Health Plan Performance Improvement Project (PIP)

Health Plan: AmeriHealth Caritas 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	3/2022	12/9/22
Version 2		12/30/22

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: Jennifer Manuel
Title: Quality Performance Specialist
Phone number: 985-222-1243
Email: jmanuel@amerihealthcaritasla.com

2. Additional Contact(s)

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

First and Last name: Rhonda Baird
Title: Director, Quality Management
Phone number: 225-300-9111
Email: rbaird@amerihealthcaritasla.com

First and Last name: Jana Blaylock
Title: Supervisor, Quality Management
Phone number: 318-816-9074
Email: jblaylock@amerihealthcaritasla.com

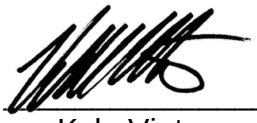
3. External Collaborators (if applicable):

Attestation

Plan Name: AmeriHealth Caritas of Louisiana
Title of Project: Improve Chronic Hepatitis C Virus (HCV) Pharmaceutical Treatment Initiation Rate

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:12/28/2022

CEO signature: 
First and last name: Kyle Viator
Date: 12/28/2022

Quality Director signature: Rhonda Baird
First and last name: Rhonda Baird
Date: 12/28/2022

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	February 2022	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	Rates exclude members with an OPH indicator of 'cured/cleared' for whom claims data is unavailable (transferred or previously uninsured).
Change 2	January 2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	NEW INTERVENTION #3B To enroll/engage members who fill an initial prescription for HCV Treatment Medication in Case Management
Change 3	February 2022	☒ Methodology ☒ Barrier Analysis ☐ Intervention ☒ ITM	NEW INTERVENTION #2Bii Outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers and HCV Care Gap Reports; Also, to obtain direct provider feedback
Change 4	April 2022	☐ Methodology ☒ Barrier Analysis ☐ Intervention ☐ ITM	Updated the following QI tools: • Fishbone Cause and Effect Diagram • Priority Matrix • SWOT Diagram
Change 5	January 2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☒ ITM	NEW INTERVENTIONS To address susceptible subpopulations: • #1cii: HCV/HIV co infection with housing disparity- linking to Care Coordination services for members with housing disparity • #1b: HCV/Drug Use-track successful calls to these members
Change 6	January 2022	☒ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	With the PIP's transition to treatment improvement, MY2022 ITM denominators were revised to reflect only members with an indicator of 'Current HCV Infection/Needs follow up'.

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.

Rationale for Project/Objectives: The Hepatitis C Virus (HCV) Performance Improvement Project (PIP) is aimed at improving the Healthy Louisiana HCV pharmaceutical treatment initiation rate by 10 percentage points. AmeriHealth Caritas Louisiana (ACLA) implemented a robust set of interventions to address key intervention objectives:
Member Intervention Objective: Outreach and educate all eligible members and assist in scheduling appointments with PCPs or HCV Providers for treatment with tailored interventions.
Provider Intervention Objective: Educate providers on evidence-based recommendations, the HCV Treatment Initiative PIP, availability of HCV Providers and coordinate referrals for treatment.

Methodology: Performance Indicators:
#1a) 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 for whom pharmaceutical treatment for HCV was initiated. Baseline rate is 32.54%.
#1b) HCV Treatment Initiation-Persons who use drugs: 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 for whom pharmaceutical treatment for HCV was initiated. Baseline rate is 32.96%.
#1c) 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 for whom pharmaceutical treatment for HCV was initiated. Baseline rate is 44.36%.

Results:
ACLA's baseline data was calculated using designated numerators and denominators from year 2021. During the year, multiple internal departments worked together to improve our treatment rates. The target goal outlined in the PIP instructions was to achieve a ten percentage point increase in the three performance indicators provided.

For the current year, performance indicator 1c exceeded the targeted rate of 54.36% by 0.73%, with a rate of 55.09%. Performance indicators 1a and 1b have shown great improvement, but have not met the ten percentage point increase. We still feel the 2022 PIP results to be a success, as these performance indicators have demonstrated an increase quarter to quarter.

Interventions:
ACLA's Quality, Care Management, Medical Informatics, Communications and Provider Network Management (PNM) Departments collaborated to initiate multiple member and provider focused interventions to assist in increasing our Hepatiis C Virus Treatment Initiation Rates. Direct outreach via telephone and in-person visits were performed to members on the OPH listing with interpretation " Current Infection/Needs follow up" by our Case Management and Community Outreach teams. Quality and PNM conducted virtual and in-person Provider visits to eductate them on the HCV Treatment Initiative. A targeted outreach was also done for providers who were not registered in our provider portal and had members on the OPH lisiting as needing treatment.

Additional member interventions included text messaging campaigns, social media posting and member newsletter. For providers, an updated Provider Alert was sent out on the HCV Treatment Initiative and clinical practive guidleines were updated on ACLA website.

Conclusions:
Our 2022 HCV PIP treatment initiation rates have shown great improvement from year 2021 to current year 2022. For the final measurement period of 2022, ACLA saw Performance Indicator 1c exceed the targeted goal by 0.73%, with a rate of 55.09%. Performance Indicator 1a has increased by 5.48% and Performance Indicator 1b has increased by 6.32% from the baseline rates , but did neither met the target goal of ten percentage point increase for MY 2022.
Next Steps:
ACLA will continue to outreach both members and providers to offer education on the importance of HCV Treatment even though this PIP will be closing this year.

Project Topic

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

Describe Project Topic and Rationale for Topic Selection

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

The hepatitis C virus (HCV) is the most common blood-borne disease and the leading cause for liver transplant in the United States (LDH, 2019a). HCV 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). While the estimated number of acute HCV cases has seen an increase from 2010 to 2019, there is a highly effective treatment that can cure HCV.

As of January 2022, AmeriHealth Caritas Louisiana (ACLA) manages the care of 13.33% of the Louisiana Medicaid population. In conjunction with the OPH listing, the Plan estimates that there are 4,932 members ages 18+ with a confirmed/probable diagnosis of HCV. It is important to increase member awareness of treatment options and resources available to prevent long term health issues related to HCV, including cirrhosis, liver failure and liver cancer (USPSTF, 2020). It is also important to monitor the effectiveness of implemented interventions and develop new strategies to address unique barriers members may face to eliminate HCV in Louisiana.

The aim of the HCV PIP aligns with ACLA's mission, to help our members 'get well, stay well, and build healthy communities.'

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

Louisiana ranks fifth in the United States 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. A person with both HCV and HIV has a threat to their overall health related to harmful effects on the immune response and treatment outcomes (LA OPH, 2015).

The most common and important risk factor for HCV infection is past or current injection drug use, accounting to about 60% of cases in the United States. As the opioid epidemic continues, the risk of acquiring HCV increases. From 2010-2017, there has been an increase of about 3.8-fold in cases of acute HCV infection due to increased drug use and enhanced monitoring. Young adults from ages 20-39 who inject drugs have seen the quickest increase in acute HCV cases, with the increase more notable in men. Around 1/3 of IV drug users from ages 18-30 have HCV and 70-90% of older IV drug users have the virus (USPSTF, 2020). People with HIV are also at risk to contract HCV due to shared transmission modes. Per the CDC, roughly 21% of adults with HIV tested positive for HCV in 2009. Liver related injuries progresses faster in people with HIV/HCV coinfections than those with HCV infection alone (Baligh Yehia, et al 2014).

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

HCV can be cured with antiviral treatment leading to sustained viral response, or SVR (LDH, 2019a). The elimination of HCV is possible with the emergence of safe, well-tolerated and highly effective (>95% cure rate) direct acting antivirals (DAA). The World Health Organization (WHO) recommended a global health

sector plan to eliminate HCV by 2030, which includes increasing connecting and access to care and broader access to treatment. A variety of health care professionals, including specialists, PCPs, NPs and PAs, can prescribe HCV treatment successfully without compromising safety or treatment success (AASLD, 2019). More people may be treated due to the simplification of treatment regimen and the increased number of providers who can prescribe the medication (AASLD-IDSA, 2021). Epclusa (sofusbuvir 400mg/velpatasvir 100mg) is a recommended treatment that can be taken over the course of 12 weeks.

- **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 ACLA 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).

ACLA recognizes that new and enhanced interventions are necessary to improve HCV treatment initiation among our members and to eliminate HCV in Louisiana. Baseline data, compiled 1/1/2021 to 12/31/2021, shows that:

- 32.54% of the total population of the members with a confirmed/probable HCV diagnosis had pharmaceutical treatment initiated.
    - Of the total population of the members with a confirmed/probable HCV diagnosis, there are 2,418 members who had past/current drug use. 32.96% of these members had pharmaceutical treatment initiated.
    - Of the total population of the members with a confirmed/probable HCV diagnosis, there are 133 members with HIV/HCV co-infection. 44.36% of these members had pharmaceutical treatment initiated.

Given the results mentioned above, there is a significant opportunity to outreach and educate at risk members for whom HCV treatment is needed.

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. **Member Intervention Objective**:

    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

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 or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N: 1,222 D: 3,755 R: 32.54%	R: 42.54%	**10 Percentage Points from Baseline Year 2021 to re-measurement year 2022**
Performance Indicator #1b (HCV Treatment Initiation-Persons who use drugs): ***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: 797 D: 2,418 R: 32.96%	R: 42.96%	**10 Percentage Points from Baseline Year 2021 to re-measurement year 2022**

Indicators	Baseline Rate[1] Measurement Period: 1/1/21-12/31/21	Target Rate[2] : CY 2022	Rationale for Target Rate[3]
Performance Indicator #1c (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: 59 D: 133 R: 44.36%	R: 54.36%	**10 Percentage Points from Baseline Year 2021 to re-measurement year 2022**

[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 (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 #1a
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 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 #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 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 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

[1] Rates exclude members with an OPH indicator of 'cured/cleared' for whom claims data is unavailable (transferred or previously uninsured).

Data Collection and Analysis Procedures

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

- Due to the change in OPH listing ,the population that was targeted by PIP interventions were only those members who have “Current Infection/Needs Follow Up “ as the PIP’s focus shifted to treatment improvement. Case Management had a targeted outreach to members with “Current Infection/Needs Follow Up “per OPH listing and a third quarter texting campaign began going to those same members as well.

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 Enterprise Analytics (Informatics) Department collects data from claims/ encounter files of all eligible members. Data sources may include the following: claims/encounter data (administrative data). Administrative data will be collected based on need, quarterly, and annually. For Intervention Tracking Measures (ITM), data was 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 Enterprise Analytics 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: 1/1/2021
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

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 *October only***
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation (**Cumulative)** **Planned Start Date:** January 2022 **Actual Start Date**: March 2022	**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 (Current HCV Infection/Needs follow-up))	N: 4 D: 1.468 R: 0.27%	N:6 D:1,376 R:0.44%	N:6 D:1,595 R:0.38%	N:0 D:1,545 R:0.00%
Intervention #1aii to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **(Non-Cumulative)** **Planned Start Date:** January 2022 **Actual Start Date**: March 2022	**Intervention #1aii tracking measure:** **N:** # members with appointment scheduled **D:** # members with confirmed or probable HCV per OPH listing not receiving treatment (Current HCV Infection/Needs follow up) with a successful telephonic contact by MCO Case Manager/Care Coordinator for HCV treatment assessment/initiation	N:4 D:44 R:9.09%	N:6 D:63 R:9.52%	N:6 D:59 R:10.17%	N:0 D:14 R:0.00%
Intervention #1b to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **(Cumulative)** **Planned Start Date:** January 2022 **Actual Start Date:** March 2022	**Intervention #1b tracking measure:** **N:** # members with a successful telephonic contact by CM for HCV Treatment Initiation or care coordination **D:** # members with past or current drug use with confirmed or probable HCV per OPH listing not receiving treatment (current HCV infection/Needs follow-up)	N: 19 D: 1,031 R: 1.84%	N:63 D:971 R:6.49%	N:59 D:1,141 R:5.17%	N:8 D:1,091 R:0.73%
Intervention #1c to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation: For persons with HIV **(Non-cumulative)** **Planned Start Date:** April 2022	**Intervention #1c tracking measure:** **N:** # members with a successful telephonic contact by CM for HCV Treatment Initiation or care coordination	N:3 D:43 R:6.98%	N:0 D:41 R:0.00%	N:5 D:64 R:7.81%	N:0 D:61 R:0.00%

Actual Start Date: March 2022	**D:** # members ever diagnosed with HIV with confirmed or probable HCV per OPH listing not receiving treatment (current HCV Infection/needs follow-up)				
Intervention #1cii to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation: For persons with a housing disparity **(non-cumulative)** **Planned Start Date:** April 2022 **Actual Start Date:** April 2022	**Intervention #1cii tracking measure:** **N:** # members receiving care coordination or case management **D:** # members ever diagnosed with HIV with confirmed or probable HCV per OPH listing not receiving treatment (Current HCV Infection/needs follow-up) with a Housing Disparity	N/A	N:1 D:1 R:100.00%	N:3 D:3 R:100.00%	N:2 D:2 R:100.00%
Barrier 2a: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification: Provider Trainings, CM Member Feedback**		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *October only***
Intervention #2a to address barrier: Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **(Non-cumulative)** **Planned Start Date:** January 2022 **Actual Start Date**: January 2022	**Intervention #2a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N:172 D:175 R:98.29%	N:198 D:210 R:94.29%	N:182 D:190 R:95.79%	N:59 D:61 R:96.72%
Barrier 2b: Providers may not be aware of HCV clinical guidelines, HCV specialists, and their patients' eligibility for treatment. **Method of barrier identification: direct provider feedback about what is working/ not working.**		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *October only***
Intervention #2bi to address barrier: Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers and HCV Care Gap Reports **(Cumulative)** **Planned Start Date:** March 2022 **Actual Start Date**: March 2022	**Intervention #2bi tracking measure:** **N**: # providers registered on Provider Portal with access to Hepatitis C Care Gap Report **D**: # providers with members on Hepatitis C Care Gap Report who need treatment (current HCV Infection/needs follow-up)	N:812 D:821 R:98.90%	N:823 D:836 R:98.44%	N:806 D:836 R:96.41%	N:815 D:833 R:97.84%
Intervention #2bii to address barrier: Intervention to outreach providers to educate about HCV CPG and to distribute listing of HCV Treatment Providers and	**Intervention #2bii tracking measure:**	N: 13 D: 292 R: 4.45%	N:35 D:291 R:12.03%	N:25 D:292 R:8.56%	N:17 D:293 R:5.80%

HCV Care Gap Reports **(Non-cumulative)** **Planned Start Date:** February 2022 **Actual Start Date:** February 2022	**N:** # TIN groups who received quarterly or ad-hoc HCV Treatment Education **D:** # TIN groups with members on Hepatitis C Care Gap Report who need treatment (Current HCV Infection/needs follow-up)				
Barrier 3a: Member lack of knowledge of HCV Treatment Initiative **Method of barrier identification: Direct Member Feedback about need for and adherence to HCV Treatment Medication**		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *October only***
Intervention #3a to address barrier: Intervention to outreach members who have a lapse in fill of HCV Treatment Medication **(Non-cumulative)** **Planned Start Date: March 2022** **Actual Start Date**: July 2022	**Intervention #3a tracking measure:** **N:** # members who filled prescription for HCV Treatment Medication within 30 days **D:** # members who received a medication adherence text message	N/A	N/A	N:5 D:5 R:100.00%	N: D: R: N/A *No member details to review for the quarter*
Intervention #3aii to address barrier: Intervention to outreach members who fill an initial prescription for HCV Treatment Medication **(Non-cumulative)** **Planned Start Date:** June 2022 **Actual Start Date**: September 2022 **No member level detail to review **	**Intervention #3aii tracking measure:** **N:** # members who started HCV Treatment Medication **D:** # members who received HCV Treatment text message	N/A	N/A	N/A	N/A
Barrier 3b: Multiple medication treatment plans for different comorbidities (HIV, BH, Diabetes, etc.)/Side effects of multiple medications **Method of barrier identification: Direct Member Feedback about unwillingness to take additional medications**		**2022**			
		Q1	**Q2**	**Q3**	**Q4 *October only***
Intervention #3b to address barrier: Intervention to engage members who fill an initial prescription for HCV Treatment Medication in Case Management (**Non-cumulative)** *Note members enrolled in CM even if opt-out or UTC and are called monthly to monitor compliance* **Planned Start Date:** January 2022	**Intervention #3b tracking measure:** **N:** # members enrolled in Case Management or receiving Care Coordination **D:** # members who filled initial Hepatitis C treatment prescription	N: 69 D: 78 R: 88.46%	N:70 D:90 R:77.78%	N:63 D:82 R:76.83%	N:5 D:28 R:17.86%

Actual Start Date: January 2022					
Barrier 3c: Homelessness/Transient Population/Unable to Contact **Method of barrier identification: Direct Member Feedback- No place to store medications, poor nutrition, no transportation**		**2022** **Q1**	**Q2**	**Q3**	**Q4 *October only***
Intervention #3c to address barrier: Intervention to outreach and educate UTC members for HCV Treatment Initiation **(Non-cumulative)** **Planned Start Date:** March 2022 **Actual Start Date**: March 2022	**Intervention #3c tracking measure:** **N:** # members with a successful face-to-face interaction (in-person) **D**: # members on OPH listing with confirmed or probable HCV and not receiving treatment (Current HCV Infection/needs follow-up) who are Unable to Contact (telephonically)	N/A	N/A	N:3 D:50 R:6.00%	N:4 D:52 R:7.69%

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	**Interim Final Period** Measure period: **1/1/22-10/31/22**	**Target Rate[1]**
Performance Indicator #1a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N: 1,222 D: 3,755 R: 32.54%	N: 1,404 D: 3,693 R: 38.02%	Rate: 42.54%
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 or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV***	N: 797 D: 2,418 R: 32.96%	N: 954 D: 2,429 R: 39.28%	Rate: 42.96%

Indicator	Baseline Period Measure period: 1/1/21-12/31/21	Interim Final Period Measure period: **1/1/22-10/31/22**	Target Rate[1]
was initiated {numerator}.			
Performance Indicator #1c (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: 59 D: 133 R: 44.36%	N:92 D: 167 R: 55.09%	Rate: 54.36%

[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.

    - Performance Indicator #1a:(HCV Treatment Initiation Overall): Overall initiation of treatment increased by 5.48% from the 2021 baseline MY (32.54% to 38.02%). There was no interim period with this PIP. The target goal of 42.54% was not achieved for this measurement year.

    - Performance Indicator #1b:(HCV Treatment Initiation-Person who use drugs: HCV Treatment Initiation for persons who use drugs increased by 6.32% from the baseline MY (32.96% to 39.28%). There was no interim period with this PIP. The target goal of 42.96% was not achieved for this measurement year.

    - Performance Indicator #1c: HVC Treatment Initiation-Persons with HIV: HCV Treatment Initiation for persons with HIV increased by 10.73% from the baseline MY (44.36% to 55.09%). There was no interim period with this PIP. The target goal of 54.36% was exceeded this measurement year with a rate of 55.09%.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**
    - Performance Indicator 1c exceeded the targeted goal rate of 54.36% with a final rate of 55.09%. Performance Indicators 1a and 1b had increases quarter over quarter but did not meet their respective target goals. Our interventions focused on outreach to members who had OPH interpretation of “Current Infection/Needs follow up” by telephonic and face to face outreach, as well as text messaging campaigns for treatment and medication adherence.

PIP Highlights:

One of the major **member barriers** we faced were members who are unable to contact telephonically. The plan addressed this barrier by implementing interventions listed below:

- Face to Face outreach by our community team. 7 members have had successful face to face interaction thus far.
- Case management telephonic outreach, tracking successful calls, as well as appointments made. 180 members had a successful telephonic outreach with 16 appointments made.
- Care Coordination offered to members with HIV facing homelessness/housing insecurity. 6 members identified as having housing issues received some form of Care Coordination services, such as being offered resources or referral to ACLA’s Housing Program Manager.
- Medication adherence text messaging campaign to those who miss one month or more of their Hep C medication refills.
- General treatment text messaging campaign to members on OPH listing with interpretation “Current Infection/Needs follow up” began in September.
- Social Media campaign ran in July for World Hepatitis Day.

The main **provider barrier** was providers unaware of the HCV Treatment Initiative and Treatment Guidelines. The plan addressed this barrier by implementing interventions listed below:

- 90 TIN groups received virtual or in-person Quality Management Provider Visits which discussed Treatment Initiative and how to use Provider Portal for Care Gap Reports.
- HCV Screening Care Gap Report available in Provider Portal.
- Provider Alert sent out to educate on LDH HCV Treatment Initiative, CDC Guidelines and Epclusa treatment option.
- Direct feedback obtained by Providers included lack of access and training in Provider Portal, staffing issues, PCP's not wanting to write RX for Epclusa, members with language / health literacy issues, lack of transportation and cell/internet service in rural areas.

- **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 that direct telephonic contact with members did not increase our appointment rates. We had 180 successful telephonic outreaches, but only 16 appointments made. This low appointment rate may be due to members opting out of case management and declining assistance with appointment scheduling. Similarly, we noted that face to face outreach was not a successful ITM either, as there were only 7 successful. Feedback provided by the Community Team included safety issues, members with unstable or no housing, members with no cell phones or incorrect numbers/addresses in our system. Attempts were made to locate other addresses / phone numbers via pharmacies and PCPs. Case managers make 3 phone calls and send an unable to contact letter to members.
    - Members who fill an initial prescription for HCV treatment are enrolled in Case Management for the duration of treatment, even if they are Unable to Contact or Opt-out of CM engagement. Members are called monthly while on the medication to monitor for compliance, by either a successful call with member or monitoring claims. Claims lag may prevent timely outreach to member after initial fill.

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.

    - Threats to the internal validity of the findings include care management process of measuring data accuracy due to limitations of episodic documentation and data abstraction from the plan's integrated care management software.
    - The administrative measure accuracy that is specified using diagnosis or procedure codes are limited to the extent that providers and coders enter correct codes and that OPH file has accurate data.
    - The change in OPH listing caused a shift mid-2022, as ITM's were revised to reflect only those members who had an interpretation "Current Infection/Needs follow-up" and our performance indicators continued to include all categories except "Cured/Cleared" that we could not identify through our records. This likely affected the validity and reliability of our findings, as the new population was smaller and did not include any members with an unknown status.

- **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).

    - Threats to the external validity of the findings included Case Management telephonic outreach had majority Unable to Contact members, as well as members opted out or declined assistance with appointment scheduling.

- **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 plan face challenges with date collection for processed measures focused on case management outreach. Limits related to episodic documentation and data abstraction from the plan's integrated case management software may have resulted in an underrepresentation of CM member interactions.

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
Enhanced Case Management Outreach for HCV Treatment Initiation:	Unable to Contact members are at risk for missing education and case management interventions as well as missing scheduled appointments	Face to Face outreach resumed for unable to contact members with current HCV infection	Continue CM telephonic outreach to all members on the OPH listing with interpretation “Current infection/needs follow up” Ensure we have the most up to date contact information for member by.
Provider Education	Providers are unaware of their assigned members HCV status and on the HCV treatment guidelines. PCPs unwilling to write RX for Epclusa Providers not using Provider Portal	No system changes	Continue to outreach and offer virtual or in-person Quality Provider Trainings that educates on HCV treatment guidelines as well as goes over Provider Portal and how to access Care Gap Reports. Educate PCPs that they can write for the Epclusa, or they need to refer member to HCV specialist for treatment.
Enhanced Member Outreach: Text messaging campaigns/social media posts	Texting campaigns / social media are beneficial ways of outreaching members and providing education on HCV Treatment	No system changes	Continue to promote HCV Treatment via social media and texting campaigns
Enhanced Member Outreach: Engaged/Enrolled by Case Managers during treatment	Members on HCV medication mainly opt-out of engaging in Case Management, but many agree to be called for a monthly check in while on the medication	No system changes	Members will be continued to be enrolled in Hep C Case Management Program even if they are Unable to Contact or Opt-out; they will still be called monthly, and Case Manager will monitor for medication compliance.
Enhanced Member Outreach: Face to Face Interaction for	UTC members have unstable housing, lack of cell phone, not following	No system changes	Increase number of UTC members referred to Community team for face-

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
members unable to contact and in need of HCV Treatment	up with assigned PCP and they miss out on case management education and interventions.		to-face interaction as staffing allows
Enhanced Case Management Outreach for HCV Treatment Initiation: For persons with HIV	Members with HCV and HIV co-infection has a threat to their overall health	HIV Housing Standard Operating Procedure has been created and awaiting approval from ACLA Compliance Department	Refer members with HIV/HCV co-infection who have housing disparities to Housing Program Manager for assistance

References

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

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

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

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

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

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

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

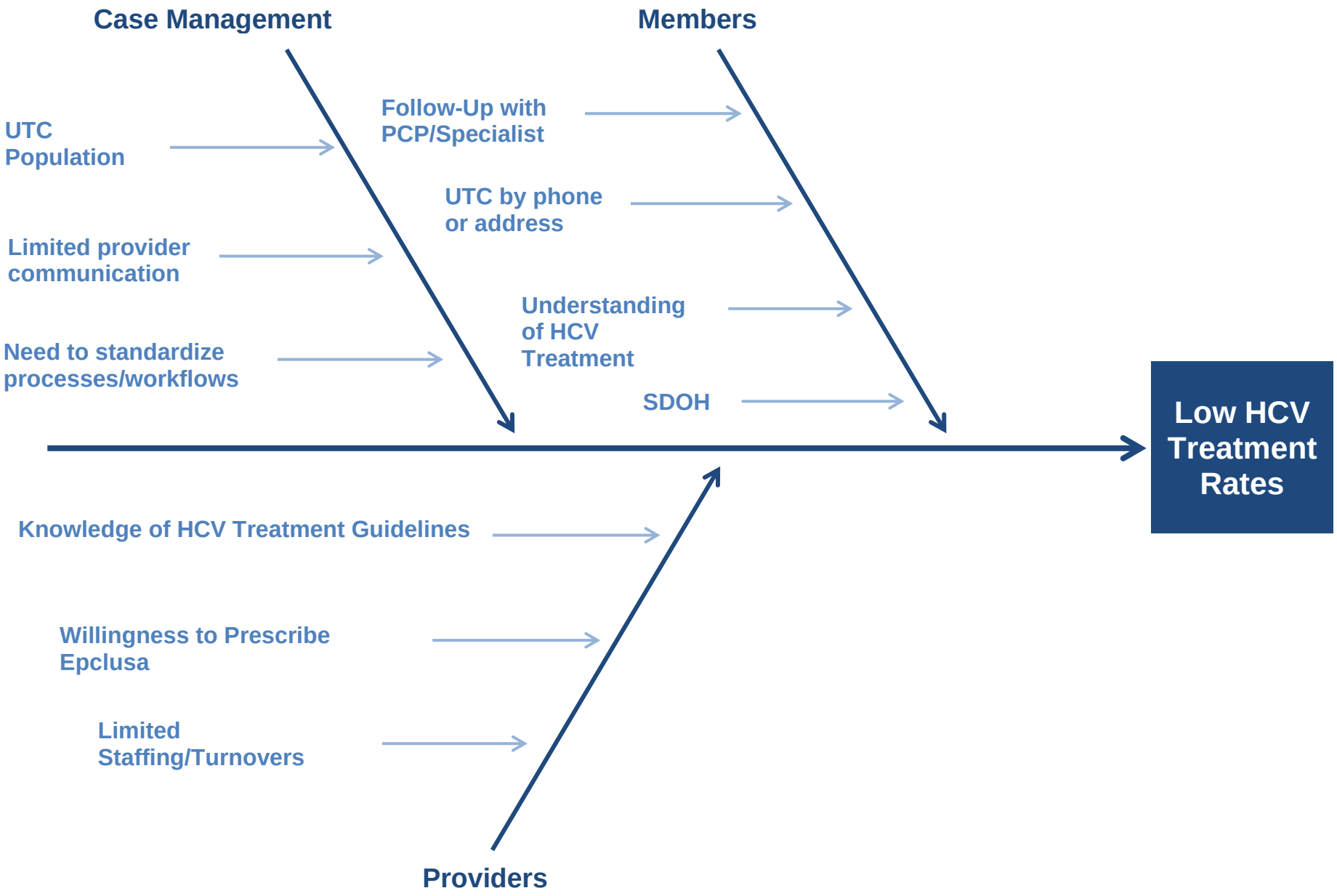
Glossary of PIP Terms

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

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

Appendix A: Fishbone (Cause and Effect) Diagram



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	• AmeriHealth Caritas Louisiana Interdepartmental Communication Regarding Treatment Options. • Provider Education: LDH Focus now on Hepatitis C Treatment and that generic Epclusa does not require PA. • Member Education and Awareness of LDH Treatment Initiative via telephonic outreach by Quality and CM. • Conducting Member Face to Face Outreach • Internal Collaboration for developing and reporting ITM's • Staff training on HCV Treatment Initiative	• Face to Face Provider Trainings
Less Feasible to Address	• Members who are Unable to Contact • Providers unwilling to Initiate Treatment Protocol	• Providers unwilling to use Provider Portal

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** Case Management referrals for At- Risk Members Ability to Outreach At-Risk Members on a Large Scale through RROT Wellness Team and CM Address Member Health Disparity by referring to CM, Housing Program Manager and Mom's Meals. Targeted Provider Outreach to those Not Registered on Provider Portal, as well as High Volume Providers	***minimize*** **WEAKNESSES** ***Examples:*** Inaccurate Reports Limits of Clinical Software Low Member Feedback via Member Surveys Improve Outreach Process
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** Member Outreach Via Health Fairs / Community Health Center Events/Faith Based Organizations Providers Registering for Provider Alerts	***protect from*** **THREATS** ***Examples:*** Unable to Contact Members Provider Participation and Availability in Trainings COVID 19 restrictions Co-morbid medical conditions Limited Workforce Capacity Limited Providers in Rural Areas

Appendix D: Driver Diagram

Aim	Primary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
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) Agent's 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 lists of members with HCV diagnosis for referral to PCPs for treatment and assign to Case management
		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 Coordination Outreach to educate, refer and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.

Appendix E: Plan-Do-Study-Act Worksheet (use power point template)

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1: Enhanced Case Management Outreach for HCV Treatment			
Plan: Document the plan for conducting the intervention.	• Telephonic outreach to members with "current HCV Infection/need	• Appointments made by CM with PCP or Specialist for Treatment.	• Face to face contact with unable to contact members in need of
Do: Document implementation of the intervention.	•Implementation began March 2022	• Implementation began March 2022	• Implementation began September 2022
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 the interventions.	• Direct contact with member did not make an impact on success or failure of this intervention	• Direct contact with member made largest impact on success or failure of this 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.	•Ensure the plan has the most current contact information for member	• Improve appointment rate by getting direct member feedback on barriers and addressing barriers as appropriate	• Increase number of referrals to Community Outreach team
Intervention #2: Enhanced Member Outreach for medication compliance			
Plan: Document the plan for conducting the intervention.	•Telephonic Outreach and Texting Campaign for medication	• CM enrollment for members who are prescribed HCV treatment	•Medication adherence text messaging campaign for those
Do: Document implementation of the intervention.	•Implementation began January 2022; May 2022	• January 2022	•May 2022
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•Direct contact with members made largest impact on success or failure of the interventions.	•Claims lag may affect timely outreach by Case Management •Members opt out of Case	•Success or failure of this intervention depends on whether the plan has the most current
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	• Ensure the plan has the most current contact information for member	• Case management will continue to auto-enroll members into CM and make monthly calls to monitor compliance	• Team members should update phone numbers with any successful calls made to member