Colorado Children's Health Insurance Program

Fiscal Year 2020–2021 PIP Validation Report

for

Colorado Access

December 2021

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

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Parts 438 and 457—managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care and July 1, 2018, for CHIP 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, conducted by an external quality review organization (EQRO), analysis and evaluation of aggregated information on 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 managed care program and Child Health Plan *Plus* (CHP+), Colorado's program to implement CHIP managed care. The Department contracts with five CHP+ MCOs across the state.

Pursuant to 42 CFR §457.1250, which requires states' CHIP managed care programs to participate in EQR, the Department required its CHP+ MCOs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **Colorado Access** (**COA**), an MCO, holds a contract with the State of Colorado for provision of medical and behavioral health services for the Department's CHP+ managed care program.

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

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

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on June 8, 2020.

Over time, HSAG and some of its contracted states identified that while the MCOs had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs had achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-2] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *Protocol 1: Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.

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

PIP Components and Process

The key concepts of the new PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is approximately 18 months, from the initial Module 1 submission date to the end of intervention testing.

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

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

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

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

Validation Scoring

During validation, HSAG determines if criteria for each module are *Met.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 4, HSAG will use the validation findings from modules 1 through 4 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

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

PIP Topic Selection

In FY 2020–2021, **COA** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen*.

COA 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 **COA**.

Table 1-1—SMART Aim Statements

PIP Measure	SMART Aim Statement
Depression Screening	By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.40% to 41.16%.
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 63.64% to 83.64%.

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 well visit at Every Child Pediatrics or Peak Vista Community Health Centers and to increase the percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goals to increase depression screening to 39.11 percent and to increase follow-up within 30 days after a positive depression screen to 83.64 percent represent statistically significant improvement over the baseline performance.

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

Table 1-2—PIP Topic and Module Status

PIP Topics	Module	Status
Depression Screening and Follow-Up After a Positive Depression Screen	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Initial submission due April 30, 2021.
	3. Intervention Testing	Targeted initiation July 2021.
	4. PIP Conclusions	Targeted for October 2022.

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

Validation Findings

At the end of FY 2019–2020, **COA** closed out the *Well-Child Visits for Members 10–14 Years of Age* PIP, which was initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from the project.

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

Below are summaries of PIP conclusions from the *Well-Child Visits for Members 10–14 Years of Age* PIP close-out report and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **COA** reported in the FY 2019–2020 PIP close-out report for the *Well-Child Visits for Members 10–14 Years of Age* PIP.

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

Interventions	In-person provider training on best practices for billing for well visits, provided collaboratively by the electronic medical record (EMR) and data analytics teams.
Successes	Established data sharing and a monthly reporting process with provider partner.
Lessons Learned	The importance of clearly communicating PIP requirements/expectations—interventions and data collection—to the provider partner and obtaining buy-in/commitment from the provider partner up front.

Module 1: PIP Initiation

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

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

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.40% to 41.16%.
Preliminary Key Drivers	• Provider standards of care and coding consistency • Depression screening occurs at every well visit • Member engagement and education • Appointment availability and access
Potential Interventions	• Standardization of depression screen scoring • Provider education on appropriate coding practices • Promotion of telehealth options for well visits • Automated well visit scheduling and reminder outreach • Member education on appointment access and availability services
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 63.64% to 83.64%.
Preliminary Key Drivers	• Provider standards of care for behavioral health referral process • Provider education on appropriate behavioral health follow-up coding practices • Internal and external provider availability for behavioral health follow-up visits • Member access, knowledge, and engagement
Potential Interventions	• Targeted provider education on effective referral processes • Provider workflow improvement and standardization • Provider education on appropriate coding practices • Expand telehealth follow-up options through COA's free Virtual Care Collaboration and Integration (VCCI) program • Develop member resources for behavioral health and referral resources

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

- Increase the percentage of members 12 years of age and older who receive a depression screening during a well visit at Every Child Pediatrics or Peak Vista Community Health Centers to 41.16 percent.

- Increase the percentage of members 12 years of age and older who screened positive for depression at Every Child Pediatrics or Peak Vista Community Health Centers that receive follow-up behavioral health services within 30 days of the positive depression screen 83.64 percent.

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

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **COA** successfully completed Module 1 and designed a methodologically sound project. **COA** was also successful in identifying an appropriate narrowed focus, building internal and external quality improvement teams, and developing collaborative partnerships with targeted providers and facilities.

Recommendations

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

Appendix A. Module Submission Form

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

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Module 1 — PIP Initiation Submission Form
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for Colorado Access CHP+

Managed Care Organization (MCO) Information	
MCO Name	Colorado Access
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Alex Scialdone
Contact Title	Quality Improvement Program Manager
Email Address	Alex.scialdone@coaccess.com
Telephone Number	720-744-5697
Submission Date	12/7/2020
Resubmission Date (if applicable)	3/16/2021

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PIP Team

Instructions:

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

Table 1—Team Members

Name	Title	Role and Responsibilities
Alex Scialdone	Quality Improvement Program Manager	PIP Project Lead
Sagar Chouksey	Quality Improvement Program Analyst	Lead Data Analyst
Bethany Himes	Vice President of Provider Engagement	Executive Sponsor
Eileen Forlenza	Practice Supports- Practice Facilitator	Practice facilitator Every Child Pediatrics
Elise Cooper	Practice Supports- Sr. Practice Facilitator	Practice facilitator for Peak Vista. SME on physician practices/referral processes
Jonathan Schmelzer	Quality Improvement Program Manager	PIP project support
Scott Threlkeld	Sr. Applications Developer	Business Intelligence and code development for data pull
Lori Cohn	Director of Integrated Services, Every Child Pediatrics	Every Child Pediatrics narrowed focus representative
Patty Northern	Director of Quality and Patient Safety, Peak Vista	Peak Vista narrowed focus representative
Mika Gans	Director of Quality Improvement	Quality leadership and support

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PIP Topic and Narrowed Focus

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

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

Table 2—PIP Topic and Narrowed Focus

PIP Topic Description
Depression Screening in Outpatient Well Visit and Follow-Up After Positive Depression Screening within 30 days: this performance improvement project (PIP) topic is mandated from the Colorado Department of Health Care Policy and Financing (the Department). This topic is timely and relevant, especially in light of the COVID-19 pandemic and the additional isolation, psychosocial stressors and barriers members are facing. This PIP topic is also aligned with U.S. Preventative Services Task Force (USPSTF) guidelines of screening for depression for all individuals 12 and older and ensuring screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.[1, 2] The 2020 Statewide Behavioral Health Needs Assessment[1] reported that 15.3% of Coloradans reported poor mental health. Improving screening rates will help identify more members who need appropriate behavioral health care. Improving follow-up after positive depression screen within 30 days will ensure at-risk members are getting connected with and receiving the right care at the right time. Lastly, research has also shown a strong relationship between physical activity, wellness, mental health, and increased medical costs for those with poorer mental health.[3, 4, 5] This PIP focus has potential to improve overall member well-being by addressing mental health needs in a timely manner.
Narrowed Focus Description
The narrowed focus for the CHP+ PIP is members aged 12 to 18 who receive services at Every Child Pediatrics and Peak Vista Community Health Centers, as defined by billing vendor tax ID's 841321485 and 840617567. Screening members aged 12 to 18 aligns with USPSTF guidelines[5] that showed the efficacy in screening this population cohort as the "USPSTF found adequate evidence

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that treatment of Major Depressive Disorder (MDD) detected through screening in adolescents is associated with moderate benefit (for example, improved depression severity, depression symptoms, or global functioning scores)."

Focusing on two practices for this PIP is strategic for multiple reasons: alignment with USPSTF guidelines[1]; the 2020 Statewide Behavioral Health Needs Assessment finding that 31.4% of Colorado high school students reported symptoms of depression which interfered with daily life[6]; increased screen time and isolation due to COVID-19 among school-aged children and research that supports poorer mental health status found among adolescents using screen time more than two to three hours per day[7]; the integration of behavioral and physical health[8] in the practices, and the diversity of the members these two practices serve. Additionally, Peak Vista Community Health Centers is a FQHC and plays a vital role in serving Colorado Access members[9]; Peak Vista Community Health Centers serves rural Colorado members, which is identified as a top three population group least likely to get behavioral health services they need[10].

Colorado Access reviewed HSAG initial Module 1 feedback following the Technical Assistance call on February 11, 2021 and explored all available options to broaden the narrowed focus area as suggested. Subsequently, Colorado Access implemented data parameter expansion to improve sample size. Narrowed focus expansion on age was limited due to CHP+ benefit structure; CHP+ membership ends on the last day of the month of a member's 19th birthday so narrowed focus age was kept at 12 to 18. After conducting a comprehensive analysis of the CHP+ member population and providers in an expanded and updated data set, Colorado Access concluded there was still no single provider or definable geographic area that met the sample size requirements while also indicating a need for improvement for both rates. Out of the 7,650 Well Visits for CHP+ members 12 to 18, only 1,040 were screened for depression; out of the 1,040 depression screens in Rate 1 (positive or negative depression screen in Well Visit) numerator, only 155 were positive and made it into the Rate 2 (positive depression screen in Well Visit) denominator. However, implementing a region wide PIP will not produce meaningful outcomes with current resources, as there are 267 different billing vendors providing Well

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Visits and 35 different billing vendors associated with the 155 positive depression screens; a CHP+-wide PIP would have significant limitations for effectiveness and measuring capabilities needed for a PIP.

Colorado Access chose two practices with large sample sizes and subsequent opportunities for improvement; Peak Vista Community Health Centers had the second largest Rate 1 denominator (443) and largest Rate 2 denominator (52), and Every Child Pediatrics had the third largest Rate 1 denominator (417). Only 3 of Every Child Pediatrics depression screens were positive and resulted in records in the Rate 2 denominator. Peak Vista Community Health Centers and Every Child Pediatrics were determined to be practices that best fit these parameters after analysis.

These practices differ in performance but were chosen to be combined into one PIP because individually, statistically significant SMART Aims couldn't be set due to small sample size. Additionally, collaborative learning opportunities exist between those two practices because one practice is performing better on depression screening [Every Child Pediatrics 7.91% (33/417) versus Peak Vista Community Health Centers 63.21% (280/443)]. Colorado Access recognizes and plans to capitalize on the opportunity for sharing best practices for both Depression Screening and Follow-Up After Positive Depression Screening between the two providers as part of Module 2.

[1]U.S. Preventive Services Task Force. (2016). Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine* 164:360–6.

[2]U.S. Preventive Services Task Force. (2016). Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement. *Journal of the American Medical Association* 315(4):380–7.

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[3]Katon, W. J., Lin, E., & Russo, J. (2003). Increased medical costs of a population-based sample of depressed elderly patients. *Arch Gen Psychiatry, 60* (9), 897-903. doi:10.1001/archpsyc.60.9.897

[4]Strohle, A. (2009). Physical activity, exercise, depression and anxiety disorders. *Journal of Neural Transmission, 116,* 777-784. DOI 10.1007/s00702-008-0092-x

[5]Zhang, Z. & Chen, W. (2019). A systematic review of the relationship between physical activity and happiness. *Journal of Happiness Studies, 20,* 1305-1322. https://doi.org/10.1007/s10902-018-9976-0

[6]Colorado Department of Human Services Office of Behavioral Health. (2020). *2020 Statewide Behavioral Health Needs Assessment State of the State.* https://drive.google.com/file/d/1R75FNfW8srXlz9GnF5hTr0_q2iDmCBxG/view

[7]Hoare, E., Milton, K., Foster, C., & Allender, S. (2016). The associations between sedentary behavior and mental health among adolescents: a systematic review. *International Journal of Behavioral Nutrition and Physical Activity, 13,* 108-130. DOI 10.1186/s12966-016-0432-4

[8]Agency for Healthcare Research and Quality. (n.d.). *What is integrated behavioral health?* The Academy Integrating Behavioral Health & Primary Care. https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

[9]Kaliebe, K. E. (2016). The future of psychiatric collaboration in federally qualified health centers. *Psychiatric Services, 67*(8), 827-829. https://doi.org/10.1176/appi.ps.201500419

[10]Colorado Department of Human Services Office of Behavioral Health. (2020). *2020 Statewide Behavioral Health Needs Assessment Priority Populations Experiencing Disparities in Behavioral Healthcare.* https://drive.google.com/file/d/1c7KRvR19bcAPlEidmI1ynxWBs2m-U7b6/view

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Narrowed Focus Baseline Measurement – *Depression Screening*

Instructions:

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

Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Numerator Description	All Well Visits in denominator where a depression screen also occurred.
Denominator Description	All Well Visits between November 1, 2019 and October 31, 2020 occurring at all Peak Vista (Tax ID 840617567) and Every Child Pediatrics (Tax ID 841321485) locations for Colorado Access CHP+ members aged 12 to 18. In the event a member has more than one Well Visit during measurement period, each visit will be counted; both paid and denied Well Visits are included.
Age Criteria (if applicable)	12 to 18, as calculated by the difference of client date of birth and claim first service date
Continuous Enrollment Specifications (if applicable)	30 days; 30 days are added to the "claims first service date" for denominators and numerators and this calculated date must be between the member enrollment effective date and member enrollment end date.
Allowable Gap in Enrollment (if applicable)	N/A

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Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Anchor Date (if applicable)	N/A
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Well Visit between November 1, 2019 and October 31, 2020.

Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 11/01/2019	End Date: 10/31/2020
Numerator: 313	Denominator: 860	Percentage: 36.40%

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

Table 3c—Narrowed Focus Baseline Data Collection Methodology – *Depression Screening*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:

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Describe the step-by-step data collection process and data elements collected: The Colorado Access Business Intelligence (BI) Developer wrote a data extraction code to pull claims from Colorado Access's internal claims database (QNXT) and Truven. The data extraction code reflects the baseline measurement period from November 1, 2019 through October 31, 2020; claims were joined based on a match for claim number and Medicaid ID. The "claims first service date" field, which corresponds to date of service, was used to account for all claims during measurement period. For claims that have been adjudicated multiple times, claims were also filtered so that only the most recent adjudication was included in the dataset. Claim paid status was ignored; both paid and denied claims were included. The original data pull also excluded members that were younger than 1 years old. For the approximate 70 attributes included in the data set from the two database sources, three tables were used to source the data: enrollment tables, provider tables, and claim tables. Matching logic for Medicaid ID and Regional Accountable Entities (RAE) location indicator, which includes CHP+, were applied during all table joins. Depending on database source, different attributes were sourced from different tables.

Colorado Access's BI Developer added 10 additional columns to the dataset that corresponded to specific data elements and aided in understanding and properly analyze the output.

- A client age column was added and is calculated by the difference of client date of birth and claim first service date.
- A Monthly Count (MC) column was added. This column corresponds to count of enrolled months in RAE monthly Accountable Care Collaborative (ACC) Snapshot data where a specific enrollment source code is not blank. This column helps ensure the continuous enrollment criteria is being applied correctly.
- A Database (DB) Source column was added to indicate which database source the claim entry is being pulled from.
- "isNum" and "isDenom" columns were added to indicate if entries met conditions for numerator and denominator; 1 indicated condition was met and 0 indicated condition was not met. These codes corresponded to an additional "Condition Type" created column, which provided the description of entry (i.e. Rate 1 Denominator, Rate 1 Numerator).
- An "IsDH" column was added to identify if record belonged to a Denver Health member; 1 indicates records is for Denver Health and 0 indicates record is not Denver Health.
- An "isExclusion" column was added to indicate any records that should not be included in dataset (i.e. members 1 or younger) in case code didn't calculate exclusions correctly. An "ExclusionType" column was added to provide description of exclusion if "isExclusion" is 1.

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- An "InsertDate" column was added to indicate the date the data process was run. This will be more useful during measurement period when we are receiving refreshes monthly to align with the 12-month rolling methodology.

Note: Every denominator and numerator record have their own entry due to the possibility of claim numbers and billing providers being different for denominator claims and numerator claim because of differences in institutional versus professional claims. As such, numerator claims look at Denominator Date and match on Medicaid ID and RAE number to determine if depression screen has occurred for corresponding Well Visit.

Truven Database Collection

22 elements sourced from Enrollment tables:

- Medicaid ID, ACC Enrollment Indicator, RAE Number, Member Snapshot Date, Client Eligibility End Date, Enrollment Effective Date, and Enrollment End Date
- Client Home City, Client Home State, Client Home County Name, and Client Home Zip Code
- Primary Care Medical Providers (PCMP) Business Provider Name (Attributed Provider), PCMP MC Provider ID, and Member Snapshot Provider Name (Clinic Level Detail for Attributed Provider)
- Race Description, Gender Code, Client Date of Birth, Disabled Eligibility Type Indicator, Special Needs Indicator, and Pregnancy Indicator

7 elements sourced from Provider tables:

- PCMP Tax ID, Intake Provider Name (matched on Attending Provider Location ID from Claims tables), Billing Vendor Tax ID (matched on Billing Provider Location ID from Claims tables), Billing Medicaid ID (matched on Billing Provider Location ID from Claims tables), Billing Provider National Provider Identifier (NPI) (matched on Billing Provider Location ID from Claims tables), Intake Provider Type (matched on Attending Provider Location ID from Claims tables), Intake Provider Description (matched on Attending Provider Location ID from Claims tables)

42 elements sourced from Claims tables:

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- Denominator Claim ID, Numerator Claim ID, Denominator Claim Line Number, Numerator Claim Line Number, and Denominator Date (Claim First Service Date when record is a Denominator)
- The following attributes to correspond to appropriate numerator or denominator record:
  - Claims First Service Date, Claim Status Code, Claim Line Status Code, Most Recent Claim Indicator, Revenue Code, Paid Amount, Admission Date, Discharge Date, Bill Type Code, Place of Service Code, Claim Type, Claim Status, Claim Line Status, Service Category, Service Code Description, Current Record Indicator
  - Health Program Code, Aid Code, Aid Description
  - Procedure Code, Procedure Code Description, Diagnosis 1-4 Codes, and Diagnosis 1-4 Descriptions
  - Billing Provider Location ID, Billing Provider Location Name, Rendering Provider Location ID, Rendering Provider Location Name, Rendering Provider Type Code, Rendering Provider Type Description, Billing Vendor, Billing Provider Type

QNXT Database Collection

52 elements sourced from Claims tables:

- Denominator Claim ID, Numerator Claim ID, Denominator Claim Line Number, Numerator Claim Line Number, and Denominator Date (Claim First Service Date when record is a Denominator)
- Procedure Code, Procedure Code Description, Diagnosis 1-4 Codes, and Diagnosis 1-4 Descriptions
- Billing Provider Location ID, Billing Provider Location Name, Billing Vendor, Billing Vendor Tax ID, Billing Provider Medicaid ID, Billing Provider NPI, Billing Provider Type, Rendering Provider Location ID, Rendering Provider Location Name, Rendering Provider Type Code, Rendering Provider Type Description, Intake Provider Name
- RAE Number, Medicaid ID, Client Home City, Client Home State, Client Home County Name, Client Home Zip Code, Race Description, Gender Code, and Client Date of Birth
- Claims First Service Date, Claim Status Code, Claim Line Status Code, Most Recent Claim Indicator, Revenue Code, Paid Amount, Admission Date, Discharge Date, Bill Type Code, Place of Service Code, Claim Type, Claim Status, Claim Line Status, Service Category, Current Record Indicator, and Aid Code

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4 elements sourced from Enrollment tables

- Member Snapshot Provider Name (Clinic Level Detail for Attributed Provider)
- Client Eligibility Date End, Enrollment Effective Date, and Enrollment End Date

3 elements sourced from Provider tables:

- PCMP MC Provider ID, PCMP MC Business Provider Name (Attributed Provider), PCMP Tax ID

There were 8 elements that were not available in QNXT data source:

- Snapshot Date, ACC Enrollment Indicator, Health Program Code, MC Count, Service Code Description, Disabled Eligibility Type Indicator, Special Needs Indicator, and Pregnancy Indicator.

For QNXT Aid Description was matched on Aid Code; Aid Description was then imported from corresponding Truven Enrollment table

Denominator Specifications

The Well Visits in the denominator follow KPI Well Visit Specification[1], as found in the KPI Code Value Sets[2]. Both paid and denied Well Visits are included. Qualifying denominator visits are identified as "1" in the "IsDenom" field. There are three ways that a Well Visit can occur:

1. CPT code in Well Visits Value Set: 99381-99387; 99391-99397
   OR
2. HCPCS in Well Visit Value Set: G0402; G0438; G0439
   OR
3. CPT Code in Office Visit Value Set: 99202-99205; 99213-99215
   AND
   ICD 10 Code in Well Visits Value Set: Z0000; Z0001; Z00110; Z00111; Z00121; Z00129; Z005; Z0070; Z0071; Z008; Z01411; Z01419; Z020-Z026; Z0281-Z0283; Z0289

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Numerator Specifications

All visits included in the denominator were evaluated for presence of the depression screening codes G8431 (positive depression screen) and G8510 (negative depression screen). If Well Visits had either depression screening code, they were included as numerators, indicated by a "1" in the "IsNum" field; Well Visits who did not have these codes present did not meet numerator qualification and were identified as "0" in the "IsNum" field.

Narrowed Focus Depression Screening Baseline Data Calculation

After full dataset was collected, dashboards and visualizations were created for analyzing and determining the appropriate Narrowed Focus. Once Narrowed Focus was identified, the following filters were applied for to calculate the CHP+ Narrowed Focus Baseline:

- RAE filter for CHP+
- Client age filter for members aged 12 to 18
- Billing Vendor Tax ID filter for 841321485 and 840617567. These Tax ID's correspond to Every Child Pediatrics and Peak Vista, respectively.
  - Tax ID was used as opposed to Billing Vendor due to differences in naming conventions in the two different data sources used.
- Sum of "IsNum" and "IsDenom" were calculated with above filters to give the numerator and denominator. The numerator was then divided by the denominator to calculate the Depression Screening Baseline Rate.

[1]Nyberg, N. (2020). *Regional Accountable Entity: The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology SFY 2020-2021, V11*. Colorado Department of Health Care Policy & Financing.

[2]Colorado Department of Health Care Policy & Financing. (n.d.). *ACC_KPI_Code_Value_Sets_V9.1*.

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

Instructions:

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

Table 4a—Narrowed Focus Baseline Specifications – *Follow–up After a Positive Depression Screen*	
Numerator Description	All visits that meet behavioral health follow-up specifications within 30 days of denominator. In the event there is more than one qualifying numerator visit for each denominator, the visit that occurs first will be the only one that counts toward the numerator; all other qualifying visits will be coded as events. The numerator visit is not restricted to a specific billing vendor.
Denominator Description	Claims present in Depression Screening Numerator for members who screened positive, as indicated by G8431, during Well Visit with billing vendors Peak Vista (Tax ID 840617567) and Every Child Pediatrics (Tax ID 841321485) during measurement period.
Age Criteria (if applicable)	12 to 18 at time of positive depression screen, as calculated by the difference of client date of birth and denominator claim date

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–up After a Positive Depression Screen*	
Continuous Enrollment Specifications (if applicable)	30 days; 30 days are added to the "claims first service date" for denominators and numerators and this calculated date must be between the member enrollment effective date and member enrollment end date.
Allowable Gap in Enrollment (if applicable)	N/A
Anchor Date (if applicable)	N/A
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	All Follow-Up After a Positive Depression Screen Denominator values must be present in Depression Screening Numerator to qualify. Additionally, the claim date of denominator is used as starting date for Follow-up After a Positive Depression Screen Numerator; all follow-up must occur within 30 days of denominator date. The Positive Depression Screen must occur by 10/31/2020. However, the Follow-Up Numerator baseline measurement period is extended 30 days to 11/30/2020 to allow for full 30 days for Follow-Up to occur.

Table 4b—Narrowed Focus Baseline Data – *Follow–up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 11/01/2019	End Date: 11/30/2020
Numerator: 35	Denominator: 55	Percentage: 63.64%

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

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: The same data sources and tables were used to source all the 71 attributes in Follow-Up After a Positive Depression Screen dataset as were in Depression Screening dataset. The positive numerator records, as defined by procedure code G8431, from the Depression Screen dataset, were used as Follow-Up After a Positive Depression Screen denominators; these records were all changed to be denominator values and Denominator Date was set as the Claims First Service Date. BI then created a new code to search for all claims that met numerator specifications with a match on MedicaidID and RAE Number. In addition to the 10 columns the BI Developer created for the Depression Screening dataset, three additional columns were created: Follow-Up Date, Follow-Up Calculated Age, and IsEvent. • **Follow-Up Date:** This column corresponds to the Claims First Service Date for all claims that meet numerator specifications. • **Follow-Up Calculated Age:** This column is calculated from taking the difference between Denominator Date and Follow-Up Date. • **IsEvent:** This column uses the same coding convention as "IsNum" and "IsDenom"; 1 indicates record is an event and 0 indicates record is not an event. Mutual exclusion logic is applied where numerator and denominator records cannot be coded		

as events. Events are either follow-up records that occur >30 days or follow-up records within 30 days when an equivalent follow-up record exists with the shorter "Follow-Up Calculated Age."

Some data elements were updated to reflect the Follow-up After a Positive Depression Screen. All changes are outlined below:

- In this data set, each denominator and numerator record are combined into one record to allow for accurate follow-up calculation filtered on the Denominator (positive depression screen) Tax ID. All data attributes from denominator records were preceded with "Screening" and all numerator data attributes were preceded with "Follow-Up." For example, in a record where a follow-up visit occurred, the follow-up rate is based on "Screening Tax ID" but data would also be present in the "Follow-Up Tax ID", which indicates where the follow-up visit occurred; a "1" would be present in both the "IsDenom" and "IsNum" columns, indicating that for this positive depression screen, a qualifying follow-up visit occurred within 30 days. Due to follow-up not being restricted to any billing provider, the data attributes preceded with "Follow-Up" will not all occur at the narrowed focus providers.
- The query for numerator claims is set to pull claims that match follow-up specifications that are within 120 days from denominator date. However, the only records that can be counted toward the numerator are those that occurred within 30 days of the denominator event. All records with a calculated age of >30 days were coded as "0" for "IsNum", "1" for "IsEvent", and with the "Condition Type" of "Greater than 30 days".
    - There can only be 1 numerator record per denominator record. If a member had multiple follow-up claims for a corresponding positive depression screen within 30 days, the only record coded as "1" for "IsNum" was the record with shortest Follow-Up Calculated Age. All other records were coded as "0" for both numerator and denominator and instead, calculated as "1" for "IsEvent." These records were also given the "Condition Type" on why they met follow-up specifications: "Outpatient visit with PCMP", "Follow-Up Assessment (CPT)", "Follow-Up Assessment (CPT/HCPCS)", or "Follow-Up Assessment UB Revenue Code 0900/0529 with CPT/HCPCS". This decision was made strategically for analyzing the data to determine narrowed focus, as well as the value it can bring in future PIP Modules. The ability to drill down and look at follow-up by condition type and billing vendor may be useful in both process mapping and intervention determination.
    - Colorado Access made the decision to include in the query follow-up visits that met numerator specifications >30 days strategically with a long-term focus approach. These records may be indicative of where potential interventions lay for future modules when evaluating referral workstreams for Every Child Pediatrics and Peak Vista.

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Denominator Specifications

All Follow-Up After a Positive Depression Screen denominator records were taken from Rate 1 Depression Screening numerator records with a G8431.

Numerator Specifications

Following Technical Assistance calls and meetings with the Department, Colorado Access made the decision to expand the numerator specifications. Seven additional codes were added to this value set, based on discussions with Peak Vista and Every Child Pediatrics on how they are currently coding the follow-up, information from Colorado Access' Practice Support, and internal reporting data analyses. Codes that were added include: H0004; H0023; H0025; H0031; H2011; H2027; and T1017. These 7 codes were added to each of the existing 4 options outlined in the BHIP to APM Depression Measure Specifications for a qualifying follow-up visit; BHIP to APM Depression Measure Specifications document referenced is document provided to Colorado Access on 9/17/20 from HSAG. Additionally, it was determined that the options with provider type specifications needed to be extracted from the Rendering and Intake Provider Type fields, not Billing; provider types are only considered for Truven claims. These options are outlined below:

1. Outpatient visit with PCMP as indicated by procedure codes 90791, 90832, 90834, 90837, 90846, 90847, H0004 H0023, H0025, H0031, H2011, H2027, or T1017

OR

2. Claims with 90791, 90792, 90832, 90834, 90837, 90846, 90847, H0004 H0023, H0025, H0031, H2011, H2027, or T1017 CPT codes and if claim is from Truven database, with Rendering or Intake Provider Type codes of 35, 37, 38, 41, 25, 26, 05, or 39

OR

3. Claims with the following CPT or HCPC codes H0002, 90833, 90836, 90838, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255, H0004 H0023, H0025, H0031, H2011, H2027, or T1017 and if claim is from Truven database, with Rendering or Intake Provider Type codes of 37, 35, 38, or 25

OR

4. Claims with UB Revenue Codes of 0529 or 0900 and the following CPT or HCPC codes H0002, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-

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99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255, H0004 H0023, H0025, H0031, H2011, H2027, or T1017 and if claim is from Truven database, with Rendering or Intake Provider Types of 32 or 45

Narrowed Focus Follow-up After a Positive Depression Screen Baseline Data Calculation

After full dataset was collected and compiled, dashboards and visualizations were created for analyzing and determining the appropriate Narrowed Focus. Once Narrowed Focus was identified, the following filters were applied for to calculate the CHP+ Narrowed Focus Baseline:

- RAE filter for CHP+
- Client age filter for members aged 12 to 18
- Screening Billing Vendor Tax ID filter on denominator records for 841321485 and 840617567. These Tax ID's corresponded to Every Child Pediatrics and Peak Vista, respectively.
  - Tax ID was used as opposed to Billing Vendor due to differences in naming conventions in the two different data sources used.
- Rates were then calculated in the following manner after filters applied:
  - Sum of IsDenom was used as denominator value
  - Sum of IsNum was used as numerator value
  - Rate was calculated by dividing numerator value by denominator value
    - This ensured that all follow-up visits determined to be a numerator counted, regardless of where they took place, with an associated Every Child Pediatrics or Peak Vista denominator record

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

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

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

Depression Screening:

By June 30, 2022, use key driver diagram interventions to *increase* the percentage of depression screens in Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.40% to 41.16%.

Colorado Access used the *HSAG Quick Start Guide for Statistical Testing* and provided website (https://www.graphpad.com/quickcalcs/contingency1.cfm) to calculate SMART Aim.

Follow-Up After a Positive Depression Screen:

By June 30, 2022, use key driver diagram interventions to *increase* the percentage of Follow-up After a Positive Depression Screen visits completed among members aged 12 to 18 within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers from 63.64% to 83.64%.

Colorado Access used the *HSAG Quick Start Guide for Statistical Testing* and provided website (https://www.graphpad.com/quickcalcs/contingency1.cfm) to calculate SMART Aim.

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

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Key Driver Diagrams

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

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

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Key Driver Diagram– *Depression Screening*

Global Aim

Improve depression screening in Well Visits to improve member health and align with the Department's 2020 Quality Strategy.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in outpatient primary care Well Visits among members aged 12 to 18 who receive care at Every Child Pediatrics and Peak Vista Community Health Centers, from 36.40% to 41.16%.

Date: 3/10/21
Version: 2

Key Drivers	Interventions
Standards of care: consistency at clinic and provider level on coding.	Standardization of depression screening scoring as positive or negative based on industry analysis of best practice.[1] Do analysis at provider and clinic levels to identify and analyze differences
Members are screened for depression at Well Visits and have at least one Well Visit annually	Standardize processes and targeted clinic and provider education. Promote telehealth Well Visit options and initiate member outreach campaign on telehealth options, safety protocols from COVID-19 and importance of Well Visits.
Members are educated about treatment options and engaged	Understand and identify outreach barriers and assist in improving member contact information for sequential/automatic Well Visit scheduling and reminder protocols.[2]
Clinic offers scheduling flexibility and hours and provides appropriate social determinants of health resources.	Engage members to learn about common clinical and non-clinical barriers, and develop educational materials to address them (i.e. transportation needs in rural area)[3]

[1]Mulvaney-Day, N., Marshall, T., Piscopo, K. D., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for behavioral health conditions in primary care settings: A systematic review of the literature. *Journal of General Internal Medicine, 33*(3), 335-346. doi: 10.1007/s11606-017-4181-0
[2]Regents of the University of Michigan. (2017). Adolescent Well-Child Exams. *Adolescent Health Initiative.* https://www.umhs-adolescenthealth.org/wp-content/uploads/2018/07/adolescent-well-child-exam-starter-guide.pdf
[3]CipherHealth. (2020). *Taking a deep dive into closing HEDIS gaps: Adolescent well-care visits (W15, W34, AWC).* https://cipherhealth.com/blog/taking-a-deep-dive-into-closing-hedis-gaps-adolescent-well-care-visits-w15-w34-awc/

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

Global Aim

Improve Follow-up After a Positive Depression Screen to improve member health outcomes and align with the Department's 2020 Quality Strategy.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits among members aged 12 to 18 completed within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Peak Vista Community Health Centers, from 63.64% to 83.64%.

Date: 3/16/21
Version: 3

Key Drivers

- Standards of care: efficient referral processes between Every Child Pediatrics, Peak Vista, and internal and external behavioral health providers.
- Standards of care: provider education, follow-up coding, and training.
- Internal and external provider availability with scheduling flexibility to provide follow-up visits.
- Member access, knowledge, and engagement.

Interventions

- Analysis at clinic and provider level to identify external partners for opportunities of improvement→ targeted education and intervention after process standardization.
- Analysis of internal tracking processes, workflows, and outreach protocols → efficiency improvements and standardize protocols that utilize automation when possible.
- Analyze records for follow-up that occurred > 30 days after positive screen and develop targeted interventions to reduce follow-up time.
- Leverage COA Secret Shopper program for additional insight and determine if problematic referral patterns with external BH partners exist.
- Gap analysis on current coding practices, encounter rate specs, PIP specs, and literature review. Develop educational materials on best practices as toolkit for providers. [1, 2]
- Expand Colorado Access' free Virtual Care Collaboration and Integration (VCCI) program to all integrated clinics to expand telehealth follow-up options by PCMP's.
- Educate members about BH benefit free costs and importance of follow-up. Safety protocols in place for COVID-19
- Literature review to understand follow-up barriers.[3] Engage members to learn about common clinical and non-clinical barriers and develop educational materials to address these barriers → Develop member facing resource for Behavioral Health FAQ and referral. communitv. and rural resources.

[1]Pickens, E., Wright, J., Bristol, T., Seashore, C., Perry, M., Nazworth, A., & Reed, R. (2019). *Adolescent depression screening and initial treatment toolkit for primary care clinicians*. https://www.med.unc.edu/ihqi/files/2019/03/Adolescent-Depression-Screening-and-Initial-Treatment-Toolkit.pdf
[2]AmeriHealth Caritas District of Columbia. (2014). *Depression toolkit for primary care clinicians: The patient health questionnaire (PHQ-9) adolescent toolkit*. https://www.amerihealthcaritasdc.com/pdf/provider/resources/clinical/depression-toolkit-adolescents.pdf
[3]Szymanski, B. R., Bohnert, K. M., Zivin, K., & McCarthy, J. F. (2013). Integrated care: Treatment initiation following positive depression screens.

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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

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

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

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

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

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

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

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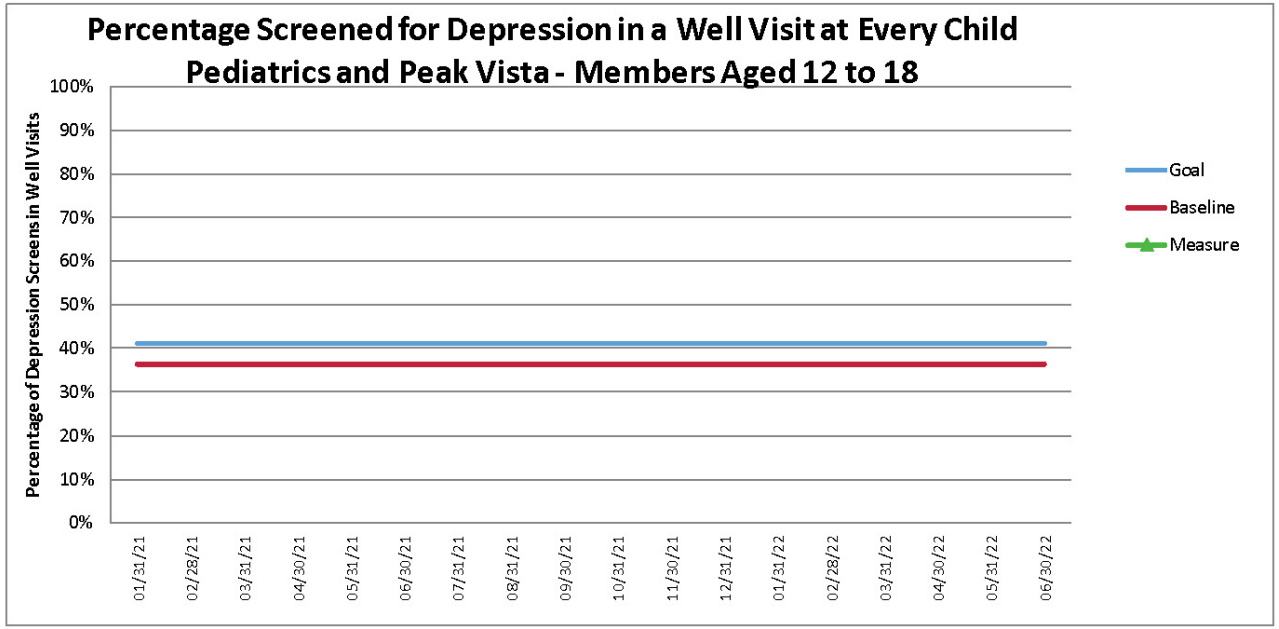
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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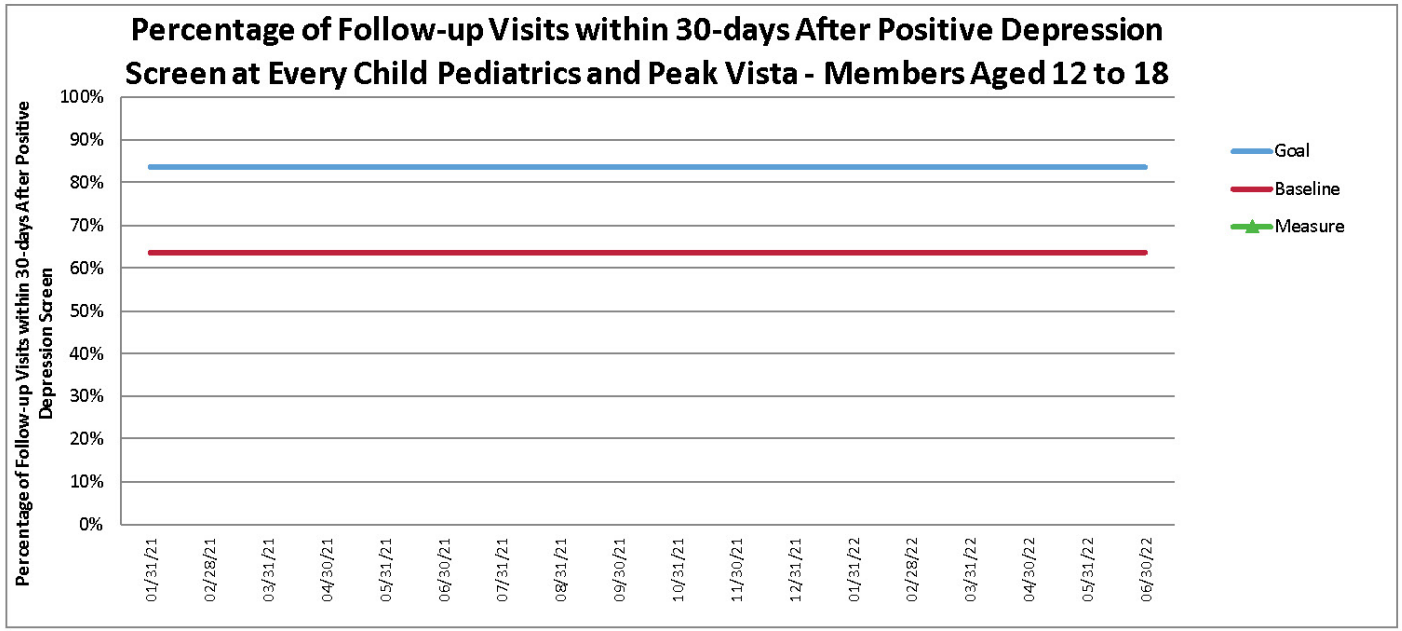
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen*.	☒ Met ☐ Not Met	**General Comment:** The health plan provided baseline data and a rationale for the selected narrowed focus. In the narrative rationale, the health plan explained that the number of positive depression screens region-wide was very low and spread across many providers (121 positive screens spread across 27 billing vendors). The health plan also discussed challenges to data access and identifying a large enough narrowed focus group during the 11/24/20 technical assistance (TA) call with HSAG prior to submitting Module 1. HSAG provided detailed guidance on the narrowed focus during the TA call. While the health plan's rationale for the narrowed focus is reasonable, the baseline denominator size reported for the *Follow-Up* measure (31) is low for a rapid-cycle PIP and may be problematic for rapid-cycle intervention testing. The health plan should explore all available options to broaden the narrowed focus by either adding another provider group(s) or widening the age range for the narrowed focus. If no other viable options exist to expand the narrowed focus, the health plan may proceed with the proposed narrowed focus but should be aware of potential intervention testing challenges. **Re-review March 2021:** In the resubmission, the health plan addressed HSAG's initial General Comment by including further rationale for the selected narrowed focus. In addition, after revising the narrowed focus baseline measure specifications in response to HSAG's feedback in Criterion 2, the baseline denominator size for the *Follow-up* measure has increased from 31 to 55. The criterion remains *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process d) Narrowed focus baseline data that considered claims completeness	☒ Met ☐ Not Met	HSAG has identified the following opportunities for improvement: ***Depression Screening*:** • The health plan should simplify the numerator and denominator descriptions to provide a clear, concise description of who/what will be counted. Description of how claims data are used, and specific code lists, can be provided in the data collection narrative, if needed. • The denominator description should specify the narrowed focus providers. • The health plan appeared to define the denominator based on well visits while the numerator was based on members. The numerator and denominator should use the same units of measure. Per the Department-defined measure specifications, both numerator and denominator descriptions should be a count of members, not a count of visits. • In the event a member has more than one well-visit during the measurement period, it was unclear how multiple well visits during the measurement period were handled. The narrative references to *claim first service date* and *most recent claim* were unclear and appeared inconsistent. Defining numerator and denominator based on members would address this issue. • The health plan should document the well visit as the denominator qualifying event. ***Follow-Up After a Positive Depression Screen measure*:** • The health plan should simplify the numerator and denominator descriptions to provide a clear, concise description of who/what will be counted. How claims data are used, and specific code lists can be provided in the data collection narrative, if needed.

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Criteria	Score	HSAG Feedback and Recommendations
		• The denominator description should specify the narrowed focused providers. • The health plan should remove "N/A" from the continuous enrollment specifications and document the enrollment requirements specific to the measure. The 30-day continuous enrollment requirement should be applied to allow 30 days of enrollment for the follow-up visit to occur. • The denominator qualifying event/diagnosis description needs clarification. Per the Department-defined incentive measure specifications, obtaining a positive depression screen is the denominator qualifying event. In addition, the health plan should clarify whether the well visit must occur 30 or more days before the end of the baseline measurement period to allow time for the follow-up service to occur within the measurement period. This requirement is in alignment with the Department's intent for the incentive measure specifications. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
3. The SMART Aims for *Depression Screening* and *Follow–Up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage e) End date	☒ Met ☐ Not Met	HSAG has identified the following opportunities for improvement in the *Follow-Up* SMART Aim: • The health plan should revise the Follow-up SMART Aim to more clearly specify the time frame for the follow-up service to occur (e.g., within 30 days of the positive depression screen). **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–Up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening key driver diagram (KDD)***: • It was unclear how the key driver, *Members receive Well Visits annually*, would support achieving the SMART Aim goal. This driver appeared to be related to the denominator (number of members receiving well visits) rather than the numerator. The health plan should consider removing this driver and related interventions. The KDD should be focused specifically on drivers and interventions that are expected to lead to an *increase in depression screening* during well–visits for the narrowed focus members.

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Criteria	Score	HSAG Feedback and Recommendations
Aim goal in each key driver diagram.		• Literature review and analyses are typically not considered interventions. The interventions should include process changes that the health plan may eventually test through PDSA cycles to achieve the goal for the PIP. ***Follow-Up for a Positive Depression Screen KDD***: • The health plan should define the acronym VCCI. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
Additional Recommendations: None.		

PIP Initiation (Module 1)

☒ Pass

Date: March 19, 2021