Health Plan Performance Improvement Project (PIP)

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Health Plan:

PIP Title: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

PIP Implementation Period: January 1, 2020-December 31, 2021

Submission Dates:

	Proposal/Baseline	Interim	Final
Version 1	02/03/2020	12/31/2020	12/31/2021
Version 2			

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Attestation

Plan Name:
Title of Project:

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

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Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.
[EXAMPLES INCLUDE: ADDED NEW INTERVENTIONS, ADDED A NEW SURVEY, CHANGE IN INDICATOR DEFINITION OR DATA COLLECTION, DEVIATED FROM HEDIS® SPECIFICATIONS, REDUCED SAMPLE SIZE(S)]

Table 1: Updates to PIP

Change	Date of change	Area of change	Brief Description of change
Change 1 CM Linkage to Treatment Rate/PDSA	9/2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	MCO outreach denominator changed to OPH population
Change 2 MCO Outreach to at Risk Members enhanced	10/2020	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	As required in the PIP, all ABH-LA members who are at risk were identified for outreach to get screening/treatment
Change 3 Member Services added for Outreach coverage	10/2020	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Outreach was our primary goal, MS added to help with the extensive outreach need
Change 4 QNXT Flag for HCV	9/2020	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	The HCV Flag allows any pro-active contact with the member to address this health concern and not wait on outreach
Change 5 Added ITM's 2a,b,c	1/2021	☐ Project Topic ☐ Methodology ☒ Barrier Analysis / Intervention ☐ Other	Although 2a was a LDH addition, the other ones under 2 (b&c) were added to show the extent of Aetna outreach based on member risk factors
Change 6 ITM 5a for additional screening	1/2021	☐ Project Topic ☐ Methodology ☐ Barrier Analysis / Intervention ☒ Other	We added this ITM to capture efforts already being done, it's a unique and different way to get screenings done via Community events
Change 7 ITM 7 a&b were added for subpopulation review	1/2021	☐ Project Topic ☒ Methodology ☐ Barrier Analysis / Intervention ☐ Other	These two ITM's were added to highlight the only 2 populations that CDC guidelines to be screened multiple times

Abstract

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

Project Topic/Rational: 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 HCV screening rate and initiation of HCV pharmaceutical treatment rate by ten percentage points by implementing a robust set of interventions directed to Members and Providers.

Methodology: Screening methodology is to measure the percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}. 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 members, 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 many of the ITM's in 2021 to measure the current Pandemic practices and environment around outreach, educations, and improving PI's. In accordance with new practices for both members and providers, LDH asked ABHLA to add at least one subpopulation ITM, we added two for those populations the CDC recently changed screening requirements on to understand if screening guidelines were being followed at the same time, we educated providers on the need for multiple screenings as well as fee codes they could use when screening Pregnant and/or members with a substance use disorder. We found that while the overall numbers did go up quarter over quarter, they were still very low (less than 50%) for what the CDC guidelines say should be 100%. We focused our HCV provider education on the CDC guidelines and algorithm for screening and treatment in the first part of the year and then adjoined the information to screen for SUD. Both ITM's (7 a&b) showed progress over time but it was not at the gains one would hope.

Results: ABHLA showed steady progress from the 2019 baseline numbers through the last two years in screening with the largest increase in the non-boomer population screenings. This group, PI 2a, went from a baseline of 33% to over 41% in two years and we expect once the quarterly educational text campaigns begin, we'll see even more improvement in 2022. The areas where we seemed to really accelerate were in treatment. All 3 treatment PI's doubled, or better, and showed progression from baseline to current 2021 performance. This is also an area we are highly focused on improving in Q4 and 2022 as the overall majority of those screened who go into treatment is around 30% which is the national average but not acceptable given the known viral status of the members. We did see a drop in the annual screening rate, PI 2b, from 2020 and are attributing that to COVID concerns which is why we had the screenings at Community events ITM added but with the push and focus on vaccinations and resurgence of the Delta variant, we had few opportunities where this unique opportunity was offered.

The last remaining refocus for this PIP in 2021 for ABHLA was around outreach to members on the OPH list or who had 1 or more of the risk factors listed in the PIP charter. The other 'new' ways we are outreaching is through our Services department who was making outbound calls to members and encourage them to get screened. This method showed significant success as over 3,400 members were outreached in 7 months and could be one of the main drivers for our Screening PI metrics improving and with the change to our text campaigns in Q4, we hope this more direct method will continue to reach more members and result in members screened.

Conclusions: Provider education continues to be an issue. Distribution of information is easy but determining if it's making it to the providers interfacing with members is not visible to us. Our ITM's that require Providers to screen in certain situations, ITM's 7a & 7b, along with 6a for those below 18 years to identify if CDC pediatric guidelines screenings were being followed showed low adherence rates, and performance in 2021 despite repeated education to providers for all was rather flat. Some Provider groups, like Ochsner, have folded HCV screenings into their annual bloodwork panels while others have not. In 2022 we look towards our Provider Network team to help facilitate guideline delivery to providers while bringing back barriers they are hearing. Simply put, educating providers will not resolve or greatly improve this metric in the next year. We will continue to stress guidelines to our Value Base Providers, while also focusing more attention on educating members that the virus can be resolved and avoiding screening and treatment in the long run is not healthy. We feel with new outreach technology, treatment might be able to show improvement.

Next Steps: ABHLA is going to build off the screening efforts, especially for non-baby boomer, in 2022. We will also we looking to identify barriers to treatment by both providers and members and define ITM's to help improve those numbers. 2022 will be a test case for finding new ways and methods to reach members and get them into treatment. As this PIP's focus in 2022 is treatment, screening and all the great efforts we put into that will roll into our Population Health (POP Health) team to continue the great screening work and performance. We will review the text campaign performance for screenings and determine if the Services outreach efforts need to resume.

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

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

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

Table 2: Goals

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	2020 Target Rate[2]	Rationale for Target Rate[3]
Performance Indicator #1a (Universal Screening): ***The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.***	N: 10849 D: 69005 R: 16%	R: 26%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #1b (Birth Cohort Screening): ***The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 3779 D: 21125 R: 18%	R: 28%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening- ever screened): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 3401 D: 10178 R: 33%	R: 43%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Annual Screening): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.***	N: 1720 D: 10178 R: 17%	R: 27%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #3a (HCV Treatment Initiation-Overall): ***The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing***	N: 364 D: 2283 R: 16%	R: 26%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C

Indicators	Baseline Rate[1] Measurement Period: 1/1/19-12/31/19	2020 Target Rate[2]	Rationale for Target Rate[3]
{denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.			
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): ***The percentage of the subset of adults with current or past drug use and a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N: 179 D: 1313 R: 14%	R: 24%	Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): ***The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per OPH listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N: 9 D: 121 R: 7%	R: 17%	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).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

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

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

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

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

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

Data Collection and Analysis Procedures

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

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:

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

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

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation that has occurred, methods to address missing data and audits that have been conducted.

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

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

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among sub-populations within the baseline period is appropriate).Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*
Describe how plan will interpret improvement relative to goal.
Describe how the plan will monitor intervention tracking measures (ITMs) for ongoing quality improvement (e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

- **Describe data analysis procedures:**

Our data collection for identifying, measuring, and reporting for needs related to HCV screening and linkage to treatment information are generated from claims. In addition, the plan integrates OPH data, Hep C performance metrics, Care Management dynamo platform of enrollment patterns and care coordination for screening and treatment, enrollee participation, and intervention tracking measures, as well as any additional process metrics. An analysis is conducted of related utilization management services, and provider/enrollee claims audits to ensure provider and/or member adherence to screening, linkage to treatment and/or evidence- based guidelines. Data is stratified by at risk populations identified for Hep C screening and linkage to treatment, including key clinical factors. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP Hep C committee members, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABH-LA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABH-LA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the HCV PIP and its corresponding goals.

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

In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional, member, and provider demographic variations, to identify variation in access and health care services. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in screening and active treatment.

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

The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is being observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

(Tentative) PIP Timeline

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

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

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

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

Submission of 1st Quarterly Status Report for Intervention Period from 1/1/21-3/31/21 Due: 4/30/2021
Submission of 2nd Quarterly Status Report for Intervention Period from 4/1/21-6/30/21 Due: 7/31/2021
Submission of 3rd Quarterly Status Report for Intervention Period from 7/1/21-9/30/21 Due: 10/31/2021

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

Final Measurement Period:
Start date: 1/1/2021
End date: 12/31/2021

Submission of Draft Final Report Due: 12/10/2021
Submission of Final Final Report Due: 12/31/2021

Barrier Analysis, Interventions, and Monitoring

Table 4: Alignment of Barriers, Interventions and Tracking Measures

Barrier 1: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification: IPRO HCV PIP guidance document.**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #1a to address barrier: Enhanced Case Management Outreach for HCV Treatment Initiation **Planned Start Date: 2/17/2020** **Actual Start Date**: **2/17/2020**	**Intervention #1a tracking measure:** **N:** # members with appointment scheduled with HCV specialist (in OPH database) or PCP for HCV treatment assessment/initiation **D:** # members with confirmed or probable HCV per OPH listing not receiving treatment	N: 94 D: 2702 R: 3.40%	N: 202 D: 2541 R: 7.9%	N: 141 D: 2267 R: 6.21%	N: 94 D: 2793 R: 3.37%	N:209 D:2706 R: 7.72%	N: 159 D: 2558 R: 6.22%	N: 141 D: 2441 R: 5.78%	N: 62 D: 1256 R:4.94%
Intervention #1b to address barrier: Enhanced Case Management Outreach for HCV Screening: Utilize MCO claims/encounter data to identify at-risk members for HCV screening and schedule a screening appointment with the member's PCP **Planned Start Date: 2/17/2020** **Actual Start Date**: **2/17/2020**	**Intervention #1b tracking measure:** **N:** Number of members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV screening **D:** Number of members at risk for HCV per MCO claims/encounter data	N: 16 D: 18315 R: 0.08%	N: 34 D: 19069 R: 0.17%	N: 24 D: 20365 R: 0.12%	N: 64 D: 20630 R: 0.31%	N: 70 D:15481 R: 0.45%	N: 75 D: 15976 R: 0.47%	N: 58 D: 16479 R: 0.35%	N: 64 D: 16765 R: 0.38%

Barrier 2: Asymptomatic enrollees may not know they are infected with HCV. Method of barrier identification: IPRO HCV PIP guidance document.		2020				2021			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intervention #2a to address barrier: Enhanced Case Management Outreach for HCV Screening **Planned Start Date: 2/17/2020** **Actual Start Date**: **2/17/2020**	**Intervention #2a tracking measure:** N: Those at risk who were outreached via Enhanced Outreach Model on SharePoint **D:** # members with any risk factors for HCV as specified within the PIP ***New***	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: 663 D: 37855 R: 1.75%	N: 2961 D: 38220 R: 7.75%	N: 377 D: 38643 R: 0.98%	N: 187 D: 38719 R: 0.48%
Intervention #2b to address barrier: **Launch education campaigns for risks and recommend members get tested** **Planned Start Date: 4/1/2021** **Actual Start Date**: **11/2021**	**Intervention #2b tracking measure:** **N: # text messages that were sent to members 18 and over** **D: # of plan members 18 and over** ***New***	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: 83163 R:	N: D: 85095 R:	N: D: 87046 R:	N: 47194 D: 89267 R: 52.87%
Intervention #2c to address barrier: **Enhanced Outreach for HCV Screening through Member Services** **Planned Start Date: 1/1/2021** **Actual Start Date**: **03/2021**	**Intervention #2c tracking measure:** **N: # members Member Services contacted off the Enhanced Risk Model** **D: # members on the Enhanced Model** ***New***	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N:579 D:15309 R: 3.78%	N: 2531 D: 15086 R: 16.78%	N: 323 D: 14931 R: 2.16%	N: 0 D: 14835 R: 0%

Barrier 3: Providers may not be aware that Epclusa does not require prior authorization. **Method of barrier identification:** Breaking Down the Barriers to Hepatitis C Virus (HCV) Treatment Among Individuals With HCV/HIV Coinfection: Action Required at the System, Provider, and Patient Levels (Grebely, 2013) , Internal PIP Hep C committee brainstorm/discussion, Understanding and addressing hepatitis C reinfection in the oral direct		2020				2021			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Was 1a part 2 **Intervention <u>#3a</u> to address barrier:** Provider education regarding SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) prescription. **Planned Start Date: 1/2020** **Actual Start Date: 1/2020**	**Intervention #3a tracking measure:** **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	N: 470 D: 472 R: 99.6%	N: 296 D: 302 R: 98.0%	N: 281 D: 287 R: 97.9%	N: 186 D: 190 R: 97.9%	N:244 D:244 R: 100%	N: 260 D: 260 R: 100%	N: 132 D: 132 R: 100%	N: 99 D: 99 R: 100%
Intervention #4a to address barrier: **Provider education of how to treat members once screened via Algorithm and other education material** **Planned Start Date: 3/1/2021** **Actual Start Date: 3/1/2021**	**Intervention #4a tracking measure:** **N: # of Providers who received education material** **D: Total # of Providers in network**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N:4282 D:27164 R: 15.76%	N: 5405 D: 27641 R: 19.55%	N: 666 D: 28082 R: 2.37%	N: 2811 D: 29543 R: 9.51%
Intervention #4b 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**	**Intervention #4b 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: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D:4166 R: N/A	N: D: 4184 R: N/A	N: D: 4198 R: N/A	N: 2648 D: 4038 R: 65.58%

Planned Start Date: 3/1/2021 **Actual Start Date: 10/2021**									
Barrier 4: New Healthy Louisiana HCV treatment benefit may be unknown to enrollee. **Method of barrier identification: Asymptomatic enrollees may not know they are infected with HCV.**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #5a to address barrier: **Conduct screenings in community events at least once a month** **Planned Start Date: 4/1/2021** **Actual Start Date: 6/1/2021**	**Intervention #5a tracking measure:** **N: # of people tested at community events** **D: # of people who attended the event** ***New***	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier 5: Identifying, screening, and treating the most 'at risk' age group for HCV in Healthy Louisiana **Method of barrier identification: Asymptomatic enrollees may not know they are infected with HCV.**		**2020**				**2021**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #6 to address barrier: **Enhanced Outreach for HCV Screening for children born to a HCV positive mother. Reviewing screening of children in general as a potential gap. CDC protocol is to screen at or over 18 months for a accurate screening.** **Planned Start Date: 1/1/2021** **Actual Start Date: 1/1/2021**	**Intervention #6a tracking measure:** **N: # children screened ≥ 18 months** **D: # children born to an untreated HCV mother** ***New***	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: 1 D: 65 R: 1.54%	N: 1 D: 73 R: 1.37%	N: 1 D: 78 R: 1.28%	N: 1 D: 82 R: 1.21%

Intervention #7a to address barrier: CDC guidelines for screening a specific subpopulation **Planned Start Date: 1/2021** **Actual Start Date: 1/1/2021**	**Intervention #7a tracking measure:** **N: Pregnant Women Screened for HCV** **D: All pregnant women**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: 240 D: 604 R: 39.74%	N: 195 D: 556 R: 35.07%	N: 227 D: 654 R: 34.71%	N: 202 D: 563 R: 35.88%
Intervention #7b to address barrier: CDC guidelines for at risk population for screening; subpopulation crossover based on behavior and outcomes **Planned Start Date: 1/2021** **Actual Start Date: 1/1/2021**	**Intervention #7b tracking measure:** **N: SUD Risk Factor HCV Members who were ever screened** **D: All SUD HCV Risk Members**	N: D: R:	N: D: R:	N: D: R:	N: D: R:	N: 4450 D: 12696 R: 35.05%	N: 4944 D: 13223 R: 37.39%	N: 5284 D: 13780 R: 38.35%	N: 5414 D: 13835 R: 39.13%

Results

To be completed upon Baseline, Interim and Final Report submissions. The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

Table 5: Results

Indicator	**Baseline Period** Measure period: 1/1/2019-12/31/2019	**Interim Period** Measure period: 1/1/2020-12/31/2020	**Final Period** Measure period: 1/1/2021 – 12/31/2021	**2021 Target Rate**[1]
Performance Indicator #1a (Universal Screening): ***The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}.***	N: 10849 D: 69005 R: 16%	N: 14238 D: 79661 R: 17.87%	N: 20921 D: 95458 R: 21.92%	Rate: 26% Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #1b (Birth Cohort Screening): ***The percentage of Healthy Louisiana enrollees for whom HCV screening is indicated by birth year between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 3779 D: 21125 R: 18%	N: 4507 D: 22531 R: 20%	N: 5373 D: 23717 R: 22.65%	Rate: 28% Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C

Indicator	**Baseline Period** Measure period: 1/1/2019-12/31/2019	**Interim Period** Measure period: 1/1/2020-12/31/2020	**Final Period** Measure period: 1/1/2021 – 12/31/2021	**2021 Target Rate[1]**
Performance Indicator #2a (Non-Birth Cohort/Risk Factor Screening-ever screened): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were ever screened for HCV {numerator}.***	N: 3401 D: 10178 R: 33%	N: 4469 D: 11834 R: 37.67%	N: 6118 D: 14469 R: 42.28%	Rate: 43% Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #2b (Non-Birth Cohort/Risk Factor Screening-Annual Screening): ***The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened during the measurement year for HCV {numerator}.***	N: 1720 D: 10178 R: 17%	N: 1926 D: 11834 R: 16.28%	N: 2761 D: 14469 R: 19.08%	Rate: 27% Baseline plus 10%, as mandated within the goals and scope of the PIP Hep C
Performance Indicator #3a (HCV Treatment Initiation-Overall): ***The***	N: 364 D: 2283 R: 16%	N: 780 D: 2835 R: 27.51%	N: 1073 D: 3427 R: 31.31%	Rate: 26%/30%

Indicator	**Baseline Period** Measure period: 1/1/2019-12/31/2019	**Interim Period** Measure period: 1/1/2020-12/31/2020	**Final Period** Measure period: 1/1/2021 – 12/31/2021	**2021 Target Rate[1]**
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}.				Baseline plus 10%, added 3% (rounded up) for stretch
Performance Indicator #3b (HCV Treatment Initiation-Drug Users): ***The percentage of the subset of adults with current or past drug use and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.***	N:179 D: 1313 R: 14%	N: 446 D: 1717 R: 25.98%	N: 684 D: 2151 R: 31.8%	Rate: 24%/30% Baseline plus 10%, added 3% (rounded up) for stretch
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): ***The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public***	N: 9 D: 121 R: 7%	N: 56 D: 133 R: 42.1%	N: 79 D: 170 R: 46.47%	Rate: 17%/45% Baseline plus 10% for 2020 was increased due to performance, added 3% in 2021 for stretch

Indicator	Baseline Period Measure period: 1/1/2019- 12/31/2019	Interim Period Measure period: 1/1/2020- 12/31/2020	Final Period Measure period: 1/1/2021 – 12/31/2021	2021 Target Rate[1]
Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.				

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

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

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

Discussion

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

Discussion of Results

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

As noted in the summary section, all screening and treatment numbers improved quarter over quarter from 2019 baseline to 2021 year to date (YTD) except for the screening for non-boomers (PI 2b) in the measurement period but that makes sense given the pool of those not screened would decrease but the overall rate per period being screened is not consistent and this needs to be reviewed in 2022 when POP Health takes over this aspect as a larger STI campaign is being planned in 2022. The pandemic didn't help with this monthly screening rate and the need to keep screening as a focus is evident with our roll-out of the educational text campaigns encouraging everyone to get screened and why it's important to the overall health and welfare of our members.

Performance Indicator	1/1/19-12/31/19	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Target	Q1 2021	Q2 2021	Q3 2021	Q4 2021	2021 Annual Performance	Target
Indicator #1a (Universal Screening): The percentage of Healthy Louisiana enrollees ages 18-79 years {denominator} who were ever screened for HCV {numerator}	N: 10849	N: 12498	N: 13245	N: 13539	N: 14238	Rate: 26%	17726	19045	20022	20664	20664	Rate: 26%
	D: 69005	D: 84402	D: 89100	D: 80435	D: 79661		102556	99292	97035	95314	95314	
	R: 16%	R: 14.8%	R: 14.8%	R: 16.8%	R: 18%		R: 17.28%	R: 19.18%	R: 20.63%	R: 21.68%	R: 21.68%	
Indicator #2b (Non-Birth Cohort/Risk Factor Screening-annual screening): The percentage of Healthy Louisiana adults aged 18 and older for whom HCV screening is indicated by any one or more risk factors other than being born between 1945 and 1965 {denominator} and who were screened for HCV during the measurement period {numerator}.	N: 1720	N: 684	N: 1081	N: 1546	N: 1926	Rate: 27%	879	834	788	587	2640	Rate: 27%
	D: 10178	D: 11793	D: 12047	D: 11735	D: 11834		14043	14207	14354	14361	14362	
	R: 17%	R: 5.8%	R: 8.9%	R: 13.2%	R: 16%		R: 6.26%	R: 5.87%	R: 5.49%	R: 4.09%	R: 18.38%	
Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.	N: 364	N:604	N:660	N: 753	N: 780	Rate: 26%	988	1034	1058	1064	1064	Rate: 26%/30%
	D: 2,283	D:2448	D:2571	D: 2855	D: 2835		3722	3611	3514	3426	3426	
	R: 16%	R:24.6%	R:25.6%	R: 26.4%	R: 28%		R: 26.54%	R: 28.63%	R: 30.11%	R: 31.06%	R: 31.06%	

Although the focus of the PIP in 2022 is going to be treatment, the text campaigns going out will not be altered due to the change. ABHLA will continue to educate members about screening as well as adding specific campaigns around treatment. Again 2020-2021 was focused on getting screening done so next steps for our members was known. Now we see that getting members into treatment has its own unique set of challenges that will need to be explored in 2022 ITM's.

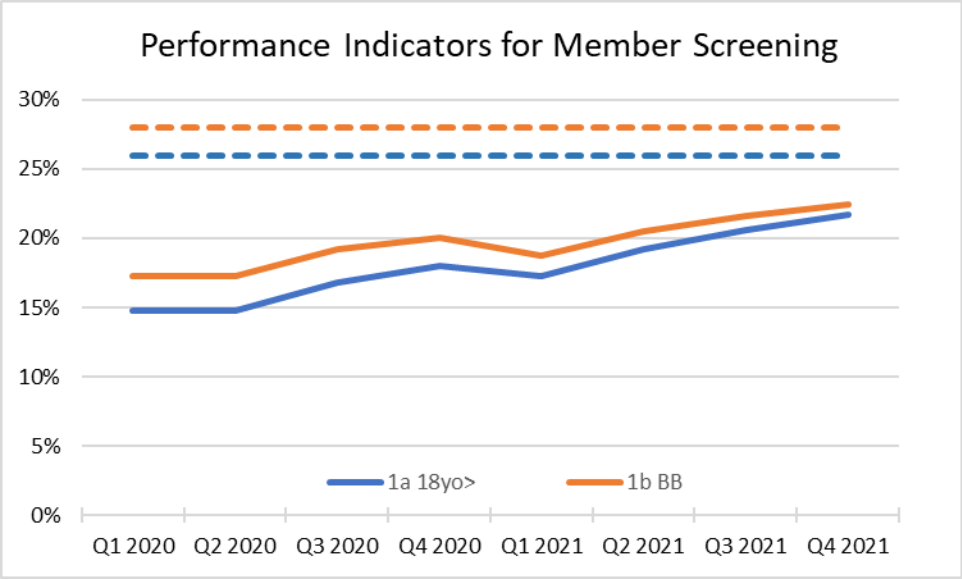
Where our PI's really accelerated was the 3 measures around treatment. We were able to almost double 2 indicators from baseline to October 2021 and the last one (PI 3c) was significantly increased from 7% at 2019 baseline, to 42% at the end of 2020 Interim, to over 46% in Q4 2021. Although there is improvement for all treatment PI's the overall number of members getting treatment is still around 30% (PI 3a) which is also the national average. This is not acceptable, and we look forward to focusing on improving this number in 2022 with help from vendor's and alignment with the other MCO's for methods that work. The other treatment item (PI 3b), which by volume has the largest specific population to push into treatment are those with a SUD diagnosis. This population makes up more than half of those in the denominator for PI 3a and as we know from the retiring IET PIP it is also one of the hardest groups to influence. We feel that

our new outreach vendors technology will be helpful here to effectively contact members in methods are not easy to ignore.

Performance Indicator	1/1/19-12/31/19	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q2 2021	Q3 2021	Q4 2021	2021 Annual Performance	Target
Indicator #3b (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 was initiated {numerator}.										
	N: 179	N:353	N:368	N: 427	N: 446	641	667	677	677	Rate: 24%/30%
	D: 1,313	D:1422	D:1513	D: 1737	D: 1717	2208	2175	2146	2146	
	R: 14%	R:24.8%	R:24.3%	R: 24.6%	R: 26%	**R: 29.03%**	**R: 30.67%**	**R: 31.55%**	**R: 31.55%**	
Performance Indicator #3c (HCV Treatment Initiation-Persons with HIV): The percentage of the subset of adults ever diagnosed with HIV and with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.										
	N: 9	N:49	N:50	N: 54	N: 56	76	77	79	79	Rate: 17% /45%
	D: 121	D:116	D:123	D: 135	D: 133	170	168	170	170	
	R: 7%	R:42.2%	R:40.6%	R: 40.7%	R: 42%	**R: 44.71%**	**R: 45.83%**	**R: 46.47%**	**R: 46.47%**	

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

Although we saw quarter over quarter improvement in PI's there were some ITM's that we could align to improved performance and some that were not able to get started in time to make an impact but will be relevant in 2022. Our ITM 2c which was the outreach our service department was doing to members at risk, not on the OPH list, was clearly a big success as the non-boomer population had the most improvement. Providers know that baby boomers should be screened for HCV at least once in a lifetime, but non-boomers have not had that attention until this PIP. ABHLA did member outreach asking them to get screened at least once in a lifetime for HCV – armed with this information more members did get screened at a higher rate than boomers noted in the graph below. The rate gap is decreasing over 2021 while both screening rates are going up.



We are only sorry that the text campaign, ITM 2b, expected to launch in June got backlogged and wasn't approved by LDH until a second submission. Our vendor sent the first one a week before Thanksgiving

to over 47,000 members, but had we reached all members 18yo and older with that text earlier the overall numbers for screening might have been more positively impacted. ABHLA loaded another HCV file into QNXT in September for follow-up by CM with any passive interaction by members as well, so we hope to see that effort reflected in the Q4 numbers.

Our new ITM's 7a and 7b around subpopulations the CDC updated as needing more frequent screenings showed that educating providers alone on things didn't really impact performance, and therefore the continued member education and contact will continue in 2022 around screening and we are going to add treatment campaigns to members as well via our outreach vendor.

The ITM's around outreach by CM for both screening and treatment, ITM's 1b and 2a, were also low given the amount of outreach calls made and small number of members who were successfully reached. ABH will be looking to revamp these metrics for treatment in 2022 by using additional outreach methods.

The most disappointing results were around providers following CDC screening guidelines which were revised almost 2 years before this PIP. In talking to other Aetna Medicaid states, those states providers took it upon themselves to be aggressive with screening and treatment and therefore no PIP required because of a good outcome rate. ABHLA has a direct path to our Value Base providers but beyond that we have no direct method for making sure providers (not office staff) are receiving the correct information for screening and treatment. Education is key and ABHLA will continue to push this effort in 2022 with multiple methods.

- **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.

Although a lot of things had to change from 2020 into 2021 due to the Pandemic, ABHLA explored methods and means we may not have used otherwise. For instance, the text education campaign. Going directly to the member allows us to get information directly to the member who ultimately makes the decision to move forward. By messaging and empowering our members directly, they can make sure their health needs are being met regardless of provider type, location, or knowledge.

ABHLA was also able to find ways to accommodate many needs within the plan by having to fulfill them in PIP's first. Care Gap reports is one of them. We can share them with our Value Base providers, but that's only about 60% of our provider base. Availity, a secure Provider email, isn't full service either since providers must sign themselves up, and not all of them have done this, so we had to come up with a direct messaging method that delivered to all providers, as needed for each health care gap and we found that in our vendor. This vendor will continue to securely deliver Care Gap reports for specific items as needed for not only this PIP but all care Gaps going forward. This new method allowed ABHLA to deliver 99.8% of members on the OPH List directly to their providers with all the information they need to follow-up. This high success rate for delivery is why we are using it for all care gaps going forward.

One area ABHLA noted a slow improvement was treatment rates, PI's 3a, b, and c. Although we improved from the single digit or low teen baseline of each to over 30% in 2 years that isn't good enough given the knowledge of our members HCV status. We need to find more direct ways to try and get them into treatment and 2022 looks to be a good opportunity to begin working on improving these 3 PI's. It is worth noting that those with HIV, PI 3c, did show the sharpest increase of improvement from 7% at baseline to over 46% YTD.

Performance Indicator	1/1/19-12/31/19	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Target	Q1 2021	Q2 2021	Q3 2021	Q4 2021	2021 Annual Performance	Target
Indicator #3a (HCV Treatment Initiation-Overall): The percentage of all adults (ages 18 and older) with a confirmed or probable diagnosis of Chronic Viral Hepatitis C per the Office of Public Health (OPH) listing {denominator} for whom pharmaceutical treatment for HCV was initiated {numerator}.						Rate: 26%						Rate: 26%/30%
	N: 364	N:604	N:660	N: 753	N: 780		**988**	1034	1058	1064	1064	
	D: 2,283	D:2448	D:2571	D: 2855	D: 2835		**3722**	3611	3514	3426	3426	
	R: 16%	R:24.6%	R:25.6%	R: 26.4%	R: 28%		**R: 26.54%**	**R: 28.63%**	**R: 30.11%**	**R: 31.06%**	**R: 31.06%**	
Indicator #3b (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 was initiated {numerator}.						Rate: 24%						Rate: 24%/30%
	N: 179	N:353	N:368	N: 427	N: 446		**594**	641	667	677	677	
	D: 1,313	D:1422	D:1513	D: 1737	D: 1717		**2234**	2208	2175	2146	2146	
	R: 14%	R:24.8%	R:24.3%	R: 24.6%	R: 26%		**R: 26.59%**	**R: 29.03%**	**R: 30.67%**	**R: 31.55%**	**R: 31.55%**	

One item for success for all PIP's and ITM's is the regular meetings the MCO's are doing where we discuss performance and what is/isn't working. By identifying things like only 30% treatment rates, we have started to work with other MCO's on not only 'new' ideas but seeing what has been done and whether it was effective. This helps us avoid things that don't work, and the time it might have taken away from methods that will help had we not shared this information. ABHLA looks forward to finding new and collaborative ways to not only improve PI's but also barriers like provider education in order to benefit all Medicaid members.

PIP Highlights

- **Highlight 1-2 Member Interventions and support with quantitative ITM data and qualitative member feedback data**

ABHLA members are being educated each quarter (ITM 2b), beginning in Q4 2021 and reaching over 47,000, on HCV screening and treatment guidelines by the CDC for all members 18 and over. These educational direct text messages will continue into 2022 and we are looking at adding text messages around treatment as well. In 2021 ABHLA highlighted two methods to outreach members who were at a higher rate for HCV, ITM 2a and 2c, by both our CM team as well as Services. These two telephonic outreaches were able to make contact with members and log responses around either screening calls via Services, or treatment follow-up by our CM team. This data will be helpful in identifying barriers around members receiving treatment as one barrier was resolved by OPH this year which was including dates around screenings which helped CM talk through the member saying 'they've never been screened'. Now we need to work on the barrier response – 'denial of HCV status'. We realize that members might be somewhere where treatment discussions aren't comfortable for them, which is why we will be looking to our outreach vendor for more direct messaging that allows members to follow-up quietly and discretely.

Member outreach ITM's are below and note in Q4 ITM 2c was replaced by the text messaging for screening in 2b while 2a is our collective outreach for both screening and treatment outreaches and in Q4 we are looking forward to outreaches CM has done to those members who need to follow-up for treatment.

ITM Barrier Alignment	ITM Definition	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Intervention #2a to address barrier:	**Intervention #2a tracking measure:**				
Enhanced Case Management Outreach for HCV Screening	N: Those at risk who were outreached via Enhanced Outreach Model on SharePoint	**N:663**	**N: 2961**	**N: 377**	**N:**
New	**D:** # members with **any risk** factors for HCV as specified within the PIP	**D:37855**	**D: 38220**	**D: 38643**	**D: 39148**
		R: 1.75%	**R: 7.75%**	**R: 0.98%**	**R:**
Intervention #2b to address barrier:	**Intervention #2b tracking measure:**				
Launch education campaigns via different methods like text	N: # opted in members ≥ 18 who received an HCV text to get tested	**N:**	**N:**	**N:**	**47194**
New	D: # of opted in plan members >18	**D:83163**	**D: 85095**	**D: 87046**	**D: 87867**
		#VALUE!	**#VALUE!**	**#VALUE!**	**R:**
Intervention #2c to address barrier:	**Intervention #2c tracking measure:**				
Enhanced Outreach for HCV Screening through Member Services	N: # members MS contacted off the Enhanced Risk Model	**N:579**	**N: 2531**	**N: 323**	**N:**
New	**D:** Number of members at risk for HCV per OPH, MCO claims and encounter data	**D:15309**	**D: 15086**	**D: 14931**	**D:**
		R: 3.78%	**R: 16.78%**	**R: 2.16%**	**R:**

Our 2021 CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey showed improvement in many areas as noted by members around their personal providers went up 2.5% from last year and the rating around specialist went up almost 18% while the rating of overall healthcare members received also went up over 4.7%. Two areas where ABHLA needs to continue work with Providers as it relates to members is around Coordination of Care and How Well Doctors Communicate. Both of these qualitative results showed small single digit decreases (less than 4%) but can impact members getting to and receiving the right next level of treatment. This shows we need to continue with both educational avenues as well as in person education to make sure Providers know what resources are available and when they should be used or accessed for Medicaid members.

- **Highlight 1-2 Provider Interventions and support with quantitative ITM data and qualitative provider feedback data**

ABHLA focused a lot of attention on educating Providers in both CDC guidelines for HCV screening, as well as our overall plan performance (ITMs 7a, 7b) for these two 'updated' screening changes by the CDC. We blasted and used the provider newsletters to highlight the CDC screening guideline changes, along with ABHLA's current rate for them and the codes for providers to use when screening. We saw little improvement in the past year but this effort will continue in 2022 since providers are the some of the main sources of knowledge our members look to for information. Continued focus on education for screening will be part of the STI screening campaigns in 2022 to educate providers on what is covered by Medicaid as well as CDC guidelines for member screening.

ITM Barrier Alignment	ITM Definition	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Intervention #4a to address barrier:	**Intervention #4a tracking measure:**				
Provider education of how to treat members once screened via Algorithm and other education material	N: # of Providers who received education material	**N:4282**	**N: 5405**	**N: 666**	**N: 2811**
	D: Total # of Providers in network	**D:27164**	**D: 27641**	**D: 28082**	**D: 29246**
		R: 15.76%	**R: 19.55%**	**R: 2.37%**	**R: 9.61%**
Intervention #7a to address barrier:					
CDC guidelines for screening a specific subpopulation	N: Pregnant Women Screened for HCV				
	D: All pregnant women	**N: 240**	**N: 195**	**N: 227**	**N: 156**
New		**D: 604**	**D: 556**	**D: 654**	**D: 385**
		R: 39.74%	**R: 35.07%**	**R: 34.71%**	**R: 40.51%**
Intervention #7b to address barrier:					
CDC guidelines for at risk population for screening; subpopulation crossover based on behavior and outcomes	N: SUD Risk Factor HCV Members who were ever screened				
	D: All SUD HCV Risk Members	**N: 4450**	**N: 4944**	**N: 5284**	**N: 5505**
New		**D: 12696**	**D: 13223**	**D: 13780**	**D: 14000**
		R: 35.05%	**R: 37.39%**	**R: 38.35%**	**R: 39.32%**

One other barrier Providers mention in PAC are conflicting priorities. Obviously COVID vaccinations and spikes in cases was a priority from a public health perspective, but also conflicting priorities between Providers practices and Medicaid requests. We can only educate providers on Medicaid items, their internal management will continue to focus on things that impact their overall performance.

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.

  The only validity potential was in the realm of doing HCV screenings at Community Events. Due to Federal rules on Community events and HIPAA requirements, we can not identify ABHLA members who attend for the denominator or the numerator for those screened. We understood the overall reporting was based on attendance and screenings as a whole but that in itself supported the PIP's intent to screen every state citizen and eventually we knew that our members would appear on the OPH list or via our claims so additional outreach towards treatment was not being omitted but only delayed. As it turns out, with the emphasis on COVID vaccinations thru Community Events we only had a few opportunities for this to happen and when these events were resumed due to COVID distancing changes, this ITM 5a did not have participation and therefore validity for screening success via this method was not an issue.

- **Were there any threats to the external validity the findings?**
  Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

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

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

  This process was much better in 2021 due in part to more clarity from the files received from LDH's Office of Public Health which allowed the MCO's more clarity and dates in which to frame the outreach conversation.

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
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	Unless ABHLA helps the member make the appointment, we have no visibility to this feature. What we have learned is that calling members is not effective as they can ignore the call and letters subsequently sent.	We are looking for more direct ways to engage members into treatment that are not reliant on phone calls for personal connection. People learn and absorb things differently, therefore we need a multi-prong approach to treatment	Outline and develop a multi-prong approach to giving members access to treatment without CM having to make the call.
Intervention #1b tracking measure: **N:** Number of members with appointment scheduled by MCO Case Manager/ Care Coordinator for HCV screening; **D:** Number of members at risk for HCV per MCO claims/encounter data	Unless ABHLA helps the member make the appointment, we have no visibility to this measure for screening. What we have learned is that calling members is not effective as they can ignore the call and letters subsequently sent.	For screening purposes, we will continue to view all options to accomplish all LA citizens being screened for HCV as the PIP states. This will continue to include Community Events offering screenings, as well as working with Providers to include this 'annual' check-ups by way of blood work.	This screening metric will transfer to the Population Health Team to use as part of the overall communicable disease program which includes screenings for all members and most notable those as early as 12.
Intervention #2a tracking measure: N: Those at risk who were outreached via Enhanced Outreach Model on SharePoint **D:** # members with any risk factors for HCV as specified within the PIP ***New***	This intervention was discussed in a meeting with IPRO and the MCO's in early 2021 and was agreed to have it as a cumulative number for all outreach. This allowed us to see the different methods requested in the PIP as well as defined by ABHLA for a total coverage model to all members who are at risk.	We learned that different approaches improve the chance to make an impact to members and then drive the desired outcome for 'next'. Understanding the different age groups, and preferred outreach methods is allowing us to find different and more effective ways to reach members.	This is a screening metric and therefore will be transferred to Population Health. The efforts to continue screening is evident in our first of 5 text message campaigns going to members on getting screened at least once in their lifetime. We look for this method to help continue the success already measured in the PIP.

Intervention #2b tracking measure: **N: # text messages that were sent to members 18 and over** **D: # of plan members 18 and over** ***New***	The largest lesson learned on this avenue is that approval processes take much longer than the idea and content did to come together. Now that we have a better understanding of timelines, we can plan for better 'start' dates.	A new vendor and changes to internal approval processes, coupled with LDH back log really impacted this initiative. Therefore we will not be changing or removing this initiative unless absolutely necessary or make sure the new campaign overlaps with the current.	This is a screening metric and therefore will be transferred to Population Health. The efforts to continue screening is evident in this text message campaigns going to members on getting screened at least once in their lifetime. We look for this method to help continue the success already measured in the PIP.
Intervention #2c tracking measure: **N: # members Member Services contacted off the Enhanced Risk Model** **D: # members on the Enhanced Model** ***New***	Necessity is the mother of invention and this high volume need prompted us to go to other areas of ABHLA to help with members at risk getting screened. We combined the reminder for annual check-ups and recommendations for HCV screening into the same message and this method was able to outreach over 3000 members in just 7 months.	This method began in March and the numbers for overall screenings in 2021 did improve but most notable for non-boomers. We feel this type of outreach helped members ask for screening for age groups most providers would not have expected but allowed ABHLA to help the state achieve its overall PIP goal.	This is a screening metric and therefore will be transferred to Population Health. The new text campaigns are expected to continue the trend but will be assessed in 2022 to determine if this method needs to be utilized again.
Intervention #3a tracking measure: **N:** # members with SOFOSBUVIR-VELPATASVIR 400-100 (AG Epclusa: Preferred) dispensed **D:** # members with any DAA dispensed	The high performance numbers show that those who receive a prescription do get it filled. In other words, those who seek treatment – do it. Its getting members to take that 'treatment' step.	This metric isn't necessarily one we need to improve as much as we need to increase the numerator or those receiving the prescription.	This metric will continue in 2022 and again the focus will be increasing the overall numbers to feed this metric.
Intervention #4a tracking measure: **N: # of Providers who received education material** **D: Total # of Providers in network**	This effort was frustrating for all MCO's as we do spend time sending information to providers but there's not way to know if the intended person received it as most have a 'practice' email or office manager who receives this information.	ABHLA learned that multiple methods of communication were best for this and began sending information in every form and method we could. Via our Provider team, Regional Outcomes team, and through email and fax blasts to out providers.	We will continue to work with our internal teams on sending out appropriate material for both CDC screenings as well as treatment in every possible way.
Intervention #4b tracking measure:	Sending member/HIPAA data via secure methods proved to be difficult. Provider emails are not required and making sure	We were able to work with a vendor to find the best secure method and were able to send all of the OPH members	We are using this method for all health care gap reports and are targeting this process to

N: Total # of at risk members distributed to Providers **D: # of at risk members who have a Confirmed Diagnosis (either claims or OPH list)**	the information is secure once received was not possible. Same goes for Fax. Availity is secure but providers have to sign themselves up so its not complete either.	needing treatment to their providers. We prefer this method as it also tracks any returns and lets us know what changed so we can update our systems. After IDA, a lot of providers have temp offices so we expect this to continue changing in the next year.	continue in the 2022 PIP on a quarterly basis.
Intervention #5a tracking measure: **N: # of people tested at community events** **D: # of people who attended the event** ***New***	In speaking to our vendor who does blood pulls at events for STI screenings, we learned they always did HCV we just didn't capture it. Although our teams focus was community events, Delta variant and vaccination drives did impact our ability to get more people screened.	For this reason, and since its such an easy way to get folks screened, the effort will continue indefinitely. We also like the idea that the vendor doing the screenings has counselors available both that day afterwards to help with findings. Due to HIPAA, we can receive this specific information but if they get reported to OPH it will end up in our pool.	This is a screening metric and therefore will be transferred to Population Health.
Intervention #6a tracking measure: **N: # children screened ≥ 18 months** **D: # children born to an untreated HCV mother** ***New***	IPRO asked all MCO's to add at least one sub-population metric for HCV and we wanted to follow our members with this risk as CDC guidelines note babies born to HCV members should be screened at 18 months or older. We wanted to identify if this was being done.	ABHLA wanted to highlight if screening for this vulnerable population was being done since carrying the virus for the first 18 years, PIP outline of age for screening, there would be a lot of damage to the liver. The results were unexpected in the worst way. It shows one 1 child this year was screened per CDC guidelines.	This effort will be transferred to Population Health Team so that screening education can continue to be sent to providers in an effort to push for CDC recommendations for this group.

Intervention #7a tracking measure: **N: Pregnant Women Screened for HCV** **D: All pregnant women**	IPRO asked all MCO's to add at least one sub-population metric for HCV and knowing that CDC guidelines want <u>each</u> pregnancy to be screened for HCV, ABHLA wanted to get a sense of guideline adherence.	We expected that since the CDC published 'revised' screening recommendations that this population would have an almost 100% rate, that was incorrect. ABHLA began screening education with treatment algorithm and included our current performance numbers to providers.	This effort will be transferred to Population Health Team so that screening education can continue to be sent to providers in an effort to push for CDC recommendations for this group.
Intervention #7b tracking measure: **N: SUD Risk Factor HCV Members who were ever screened** **D: All SUD HCV Risk Members**	IPRO asked all MCO's to add at least one sub-population metric for HCV and knowing that SUD was a leading cause for HCV, as well as a risk factor in the PIP, we wanted to follow our members with this risk.	We expected that since the CDC published 'revised' screening recommendations that this population would have an almost 100% rate, which was incorrect. ABHLA began screening education with treatment algorithm and included our current performance numbers to providers.	This effort will be transferred to Population Health Team so that screening education can continue to be sent to providers in an effort to push for CDC recommendations for this high risk group.

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

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

Table B. Persons ever on long term hemodialysis (any one or more of diagnosis codes in this table, not restricted to place of service and not restricted to principal or primary diagnosis)

ICD-9 code	ICD-10 code	Description
	Z49-	Encounter for care involving renal dialysis (Hyphen indicates that all codes within Z49 should be included. This applies to all other ICD-10 and ICD-9 codes with hyphens that are listed in this table, as well.)
	Z99.2	Dependence on renal dialysis
V4511		Dependence on renal dialysis
V560 or V561 or V562 or V5631 or V5632 or V568		Encounter for care involving renal dialysis

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

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

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

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

Glossary of PIP Terms

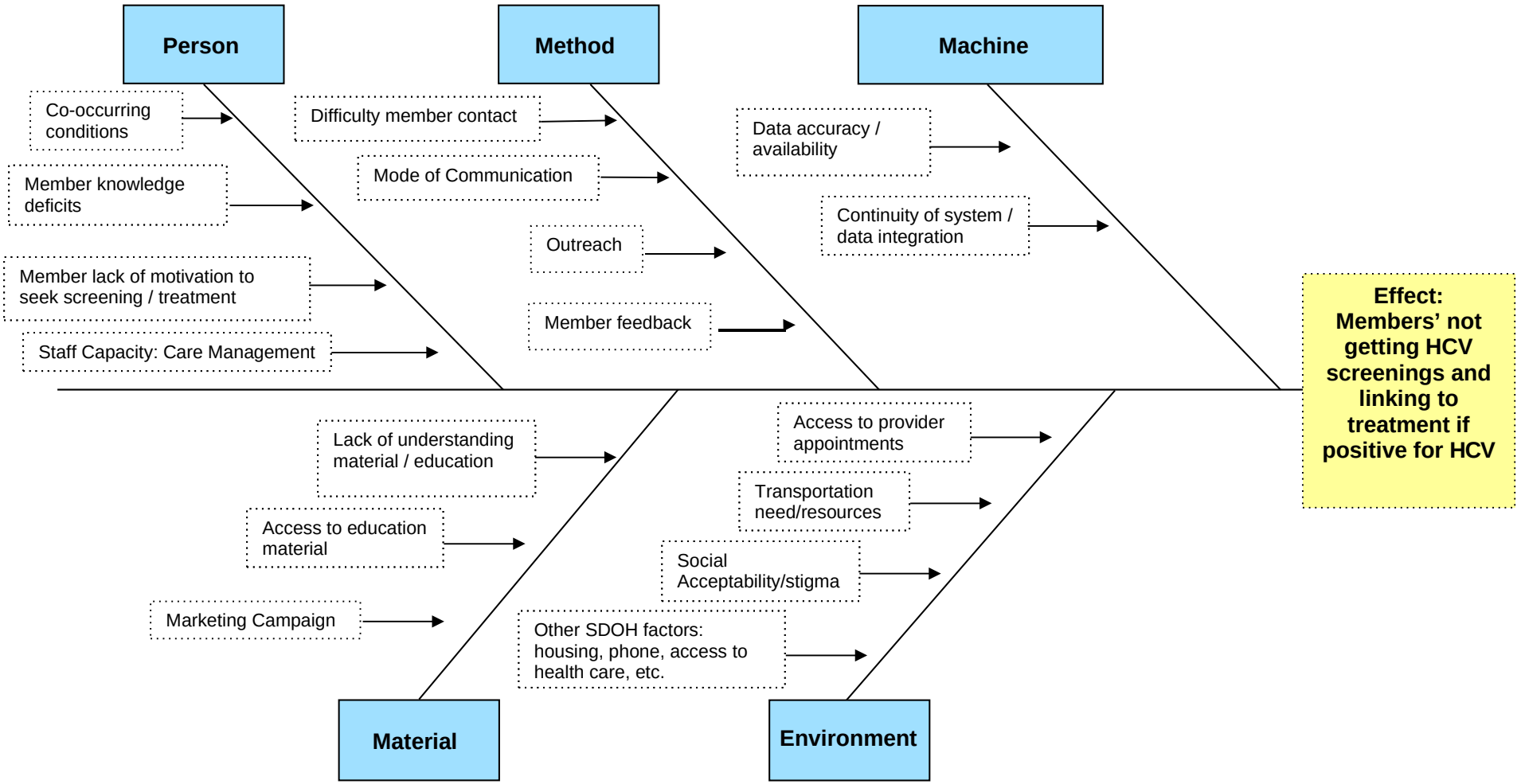
Table 7: PIP Terms

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

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

Appendix A: Fishbone (Cause and Effect) Diagram

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



Appendix A:

Member Challenges/Opportunities for Improvement

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

Person:

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

Method:

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

Machine

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

Material:

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

Environment:

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

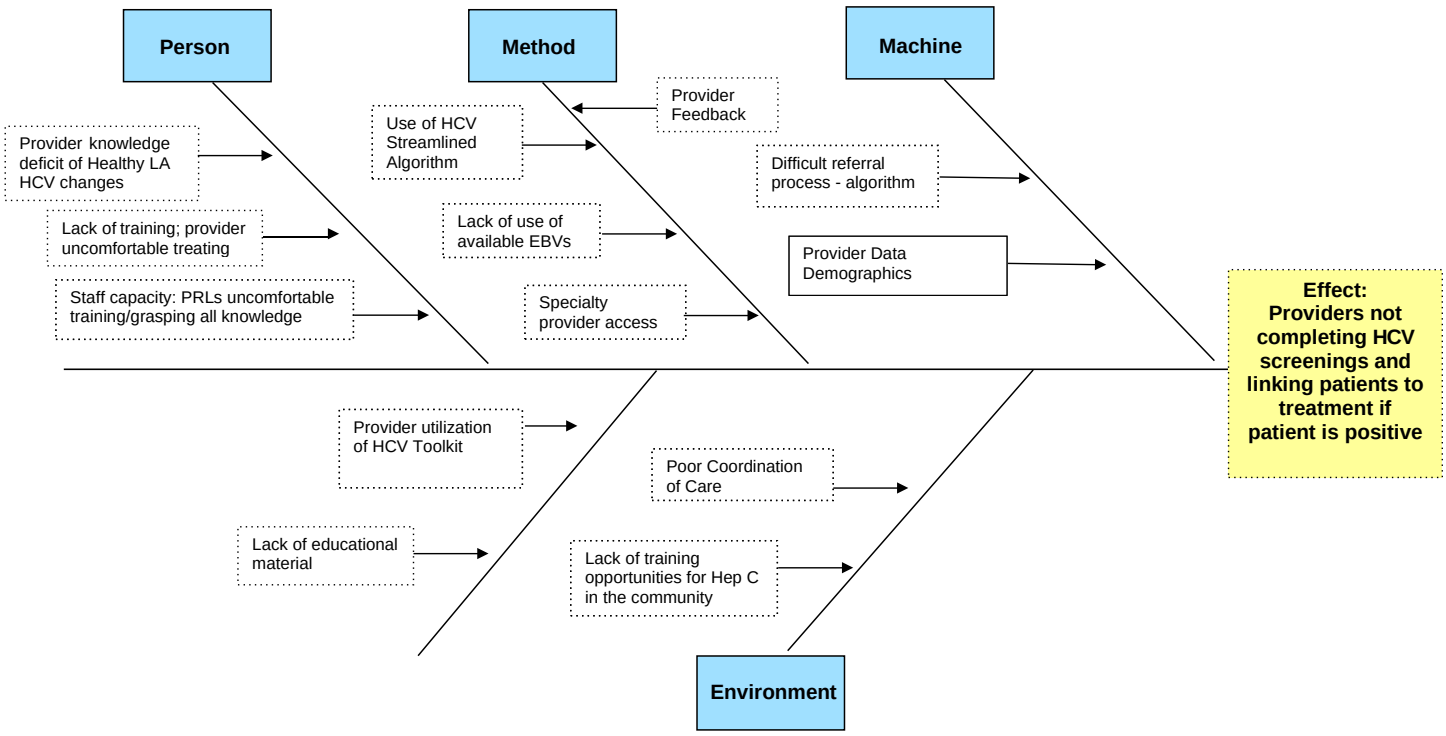
Opportunities for Improvement:

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

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

Appendix A: Fishbone (Cause and Effect) Diagram

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



Appendix A:

Provider Challenges/Opportunities for Improvement

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

Person:

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

Method:

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

Machine:

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

Material:

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

Environment:

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

Opportunities for Improvement:

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

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

Appendix B: Priority Matrix

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

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

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

Appendix D: Driver Diagram

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 1. Increase the HCV screening rates among Healthy Louisiana adults at risk for HCV by 10 percentage points from CY 2019 to CY 2020.	**PCPs screen the following high risk Healthy Louisiana adults for HCV antibody:** **a. Beneficiaries born between the years 1945 and 1965** **b. Beneficiaries with Current or past injection drug use** **c. Beneficiaries ever on long term hemodialysis** **d. Persons who were ever incarcerated** **e. Beneficiaries with HIV infection**	**Educate PCPs about evidence-based guidelines (EBGs) for HCV screening:** **-U.S. Preventive Service Task Force Guidelines** **-American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA).** **-Office of Public Health streamlined test and treat strategy (forthcoming)** **-Medicaid reimbursable CPT/HCPCS codes**	**-Notify providers regarding Provider Portal access to HCV EBGs** **-Medical Director and Provider Relations face-to-face Outreach for Education** **-Incorporate USPSTF and AASLD/IDSA HCV screening guidelines into Clinical Practice Guideline repository** **-Disseminate Office of Public Health streamlined test and treatment strategy (forthcoming)** **-Develop and disseminate billing guidelines for HCV screening and Medicaid reimbursement** **- Encourage providers to participate in OPH-provided HCV treatment training [this covers screening as well]**
		Identify adult members at risk for HCV	**-Utilize HCV PIP specifications to identify at risk members using historical and current claims** **-Develop PCP lists of members eligible for screening** **-Develop Care Coordinator lists of members eligible for HCV screening**
		Inform PCPs of their patients who are at risk/ eligible for screening	**-Distribute to each PCP their listing of eligible members with instructions to contact patients to schedule an appointment for HCV screening**
		Educate at risk members about HCV screening	**-Care Coordinators Outreach, educate and counsel members at risk who are eligible for HCV screening**
		Refer at risk members to PCPs and facilitate appointment scheduling for HCV screening	**-Care Coordinators refer and schedule appointments with PCPs for HCV screening**

Aims	Primary Drivers	Secondary Drivers	Specific Ideas for Interventions to Test/ Implement (Change Concepts)
Aim 2. Increase the HCV pharmaceutical treatment initiation rate among Healthy Louisiana adults ever diagnosed with HCV by 10 percentage points from CY 2019 to CY 2020.	**HCV Providers identified in the OPH database (e.g., gastroenterologists, infectious disease specialists) and/or PCPs prescribe LDH-approved Hepatitis C Virus Direct Acting Antiviral Agent {DAA} for beneficiaries diagnosed with HCV**	**Educate PCPs about evidence-based guidelines (EBGs) for HCV diagnosis and treatment: -Office of Public Health streamlined test and treat guideline -American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA).**	**-Provider Portal notification regarding access to HCV EBGs -Medical Director and Provider Relations face-to-face Outreach for Education -Incorporate the Office of Public Health streamlined test and treat guideline into Clinical Practice Guideline repository -Educate providers that prior authorization is not required for Epclusa generic for any Medicaid member -Develop and disseminate billing guidelines for HCV DAA agents and Medicaid reimbursement -Disseminate existing LDH resources to providers, including (1) the DAA Agent Medication Therapy Worksheet, (2) the HCV Treatment Agreement for Louisiana Medicaid Recipients, and (3) the Louisiana Medicaid Hepatitis C Direct-Acting Antiviral (DAA) Agents criteria, and (4) Office of Public Health (OPH) streamlined test and treatment guideline. - Encourage providers to participate in OPH-provided HCV treatment training**
		Foster collaboration between PCPs, behavioral health and HCV specialists	**-Develop and implement new processes to facilitate communication and coordinate care between PCPs, behavioral health and HCV providers listed in the OPH database (e.g., gastroenterologists, infectious disease specialists)**
		Identify all members diagnosed with HCV	**-Utilize the Office of Public Health listing of members with probable or confirmed HCV PIP to identify members with HCV diagnosis -Collaborate with OPH to develop PCP-specific listings of their patients who are potential candidates for HCV treatment -Develop Care Coordinator lists of members with HCV diagnosis for referral to PCPs for treatment**
		Inform PCPs of their patients with HCV	**-Distribute to each PCP their listing of members with HCV for medical assessment of appropriate treatment and/or referral to/ coordination with HCV specialist for treatment**
		Educate and refer members with HCV for treatment assessment	**-Care Coordinators Outreach, educate, refer and schedule member's appointment with HCV provider on OPH listing or PCP for treatment assessment.**

Appendix E: Plan-Do-Study-Act Worksheet

	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.	•	•	•