COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2020–2021 PIP Validation Report

for

Colorado Community Health Alliance Region 7

April 2021

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) 2018–2019, 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. **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 fiscal year (FY) 2020–2021, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve quality improvement
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

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, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on June 8, 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, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.

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 approximately 18 months, from the initial Module 1 submission date to the end of intervention testing.

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 uses four modules with an accompanying reference guide to assist MCOs in documenting PIP activities for validation. Prior to issuing each module, HSAG holds technical assistance sessions with the MCOs to educate about application of the modules. The four modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the MCO sets aims (Global and SMART), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.
- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the quality improvement activities reasonably expected to impact the SMART Aim. The MCO updates the key driver diagram from Module 1 after completing process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking for a more in-depth understanding of the improvement strategies that are most likely to support achievement of the SMART Aim goal.
- **Module 3—Intervention Testing:** In Module 3, the MCO defines the intervention plan for the intervention to be tested, and the intervention effectiveness measure and data collection process are defined. The MCO will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, the MCO summarizes key findings, compares successful and unsuccessful interventions, and reports outcomes achieved. The MCO will synthesize data collection results, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement after the project ends.

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **CCHA R7**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **CCHA R7**'s PIP and the activities completed in Module 1. (See Appendix A. Module Submission Form.)

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 *Met.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 4, HSAG will use the validation findings from modules 1 through 4 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 2020–2021, **CCHA R7** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen*.

CCHA R7 defined a Global Aim and SMART Aim for the 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 the 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 measure will be used? What current data (i.e., count, percent, or rate) are available for that measure? How much increase or decrease in the indicator will demonstrate improvement?
- **A**ttainable: Rationale for setting the goal: Is the desired achievement 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 SMART Aim statements established by **CCHA R7**.

Table 1-1—SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 52.12% to 54.81%.
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 90.3% to 96.7%.

The focus of the PIP is to increase the percentage of members 12 years of age and older who receive a depression screening during a primary care visit at Peak Vista Community Health Centers and to increase the percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goals to increase depression screening to 58.41 percent and to increase follow-up within 30 days after a positive depression screen to 96.7 percent represent statistically significant improvement over the baseline performance.

Table 1-2 summarizes the progress **CCHA R7** has made in completing the four PIP modules.

Table 1-2—PIP Topic and Module Status

PIP Topic	Module	Status
Depression Screening and Follow-Up After a Positive Depression Screen	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Initial submission due April 14, 2021.
	3. Intervention Testing	Targeted initiation June/July 2021.
	4. PIP Conclusions	Targeted for October 2022.

At the time of the FY 2020–2021 PIP validation report, **CCHA R7** had passed Module 1, achieving all validation criteria for the PIP. **CCHA R7** has progressed to Module 2, Intervention Determination. Module 2 and Module 3 validation findings will be reported in the FY 2021–2022 PIP validation report.

2. Findings

Validation Findings

At the end of FY 2019–2020, **CCHA R7** closed out the *Well-Care Visits for Children Between 15–18 Years of Age* and *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIPs, which were initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from each project.

In FY 2020–2021, **CCHA R7** initiated a new PIP, *Depression Screening and Follow-Up After a Positive Depression Screen*. The health plan submitted Module 1 for validation in December 2020. The objective of Module 1 is for the health plan to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, **CCHA R7** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. HSAG reviewed Module 1 and provided feedback and technical assistance to the health plan until all Module 1 criteria were achieved.

Below are summaries of PIP conclusions from the *Well-Care Visits for Children Between 15–18 Years of Age* and *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIP Close-Out Reports and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **CCHA R7** reported in the FY 2019–2020 PIP close-out report for the *Well-Care Visits for Children Between 15–18 Years of Age* and *Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening* PIPs .

Table 2-1—PIP Conclusions Summary

Improving Well-Care Visits for Children Between 15–18 Years of Age PIP	
Interventions	• Targeted outreach to 15–18-year-olds who were due for annual well-care visits. • Updated member recall workflow by the partner provider to better identify members for outreach.
Successes	• Member recall process improved by partner provider. • Increased understanding by partner provider of member attribution and their responsibility for those members.
Lessons Learned	The importance of educating practices on regularly looking at attribution and empanelment, regardless of claims history, to ensure adequate resources are available to service all members.

Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening PIP	
Interventions	• Provider training in best practices for facilitating follow-up care after positive depression screening. • Developed an automated internal provider practice reminder to identify members due to depression screening. • Integration of the Patient Health Questionnaire-9 (PHQ-9) depression assessment tool into the provider partner's workflow.
Successes	• Developed improved tools, workflows, and processes to support provider partner's depression screening and follow-up efforts. • Increased behavioral health follow-up rates during the project.
Lessons Learned	• The importance of accurately estimating staff and resources needed for data collection and reporting. • The importance of adequate provider capacity to address performance improvement.

Module 1: PIP Initiation

Table 2-2 presents the FY 2020–2021 validation findings for **CCHA R7**'s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Table 2-2—Module 1 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 52.12% to 54.81%.
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance

Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 90.3% to 96.7%.
Preliminary Key Drivers	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement
Potential Interventions	• Provider and staff training and education • Offering same-day appointments to members • Expanding appointment availability • Offering translation services • Transportation assistance

In Module 1, **CCHA R7** set two goals to achieve by June 30, 2022:

- Increase the percentage of members 12 years of age and older who receive a depression screening during a primary care visit at Peak Vista Community Health Centers to 54.81 percent.
- Increase the percentage of members 12 years of age and older who screened positive for depression at Peak Vista Community Health Centers that receive follow-up behavioral health services within 30 days of the positive depression screen to 96.7 percent.

The health plan completed key driver diagrams in Module 1 that identified evidence-based key drivers and potential interventions to support achievement of these goals. **CCHA R7**'s identified key drivers focused on provider engagement, availability, and standards of care; member access and engagement; and data accuracy and integration. **CCHA R7** has identified both provider-focused and member-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **CCHA R7** will use process mapping and FMEA to further analyze the processes related to depression screening and follow-up after a positive depression screen for members served by the narrowed focus provider. The health plan will have the opportunity to update key drivers and interventions in the key driver diagram at the conclusion of Module 2, prior to selecting interventions to test through PDSA cycles in Module 3. Validation findings for Module 2 and Module 3 will be described in the FY 2021–2022 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **CCHA R7** successfully completed Module 1 and designed a methodologically sound project. **CCHA R7** was also successful in building internal and external quality improvement teams and developing collaborative partnerships with targeted providers and facilities.

Recommendations

- When mapping and analyzing the process(es) related to depression screening and follow-up care after a positive depression screen for the PIP, **CCHA R7** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **CCHA R7** should clearly identify the steps in the process map(s) that represent the greatest opportunities for improvement and further analyze those process steps through an FMEA. For each process step included in the FMEA, the health plan should identify failure modes, causes, and effects that can be logically linked to each step.
- When ranking failure modes identified through the FMEA, **CCHA R7** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **CCHA R7** should review and update the key driver diagram after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as **CCHA R7** progresses through determining and testing interventions.
- **CCHA R7** should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, **CCHA R7** should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Appendix A. Module Submission Form

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

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Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
***for* Colorado Community Health Alliance – RAE 7**

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 7
PIP Title	*Depression Screening and Follow–Up After a Positive Depression Screen*
Contact Name	Elizabeth Holden
Contact Title	Director Clinical Quality Management
Email Address	Elizabeth.holden@cchacares.com
Telephone Number	720-768-9894
Submission Date	December 7, 2020
Resubmission Date (if applicable)	February 9, 2021; March 3, 2021

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PIP Team

Instructions:

- In Table 1, list the project team members, including their titles and roles and responsibilities.
- The team should include an executive-level sponsor and data analyst.
- If applicable, a representative from the selected narrowed focus should be included on the team.

Table 1—Team Members

Name	Title	Role and Responsibilities
Patrick Fox, M.D.	CCHA Plan President	Executive Sponsor & Subject Matter Expert
Elizabeth Holden	CCHA Director of Clinical Quality Management	Management Oversight
Lilet Vallangca	CCHA Project Director, Clinical Info & Reporting, West Region QM Medicaid	Data Analyst
Camila Joao	CCHA Clinical Quality Program Manager	PIP Development and Documentation Support
Patricia Northern	Peak Vista Director of Quality and Patient Safety	Quality and Performance Outcomes
Sherri Sharp	Peak Vista Vice President of Behavioral Health	Process Development and Oversight
Cassidy Palermo	Peak Vista Senior Director of Care Coordination and Ambulatory Special Operations	Process Execution

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PIP Topic and Narrowed Focus

Instructions: In Table 2, document the rationale for selecting the topic and narrowed focus.

- The topic should be selected through a comprehensive analysis of MCO member needs and services.
- The narrative should describe how the topic has the potential to improve member health, functional status, and/or satisfaction.
- If the topic was mandated by the state, indicate this in the documentation.

Table 2—PIP Topic and Narrowed Focus

PIP Topic Description
Increasing the rates of depression screenings conducted in primary care settings and providing timely access to behavioral health support are the aims for this Performance Improvement Plan (PIP), as mandated by the State. This topic aligns with the CO Department of Health Care Policy and Financing (HCPF) Behavioral Health Incentive Measure: Follow-up after a Positive Depression Screen. Universal depression screening and referral to behavioral health services have the potential to improve member health, functional status, and/or satisfaction through the following outcomes: ➢ Early screening, detection, and treatment referral has the potential to decrease and/or prevent worsening of depressive symptoms. ➢ Timely referral and initiation of treatment may diminish suicide risk. ➢ Referral to a behavioral health provider may result in improved functional status at school, work, within the family and community. ➢ Better care coordination may reduce duplicative services, potentially reducing costs. ➢ Improvement in care collaboration between physical and behavioral health providers may increase member satisfaction. ➢ Coordination of care may improve health outcomes, reduce ED and inpatient stays, and reduce overall healthcare costs.

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Narrowed Focus Description
To meet the intended targets of this PIP, CCHA has partnered with Peak Vista Community Health Centers to increase depression screening rates for members age 12 years or older attributed to CCHA who have an in-person or virtual outpatient primary care visit between January 1, 2021 and June 30, 2022. Furthermore, the process will seek to improve rates of timely access to behavioral health aftercare for members whose screen is positive. Peak Vista Community Health Centers is one of the largest providers in the CCHA network and, thus, a significant portion of members are attributed to the practice. As the primary provider in the Region, Peak Vista has the highest probability to meaningfully impact health outcomes for an extensive segment of the Region's population. As a leader in Region 7, CCHA hopes to assist Peak Vista in successfully establishing the necessary processes and workflows to achieve targets and provide a model that can be replicated at other practices. Peak Vista has implemented expectations regarding follow-up after a positive depression screen, however a slight but steady decline is observed in these rates between July/2019 and July/2020. This decrease is inversely correlated with rates of Depression Screening, which suggests current operations may be impacted by the higher volume of members identified for additional support. Additionally, efforts were not as comprehensive as it did not target overall rates of Depression screening. Current internal data indicates that approximately half the outpatient primary care visits that occurred at Peak Vista did not include a depression screening during the 12-month baseline measurement period. This data does not account for duplicated members or those who receive a Depression Screening at every visit. It is likely this rate is inflated in relationship to the overall client population and a large portion of members remain unscreened. Increasing the rates of screening may considerably increase the need for additional access to follow-up behavioral health services. It is imperative, therefore, to ensure clinical operations and workflows can sustain

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the increased volume of members that qualify for additional services that will likely result from the practice continuous progress towards universal screening.

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Narrowed Focus Baseline Measurement – *Depression Screening*

Instructions:

- For Table 3a:
  - The information should represent the *Depression Screening* baseline measurement period specifications used for baseline data collection and not the rolling 12-month SMART Aim measure methodology that is attested to below.
  - The baseline should represent the most recent 12-month fixed time period based on the module submission due date to HSAG and take into consideration claims completeness for the 12-month measurement period.
- For Table 3b:
  - If two or more entities are selected as the narrowed focus, only one combined percentage should be entered in the table.
  - The summed numerators are divided by the summed denominators and multiplied by 100 to arrive at the combined percentage.
  - The information should represent the narrowed focus *Depression Screening* baseline measurement information and include the dates, numerator value, denominator value, and percentage.

Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Numerator Description	Total number of depression screenings provided to CCHA members age 12 years or older during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers during the measurement period.
Denominator Description	Total number of in-person or virtual outpatient primary care visits attended by a CCHA member age 12 years or older at Peak Vista Community Health Centers within the measurement period.
Age Criteria (if applicable)	Members under age 12 years on the date of the outpatient primary care visit are excluded from the denominator.
Continuous Enrollment Specifications (if applicable)	Members must be continuously enrolled in the ACC on the date of the outpatient primary care visit for 30 days, with no gaps.
Allowable Gap in Enrollment (if applicable)	No gaps in the 30 day enrollment.

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Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Anchor Date (if applicable)	The first day of the month of the baseline measurement period.
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	An in-person or virtual outpatient primary care visit for a CCHA member age 12 years or older provided at Peak Vista Community Health Centers during the measurement period.

Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 08/01/2019	End Date: 07/31/2020
Numerator: 16,759	Denominator: 32,154	Percentage: 52.12%

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Instructions: **For Table 3c**, check the applicable data source and describe the step-by-step process for how the ***Depression Screening*** baseline data were collected for the selected narrowed focus.

Table 3c—Narrowed Focus Baseline Data Collection Methodology – *Depression Screening*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: Encounter and Fee-for-Service (FFS) claims data were utilized to determine the baseline for this improvement plan. The Depression Screening denominator group includes all in-person or virtual primary care services provided to CCHA members age 12 years or older at Peak Vista Community Health Centers that occurred within the 12-month baseline measurement period. Only members continuously enrolled in the ACC for 30 days from the date of service were included. The presence of a positive or negative Depression Screening Code (G8431, G8510) provided to an eligible member during a qualifying service within the measurement period as identified in the denominator group was included in the numerator for this rate.		

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Narrowed Focus Baseline Measurement – *Follow–Up After a Positive Depression Screen*

Instructions:

- **For Table 4a:**
  - The information should represent the ***Follow–up After a Positive Depression Screen*** baseline measurement period specifications used for baseline data collection and not the rolling 12-month SMART Aim measure methodology that is attested to below.
  - The baseline should represent the most recent 12-month fixed time period based on the module submission due date to HSAG and take into consideration claims completeness for the 12-month measurement period.
- **For Table 4b:**
  - If two or more entities are selected as the narrowed focus, only one combined percentage is entered in the table.
  - The summed numerators are divided by the summed denominators and multiplied by 100 to arrive at the combined percentage.
  - The information should represent the narrowed focus ***Follow–up After a Positive Depression Screen*** baseline measurement information and include the dates, numerator value, denominator value, and percentage.

Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Numerator Description	Total number of unduplicated CCHA members age 12 years or older who received a qualifying in-person or virtual Behavioral Health service the same day or within 30 days of a positive Depression Screen completed during an outpatient primary care visit at Peak Vista Community Health Centers during the measurement period.
Denominator Description	Total number of unduplicated CCHA members age 12 years or older who had a positive Depression Screening provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Clinic within the measurement period.
Age Criteria (if applicable)	Members under age 12 year on the date of the outpatient primary care visit are excluded from the denominator.
Continuous Enrollment Specifications (if applicable)	Members must be continuously enrolled in the ACC on the date of the positive depression screen for 30 days, with no gaps.

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Allowable Gap in Enrollment (if applicable)	No gaps in the 30 day enrollment.
Anchor Date (if applicable)	The first day of the month of the baseline measurement period.
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	A positive depression screening as identified by procedure code G8431 for a CCHA member age 12 years or older provided at Peak Vista Community Health Centers during the measurement period.

Table 4b—Narrowed Focus Baseline Data – *Follow–Up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 08/01/2019	End Date: 07/31/2020
Numerator: 3,911	Denominator: 4,331	Percentage: 90.3%

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Instructions: **For Table 4c**, check the applicable data source and describe the step-by-step process for how the *Follow-up After a Positive Depression Screen* baseline data were collected for the selected narrowed focus.

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: Encounter and Fee-for-Service (FFS) claims data were utilized to determine the baseline for this improvement plan. The Follow-up After a Positive Depression Screen denominator group includes unduplicated members included in the numerator group for Rate 1 who had a positive depression screen, identified by the presence of a positive Depression Screening Code (G8431). Cases included were: • Unduplicated • Attributed to CCHA • 12 years or older • Continuously enrolled in the ACC from the day of the service/screen for 30 days, without gaps • Who had a positive Depression Screen • During an in-person or virtual primary care service • At Peak Vista Community Health Centers • Within the baseline measurement period. The numerator for Rate 2 includes only those members within the denominator group who received a qualifying in-person or virtual Behavioral Health service the day of or within 30 days of the screen, as outlined in the Specification Document provided by the State.		

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SMART Aims (Specific, Measurable, Attainable, Relevant, and Time-bound)

Instructions: In the space below, complete the SMART Aim statement for each outcome. NOTE:

- Each SMART Aim must be specific, measurable, attainable, relevant, and time-bound.
- Each SMART Aim goal should represent statistically significant (95 percent confidence level, $p < 0.05$) improvement over the baseline performance for the narrowed focus.
- At the end of the project, HSAG will use the SMART Aims to evaluate the outcomes of the PIP and assign a level of confidence as part of the final validation.

Depression Screening:

By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 52.12% to 54.81%.

Follow-Up After a Positive Depression Screen:

By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying Behavioral Health service the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years or older from 90.3% to 96.7%.

Note: Once Module 1 has passed, the SMART Aim statements should never be modified. If changes need to occur, the MCO must contact HSAG prior to making any changes to the approved methodology.

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Key Driver Diagrams

Instructions: Complete the key driver diagram templates on the following pages.

- The first key driver diagram should be completed for ***Depression Screening*** and the second key driver diagram should be completed for ***Follow–Up After a Positive Depression Screen*** as specified in the key driver diagram template headers on the following pages.
- The key drivers and interventions listed at this stage of the PIP process should be based on the MCO's knowledge, experience, and research and literature review.
- Drivers are factors that contribute directly to achieving the SMART Aim and "drive" improvement. Key drivers are written in support of achieving the improvement outlined in the SMART Aim. For example, "Member transportation to appointment" would support achieving a SMART Aim. Refer to Section 3 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* "Key Driver Diagram" for additional instructions for completing the key driver diagram.
- The identified interventions should be culturally and linguistically appropriate for the narrowed focus population.
- Single interventions can address more than one key driver. Add additional arrows as needed.

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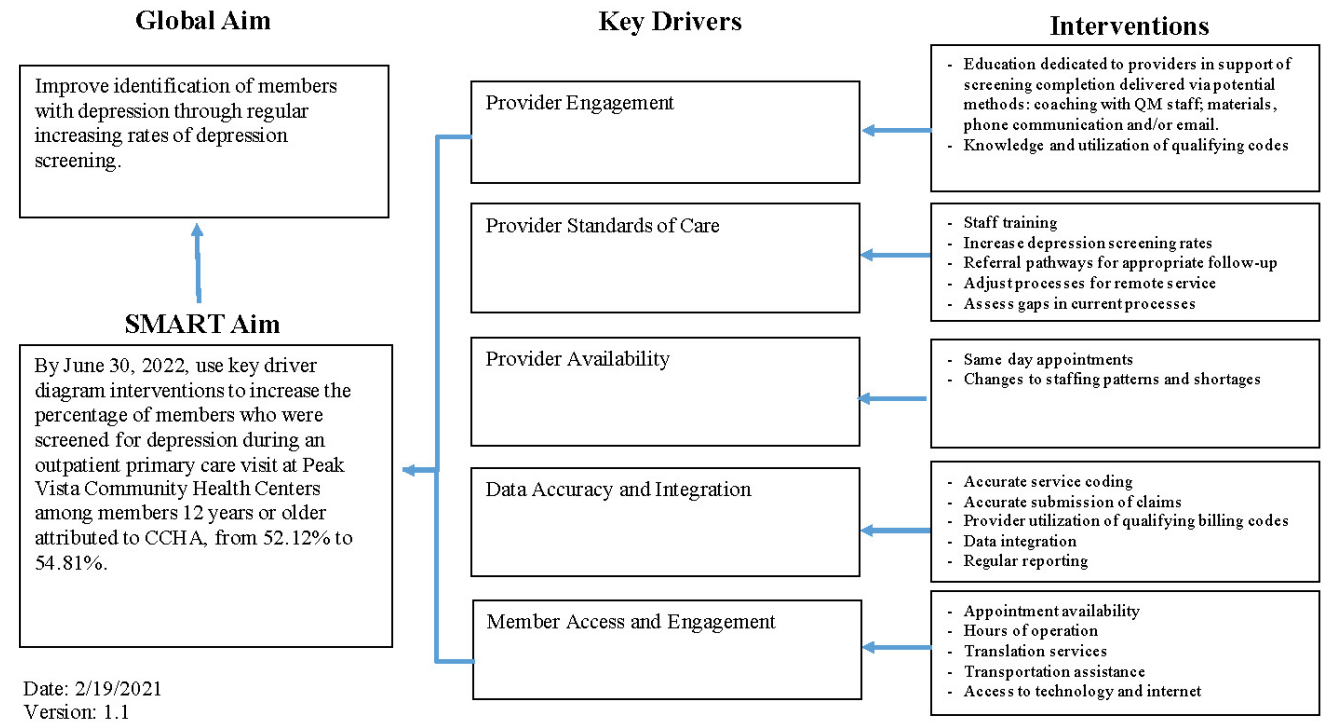
Key Driver Diagram– *Depression Screening*



Date: 2/19/2021
Version: 1.1

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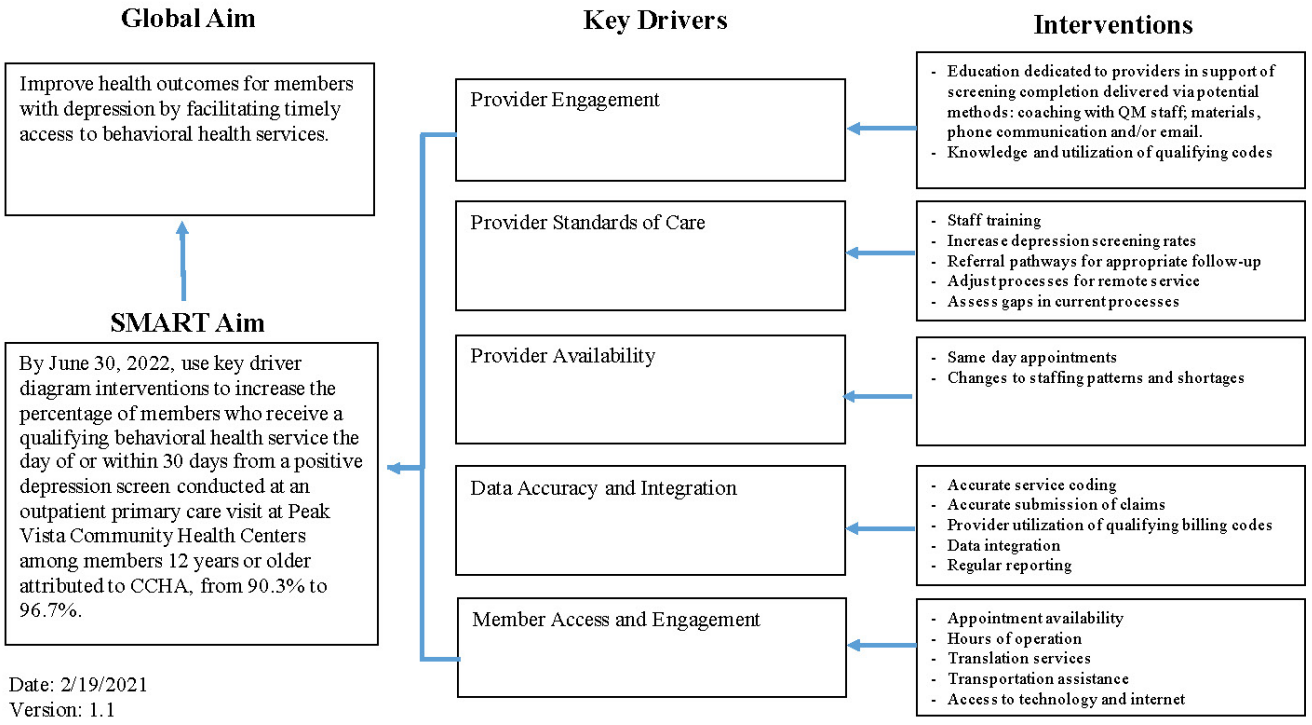
Key Driver Diagram – *Follow–Up After a Positive Depression Screen*



Date: 2/19/2021
Version: 1.1

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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

The MCO will use a rolling 12-month measurement data collection methodology to determine if each SMART Aim goal was achieved.

Data collection for the rolling 12-month measurements should align with the baseline data collection method. For example, if the baseline data were collected administratively, then the rolling 12-month measurement data should be collected administratively. The MCO will compare each rolling 12-month data point with the SMART Aim goal to determine if the goal was achieved. The MCO should start the rolling 12-month calculations following HSAG's approval of Module 1.

Refer to Section 8 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Rolling 12-Month SMART Aim Measure Methodology") for a description of how to calculate rolling 12-month measurements. To confirm understanding of the rolling 12-month methodology requirement, check the box below.

ROLLING 12-MONTH ATTESTATION
☒ **The MCO confirms that the reported SMART Aim run chart data will be based on rolling 12-month measurements.**

Run Chart Instructions: The first run chart template below should be completed for *Depression Screening*, and the second run chart template should be completed for *Follow–up After a Positive Depression Screen*, as specified in the run chart template headers on the following pages. Edit each run chart template below to include:

- Enter the run chart's title (e.g., The Percentage of Diabetic Eye Exams for Provider A).
- Enter the y-axis title (e.g., The Percentage of Diabetic Eye Exams).
- Enter x-axis dates with monthly intervals through the SMART Aim end date.
- Enter the narrowed focus baseline and SMART Aim goal percentages.
- The y-axis should be scaled 0 to 100 percent.

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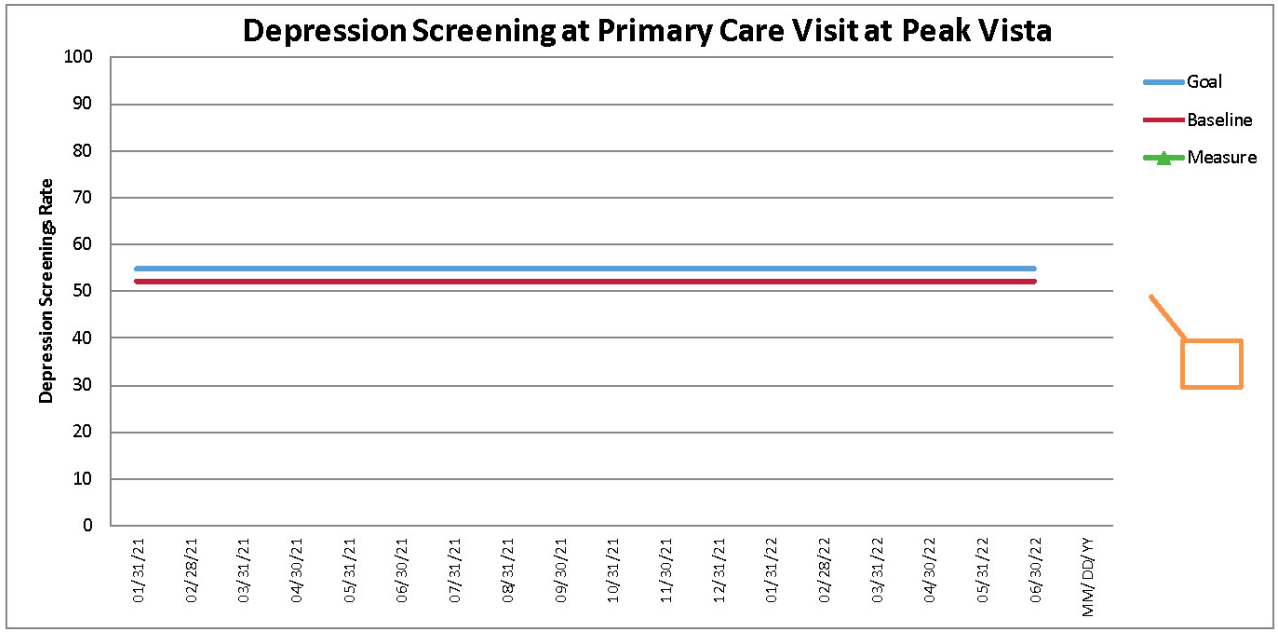
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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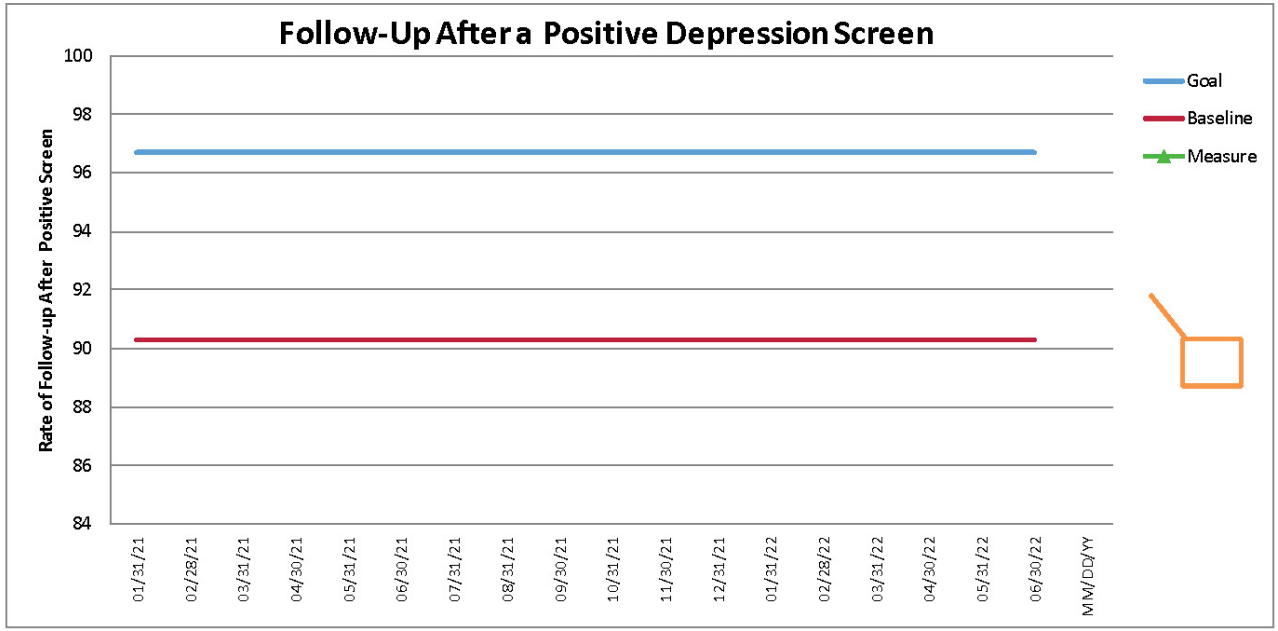
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations

1. The health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen.*	☒ Met
	☐ Not Met
		General Comment:
		• The narrowed focus baseline denominator sizes for both measures are larger than typically recommended for a rapid-cycle PIP. The health plan should ensure the following is feasible for the selected narrowed focus:
		  ○ Timely data collection to identify members/providers eligible for interventions.
		  ○ Enough members/providers in the narrowed focus can be reached with interventions to support achievement of the SMART Aim goals.
		• The narrowed focus baseline percentage for the *Follow–Up After a Positive Depression Screen* measure is quite high (90.3%); however, it is still possible for the health plan to demonstrate statistically significant improvement of the baseline percentage.
		• Given the large denominator sizes for both measures and the high baseline percentage for the *Follow–Up After a Positive Depression Screen* measure, the health plan may want to consider selecting a narrower focus, or a sub-group within the currently selected narrowed focus that may provide greater opportunity for improvement and/or a more manageable number of members to reach for improvement.
		• If the health plan is confident in conducting intervention testing with the current narrowed focus, the health plan should include this information as part of the rationale provided in the Narrowed Focus Description section of Table 2.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review March 2021: The health plan's narrowed focus remained the same in the resubmission. The health plan should keep in mind HSAG's General Comment when planning intervention testing for Module 3.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process d) Narrowed focus baseline data that considered claims completeness	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*** • The anchor date should be specified for the baseline measurement period, not the 12-month rolling measurement period. • The baseline measurement period dates reported in Table 3b encompassed one day more than a complete 12-month period. It appeared that the start date should have been reported as 8/1/2019, rather than 7/31/2019. • The data collection process narrative description referred to "the 12-month rolling baseline measurement period." This phrase was also used in the narrowed focus narrative description. All references to a rolling baseline measurement period should be removed. The narrowed focus baseline measurement for each SMART Aim should be based on a fixed 12-month baseline measurement period. As the health plan attested to on page 12 of the Module 1 submission form, subsequent 12-month rolling measurement periods will be used to track progress toward achieving the SMART Aim goals throughout the project; however, the baseline measurement period remains fixed.

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Criteria	Score	HSAG Feedback and Recommendations
		Follow–Up After a Positive Depression Screen • The anchor date should be specified for the baseline measurement period, not the 12-month rolling measurement period. • The baseline measurement period dates reported in Table 4b encompassed one day more than a complete 12-month period. It appeared that the start date should have been reported as 8/1/2019, rather than 7/31/2019. **Re-review March 2021:** The health plan addressed all of HSAG's initial feedback. The criterion has been *Met*.
3. The SMART Aims for *Depression Screening* and *Follow–Up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage e) End date	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement for both SMART Aims: • The SMART Aim end date for the PIP is June 30, 2022. The health plan should correct the end date.

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Criteria	Score	HSAG Feedback and Recommendations
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement for both run charts: • The run chart title should be updated to specify the SMART Aim measure and the narrowed focus. • The y-axis title should be updated to reflect the percentage being measured and plotted on the run chart. • The red line on the run chart should represent the fixed baseline percentage reported in the SMART Aim statement. The baseline and goal percentages are the only data that should be provided in the Module 1 run charts. The health plan will plot results of subsequent rolling 12-month measurement periods as the project progresses and will submit those results to HSAG in the final run charts completed as part of the final Module 4 submission, at the end of the project. • The dates on the x-axis should begin no earlier than 1/31/2021, to reflect the month when the Module 1 is expected to be approved. The dates on the x-axis should be labelled through the SMART Aim end date of 6/30/2022. **Re-review March 2021:** The health plan addressed all of HSAG's initial feedback. The criterion has been *Met*.
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	

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Criteria	Score	HSAG Feedback and Recommendations
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–Up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal in each key driver diagram.	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement for key driver diagrams (KDDs): • The SMART Aim in each KDD will need to be revised based on feedback for Criterion #3. • All interventions included in the KDD should be specific changes that the health plan may test to support achieving the SMART Aim goal through PDSA cycles. The health plan should further clarify these intervention descriptions or remove them from the KDD. The following descriptions listed in the intervention boxes did not appear to be interventions that would support achievement of the SMART Aim goal: ○ State mandated lockdowns/workforce reduction ○ Staff turnover **Re-review March 2021:** The health plan addressed all of HSAG's initial feedback. The criterion has been *Met*.
Additional Recommendations: None		

PIP Initiation (Module 1)

☒ Pass

Date: March 3, 2021