Health Plan Performance Improvement Project (PIP)

Health Plan: Aetna Better Health of Louisiana

PIP Title: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

PIP Implementation Period: January 1, 2022-December 31, 2022

Submission Dates:

	Proposal/Baseline	Interim/Final
Version 1	2/3/2022	12/9/2022
Version 2		12/30/2022

MCO Contact Information

1. Principal MCO Contact Person

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

First and last name: Madelyn Meyn, M.D.
Title: Chief Medical Off/Medical Director
Phone number: 504-667-4541
Email: MeynM@aetna.com

2. Additional Contact(s)

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

First and last name: Arlene Pangan-Loots
Title: Quality Management Director
Phone number: 504-667-4648
Email: pangan-lootsa@aetna.com

First and last name: Melder Burton
Title: QM Operations Manager
Phone number: 225-316-1127
Email: BurtonM1@Aetna.com

First and last name: Julie LoMaglio
Title: Quality Manager, Project Manager
Phone number: 504-667-4496
Email: LomaglioJ@aetna.com

3. External Collaborators (if applicable):

Peter Leighton, M.D.
Email: LeightonP@aetna.com

David R. Gilchrist, M.D.
Email: GilchristD1@aetna.com

Attestation

Plan Name: Aetna Better Health of Louisiana-ABHLA
Title of Project: HCV Treatment PIP

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: 12/30/2022

CEO signature: Richard C Born
First and last name: Richard C. Born
Date: 12/30/2022

Quality Director signature: Arlene Pangan-Loots
First and last name: Arlene Pangan-Loots
Date: 12/30/2022

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 Performance Indicators were redefined and aligned to Initiation of Treatment in the second Quarter	May 19, 2022	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	Email of communication and guidelines attached.  EXTERNAL FW HCV Treatment Initiation
Change 2		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	
Change 3		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ Intervention Tracking Measure (ITM)	

Abstract

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

Project Topic/Rational: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate. 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 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).

Objectives: Improve the Healthy Louisiana 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: For all eligible members on the OPH listing, outreach and educate members, and facilitate referrals to/schedule appointments with 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: persons who use drugs and or are HIV positive. 2) Provider Intervention Objective: Educate providers on evidence-based recommendations (AASLD/IDSA, 2018) and availability of providers trained in HCV treatment, and coordinate referrals for treatment. Distribute member care gap reports to providers.

Methodology: Treatment is 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}. We analyze results in workgroups with key leaders and PIP committee enrollees, comparing target goals and conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers to success. In addition, ABHLA may use Quality Improvement process items from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABHLA regularly conducts evaluations using both quantitative and qualitative (when applicable) methods. All measures are continuously monitored to evaluate the plan's path to attaining the target rates established in each PIP.

Interventions: ABHLA redefined some of the ITM's of 2021 to accommodate the narrowed focus of treatment in 2022 identifying those that will improve PI's. One of the ITM's we had for 2022 was measuring all enrollees who received a letter from CM to contact Aetna. LDH asked ABHLA to change the ITM to reflect those who initiated treatment out of those who received the letter. We had a shift in responsibilities at the end of July from CM/CMA outreaching those on the OPH list to our Quality Outreach Coordinators doing it. This allowed a more thorough effort for connection to occur since this was the only population our coordinator needed to focus on. It was successful in many ways like getting a legacy enrollee finally convinced to received treatment in October, and there are more stories but her persistence made a difference in the PIP and our enrollees lives as she helped them schedule and fulfill other wellness needs.

Results: ABHLA showed steady progress from 2021 baseline numbers through 2022, but even more important were the improvements quarter over quarter. This group, PI 1a, went from 2.89% in Q1 2021 to over 4.1% in Q3 of 2022. The areas where we seemed to be strongest were non-legacy as well as those with HIV. All 3 treatment PI's showed progression from 2021 baseline to Q3 2022 with Q4 still in progress we are encouraged by the fact we are already at 4.05% with one full month of claims still to process. We have been very focused on the BH Provider education since over 70% of our HCV population also have a SUD diagnosis in their history but are also the lowest treatment rate and it improved – it was at a lower rate than those with HIV.

Conclusions: Provider education continues to be our focus. Some Provider groups, like Ochsner, have folded HCV screenings into their annual bloodwork panels while others have not. This requires an additional screening outside of annual wellness checks. Our Provider Network team is helping to facilitate information on screening and treatment with a specific and ongoing focus with our BH Providers. Simply put, educating providers will not resolve or greatly improve this metric if its not included as a regular part of screenings. We would encourage all providers to adopt Ochsner's stance or for Medicaid to change Wellness Screenings to include HCV as standard.

Next Steps: ABHLA is going to build off this PIP for all future infectious programs. We will use experiences of failure/success to help get new PIP's further along now that we have more robust internal processes and resources dedicated to the outcomes of PIPs. Our Population Health team will be using this PIP for both screening and treatment efforts for all infectious diseases and hope to have an impact on enrollees with a high-risk factor get the treatment and support they need before their overall health is permanently impacted.

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 was 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

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-

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 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. **<u>Member Intervention Objective</u>**:

    a. For all eligible members on the OPH listing, outreach and educate members, and facilitate referrals to/schedule appointments with 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):

b. Persons who use drugs
c. Persons with HIV

2. **Provider Intervention Objective**: Educate providers on evidence-based recommendations (AASLD/IDSA, 2018) and availability of providers trained in HCV treatment, and coordinate referrals for treatment. Distribute member care gap reports to providers.

Table 2: Goals (Updated with New Definition)

Indicators	Baseline Rate[1] Measurement Period: 1/1/21-12/31/21	Target Rate[2]: CY 2022	Rationale for Target Rate[3]
Performance Indicator #1a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	N: 72 D: 1366 R: 5.27%	R: 5.79%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #1aii (HCV Treatment Initiation-Non Legacy): ***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C after 2015; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	N: 40 D: 515 R: 7.77%	R: 8.55%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #1aiii (HCV Treatment Initiation-Legacy): ***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C after 2015; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	N: 19 D: 330 R: 5.76%	R: 6.34%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs): ***The percentage of the***	N: 50 D: 938 R: 5.33%	R: 5.86%	Baseline plus 10%, as mandated within the goals and scope of the

Indicators	Baseline Rate[1] Measurement Period: 1/1/21-12/31/21	Target Rate[2] : CY 2022	Rationale for Target Rate[3]
subset of adults with current or past drug use and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month			PIP Hep C
Performance Indicator #1c (HCV Treatment Initiation-Persons with HIV): ***The percentage of the subset of adults with HIV and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month***	N: 5 D: 47 R: 10.64%	R: 11.7%	Baseline plus 10%, 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).
[4] Footnote: OPH Email with complete PI guidance is reflected in Table 3 as well as all calculations for 2021 and 2022. The complete email can be found imbedded in Table 1. Primarily the difference is when the last diagnosis was in relation to a status to confirm need for treatment.

•Non-Legacy: Current HCV Status Unknown/Encourage HCV RNA testing to determine current HCV status (all with "hcv_dx_dt" year of between 2016-2022)- EXCLUDE from the denominator. Create a separate performance indicator to measure enrollees referred for HCV RNA testing to determine current HCV status (numerator) among enrollees with unknown HCV status. This new performance indicator will include this measure as well as the below "legacy cases".

•Legacy: Current HCV Status Unknown/legacy case/Encourage HCV RNA testing to determine current HCV status (all with "hcv_dx_dt" year between 1994-2015)-EXCLUDE from the denominator. Include in the new separate performance indicator to measure enrollees referred for HCV RNA testing to determine current HCV status (numerator) among enrollees with unknown HCV status.

Methodology

To be completed upon Proposal submission.

Performance Indicators: On May 19, 2022, OPH refined the definition of the population to include in the Performance Indicators (PI's). This refinement removed all enrollees who had begun treatment via claims and OPH file. The Population for the PI's was to show those enrollees who had initiated treatment in that measure period (monthly/quarterly/annually) from the whole population of those who were diagnosed with HCV but had not been treated. The email is attached in Table 1, with an excerpt below outlining the guidance of the new PI's as well as the addition of both Legacy and Non-Legacy which are defined below Table 3. In reviewing the definitions, we went through the 2021 claims information and ran those numbers for that population using the same guidance in order to have a baseline for the previous year. As the OPH files only come out once every 3 months or so, the practice has been to remove those who initiated treatment in one month (reflected in the numerator and included in denominator) and remove from the denominator for the following month since they had met the requirement of the PIP. As new OPH files were received, any enrollee who had been diagnosed since the previous file were added. This method of how OPH information has been used for PI's has remained the same since the PIP's inception in 2020, only the definitions of the population in 2022 have changed.

In the new listing, the last column (H) is titled "interp" and includes the below values.

1. *Each of the below bullet statements indicates which value in the "interp" column to EXCLUDE or INCLUDE from the HCV Treatment Initiation Performance Indicator denominators.*
2. *For the two categories of "interp"= "Current HCV Status Unknown", include these enrollees in one separate performance indicator to measure enrollees referred for HCV RNA testing. This way, you can create a separate gap report for members with a history of HCV but current unknown status and refer them to their providers for RNA testing. If positive, they would show up on a future report and be referred for treatment.*

- *Cured/Cleared-EXCLUDE from the denominator*
- *Current HCV Infection/Needs follow up-INCLUDE in the denominator*
- *In Treatment/Recently Treated-EXCLUDE from the denominator*
- *Treated, No documentation of cure/Encourage HCV RNA testing to confirm SVR-EXCLUDE from the denominator*

Table 3: Performance Indicators

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1ai (HCV Treatment Initiation-Overall)	***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	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 #1ai
Performance Indicator #1aii (HCV Treatment Initiation-Non Legacy):	***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C after 2015; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	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 #1aii

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1aiii (HCV Treatment Initiation-Legacy):	***The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C after 2015; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.***	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 #1aiii
Performance Indicator #1b #1b (HCV Treatment Initiation-Drug Users):	***Performance Indicator #1b (HCV Treatment Initiation-Drug Users): The percentage of the subset of adults with current or past drug use and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month***	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 #1b

Indicator	Description	Data Source	Eligible Population	Exclusion Criteria	Numerator	Denominator
Performance Indicator #1c (HCV Treatment Initiation- Persons with HIV)	***The percentage of the subset of adults with HIV and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month***	Administrative/ Claims/ Encounter data	Healthy Louisiana adults ever diagnosed with HIV (ICD-9 or ICD-10 codes in Appendix B) 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 #1c

Footnote: OPH Email with complete PI guidance is reflected in Table 3 as well as all calculations for 2021 and 2022. The complete email can be found imbedded in Table 1. Primarily the difference is when the last diagnosis was in relation to a status to confirm need for treatment.

- *Non-Legacy: Current HCV Status Unknown/Encourage HCV RNA testing to determine current HCV status (all with "hcv_dx_dt" year of between 2016-2022)- EXCLUDE from the denominator. Create a separate performance indicator to measure enrollees referred for HCV RNA testing to determine current HCV status (numerator) among enrollees with unknown HCV status. This new performance indicator will include this measure as well as the below "legacy cases".*

- *Legacy: Current HCV Status Unknown/legacy case/Encourage HCV RNA testing to determine current HCV status (all with "hcv_dx_dt" year between 1994-2015)- EXCLUDE from the denominator. Include in the new separate performance indicator to measure enrollees referred for HCV RNA testing to determine current HCV status (numerator) among enrollees with unknown HCV status.*

Data Collection and Analysis Procedures

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

The population for this PIP, as defined by OPH, will be those Medicaid Enrollee's 18 and over who have been screened and diagnosed with the Hep-C virus. The age at which the enrollee is outreached, per the diagnosis, is relevant to the legal age of consent and is aligned to the requirements of the PIP.

There are no sample populations for this PIP, all enrollees for whom receive the diagnosis will be equally measured, outreached, and offered treatment.

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 enrollees 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.
- **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 enrollees, 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.

(Tentative) PIP Timeline

Report the baseline, interim and final measurement data collections periods below.
Baseline Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Proposal/Baseline Report Due: 2/3/2022

Interim/Final Measurement Period:
Start date: 1/1/2022
End date: 12/31/2022

PIP Interventions (New or Enhanced) Initiated: 2/1/2022

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/22-3/31/22 Due: 4/30/2022
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/22-6/30/22 Due: 7/31/2022
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/22-9/30/22 Due: 10/31/2022

Submission of Draft Final Report Due: 12/10/2022
Submission of Final Report Due: 12/31/2022

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures (All Quarterly measures, no cumulative)

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification: IPRO HCV PIP guidance document. Each MCO should identify additional barriers for the overall population, as well as barriers unique to persons who use drugs and persons with HIV. Direct member feedback is recommended.**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **Planned Start Date: 1/2022** **Actual Start Date**:1/1/2022	**Intervention #1a tracking measure:** N: # members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV treatment assessment/initiation D: # members with confirmed or probable HCV per OPH listing not receiving treatment	N: 377 D: 1367 R: 27.6%	N: 355 D: 1361 R: 26.1%	N: 365 D: 1361 R: 26.82%	N: 347 D: 1342 R: 25.86%
Intervention #1b to address barrier: Member Intervention Objective: HCV treatment initiation-members with current or history of substance abuse **Planned Start Date: 2/2022** **Actual Start Date**:4/2022	**Intervention #1b tracking measure:** N: # of Members with SUD who received a letter and initiated treatment D: # of Members with SUD history who were sent letters to contact CM	N: D: R:	N: 22 D: 145 R: 15.2%	N: 0 D: 0 R:	N: 0 D: 0 R:
Intervention #1c to address barrier: HCV treatment initiation for members diagnosed with HIV **Planned Start Date: 2/2022** **Actual Start Date**: 4/2022	**Intervention #1c tracking measure:** N: # of Members with HIV who received a letter and initiated treatment D: # of Members with HIV who were sent letters to contact CM	N: D: R:	N: 0 D: 2 R: 0%	N: 0 D: 0 R:	N: 0 D: 0 R:
Barrier 2a: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification:**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date: 1/2022** **Actual Start Date**:	**Intervention #2a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N: 116 D: 121 R: 95.9%	N: 128 D: 131 R: 97.7%	N: 126 D: 128 R: 98.44%	N: 110 D: 112 R: 98.21%
Barrier 2b: Providers may not be aware of HCV clinical guidelines, HCV specialists, and their patients' eligibility for treatment. **Method of barrier identification: Each MCO is advised to obtain direct provider feedback about what is working/ not working.**		**2022**			
		Q1	**Q2**	**Q3**	**Q4**

Intervention #2b to address barrier: Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers **Planned Start Date: 2/2022** **Actual Start Date**:	**Intervention #2b tracking measure:** **N:** # of Providers who received education material **D:** Total # of Providers in network	N:0 D:30155 R: 0%	N: 125 D:30664 R: 0.41%	N: 4184 D: 31286 R: 13.4%	N: 4661 D: 31730 R: 14.69%
Intervention #2c to address barrier: Inform Providers of their patients who are at risk by distributing to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV follow-up **Planned Start Date: 2/2022** **Actual Start Date**:2/2022	**Intervention #2c tracking measure:** **N:** Total # of at risk members distributed to Providers **D:** # of at risk members who have a Confirmed Diagnosis (either claims or OPH list)	N:0 D:4575 R:0%	N: 253 D: 2095 R: 12.1%	N: 0 D: 2085 R: 0%	N: 364 D: 2080 R: 17.5%
Barrier 3: **Method of barrier identification:**		**2022** **Q1**	**Q2**	**Q3**	**Q4**
Intervention #3a to address barrier: Intervention to address member barrier: Total (ITM's 1a +3c) Outreach for HCV Treatment Initiation **Planned Start Date:** 2/2022 **Actual Start Date**:2/2022	**Intervention #3a tracking measure:** Complete telephonic outreach by all areas N: Those members with HCV who were outreached by CM/CMA D: # members > 18 with an HCV diagnosis either by OPH list or claims	N: 693 D: 2109 R: 32.9%	N: 727 D: 2089 R: 34.8%	N: 580 D: 2085 R: 27.82%	N: 304 D: 2080 R: 14.62%
Intervention #3b to address barrier: Outreach for HCV Treatment Initiation **Planned Start Date:** 2/2022 **Actual Start Date**:2/2022	**Intervention #3b tracking measure:** N: # opted in members > 18 who received an HCV treatment education text D: # of opted in plan members >18	N: 81,093 D: 87,334 R: 92.9%	N: 5,205 D:18,523 R: 28.1%	N: 2480 D: 2480 R:100%	N: 0 D: 2,842 R: 0.00%
Intervention #3c to address barrier: Outreach for HCV Treatment Initiation **Planned Start Date:** 2/2022 **Actual Start Date**: 2/2022	**Intervention #3c tracking measure:** **N:** Members telephonically outreached from the HCV Enhanced Outreach Model on Sharepoint **D:** # members $\geq$ 18 with an HCV diagnosis either by OPH list or claims	N: 146 D: 324 R: 45.1%	N: 204 D: 204 R: 100%	N: 91 D: 118 R: 77.12%	N: 57 D: 113 R: 50.44%

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: 1/1/21-12/31/21	Updated Baseline (if needed to update with complete claims data) Measure period: 1/1/21-12/31/21	Final Period Measure period: 1/1/2022-12/31/2022	Target Rate[1]
Performance Indicator #1ai (HCV Treatment Initiation-Overall): *The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.*	N: 72 D: 1366 R: 5.27%	N: D: R:	N: 66 D: 1286 R: 5.13%	R: 5.79%
Indicator #1aii (HCV Treatment Initiation-Non Legacy): *The percentage of all adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C after 2015; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.*	N: 40 D: 515 R: 7.77%	N: D: R:	N: 33 D: 452 R: 7.3%	R: 8.55%
***Indicator #1aiii (HCV Treatment Initiation-Legacy): *** *The percentage of all*	N: 19 D: 330 R: 5.76%	N: D: R:	N: 5 D: 244 R: 2.05%	R: 6.34%

Indicator	Baseline Period Measure period: 1/1/21-12/31/21	Updated Baseline (if needed to update with complete claims data) Measure period: 1/1/21-12/31/21	Final Period Measure period: 1/1/2022-12/31/2022	Target Rate[1]
adults (ages 18 and older) with a confirmed diagnosis of Chronic Viral Hepatitis C before 2016; and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month.				
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs): *The percentage of the subset of adults with current or past drug use and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator} that month*	N: 50 D: 938 R: 5.33%	N: D: R:	N: 46 D: 898 R: 5.12%	R: 5.86%
Performance Indicator #1c (HCV Treatment Initiation-Persons with HIV): *The percentage of the subset of adults with HIV and with a confirmed diagnosis of Chronic Viral Hepatitis C and not previously treated per the Office of Public Health listing {denominator} for whom pharmaceutical treatment for HCV was*	N: 5 D: 47 R: 10.64%	N: D: R:	N: 17 D: 51 R: 33.33%	R: 11.7%

Indicator	Baseline Period Measure period: 1/1/21-12/31/21	Updated Baseline (if needed to update with complete claims data) Measure period: 1/1/21-12/31/21	Final Period Measure period: 1/1/2022-12/31/2022	Target Rate[1]
initiated {numerator} that month				

[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.
[2] PI's 1aii, and 1aiii are referenced from the OPH email of 5/19/2022 where the definition separates enrollees needing treatment as those screened in 2016 thru current as non-legacy while those who have been screened to have the virus prior to 2016 as legacy. The difference is merely the initial screening of the diagnosis coupled with the fact they have not received treatment (via claims) since that diagnosis. It is presumed from the definitions that legacy would hold a heightened urgency for treatment given the longer exposure and potential scarring to the liver.

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.

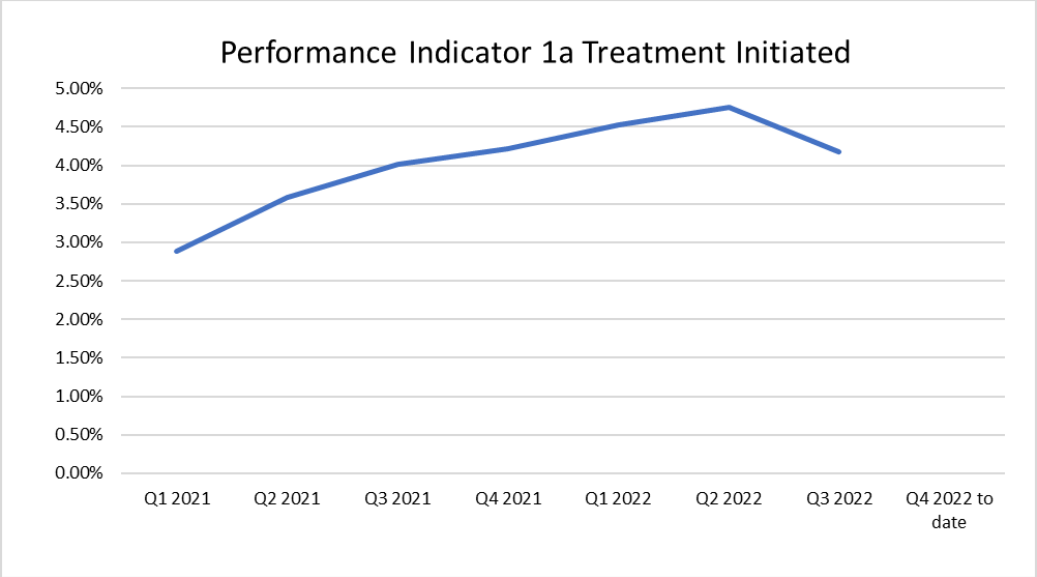
Discussion

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

Discussion of Results

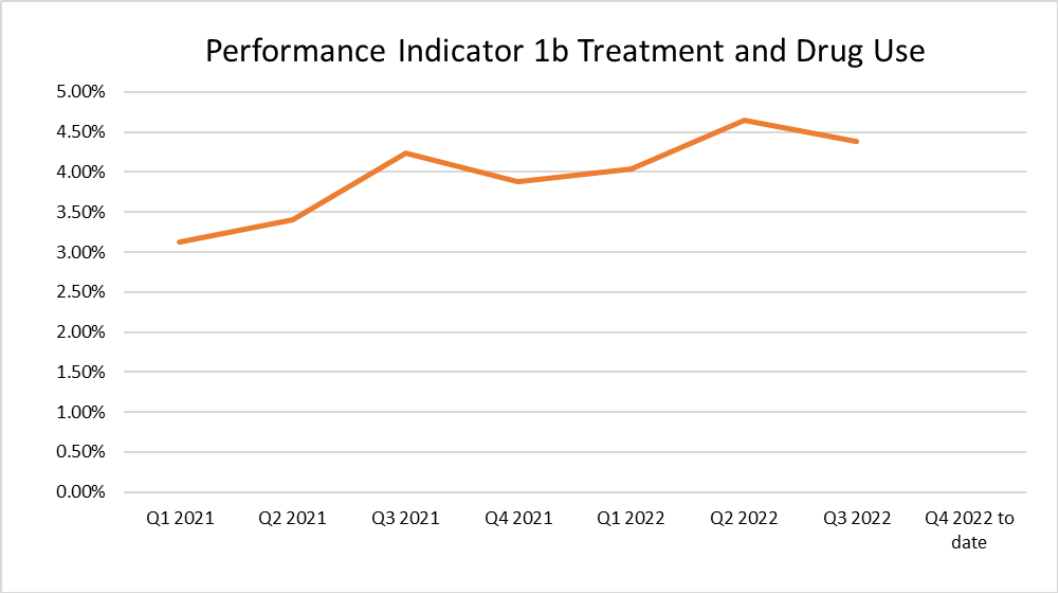
- **Interpret the performance indicator rates for each measurement period,** i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.

The performance indicators were modified in May of 2022 to only include those not in treatment on the OPH list which forms the denominator for all PI's. This change did significantly drop the value of treatment rate, Q1 original report was around 33% to an adjusted rate of 4.53%. This drop is not due to failure to get enrollees into treatment but because we removed all those already in some phase of treatment which inflated the treatment initiation rate. This outcome rate is more concise for those who needed to get into treatment. We were able to apply the same metric definitions to 2021 and get a clearer trend on performance over time as illustrated by the trend line graph below. Using the current PI#1a performance, we were able to climb from 2.89% in Q1 of 2021 to over 4.1% in late 2022. Almost doubling our treatment rate.



With the change in PI definitions, OPH also added two more PI's under the PI #1a splitting out population between legacy and non-legacy. This distinction showed how those with the virus for a longer period of time were less likely to seek treatment (please see definitions of both in Table 5). This distinction also supported the PIP focus to treat the virus to avoid scarring of the liver over time. Our experience was that Legacy, those diagnosed prior to 2016, did not seek treatment at the same rate as non-legacy or those diagnosed after 2015 (2016-present). One of our experiences with a legacy member was that he was fully aware of the diagnosis and issues but wasn't willing to seek treatment due to other circumstances in his life. He had recently lost members of his family and was now alone, but our outreach coordinator persisted in her outreach and was able to get him into treatment and from there, once he felt someone cared, was able to get his annual check-up down and other supportive needs. It seems that potentially our enrollees have other issues for not seeking treatment that might take a little more effort to impact.

Along with the new denominator definitions, the SUD population did remain both the highest segment of the HCV population as well as the lowest rate for treatment as the graph below illustrates. We did improve but from Q1 2021 of 3.13% to 4.38% is about a 40% improvement but far less of an increase given the fact this is our largest population.



The PI#1c for those with HCV/HIV receiving treatment also had a large improvement from Q1 2021 of 6.25% to over 13% late in 2022 but this population is also our lowest with our denominator hovering at or below 40 enrollees.

Although some PI's did improve from Q1 2021 to the current period, and in most cases the rate doubled, the overall number of enrollees initiating treatment was much lower than we would have liked. The persistence of the Quality Team needing dedicated outreach resources for PIPs did allow the hiring of our HCV coordinators, who in turn were able to get both legacy and non-legacy enrollees into treatment with polite persistent calls. We feel these wins are not just good for the metric, but with that connection the enrollees were able to also get support during treatment with regular calls as well as additional services beyond just treatment as needed. These interactions help remove both cultural and trust barriers with some enrollees who might otherwise ignore regular check-ups and inquiries when things are not good. This allows us to change the perspective from using the ED for treatment to more preventative which will help enrollees trust their MCO and requests from the medical community as a whole.

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

In September of 2022, ABHLA Quality department was able to add outreach coordinators who were able to deliver great outreach effort numbers very much aligned to the CMA's coverage in the first 2 quarters of ITM 3c, but with one important difference; our outreach coordinators were able to call until there was an answer so even if the enrollee said they weren't interested, she would keep calling until they agreed. This was most effective on our legacy population. Another difference was that she would call them once a week and follow-up on appointment outcomes (did you go? Etc) as well as address any issues they may be experiencing with side effects or depression from the diagnosis. Her ability to stay in touch through the whole process allowed barriers along the way to be addressed with clinical knowledge and resource support which kept them in treatment and moving forward to a final outcome of virus free. Many enrollees phone calls went unanswered or told us we had the wrong person. This continues to be a barrier via both Privacy rules for 'wrong' number as well as calls being avoided via caller ID. This is where the addition of the letter is a good secondary tool, and our team was trained in November on the tool that allows that to happen. Going forward they will be able to initiate standard letters but the experience of both

persistent calls coupled with responses from letters allows us to use this experience and knowledge going forward on all similar efforts.

One other ITM that showed good improvement for an internal change was ITM 1a for those who had an appointment scheduled by an Aetna employee. By adding HCV to our Gaps in Care list, even passive interactions about other items allows our team to see if enrollees have something outstanding via their health. So even if an enrollee calls in for a new card or to get a new PCP, or team can see there are outstanding items they need to follow-up on and can help deliver the outstanding items as well as get appointments met. Likewise, if our CM/CMA teams are calling enrollees about something else like a recent discharge, they will see the Gaps In Care flag for HCV and can take that opportunity to get them to the right resources. We found that each time the flags were update in our enrollees database, the appointments metric of ITM 1a went up for several months until the bulk of that population had completed the interaction. This practice will continue internally.

- **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.

Removing those already in treatment gave a more realistic view of the population that needed treatment. The addition of 'when' the virus was detected gave our outreach coordinators a better understanding of not only the difficulty they might be up against in moving enrollees to treatment but also allowed them to understand that a specialist might be needed given the length of time. All of this helped carry on a more complete and educational conversation, but also determined where the enrollees next steps really needed to be directed. For instance, our enrollee legacy individual who had it for 30 years needed both a different focus for education as well as what Provider would be most beneficial. Sending someone in the legacy group to a testing clinic may not get them into treatment but a 1x1 with Providers who are specialist allows a more personal conversation with concern to be had and more likely for the enrollee to take those next steps knowing there are specific individuals in their care corner.

The addition of the letters to outreach enrollees was, ITM's 1b&1c, was also enlightening as we were able to note that enrollees do respond to notifications and call us to follow-up. This process, already done in CM/CMA, will continue but we will also make sure it reviewed for future PIPs. Noting that while changing from CM to our internal quality coordinators and no letters were able to be sent for several months will now be possible going forward since they have the full training and access to the system which initiates that standard letter.

The ITM around Provider Education, ITM 2b, was focused this year towards our BH Providers in one to one regular meetings to help educate them on the linkage of SUD and HCV, while our regular newsletter articles continue to be directed towards all providers and the education to screen for all STI's with HCV listed. We noted that while Ochsner includes HCV in regular blood chem panels, most providers do not. To screen for STI's, including HCV, it is an additional test which most providers in the regular annual appointments do not include. We feel that if Ochsner's practice was more wide spread than providers would be able to have those conversations with enrollees relevant to the appointment. Waiting for a claim to be processed and HCV status to be noted for follow-up often months down the road by the MCO rather than the provider does create a time barrier and also mis-trust by the enrollee who wants to know how we got their results.

One good example of new techniques was our HCV text campaigns that in Q4 of 2021 and Q1 of 2022 showed a large delivery rate of 80-90% of those targeted (ie enrollees over 17). This campaign was geared to education which included stats on screening, treatment, and long term effects while supplying contact information to get enrollees an appointment. We did find however that this campaign was good at screening increases, but not so much for treatment.

- **PIP Highlights**

Member Intervention highlights primarily centered on ITM 3c with our change from CM to PIP dedicated quality outreach coordinators. CM is a separate department and while they do outreach for all kinds of health issues, they have a large population to cover and have a standard outreach method before moving on. Our outreach coordinators are able to not only repeatedly call, but are also calling after treatment is initiated and making other arrangements for them if needed. This interaction around treatment helps keep the member in treatment while building a caring relationship. Our minority enrollees, from a cultural perspective might have trust issues with healthcare in general but our coordinators are able to relate to enrollee concerns, overcome them, and keep them on track. Its like a CM relationship but with a resource that can take the extra time and meet the needs of each enrollee they encounter because they are focusing on just PIP's. We are also finding that outreach efforts that are passive, like Gaps in Care flags (ITM 1a) and letters (ITMs 1b&1c), are offering opportunities for discussion with the enrollees since they usually call into ABHLA. This helps to offset the negative outreach efforts associated with bad phone numbers and call blockers. Our final intervention around enrollees were the text campaigns for education which focused on enrollees over 17 to get messages about screening, treatment, and long terms consequences of having HCV.

Provider Interventions highlights were definitely in changing which providers we wanted to education and focus on for 2022. Given the PI 1b and its high population of HCV enrollees with a SUD history, but the low rate of treatment, we focused our education on the BH Providers as part of their standard monthly meeting with our Provider team. By educating them on the connection, we are targeting the largest HCV population to get screened at times of assessment, treatment, or admit to a facility. The focus includes all of our BH Hospital and inpatient providers. This has allowed our quarter-to-quarter comparisons from 2021 to 2022 to show improvement so far this year. This information will continue to be part of the education deck as part of the STI screening efforts from the Population Health team.

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).

As noted in previous sections; the OPH file definitions changed in mid-2021 to be more specific in the viral state of the enrollee. Due to this more detailed data being shared, it was also determined that populations already in treatment were being included in the denominator while the PIP's scope was to get enrollees with HCV to initiate treatment. Based on the information and existing scope of the PIP, it was determined that denominators would **exclude** anyone who had begun treatment but no 'clear' status was known and such the denominator definition was narrowed. This did not affect validity or reliability of the data as the population to be included was not changed but only narrowed in its scope to match the PIP definition. The population of the PIP was clearly defined in the initial PIP template outline in 2020 when CPT and other claims information was supplied to all the MCO's for appropriate measurement and data collection. Subsequently, when OPH changed the denominators definitions for the PI's in May of 2022, they clearly outlined what OPH status's were to be excluded (please see Results and Table 3). We were able, since its all claim driven, to go back and apply the 2022 changes to 2021 to form the baseline for this years performance since including all of the OPH list in 2021 to the same PI's in 2022 would have created a reliability issues for measurement.

- **Were there any factors that may pose a threat to the internal validity of 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.

  No internal issues were experienced.

- **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).

  No samples were used and therefore no external issues were experienced.

- **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.

  No issues were experienced.

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) ITM for Enhanced Case Management Outreach for HCV Treatment Initiation: **N**: # members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV treatment assessment/initiation; **D**: # members with confirmed or probable HCV per OPH listing not receiving treatment	Overall this metric improved in 2022, but would expect it had more to do with population being redefined. This scheduling method is difficult as getting individuals to answer phone calls of unknown numbers is easy to ignore.	Gaps in Care support and outreach is a constant moving target and HCV is one of the health risks we were able to add to the system for Member Services and CM to see, so when an enrollee calls they can see there is an outstanding item for follow-up. That mechanism was not turned on for HCV prior to the PIP. It is a permanent addition.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#1b) Member Intervention Objective: HCV treatment initiation-members with current or history of substance abuse **N:** # of Members with SUD who received a letter and initiated treatment **D:** # of Members with SUD history who were sent letters to contact CM	CM sends letters if the initial phone contact doesn't get answered, we found that enrollees do respond to letters and call in to understand our need to communicate. This was important to understand as we moved outreach from CM to Quality. The SUD recipients reached out better via letters than phone calls.	Our quality outreach coordinators did not have access to the the system that sends letters to enrollees right away but were able to complete training with access in November so for several months we did not send letters.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#1c) HCV treatment initiation for members diagnosed with HIV **N:** # of Members with HIV who received a letter and initiated treatment **D:** # of Members with HIV who were sent letters to contact CM	CM sends letters if the initial phone contact doesn't get answered, we found that enrollees do respond to letters and call in to understand our need to communicate. This was important to understand as we moved outreach from CM to Quality.	Our quality outreach coordinators did not have access to the the system that sends letters to enrollees right away but were able to complete training with access in November so for several months we did not send letters.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#2a) ITM for SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred): **N:** # members who were dispensed SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) **D:** # members with any DAA dispensed	This metric stayed very high, usually right at 100% but with the addition of a few new and shorter duration medications we did see some variation month to month. In q3 we saw the numbers rebound.	We need to educate providers on the algorithm and preferred medications, but we also need to be sure to compare those to new drugs so providers can see and understand there is one preferred for Medicaid Rx.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#2b) Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers	After sending education material to all providers in 2021, we took a targeted focus in 2022 to educate our BH providers on the linkage	Our Practice Transformation Specialists on the Provider team will continue to educate on this connection.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the

N: # of Providers who received education material **D:** Total # of Providers in network	between SUD and HCV. This population is the hardest to reach and we hoped BH Providers could help get more into treatment.		Gaps in Care.
#2c) Intervention to outreach providers with HCV Care Gap Reports **N:** Total # of at risk members distributed to Providers **D:** # of at risk members who have a Confirmed Diagnosis (either claims or OPH list)	This required method proved less effective than all others as there was no way to determine if follow-up was done.	For a more direct and trackable method, we will continue the letters via CM and outreach by phone	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#3a) Intervention to address member barrier: Total (ITM's 1a +3c) Outreach for HCV Treatment Initiation **N:** Those members with HCV who were outreached by CM/CMA **D:** # members > 18 with an HCV diagnosis either by OPH list or claims	The metric was developed to show the total outreach efforts of both CM for specialist, and regular outreach for appointments. It was designed to show the total telephonic outreach to enrollees in trying to get them into treatment.	This metric was not a specific method but more of a roll up. Both 1a and 3c follow the same full outreach efforts of education on viral status, conditions associated with the virus, and help making appointments as well as all resources needed to start treatment.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#3b) Intervention to address member barrier: **N:** # opted in members > 18 who received an HCV treatment education text **D:** # of opted in plan members ≥18	This educational text campaign was very effective in reaching enrollees but seemed to have more impact on screening in 2021 than treatment.	The vendor with the campaign was bought out, the campaign changed its focus after March to just 'new' enrollees the rest of the year.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.
#3c) Intervention to address member barrier: **N:** Members telephonically outreached from the HCV Enhanced Outreach Model on Sharepoint **D:** # members > 18 with an HCV diagnosis by OPH list and not previously outreached	This outreach model built in SharePoint allowed a very detailed but easy to use tool for not only tracking efforts to contact, but for reporting as well. The information was loaded by informatics, and most fields were drop down for outcomes.	We are most likely going to use the same model for future PIP outreaches, like HIV.	All aspects of HCV will transition to Population health for ongoing programs, and the regular CM outreach as part of the Gaps in Care.

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Appendix 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)

Appendix B. 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

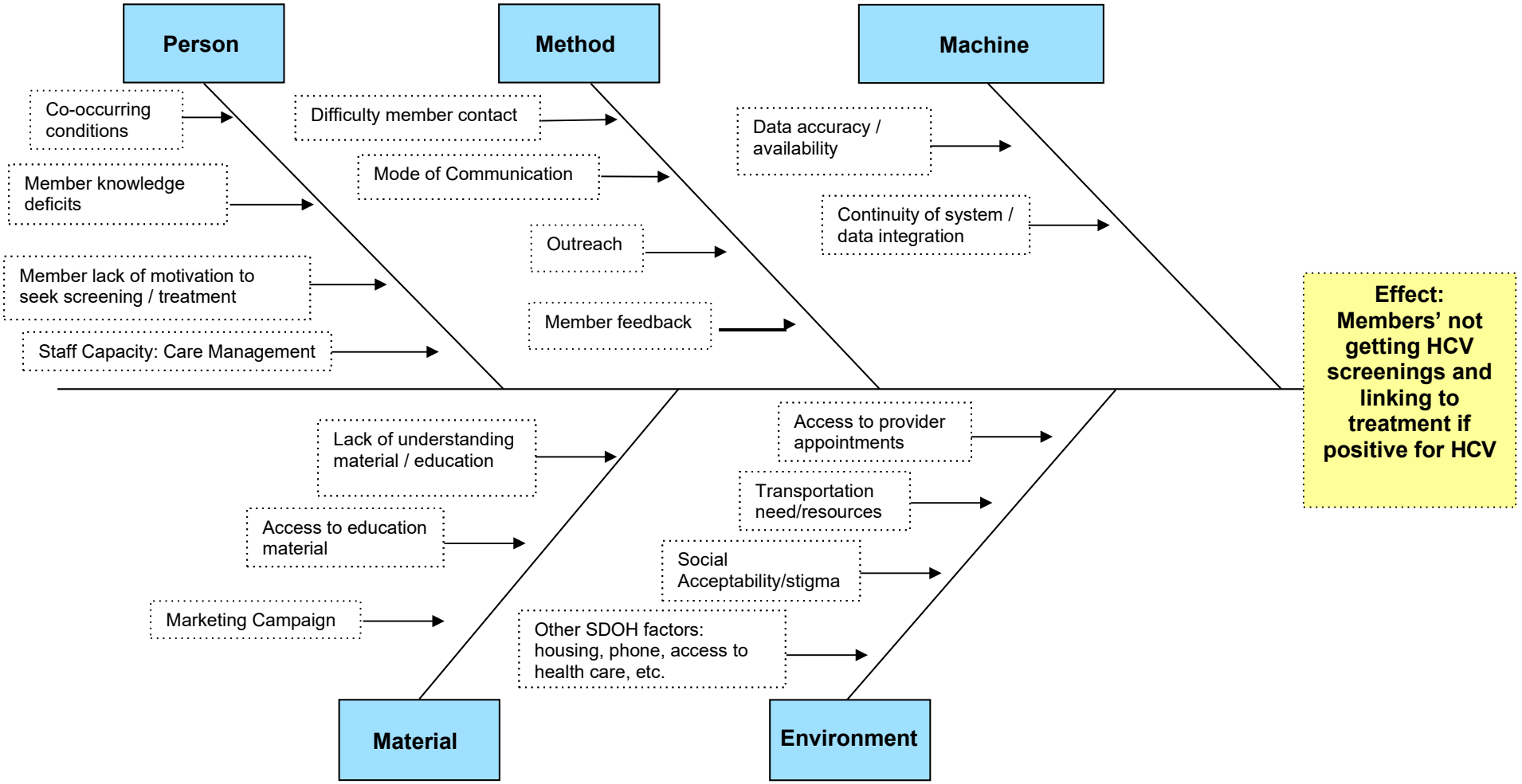
Glossary of PIP Terms

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: 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
- 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. 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

Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• 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 • Increase staff capacity	• Partnership with external entities such as community-based organizations & affect community/population
Less Feasible to Address	• Member may feel stigma related to screening • Member adherence to treatment • 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	• Provider collaboration and coordination

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

	Positives	Negatives
INTERNAL *under your control*	***build on*** **STRENGTHS** ***Examples:*** □	***minimize*** **WEAKNESSES** ***Examples:*** □
EXTERNAL *not under your control, but can impact your work*	***pursue*** **OPPORTUNITIES** ***Examples:*** □	***protect from*** **THREATS** ***Examples:*** □

Appendix D: Driver Diagram

Aim:. Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2021 to CY 2022.	**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:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•