birthing cohort. Lastly, the third quarter interventions included the initiation of a texting campaign for the larger 18 – 79 age cohort.

Sampling Procedures

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

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

Data Collection

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

- **Describe data collection:**
    - AmeriHealth Caritas Louisiana's Medical Economics (Informatics) Department will collect data from claims / encounter files of all eligible members. Data sources may include: claims / encounter data (administrative data). Administrative data will be collected based on need, quarterly, and annually. For Intervention Tracking Measures (ITM), data will be collected monthly utilizing claims / encounter data, clinical documentation software, and departmental tracking tools.

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:**
    - Administrative data is collected by the Medical Informatics team. The process for verifying ITM data validity and reliability is conducted by quality associates within each department. Through the PDSA cycle, analysis will be conducted to determine process improvements, strengths and opportunities.

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:**

    - Analysis will address the comparability of baseline and re-measurement data, including factors that impact validity. Results with present numerical data that is accurate, clear, and easily understood. Interpretation will involve looking at all possible explanations for results and factors that may have affected them. Historical circumstances will be considered. Visual displays of data will facilitate analysis and communicate results.

- **Describe how plan will interpret improvement relative to goal:**
    - Data analysis will guide how well interventions are influencing performance indicator rates and outcomes. This data will be assessed against established goals and will drive decisions on effectiveness of change.

- **Describe how plan will monitor ITMs for ongoing QI:**
    - ITMs will be validated and monitored weekly and monthly as appropriate through trending, PDSA cycles, run charts, and other QI tools to analyze impact and effectiveness. The process for verifying ITM data validity and reliability will be conducted by quality associates with each department.

(Tentative) PIP Timeline

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

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

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

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

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

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

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: New Healthy Louisiana HCV Treatment Benefit May be Unknown to Enrollee. **Method of Barrier Identification: IPRO HCV PIP Guidance Document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation Planned Start Date: February 2020 Actual Start Date: February 2020	Intervention #1a tracking measure : N: # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation D: # members with confirmed or probable HCV per OPH listing not receiving treatment	N: 28 D: 2,859 R: 0.98%	N: 9 D: 2,690 R: 0.33%	N: 56 D: 2,588 R: 2.16%	N: 6 D: 2,451 R: 0.24%
Intervention #1b to Address Barrier: Enhanced Case Management Outreach for HCV Screening / Treatment Initiation Planned Start Date: February 2020 Actual Start Date: February 2020	Intervention #1b Tracking Measure: N: # Members with Appointment Scheduled with HCV Specialist or PCP for HCV Screening / Treatment D: # Members from OPH List with Successful Contact by CM Outreach	N: 28 D: 78 R: 35.9%	N: 9 D: 19 R: 47.37%	N: 56 D: 303 R: 18.48	N: 6 D: 85 R: 7.06%
Barrier 2: Asymptomatic Enrollees May Not Know They are Infected with HCV. **Method of Barrier Identification: IPRO HCV PIP Guidance Document.**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Enhanced Case Management Outreach for HCV Screening Planned Start Date: July 2020 Actual Start Date: July 2020	Intervention #2a Tracking Measure: N: # members with appointment scheduled with PCP for HCV screening D: # members at risk for HCV per MCO claims/encounter data	N: N/A D: N/A R: N/A	N: N/A D: N/A R: N/A	N: 13 D: 94,483 R: 0.014%	N: 22 D: 95,637 R: 0.023%

Barrier 3: Providers May Not be Aware That Epclusa Does Not Require Prior Authorization. **Method of Barrier Identification: CM Outreach Feedback / Analysis**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #3a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. Planned Start Date: January 2020 Actual Start Date: January 2020	Intervention #3a Tracking Measure: N: # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed D: # members with any DAA dispensed	N: 501 D: 508 R: 98.62%	N: 344 D: 354 R: 97.18%	N: 340 D: 358 R: 94.97%	N: 188 D: 195 R: 96.41%
Intervention #3b to Address Barrier DAA Treatment Initiation of OPH Confirmed / Probable Members Planned Start Date: February 2020 Actual Start Date: February 2020	N: # Members who Received First DAA Treatment Medication in 2020 D: # Members with Confirmed / Probable HCV on OPH List Not Receiving Treatment	N: 141 D: 2,859 R: 4.93%	N: 93 D: 2,690 R: 3.46%	N: 81 D: 2,588 R: 3.13%	N: N/A D: R:
Barrier 4: Member Unawae of Hepatitis C Virus Screening / Treatment Initiative **Method of barrier identification: QM / CM Outreach Feedback / Analysis**		**2020**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #4a to address barrier: Enhanced Member Outreach to Increase Awareness of HCV Screening / Treatment Initiative via Mailed Member Newsletter Planned Start Date: July 2020 Actual Start Date: September 2020	Intervention #4a tracking measure: N: # of ACLA Members who were screened for Hepatitis C after Newsletter Mailed Date D: # of Members Mailed Newsletter with Hepatitis C Virus Screening / Treatment Education	N: N/A D: R:	N: N/A D: R:	N: N/A D: R:	N: 175 D: 10,894 R: 1.61%
Intervention #4b to address barrier: Enhanced Member Outreach to Increase Awareness of HCV Screening / Treatment Initiative via Texting Campaign Planned Start Date: July 2020 Actual Start Date: September 2020	Intervention #4b tracking measure: N: # of ACLA Members who were screened for Hepatitis C after Texting Campaign Began D: # of Members on the Texting Campaign Distribution List	N: N/A D: R:	N: N/A D: R:	N: N/A D: R:	N: 1,173 D: 75,725 R: 1.55%

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 – 12/31/2019	Interim Period Measure period: 1/1/2020 – 6/30/2020	**Final Period** Measure period: 1/1/2020 – 11/30/2020	**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:** 14,224 **D:** 91,922 **R:** 15.47%	**N:** 16,579 **D:** 91,922 **R:** 18.04%	**N:** 18,182 **D:** 95,637 **R:** 19.01%	**Rate:** 30.47%
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:** 1,190 **D:** 13,956 **R:** 8.53%	**N:** 3,722 **D:** 14,541 **R:** 25.6%	**N:** 3,679 **D:** 14,231 **R:** 25.85%	**Rate:** 23.53%

Indicator	**Baseline Period** Measure period: 1/1/2019 – 12/31/2019	Interim Period Measure period: 1/1/2020 – 6/30/2020	**Final Period** Measure period: 1/1/2020 – 11/30/2020	**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:** 1,137 **D:** 10,348 **R:** 10.99%	**N:** 3,507 **D:** 11,717 **R:** 29.93%	**N:** 3,755 **D:** 12,438 **R:** 30.19%	**Rate:** 25.99%
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening-Annual Screening): *The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.*	**N:** 1,215 **D:** 11,717 **R:** 10.37%	**N:** 727 **D:** 11,717 **R:** 6.2%	**N:** 1,271 **D:** 12,438 **R:** 10.22%	**Rate:** 25.37%
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*	**N:** 495 **D:** 3,558 **R:** 13.91%	**N:** 515 **D:** 3,559 **R:** 14.47%	**N:** 686 **D:** 3,793 **R:** 18.09%	**Rate:** 28.91%

Indicator	**Baseline Period** Measure period: 1/1/2019 – 12/31/2019	Interim Period Measure period: 1/1/2020 – 6/30/2020	**Final Period** Measure period: 1/1/2020 – 11/30/2020	**Target Rate**[1]
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:** 256 **D:** 1,981 **R:** 12.92%	**N:** 274 **D:** 2,065 **R:** 13.27%	**N:** 393 **D:** 2,227 **R:** 17.65%	**Rate:** 27.92%
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:** 39 **D:** 226 **R:** 17.26%	**N:** 44 **D:** 231 **R:** 19.05%	**N:** 56 **D:** 212 **R:** 26.42%	**Rate:** 32.26%

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

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

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

Discussion

To Be Completed Upon Interim / Final Report Submission –

The discussion section is for explanation and interpretation of the results.

Discussion of Results

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

    - As outlined earlier, 6 of the 7 performance indicators improved from baseline to the final measurement period. 2 performance indicators exceeded ACLA's 15 percentage point increase, and 4 of the 7 performance indicators were within five percentage points of LDH's suggested 10 percentage point increase.

    - Of importance, AmeriHealth chose to calculate cumulative numerator and denominators for Table 5, but NOT for Table 4 / Quarterly ITM Tracking results. We believe these non-cumulative results represent the true performance of our interventions, and the results are not skewed by increased rates that we would see with cumulative numerators and denominators. These quarterly results also show the impact of the various barriers we faced throughout the year. At least one aspect of either Quarter Two's numerators, denominators, or rates saw drastic decrease due to the COVID-19 Pause. Quarter Four's numbers appear to be significantly lower than Quarter Three, but we attribute this to incomplete data not encompassing the entire fourth quarter.

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

    - Ultimately, the performance indicators that improved the most during the PIP were the original performance indicators, the 1945 – 1965 birthing cohort and the High Risk-Factors population. We cannot conclude with certainty the reason why these two performance indicators exceeded the LDH 10 percentage point increase, as well as ACLA's 15 percentage point increase. However, it is evident that the majority of our interventions were focused towards these two groups. CM Outreach from the OPH Confirmed / Probable list included those most at risk, due to either their age or previous behavior. Also our member newsletter mailings were sent to this birthing cohort, and the texting campaign targeting those aged 18-79 ultimately encompassed that same cohort.

- **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.

    - We found direct contact with either members or providers was a factor most associated with success. This is evident in our CM success rate in making screening / treatment appointments when comparing denominator distinctions, e.g. total OPH confirmed / probable list or successful contact with members. When comparing the appointment rate with the OPH list and the successful contact amount, we saw tremendous rate increases when actual contact was made with our members. Similarly though, we also found our greatest failure to be the results of the CM Outreach simply for reasons such as the large amount of members who were Unable to Contact and unfortunately those that chose to opt-out.

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.

    - AmeriHealth can conclude that there were no factors that posed a threat to the internal validity of the findings. We feel our Medical Economics (Informatics) effectively utilized the PIP Methodology provided by LDH, and the results of each report provided sufficient data for ongoing monitoring and assessment of multiple PIP aspects.

- **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).

    - We feel there were no threats to the external validity of our findings. Overall, the findings we observed for our entire member population, closely coincided with the findings of the subpopulations.

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

    - The retrieval of data was affected by several factors outside the control of AmeriHealth Caritas Louisiana. For instance, our CM Outreach experienced several Unable to Contact members, as well as member opt-outs. Further, the COVID-19 Pandemic impacted our outreach for several months, and the various extreme weather events in Louisiana pulled our focus away from HCV Outreach and prioritized overall member care during these stressful events.

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
CM Outreach – OPH Confirmed / Probable List	Direct Contact is Pivotal	Explore New Ways to Achieve Contact with Members – Community Health Centers; Mobile Screening Options	Collaborate Further Within ACLA and Other MCOs on Direct Contact Interventions
Provider Education – CPG and Provider Newsletter	Direct Contact is Pivotal Education is Available Through Email / Website Only to Those Who Access Them	More Involvement with Provider Network Management on LDH Initiative / Screening / Treatment	Collaborate Further Within ACLA and Other MCOs to Initiate More Active Provider Interventions
Member Outreach – Newsletter and Texting Campaign	Large Scale Interventions Initially Produce Small Results	60-Day Claims Lag Hindered True Results of Effectiveness – Will Assess Monthly in 2021 for True Effectiveness	Collaborate with Medical Informatics for Monthly Production Report on Success of Claims vs. Outreach
Provider Outreach – QM Zoom Provider Visits	Direct Contact is Pivotal	Will Explore Options for Increased Involvement with Provider Network Management to Focus on HCV Initiatives	Collaborate Within ACLA and Other MCOs so Initiate More Active Provider Relations
Provider Outreach – OPH List / Care Gaps Distribution via Provider Portal	Provider Access to Member Health Portal Required due to Sensitive Member Information	Working with Analytics Department to Publish Monthly / Quarterly to Provider Portal	Awaiting Plan Approval / Reporting of Existing Care Gaps in Provider Portal

References

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

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

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

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

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

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

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

ICD-9 code	ICD-10 code	Description
V560 or V561 or V562 or V5631 or V5632 or V568		Encounter for care involving renal dialysis

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

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

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

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

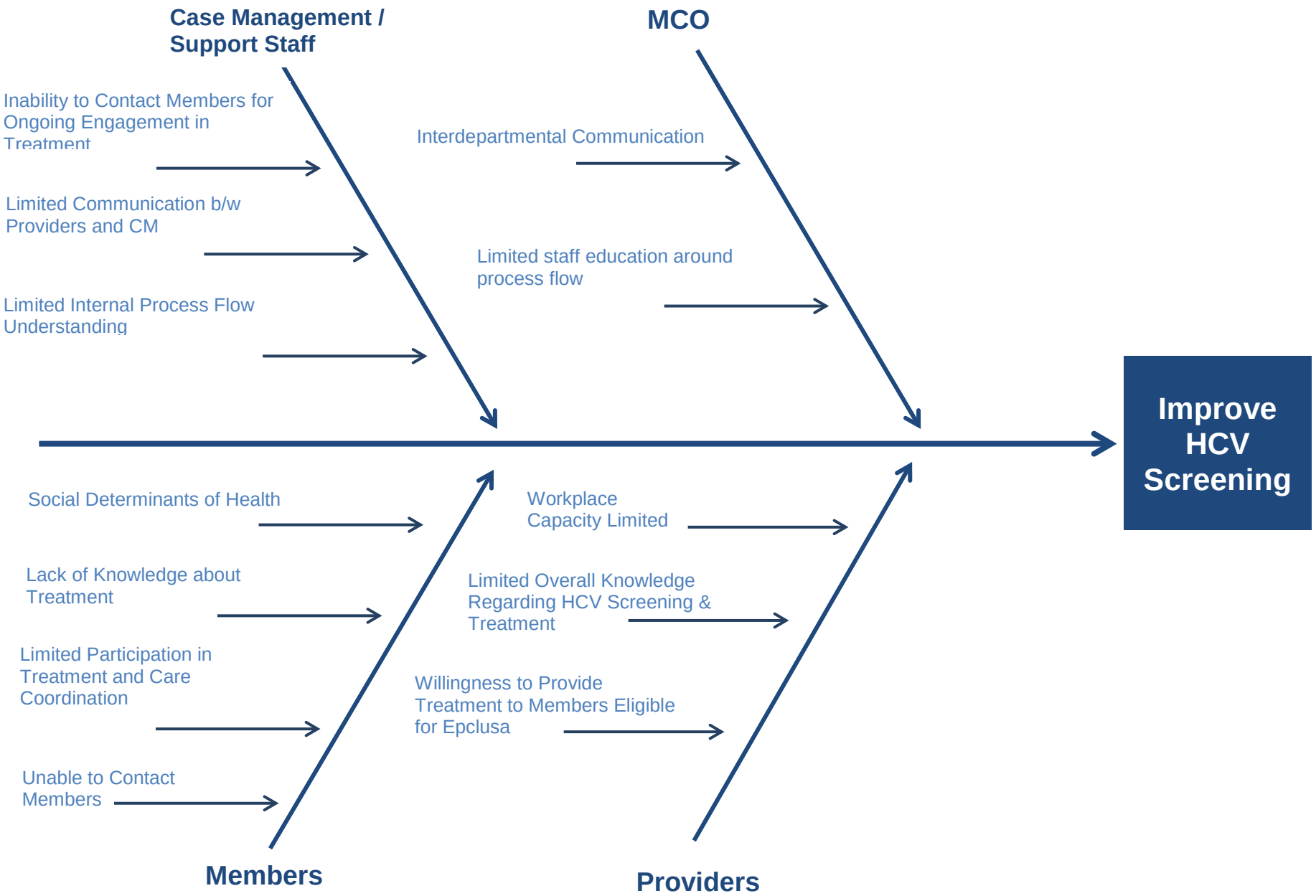
Glossary of PIP Terms

Table 7: PIP Terms

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

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

Appendix A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• AmeriHealth Caritas Louisiana Interdepartmental Communication Regarding Initiative and Screening / Treatment Options • Provider Education on Appropriate Evidence-Based Practices via ACLA Clinical Practice Guidelines • Member Education and Awareness of New LDH Initiative	• Face to Face Provider Trainings
Less Feasible to Address	• Member Unable to Contact • Providers Unwilling to Initiate Treatment Protocol • Fee Schedule Discrepancies Regarding RNA Testing and Reimbursement	• Locating Transient At-Risk Members • Differentiating Between IV Drug Users and Drug Users

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

	Positives	Negatives
INTERNAL *under your control*	***build on*** **STRENGTHS** ***Examples:*** ▪ Medical Economics (Informatics) Reports Accessibility ▪ Case Management Linkage to At-Risk Members ▪ Ability to Outreach At-Risk Members on a Large Scale Communication Basis	***minimize*** **WEAKNESSES** ***Examples:*** ▪ Compliance Regarding Communicating with Members
EXTERNAL *not under your control, but can impact your work*	***pursue*** **OPPORTUNITIES** ***Examples:*** ▪ Member Outreach Opportunities via Health-Fairs and Community Health Center Screening Events ▪ Provider Education Through Provider Network Management with Appropriate Evidence-Based Practice Guidelines	***protect from*** **THREATS** ***Examples:*** ▪ IV Drug User & Drug User Differentiation ▪ Unable to Contact Members ▪ Provider Participation ▪ Limited Workforce Capacity

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

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1: Enhanced Case Management Outreach for HCV Screening and Treatment			
Plan: Document the plan for conducting the intervention.	• Telephonic Outreach to Members with Confirmed / Probable HCV Who are Not Receiving Treatment to Assist with Appointment Scheduling	• Screening Appointments Scheduled by Case Management with HCV Specialist or PCP	• Treatment Appointments Scheduled by Case Management with HCV Specialist or PCP
Do: Document implementation of the intervention.	• Implementation Began February 2020	• Implementation Began February 2020	• Implementation Began February 2020
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	• Direct Contact with Member Made Largest Impact on Success or Failure of Intervention	• Direct Contact with Member Made Largest Impact on Success or Failure of Intervention	• Direct Contact with Member Made Largest Impact on Success or Failure of Intervention
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	• Improve Contact Rate by Exploring Other Options – Health Clinics; Mobile Testing Units	• Improve Contact Rate by Exploring Other Options – Health Clinics; Mobile Testing Units
Intervention #2: Enhanced Member Outreach to Provide Education Regarding Hepatitis C Virus Initiative			
Plan: Document the plan for conducting the intervention.	• Member Newsletter and Texting Campaign Outreach	• Screening Appointments Made After Receiving Text	• Screening Appointment Made After Receiving Newsletter
Do: Document implementation of the intervention.	•	• 3rd Party Texting Initiative Based off of ACLA's Med Informatics At-Risk Report	• ACLA-Originated Delivery of HCV Newsletter
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	• 60-Day Claims Lag Affecting Current Results – Will Have Monthly Assessment Moving Forward	• 60-Day Claims Lag Affecting Current Results – Will Have Monthly Assessment Moving Forward
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	• We Expect to See a Screening Rate Increase in Contacted Members – Will Assess Further	• We Expect to See a Screening Rate Increase in Contacted Members – Will Assess Further