COLORADO

Department of Health Care Policy & Financing

Regional Accountable Entities (RAEs)
For the Colorado Accountable Care Collaborative

Fiscal Year 2019–2020 PIP Validation Report

for

Colorado Community Health Alliance

Region 6

April 2020

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for Medicaid programs, with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2019–2020, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. One RAE, **Colorado Community Health Alliance Region 6**, referred to in this report as **CCHA R6**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

For FY 2019–2020, the Department required RAEs to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i-iv), and each PIP must include:

Measurement of performance using objective quality indicators.

- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on January 27, 2020.

Over time, HSAG and some of its contracted states identified that while the MCOs had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs had achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-2] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that given the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed.

PIP Components and Process

The key concepts of the new PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

PIP Terms

SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim directly measures the PIP's outcome by answering the following: *How much improvement, to what, for whom, and by when?*

Key Driver Diagram is a tool used to conceptualize a shared vision of the theory of change in the system. It enables the MCO's team to focus on the influences in cause-and-effect relationships in complex systems.

FMEA (Failure Modes and Effects Analysis) is a systematic, proactive method for evaluating processes that helps to identify where and how a process is failing or might fail in the future. FMEA is useful to pinpoint specific steps most likely to affect the overall process, so that interventions may have the desired impact on PIP outcomes.

PDSA (Plan-Do-Study-Act) cycle follows a systematic series of steps for gaining knowledge about how to improve a process or an outcome.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on February 6, 2020.

For this PIP framework, HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **CCHA R6**'s module submission forms. In FY 2019–2020, these forms provided detailed information about **CCHA R6**'s PIPs and the activities completed in Module 3. (See Appendix A. Module Submission Forms.)

Following HSAG's rapid-cycle PIP process, the health plan submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the health plan during the PIP. HSAG's scoring methodology evaluates whether the health plan executed a methodologically sound improvement project and confirms that any improvement achieved could be clearly linked to the quality improvement strategies implemented by the health plan.

Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

PIP Topic Selection

In FY 2019–2020, **CCHA R6** submitted the following PIP topics for validation: *Well-Care Visits for Children Between 15–18 Years of Age* and *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening.*

CCHA R6 defined a Global Aim and SMART Aim for each PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Table 1-1 includes the PIP titles and SMART Aim statements selected by **CCHA R6**.

Table 1-1—PIP Topic and SMART Aim Statements

PIP Topics	SMART Aim Statements
Well-Care Visits for Children Between 15–18 Years of Age	To increase well-care visits in children at Rocky Mountain Pediatrics 15–18 years of age from 5.2% to 10.2% by June 30, 2020.
Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening	By June 30, 2020, increase the percentage of members who had a follow-up behavioral health assessment visit within 30 days following a positive depression screening among members 12+ at Clinica Family Health (Lafayette & Peoples Clinics) from 19.9% to 24.9%.

The focus of the well-care visits PIP is to increase the rate of well-care visits among members 15 through 18 years of age who receive care from the narrowed focus provider group. The focus of the behavioral health PIP is to increase the rate of members who had a follow-up behavioral health assessment within 30 days following a positive depression screen. Table 1-2 summarizes the progress **CCHA R6** has made in completing the five PIP modules for each PIP.

Table 1-2—PIP Topic and Module Status

PIP Topics	Module	Status
Well-Care Visits for Children Between 15–18 Years of Age	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in July 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.
Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in November 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.

At the time of the FY 2019–2020 PIP validation report, **CCHA R6** had passed Module 1, Module 2, and Module 3, achieving all validation criteria for each PIP. **CCHA R6** has progressed to intervention testing in Module 4—Plan-Do-Study-Act. The final Module 4 and Module 5 submissions are targeted for October 2020; the Module 4 and Module 5 validation findings and the level of confidence assigned to each PIP will be reported in the FY 2020–2021 PIP validation report.

Validation Findings

In FY 2019–2020, **CCHA R6** completed and submitted Module 3 for validation for each PIP. Detailed module documentation submitted by the health plan is provided in Appendix A. Module Submission Forms.

The objective of Module 3 is for the MCO to determine potential interventions for the project. In this module, the MCO asks and answers the question, "What changes can we make that will result in improvement?"

The following section outlines the validation findings for each PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

Module 3: Intervention Determination

In Module 3, **CCHA R6** completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions for each PIP.

Well-Care Visits for Children Between 15–18 Years of Age

Table 2-1 summarizes the potential interventions **CCHA R6** identified for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-1—Intervention Determination Summary for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Failure Modes	Potential Interventions
Not enough schedule availability based on member's time preference	Summer hours to have a walk-in clinic every other Saturday
Member unable to receive communication via patient portal	• Having members be required to have a Patient Portal account. • More promotion of the Patient Portal; this way, the practice can always be in contact with the patient • Utilizing the Patient Portal to help do recall outreach
Member mailing address and/or phone number are outdated or incorrect	Utilizing multimodal efforts to outreach to members and provide information about how to update their contact information via the Peak App at every appointment and have resources available on the patient portal

At the time of this FY 2019–2020 PIP validation report, **CCHA R6** had completed Module 3 and initiated the intervention planning phase in Module 4. **CCHA R6** submitted one intervention plan in July 2019. Table 2-2 summarizes the intervention **CCHA R6** selected for testing through PDSA cycles for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP.

Table 2-2—Planned Interventions for the *Well-Care Visits for Children Between 15–18 Years of Age* PIP

Intervention Description	Key Drivers	Failure Mode
Extended hours, summer walk-in clinic every other Saturday	*Not reported in Module 4*	• Not enough schedule availability based on member's time preference • Member unable to receive communication via the portal

CCHA R6 selected one intervention for the well-care visit PIP to test using PDSA cycles in Module 4. The member-focused intervention expanded clinic hours to include Saturday options and outreach to members reminding them to schedule their annual well-care visit and informing them of available Saturday clinic hours. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **CCHA R6**. **CCHA R6** is currently in the "Do" stage of the PDSA cycles for this intervention, carrying out the tested intervention and evaluating for impact. HSAG will report the intervention testing results and final Module 4 and Module 5 validation outcomes in the next annual PIP validation report.

Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening

Table 2-3 summarizes the potential interventions **CCHA R6** identified for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-3—Intervention Determination Summary for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Failure Modes	Potential Interventions
No current process for when primary care provider (PCP) does not see positive PHQ-9 (depression screen)	Highlight the PHQ-9 to reduce the incidence of the positive screen getting lost in a stack of papers
No current coding standardization process	Optimize use of codes that work effectively in an integrated setting and to support the PIP
No current process with external providers to ensure follow-up visit occurred	Collaborate and strengthen partnership with Mental Health Partners (MHP) to improve sharing of information and closure of feedback loop

At the time of this FY 2019–2020 PIP validation report, **CCHA R6** had completed Module 3 and initiated the intervention planning phase in Module 4. **CCHA R6** submitted one intervention plan in

November 2019. Table 2-4 summarizes the intervention **CCHA R6** selected for testing through PDSA cycles for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP.

Table 2-4—Planned Interventions for the *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP

Intervention Description	Key Drivers	Failure Mode
Brightly color the PHQ-9 screening document	Provider engagement	No current process for when PCP does not see positive PHQ-9

For the behavioral health PIP, **CCHA R6** selected one intervention to test using PDSA cycles in Module 4. The provider-focused intervention included educating medical assistants on relaying information to the PCP and making the PHQ-9 a brightly colored piece of paper to better highlight it in a sea of medical documents. This intervention is meant to address the failure mode related to PCPs not seeing the positive depression screen. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **CCHA R6**. The health plan is currently in the "Do" stage of the PDSA cycles for all interventions, carrying out the intervention and evaluating impact for each PIP. HSAG will report the intervention testing results and final Module 4 and Module 5 validation findings in the next annual PIP validation report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **CCHA R6** successfully completed Module 3 and identified opportunities for improving the process related to obtaining a well-care visit for members 15 through 18 years of age and a follow-up visit for members with a positive depression screen. **CCHA R6** further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps and increase the percentage of members who receive a well-care visits and the percentage of members who receive appropriate and timely follow-up services for a positive depression screen. The health plan also successfully initiated Module 4 by selecting interventions to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. **CCHA R6** will continue testing interventions for the PIPs through June 30, 2020. The health plan will submit complete intervention testing results and PIP conclusions for each PIP for validation in FY 2020–2021. HSAG will report the final validation findings for the PIP in the FY 2020–2021 PIP validation report.

Recommendations

- When planning a test of change, **CCHA R6** should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, **CCHA R6** should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- **CCHA R6** should consistently use the approved Module 2 SMART Aim measure data collection and calculation methods for the duration of the PIP so that the final SMART Aim measure run chart provides data for a valid comparison of results to the goal.
- The key driver diagram for the PIP should be updated regularly to incorporate knowledge gained and lessons learned as **CCHA R6** progresses through determining and testing interventions. **CCHA R6** should also update the key driver diagram to include the key driver(s) addressed by intervention(s) selected for testing in Module 4.
- When reporting the final PIP conclusions, **CCHA R6** should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.
- If improvement is achieved through the PIP, **CCHA R6** should develop a plan for continuing and spreading effective interventions and sustaining improvement in the long term.

Appendix A. Module Submission Forms

Appendix A contains the Module Submission Forms provided by the health plan.

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Performance Improvement Project (PIP)
Module 3 — Intervention Determination Submission
Well–Care Visits for Children Between 15–18 Years of Age
for Colorado Community Health Alliance Region 6 (RAE 6)

Managed Care Organization (MCO) Information	
MCO Name:	Colorado Community Health Alliance- Region 6
PIP Title:	Well-Care Visits for Children Between 15 – 18 years of age
Contact Name:	Clara Cabanis, MHA, CPHQ
Contact Title:	Sr. Manager, Strategy and Performance
E-mail Address:	Clara.Cabanis@cchacares.com
Telephone Number:	(720) 612-6625
Submission Date:	5/16/19

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Process Mapping

Indicate when the process map(s) was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 1—Process Mapping Team	
Development Period	
02/13/2019 to 03/08/2019	
Team Members Involved	**Role/Responsibilities**
Roseann Zamora	Office Manager - provides overview of processes and workflows
Felicia Rickard	Supervisor Billing Coordinator - provides billing workflows and data from EHR
Alice Hudson, MD	Provider Champion
Mai Huynh	CCHA, Practice Transformation Coach - created process map an FMEA, collects and analyzes data

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Failure Modes and Effects Analysis (FMEA)

Indicate when the FMEA was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
02/13/2019 to 03/08/2019	
Team Members Involved	**Role/Responsibilities**
Roseann Zamora	Office Manager - provides overview of processes and workflows
Felicia Rickard	Supervisor Billing Coordinator - provides billing workflows and data from EHR
Alice Hudson, MD	Provider Champion
Chris Lively	Billing Manager - provides billing workflows and data from EHR
Mai Huynh	CCHA, Practice Transformation Coach - created process map an FMEA, collects data

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Please see the following page for the process map

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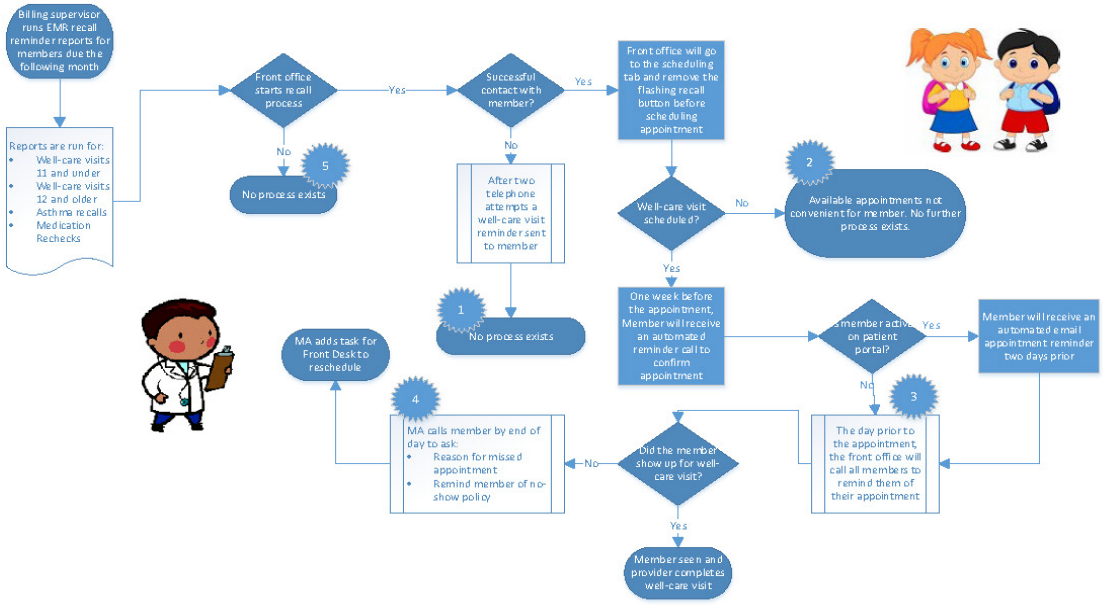

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Description of process and rationale for selection of subprocesses:

To create the process map and select subprocesses, CCHA and Rocky Mountain Pediatrics staff convened to map out which processes were most likely to lead to failures to get Health First Colorado members, age 15-18, in for their annual well-care visit. Rocky Mountain Pediatrics staff identified the following subprocesses that are directly related to scheduling, completing and billing for annual well-care visits: entering recall alerts, the recall process, and annual well-care visits. The process map was created to help uncover potential barriers that may be inhibiting eligible members from receiving an annual well-care visit. Staff members who helped create the process map are all involved in the doing, managing, and/or providing data for each of the subprocesses. Each subprocess identifies opportunities where there is potential to identify and act on gaps in well-care visits

1. Unsuccessful contact with member – this subprocess was examined due to the high frequency that the office can't contact members due to outdated or incorrect contact information. Additionally, sometimes they do have the correct phone number but are unable to leave a voicemail. This leads to either staff having to make multiple attempts, mailing a letter to an address that may also be out of date, or having to wait to see if the member calls into the office themselves.

2. Unscheduled well-care visits – this subprocess was examined because it's an opportunity for the practice to impact members who they were able to reach, which means they have already passed the first hurdle. There have been several instances where members either don't schedule a well-care visit, or schedule and no-show, because appointment times aren't convenient.

3. Members not active in-patient portal – members who are active in the patient portal are open to regular and automated communication with their provider. It allows members to access their test results and reminders on their own, while additionally freeing up front desk staff from having to make appointment reminder calls. It also allows members to update their own contact information, related to the inability to contact member sub process above.

4. Member doesn't show for well-care visit – when members no-show to an appointment it not only means they won't be getting their annual well-care visit, but it also waists time and resources for the clinic. Staff to their best to try to follow-up with the member to determine why they missed their appointment, reschedule the missed appointment, and try to help address any barriers to attending future appointments but no-show rates continue to be high.

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5. Front office did not complete recall process with all members – in some instances the front desk has long list of members to recall and the time spend on this effort is significant with limited resources. If a member doesn't get outreached by the front desk this member might not get the well-care visit completed on time.

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Failure Modes and Effects Analysis

From the completed process map(s), enter up to three subprocesses that have the potential to make the greatest impact on the SMART Aim. The assigned priority number in the process map should align with the subprocess number in the FMEA table. This will help clearly link each opportunity for improvement to an identified subprocess.

Complete the table with the corresponding failure modes, failure causes, and failure effects. Note: The MCO should ensure that the same language is used consistently to describe the failure modes throughout Modules 3, 4, and 5.

The three subprocesses identified below were the ones that Rocky Mountain Pediatrics staff identified as having the most potential for failure due to number of people and steps involved. While there may be failures in entering recall alerts and members no showing to their visits it has a lesser impact on the SMART Aim goal.

Table 3—Failure Modes and Effects Analysis Table

Subprocesses	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. Unsuccessful contact with member	Member mailing address and/or telephone number are outdated or incorrect	Member forgets to inform practice/Medicaid of their updated contact info	Practice is unable to reach member to schedule for well-care visits
	Front office is unable to leave a voice mail.	Member voice mail is full or not setup	Practice is unable to contact member to schedule appointment or remind member of the need for the appointment
2. Unscheduled well-care visits	Not enough schedule availability based on member preference	Not enough well-care visits time slots available in the week	Member says they will reschedule another time and sometimes it never happens

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3. Members not active in-patient portal	Members unable to receive communication via the portal	Staff have to call all members not active in the patient portal to remind them of their appointments, taking them away from other tasks	Staff are unable to do other outreach efforts because they're too busy doing reminder calls.

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Failure Mode Priority Ranking

Based on the results of the priority ranking process, list the numerically ranked failure modes from highest to lowest priority. In the space below the table, please describe the process used to assign the priority ranking.

Table 4—Failure Mode Priority Ranking	
Priority Ranking	**Failure Modes**
1	Not enough schedule availability based on member preference
2	Members unable to receive communication via the portal
3	Member mailing address and/or phone number are outdated or incorrect
4	Front office is unable to leave a voice mail

Description of priority ranking process (i.e., Risk Priority Number (RPN) method). If the RPN method was used, please provide the numeric values from the calculations:

CCHA used the risk priority number (RPN) method to calculate priority of ranking processes. This method was specific to the issue of getting 15-18-year old's in for well-care visits. The highest risk process not having enough schedule availability based on member time preferences. See table 5 for calculations.

Table 5 —Risk Priority Number				
	Severity	**Occurrence**	**Detection**	**Total**
Not enough schedule availability based on member time preference	9	5	5	225
Members unable to receive communication via the portal	5	8	4	160
Member mailing address and/or phone number are outdated or incorrect	6	4	3	72
Front office is unable to leave a voice mail	7	4	2	56

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Intervention Determination

In the Intervention Determine table, enter at a minimum, the top three ranked failure modes and the identified intervention to address the failure mode.

Table 6—Intervention Determination Table

Failure Modes	Interventions
Not enough schedule availability based on members time preference	Summer hours to have a walk-in WCC clinic every other Saturday (similar structure, like flu clinic)
Members unable to receive communication via the portal	Having members be required to have a Patient Portal account. More promotion of the Patient Portal. This way practice can always be in contact with patient. Utilizing the Patient Portal to help do recall outreach
Member mailing address and/or phone number are outdated or incorrect	Utilizing multimodal efforts to outreach members and providing information to all Health First Colorado members around how to update their contact information via the Peak App at every appointment and have resources available on the patient portal

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Managed Care Organization (MCO) Information	
MCO Name:	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 6
PIP Title:	Supporting member's engagement in mental health services following a positive depression screening
Contact Name:	Elizabeth Holden
Contact Title:	Director Clinical Quality Management
E-mail Address:	Elizabeth.holden@cchacares.com
Telephone Number:	720-768-9894
Submission Date:	August 23, 2019

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Process Mapping

Indicate when the process map(s) was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 1—Process Mapping Team	
Development Period	
03/08/2019 to present	
Team Members Involved	**Role/Responsibilities**
Janet Rasmussen	Clinica –Vice President of Integrated Services - Executive sponsor
Emily Vellano	Clinica – Director of Behavioral Services – provides workflow and operations information
Jennifer Kikla	Clinica – Clinical Quality Manager – provides data, data analyst assistance
Ben Schmudlach	Clinica – Director of Business Intelligence
Matthew Mosher	CCHA – Practice Transformation Coach, assists with coordination of data collection, group activities
Mary Smith	CCHA – Clinical Quality Manager – provides specification assistance, collection and population of PIP documents

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Failure Modes and Effects Analysis (FMEA)

Indicate when the FMEA was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
03/08/2019 to present	
Team Members Involved	**Role/Responsibilities**
Janet Rasmussen	Clinica – Vice President of Integrated Services - Executive sponsor
Emily Vellano	Clinica – Director of Behavioral Services – provides workflow and operations information
Jennifer Kikla	Clinica – Clinical Quality Manager – provides data, data analyst assistance
Ben Schmudlach	Clinica – Director of Business Intelligence
Matthew Mosher	CCHA – Practice Transformation Coach, assists with coordination of data collection, group activities
Mary Smith	CCHA – Clinical Quality Manager – provides specification assistance, collection and population of PIP documents

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Please see next page for process map

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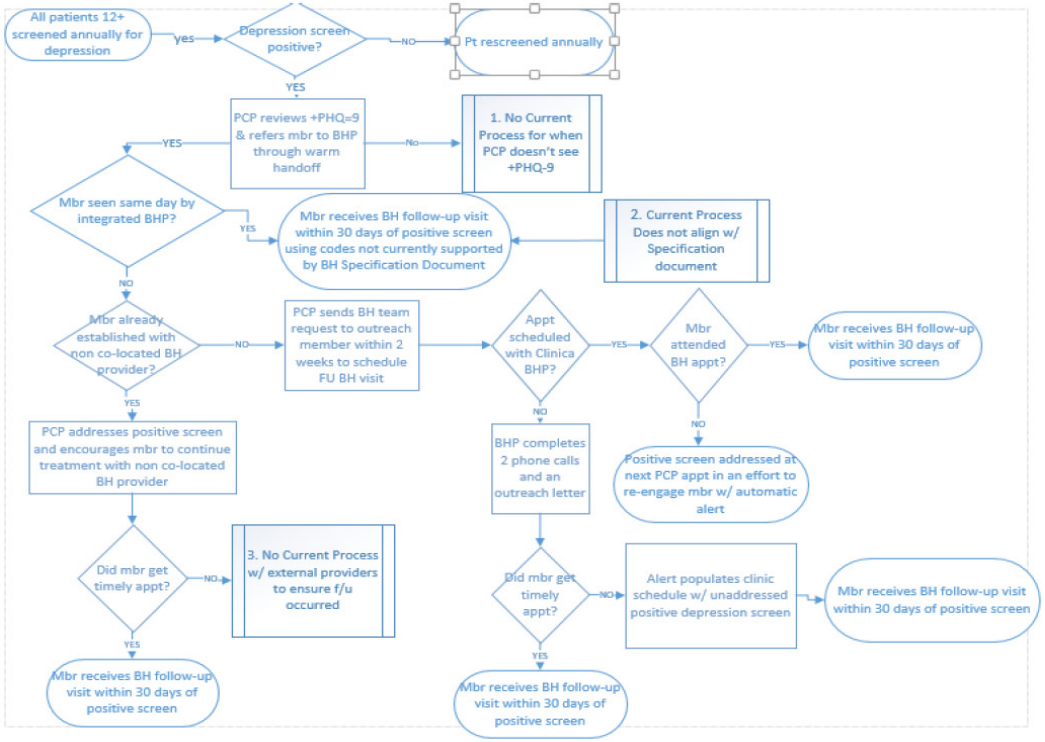

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Description of process and rationale for selection of subprocesses:

1. **No Current Process for when PCP doesn't see +PHQ-9:** Upon further review of internal processes, there is a gap between the transfer and/or communication of information between the MA and the PCP. This gap in information transfer occurs because of multiple demands on the MA and many paper forms needed to complete a patient's comprehensive exam. This sub-process was chosen because if the PCP is not aware of the +PHQ-9 and therefore doesn't support the member to engage in follow-up services.

2. **No Current Coding Standardization Process:** Upon review of data, visits with the integrated BH provider are occurring but due to the use of codes that are not included in the numerator BH incentive specifications as accepted codes, the visits are not being counted as follow-up towards the measure.

3. **No Current Process w/ external providers to ensure f/u occurred:** Ideally, following a referral to an outside provider the patient will attend the appointment and the documentation from that visit are forwarded back to the PCMP. There are several challenges encountered: follow-up to ensure that the patient attended the appointment; willingness of patient to engage in treatment; and obtaining documentation regarding the visit from the external Behavioral Health (BH) provider. This sub-process was chosen due to the essential component of the patient's understanding of the importance of follow-up and barriers to follow-up due to BH access issues. Follow-up when a referral is given to an outside provider as well as obtaining the treatment plan from that provider once the patient is seen in order that the PCMP can reinforce the plan is crucial. This is the same process whether the member is referred to a CMHC or a non-co-located BH provider.

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Failure Modes and Effects Analysis

From the completed process map(s), enter up to three subprocesses that have the potential to make the greatest impact on the SMART Aim. The assigned priority number in the process map should align with the subprocess number in the FMEA table. This will help clearly link each opportunity for improvement to an identified subprocess.

Complete the table with the corresponding failure modes, failure causes, and failure effects. Note: The MCO should ensure that the same language is used consistently to describe the failure modes throughout Modules 3, 4, and 5.

Table 3—Failure Modes and Effects Analysis Table

Subprocesses	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. No Current Process for when PCP doesn't see +PHQ-9	PHQ-9 gets lost in a pile of like colored papers	Too many forms to review	Depression screen not addressed
	MA forgot to make the PCP aware of + PHQ-9	Other priorities in supporting total member care	Member doesn't get follow-up
2. No Current Coding Standardization Process	Code used for BH visit that is not within the BH incentive specs	BH incentive codes not part of the standard workflow	BH follow-up visit occurred, but not included in numerator
3. No Current Process w/ external providers to ensure f/u occurred	Unable to ascertain if patient attended external appointment	No documentation of follow-up visit	Unable to ascertain if patient attended visit
	No documentation of BH visit details/plan	BH provider unaware of PCMP/ need for follow-up/ perceived HIPAA barrier between BH and BH re: sharing of information	PCMP unaware of treatment plan

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Failure Mode Priority Ranking

Based on the results of the priority ranking process, list the numerically ranked failure modes from highest to lowest priority. In the space below the table, please describe the process used to assign the priority ranking.

Table 4—Failure Mode Priority Ranking	
Priority Ranking	**Failure Modes**
1	No Current Process for when PCP doesn't see +PHQ-9
2	No Current Coding Standardization Process
3	No Current Process w/ external providers to ensure f/u occurred

Description of priority ranking process (i.e., Risk Priority Number (RPN) method). If the RPN method was used, please provide the numeric values from the calculations:
CCHA used the risk priority number (RPN) method to calculate priority of ranking processes. The table below displays the calculations.

Risk Priority Number Ranking				
	Occurrence Likelihood	Detection Likelihood	Harm/Damage if failure occurs	**TOTAL**
No Current Process for when PCP doesn't see +PHQ-9	4	10	10	400
No Current Coding Standardization Process	10	3	10	300
No Current Process w/ external providers to ensure f/u occurred	3	4	10	120

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Intervention Determination

In the Intervention Determine table, enter at a minimum, the top three ranked failure modes and the identified intervention to address the failure mode.

Table 5—Intervention Determination Table	
Failure Modes	**Interventions**
No Current Process for when PCP doesn't see +PHQ-9	Highlight the PHQ-9 to reduce the incidence of the +screen getting lost in a stack of papers
No Current Coding Standardization Process	Optimize use of codes that work effectively in an integrated setting and to support the PIP
No Current Process w/ external providers to ensure f/u occurred	Collaborate and strengthen partnership with Mental Health Partners (MHP) to improve sharing of information and closure of feedback loop

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	**General Comment**: The health plan must clarify if there was a representative from the narrowed focus provider during process map and FMEA completion.
2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes ☐ No	There were no subprocesses identified in the process map. It is unclear if the two yellow highlighted boxes are the identified subprocesses for improvement. Generally, subprocesses are identified from yes/no decision points where a gap or opportunity for improvement is noted. Once identified, each subprocess should be assigned a priority ranking based on its potential of impacting the SMART Aim. Additionally, based on the process map, it appears that there may be multiple gap areas that may have not been identified. For example, based on the process map it appears that the front office is able to schedule all members who are successfully reached; however, based on the FMEA table, it appears that there may be scheduling issues. HSAG recommends that the health plan schedule a technical assistance call with HSAG prior to resubmission. **Re-review May 2019:** In the resubmission, the health plan revised the process map and opportunities for improvement were prioritized and assigned a numerical ranking. However, based on the documentation (second failure mode) in the FMEA table, it appears that not all members are being outreached by the health plan. Therefore, the health plan must include the step "Front office completed

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		outreach calls to members" as a yes/no decision box with an opportunity for improvement. Additionally, the fourth subprocess documented in the narrative was not labeled within the process map. **Re-review June 2019**: In the resubmission, the health plan revised the process map to include a decision point for the recall process and clearly labeled and documented all subprocesses. The criterion was achieved.
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	Even though the health plan included the description of its process, the subprocesses listed on page 6 are broad. "Entering recall alerts", "Recall Process" and "Annual Well-Check Visits" appears to be the titles of the three swim lanes in the process map. Subprocesses in the narrative should be identified and clearly marked as a gap or opportunity for improvement in the process map. **Re-review May 2019**: In the resubmission, the health plan included the rationale used for selection of the subprocesses. The criterion was achieved. **General Comment**: On page 6, the health plan included a fourth sub-process "No-show follow up" under the description of the process and rationale used for the selection of subprocesses. This subprocess was not included in the process map as an opportunity for improvement. The health plan must include and rank this subprocess in the process map or remove it from the narrative description.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		Re-review June 2019: In the resubmission, the health plan clearly labeled and documented all subprocesses in the process map and narrative. The general comment has been addressed.
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	The health plan must use consistent language when describing subprocesses and failure modes throughout the module. For example, if the highlighted selections on the process map are the identified subprocesses, then the first sub-process may be worded as "Was member reached successfully" and the second subprocess may be "Did member show up for WCC appointment." The FMEA table will need to be updated based on a revised process map. **Re-review May 2019**: In the resubmission, the FMEA table appears accurate and the health plan used consistent language when describing subprocesses and failure modes throughout the module. The criterion was achieved. **General Comment**: The paragraph above the FMEA table on page 7 includes language from the initial Module 3 submission which references the subprocesses identified in the initial submission. The health plan must remove/update the paragraph above the FMEA table on page 7. **Re-review June 2019:** In the submission, the health plan updated the paragraph above the FMEA table on page 7. The general comment has been addressed.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	For the third intervention, the health plan must include more details about how it will provide information to members to update the contact information via the Peak app? Will this be a face-to-face communication when the member is in office? Additionally, the health plan must list failure modes consistently thought out the module. **Re-review May 2019**: In the resubmission, the health plan added details for the third intervention regarding how information will be provided to members. The criterion was achieved. **General Comment:** The health plan must ensure that it develops a robust tracking mechanism for the interventions being tested to evaluate the linkage of each intervention with a numerator compliant well-care visit.

Intervention Determination (Module 3)

☒ Pass

Date: June 4, 2019

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	
2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes ☐ No	It appears that there may be steps missing in the documented process map. For example, after the member screens positive for depression screen, it is unclear when and who schedules a follow-up behavioral health (BH) appointment. Does the clinic help schedule a follow-up appointment before member leaves the provider office or is it up to the member to schedule a follow-up visit? Additionally, it appears follow-up scheduling may be a decision box with a Yes/No option based on the current process map, every member has a scheduled BH follow-up visit. Also, it is unclear what the health plan means by external and internal referrals and how these fit into the current care process. The goal of this PIP is to increase the rate of 30-day follow-up visits for members who were screened positive for depression. The process map should end with what identifies the member as numerator compliant, the member receiving a follow-up visit within 30-days of the positive screen. Lastly, the health plan should spell out acronyms at first use. For example, the reviewer cannot determine what PHQ-A and PHC-9 are referencing

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		HSAG recommends the health plan schedule a technical assistance call. **Re-review October 2019**: In the resubmission, the health plan addressed HSAG's feedback. The criterion was achieved. **Re-review December 2019**: The health plan resubmitted after HSAG determined during a TA call that the processes at the narrowed focus may be different than what was submitted in the previous Module 3. In the resubmission, the criterion remains achieved.
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	**General Comment**: Based on the description on page 6, it appears that the health plan must make changes in the process map to include "member referred to internal BH provider" and "member scheduled a follow-up BH appointment" as decision boxes. The health plan will need to update this information following revisions to the process map.
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	Not all failure modes align with the process map. For example, the second failure mode references lack-of documentation of a follow-up visit; however, this gap in the current process is not identified within the process map. Additionally, it is unclear why "Unable to contact patient for reminder" is a failure mode for external referrals? The FMEA table will also need to be updated following revisions to the process map.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		Re-review October 2019: In the resubmission, the health plan updated the process map and addressed HSAG's feedback. The criterion was achieved. **Re-review December 2019**: In the resubmission, the health plan updated the FMEA table. The criterion remains achieved.
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	**General Comment**: One failure mode "Unable to contact patient for reminder" is documented twice within the FMEA table but only once in the priority ranking. The health plan should include the all the failure modes in the ranking table and clearly document which subprocess each ranked failure mode is linked to. Additionally, the health plan will need to update this information following revisions to the process map.
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	**General Comment** : The first intervention for appropriate coding will help capture accurate data; however, it will not improve the actual number of members who receive a numerator compliant follow-up visit. Therefore, this intervention must not be the only intervention chosen to test for this PIP. Additionally, the health plan may need to update the intervention information following revisions to the process map and FMEA table.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		Re-review October 2019: The health plan must ensure that it addresses HSAG's general comment and does not test only coding intervention for the PIP. Also, for the third intervention, Increased Sharing of Information with Mental Health Partners, the health plan must ensure it acts on the information to improve member compliance. **Re-review December 2019**: In the resubmission, the health plan updated one of the interventions. The criterion remains achieved.

Intervention Determination (Module 3)

☒ Pass

Date: December 6, 2019