Colorado Children's Health Insurance Program

Fiscal Year 2021–2022 PIP Validation Report

for

Colorado Access

April 2022

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 Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc., (HSAG) serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)— the agency responsible for the overall administration and monitoring of Colorado's Medicaid 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 §457.1520, 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**, referred to in this report as **COA**, an MCO, holds a contract with the State of Colorado for provision of medical and behavioral health (BH) services for the Department's CHP+ managed care program.

For fiscal year (FY) 2021–2022, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

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

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services

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

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-2] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous QI. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. CMS agreed that given the pace of QI science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed and provided HSAG with approval to use this approach in all requesting states.

PIP Components and Process

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

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

PIP Terms

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

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

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

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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 23, 2022.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 23, 2022.

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

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **COA**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **COA**'s PIP and the activities completed in Module 2 and Module 3. (See Appendix A. Module Submission Forms.) Following HSAG's rapid-cycle PIP process, the health plan submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2021–2022, 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 Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in well visits among members ages 12 to 18 years who receive care at Every Child Pediatrics and Peak Vista Community Health Centers from 36.36% to 41.14%.*
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 ages 12 to 18 years within 30 days of positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Peak Vista Community Health Centers from 73.58% to 90.57%.*

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

The focus of the PIP is to increase the percentage of members 12 years of age and older who receive a depression screening during a well visit at Every Child Pediatrics or Peak Vista Community Health Centers and to increase the percentage of those members who receive BH services within 30 days of screening positive for depression. In April 2021, COA communicated to HSAG the need to revise the initial SMART Aim statements to correct the baseline percentages and establish new goals, as a result of baseline data collection issues that were identified and resolved. After a technical assistance discussion and receiving a written rationale from the health plan, HSAG approved COA to revise the data collection methodology and SMART Aims. COA submitted an updated Module 1 submission form with

revised documentation to HSAG on June 18, 2021. HSAG reviewed the revised data and confirmed that the goals to increase depression screening to 41.14 percent and to increase follow-up within 30 days after a positive depression screen to 90.57 percent represent statistically significant improvement over the revised baseline percentages.

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

Table 1-2—PIP Topic and Module Status

PIP Topic	Module	Status
Depression Screening and Follow-Up After a Positive Depression Screen	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

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

Validation Findings

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

Module 2: Intervention Determination

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

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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Depression Screening	• Medical assistant (MA) forgets to tell provider of elevated score during handoff • Handoff does not occur • Members who may be depressed are not being evaluated by a standardized instrument • MA's manual process could be impacted by daily clinic operations (resources, memory) and does not account for other administrative errors in chart • MA does not correctly identify need	• Standards of care: consistency at clinic and provider level on coding • Financial stability and billing accuracy • Members are screened for depression at well and sick visits and have at least one well visit annually • Members are educated about treatment options and engaged • Clinic offers scheduling flexibility and hours and provides appropriate social	• Standardization of depression screening scoring • Standardize sick visit screening protocols • Standardize processes and targeted clinic and provider education • Electronic health record (EHR) optimization and support for ordering and coding • Promote telehealth well visit options through member outreach campaign • Identify outreach barriers and assist in improving member

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
	• Physician does not receive information needed for order entry	determinants of health resources	contact information for sequential/automatic well visit scheduling and reminder protocols • Develop educational materials to address member barriers to depression screening access
Follow-Up After a Positive Depression Screen	• Providers unaware of appropriate specification codes for the follow-up visit • Follow-up visit is occurring but not within 30 days • Individual with identified BH needs is not reached or seen by a provider • Providers not aware of appropriate billing codes they could use that meet specifications • Follow-up visit is occurring but not within 30 days • Individual with identified BH needs is not reached or seen by a provider	• Standards of care: efficient referral processes between primary care provider partners and BH providers • Standards of care: provider education and training • Flexible and available BH follow-up appointments • Financial stability and billing accuracy • Member access, knowledge, and engagement	• Targeted provider education • Improved efficiency of clinical tracking processes, workflows, and outreach protocols through automation • Coding best practices toolkit for providers • Expansion of COA's Virtual Care Collaboration and Integration (VCCI) Program to all integrated clinics to increase access to telehealth follow-up services • Member education on BH benefits and importance of follow-up care • Member resource reference for understanding available BH, referral, community, and rural resources

In Module 2, **COA** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **COA** identified to improve depression screening focused on improving clinic workflows and processes, increasing telehealth service options, and member outreach and education. The potential interventions **COA** identified to improve follow-up services focused on provider education, improving clinical workflows and processes, expansion of telehealth services, and member education.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **COA** developed the intervention *Plan* component of the PDSA cycle. In addition to validating the intervention plan submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to

provide support and technical assistance, if needed, as **COA** carried out PDSA cycles to evaluate intervention effectiveness. In FY 2021–2022, **COA** submitted testing plans for four interventions. Table 2-2 presents the FY 2021–2022 Module 3 validation findings for **COA**'s four interventions.

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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Every Child Pediatrics depression screening coding change	• Incorrect coding for depression screening services by provider • EHR errors	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Financial stability and billing accuracy	• Percentage of well-visit claims with a corresponding depression screening Current Procedural Terminology (CPT) code (G8510 or G8431)
Peak Vista EHR optimization and coding changes: standardize depression screen scoring (positive and negative), adapt EHR to support ordering and coding of depression screening and follow-up services, provider education and best practices toolkit for depression screening and follow-up services and workflows	• Missed depressive symptoms • Lack of standardized depression screening instrument • Lack of provider awareness of appropriate codes • Providers unaware of unmet needs • EHR errors	• Standards of care: consistency at clinic and provider level on coding, provider education, and training • Standards of care: provider education, follow-up coding, and training • Financial stability and billing accuracy	• Percentage of members documented as "Watchful waiting; reassess at next visit" with a corresponding G8510 CPT code • Percentage of members documented as "Patients without a follow-up" with a corresponding G8510 CPT code • Percentage of members not documented as "PHQ-9[1] Declined," or ""Medically Excluded from PHQ-9" with a corresponding depression screening code (G8510 or G8431) • Percentage of members documented as "PHQ-9 Declined" • Percentage of members documented as "Medically Excluded from PHQ-9" • Percentage of claims with a depression screening result code (G8510 or G8431) that were coded G8510

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of EHR to support for protocol and coding standardization, using automation where possible	• Providers not aware of appropriate specification codes for the follow-up visit	• Financial stability and billing accuracy • Standards of care: provider education, follow-up coding, and training.	• Percentage of well visits with a positive depression screening result, indicated by code G8431, with a follow-up service within 30 days, indicated by code H0002
A two-pronged approach to expanding behavioral health (BH) services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the Virtual Care Collaboration and Integration (VCCI) program for follow-up BH services via telehealth	• Follow-up visit is not occurring within 30 days of positive screen • Member is not reached for follow-up BH services • BH needs are not communicated to BH provider	• Standards of care: efficient referral processes • Internal and external BH provider availability • Financial stability and billing accuracy • Member access, knowledge, and engagement	• Percentage of available hiring and retention bonuses received by future and/or current BH staff (multiple measures) • Percentage of consults and therapy/assessments conducted via telehealth through the VCCI program (multiple measures)

[1]PHQ = Patient Health Questionnaire

In Module 3, **COA** selected four interventions to test for the PIP. The detailed intervention testing plans **COA** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process failures in clinic workflows, coding practices, and BH provider availability. For each intervention, **COA** defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **COA** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

3. Conclusions and Recommendations

Conclusions

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

Recommendations

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

Appendix A. Module Submission Forms

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

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado 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	4/30/2021
Resubmission Date (if applicable)	

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Process Map – *Depression Screening*

Instructions:

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

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

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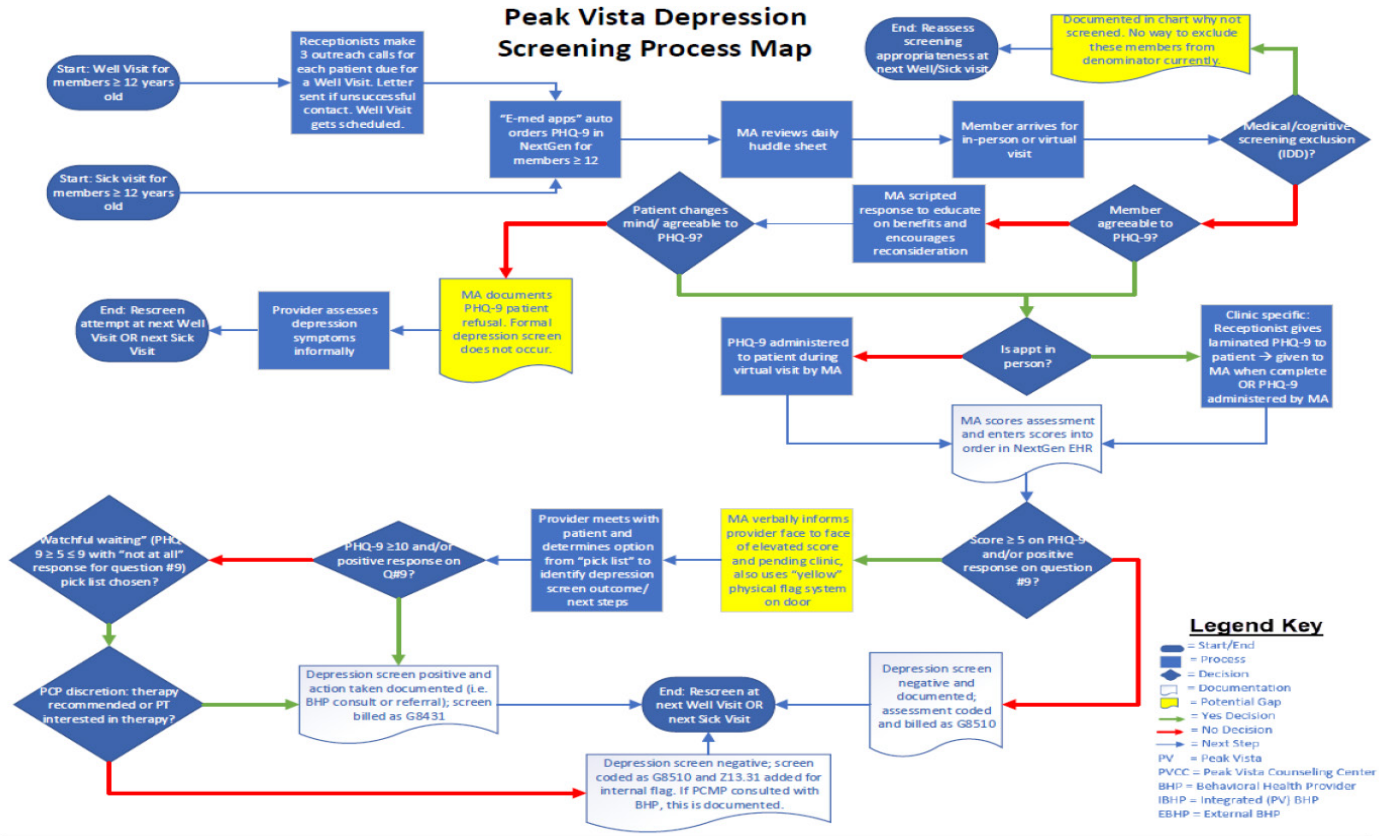

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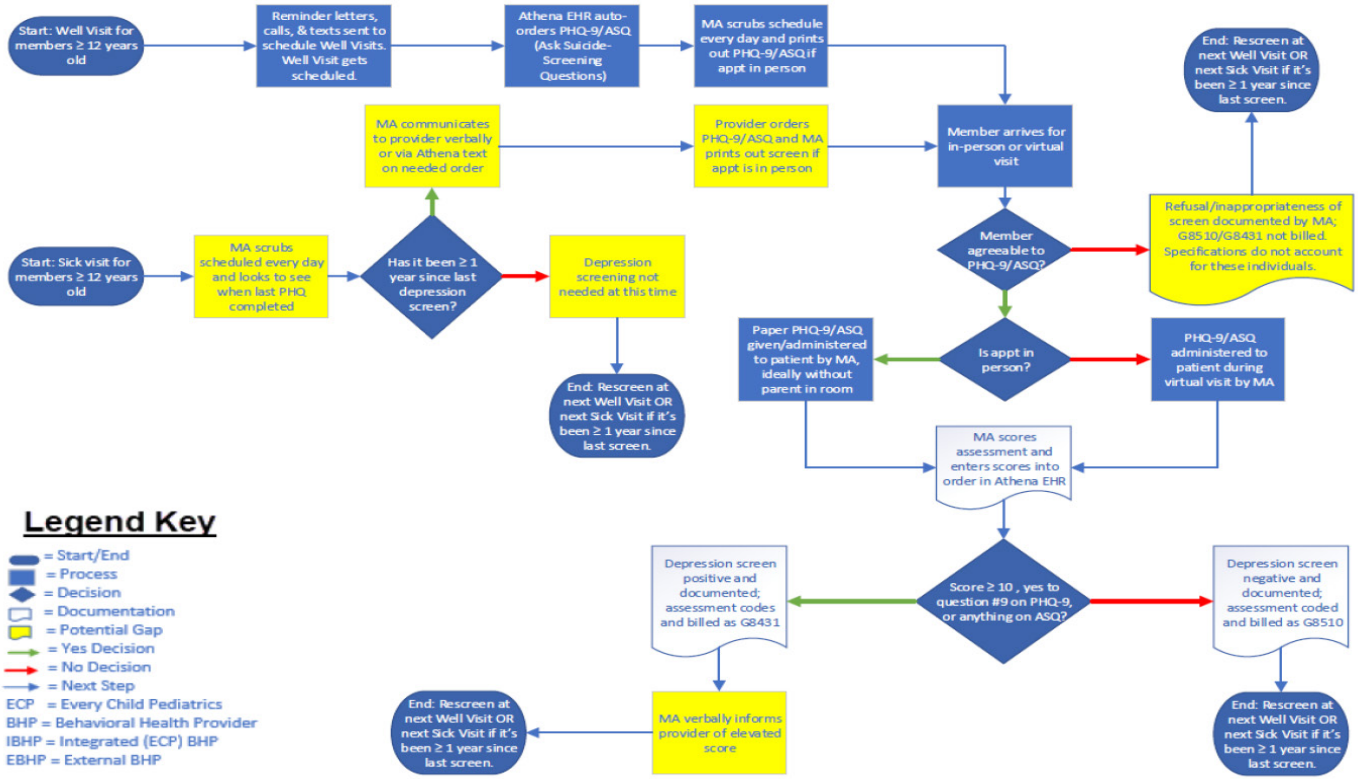
Every Child Pediatrics Depression Screen Process Map



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

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

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

	Table 1a—Failure Modes and Effects Analysis Table – *Depression Screening*			
Organization	**Steps from the Process Map**	**Failure Mode(s) (What could go wrong?)**	**Failure Cause(s) (Why would the failure happen?)**	**Failure Effect(s) (What are the consequences?)**
Peak Vista	MA verbally informs PCP of elevated PHQ-9 and in some clinics, uses yellow physical flag system	• MA forgets to tell provider of elevated score during handoff • Handoff does not occur	• Patient has other issues going on that are more pressing during handoff • Busy practice and workforce constraints	• PCP unaware of positive depression screen and does not address or involve BHP for follow-up during visit • Providers will not know about positive depression screen with no follow-up until receive monthly report

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				from internal quality team
Peak Vista	Documented in chart why not screened. No way to exclude these members from denominator.	Missed depressive symptoms	• No standardized instrument for screening • No training for screening specialized populations • Current specifications do not allow for members to be excluded	• Members who have depression aren't identified • Members that meet medical exclusion are included in measure and are counting against provider when they shouldn't • Volume is not known so impact on screening rate not able to be determined
Peak Vista	MA documents PHQ-9 patient refusal. Formal depression screen does not occur.	Members who may be depressed are not being evaluated by a standardized instrument	Members have decision making authority that practitioners must respect to avoid abrasion	Members who have depression aren't able to be stratified according to recommended treatment guidelines
Every Child Pediatrics (ECP)	MA scrubs schedule every day and looks to see when last PHQ completed	MA's manual process could be impacted by daily clinic operations (resources, memory) and doesn't account for other administrative errors in chart	Relies on human processes and human memory (i.e. no automation)	Members who have depression do not have the opportunity to be screened and aren't identified

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ECP	Depression screening not needed at this time	Individuals with new mental health issues will not be caught	Members mental health can change at any point since last visit	Newly mental health issues aren't identified or addressed in a timely manner
ECP	MA communicates to provider verbally or via Athena text on needed order	• MA doesn't correctly identify need • Physician doesn't receive information needed for order entry • EHR errors/failure	Relies on human processes and human memory (i.e. no automation)	Members who have depression do not have the opportunity to be screened and aren't identified
ECP	Provider orders PHQ-9/ASQ and MA prints out screens if appt is in person	• Provider doesn't input order on time • MA doesn't print PHQ-9 in time • Printer malfunction	Relies on two different people within process and increases likelihood of error	Member isn't able to complete PHQ-9
ECP	MA verbally informs provider of elevated score	• MA forgets to tell provider of elevated score during handoff • Handoff does not occur	• Patient has other issues going on that are more pressing during handoff • Busy practice and workforce constraints	PCP unaware of positive depression screen and does not address or involve BHP for follow-up during visit

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ECP	Refusal/inappropriateness of screen documented by MA; G8510/G8431 not billed. Specifications do not account for these individuals.	Members who may be depressed are not being evaluated by a standardized instrument	Members have decision making authority that practitioners must respect to avoid abrasion	Members who have depression aren't able to be stratified according to recommended treatment guidelines

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Failure Mode Priority Ranking – *Depression Screening*

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

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

Table 2a—Failure Mode Priority Ranking – *Depression Screening*		
Organization	**Priority Ranking**	**Failure Modes**
Peak Vista	**1**	MA forgets to tell provider of elevated score during handoff
Peak Vista	**2**	Handoff does not occur
Peak Vista	**3**	Members who may be depressed are not being evaluated by a standardized instrument
Peak Vista	**4**	Missed depressive symptoms
ECP	**1**	MA's manual process could be impacted by daily clinic operations (resources, memory) and doesn't account for other administrative errors in chart
ECP	**2**	MA doesn't correctly identify need
ECP	**3**	Physician doesn't receive information needed for order entry
ECP	**4**	Provider doesn't input order on time
ECP	**5**	MA doesn't print PHQ-9 in time
ECP	**6**	EHR errors/failures

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ECP	**7**	Individuals with new mental health issues will not be caught
ECP	**8**	MA forgets to tell provider of elevated score during handoff
ECP	**9**	Handoff does not occur
ECP	**10**	Printer malfunction
ECP	**11**	Members who may be depressed are not being evaluated by a standardized instrument

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

Instructions:

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

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

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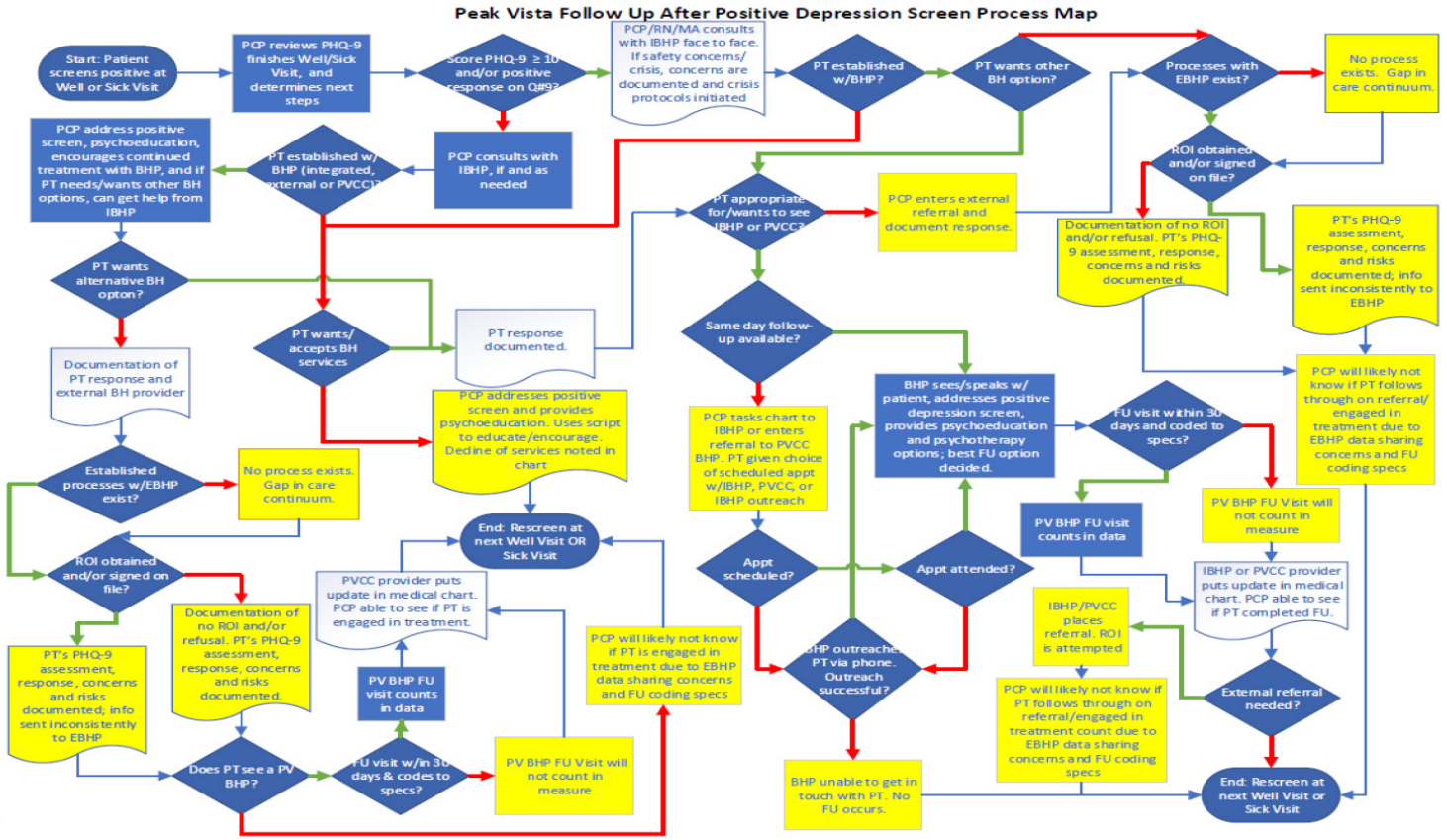
Peak Vista Follow Up After Positive Depression Screen Process Map



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

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

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

	Table 1b—Failure Modes and Effects Analysis Table – *Follow–up After a Positive Depression Screen*			
Organization	**Steps from the Process Map**	**Failure Mode(s) (What could go wrong?)**	**Failure Cause(s) (Why would the failure happen?)**	**Failure Effect(s) (What are the consequences?)**
Peak Vista	PV BHP follow up (FU) Visit will not count in measure	• Follow-up visit is occurring but not within 30 days • Providers not aware of appropriate specification codes that they could use to count visit	• BHP access issues • Lack of education and coding consistency • Other codes are more optimal to use than what are in the specifications	• Members are receiving untimely follow-up • Providers are not getting credit for all follow-up visits that

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				are happening based on specifications
Peak Vista	BHP unable to get in touch with PT. No FU occurs.	Individual with identified BH needs is not reached or seen by a provider	• Incorrect contact information on file • Member busy when outreach occurred • Member changed mind and no longer wants services	• Members needing services are not receiving them • Providers are not getting credit for outreach attempt
Peak Vista	No process exists. Gap in care continuum.	Inability for providers to communicate and ensure a continuum of care for mutual patient	No relationship with external provider	Inability to coordinate care
Peak Vista	Documentation of no ROI and/or refusal. PT's PHQ-9 assessment, response, concerns and risks documented	• Members aren't asked to sign a ROI • ROI on file is not valid • Members refuse to sign ROI when prompted • Members aren't educated on benefits of care coordination	• Members have decision making authority that practitioners must respect to avoid abrasion • MA's/Providers forget to ask patient • Members not provided information about importance of coordination • MA's/Providers do not input signed ROI into chart	• Collaboration and coordination of care leading to optimal patient outcomes not possible • External providers not made aware of current depression assessment and/or contributing physical health issues

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			• ROI has expired or has been revoked	
Peak Vista	PT's PHQ-9 assessment, response, concerns and risks documented; info sent inconsistently to EBHP	• EBHP not informed of current depression assessment and/or relevant information impacting patients mental health • Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination	• Daily clinic operations and constraints (i.e. personnel, time, and cost) impede consistency of information sharing • EHR incompatibility	• Poor patient outcomes due to coordination of care is not occurring consistently despite patient agreement • Patient confusion, frustration, and/or abrasion
Peak Vista	PCP tasks chart to Integrated Behavioral Health Partner (IBHP) or enters referral to PVCC BHP. PT given choice of scheduled appt w/IBHP, PVCC, or IBHP outreach	• PCP forgets to input referral • IBHP/PVCC never receives referral after input • EHR errors/failures • IBHP/PVCC unaware of unmet needs	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows	• Members needing services are not receiving them • Patient confusion, frustration, and/or abrasion
Peak Vista	IBHP/PVCC places referral. ROI is attempted	• IBHP/PVCC forgets to input referral • EBHP never receives referral after input • EHR errors/failures • PCP unaware of unmet needs	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows • EHR incompatibility	• Members needing services are not receiving them • Patient confusion, frustration, and/or abrasion

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Peak Vista	PCP enters external referral and document response.	• PCP forgets to input referral • EBHP never receives referral after input • EHR errors/failures	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows • EHR incompatibility	• Members needing services are not receiving them • Patient confusion, frustration, and/or abrasion
Peak Vista	PCP will likely not know if PT follows through on referral/engaged in treatment due to external provider data sharing concerns and FU spec requirements	• EBHP does not code according to specifications • Symptom exacerbation without treatment • Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows • EHR incompatibility • Lack of education and coding consistency • Other codes are more optimal to use than what are in the specifications	• Members needing services are not receiving them • PCP unaware of any symptom exacerbation or management • Patient confusion, frustration, and/or abrasion
Peak Vista	PCP addresses positive screen and provides psychoeducation. Uses script to educate/encourage. Decline of services noted in chart.	Member is not interested in treatment at visit and later changes mind	Members have decision making authority that practitioners must respect to avoid abrasion	Members needing services according to standardized instruments are not receiving them

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ECP	Follow-up visit documented and coded	• Follow-up visit is occurring but not within 30 days • Providers not aware of appropriate billing codes they could use that meet specifications	• BHP access issues • Lack of education and coding consistency • Other codes are more optimal to use than what are in the specifications	• Members are receiving untimely follow-up • Providers are not getting credit for all follow-up visits that
ECP	Unsuccessful outreach attempt(s) made are documented; follow-up attempts don't count due to coding specifications	Individual with identified BH needs is not reached or seen by a provider	• Coding limitations do not allow to bill for unsuccessful outreach • Incorrect contact information on file • Member busy when outreach occurred • Member changed mind and no longer wants services	• Members needing services are not receiving them • Providers are not getting credit for outreach attempts
ECP	No process exists. Gap in care continuum.	Inability for providers to communicate and ensure a continuum of care for mutual patient	No relationship with external provider exists	Inability to coordinate care
ECP	PT and BHP decide best option. Internal appt or external referral placed if needed.	• IBHP forgets to input referral to EBHP • EBHP never receives referral after input • EHR errors/failures • PCP unaware of unmet needs	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows • EHR incompatibility	• Members needing services are not receiving them • Patient confusion, frustration, and/or abrasion

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ECP	Documentation of no/refusal ROI; will not know if follow up occurs.	• Members aren't asked to sign a ROI • ROI on file is not valid • Members refuse to sign ROI when prompted • Members aren't educated on benefits of care coordination • Provider not aware of appropriate billing codes they could use that meet specifications	• Members have decision making authority that practitioners must respect to avoid abrasion • MA's/Providers forget to ask patient • Members not provided information about importance of coordination • MA's/Providers do not input signed ROI into chart • ROI has expired or has been revoked	• Collaboration and coordination of care leading to optimal patient outcomes not possible • External providers not made aware of current depression assessment and/or contributing physical health issues
ECP	PCP enters referral to BHP. IBHP sees referral and initiates phone outreach as soon as possible. At least 2 outreach attempts made.	• PCP forgets to enter referral to BHP • IBHP does not see referral in a timely manner and symptom exacerbation occurs with recent crisis patient • EHR errors/failures	• Relies on human processes and human memory (i.e. no automation) • Incorrect contact information on file • Member busy when outreach occurred • Member changed mind and no longer wants services	Members needing services are not receiving them

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ECP	Communication sent to EBHP inconsistently on assessment score and any additional risk factors noted	• EBHP not informed of current depression assessment and/or relevant information impacting patients mental health • EHR errors/failures • Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination	• Daily clinic operations and constraints (i.e. personnel, time, and cost) impede consistency of information sharing • EHR incompatibility	• Poor patient outcomes due to coordination of care is not occurring consistently despite patient agreement • Patient confusion, frustration, and/or abrasion
ECP	IBHP sees referral and initiates at least 1 phone outreach when available	• EHR errors/failures • IBHP does not see referral in a timely manner and symptom exacerbation occurs	• Relies on human processes and human memory (i.e. no automation) • Inefficient referral workflows • Incorrect contact information on file • Member busy when outreach occurred • Member changed mind and no longer wants services	Members wanting needed services are not receiving them
ECP	PT response documented and referral to IBHP entered	• PCP forgets to enter referral to IBHP • EHR errors/failures	Relies on human processes and human memory (i.e. no automation)	Members wanting needed services are not receiving them

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		• IBHP never receives referral after input • IBHP unaware of unmet needs		
ECP	Any known follow-up plan with EBHP documented.	• PCP not aware of care plan • Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination • PT sees EBHP for FU and visit does not meet FU code specifications	• EBHP does not have ROI/ isn't willing to disclose information • Feedback loop and processes aren't established • EHR incompatibility	Inability to coordinate care
ECP	Decline of services noted in chart; no codes available to indicate PT refusal	• PT is not interested in treatment at visit	Members have decision making authority that practitioners must respect to avoid abrasion	Members needing services according to standardized instruments are not receiving them

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

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

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

	Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*	
Organization	**Priority Ranking**	**Failure Modes**
Peak Vista	1	Providers not aware of appropriate specification codes that they could use to count visit
Peak Vista	2	Follow-up visit is occurring but not within 30 days
Peak Vista	3	Individual with identified BH needs is not reached or seen by a provider
Peak Vista	4	Inability for providers to communicate and ensure a continuum of care for mutual patient
Peak Vista	5	PCP forgets to input referral
Peak Vista	6	IBHP/PVCC unaware of unmet needs
Peak Vista	7	IBHP/PVCC never receives referral after input
Peak Vista	8	IBHP/PVCC forgets to input referral
Peak Vista	9	EBHP never receives referral after input
Peak Vista	10	PCP unaware of unmet needs

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

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- Use the same language for the listed failure mode that was used in the FMEA table.

	Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*	
Peak Vista	11	EHR errors/failures
Peak Vista	12	Members aren't educated on benefits of care coordination
Peak Vista	13	EBHP does not code according to specifications
Peak Vista	14	EBHP not informed of current depression assessment and/or relevant information impacting patients' mental health
Peak Vista	15	Members aren't asked to sign a ROI
Peak Vista	16	ROI on file is not valid
Peak Vista	17	Members refuse to sign ROI when prompted
Peak Vista	18	Symptom exacerbation without treatment
Peak Vista	19	Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination
Peak Vista	20	Member is not interested in treatment at visit and later changes mind

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

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- Use the same language for the listed failure mode that was used in the FMEA table.

	Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*	
ECP	1	Providers not aware of appropriate billing codes they could use that meet specifications
ECP	2	Follow-up visit is occurring but not within 30 days
ECP	3	Individual with identified BH needs is not reached or seen by a provider
ECP	4	PT sees EBHP for FU and visit does not meet FU code specifications
ECP	5	Inability for providers to communicate and ensure a continuum of care for mutual patient
ECP	6	PCP forgets to enter referral to IBHP
ECP	7	IBHP unaware of unmet needs
ECP	8	IBHP does not see referral in a timely manner and symptom exacerbation occurs
ECP	9	IBHP never receives referral after input
ECP	10	IBHP forgets to input referral to EBHP
ECP	11	EBHP never receives referral after input

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

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- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

	Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*	
ECP	12	PCP unaware of unmet needs
ECP	13	EHR errors/failures
ECP	14	EBHP not informed of current depression assessment and/or relevant information impacting patients mental health
ECP	15	Members aren't educated on benefits of care coordination
ECP	16	Members aren't asked to sign a ROI
ECP	17	ROI on file isn't valid
ECP	18	Members refuse to sign ROI when prompted
ECP	19	PCP not aware of care plan
ECP	20	Medical errors and clinical (i.e. prescriptions) contraindications due to lack of coordination
ECP	21	IBHP does not see referral in a timely manner and symptom exacerbation occurs with recent crisis patient

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

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- Use the same language for the listed failure mode that was used in the FMEA table.

	Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*	
ECP	22	PT is not interested in treatment at visit

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Key Driver Diagrams

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

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

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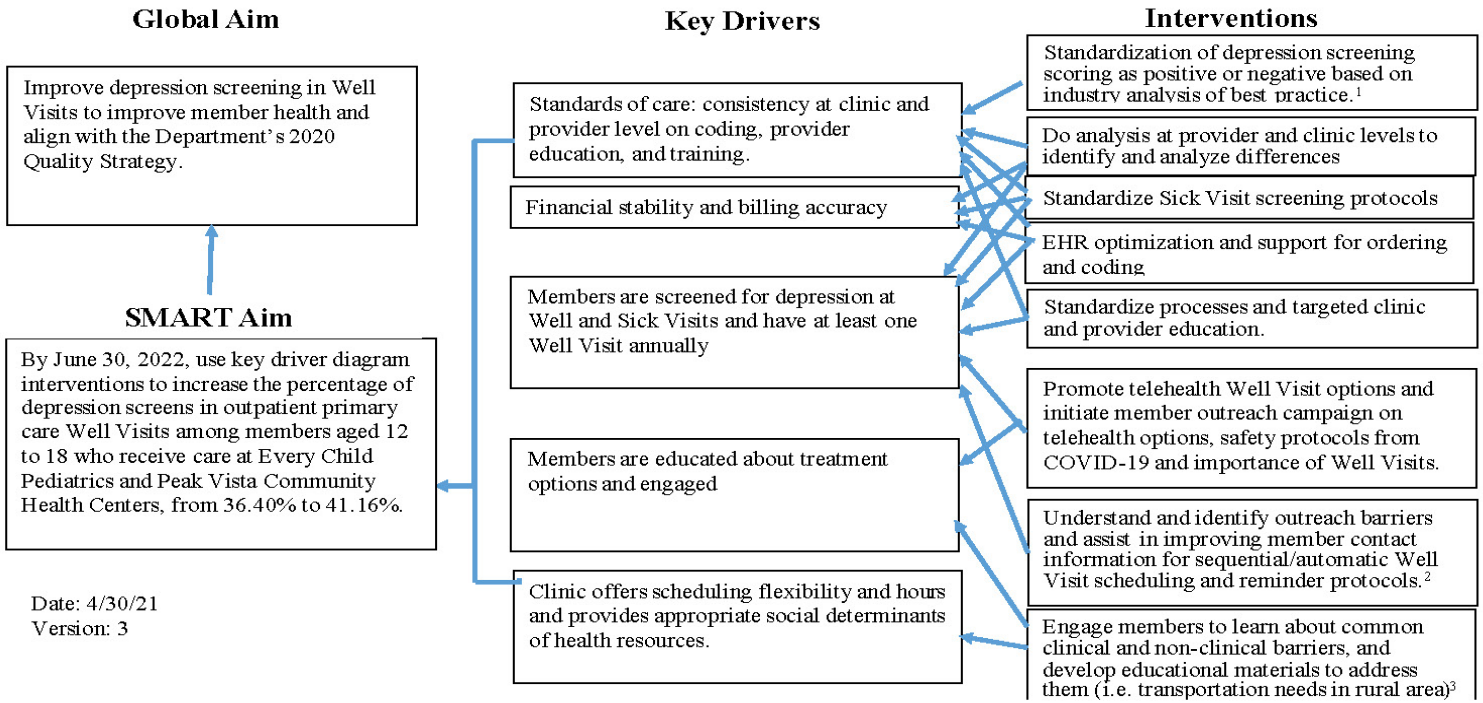
Key Driver Diagram– *Depression Screening*



[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: 4/30/21
Version: 4

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 and training.
- Internal and external provider availability with scheduling flexibility to provide follow-up visits.
- Financial stability and billing accuracy
- 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's 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, community, 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. *Journal of General internal Medicine, 28* (3), 346-352.

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Managed Care Organization (MCO) Information	
MCO Name	Colorado Access CHP+
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Every Child Pediatrics CHP+ Depression Screening Coding Change
Contact Name	Alex Scialdone
Contact Title	Quality Improvement Program Manager
Email Address	Alex.Scialdone@coaccess.com
Telephone Number	720-744-5697
Submission Date	7/12/21
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

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

Table 1—Intervention Plan	
Intervention Being Tested	a. EHR optimization and support for ordering and coding b. Standardize processes and targeted clinic and provider education
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	a. EHR errors/failures b. Incorrect coding (not on Module 2 paperwork due to coding change already implemented prior to Module 2 submission)
Key Driver Addressed	a. Financial stability and billing accuracy b. Standards of care: consistency at clinic and provider level on coding, provider education, and training
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Meet with Every Child Pediatrics operations and billing team to review significant depression screening differences across LOB's. 2. Discovery of incorrect coding. Change depression screening coding workflow from 96127/96160 to G8510/G8431 for CHP+ to align with RAE workflows based on PHQ-9 results.

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Table 1—Intervention Plan	
	3. Monitor coding change impact.
What are the predicted results of this test?	It is predicted that depression screening rates will increase from this coding change and Every Child Pediatrics will have depression screening rates similar to the RAE 3 and RAE 5 LOB's by the end of the PIP. *Note: This was disclosed during TA call 4/19/21 and is being included as an intervention for Module 3 per HSAG recommendations. Coding change occurred 4/14/21.

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Intervention Effectiveness Measure

Instructions:

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

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)**
	Every Child Pediatrics: CHP+ Depression Screening Coding Change
Numerator Description	Depression screening as indicated by G8431/G8510
Denominator Description	Well Visits

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	This intervention will look at the frequency of G8431/G8510 and depression screening rate on a monthly basis
Describe the Data Sources	Claims databases
Describe how Data will be Collected	This data will be collected from COA claims
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	This data will be collected on a monthly basis and use the same parameters the depression screening metric uses but rates will be calculated on a monthly basis versus rolling 12-months.

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Managed Care Organization (MCO) Information	
MCO Name	Colorado Access CHP+
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Every Child Pediatrics CHP+ Follow-Up H0002 Clarification
Contact Name	Alex Scialdone
Contact Title	Quality Improvement Program Manager
Email Address	Alex.Scialdone@coaccess.com
Telephone Number	720-744-5697
Submission Date	7/12/21
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

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

Table 1—Intervention Plan	
Intervention Being Tested	Every Child Pediatrics: a. Gap analysis on current coding practices, encounter rate specs, PIP specs, and literature review. Develop educational materials on best practices as toolkit for providers. b. Analysis of internal tracking processes, workflows, and outreach protocols → EHR efficiency & optimization improvement support for protocol and coding standardization that utilize automation when possible.
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Providers not aware of appropriate billing codes they could use that meet specifications
Key Driver Addressed	Every Child Pediatrics: a. Financial stability and billing accuracy b. Standards of care: provider education, follow-up coding, and training.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Follow-up code analysis and discussion with Every Child Pediatrics operations and billing team

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Table 1—Intervention Plan	
	2. Consult with COA compliance team to review H0002 billing requirements 3. Review H0002 billing requirements with Every Child Pediatrics 4. Provider education and begin billing H0002 for follow-ups that previously were not being billed 5. Monitor code frequency to see impact on follow-up after a positive depression screen outcome
What are the predicted results of this test?	It is predicted that follow-up rates will increase from this coding change, as providers previously were not billing or submitting claims for follow-ups that didn't meet time constraints required in other follow-up codes.

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Intervention Effectiveness Measure

Instructions:

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

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)** Every Child Pediatrics CHP+ H0002 Follow-Up Clarification
Numerator Description	Follow up in 30 days as indicated by H0002
Denominator Description	Positive depression screen during Well Visits as indicated by G8431

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	COA developed a BI dashboard to look at follow-up code specific frequency over time with different filters. See screenshot how data will be evaluated.
Describe the Data Sources	COA claims database.
Describe how Data will be Collected	This data will be collected from COA claims and organized in a PowerBI dashboard.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	This data will be collected on a monthly basis and use the same parameters the follow-up metric uses but rates will be calculated on a monthly basis versus rolling 12-months.

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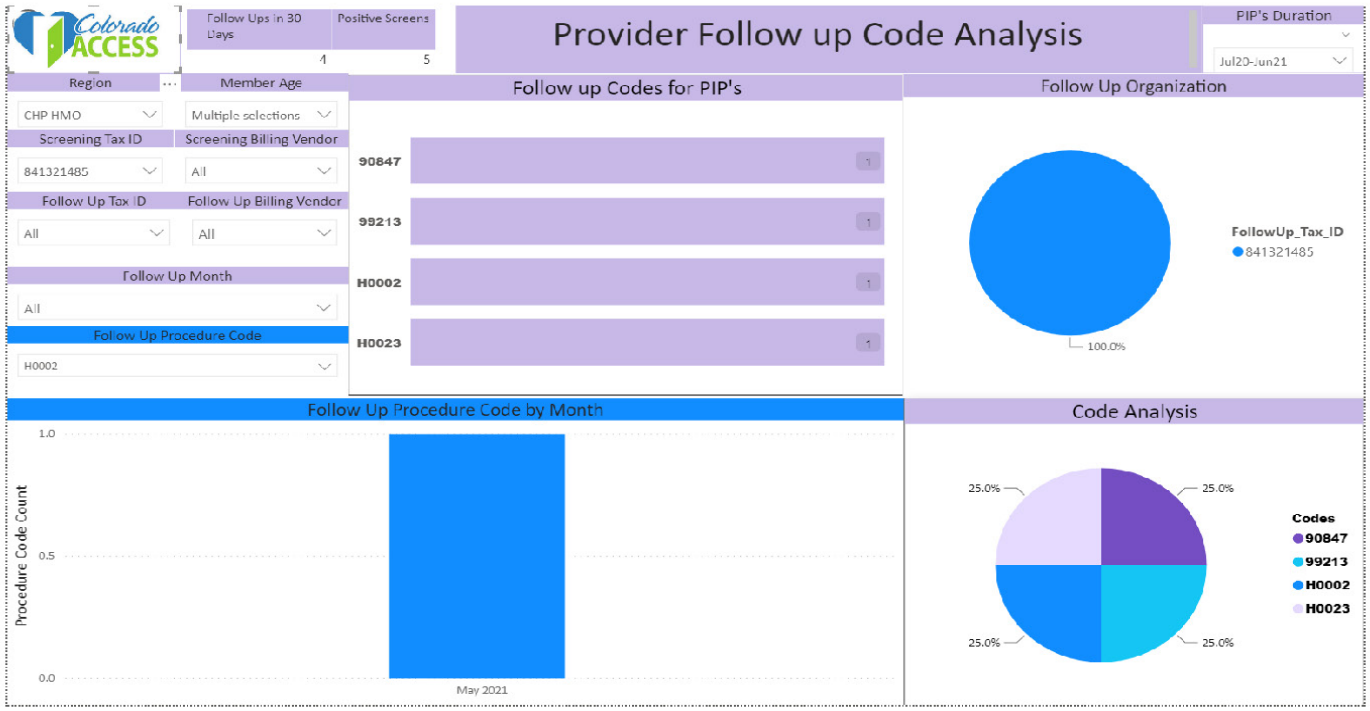

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Managed Care Organization (MCO) Information	
MCO Name	Colorado Access
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Peak Vista EHR Optimization and Coding Changes
Contact Name	Alex Scialdone
Contact Title	Quality Improvement Program Manager
Email Address	Alex.Scialdone@coaccess.com
Telephone Number	720-744-5697
Submission Date	9/17/21
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

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

Table 1—Intervention Plan	
Intervention Being Tested	Depression Screening a. Standardization of depression screening scoring positive or negative based on industry analysis of best practice b. Standardize processes and targeted clinic and provider education c. EHR optimization and support for ordering and coding Follow-Up After Positive Depression Screen a. Analysis of internal tracking processes, workflows, and outreach protocols; EHR efficiency & optimization improvement support for protocol and coding standardization that utilize automation when possible. b. Gap analysis on current coding practices, encounter rate specs, PIP specs, and literature review. Develop educational materials on best practices as toolkit for providers. *Note:* The MCO is aware that these interventions impact both outcomes. Per HSAG TA call on 8/11/21, Colorado Access is combining the interventions for each measure separately

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Table 1—Intervention Plan	
	submitted into one intervention that addresses both outcomes due to the EHR and coding changes being implemented simultaneously by the practice.
Outcome Addressed	☒ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Depression Screening a. Missed depressive symptoms b. Members who may be depressed are not being evaluated by a standardized instrument Follow-up After a Positive Depression Screen a. Provider not aware of appropriate specification codes that they could use to count visit b. PCP forgets to input referral to follow up services c. IBHP/PVCC unaware of unmet needs d. PCP unaware of unmet needs e. EHR errors/failure
Key Driver Addressed	Depression Screening a. Standards of care: consistency at clinic and provider level on coding, provider education, and training b. Financial stability and billing accuracy Follow-up After a Positive Depression Screen a. Standards of care: provider education, follow-up coding, and training b. Financial stability and billing accuracy

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Table 1—Intervention Plan	
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Meet with Peak Vista to understand current coding procedures for depression screening and follow-up 2. Sent Peak Vista list of patients without follow-up claims for audit activity and gap analysis 3. Peak Vista completes audit activity by looking up recent office visit details in EHR 4. Review completed audit and identify gaps. The below are findings based on audit results: a. There was no way to measure the number of patients that are declining depression screening or who are medically excluded from depression screening. b. There was inconsistent/inaccurate billing code for members who score 5-9 on PHQ-9; these "watchful waiting" members were being scored as positive (G8431) even though no follow-up was indicated, which negatively impacts the Follow-up After a Positive Depression Screen rate c. Providers were consistently documenting follow-up next steps in chart documentation but not consistently selecting follow-up radio buttons in EHR that drops appropriate billing code because it wasn't required within the EHR; this negatively impacts follow-up appointments and subsequently follow up rates 5. Brainstorm how both gaps can be best addressed and measured 6. Identify and implement coding and EHR changes: a. Peak Vista implements EHR hard stop that requires provider to select an option for follow-up before encounter can be closed/submitted for billing. Pop-up notification initially appears after positive PHQ-9 score is entered to remind providers the need for a follow-up selection. If follow-up selection has not

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Table 1—Intervention Plan	
	been identified following all encounter documentation, pop-up will reappear and prevent documentation to be considered complete and billable. • Add "Watchful waiting; reassess at next visit" follow-up option for identification of members who score 5-9 on PHQ-9 • Providers will now have 5 different follow-up options: 1. Peak Vista BHP consulted; see BHP note 2. Follow-up performed by Medical Provider; see A/P Details 3. Community BH referral placed today for follow-up 4. Questionnaire performed as part of follow-up on known diagnosis; see A/P Details 5. Watchful waiting; reassess at next visit b. For members who score 5-9 on PHQ-9, implement billing coding change from G8431 (Positive) to G8510 (Negative). c. Begin capturing number of patients who are declining depression screening and who are medically excluded from screening. d. Add diagnosis code of Z13.31 for all depression screens performed, regardless of outcome, for additional tracking purposes. 7. Distribute updated process flow information to all providers via email 8. Obtain monthly data from practice to monitor impact of EHR and coding changes on billing accuracy and depression screening and follow-up after positive depression screening rates. This data will also be reviewed for purposes of steering and/or identifying future interventions. In particular, the following elements will be reviewed and/or discussed monthly during PIP collaborative meetings a. Patients declining depression screening and patients medically excluded from depression screening volumes.

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Table 1—Intervention Plan	
	b. Volumes by specific follow-up pathway, including watchful waiting, and corresponding CPT code (G8510/G8431) billed. c. Discussion and determination if EHR follow-up options need to be altered/more clearly operationally defined after workflow implementation and provider feedback.
What are the predicted results of this test?	It is predicted that these EHR optimization and coding changes will allow the practice to increase follow-up screening rates due to a) implementation of an EHR hard stop on follow-up requirement that facilitates the appropriate documentation of billing codes and b) removal of "watchful waiting" members (who were previously scored as positive) from the Follow-up After Positive Depression Screen denominator. This intervention is predicted to improve data accuracy for both depression screening and follow-up after depression screening rates. Additionally, the hard stop change in the EHR is predicted to result in more consistent billing practices across the organization and improve provider education on the importance of depression screening and follow-up. Lastly, Colorado Access expects to see an increase in the percentage of negative depression screens as a result of these changes.

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Intervention Effectiveness Measure

Instructions:

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

Table 2—Intervention Effectiveness Measure	
	(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)
Intervention Measure Title	Peak Vista EHR Optimization and Coding Changes. Six measures will be used to determine the effectiveness of this measure; the numerators and denominators are categorized by A through F to indicate the six separate measures that will be calculated. Measures A-E represent all members across all Peak Vista locations and the monthly Peak Vista PHQ-9 Report will be used as the data source. Measure F represents all Colorado Access members and Colorado Access claims database and PIP dashboards will be used as the data source. Please see additional details and rationale regarding measures following PIP TA call and discussions with Peak Vista and Colorado Community Health Alliance (CCHA) in the "how often data will be collected" and "how data completeness will be addressed" sections in Table 3.
Numerator Description	a. Total number of "Watchful waiting; reassess at next visit" members with a corresponding G8510 CPT code

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Table 2—Intervention Effectiveness Measure	
	b. Total number of "Patients without a follow-up" with a corresponding G8510 CPT code c. Total number of "Unique Patients" minus "PHQ-9 Declined" and "Medically Excluded from PHQ-9" with a corresponding G8510/G8431 CPT code d. Total number of "PHQ-9 Declined" e. Total number of "Medically Excluded from PHQ-9" f. Total number of claims with a G8510 code
Denominator Description	a. Total number of "Watchful waiting; reassess at next visit" members b. Total number of members without a follow-up c. Total number of "Unique Patients" minus PHQ-9 Declined and Medically Excluded from PHQ-9 d. Total number of Unique Patients e. Total number of Unique Patients f. Total number of claims with a G8510 or G8431 code

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	For measures A through E: The data will be provided to Colorado Access from Peak Vista monthly in the form of an Excel spreadsheet that breaks down the data into multiple categories. Please see Appendix A for screenshot examples of this monthly report. To test the intervention effectiveness, Colorado Access will calculate 5 measures based on the data provided. The data report from Peak Vista includes a summarized tab and a raw data tab. The summarized tab will include totals and percentages for the following data elements:

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	a. Unique Patients b. PHQ-9 Declined c. Medically Excluded from PHQ-9 d. Patients with a Follow-up e. Follow-up type: 1. Peak Vista BHP consulted; see BHP note 2. Follow-up performed by Medical Provider; see A/P Details 3. Community BH referral placed today for follow-up 4. Questionnaire performed as part of follow-up on known diagnosis; see A/P details 5. Watchful waiting; reassess at next visit f. Patients without a follow-up In addition to the summary tab, raw data will be provided for each unique patient. The following data elements will be provided for each unique patient: a. First name b. Last name c. DOB d. Provider Department (corresponds to clinic location) e. Provider Name f. Person ID g. Encounter number h. Most Recent PHQ-9 date i. PHQ-9 Decline (Y/N) j. Follow-up Option number [selection options are 1-5 (corresponding to follow-up options outlined in item k below) or NULL) k. PHQ-9 Follow-up Text

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	• Peak Vista BHP consulted; see BHP note • Follow-up performed by Medical Provider; see A/P details • Community BH referral placed today for follow-up • Questionnaire performed as part of follow-up on known diagnosis; see A/P details • Watchful waiting; reassess at next visit l. Recent exclusion date m. Exclusion details n. Depression screening code billed (G8510/G8431)* • *at the time of this report submission, Colorado Access was still awaiting confirmation from Peak Vista that this could be added. <u>For measure F</u> This measure will be retrieved from Colorado Access claims databases and analyzed using a dashboard based on the narrowed focus area. Please see Appendix B for a screenshot example of this internal dashboard use for calculating this measure. Colorado Access will track negative (G8510) and positive (G8431) depression screening distribution on a monthly basis for trending and watchful waiting code change intervention assessment purposes.
Describe the Data Sources	a. **Measures A-E:** Peak Vista report from NextGen EHR b. **Measure F:** Colorado Access claims database/PIP dashboard
Describe how Data will be Collected	a. **Measures A-E:** Data will be collected via provider documentation in NextGen EHR and report generation b. **Measure F:** Data will be collected monthly using existing Colorado Access extraction code but the rolling 12-month data will be broken down further to be analyzed on a monthly basis.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	a. **Measures A-E:** Data will be collected monthly and provided to Colorado Access from Peak Vista. b. **Measure F:** Data will be collected monthly with appropriate filters for narrowed focused (members aged 12 to 18). <u>Updates following PIP TA call on 8/11 on HSAG's recommendations</u> • Colorado Access will use data from this intervention to determine the need for and to test additional interventions that directly impact the number of members screened and number of members receiving follow-up. For example, an intervention designed to decrease the percentage of members who decline the depression screening during a visit, as recommended by HSAG. • Colorado Access requested that Peak Vista add depression screening CPT code (G8510/G8431) to more effectively evaluate the impact of the "Watchful Waiting" (members who score 5-9 on the PHQ-9) code change from G8431 to G8510, as recommended by HSAG. This was first requested via email on August 26th and revisited during the monthly PIP meeting on September 13th. Peak Vista Quality Director was hopeful their Business Intelligence team could add this data element. Colorado Access and CCHA followed up via email on September 15th and September 17th, respectively, to confirm additional reporting enhancements but as of intervention resubmission, Colorado Access still had not received confirmation. • Regarding narrowing "Unique Patients" down to Colorado Access-only members, Colorado Access and CCHA discussed this further with Peak Vista during the combined September monthly PIP meeting. Colorado Access and CCHA inquired if Peak Vista could add in a payor filter to be

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	able to distinguish Colorado Access-only and CCHA-only Medicaid and CHP+ members versus all other members. Peak Vista was not able to accommodate this additional request, as this would create additional provider burden. Peak Vista's EHR system uses the umbrella "Medicaid" category for payor and the ability to calculate these measures for Colorado Access-only members is not possible. This newly created report will also be used for data the organization provides Colorado Community Managed Care Network (CCMCN) and creating three separate reports for Colorado Access, CCHA, and CCMCN consumes valuable organizational resources and creates undue hardship on the provider. Additionally, Peak Vista is committed to implementing this as an organization wide intervention across their 28 locations with the aim of improving depression screening rates and follow-up care for all the members they serve; creating three separate reports would divert important resources away from the ability to evaluate the effectiveness of this intervention and to identify any gaps or further education needed across the organization. Peak Vista is committed to health equity and has workflows in place that apply to all members regardless of payor. • Member health insurance churn, secondary/tertiary payors, and insurance reporting in Peak Vista EHR could also all negatively impact the completeness of this data if measures were calculated for Colorado Access-only members versus all members. Due to all aforementioned concerns, even if a filter for Colorado Access-only members was possible in this data source, data would likely be incomplete and have inaccuracies. Therefore, calculating these measures for all members regardless of payor type improves data accuracy and data completeness.

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Appendix A- Peak Vista PHQ-9 Monthly Report example

*Note: These report screenshots are from July and are examples of the monthly report prior to the billed CPT code (G8510/G8431) enhancements request. At time of this Module 3 resubmission, Colorado Access had not yet received a new monthly report with the additional column.

Summary Tab

Category	Totals	Percentage
Unique Patients	6,679	---
PHQ-9 Declined	970	14.52%
Medically Excluded from PHQ-9	15	0.22%
Patients with a Follow-up	2,383	35.68%
Patients without a followup	4,296	64.32%
1] Peak Vista BHP consulted; see BHP note	343	5.14%
2] Follow-up performed by Medical Provider; see A/P Details	794	11.89%
3] Community BH referral placed today for follow-up	23	0.34%
4] Questionnaire performed as part of follow-up on known diagnosis; see A/P Details	365	5.46%
5] Watchful waiting; reassess at next visit	858	12.85%

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Raw Data Tab

*All PHI is blurred due to purpose of screenshot to demonstrate reporting example for Module 3 PIP resubmission only.

fname	lname	dob	provider_dept	provider_name	enc_nk	most recent phq	PHQ-9 Decline	opt_followu	txt_phq9_followup	Recent Exd Date	exclusion_deta
			Pediatric Health Center	Figueroa NP MaryAnn	10347307	7/13/2021	N	2	Follow-up performed by Medical Provider; see A/P Details	7/13/2021	cognitive impairment
			DDHC	Johnson MD Emily	10394033	7/27/2021	N			6/22/2021	cognitive impairment
			DDHC	Johnson MD Emily	10353095	7/14/2021	N			5/26/2021	cognitive impairment
			DDHC	Johnson MD Emily	10354329	7/14/2021	N			4/27/2021	cognitive impairment
			DDHC	Johnson MD Emily	10358456	7/14/2021	Y			4/5/2021	cognitive impairment
			Health Center At Intl Circle	Pienciak NP Hannah	10336356	7/8/2021	N			12/21/2020	cognitive impairment
			Pediatric Health Center	Miller MD Monica	10357092	7/15/2021	N	1	Peak Vista BHP consulted; see BHP note	12/10/2020	GMOC declines
			DDHC	Johnson MD Emily	10395302	7/27/2021	N			9/14/2020	cognitive impairment
			DDHC	Johnson MD Emily	10348314	7/13/2021	Y			9/9/2020	cognitive impairment
			DDHC	Johnson MD Emily	10385027	7/23/2021	N			6/22/2020	cognitive impairment
			Health Center At Myron Stratton	Voget MD Kyle C	10311593	7/4/2021	Y			5/8/2020	patient already sees a psychiatrist so does not wish to share these details
			Pediatric Health Center At Academy	Redinger PAC Kim R	10361373	7/16/2021	Y			8/21/2019	cognitive impairment secondary to developmental delay
			DDHC	Orr NP Lindsay	10321404	7/5/2021	N			8/14/2018	cognitive impairment
			Health Center At Intl Circle	Lomberdi DO Stephanie	10325250	7/6/2021	N	4	Questionnaire performed as part of follow-up or known diagnosis; see A/P Details	7/26/2018	Autism
			No Provider	No Provicer	10327572	7/6/2021	Y			3/26/2018	intellectual developmental delay
			Health Center At Jetwing	Waite PAC Brett	10312234	7/1/2021	N				
			Health Center At Jetwing	Waite PAC Brett	10312317	7/1/2021	N	2	Follow-up performed by Medical Provider; see A/P Details		
			Health Center At Fountain	White PAC Richard	10312251	7/1/2021	N				
			Health Center At 340 Printers Parkway	Robinson DC Scott	10312353	7/1/2021	N	2	Follow-up performed by Medical Provider; see A/P Details		
			Health Center At Fountain	Marchesani PAC Kayla	10312340	7/1/2021	Y				
			Health Center Suite 3500 At Academy	Jewell DO Joshua E	10312348	7/1/2021	N				
			Health Center At 340 Printers Parkway	Epperly MD John	10312257	7/1/2021	Y				
			Health Center At 340 Printers Parkway	Belanger DO Ann	10312341	7/1/2021	N				

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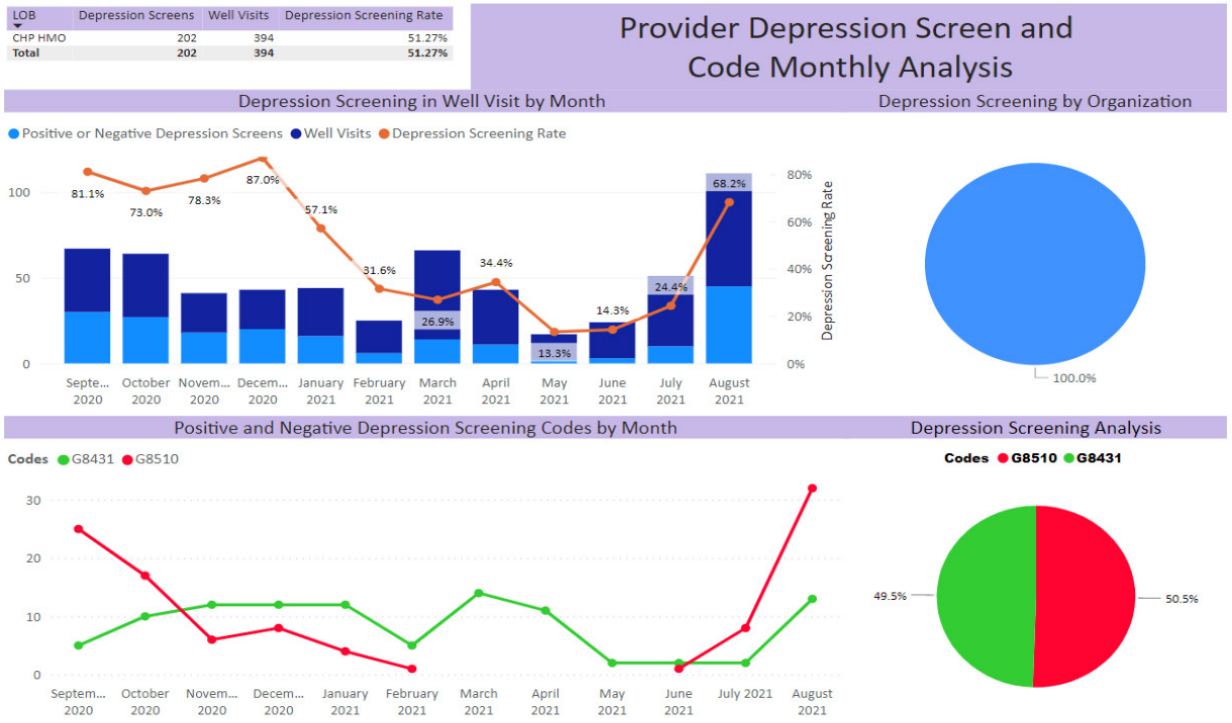
Appendix B: Internal Colorado Access PIP dashboard for narrowed focus sourced from claims

LOB	Depression Screens	Well Visits	Depression Screening Rate
CHP HMO	202	394	51.27%
Total	**202**	**394**	**51.27%**



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Managed Care Organization (MCO) Information	
MCO Name	Colorado Access CHP+
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Every Child Pediatrics Behavioral Health Access Improvements
Contact Name	Sarah Thomas
Contact Title	Quality Improvement Program Manager
Email Address	Sarah.thomas@coaccess.com
Telephone Number	720-951-6211
Submission Date	03/23/2022
Resubmission Date (if applicable)	04/13/22

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Intervention Testing Plan

Instructions:

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

Table 1—Intervention Plan	
Intervention Being Tested	Every Child Pediatrics: 1. Utilize the Colorado Access (COA) Behavioral Health (BH) Incentive Funding grant to promote the hiring of new BH staff. 2. Expand Colorado Access's free Virtual Care Collaboration and Integration (VCCI) Program to all integrated clinics to expand telehealth follow-up options by Primary Care Medical Providers (PCMP's).
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	1. Follow-up visit is occurring but not within 30 days 2. Individual with identified BH needs is not reached or seen by a provider 3. External Behavioral Health Provider (EBHP) not informed of current depression assessment and/or relevant information impacting patients mental health 4. Internal Behavioral Health Provider (IBHP) does not see referral in a timely manner and symptom exacerbation occurs
Key Driver Addressed	1. Standards of care: efficient referral processes between Every Child Pediatrics and internal and external behavioral health providers.

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Table 1—Intervention Plan	
	2. Internal and external provider availability with scheduling flexibility to provide follow-up visits. 3. Financial stability and billing accuracy 4. Member access, knowledge, and engagement.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Meet with Every Child Pediatrics (ECP) to rediscuss current barriers for patients engaging in Behavioral Health (BH) follow-up care after a positive depression screening 2. Agreed upon interventions: • COA worked with internal Practice Support team and ECP to discuss BH funding options. Determined the Behavioral Health Incentive Funding grant through COA would assist ECP to attract BH talent for hire and retain current BH staff by passing incentive funding on to these staff, in order to expand follow-up care for their patients. • COA worked with the internal AccessCare Services team to promote utilization of the telehealth Virtual Care Collaboration and Integration (VCCI) Program to ECP. 3. Intervention process steps to carry out the hiring of new BH staff and retain current BH staff at ECP: • ECP applied for grant in January 2022, received approval and funding from COA in February 2022. ECP will begin to utilize funding. • ECP to post positions for BH talent, and include descriptions of sign-on bonus and retention bonus to incentivize new hires • ECP to give retention bonus to current FT and PT/Per diem ECP staff • ECP to utilize differential bonus to retain specialized staff 4. Intervention process steps to carry out VCCI Expansion at ECP: • COA drafted a VCCI 1-pager that includes "Patient/Parent Key Talking Points" and "Provider Key Points" to provide accessible, targeted information and

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Table 1—Intervention Plan	
	education. ECP to use this document to encourage patients to try VCCI and explain how VCCI works to ECP internal providers. • COA will conduct a root cause analysis to resolve ECP confusion around available VCCI services. This includes: - VCCI ADHD services for therapy, evaluations/assessments, and psychiatry - Confusion surrounding contracting requirements for BH and PH services and associated LOB's (CHP+, RAE 3, RAE 5, and commercial insurance). COA to communicate coverage regulations to ECP, and answer any questions related to services VCCI offers for patients. • COA to investigate patient experience and send ECP information on how the VCCI program would work from the patient perspective (email the patient receives, attachments, steps for the patient to complete before the virtual visit, etc.) • COA will work with AccessCare Services team to create an enhanced workflow for ECP to submit VCCI patient referrals. The team began to draft an ECP VCCI Workflow document outlining the process for how ECP would submit patient referrals for VCCI. • COA had representatives from the AccessCare Services team present the VCCI program to ECP during a PIPs team meeting in March to address follow-up questions and provide education. This meeting explained the concept of different VCCI referrals and visit types depending on what the ECP provider and patient needs (E-consults, Collaborative Consults, Therapy and Assessments). ECP to take this presentation back to staff to answer any questions surrounding VCCI before starting the intervention. 5. ECP and COA will prepare correlated measurements to assess if intervention is successful.

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Table 1—Intervention Plan	
	6. Clinic decision / agreement on proposed interventions and start date. ECP will present VCCI workflow at March staff meeting and begin pilot to increase VCCI patient referrals for BH services. Implement intervention and complete monthly measurements to ensure and monitor execution. Make any necessary adjustments and changes (Plan-Do-Study-Act (PDSA) Cycles) to proposed solutions as needed.
What are the predicted results of this test?	It is predicted that ECP follow-up rates will increase from this intervention. The BH Incentive Funding will help ECP to hire more BHP and therefore increase the quantity of staff available to conduct follow-ups after positive depression screening. The VCCI program will assist ECP in utilizing an external source to refer patients for follow-up services if internal BHP are unavailable to conduct follow-up services.

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Intervention Effectiveness Measure

Instructions:

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

Table 2—Intervention Effectiveness Measure	
	(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)
Intervention Measure Title	Every Child Pediatrics Behavioral Health Access Improvements Eight measures will be used to determine effectiveness of this measure; numerators and denominators will be categorized by A through H to indicate the eight separate measures that will be calculated. Measures E-H will represent all members across Every Child Pediatrics locations.
Numerator Description	**BH Incentive Funding Measures:** a. Number of retention bonus ($7,500 per staff, max 3) given to current FT staff b. Number of sign-on bonus ($5,000 per staff, max 2) given to future FT staff c. Number of retention bonus ($2,500 per staff, max 2) given to current PT/Per diem staff d. Number of differential bonus ($2,500, max 4) to retain specialized staff (ex: Bilingual language BHP) **VCCI Measures:** e. Total number of VCCI e-consults ECP completes each month f. Total number of VCCI collaborative consults ECP completes each month

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Table 2—Intervention Effectiveness Measure	
	g. Total number of VCCI therapy/assessments ECP completes each month h. Total number of VCCI consults (all types) ECP completes each month
Denominator Description	**BH Incentive Funding Measures:** a. 3 retention bonus ($7,500 per staff) available to give to current FT staff b. 2 sign-on bonus ($5,000 per staff) available to give to future FT staff c. 2 retention bonus ($2,500 per staff) available to give to PT/Per diem staff d. 4 differential bonus ($2,500) available to give to specialized staff **VCCI Measures:** e. Total number of VCCI consults (all types) ECP completes each month f. Total number of VCCI consults (all types) ECP completes each month g. Total number of VCCI consults (all types) ECP completes each month h. The "average" number of monthly VCCI consults (all types) ECP completed for the months prior to intervention start (Jan 2021 – Feb 2022).

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	**Measures A-D:** The data will be provided to Colorado Access from Every Child Pediatrics at our monthly PIP meetings in the format of emails and verbal updates. Data will also be gathered via COA's internal Practice Support team, who may have further insights or updates regarding the usage of BH Incentive funding by ECP. Please see Appendix E for screenshot examples of the full BH Incentive funding grant (not all of these deliverables are utilized in this PIP intervention). To test intervention effectiveness, Colorado Access will calculate 4 measures based on the data provided.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	a. "Percent of retention bonuses given to current FT staff by ECP" will be assessed via the count of retention bonuses given, divided by the total count of retention bonuses available for ECP to give to current FT staff. b. "Percent of sign-on bonuses given to future FT staff by ECP" will be assessed via the count of sign-on bonuses given, divided by the total count of sign-on bonuses available for ECP to give to future FT staff. c. "Percent of retention bonuses given to PT/per diem staff by ECP" will be assessed via the count of retention bonuses given, divided by the total count of retention bonuses available for ECP to give to PT/per diem staff. d. "Percent of differential bonuses given to staff by ECP" will be assessed via the count of differential bonuses given, divided by the total count of differential bonuses available for ECP to give to specialized staff. **Measures E-H:** The data will be provided to Colorado Access from AccessCare Services monthly in the form of an Excel spreadsheet that breaks down the data into multiple categories. Please see Appendix D for screenshot examples of this monthly report. To test intervention effectiveness, Colorado Access will calculate 4 measures based on the data provided. e. "Percent of e-consults" will be assessed via the Subject column labeled as E-Consult (count), divided by the Grand Total (count) of VCCI services completed that month. f. "Percent of collaborative consults" will be assessed via the Subject column labeled as Collaborative Consultation (count), divided by the Grand Total (count) of VCCI services completed that month.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	g. "Percent of therapy/assessments" will be assessed via the Subject column labeled as Therapy and/or Assessments (count), divided by the Grand Total (count) of VCCI services completed that month. h. "Percent of VCCI Consults completed in the month of interest" will be assessed via the Grand Total of consults completed by ECP in the month of interest, divided by the average (count) of monthly VCCI consults (all types) ECP completed for the months prior to intervention start (Jan 2021 – Feb 2022). Although the Every Child Pediatrics VCCI 1-pager, VCCI Program Patient Perspective email, and ECP VCCI Workflow are not measurable outcomes, please see Appendices A-C for a screenshot example of these interventions.
Describe the Data Sources	**Measures A-D:** Every Child Pediatrics verbal communication and email updates; COA internal Practice Support team communication **Measures E-H:** AccessCare Services internal VCCI report sent monthly to COA via email in excel spreadsheet format
Describe how Data will be Collected	**Measures A-D:** Data will be collected by Every Child Pediatrics, who will gather and report the information of their hiring status and incentive funding usage to COA. **Measures E-H:** Data will be collected via the AccessCare Services team, who uses an internal database to track the usage of VCCI telehealth encounters by each clinic.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	**Measures A-D**: Data and verbal updates will be collected monthly and provided to Colorado Access from Every Child Pediatrics. **Measures E-H**: Data will be collected monthly and provided to Colorado Access from the AccessCare Services VCCI team.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	Data completeness will be addressed via communication with the ECP team to gain a detailed understanding of the hiring status and how grant funding is being utilized. COA and ECP participate in a monthly PIP meeting to review all interventions and make sure the intervention and data reporting happens according to plan. COA will also work with the AccessCare Services team to review VCCI data each month and make sure it looks accurate.

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Appendix A- Every Child Pediatrics VCCI Program 1-pager

AccessCare Virtual Care Collaboration and Integration (VCCI)
Program Overview and Benefits
for Every Child Pediatrics (ECP)

Patient/Parent Key Talking Points for ECP Coordinators/Providers:

- **Appointment Timeliness:** VCCI providers can often "see" you much quicker than different community behavioral health provider options. You should receive initial communication from them within 2 business days after we make the referral.
- **Telehealth Convenience:** You can choose to see a VCCI provider in the convenience and privacy of your own home, or virtually in an ECP office
- **Ease of Use:** VCCI uses Zoom as their video-conferencing platform, which is free, easy, and HIPAA-compliant. We've seen how the process works and it is very easy. VCCI will send you an email with the links and everything you need to know to get started – they will even schedule a quick technology test to make sure everything works correctly before your appointment.
- **Care Coordination/Services Offered:** The relationship VCCI and ECP have allow for ECP providers to stay up to date easily about important care and treatment progress. This type of collaboration benefits both you and us. VCCI also has multiple kinds of services and providers to help meet your needs—this is similar to our team-based care approach at Every Child Pediatrics.
- **Clinical Rigor:** In addition to all counselors being licensed, all staff are also accredited by Triple P (Positive Parenting Program) America
  - Triple P America is an evidence-based parent coaching and training program that focuses on working with parents surrounding behavioral modification and skill building with children ages 0-12 in the primary care setting.

Provider Key Points:

- **Timeliness:** VCCI Providers will coordinate care within 2 business days of referral.
- **Services:** VCCI model follows a "Brief Intervention" short-term treatment program and services include:
  - Collaborative Consultations
  - Short-term therapy
  - Care coordination, including referrals and warm hand-offs to next/higher level of care whenever possible
  - Psychiatric evaluations and medication management support, including bridging and prescribing when necessary
  - E-Consults
  - Diagnostic assessments
- **Visibility/Transparency and Approach:** ECP providers can easily see notes and progress for their patients that have received VCCI services. Emphasis is on collaborative and team-based care. This is the next best thing to a warm handoff.
- **Easy Process:** Making a referral for VCCI is easy and the ECP BH Case Manager will help coordinate with patients.
  - For quick psychiatric treatment recommendations, you can electronically submit an asynchronous eConsult, which will be answered within 2 business days. eConsults are payor blind, no separate log-in is needed to initiate the request, and the eConsult template captures minimal PHI so that the patient cannot be identified. eConsults are a great way to get rapid response to a specific psychiatric question!
- **Insurance and Cost:** VCCI accepts multiple insurances: Colorado Access Medicaid (Regions 3 and 5) and CHP+, Aetna, Cigna, and United. Utilizing VCCI is free of charge for ECP to use for Colorado Access members
- **Conditions Treated:** Examples of behavioral health conditions that VCCI can support include, but are not limited to:
  - ADHD (Therapy, Evals, and Med Recs)
  - Mood Disorders
  - Perinatal Care (Mental health support for perinatal population)
  - Situational Stressors
  - Co-occurring Disorders
  - Parent Coaching
  - Couples and Family Therapy

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Appendix B- VCCI Program Patient Perspective email sent to ECP

Hello,

Thank you for using our Virtual Behavioral Health Services! Your provider has approved the delivery of our services to you directly in your home, and to make sure that this can be done, we will need to make sure that you have the items necessary to deliver our services.

These include:

1. Stable Internet Connection
2. Computer, Tablet or Phone
3. Cell Phone or Landline
4. External **OR** Internal Camera in Computer or Tablet
5. External **OR** Internal Microphone for Computer or Tablet
6. External **OR** Internal Speakers for Computer or Tablet
7. A private space to hold the appointment (Place where your conversations will not be overheard)
8. Do you have a limited data plan? Any setbacks?

*please note that Chromebooks will not work as they have many limitations.

*please note **that if the patient is under 18 years old**, the Parent or Legal Guardian must be present during the session for psychiatric medication evaluation and follow-up.

If you do have these items, or if you have most and still want to try and see if it will work, If you do have these items, or if you have most and still want to try and see if it will work, please respond to this email with a time and day (Monday - Friday 8:00 am – 4:45 pm) that works best for you to schedule a 10-15 minute virtual meeting to do a Technology Test of your system. If that test is successful, we will schedule your virtual appointment with you after the Test. If you feel that you do not have the necessary items to hold the Technology Test, please either respond to this e-mail or call us at 855-406-2700 to let us know and we will work with your primary care office to explore any other options.

We will send you DocuSign forms via email before the Tech Test that must be filled out before your first appointment. If we do not receive the DocuSign forms in time, we will cancel the appointment.

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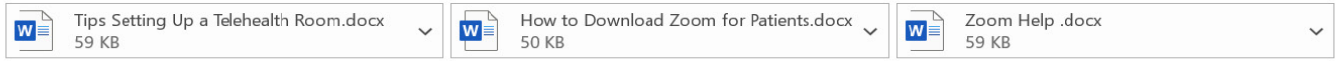
- Also attached are documents on How to setup a Telehealth Room, Zoom Help, and How to Download Zoom
- Please see https://support.zoom.us/hc/en-us/articles/201362193 on how to Join a Meeting, depending on what type of tablet, computer or cellphone you are using

Thank you!

Additional email attachments for patients:



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Appendix C- Every Child Pediatrics VCCI Workflow (Pg. 1 of 5)

Every Child Pediatrics VCCI Workflow

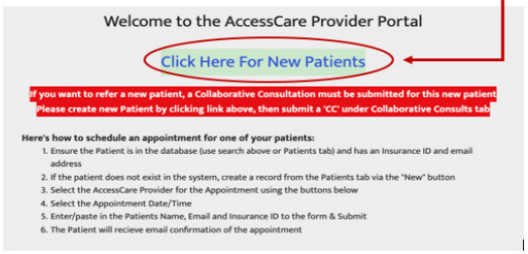
Insurances accepted: CO Access, CHP+, Aetna, United, Cigna

VCCI Services "Communities" Login Page:
https://accesscare.force.com/Providers/s/login/

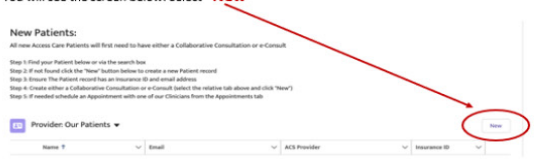
- **Username:** vccibhp@everychildpediatrics.org
- **Password:** !ecpvcci1

How to submit a referral through VCCI:

1. You must first make a new patient account. Select: **"Click Here For New Patients"**
   *If you have already submitted a VCCI referral request in the past for this patient, skip this step and move to step #5.



2. You will see the screen below: Select **"New"**



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Appendix D- AccessCare Services ECP VCCI Data Example

Report for Sarah
As of 2022-03-03 08:40:53 Mountain Standard Time/MST • Generated by Robyn Diseati

Filtered By
Show: All appointments
Show: Open & Completed Appointments
Show: Events
Date Field: Start equals Custom (2/1/2022 to 2/28/2022)
Account Name contains every child
Subject contains initial,exp,no,cc,15,collaborative,follow,90,60

First Name	Last Name	Subject	Date	Insurance Name	Which Region?	Insurance ID	Assigned	Type
		Collaborative Consultation 15 Minutes	2/2/2022	ABC Medicaid	RAE 5		Melanie Creach, LCSW	Seen
		Collaborative Consultation 15 Minutes	2/4/2022	ABC Medicaid	RAE 5		Jordan Gardner, MD, Psychiatrist	Seen
		Collaborative Consultation 15 Minutes	2/2/2022	ABC Medicaid	RAE 5		Melanie Creach, LCSW	Seen
		Therapy Follow-up 60 Minutes	2/23/2022	ABC Medicaid	RAE 5		Melanie Creach, LCSW	Seen
		Collaborative Consultation 15 Minutes	2/15/2022	ABC Medicaid	RAE 3		Amy Donahue, MD, Psychiatrist	Seen
		Collaborative Consultation 15 Minutes	2/11/2022	ABC Medicaid	RAE 5		Jordan Gardner, MD, Psychiatrist	Seen

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Appendix E – BH Incentive Funding Request Outline

Every Child Pediatrics
Workforce Support Funding Request

Funding request to support workforce recruitment, retention, and program development.

Goals:

1. Stabilize and enhance Behavioral Health programming through staff bonus
   a. $7500.00 (X3) retention bonus for current FT staff
   b. $5000.00 (X2) sign-on bonus for FT staff (we need to hire)
   c. $2500.00 (X2) retention bonus for PT/Per diem staff
2. Retain specialized staff through differential bonus
   a. $2500.00 (X4) differential for (FT) bilingual staff and/or specialized credentials (i.e. Infant MH)
3. Expansion of HealthySteps program through creation of new position HealthySteps Supervisor/Trainer
   a. $7000.00 to promote our current HealthySteps Lead to Early Childhood Supervisor/Trainer
4. Resilience support using a program like HeartMath
   a. $7000.00

Payment Method

COA will provide a one time lump some payment to be allocated in the following areas following signing of MOU

Funding Allocation	Amount	Total	Total request amount
FT Retention Bonus	7,500.00 (X3)	22,500	
PT Retention Bonus	2,500.00 (X2)	5,000	
Sign on Bonus	5,000.00 (X2)	10,000	
Specialized training differential bonus	2,500.00 (X4)	10,000	
New position	7,000 (X1)	7,000	
Program Investment	7,000 (X1)	7,000	
			61,5000

Evaluation/Measurement:

1. Goal: Stabilize and enhance our Behavioral Health program through funding for hiring and retention:
   a. Retention bonus for current FT staff and PT/Per diem staff
      i. Measurement:
         1. Report on distribution of funds including amount and date distributed.
   b. Sign-on bonus for new FT staff
      i. Measurement:
         1. Report including job description and terms of sign on bonus, date of job posting, date of hire and date of distribution of funds.
2. Goal: Retain bilingual therapist and specialized staff serving infant mental health through differential bonus
   a. Differential bonus for (FT) bilingual staff and/or specialized credentials (i.e. Infant MH)
      i. Measurement:
         1. ECP will provide job title and job description indicating specialized credentials and/or training, amount of bonus, and date of distribution of funds.
3. Goal: Expansion of HealthySteps program through creation of new position HealthySteps Supervisor/Trainer
   a. Promote current HealthySteps Lead to Early Childhood Supervisor/Trainer
      i. Measurement:
         1. ECP will provide updated job description, hiring date and distribution of funding in report to COA.
         2. ECP will report back positive outcomes from staff promotion such as trainings completed, supervision provided, or increase in members served
4. Goal: Resilience support using a program like HeartMath
   a. $7000.00
      i. Measurement: ECP will provide narrative report on positive outcomes from utilizing HeartMath Program.

Performance Measures:

Provider will complete the progress report template by (date) addressing all areas outlined in the evaluation measurement strategy.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan included process maps for *Depression Screening* and *Follow–Up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	☒ Met ☐ Not Met	
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	
5. The health plan prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the health plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	

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Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: May 28, 2021

State of Colorado
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Intervention: Every Child Pediatrics CHP+ Depression Screening Coding Change

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	**General Comment:** It may be beneficial for the health plan to also track the percentage of depression screening with the code 96127/96160 to determine if the old code is still being used.
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations:		

Intervention Testing (Module 3)

☒ Pass

Date: August 13, 2021

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Intervention: Every Child Pediatrics CHP+ Follow–Up H0002 Clarification

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations:		

Intervention Testing (Module 3)

☒ Pass

Date: August 13, 2021

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Intervention: Peak Vista Screening and Follow-Up EHR Optimization and Coding Changes

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

Intervention Testing (Module 3)

☒ Pass

Date: September 29, 2021

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Intervention: Every Child Pediatrics Behavioral Health Access Improvements

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

Intervention Testing (Module 3)

☒ Pass

Date: April 19, 2022