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 7

*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 7**, referred to in this report as **CCHA R7**, 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 R7**'s module submission forms. In FY 2019–2020, these forms provided detailed information about **CCHA R7**'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 R7** 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 R7** 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 R7**.

**Table 1-1—PIP Titles and SMART Aim Statements**

| PIP Titles | SMART Aim Statements |
|---|---|
| *Well-Care Visits for Children Between 15–18 Years of Age* | To increase well-care visits in children at Iron Horse Pediatrics 15–18 years of age from 14.8% to 19.8% 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 years and older attributed to Center Pointe Family Medicine LLC from 17.3% to 22.3%. |

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 R7** has made in completing the five PIP modules for each PIP.

**Table 1-2—PIP Titles and Module Status**

| PIP Titles | 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 October 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 R7** had passed Module 1, Module 2, and Module 3, achieving all validation criteria for each PIP. **CCHA R7** 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 R7** 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 R7** 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 R7** 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 setting "tickler" reminder in electronic health record (EHR) | Updating established member recall workflows including processes to catch missed tickler reminders |
| Incorrect contact information for member | 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 through mailed resources |
| Member ineligible for Medicaid on day of service | Established processes to check member eligibility on the day of service and connect ineligible members with CCHA care coordinators |

At the time of this FY 2019–2020 PIP validation report, **CCHA R7** had completed Module 3 and initiated the intervention planning phase in Module 4. **CCHA R7** submitted one intervention plan in

July 2019 for the well-care visits PIP. Table 2-2 summarizes the intervention **CCHA R7** 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 |
|---|---|---|
| Update established member recall workflows including processes to catch missed tickler reminders | *Not reported in Module 4* | Not setting "tickler" reminder in EHR |

**CCHA R7** selected one intervention for the well-care visit PIP to test using PDSA cycles in Module 4. The member-focused intervention included outreach to members due for their annual well-care visit based on EHR and claims data and entering a tickler reminder within the EHR for compliant members for the following year. This intervention is meant to address the failure mode related to tickler reminders not being set in the EHR. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **CCHA R7**.

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

Table 2-3 summarizes the potential interventions **CCHA R7** 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 |
|---|---|
| Unable to ascertain if patient attended appointment/unclear which behavioral health (BH) provider the member has chosen | **Tracking Mechanism:** CCHA and CenterPointe collaborated to develop a tracking mechanism for all members who screen positive for depression. This will include Medicaid ID, member name, date of screening, date of BH referral, whether member scheduled the appointment, BH referral name/practice, date of reminder call, and date of BH follow-up visit. CenterPointe—Widefield office staff members will outreach to the member after one week to determine which provider he or she plans to see, if the appointment is scheduled, and determine any other barriers to attending the appointment. |
| Member does not contact BH provider | **Warm Handoff:** Utilizing a warm handoff of member to BH provider of his or her choice, member will be assisted at the primary care provider's office in scheduling the BH follow-up appointment before the member leaves the office. |
| Long wait time for BH provider appointment | **Collaboration with AspenPointe:** CCHA to establish a Care Compact (to give CenterPointe members priority appointments) with AspenPointe Community Mental Health Center to assist in getting members seen within 30 days of a positive screen. |

At the time of this FY 2019–2020 PIP validation report, **CCHA R7** had completed Module 3 and initiated the intervention planning phase in Module 4. **CCHA R7** submitted one intervention plan in October 2019 for the behavioral health PIP. Table 2-4 summarizes the intervention **CCHA R7** 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 |
|---|---|---|
| Referral and tracking mechanism for a follow-up visit | Provider standards of care | Unable to ascertain if patient attended appointment/unclear which BH provider the member has chosen |

For the behavioral health PIP, **CCHA R7** selected one intervention to test using PDSA cycles in Module 4. The provider-focused intervention included identifying and tracking members who have had a positive depression screen followed by member outreach and reminders conducted by the provider. This intervention is meant to address the failure mode related to being unable to ascertain if the patient attended their appointment and being unclear which behavioral health provider a member has chosen. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **CCHA R7**.

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 R7** successfully completed Module 3 and identified opportunities for improving the process related to obtaining a well visit for members 15 through 18 years of age and a follow-up visit for members with a positive depression screen. **CCHA R7** 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 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 R7** 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 R7** 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 R7** 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 R7** 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 R7** progresses through determining and testing interventions. **CCHA R7** 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 R7** 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 R7** 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.

State of Colorado
## 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 7 (RAE 7)

| Managed Care Organization (MCO) Information | |
|---|---|
| MCO Name: | Colorado Community Health Alliance- Region 7 |
| 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: | May 3,2019 |

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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** | |
| 02/13/2019 to 03/08/2019 | |
| **Team Members Involved** | **Role/Responsibilities** |
| **Justin Woody** | Manager, Operations and Care Coordination – provides workflow information |
| **Ellen Montgomery** | Supervisor, Billing and Coding – provides data from EHR and billing processes |
| **Marissa Kirby** | NP, Provider Champion |
| **Steven Walsh** | 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** |
| **Justin Woody** | Manager, Operations and Care Coordination – provides workflow information |
| **Ellen Montgomery** | Supervisor, Billing and Coding – provides data from EHR and billing processes |
| **Marissa Kirby** | NP, Provider Champion |
| **Steven Walsh** | CCHA, Practice Transformation Coach - created process map an FMEA, collects and analyzes 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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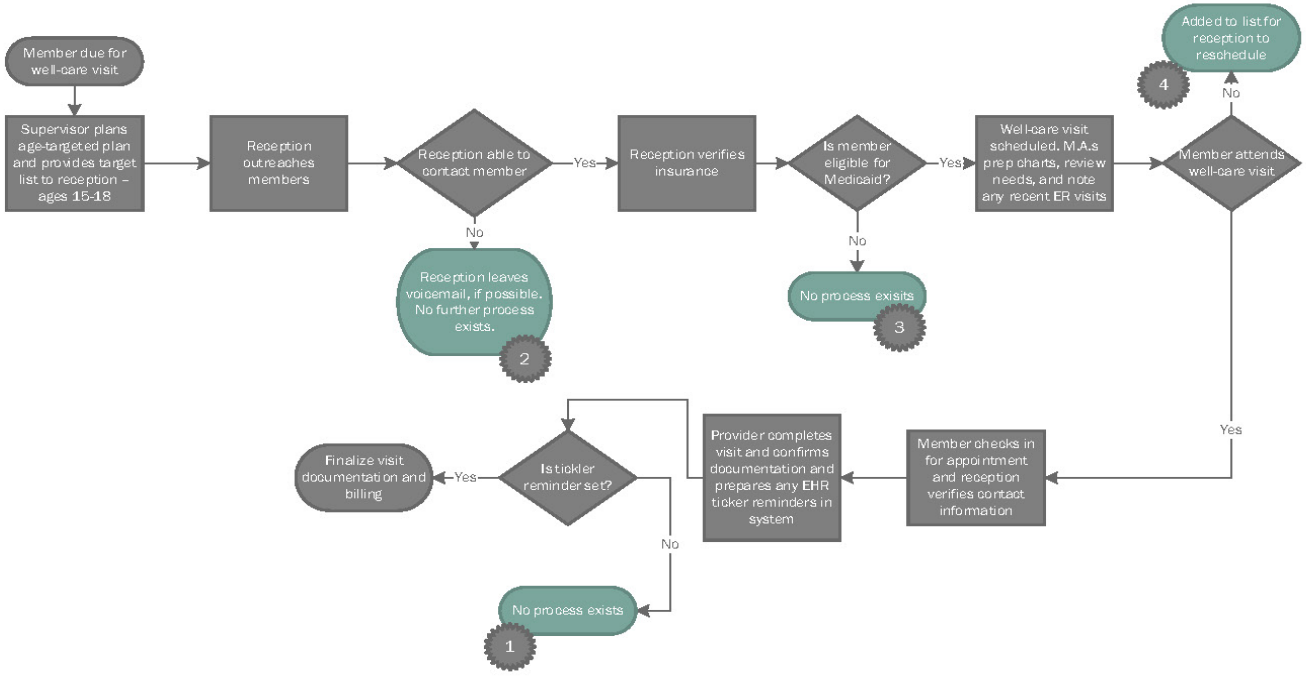


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**Description of process and rationale for selection of subprocesses:**

To create the process map and select subprocesses, CCHA and Iron Horse Pediatrics staff convened to map out which processes were most likely to lead to failures to get Health First Colorado embers, age 15-18, in for their annual well-care visit. Iron Horse Pediatrics staff identified the following subprocesses that are directly related to scheduling, completing and billing for annual well-care visits: pre-visit planning, visit, post-visit follow up. 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. Tickler set for well-care visit - Following an appointment, staff should be updating ticklers, making follow up appointments not made in the office, and following up on referrals. These are also imperative to starting the outreach process to get members scheduled.

2. Reception unable to contact 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.

3. Member not eligible for Medicaid – Currently, staff checks eligibility when they're trying to schedule a well-care visit but there is no process for helping ineligible members apply for Medicaid, meaning that these may be missed opportunities, especially if these members become eligible again quickly. Additionally, staff doesn't check eligibility the day of visits, and the clinic may not be paid for services rendered if the member wasn't eligible that day.

4. Member doesn't attend 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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## 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 subprocesses below were selected by Iron Horse Pediatric staff for failure mode and effect analysis based on potential downstream impact. While member no-shows are a problem, the greatest impact on well-care visits is outreaching members who are overdue for a well-care visit.

**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. Tickler set for well-care visit | Not setting "tickler" reminder in EHR | Lack of attention to detail/following process/system errors | All staff not aware of member requirements/outreach efforts |
| 2. Reception unable to contact Member | Incorrect contact information for member | Member forgets to inform practice/Medicaid of their updated contact information | Practice is unable to reach member to schedule a well-care visit. |
| | Reception unable to leave voicemail | Member voice mail is full or not setup | Practice is unable to contact member to schedule appointment to remind member of the need for the appointment. |
| 3. Member not eligible for Medicaid | Member ineligible for Medicaid on day of service | Eligibility checked when member contacted but not on day of service | Loss of payment for services rendered and missed well-care visits for members who quickly become eligible again. |

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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 setting "tickler" reminder in EHR |
| 2 | Incorrect contact information for member |
| 3 | Member ineligible for Medicaid on day of service |
| 4 | Reception unable to leave voicemail |

**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 olds in for well-care visits. The highest risk process was not setting "tickler" reminder in EHR. See table 5 for calculations.

**Table 5 —Risk Priority Number**

| | Severity | Occurrence | Detection | Total |
|---|---|---|---|---|
| Not setting "tickler" reminder in EHR | 7 | 6 | 5 | 210 |
| Incorrect contact information for member | 4 | 8 | 5 | 160 |
| Member ineligible for Medicaid on day of service | 10 | 2 | 5 | 100 |
| Reception unable to leave voicemail | 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 setting "tickler" reminder in EHR | Updating established member recall workflows including processes to catch missed tickler reminders |
| Incorrect contact information for member | 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 may mail resources |
| Member ineligible for Medicaid on day of service | Established processes to check member eligibility on the day of service and connect ineligible members with CCHA Care Coordinators. |

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| Managed Care Organization (MCO) Information | |
|---|---|
| MCO Name: | Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 7 |
| 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 16, 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** |
| **Tonnie Darling** | Center Pointe – Widefield, Executive Sponsor, Technical Expert |
| **Priscilla Maes** | Center Pointe – Widefield, day-to-day operations |
| **Dawn Kofahl** | Center Pointe – Widefield, scheduling expert |
| **Steven Walsh** | 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** |
| **Tonnie Darling** | Center Pointe – Widefield, Executive Sponsor, Technical Expert |
| **Priscilla Maes** | Center Pointe – Widefield, day-to-day operations |
| **Dawn Kofahl** | Center Pointe – Widefield, scheduling expert |
| **Steven Walsh** | 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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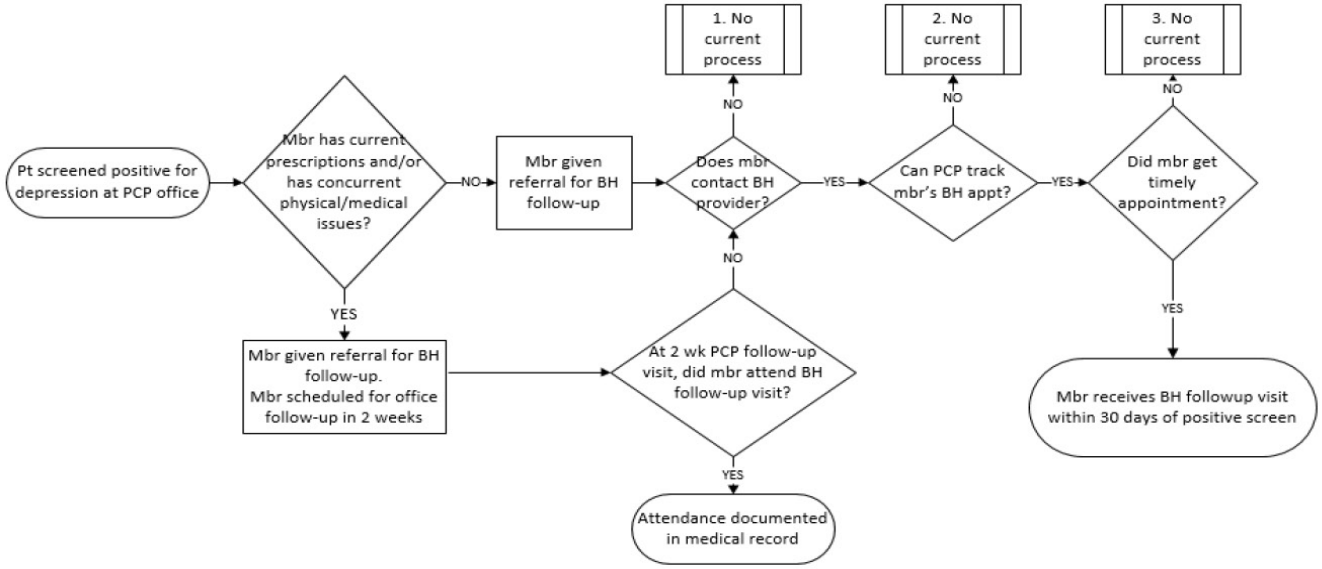


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**Description of process and rationale for selection of subprocesses:**

CCHA and CenterPointe – Widefield staff mapped out the flow of members who screen positive for depression and their subsequent engagement with Behavioral Health services in follow-up. Together we identified subprocesses which helped identify potential barriers that may affect the ability of the member to obtain timely follow-up, or the CenterPointe office in tracking and assisting the member to obtain services.

1. **Member does not contact BH provider:** This process was examined due to the gap which may occur because the PCP office is unaware whether the member made an appointment for BH follow-up.

2. **Tracking mechanism for follow-up visit:** This process was examined due the current lack of a tracking mechanism to document which BH provider the member was referred to, was the member able to obtain follow-up in a timely manner, and whether the member attended the appointment. The gap in tracking occurs in both situations of when the member has concurrent physical or no concurrent medical issues.

3. **Timely Follow-up:** The member who screens positive for depression is provided with a referral to a Behavioral Health (BH) provider. This process was examined due the challenges encountered in finding a BH provider close to the member who is accepting new patients in addition to finding a BH provider who has the ability to see the member within a timely manner. Feedback received from members has been that some BH providers are not accepting new patients, or are not located conveniently, or that there is an extensive wait time to be seen.

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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. **Member does not contact BH provider** | Member does not contact BH provider | Lack of willingness of member | Member does not seek BH follow-up |
| 2. **Tracking mechanism for follow-up visit** | Unable to ascertain if member attended appointment /Unclear which BH provider member has chosen | No tracking mechanism | BH referral not completed/ Unable to assist member if they encounter difficulties in obtaining an appointment |
| 3. **Timely Follow-up** | No convenient BH provider/BH provider not accepting new members | Few BH providers | Member not seen |
| | Long wait time for BH provider appointment | Few BH providers | Member not seen in timely manner |

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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** | Unable to ascertain if member attended appointment /Unclear which BH provider member has chosen |
| **2** | Member does not contact BH provider |
| **3** | Long wait time for BH provider appointment |
| **4** | No convenient BH provider/BH provider not accepting new members |

**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 convenient BH provider/BH provider not accepting new members | 8 | 6 | 8 | 384 |
| Long wait time for BH provider appointment | 8 | 6 | 9 | 432 |

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| Risk Priority Number Ranking | | | | |
|---|---|---|---|---|
| Unable to ascertain if patient attended appointment /Unclear which BH provider member has chosen | 9 | 9 | 7 | 567 |
| Member does not contact BH provider | 7 | 9 | 8 | 504 |

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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 |
|---|---|
| Unable to ascertain if patient attended appointment /Unclear which BH provider member has chosen | **Tracking Mechanism:** CCHA and CenterPointe collaborated to develop a tracking mechanism (see attached) for all members who screen positive for depression. This will include Medicaid ID, member name, date of screening/date of BH referral, whether member scheduled the appointment, BH referral name/practice, date of reminder call, and date of BH follow-up visit. CenterPointe – Widefield office staff will outreach member after one week to determine which provider they plan to see, if the appointment is scheduled, and determine any other barriers to attending the appointment. |
| Member does not contact BH provider | **Warm Handoff:** Utilizing a warm handoff to BH provider of their choice, member will be assisted at the PCP's office in scheduling the BH follow-up appointment before the member leaves the office. |
| Long wait time for BH provider appointment | **Collaboration with AspenPointe:** CCHA to establish a Care Compact (to give CenterPointe members priority appointments) with AspenPointe Community Mental Health Center to assist in getting members seen within 30 days of positive screen. |

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**Tracking for Patients Screening Positive for Depression - Follow-up BH appointments**

| Medicaid ID | Member Name | Date BH Referral Generated/Date Positive Screen | Did Member Schedule Appt? | BH Provider Name/Practice | Date of Reminder Call to Member to attend BH appt | BH Appt Date |
|---|---|---|---|---|---|---|
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# 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<br>☐ 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<br>☐ No | There were no subprocesses identified in the process map. Subprocesses should be 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.<br><br>The process map should end with a completed well-care visit which identifies a member as numerator compliant.<br><br>It appears that several steps should be decision points based on the information within the FMEA table. For example:<br>• **Pre-visit planning**: Does the "Reception" make contact with every member they attempt to reach? Is the "Reception" able to verify insurance with each successful contact they reach? Are there instances when the "Reception" does not schedule an appointment for a member they have contacted?<br>• **Visit**: Do members ever no-show for an appointment?<br><br>Does the health plan have any processes in place to facilitate compliance with the well-care visit? |

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| Criteria | Achieved (Y/N) | HSAG Feedback and Recommendations |
|---|---|---|
| | | HSAG recommends that the health plan schedule a technical assistance call with HSAG prior to the resubmission.<br><br>**Re-review May 2019:** In the resubmission, the health plan appropriately identified and prioritized the first three subprocesses within the process map. However, based on the narrative on page 7, it appears that "Member doesn't attend well-care visit" must be identified and ranked as a fourth subprocess in the process map.<br><br>**Re-review June 2019:** In the resubmission, the health plan identified and prioritized 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<br>☐ No | The health plan provided a description of their selection process; however, there were no subprocesses identified or prioritized in the process map. In addition, the subprocesses documented within the FMEA table are not considered subprocesses but appear to be the three "swim-lane" categories within the process map. Subprocesses in the narrative should be identified and clearly marked as a gap or opportunity for improvement in the process map.<br><br>**Re-review May 2019**: In the resubmission, the health plan revised the process map and included a description of the process and rationale used for the selection and priority ranking of subprocesses in the FMEA table. The criterion was achieved. |

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| Criteria | Achieved (Y/N) | HSAG Feedback and Recommendations |
|---|---|---|
| 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<br>☐ No | The health plan provided a description of their selection process; however, there were no subprocesses identified or prioritized in the process map.<br><br>Within the current FMEA table, failure modes, causes and effects are described incorrectly. The failure mode is *what could go wrong*, the failure cause is *why would the failure happen*, and the failure effect is *what are the consequences*.<br><br>The FMEA table may need to be updated based on a revised process map. The health plan must use consistent language when describing subprocesses and failure modes throughout the module.<br><br>**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. |
| 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<br>☐ No | The FMEA table contains two failure modes (Not setting "tickler" reminder in EHR) that are the same but for two different subprocesses. In these instances, the health plan must clarify which subprocess is linked to the failure modes within the Priority Ranking table. All failure modes within the FMEA table must be included in the Priority Ranking table. |

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| Criteria | Achieved (Y/N) | HSAG Feedback and Recommendations |
|---|---|---|
| | | **Re-review May 2019:** Based on the Risk Priority Numbers calculation, the second ranked failure mode should be "Incorrect contact information for member" and the third ranked should be "Member ineligible for Medicaid on day of service". The health plan must correct the priority ranking in the table.<br><br>**Re-review June 2019:** In the resubmission, the health plan correctly ranked all failure modes based on the Risk Priority Numbers calculation. The criterion was achieved. |
| 6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes. | ☒ Yes<br>☐ 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?<br><br>The Intervention Determination table may need to be updated once revisions to the Process Map and FMEA table have been completed.<br><br>**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.<br><br>**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. |

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**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<br>☐ 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<br>☐ No | The process map must identify the current steps (subprocesses) which may have resulted in the member not receiving a timely follow-up behavioral health visit.<br><br>It is unclear from the process map and the narrative how "external referrals" fit in the current process. If members are currently not being referred to external behavioral health providers, then this should not be included in the process map. It appears "Could member obtain timely appointment" may be the subprocess which may be linked to the failure modes "No convenient BH provider/BH provider not accepting new members" and "Long wait time for BH provider appointment."<br><br>The process map should end with what identifies the member as numerator compliant; i.e., the member receiving a follow-up visit within 30 days of the positive screen.<br><br>HSAG recommends the health plan schedule a technical assistance call, prior to resubmitting. |

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| Criteria | Achieved (Y/N) | HSAG Feedback and Recommendations |
|---|---|---|
| | | **Re-review September 2019**: In the resubmission, the health plan addressed HSAG's concerns about the process map. 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<br>☐ No | **General Comment**: Based on HSAG's feedback in Criterion 2 above, the health plan may need to update the description of the subprocesses selected for the FMEA table, as applicable.<br><br>**Re-review September 2019**: In the resubmission, the health plan updated the description of the rationale used for subprocesses selection. The criterion remains achieved. |
| 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<br>☐ No | **General Comment**: Based on HSAG's feedback in Criterion 2 above, the health plan may need to update the FMEA table, as applicable.<br><br>**Re-review September 2019**: In the resubmission, the health plan updated the FMEA table based on changes made to the process map. 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<br>☐ No | **General Comment**: Based on HSAG's feedback in Criterion 2 above, the health plan may need to update the failure modes ranking process, as applicable. |

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| Criteria | Achieved (Y/N) | HSAG Feedback and Recommendations |
|---|---|---|
| | | **Re-review September 2019**: In the resubmission, the health plan updated the failure modes priority ranking table accurately. The criterion remains achieved. |
| 6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes. | ☒ Yes<br>☐ No | It is unclear how tracking positive depression screenings or receiving visit details from behavioral health providers (the first and second listed interventions) increase member engagement in mental health services. Will the members who will be tracked, also be reached out by the provider or the health plan before the 30-day follow up period ends? The health plan must provide additional information describing the interventions.<br><br>**Re-review September 2019**: In the resubmission, the health plan included additional details about the interventions. The documented interventions appear appropriate. The criterion has been achieved. |

**Intervention Determination (Module 3)**

☒ Pass

Date: September 12, 2019