COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2021–2022 PIP Validation Report

for

Colorado Community Health Alliance Region 7

April 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—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) 2021–2022, 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 (QI)
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and 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, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[1-1]

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 QI. 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. CMS agreed that given the pace of QI 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 and provided HSAG with approval to use this approach in all requesting states.

PIP Components and Process

The key concepts of the rapid-cycle 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 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.

There are four modules with an accompanying reference guide for the MCOs to use to document their PIPs. Prior to issuing each module, HSAG held module-specific trainings with the

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.

[1-1] 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: Feb 23, 2022.

[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: Feb 23, 2022.

MCOs to educate them about the documentation requirements and use of specific QI tools for each of the modules. The four modules are defined below:

- **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 QI 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

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **CCHA R7**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **CCHA R7**'s PIP and the activities completed in Module 2 and 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.

Validation Scoring

During validation, HSAG determines if criteria for each module are *Met.* Any validation criteria not applicable (*N/A*) were not scored. At the completion of Module 4, HSAG uses the validation findings from modules 1 through 4 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.

- ***High confidence*** = The PIP was methodologically sound; the SMART Aim goals, statistically significant, clinically significant, or programmatically significant improvements were achieved for both measures; at least one tested intervention for each measure could reasonably result in the demonstrated improvement; and the MCO accurately summarized the key findings and conclusions.
- ***Moderate confidence*** = The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:

  ☐ The SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved *for only one measure*, and the MCO accurately summarized the key findings and conclusions.

  ☐ Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure*, and the MCO accurately summarized the key findings and conclusions.

  ☐ The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.

- ***Low confidence*** = One of the following occurred:

  ☐ The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.

  ☐ The PIP was methodologically sound. The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.

  ☐ The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.

- ***No confidence*** = The SMART Aim measure methodology and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

PIP Topic Selection

In FY 2021–2022, **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 unduplicated CCHA members 12 years of age or older from 62.08% to 63.53%.
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 (BH) service by any BH provider on 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 of age or older from 72.1% to 75.74%.

* HSAG approved revisions to the SMART Aim statements in November 2021.

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 BH services within 30 days of screening positive for depression. In November 2021, **CCHA R7** communicated to HSAG the need to revise the initial SMART Aim statements and data collection methodology to better align with the improvement goals for the project. After a technical assistance discussion and receiving a written rationale from the health plan, HSAG approved **CCHA R7** to revise the data collection methodology and SMART Aims. **CCHA R7**

submitted updated Module 1 and Module 2 submission forms with revised documentation to HSAG on November 19, 2021. HSAG reviewed the revised data and confirmed that the goals to increase depression screening to 65.53 percent and to increase follow-up within 30 days after a positive depression screen to 75.74 percent represent statistically significant improvement over the revised baseline percentages.

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	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

At the time this FY 2021–2022 PIP validation report was produced, **CCHA R7** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **CCHA R7** had also passed all validation criteria for the Module 3 submission form submitted for each intervention being tested and was continuing to test interventions. The health plan will conclude all intervention testing on June 30, 2022. Module 4 validation findings will be reported in the FY 2022–2023 PIP validation report.

Validation Findings

In FY 2021–2022, **CCHA R7** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan passed Module 2 and Module 3 of the rapid-cycle PIP process during FY 2021–2022. HSAG reviewed Module 2 and Module 3 submission forms and provided feedback and technical assistance to the health plan until all validation criteria were achieved. Below are summaries of the Module 2 and Module 3 validation findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

Module 2: Intervention Determination

The objective of Module 2 is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In this phase, **CCHA R7** developed process maps, conducted FMEAs, and updated key driver diagrams to identify potential interventions for the PIP. The detailed process maps, FMEA results, and updated key driver diagrams that **CCHA R7** documented in the Module 2 submission form are included in Appendix A. Module Submission Forms. Table 2-1 presents the FY 2021–2022 Module 2 validation findings for **CCHA R7**'s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Depression Screening	• Medical assistant (MA)/Receptionist does not give eligible members the depression screening questionnaire at check-in • Members who refuse to complete the PHQ-9[1] screen are not formally assessed for depression • MA/Receptionist does not use the script, or the script is insufficient to persuade members to complete the screen • Members meeting medical exclusion criteria are not given a depression screen	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement	• Provider education on screening completion and correct coding • Staff training to improve processes and address gaps • Address process for telehealth services • Improve appointment availability through same-day appointments, hours of operation • Accurate service coding and claims submission • Member transportation assistance

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
	• MA does not inform provider of elevated score • Members meeting medical exclusion criteria are not excluded from the denominator		• Increase member access to technology and Internet
Follow-Up After a Positive Depression Screen	• Procedure code selected for follow-up services may not be included in the list of eligible codes for the follow-up metric numerator • Referring providers do not verify and cannot ensure completion of referral process • Members' existing BH provider is not informed/aware of positive screen • BH provider is unable to reach members by phone and member has no planned follow-up after a positive depression screen	• Provider engagement • Provider standards of care • Provider availability • Data accuracy and integration • Member access and engagement	• Provider education on screening completion and correct coding • Staff training to improve processes and address gaps • Address process for telehealth services • Improve appointment availability through same-day appointments, hours of operation • Accurate service coding and claims submission • Member transportation assistance • Increase member access to technology and Internet

[1]PHQ = Patient Health Questionnaire

In Module 2, **CCHA R7** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **CCHA R7** identified to improve depression screening focused on provider and staff education, telehealth service availability, appropriate coding and billing practices, and addressing barriers to members accessing care. The potential interventions **CCHA R7** identified to improve follow-up services focused on provider and staff education, improved clinic workflow, appointment access and availability, and appropriate coding and billing practices.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **CCHA R7** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **CCHA R7** submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **CCHA R7** carried out PDSA cycles to evaluate intervention

effectiveness. Table 2-2 summarizes the FY 2021–2022 Module 3 validation findings for **CCHA R7**'s two interventions.

Table 2-2—Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Revise Peak Vista's depression screen coding protocol to include a category of "Watchful Waiting" for those members whose depression screen score does not warrant immediate follow-up care and adapt the electronic health record (EHR) to require a follow-up option is selected (hard stop before exiting form) to ensure that each depression screen entered has a documented follow-up plan.	Procedure code selected for follow-up services may not be included in the list of eligible codes for the follow-up metric numerator	Data accuracy and integration	Percentage of depression screens categorized as "Watchful waiting; reassess at next visit" with a corresponding G8510 Current Procedural Terminology (CPT) code
Revise Peak Vista's depression screening (PHQ-9) script to guide providers in educating patients on the benefits of depression screening and help motivate members to complete the screening. The EHR depression screening forms were also adapted to capture member refusals and medical exclusions more consistently.	Members that refuse to complete the PHQ-9 form are not formally assessed for depression	Provider standards of care	Percentage of unique members 12 years or older who receive qualifying outpatient primary care services at Peak Vista and refuse a depression screen during the primary care service

In Module 3, **CCHA R7** selected two interventions to test for the PIP. The detailed intervention testing plans **CCHA R7** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process gaps or failures in completing the depression screening and coding and reporting depression screening results. For each intervention, **CCHA R7** defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data

to guide intervention revisions. The health plan was continuing to test interventions at the time this FY 2021–2022 PIP validation report was produced. **CCHA R7** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **CCHA R7** successfully completed Module 2 of the rapid-cycle PIP process, using QI science-based tools to identify process gaps and failures, and to select PIP interventions. **CCHA R7** also passed Module 3 for two interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **CCHA R7** will continue to test interventions for the PIP through the end of FY 2021–2022. The health plan will submit final intervention testing results, PIP outcomes, and project conclusions for validation in FY 2022–2023.

Recommendations

- **CCHA R7** should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should record intervention testing results and interpretation of results in the PDSA worksheet for each intervention, which will be submitted as part of Module 4—PIP Conclusions in FY 2022–2023.
- **CCHA R7** should ensure that the approved SMART Aim data collection methodology defined in Module 1 is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, **CCHA R7** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **CCHA R7** should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to documenting any improvement achieved through the project, the health plan should document which interventions had the greatest impact, including the evaluation data used to determine intervention effectiveness.

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 2 — Intervention Determination 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	Kathryn Morrison
Contact Title	Medicaid Quality Management Health Plan Director
Email Address	kathryn.morrison2@anthem.com
Telephone Number	(719) 235-0384
Submission Date	4/14/2021
Resubmission Date (if applicable)	5/28/2021
Revision Date	11/19/2021

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

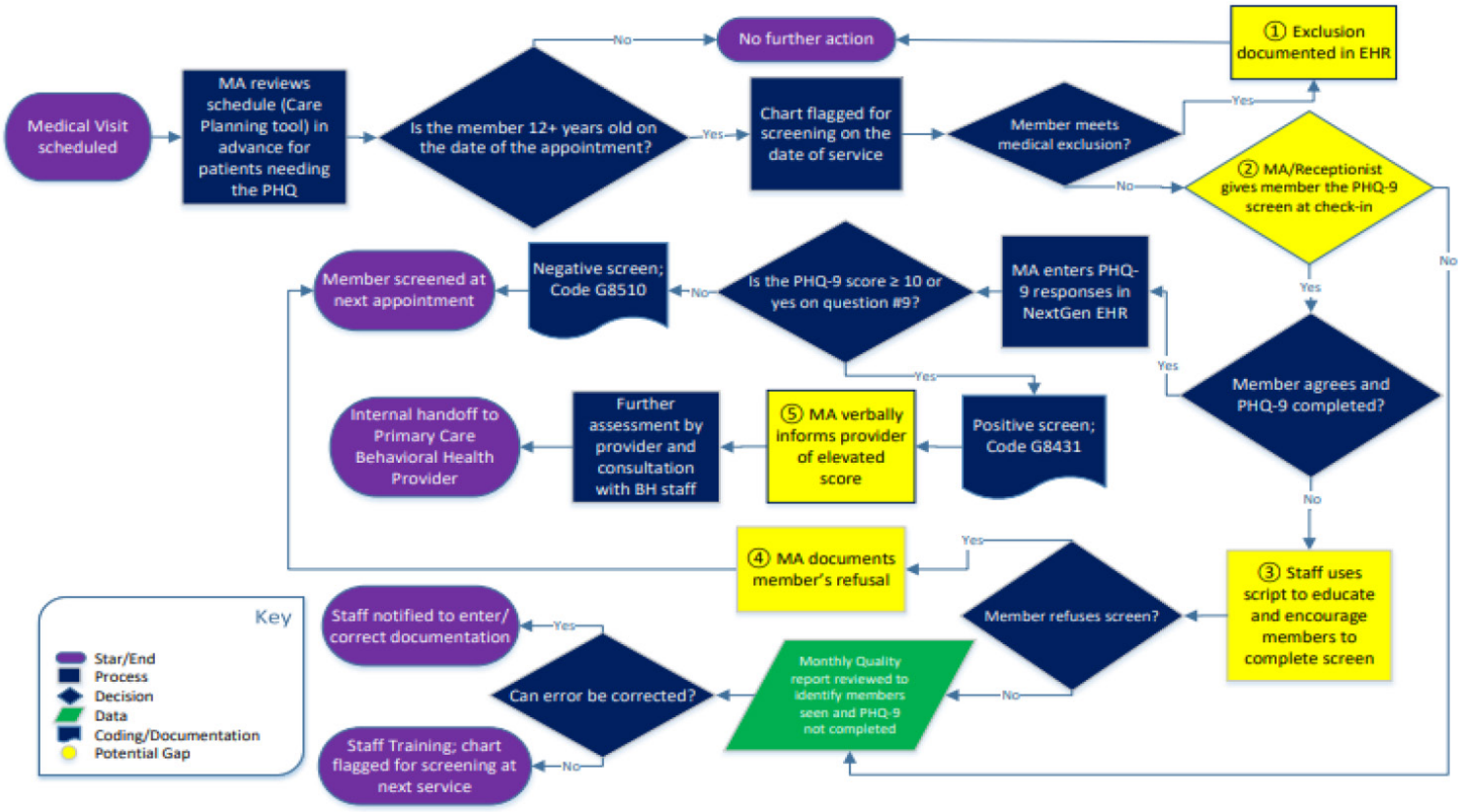
Process Map – *Depression Screening*

Instructions:

- Map the current process for members to receive ***Depression Screening*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7



State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Failure Modes and Effects Analysis (FMEA) – *Depression Screening*

Instructions: In Table 1a, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Depression Screening*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1a—Failure Modes and Effects Analysis Table – *Depression Screening*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
① Exclusion Documented in EHR	Members meeting Medical Exclusion criteria are not given a Depression screen.	Depression screening are not administered, as tools may not adequately assess or be understood by members meeting Medical Exclusion criteria (e.g. cognitive limitations/IDD).	Members meeting medical exclusion criteria are not assessed for Depression.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

	Members meeting Medical Exclusion criteria are not excluded from the denominator.	No process is available to exclude members ineligible for Depression screening from the denominator.	Depression screening rates will be impacted by ineligible members.
② MA/Receptionist gives member the PHQ-9 screen at check-in	MA/Receptionist does not give eligible members the Depression screen at check-in.	Staff training.	Eligible members may not have a Depression screen administered at the time of service.
③ Staff uses script to educate and encourage members to complete the screen	MA/Receptionist does not use the script or the script is insufficient to persuade members to complete the screen.	Staff training. Script is not successful in persuading members to complete the screen.	Eligible members may not have a Depression screen administered at the time of service.
④ MA documents member's refusal	Members that refuse to complete the PHQ-9 screen are not formally assessed for Depression.	Members may not want to discuss or answer questions related to mental health.	Members that refuse to complete the screening tool are not assessed for Depression.
⑤ MA verbally informs provider of elevated score	MA does not inform provider of elevated score.	Staff training. Competing demands from other services rendered.	Provider is not aware of elevated score on Depression screen and no intervention/referral is provided.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Failure Mode Priority Ranking – *Depression Screening*

Instructions: In Table 2a, list from highest- to lowest-priority at least two failure modes identified in the ***Depression Screening*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

Table 2a—Failure Mode Priority Ranking – *Depression Screening*

Priority Ranking	Failure Modes
1	MA/Receptionist does not give eligible members the Depression screen at check-in.
2	Members that refuse to complete the PHQ-9 screen are not formally assessed for Depression.
3	MA/Receptionist does not use the script or the script is insufficient to persuade members to complete the screen.
4	Members meeting Medical Exclusion criteria are not given a Depression screen.
5	MA does not inform provider of elevated score.
6	Members meeting Medical Exclusion criteria are not excluded from the denominator.

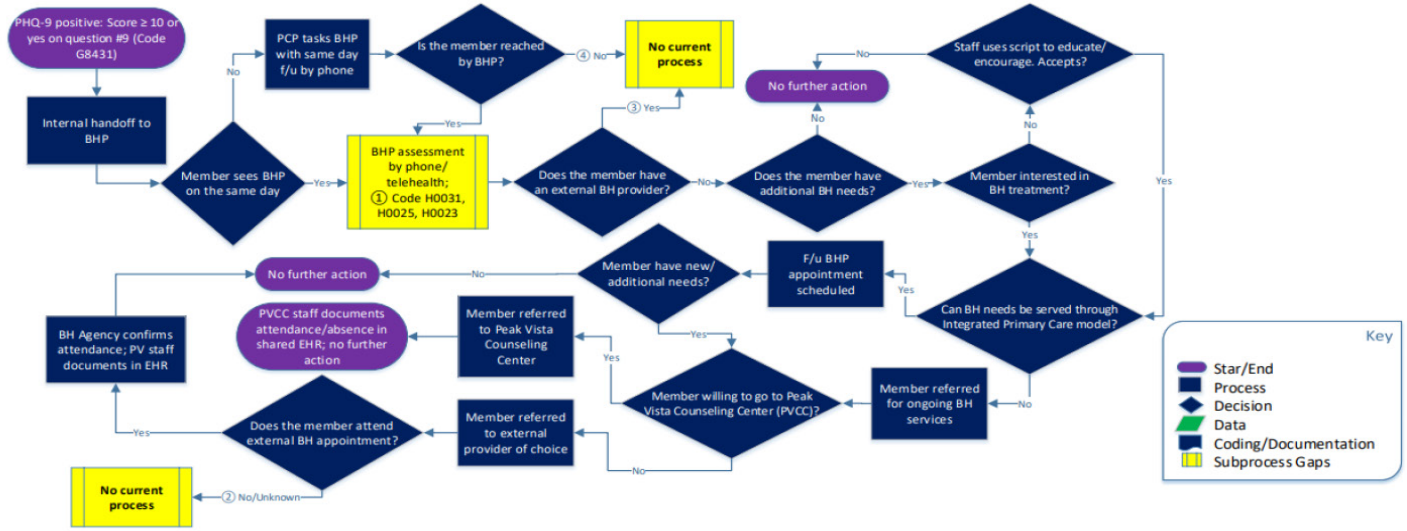
State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Process Map – *Follow–up After a Positive Depression Screen*

Instructions:

- Map the current process for members to receive ***Follow–up After a Positive Depression Screen*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)



State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Failure Modes and Effects Analysis (FMEA) – *Follow–up After a Positive Depression Screen*

Instructions: In Table 1b, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Follow–up After a Positive Depression Screen*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1b—Failure Modes and Effects Analysis Table – *Follow–up After a Positive Depression Screen*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
① **No verification of eligibility for procedure codes for follow-up services is performed.**	Procedure Code selected for follow-up services may not be included in the list of eligible codes for the Rate 2 numerator.	• Procedure code is selected based on service rendered and not based on eligible codes. • Restrictions to eligible codes prevents all follow-up services from being captured in outcomes.	Follow-up services are provided but not captured in outcome performance data.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

② **No Current Process to verify member attended external BH appointment.**	Referring providers don't verify and cannot ensure completion of referral process.	• External Agency fails to inform referring provider of member's attendance/absence. • Referring provider fails to verify member's attendance with referral provider. • Training issue: Referral provider refuses to disclose attendance information due to confidentiality concerns. • Member refuses to authorize care coordination between practices.	Referral may be unsuccessful, and member doesn't access/receive needed services.
③ **No Current Process in place to inform members' existing BH providers of positive screen.**	Members' existing behavioral health provider is not informed/aware of positive screen.	• No process is in place to inform ongoing providers of depression screening scores/findings. • Member refuses to authorize care coordination between practices.	Members' provider does not take positive screen into account when providing treatment and follow-up appointment may not occur/be scheduled within the timeframe.
④ **No current process in place when staff is unable to reach member for follow-up.**	BHP is unable to reach member by phone and member has no planned follow-up after a positive depression screen.	• Members contact information is not up to date in the system.	Members' depression/risk level are insufficiently assessed. Members may not receive follow-up care or information on indicated

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

		• Member does not answer or call back due to lack of availability or interest.	services after a positive depression screen.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Instructions: In Table 2b, list from highest- to lowest-priority at least two failure modes identified in the ***Follow–up After a Positive Depression Screen*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Priority Ranking	Failure Modes
1	**Procedure Code selected for follow-up services may not be included in the list of eligible codes for the Rate 2 numerator.**
2	**Referring providers don't verify and cannot ensure completion of referral process.**
3	**Members' existing behavioral health provider is not informed/aware of positive screen.**
4	**BHP is unable to reach member by phone and member has no planned follow-up after a positive depression screen.**

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

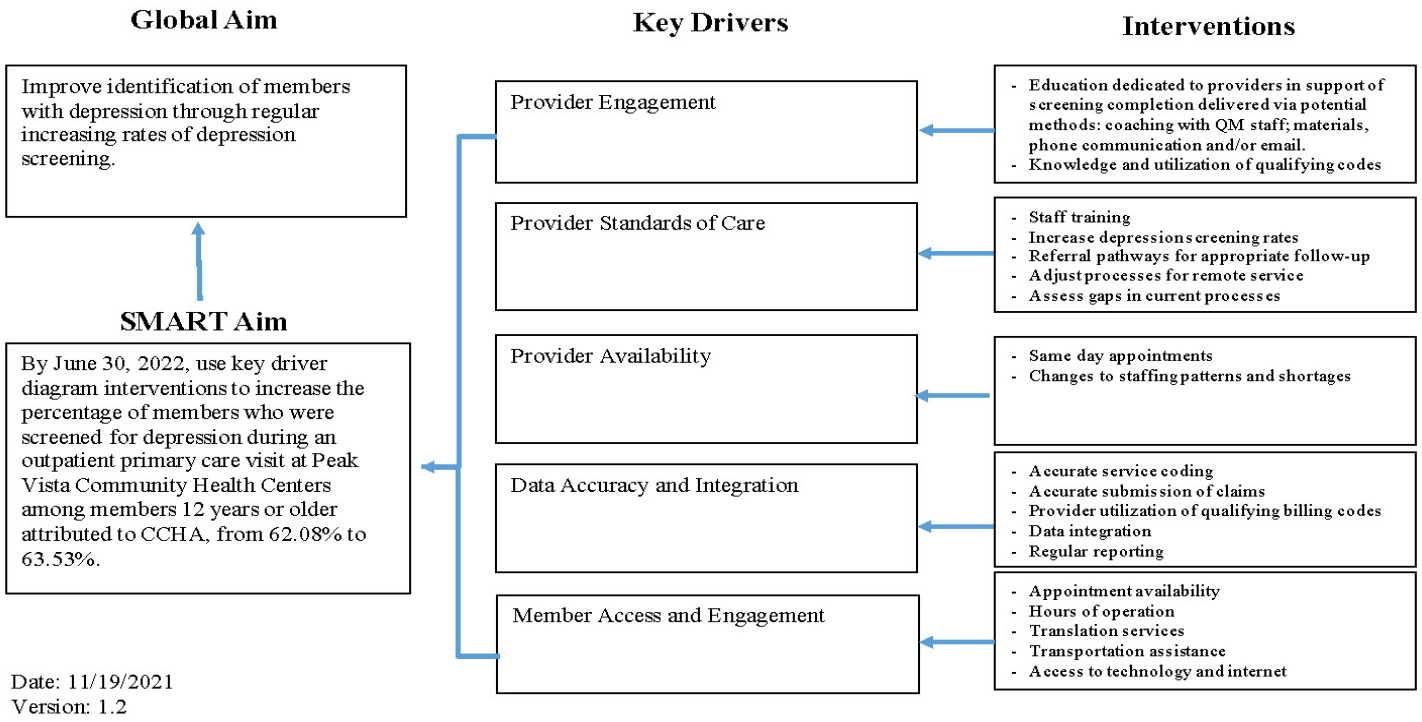
Key Driver Diagrams

Instructions: Update the ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams from Module 1.

- At this stage of the PIP process, the MCO should use the findings from the process map, FMEA, and failure mode ranking to update drivers and interventions in each key driver diagram, as necessary. The MCO should ensure that the interventions are culturally and linguistically appropriate for the targeted population.
- Single interventions can address more than one key driver. Add additional arrows as needed.
- After passing Module 3 for each planned intervention and completing the testing of each intervention, the MCO should update the appropriate key driver diagram to reflect the status of each tested intervention (adapted, adopted, abandoned, or continue testing). The MCO should use the following color coding to distinguish the intervention status:
  - Green highlight for successful adopted interventions.
  - Yellow highlight for interventions that were adapted or not tested.
  - Red highlight for interventions that were abandoned.
  - Blue highlight for interventions that require continued testing.
- The finalized ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams will be submitted at the end of the PIP with Module 4.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Key Driver Diagram– *Depression Screening*



Date: 11/19/2021
Version: 1.2

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

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

Global Aim

Improve health outcomes for members with depression by facilitating timely access to behavioral health services.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive a qualifying behavioral health service the day of or within 30 days from a positive depression screen conducted at an outpatient primary care visit at Peak Vista Community Health Centers among members 12 years or older attributed to CCHA, from 72.1% to 75.74%.

Date: 11/19/2021
Version: 1.2

Key Drivers	Interventions
Provider Engagement	- Education dedicated to providers in support of screening completion delivered via potential methods: coaching with QM staff; materials, phone communication and/or email. - Knowledge and utilization of qualifying codes
Provider Standards of Care	- Staff training - Increase depressions creening rates - Referral pathways for appropriate follow-up - Adjust processes for remote service - Assess gaps in current processes
Provider Availability	- Same day appointments - Changes to staffing patterns and shortages
Data Accuracy and Integration	- Accurate service coding - Accurate submission of claims - Provider utilization of qualifying billing codes - Data integration - Regular reporting
Member Access and Engagement	- Appointment availability - Hours of operation - Translation services - Transportation assistance - Access to technology and internet

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing 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*
Intervention Name:	Utilization of "Watchful Waiting" category to identify subclinical screens.
Contact Name	Camila Joao
Contact Title	Clinical Quality Program Manager
Email Address	Camila.Joao@cchacares.com
Telephone Number	720-612-6935
Submission Date	**7/28/2021**
Resubmission Date (if applicable)	**9/17/2021**

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Utilization of "Watchful Waiting" category to identify subclinical screens.
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	**Procedure Code selected for follow-up services may not be included in the list of eligible codes for the Rate 2 numerator.**
Key Driver Addressed	Data Accuracy and Integration
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Review of Peak Vista's coding protocol was conducted to ensure the utilization of eligible codes. Review identified subclinical screens (5-9 scores) coded as G8431 to allow for providers to monitor symptoms without necessarily triggering a Behavioral Health follow-up service. 2. Exclude false-positive screens by creating a "Watchful Waiting" category to the Depression screen follow-up list on the PHQ-9 form in the EHR. for screening scores 5-9. 3. Implement a hard stop to PHQ form in the EHR to ensure a follow-up option is selected before providers can exit the form.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Table 1—Intervention Plan	
	4. Modify workflow to automatically code screens scored 5-9 as G8510. 5. Process change rollout and staff training. 6. Develop internal tracking report to monitor utilization of the negative depression screening code for members in the "Watchful Waiting" category. 7. Calculate and review rates monthly to provide training and/or adjust workflow as needed.
What are the predicted results of this test?	A follow-up Behavioral Health service may not be indicated for "Watchful Waiting" members. By excluding these members from the Rate 2 Denominator, it is predicted that screening rates will be unaffected while the follow-up rate will improve, as the rate 2 denominator will only include members with a true positive screen (10+ score) to be referred for follow-up by a behavioral health provider. It is also predicted that the hard stop will facilitate greater consistency of documentation and that a follow-up plan is in place.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)** Utilization of "Watchful Waiting" category to identify subclinical screens.
Numerator Description	Total number of depression screens categorized as "Watchful Waiting" members with a corresponding G8510 CPT code.
Denominator Description	Total number of depression screens categorized as "Watchful waiting; reassess at next visit".

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	To verify the intervention effectiveness, the PIP team will monitor the utilization of the "Watchful Waiting" category to verify the CPT code is accurately reflected on the associated claim. A monthly report will be provided by Peak Vista and reviewed by the PIP team that identifies: • Number of unique patients who receive a qualifying outpatient primary care service during the measurement period. • Patients who decline a depression screen. • Patients medically excluded from receiving a standardized screen.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Table 3—Intervention Effectiveness Measure Data Collection Process	
	• Patients with a follow-up by Peak Vista Behavioral Health provider (per Peak Vista's clinical records) • Patients without a follow-up (per Peak Vista's clinical records) • PHQ follow-up options: 1. Peak Vista BHP consulted 2. Follow-up performed by Medical Provider 3. Community BH referral placed for follow-up (external provider) 4. Questionnaire performed as part of follow-up on known diagnosis 5. Watchful waiting, reassess at next visit • CPT Code reflected on claim generated from Depression screening service.
Describe the Data Sources	Peak Vista's Electronic Health Record and monthly Depression Screening report.
Describe how Data will be Collected	1. Peak Vista staff will review the "huddle tool" daily to identify members who need a PHQ screen, using the following criteria: - New members who are 12 years or older on the date of service. - Existing members who turned 12 years old since the prior visit. - Members who have not received a Depression screen in the 12 months prior to the visit. - Members with an elevated depression screening score. - Members with an existing Depression diagnosis. - "Watchful waiting" members. 2. Identified members will be given a depression screen prior to the visit. 3. MA will enter the screen results in the EHR and will select the appropriate follow-up option on the electronic PHQ form. - Hard stop on the form will ensure a follow-up action is selected.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Table 3—Intervention Effectiveness Measure Data Collection Process	
	4. EHR automatically submits a claim for a positive or negative Depression screening (G8510, G8431 codes) claim when the screen is completed. 5. Peak Vista's Analytics team will pull a Depression Screening report monthly to be provided for review by the PIP team.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Depression screening reports will be automatically pulled directly from the EHR for the full Peak Vista patient population regardless of payor source. The report will be submitted to the PIP team monthly for review, to identify gaps, trends and address noted deficits in the process or in staff training.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing 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*
Intervention Name:	Decrease patient refusal to complete Depression screen.
Contact Name	Camila Joao
Contact Title	Clinical Quality Program Manager
Email Address	Camila.Joao@cchacares.com
Telephone Number	720-612-6935
Submission Date	**3/8/2022**
Resubmission Date (if applicable)	

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance – RAE 7**

Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Decrease patient refusal to complete Depression screen.
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Members that refuse to complete the PHQ-9 screen are not formally assessed for Depression.
Key Driver Addressed	Provider Standards of Care.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Review Peak Vista's depression screening process to establish criteria for completion and exclusions from Depression screening. 2. Review EHR forms to determine documentation process for medical exclusions and patient's refusal to complete the screen. 3. Ensure operational definitions of medical exclusions and refusals don't overlap and are documented in different fields in the EHR.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance – RAE 7**

Table 1—Intervention Plan	
	4. Modify documentation protocol for screenings to include consistent utilization of reportable functions in the EHR instead of documenting refusals in text on service notes or through exclusions function. 5. Update PHQ-9 script to guide providers in educating patients on the benefits of identification and early intervention to manage Depression symptoms, and to support motivation of hesitant members to complete the screen. 6. Develop internal tracking report to monitor utilization of the Patient Refusal functions in the EHR. 7. Process change rollout and staff training. 8. Calculate and review patient refusal rates monthly to provide training and/or adjust workflow as needed.
What are the predicted results of this test?	The PHQ-9 Script used by staff to engage members who refuse the screen will be reviewed and updated to enhance its efficacy to communicate the benefits of timely identification and early intervention in managing Depression symptoms. Provider training and guidance to support patient education and motivation is expected to decrease patient hesitancy and promote engagement; thus, reducing rates of patient refusals and increasing rates of Depression Screening at the practice.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance – RAE 7**

Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)** Decrease patient refusal to complete Depression screen.
Numerator Description	Total number of eligible patients who refuse a Depression screen at the primary care service.
Denominator Description	Total number of unique patients 12 years or older who receive qualifying outpatient primary care service at Peak Vista during the measurement period.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	To verify the intervention effectiveness, the PIP team will monitor the utilization of the patient refusal function in the EHR to gauge the impact of the updated PHQ-9 script in decreasing patient refusals. A monthly report will be provided by Peak Vista and reviewed by the PIP team that identifies: 1. Number of unique patients who receive a qualifying outpatient primary care service during the measurement period. 2. Patients who decline a depression screen.

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance – RAE 7**

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Sources	Peak Vista's Electronic Health Record and monthly Depression Screening report.
Describe how Data will be Collected	1. Peak Vista staff will review the "huddle tool" daily to identify members who need a PHQ screen, using the following criteria: - New members who are 12 years or older on the date of service. - Existing members who turned 12 years old since the prior visit. - Members who have not received a Depression screen in the 12 months prior to the visit. - Members with an elevated depression screening score. - Members with an existing Depression diagnosis. - "Watchful waiting" members. 2. Identified members will be given a depression screen prior to the visit. 3. For patients who decline the Depression screen, MA will attempt to encourage completion by using the updated PHQ-9 script. 4. If the member continues to refuse, MA will document refusal by checking the "Patient Declined" box in the PHQ-9 assessment form in the EHR. 5. Peak Vista's Analytics team will pull a Depression Screening report monthly to be provided for review by the PIP team.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Depression screening reports will be automatically pulled directly from the EHR for the full Peak Vista patient population regardless of payor source. The report will be submitted to the PIP team monthly for review, to identify gaps, trends and address noted deficits in the process or in staff training.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Criteria	Score	HSAG Feedback and Recommendations
1. The MCO included process maps for *Depression Screening* and *Follow–Up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	**General Comment:** It appeared that the *Depression Screening* process map included steps beyond a member having the depression screening completed; the process map also appeared to include steps that occur after a member receives positive depression screen, which should be included in the *Follow–Up After a Positive Depression Screen* process map. **Re-review June 2021:** The health plan addressed the General Comment in the resubmission.
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	HSAG identified opportunities for improvement in the *Depression Screening* process map. The highlighted Step 1 in the *Depression Screening* process map, "No current process in place when staff is unable to reach member for follow-up" appeared to be part of the process for the *Follow–Up After a Positive Depression Screen* measure, not the *Depression Screening* measure. The health plan should revise the *Depression Screening* process map to ensure that all highlighted steps are leading up to completion of a depression screen for members. Any highlighted steps related to follow–up services after a positive depression screen should be included and highlighted in the *Follow–Up After a Positive Depression Screen* process map. **Re-review June 2021:** The health plan revised the process maps to address HSAG's feedback. The criterion has been changed to *Met*.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Criteria	Score	HSAG Feedback and Recommendations
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	☒ Met ☐ Not Met	HSAG identified opportunities for improvement in the FMEA tables for *Depression Screening* (Table 1a) and *Follow–Up After a Positive Depression Screen* (Table 1b). It appeared that the first step listed in Table 1a, "No current process in place when staff is unable to reach member for follow–up," should have been part of the *Follow–Up After a Positive Depression Screen* process map and included in Table 1b for the *Follow–Up After a Positive Depression Screen* FMEA. Table 1a should only include steps leading up to completion of the depression screen and failure modes associated with those steps. Table 1b should include steps, and associated failure modes, occurring after a positive depression screen is received and leading up to the completion of follow–up services for the positive depression screen. **Re-review June 2021:** The health plan revised the process maps to address HSAG's feedback. The criterion has been changed to *Met*.
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	
5. The MCO prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement: • The health plan listed steps from the process map, instead of failure modes, in the Failure Mode Priority Ranking Tables 2a and 2b. The health plan should revise the documentation in these tables to reflect the failure modes linked to the identified steps. For example, in the Failure Modes column in Table 2a, the health plan should remove the step description, "No Current Process in place when staff is unable to

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Criteria	Score	HSAG Feedback and Recommendations
		reach member for follow–up," and replace it with the failure mode description, "BHP is unable to reach member by phone and member has no planned follow–up after a positive depression screen." **Re-review June 2021:** The health plan revised the process maps to address HSAG's feedback. The criterion has been changed to *Met*.
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the MCO included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	**General Comment:** The health plan should remove the highlighting form the KDD. No highlighting is required in the Module 2 KDD. Highlighting should be used to reflect the status of interventions in the KDD in the final Module 4 submission form, after intervention testing is complete for the project. **Re-review June 2021:** The health plan addressed the General Comment in the resubmission.
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: June 14, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Intervention: Utilization of "Watchful Waiting" Category to Identify Subclinical Screens

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: • The health plan should consider limiting the intervention effectiveness measure to RAE 7 members only, if possible, within data source and other resource constraints. • The health plan should consider tracking an additional intervention effectiveness measure(s), based on submitted and received depression screening claims data, if feasible, within data source and other resource constraints.		

Intervention Testing (Module 3)

☒ Pass

Date: September 29, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance – RAE 7

Intervention: Decrease Patient Refusal to Complete Depression Screen

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The MCO included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: March 24, 2022