

Bayou Health Plan Performance Improvement Project (PIP)

Amerigroup Louisiana, Inc.

**Appropriate ADHD Drug
Utilization**

Project Proposal

Submission to:
LA Department of Health and Hospitals
IPRO

Health Plan and Project Identifiers

Please complete all fields as accurately and as completely as possible.

1. Name of Health Plan: Amerigroup Louisiana, Inc.

2. Select the Report Submission: [If any change from initial submission, please complete section 7 below.]

| | |
|--|---|
| <input checked="" type="checkbox"/> PIP Part I: Project Proposal | Date submitted: <u> / / </u> |
| <input type="checkbox"/> PIP Part II: Interim Report | Date submitted: <u> / / </u> |
| <input type="checkbox"/> PIP Part III: Final Report | Date submitted: <u> / / </u> |

3. Contract Year: 2015

4. Principal Contact Person: Angela Olden

[person responsible for completing this report]

4a. Title: Director II Quality Management

4b. Phone: (225) 819 - 4893 ext. 88871

4c. Email Address: angela.olden@amerigroup.com

5. Title of Project: Appropriate ADHD Drug Utilization

6. External Collaborators (if any): N/A

7. For Interim and Final Reports Only: If Applicable, Report All

Changes from Initial Proposal Submission: [Examples include: added a new survey, added new interventions, changed interventions, deviated from HEDIS® specifications, reduced sample sizes]

8. Attestation

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

Amerigroup Louisiana, Inc.

Health Plan Name

Appropriate ADHD Drug Utilization

Title of Project

Dr. Marcus Wallace

Medical Director (print, sign and date)

Angela Olden

Quality Director (print, sign and date)

N/A

IS Director (when applicable) (print, sign and date)

Sonya Nelson

CEO (print, sign and date)

Project Topic

Provide a general description of the project topic that is clearly stated and relevant to the enrolled population.

1. Describe Project Topic

[Project topics should be based on the needs of the plan's member population (i.e., should reflect member needs, care and services and reflect high-volume or high-risk conditions/events) and should be supported by current research, clinical guidelines or standards. The Health Plan should provide a clear and detailed description of the selection and prioritization process used in topic selection.]

This Performance Improvement Project (PIP) addresses one of the most common developmental disorders among Louisiana's children – Attention-Deficit Hyperactivity Disorder (ADHD). ADHD has been designated as a Section 2 PIP focus for contract year 2016, as described in the Louisiana Bayou Health Managed Care Organizations RFP Performance Improvement Projects Appendix DD.

2. Rationale for Topic Selection

[Explain why this activity is important to members or practitioners, *and* why there is an opportunity for improvement. Describe how the project or results will help practitioners, members, or plan processes. The rationale for the topic selected should be reasonable given Health Plan demographics, be based on objective supporting data (e.g., HEDIS®, Health Plan baseline data, member/provider surveys), and pertain to a sufficient number of members to yield interpretable findings. Support rationale with documentation from the literature, using citations].

The first diagnosis of ADHD usually occurs in childhood, but it can last into adulthood. Common childhood ADHD behavioral characteristics include being overly active or having trouble paying attention or controlling impulsive behavior. While it is normal for children to have trouble focusing or behaving at one time or another, they normally grow out of these behaviors; for children with ADHD, many of the behaviors continue, causing difficulties at school, at home, and with friends.

In 2011, the National Survey of Children's Health was conducted among parents or guardians of children aged 4-17. According to that survey:

- 8.8% of children in the United States currently had ADHD.
- 13.3% of children in Louisiana currently had ADHD.
- Louisiana ranked 3rd highest in the nation for children who currently had ADHD.

Further statistics from the 2011 National Survey of Children's Health revealed the following:

- 6.1% of children in the United States were currently taking medication for ADHD.
- 10.4% of children in Louisiana were currently taking medication for ADHD.
- Louisiana ranked 1st highest in the nation for children currently taking medication for ADHD.

Various studies have demonstrated the need for Louisiana to improve the overall health status of our children. According to the CDC, good treatment plans for ADHD should include close monitoring and follow-ups, with needed changes occurring along the way.

The research and statistics to support this study project was reviewed by a focus group that included the Medical Director and representatives from the Medical Management and Quality Management departments. Collectively, the group felt it can be successful in assisting with treatment plans to manage ADHD for our children.

3. Aim Statement

[State the question(s) that the project is designed to answer. Address what the project is trying to accomplish, including WHO (patient population), WHAT (the intent of the project), WHERE (pilot site and spread sites), and WHEN (timeline). Align the aim with the strategic goal of the organization. The project objectives should be clear and set the framework for data collection, analysis, and interpretation. Anticipated barriers and how they will be addressed may be considered. Examples of objectives include improving HEDIS rates, member satisfaction, access to care, and adherence to clinical guidelines. Specify a target or goal for improvement that is practical, achievable, unambiguous, and quantifiable. Benchmark data can be used for comparative purposes (e.g., HEDIS® rates, Healthy People 2010, published articles).]

The purpose of this PIP is to increase appropriate ADHD diagnosis and drug utilization among children, especially those aged 6-12, through education and ensuring continuity and coordination of care. Therefore, its aim is to reduce the incidence of inappropriate follow-up treatment for children newly prescribed ADHD medication, during the measurement period. The target goal is to exceed the state's goal for ADHD follow-up care visits.

Amerigroup Louisiana (AGP) is targeting the 6-12 year age group in alignment with HEDIS technical specifications; the Louisiana Bayou Health Managed Care Organizations RFP Performance Improvement Projects Appendix DD targets the 0-6 age group. AGP will seek clarification on the proper target group prior to the initiation of this PIP.

Methodology

The methodology section describes how the data for the project are obtained.

1. Performance Indicators

[Indicators should be measurable, objective, clearly defined, and flow directly from the study aim. If using HEDIS®, specify reporting year used. If not using HEDIS®, or using a modified HEDIS® measure, clearly state how your indicators will be measured, including a description of the indicator numerator and denominator. Health Plan developed indicators should be evidence-based and refer to recognized clinical guidelines or expert consensus. Define the criteria used for selecting the eligible population, and describe any exclusion criteria. State whether the methodology for the remeasurement differs in any way from that used for the baseline assessment, include type of change, rationale for change, and any bias that could affect the results. When employing a quality improvement model, it is preferable to report an intermediate measure to evaluate performance and the further need for change. Process measures are the workings of the system (the parts/steps in the system) whereas outcome measures are the result (how the system is performing). Examples are the percentage of patients with an LDL test in the past year, (process) and percentage of patients with LDL <100 (outcome).]

Rate 1 – Initiation Phase

Study Indicator 1: The HEDIS measure, Follow-Up Care for Children Prescribed ADHD Medication (ADD), will be used for this PIP. This measure is mandated by the Louisiana DHH, using HEDIS technical specifications. This measure is an audited NCQA measure that should improve if the interventions to monitor and improve compliance of follow-up visits for children, aged 6-12, with newly prescribed ADHD medication, are successful. As a HEDIS measure, the indicator has a national benchmark that can be compared over time, internally and externally.

We will track the Initiation Phase, as a sub measure of ADD, as Study Indicator 1. The Initiation Phase of the ADD measure gives the percentage of children, 6-12 years of age as of the Index Prescription Start Date (IPSD), with an ambulatory prescription (newly prescribed) dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority, during the 30-day Initiation Phase.

The following definitions apply:

- **Intake Period:** The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
- **Negative Medication History:** A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions. The following table contains those medications recognized as ADHD medications:

Table ADD-1: ADHD Medications

| Description | Prescription | |
|--------------------------------|---|---|
| CNS stimulants | <ul style="list-style-type: none"> • Amphetamine-dextroamphetamine • Dexmethylphenidate | <ul style="list-style-type: none"> • Dextroamphetamine • Lisdexamfetamine • Methamphetamine • Methylphenidate |
| Alpha-2 receptor agonists | <ul style="list-style-type: none"> • Clonidine | <ul style="list-style-type: none"> • Guanfacine |
| Miscellaneous ADHD medications | <ul style="list-style-type: none"> • Atomoxetine | |

- **IPSD:** The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
- **Initiation Phase:** The 30 days following the IPSD.
- **New Episode:** The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.

Further background for Rate 1 is as follows:

- a) **Eligible population:** Members six years of age as of March 1st of the year prior to the measurement year to 12 years of age as of February 28 of the measurement year. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD, with no allowable gaps.
- b) **Exclusions:** The following members should be excluded from the eligible population:
 - Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. An acute inpatient encounter in combination with any of the following meet criteria:
 - A principal mental health diagnosis (ICD-9-CM Diagnosis Codes 290, 293-302, 306-316).

- A principal diagnosis of chemical dependency (ICD-9-CM Diagnosis Codes 291-292, 303-305, 535.3, 571.1).
 - Optional denominator exclusion (see denominator definition, below):
 - Exclude members with a diagnosis of narcolepsy (ICD-9-CM Diagnosis Code 347) any time during their history through December 31 of the measurement year.
- c) **Numerator:** An outpatient, intensive outpatient, or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSP; a visit on the IPSP does not count as an Initiation Phase visit. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

Table ADD-2: Follow-up Visit Codes

| CPT | HCPCS | UB Revenue | |
|--|--|---|--|
| 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510 | G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 | 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983 | |
| CPT | POS | | |
| 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876 | <i>WITH</i> | 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72 | |
| 99221-99223, 99231-99233, 99238, 99239, 99251-99255 | <i>WITH</i> | 52, 53 | |

- d) **Denominator:** The total eligible population for Rate 1.
- e) **Measurement periods:**
 Baseline measurement period: January 2015 – December 2015.
 Remeasurement period 1: January 2016 – December 2016.
 Remeasurement period 2: January 2017 – December 2017.
- f) **Project goal:** Achieve a rate, at or above the state’s goal, for one follow-up visit within 30 days of the dispensing of a newly prescribed ADHD medication, for children aged 6-12.

To obtain the administrative rates, data sources used for this study indicator include:

- AGP FACETS claim system data
- Encounter data extracted from the AGP FACETS/Internal data warehouse, along with provider files.

These files were loaded to the Inovalon warehouse, which is AGP’s HEDIS certified software. Inovalon loaded all of the above mentioned files, following AGP’s instruction of reporting population definition, to create a warehouse which generates HEDIS events, to produce the HEDIS measure.

- g) **Intermediate measure to evaluate performance:** AGP creates the intermediate HEDIS ADD rate monthly to monitor the performance.

- h) **Additional change:** N/A for submission.
- i) **Process measures (steps in the system):** N/A for submission.
- j) **Outcome measures:** N/A for submission.

Rate 2 – Continuation and Maintenance Phase

Study Indicator 2: The HEDIS measure, Follow-Up Care for Children Prescribed ADHD Medication (ADD), will be used for this PIP. This measure is mandated by the Louisiana DHH, using HEDIS technical specifications. This measure is an audited NCQA measure that should improve if the interventions to monitor and improve compliance of follow-up visits for children, aged 6-12, with newly prescribed ADHD medication, are successful. As a HEDIS measure, the indicator has a national benchmark that can be compared over time, internally and externally.

We will track the Continuation and Maintenance (C&M) Phase, as a sub measure of ADD, as Study Indicator 2. The C&M Phase of the ADD measure gives the percentage of children, 6-12 years of age as of the IPSD, with an ambulatory prescription (newly prescribed) dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

The following definitions, in addition to those listed for Rate 1, apply:

- **C&M Phase:** The 300 days following the IPSD (10 months).
- **Continuous Medication Treatment:** The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 300 treatment days – 90 gap days).
- **Treatment days (covered days):** The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Further background for Rate 2 is as follows:

- a) **Eligible population:** Members six years of age as of March 1st of the year prior to the measurement year to 12 years of age as of February 28 of the measurement year. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. Members who switch product lines between the Rate 1 and the Rate 2 continuous enrollment periods should only be included in Rate 1. One 45-day gap in enrollment, between 31 days and 300 days (10 months) after the IPSD, is allowed. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Members are required to have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

- b) **Exclusions:** The following members should be excluded from the eligible population:
- Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSP. An acute inpatient encounter in combination with any of the following meet criteria:
 - A principal mental health diagnosis (ICD-9-CM Diagnosis Codes 290, 293-302, 306-316).
 - A principal diagnosis of chemical dependency (ICD-9-CM Diagnosis Codes 291-292, 303-305, 535.3, 571.1).
 - Optional denominator exclusion (see denominator definition, below):
 - Exclude members with a diagnosis of narcolepsy (ICD-9-CM Diagnosis Code 347) any time during their history through December 31 of the measurement year.
- c) **Numerator:** All members who meet the following criteria:
- Numerator compliant for Rate 1, **and**
 - At least two follow-up visits from 31–300 days (9 months) after the IPSP with any practitioner.

One of the two visits (during days 31–300) may be a telephone visit (CPT Codes 98966-98968, 99441-99443) with any practitioner. Any of the following code combinations identify follow-up visits:

Table ADD-3: Follow-up Visit Codes

| CPT | HCPCS | UB Revenue | |
|--|--|---|--|
| 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99510 | G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 | 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983 | |
| CPT | POS | | |
| 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876 | WITH | 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72 | |
| 99221-99223, 99231-99233, 99238, 99239, 99251-99255 | WITH | 52, 53 | |
| CPT | | | |
| 98966-98968, 99441-99443 | | | |

- d) **Denominator:** The total eligible population for Rate 2.
- e) **Measurement periods:**
 Baseline measurement period: January 2015 – December 2015.
 Remeasurement period 1: January 2016 – December 2016.
 Remeasurement period 2: January 2017 – December 2017.
- f) **Project goal:** Achieve a rate, at or above the state’s goal, for two follow-up visits within 270 days (9 months) after the Initiation Phase ended, for children aged 6-12.

To obtain the administrative rates, data sources used for this study indicator include:

- AGP FACETS claim system data

- Encounter data extracted from the AGP FACETS/Internal data warehouse, along with provider files.

These files were loaded to the Inovalon warehouse, which is AGP's HEDIS certified software. Inovalon loaded all of the above mentioned files, following AGP's instruction of reporting population definition, to create a warehouse which generates HEDIS events, to produce the HEDIS measure.

- g) **Intermediate measure to evaluate performance:** AGP creates the intermediate HEDIS ADD rate monthly to monitor the performance.
- h) **Additional change:** N/A for submission.
- i) **Process measures (steps in the system):** N/A for submission.
- j) **Outcome measures:** N/A for submission.

2. Procedures

[Describe the method of data collection, including who collects the data and the instruments used, as well as efforts to ensure validity and reliability. Clearly identify the sources of data, and specify if using administrative data, medical record data, hybrid methodology, and/or surveys. Describe any data collection tools that are employed. Report whether sampling is used. If so, describe the sampling method, and if stratification was used. Report the sample size and verify that it includes all relevant subsets of the population. Describe measures taken to ensure that members with special health care needs are not excluded. If a survey is used, detail the mode of survey (e.g., mail, phone), the number of cases to receive a survey, and follow-up attempts to increase response rates, if any (e.g., re-mailing of surveys). If using statistical testing, specify the procedures used for analysis.]

Study indicator 1: The Initiation Phase, as a sub measure of the HEDIS measure, ADD, will be used as Study Indicator 1, to track the rates of one follow-up visit during the 30-day Initiation Phase, among 6-12 year olds.

- a) **Method of data collection:** HEDIS 2016 administrative data will be utilized. HEDIS administrative rates are obtained using claim data up to DOS 12/31/15 for HEDIS 2016. Preliminary HEDIS 2016 run will be done at the end of January 2016. A refresh run will be performed in April 2016, which produces the final HEDIS 2016 administrative rates.
- b) **Instruments used for data collection:** AGP will use 2015 encounter data. The entire eligible population, including those with special health care needs, will be used for this study.

To obtain the administrative rates, data sources used for this study indicator include:

- AGP FACETS claim system data
- Encounter data extracted from the AGP FACETS/Internal data warehouse, along with provider files.

These files were loaded to the Inovalon warehouse, which is AGP's HEDIS certified software. Inovalon loaded all of the above mentioned files, following AGP's instruction of reporting population definition, to create a warehouse which generates HEDIS events, to produce the HEDIS measure.

- c) **Data validity and reliability:** The validity and reliability of the data is ensured, since the data is a HEDIS measure.
- d) **Sample Size:** No sampling techniques were used. The entire eligible population, including those with special health care needs, was used for this study.
- e) **Stratification:** N/A for submission.
- f) **Survey:** N/A for submission.
- g) **Statistical testing:** N/A for submission.

Study indicator 2: The C&M Phase, as a sub measure of the HEDIS measure, ADD, will be used as Study Indicator 2, to track the rates of at least two follow-up visits, in addition to the Initiation Phase visit, during the 270 days (9 months) after the Initiation Phase ended, among 6-12 year olds.

- a) **Method of data collection:** HEDIS 2016 administrative data will be utilized. HEDIS administrative rates are obtained using claim data up to DOS 12/31/15 for HEDIS 2016. Preliminary HEDIS 2016 run will be done at the end of January 2016. A refresh run will be performed in April 2016, which produces the final HEDIS 2016 administrative rates.
- b) **Instruments used for data collection:** AGP will use 2015 encounter data. The entire eligible population, including those with special health care needs, will be used for this study.

To obtain the administrative rates, data sources used for this study indicator include:

- AGP FACETS claim system data
- Encounter data extracted from the AGP FACETS/Internal data warehouse, along with provider files.

These files were loaded to the Inovalon warehouse, which is AGP's HEDIS certified software. Inovalon loaded all of the above mentioned files, following AGP's instruction of reporting population definition, to create a warehouse which generates HEDIS events, to produce the HEDIS measure.

- c) **Data validity and reliability:** The validity and reliability of the data is ensured, since the data is a HEDIS measure.
- d) **Sample Size:** No sampling techniques were used. The entire eligible population, including those with special health care needs, was used for this study.
- e) **Stratification:** N/A for submission.

f) **Survey:** N/A for submission.

Statistical testing: N/A for submission.

3. Project Timeline

[The timeline should include all important dates regarding the conduct of the study, including baseline measurement period, interventions, remeasurement period, analysis, final report. Complete the table below. For each event, provide a date or date range (start and end dates), as applicable.]

| Event | Timeframe |
|--|------------------------------|
| Baseline Measurement Period | January 2015 – December 2015 |
| Interim Measurement Period | Biannually |
| Submission of Interim Report (if applicable) | To Be Determined |
| Re-measurement Period | January 2016 |
| Intervention Implementation | 2015 |
| Analysis of Project Data | 2016 and on-going |
| Submission of Final Report | To Be Determined |

Interventions/Changes for Improvement

Interventions should be targeted to the study aim and should be reasonable and practical to implement considering plan population and resources.

1. Interventions Planned and Implemented

[Describe each intervention and the decision-making process leading to the selection of the intervention. Detail how the intervention is reasonably able to impact the enrolled population/improve health outcomes, and likely to induce a permanent change rather than a short-term or one-time effect. Interventions should be based on evidence of effectiveness. If the intervention is based on literature, include appropriate citations. Specify identified barriers to care that interventions are designed to impact. Describe whose performance the intervention is intended to affect (e.g., members, Health Plan clinical staff, providers, community). Provide the start and end dates of each discrete intervention. The interventions should be timed for optimal impact, ideally after baseline, allowing enough time to impact remeasurement. Given the time parameters of the project, an interval of at least 6 to 9 months is generally necessary to detect measurable impact of your interventions.]

Complete the sections in the table below, and add more rows as needed. For each intervention, provide date ranges (start and end dates) in the first column of the table. Interventions that began post-remeasurement should not be listed as interventions since they could not impact the rates. They should be highlighted in the Next Steps section.

| Intervention Timeframe | Description of intervention |
|------------------------|-----------------------------|
| | |
| | |

| | |
|--|--|
| | |
|--|--|

2. Barrier Analyses

[Barrier analysis should be conducted as part of the project design. Describe the barriers that your interventions are designed to overcome, e.g., lack of member or provider knowledge, lack of transportation, lack of standardized tools, lack of adequate discharge planning. Barrier analyses should include analyses of data, both quantitative and qualitative (such as focus groups or interviews) and published literature where appropriate. Barriers are distinguished from challenges you confronted in conducting the study. Those challenges should be described in the Limitations section.]

Results

The results section should quantify project findings related to each study question and project indicators. **Do not** interpret the results in this section.

[Explain how the data were analyzed to address the objectives. Important results to include:

- Entire population size and number of cases in the project sample
- Number of cases excluded due to failure to meet criteria
- Rates for project indicators—numerator and denominator for baseline and remeasurement
- Performance targets
- Statistical tests and results (if applicable)
- Run/Control Charts
- How missing data and outliers were handled

Tables/graphs/bar charts are an effective means of displaying data in a concise way to the reader. Appendix A contains examples of tables as well as instructions on creating useful tables.

Tables should be accompanied by text that points out the most important results, simplifies the results, and highlights significant trends or relationships. Tables should be able to stand alone.

If a survey was conducted, list the final sample size, the number of responses received, and the response rate. Reasons for low response rates or failure to obtain eligible records should be described.]

Discussion

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

1. Discussion of Results

[Explain and interpret the results by reviewing the degree to which objectives and goals were achieved, the meaningfulness of improvements or changes, and what factors were associated with success or failure. Describe whether results were expected or unexpected, and provide other possible explanations for the results. Comment on “face validity,” i.e., does the improvement in performance appear to be the result of the quality improvement interventions. A brief conclusion should be provided based on the reported results. The basis for all conclusions should be explained.]

2. Limitations

[Address the limitations of your project design. Identify methodological factors that may jeopardize the internal or external validity of the findings. Describe any challenges or barriers identified in implementing the interventions and how they were addressed (e.g., difficulty locating Medicaid members, lack of resources, reasons for low survey response rates, insufficient number of providers in rural areas. Indicate if an intervention was planned but was not implemented or if the intervention was changed in any way, and why.]

Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

1. Lessons Learned

[Describe what was learned from the project, what remains to be learned, what can be changed as a result of the project, and whether findings can be extrapolated to other members or systems.]

2. System-level Changes Made and/or Planned

[Describe how findings will be used, actions that will be taken to sustain improvement, and plans to spread successful interventions to other applicable processes in your organization.]

Appendix A: Examples of Tables

Tables can include 95% confidence intervals corresponding to each of the proportions, goals and benchmarks (such as the statewide average), or other descriptive statistics such as average, median, range, and outliers, if appropriate.

You do not have to choose one of these tables: they are for reference purposes only. Create a table that is appropriate for your unique data, but follow the general guidelines:

- Table titles should always be understandable and stand-alone.
- Table column headings should include the number of members in each group.
- Each column should have a heading.
- Report statistical significance using asterisks or significance level in a column.

Sample Table 1: Rate of [Project Indicator], Year 1-3

| Year | Numerator | Denominator | % | 95% CI |
|--------|-----------|-------------|---|--------|
| Year 1 | | | | |
| Year 2 | | | | |
| Year 3 | | | | |

Sample Table 2: Baseline and Remeasurement Rates for Each Project Indicator

| Indicator | Baseline | | Remeasurement | | P value |
|-------------|----------|---|---------------|---|---------|
| | n | % | n | % | |
| Indicator 1 | | | | | |
| Indicator 2 | | | | | |
| Indicator 3 | | | | | |

Sample Table 3: Baseline and Remeasurement Rates for Plan and Statewide Average

| Indicator | Plan | | SWA | | P value |
|--------------------|------|---|-----|---|---------|
| | n | % | n | % | |
| Baseline Year | | | | | |
| Remeasurement Year | | | | | |
| Difference | | | | | |

Sample Table 4: Record Retrieval Information by Provider

| | Records from Provider 1 | Records from Provider 2 | Total |
|---|-------------------------|-------------------------|-------|
| Records Requested | | | |
| Records Received | | | |
| Records Not Received (but included in analysis) | | | |
| Records Excluded | | | |
| Total Usable Cases | | | |