COLORADO

Department of Health Care Policy & Financing

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

Fiscal Year 2019–2020 PIP Validation Report

for

Colorado Access

Region 5

April 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. One RAE, **Colorado Access Region 5**, referred to in this report as **COA R5**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

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

Measurement of performance using objective quality indicators.

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

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

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

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

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

PIP Components and Process

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

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **COA R5**'s module submission forms. In FY 2019–2020, these forms provided detailed information about **COA R5**'s PIPs and the activities completed in Module 3. (See Appendix A. Module Submission Forms.)

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

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

Validation Scoring

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

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

PIP Topic Selection

In FY 2019–2020, **COA R5** submitted the following PIP topics for validation: *Well-Child Visits for Members 10–14 Years of Age* and *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age.*

COA R5 defined a Global Aim and SMART Aim for each PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for each PIP:

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

Table 1-1 includes the PIP titles and SMART Aim statements selected by **COA R5**.

Table 1-1—PIP Titles and SMART Aim Statements

PIP Titles	SMART Aim Statements
Well-Child Visits for Members 10–14 Years of Age	By June 30, 2020, increase the percentage of well-child visits among members 10–14 years of age, attributed to Sr. Joanna Bruner Family Medicine Center (Bruner), from 39.92% to 44.92%.
Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age	By June 30, 2020, increase the percentage of members with a positive depression screen who received at least one follow-up service within 30 days among members 10–14 years of age, from 1.13% to 7.34%.

The focus of the well-child visits PIP is to increase the rate of well-child visits among members 10 through 14 years of age who receive care from the narrowed focus provider group. The focus of the behavioral health PIP is to increase the rate of follow-up service within 30 days among members 10 through 14 with a positive depression screen. Table 1-2 summarizes the progress **COA R5** has made in completing the five PIP modules for each PIP.

Table 1-2—PIP Progress and Module Status

PIP Topics	Module	Status
Well-Child Visits for Members 10–14 Years of Age	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in July 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.
Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in July 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.

At the time of the FY 2019–2020 PIP validation report, **COA R5** had passed Module 1, Module 2, and Module 3, achieving all validation criteria for each PIP. **COA R5** has progressed to intervention testing in Module 4—Plan-Do-Study-Act. The final Module 4 and Module 5 submissions are targeted for October 2020; HSAG will report the Module 4 and Module 5 validation findings and the level of confidence assigned to each PIP in the FY 2020–2021 PIP validation report.

Validation Findings

In FY 2019–2020, **COA R5** completed and submitted Module 3 for validation for each PIP. Detailed module documentation submitted by the health plan is provided in Appendix A. Module Submission Forms.

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

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

Module 3: Intervention Determination

In Module 3, **COA R5** completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions for each PIP.

Well-Child Visits for Members 10–14 Years of Age

Table 2-1 summarizes the potential interventions **COA R5** identified for the *Well-Child Visits for Members 10–14 Years of Age* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-1—Intervention Determination Summary for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Physicians are performing qualifying well visit services during a sick visit but are not billing appropriately	Face-to-face and/or virtual training on appropriate billing practices for well visit services for providers and billing staff members. Training would be accompanied by ongoing support from **COA R5** as needed.
Sick visit appointment times cannot be extended to incorporate well visit services	Adding an additional step in the sick visit process flow to ensure that a follow-up well visit appointment is scheduled for members who could not have their sick visit appointment time extended for well visit services. The process change would eventually incorporate digital appointment reminders and provider outreach activities.
Parent does not schedule a well visit appointment for their child or any other qualifying well visit service	Partner with providers to educate parents about the importance of a well visit for their adolescent. Educational materials would be provided in both English and Spanish.

At the time of this FY 2019–2020 PIP validation report, **COA R5** had completed Module 3 and initiated the intervention planning phase in Module 4. **COA R5** submitted one intervention plan in July 2019 for

the well-child visits PIP. Table 2-2 summarizes the intervention **COA R5** selected for testing through PDSA cycles for the *Well-Child Visits for Members 10–14 Years of Age* PIP.

Table 2-2—Planned Interventions for the *Well-Child Visits for Members 10–14 Years of Age* PIP

Intervention Description	Key Driver	Failure Mode
Chart audits to identify providers who missed opportunities to bill for well visit services and targeted training for these providers on when and how to bill for well visit services	Coding consistencies for well visits across clinic settings	Physicians are performing qualifying well visit services during a sick visit but are not billing appropriately

COA R5 selected one intervention for the well-child visit PIP to test using PDSA cycles in Module 4. The provider-focused intervention included training to promote appropriate well visit billing practices to address a failure mode related to services occurring but not being accurately documented in the billing process. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **COA R5**. The health plan is currently in the "Do" stage of the PDSA cycles for each intervention, carrying out the intervention and evaluating impact. HSAG will report the intervention testing results and final Module 4 and Module 5 validation findings in the next annual PIP validation report.

Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age

Table 2-3 summarizes the potential interventions **COA R5** identified for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-3—Intervention Determination Summary for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Failure Modes	Potential Interventions
Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services	Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done
Behavioral health specialists are not performing qualifying follow-up services after a positive depression screen for members ages 10–14	Educate providers at integrated primary health/behavioral health practices regarding appropriate follow-up services for members who screen positive for depression
Limited availability of behavioral health providers to provide follow-up service to members within 30 days of a positive depression screen	Collaborate with primary care pediatric practices to offer virtual behavioral health consultation and clinical services to their patients via **COA R5**'s telehealth program, with a focus on members ages 10–14 who screened positive for depression to ensure timely access to qualifying behavioral health follow-up services

At the time of this FY 2019–2020 PIP validation report, **COA R5** had completed Module 3 and initiated the intervention planning phase in Module 4. **COA R5** submitted one intervention for the behavioral health PIP. Table 2-4 summarizes the intervention **COA R5** selected for testing through PDSA cycles for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP.

Table 2-4—Planned Interventions for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age* PIP

Intervention Description	Key Drivers	Failure Mode
Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done	Availability and timeliness of applicable behavioral health services following a positive depression screening in primary care	Behavioral health specialists are performing on-site follow-up services after a positive depression screen but are not using the proper codes for follow-up services

For the behavioral health PIP, **COA R5** selected one intervention to test using PDSA cycles in Module 4. The provider-focused intervention included educating providers at integrated primary care/behavioral healthcare practices on proper billing codes and practices for follow-up behavioral health services provided to members who screened positive for depression. HSAG reviewed the intervention plan for the intervention and provided written feedback and technical assistance to **COA R5**.

The health plan is currently in the "Do" stage of the PDSA cycles for all interventions, carrying out the intervention and evaluating impact for each PIP. HSAG will report the intervention testing results and final Module 4 and Module 5 validation findings in the next annual PIP validation report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **COA R5** successfully completed Module 3 for both PIPs. For the *Well-Child Visits for Members 10–14 Years of Age* PIP, the health plan identified opportunities for improving the process related to obtaining a well visit for members 10 through 14 years of age, and for the *Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*, the health plan identified opportunities for improving the process related to members receiving appropriate and timely follow-up services after a positive depression screen. **COA R5** further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps and increase the percentage of members who receive a well visit and the percentage of members who receive appropriate and timely follow-up services for a positive depression screen.

The health plan also successfully initiated Module 4 by selecting interventions to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles. **COA R5** will continue testing interventions for the PIPs through June 30, 2020. The health plan will submit complete intervention testing results and PIP conclusions for each PIP for validation in FY 2020–2021. HSAG will report the final validation findings for the PIP in the FY 2020–2021 PIP validation report.

Recommendations

- When planning a test of change, **COA R5** should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, **COA R5** should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- **COA R5** should consistently use the approved Module 2 SMART Aim measure data collection and calculation methods for the duration of the PIP so that the final SMART Aim measure run chart provides data for a valid comparison of results to the goal.
- When reporting the final PIP conclusions, **COA R5** should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.
- If improvement is achieved through the PIP, **COA R5** should develop a plan for continuing and spreading effective interventions and sustaining improvement in the long term.

Appendix A. Module Submission Forms

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

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Determination Submission
Well–Child Visits for Members 10–14 Years of Age
for Colorado Access Region 5 (RAE 5)

Managed Care Organization (MCO) Information	
MCO Name:	Colorado Access (COA)
PIP Title:	Well-Child Visits, Ages 10-14
Contact Name:	Kiah Vandergrift
Contact Title:	Quality Improvement Program Manager
E-mail Address:	Kiah.vandergrift@coaccess.com
Telephone Number:	720-744-5375
Submission Date:	5/31/2019

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Process Mapping

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

Table 1—Process Mapping Team

Development Period	
5/16/2019-5/24/2019	
Team Members Involved	**Role/Responsibilities**
Kiah Vandergrift	Quality Improvement Program Manager, Colorado Access. PIP project management, internal and external stakeholder engagement, coordinating data collection process, developing process maps.
Catherine Morrisey	Quality Improvement Program Manager, Colorado Access. PIP project support.
Brian Bandle	Quality Improvement Program Analyst, Colorado Access. Responsible for data collection and report generation, providing subject matter expertise on data needed and available for prioritization of failure modes and interventions.
Jean Cunningham	Practice Administrator. Subject matter expert and process owner at Bruner.
Bethany Himes	Vice President of Provider Engagement, Colorado Access. PIP Executive Sponsor.

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Failure Modes and Effects Analysis (FMEA)

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

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
5/24/2019-5/31/2019	
Team Members Involved	**Role/Responsibilities**
Kiah Vandergrift	Quality Improvement Program Manager, Colorado Access. PIP project management, internal and external stakeholder engagement, coordinating data collection process, developing process maps.
Catherine Morrisey	Quality Improvement Program Manager, Colorado Access. PIP project support.
Brian Bandle	Quality Improvement Program Analyst, Colorado Access. Responsible for data collection and report generation, providing subject matter expertise on data needed and available for prioritization of failure modes and interventions.
Jean Cunningham	Practice Administrator. Subject matter expert and process owner at Bruner.
Tyler Watlington	Medical Director, Colorado Access. Clinical subject matter expert and project support.
Bethany Himes	Vice President of Provider Engagement, Colorado Access. Executive Sponsor for the Performance Improvement Project.

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Process Mapping

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

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

(Insert Process Map Here—Use attachments or additional pages if more space is required)

Please see the attached document titled:

- Bruner Process Map Well Visits.vsdx

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for Colorado Access Region 5 (RAE 5)

Process Mapping

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

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

Description of process and rationale for selection of subprocesses:

Description of Process

First, the team (listed in Table 1) identified which process to map. The attached process map identifies the process for members ages 10-14 receiving a well visit, with input provided by Bruner and provider-facing staff at Colorado Access. We chose to map this process because we believe it is within this process that COA will have the best chance to move this measure within the Rapid-Cycle PIP timeline.

The PIP process mapping team included subject matter experts including the Practice Administrator at Bruner who is the process owner. We leveraged this expertise to learn the process from our clinic partner to create the attached process map. The FMEA team included those same individuals with the addition of an internal COA Medical Director to identify potential failure modes and interventions. This FMEA team conducted meetings to identify the sub-processes with critical failure modes that could lead to COA not achieving our PIP SMART aim and to brainstorm potential interventions.

Rationale for Selection of Sub-Processes:

The process mapping team identified three (3) key criteria to use when selecting sub-processes for the FMEA analysis. These include:

1. Is there sufficient data (qualitative and quantitative) for each sub-process to measure performance over time?

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Process Mapping

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

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

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2. Does COA have the ability to significantly impact the sub-process within the Rapid-Cycle PIP timeline?
3. How great of an impact does the failure mode have on the SMART aim?

After talking through each of these criteria for these sub-processes, the team identified the following three (3) processes to prioritize:

1. Bill Appropriate Wellness Codes
2. Day-of morning huddle to identify opportunities to incorporate well-visit
3. Member's parent schedules well-visit.

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Failure Modes and Effects Analysis

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

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

Table 3—Failure Modes and Effects Analysis Table

Subprocesses	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. **Bill appropriate wellness codes**	Physicians are performing qualifying well-visit services during a sick visit but are not accurately capturing that work in their billing practices.	Provider not educated about proper billing process for qualifying well-visit services.	Member receives well-visit, but it is not captured in the data to count towards this measure.
2. **Day-of morning huddle to identify opportunities to incorporate well-visit**	Appointment times cannot be extended to incorporate well-visit activities.	The clinic is at full appointment capacity for the day.	Members aged 10-14 who are coming in for a sick visit do not get added benefits of well-visit activities and would need to return for subsequent visit for service to occur.

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3. Member's parent schedules a well-visit	Parent does not schedule the appointment or any other qualifying well-visit service.	Parents have concerns about the cost of care. Purpose of "well-visit" deemed unnecessary to members when the individual is already in good health.	Member aged 10-14 does not receive well-visit.

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Failure Mode Priority Ranking

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

Table 4—Failure Mode Priority Ranking	
Priority Ranking	**Failure Modes**
1	Physicians are performing qualifying well-visit services during a sick visit but are not accurately capturing that work in their billing practices.
2	Appointment times cannot be extended to incorporate well-visit activities.
3	Parent does not schedule the appointment or any other qualifying well-visit service.

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

COA identified three (3) key criteria to use when selecting and prioritizing sub-processes for the FMEA analysis. These include:

1. Is there sufficient data (qualitative and quantitative) for each sub-process to measure performance over time?
2. Does COA have the ability to significantly impact the sub-process within the Rapid-Cycle PIP timeline?
3. How great of an impact does this have on the SMART aim?

The FMEA team qualitatively walked through each of these questions and determined the priority rankings above. We incorporated feedback from the practices themselves as well as internal COA subject matter experts who work alongside the practices to implement quality interventions, including COA Medical Directors and Practice Facilitators. We believe that prioritizing the failure modes in this order will give COA the optimal chance of success within the Rapid-Cycle PIP timeline.

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Intervention Determination

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

Table 5—Intervention Determination Table

Failure Modes	Interventions
Physicians are performing qualifying well-visit services during a sick visit but are not accurately capturing that work in their billing practices.	Ensure that providers are itemizing well-visits, particularly if these services are added-on to other appointments that a member receives. Colorado Access would do this by conducting face-to-face and/or virtual training and ongoing support as needed to Bruner providers and billing staff.
Appointment times cannot be extended to incorporate well-visit activities.	Pilot an additional step to the process to ensure that, upon checkout, members who attended for a sick visit but could not have their appointment time extended are scheduling a follow-up well-visit. With time, work to ensure this subsequent appointment is incorporated into digital reminders and provider outreach.
Parent does not schedule the appointment or any other qualifying well-visit service.	Develop best practice messaging to parents about the importance of a well-visit for their adolescent. Disseminate educational materials to encourage parents to schedule a well-visit, including talking points for providers and educational flyers in English and Spanish to hand out at the clinic.

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Managed Care Organization (MCO) Information	
MCO Name:	Colorado Access (COA)
PIP Title:	Referral from Primary Care to Behavioral Health Following a Positive Depression Screen, Ages 10-14
Contact Name:	Kiah Vandergrift
Contact Title:	Quality Improvement Program Manager
E-mail Address:	Kiah.vandergrift@coaccess.com
Telephone Number:	720-744-5375
Submission Date:	April 12, 2019

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Process Mapping

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

Table 1—Process Mapping Team	
Development Period	
03/12/2019 – 3/28/2019	
Team Members Involved	**Role/Responsibilities**
Kiah Vandergrift	Quality Improvement Program Manager. PIP project management, internal and external stakeholder engagement, coordinating data collection process, developing process maps, coordinating and recording FMEA analysis.
Catherine Morrisey	Quality Improvement Program Manager. PIP project support and subject matter expert on data methodology.
Elise Cooper	Practice Facilitator. Subject matter expert on physician practices and partners.
Jenny Nate	Director, Behavioral Health Provider and Network Support. Subject matter expert for behavioral health network.
Brian Bandle	Quality Improvement Program Analyst. Responsible for data collection and report generation, providing subject matter expertise on data needed and available for prioritization of failure modes and interventions.
Bethany Himes	Vice President of Provider Engagement, Colorado Access. PIP Executive Sponsor.

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Failure Modes and Effects Analysis (FMEA)

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

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
4/1/2019 to 4/5/2019	
Team Members Involved	**Role/Responsibilities**
Kiah Vandergrift	Quality Improvement Program Manager. PIP project management, internal and external stakeholder engagement, coordinating data collection process, developing process maps, coordinating and recording FMEA analysis.
Catherine Morrisey	Quality Improvement Program Manager. PIP project support and subject matter expert on data methodology.
Elise Cooper	Practice Facilitator. Subject matter expert on physician practices and referral processes.
Jenny Nate	Director, Behavioral Health Provider and Network Support. Subject matter expert for behavioral health network.
Brian Bandle	Quality Improvement Program Analyst. Responsible for data collection and report generation, providing subject matter expertise on data needed and available for prioritization of failure modes and interventions.

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Process Mapping

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

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

(Insert Process Map Here—Use attachments or additional pages if more space is required)

Please see the 2 attached documents titled:

- BHProcessMap_IntegratedSiteV2.vsdx
- BHProcessMap_NonIntegratedSiteV2.vsdx

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Process Mapping

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

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

Description of process and rationale for selection of subprocesses:

Description of Process:

To develop the process maps, the process mapping team (listed in Table 1) first identified the key provider types that affect this measure. We decided to map the general referral process for integrated primary/behavioral health sites and for non-integrated (i.e. pediatric primary care) sites.

The PIP process mapping team included subject matter experts who are liaisons with our primary care practices and behavioral health practices and are familiar with the overall processes for members in our selected age group. We leveraged this expertise and held a meeting to draw preliminary process maps on a whiteboard for those identified clinic sites. Then, we transferred those whiteboard drawings to Visio files. Finally, the process mapping team conducted meetings to identify the sub-processes with critical failure modes that could lead to COA not achieving our PIP SMART aim.

Rationale for Selection of Sub-Processes:

The process mapping team identified three (3) key criteria to use when selecting sub-processes for the FMEA analysis. These include:

1. Is there sufficient data (qualitative and quantitative) for each sub-process to measure performance over time?

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Process Mapping

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

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

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2. Does COA have the ability to significantly impact the sub-process within the Rapid-Cycle PIP timeline?
3. To what extent does a failure within the sub-process lead to a failure to achieve the overarching goal?

After talking through each of these criteria for these sub-processes, the team identified the following 2 sub-processes to prioritize:

1. Behavioral Health Intervention *(Integrated Primary/Behavioral Health Site)*
2. Refer to external Behavioral Health partner *(both clinic types)*

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Failure Modes and Effects Analysis

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

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

Table 3—Failure Modes and Effects Analysis Table

Sub-processes	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. Behavioral Health Intervention *(Integrated Primary/Behavioral Health Clinic)*	1) Behavioral Health specialists are performing on-site follow up services after a positive depression screen, however they are not billing the proper follow-up codes.	a) Provider not educated about proper billing process for qualifying follow-up services	Members receive follow-up services, however they are not captured in claims data to count towards this measure.
	2) Behavioral Health specialists are not performing qualifying follow-up services after a	a) Provider not aware of qualifying follow-up services and therefore not providing them.	Members do not receive qualifying follow-up services in an integrated care setting within 30 days of a positive depression screen.

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	positive depression screen for members aged 10-14.		
2. Refer to external Behavioral Health partner *(both clinic types)*	3) No nearby BH providers have availability within the next 30 days.	a) Not enough BH providers in the member's area to meet demand.	Member does not receive a follow-up BH service within 30 days of their positive depression screen.

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Failure Mode Priority Ranking

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

Table 4—Failure Mode Priority Ranking

Priority Ranking	Failure Modes
1. **Behavioral Health Intervention** *(Integrated Primary/Behavioral Health Clinic)*	1) Behavioral Health specialists are performing on-site follow up services after a positive depression screen, however they are not billing the proper follow-up codes. 2) Behavioral Health specialists are not performing qualifying follow-up services after a positive depression screen for members aged 10-14.
2. **Refer to external Behavioral Health partner** *(Both clinic types)*	3) No nearby BH providers have availability within the next 30 days.

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

COA identified three (3) key criteria to use when selecting and prioritizing sub-processes for the FMEA analysis. These include:

1. Is there sufficient data (qualitative and quantitative) for each sub-process to measure performance over time?
2. Does COA have the ability to significantly impact the sub-process within the Rapid-Cycle PIP timeline?
3. To what extent does a failure within the sub-process lead to a failure to achieve the overarching goal?

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The FMEA team qualitatively walked through each of these questions and determined the priority rankings above. We believe that prioritizing the failure modes in this order will give COA the optimal chance of success within the Rapid-Cycle PIP timeline.

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Intervention Determination

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

Table 5—Intervention Determination Table

Failure Modes	Interventions
1) Behavioral Health specialists are performing on-site follow up services after a positive depression screen, however they are not billing the proper follow-up codes.	Develop and disseminate provider education regarding the qualifying follow-up services for this measure to enhance billing practices and more effectively capture work that is already being done. This will also help ensure an accurate look at members not receiving timely follow-up services, and allow COA and providers to put more emphasis in these populations. COA will disseminate this information through in-person and/or online webinar trainings. *Note:* this intervention would be focused primarily on integrated primary/behavioral health sites.
2) Behavioral Health specialists are not performing qualifying follow-up services after a positive depression screen for members aged 10-14.	Develop and disseminate provider education regarding the qualifying follow-up services for this measure to enhance the quality of care and ensure that members receive timely access to behavioral health services. COA will disseminate this information through in-person and/or online webinar trainings. *Note:* this intervention would be focused primarily on integrated primary/behavioral health sites.
3) No nearby BH providers have availability within the next 30 days.	Develop solutions to leverage telehealth to increase access to behavioral health services. Specifically, COA will collaborate with primary care pediatric practices to offer virtual behavioral health consultation and clinical services to their patients via COA's telehealth program, with particular focus on members aged 10-14 who screened positive for depression to ensure timely access to qualifying behavioral health follow-up services.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	
2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement with the process map: • Subprocess 3, "Member's parent schedules a well-visit" should be a decision point step with yes/no. When no, the health plan should include what is the follow-up. If none, the health plan should document a step as "no plan exists." • Additionally, it appears "Member arrives for their visit on the scheduled date" should be a decision point step with yes/no. When no, the health plan should include what is the follow-up. If none, the health plan should document a step as "no plan exists." • It also appears that after the step, "Practice staff calls parents to remind them to schedule an appointment for their child", the health plan should indicate what happens when parents cannot be reached by telephone. **Re-review June 2019**: The health plan updated the process map for the new narrowed focus provider (Bruner) and revised the process map to address HSAG's feedback. The criterion was achieved.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The first listed failure mode in the Intervention Determination table was the subprocess. The health plan should list the failure mode. • For the second intervention, the health plan did not list an intervention and included analysis that it would complete. The health plan should list the actual change(s) to address the failure. If the health plan does not yet have changes for the failure, then it should not be included in the Intervention Determination table at this time.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		• For the third failure mode, the intervention description "Identify best practice messaging…" does not specify how parent educational materials would be delivered. The health plan should provide more specific details about the type of best practice messaging that would be tested as an intervention. **Re-review June 2019**: The health plan updated the Intervention Determination table for the new narrowed focus provider and addressed HSAG's previous feedback. The criterion was achieved. **General Comment**: In the third row of the Intervention Determination table, the health plan referred to "educational flyers." If flyers are incorporated into an intervention selected for testing in Module 4, HSAG recommends that the flyers be provided as part of face-to-face member education. HSAG does not recommend mass mailers or leaving flyers in a provider waiting area. Interventions selected for Module 4 will need to be measurable and have the potential to directly impact the SMART Aim measure.

Intervention Determination (Module 3)

☒ Pass

Date: June 5, 2019

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	

2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes
	☐ No
		HSAG identified the following opportunities for improvement with the *Integrated Primary/BH* process map:
		• It appears the following steps should be decision points with yes/no. When no, the health plan should include what is the follow-up. If none, the health plan should document a step as "no plan exists."
		  ○ "Obtain parental consent to provide BH services"
		  ○ "Parent schedules appointment"
		  ○ "Member attends appointment"
		• Based on the FMEA, it appears that Subprocess 1, "Behavioral Health Intervention" should also be a decision point with yes/no. If yes for a qualifying follow-up service, it signifies numerator compliance (follow-up service within 30 days of a positive depression screen)?
		
		HSAG identified the following opportunities for improvement with the *Non-integrated* process map:

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		• It appears the following steps should be decision points with yes/no. When no, the health plan should include what is the follow-up. If none, the health plan should document a step as "no plan exists." ○ "Member's parent schedules a follow-up appointment" ○ "PCP follows-up to ensure parent was able to make BH appointment" ○ "Member attends appointment" ○ Additionally, on the Non-Integrated Site map, it appeared that "Member's parent schedules a follow-up appointment" should include "…date within 30 days of positive depression screen." **Re-review May 2019**: The health plan revised both process maps and addressed HSAG's feedback. The criterion was achieved.
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement with the potential interventions: • For the first and second interventions, the health plan should explain how it would "disseminate" provider education. • The third failure mode did not have an actual change or intervention provided in the Intervention Determination table. The health plan should list the actual change(s) to address the failure. If the health plan has not yet identified specific changes to address the failure, then it should not be included in the Intervention Determination table at this time.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		• It appeared that the fourth intervention was initiation and/or increased use of telehealth services. The health plan should provide more details. • For the fifth failure mode, the intervention description "Identify best practice messaging…" does not specify how parent educational materials would be delivered. The health plan should provide more specific details about the type of best practice messaging that would be tested as an intervention. **Re-review May 2019**: The health plan revised the intervention descriptions and addressed HSAG's feedback. The criterion was achieved.

Intervention Determination (Module 3)

☒ Pass

Date: May 30, 2019