COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 PIP Validation Report

for

Denver Health Medical Plan, Inc.

April 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for Medicaid programs, with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include, conducted by an external quality review organization (EQRO), analysis and evaluation of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid managed care program.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its Medicaid health plans to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **Denver Health Medical Plan** (**DHMP**), an MCO, holds a contract with the State of Colorado for provision of services for the Department's managed care program.

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

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

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

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

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

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

PIP Components and Process

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

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

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

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

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

Validation Scoring

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

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

PIP Topic Selection

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

DHMP 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 **DHMP**.

Table 1-1—SMART Aim Statements

PIP Measure	SMART Aim Statement
Depression Screening	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39%.
Follow-Up After a Positive Depression Screen	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58%.

The focus of the PIP is to increase the percentage of members 12 to 21 years of age assigned to the Westside Pediatrics patient-centered medical home (PCMH) who receive an annual depression screening and to increase the percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goals to increase depression screening to 74.39 percent and to increase follow-up within 30 days after a positive depression screen to 51.58 percent represent statistically significant improvement over the baseline performance.

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

Table 1-2—PIP Topic and Module Status

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

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

Validation Findings

At the end of FY 2019–2020, **DHMP** closed out the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP, which was initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from the project.

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

Below are summaries of PIP conclusions from the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP close-out report and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **DHMP** reported in the FY 2019–2020 PIP close-out report for the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP.

Table 2-1—PIP Conclusions Summary for the *Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age* PIP

Interventions	Partnering with school-based health centers (SBHCs) to outreach, schedule, and deliver well care visits for adolescent members consented to receive care at SBHCs.
Successes	• Established partnership with SBHC leadership. • Developed communication system with community partners. • Developed electronic medical record (EMR) data extraction process to support automated text messages. • Improved adolescent well care rates during the project.
Lessons Learned	• Partnership with SBHCs was critical to the success of the project and suggests continued partnership can lead to further improvement in outcomes for the adolescent member population. • Technology development to support the intervention took longer than expected; going forward, additional time will be allowed for interventions relying on further development of technology.

Module 1: PIP Initiation

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

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

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39%.
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of depression screening in EMR and data systems. • Adequate appointment length to allow for depression screening.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health Medicaid Choice members aged 12–21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58%.
Preliminary Key Drivers	• Well-child visit access and attendance. • Accurate documentation of behavioral health follow-up services in EMR and data systems. • Adequate appointment length to address positive depression screen. • Attendance of scheduled behavioral health follow-up appointment.
Potential Interventions	• Member outreach and reminders to schedule well-child visit. • Provide transportation services for members. • Provider education on appropriate depression screening and follow-up documentation. • Same-day warm handoff to in-clinic behavioral health provider following positive depression screen.

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

- Increase the percentage of members 12 to 21 years of age attributed to Westside Pediatrics PCMH who receive an annual depression screening to 74.39 percent.
- Increase the percentage of members 12 to 21 years of age attributed to Westside Pediatrics PCMH who screened positive for depression that receive follow-up behavioral health services within 30 days of the positive depression screen to 51.58 percent.

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

3. Conclusions and Recommendations

Conclusions

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

Recommendations

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

Appendix A. Module Submission Form

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

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Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
***Depression Screening and Follow–Up After a Positive Depression Screen for* Denver Health Medical Plan (MCO)**

Managed Care Organization (MCO) Information	
MCO Name	Denver Health Medical Plan
PIP Title	*Improving Depression Screening and Follow–Up After a Positive Depression Screen for DHMP Medicaid Choice Members*
Contact Name	Gregg Kamas
Contact Title	Quality Improvement Director
Email Address	Gregg.Kamas@dhha.org
Telephone Number	303-602-2051
Submission Date	December 7, 2020
Resubmission Date (if applicable)	March 10, 2021

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PIP Team

Instructions:

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

Table 1—Team Members

Name	Title	Role and Responsibilities
Gregg Kamas	Quality Improvement Director	PIP operational oversight and direction
Claire Ulrickson	Population Health and Quality Improvement Project Manager	Project write up, business rule, communication, and liaison to external partners and HSAG / HCPF
Elizabeth Flood	Population Health and Quality Improvement Project Manager	Project consultant
Rene Horton	Sr. Data Analyst	SQL querying, Tableau report creation, data mining and support
Meg Tomcho, MD	Team Lead – Westside Pediatrics	Clinic contact, Communication with ACS providers, assistance with intervention implementation
Christine Seals, MD	Medical Director	Clinical project oversight and resource allocation

*DHMP is a wholly-owned subsidiary of Denver Health and Hospital (DHHA). DHHA also contains the department of Ambulatory Care Services (ACS), comprised of primary and specialty ambulatory care providers who practice at 10 Patient Centered Medical Homes (PCMHs) and in outpatient specialty clinics at Denver Health. ACS comprises the majority of the care delivery system of DHMP and is governed by a separate corporate reporting structure and operations personnel. DHMP frequently partners with ACS to implement clinical interventions. Both DHMP and ACS are separate business units in DHHA. For these reasons, ACS staff members are categorized into the "External Partners" for this PIP.

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PIP Topic and Narrowed Focus

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

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

Table 2—PIP Topic and Narrowed Focus

PIP Topic Description
Improving Depression Screening and Follow-up after a Positive Depression Screen has been an area of focus at Denver Health Medical Center (DHMC) and for members of Denver Health Medical Plan (DHMP). DHMC is Colorado's primary safety-net institution and provides comprehensive care for several specialty groups including the poor, un- or under-insured and the homeless. Denver Health Medicaid (MCD) Choice members, who have household income at or below 138% of the Federal Poverty Level can certainly fall into one of these special need's groups. In recent years, Depression Screening and documentation of Follow-up plan after a positive depression screen has been a priority area for DHMC and has been tracked as priority metric. This topic was also mandated by the Colorado Department of Healthcare Policy and Finance (HCPF) for the PIP cycle beginning in December of 2020.
Narrowed Focus Description
Depression screening and follow-up after a positive screen are topics that are particularly important for adolescents in Colorado. An analysis of Colorado Medicaid data showed that 8.6% of Colorado teens aged 12–17 with Medicaid coverage are diagnosed with depression. This rate is slightly higher than the national rate of 8% for the same population. This issue is particularly salient in Denver County, where a 2018 assessment from Denver Public Health reported that 15% of Denver youth noted that mental health issues were the most important factor impacting their health. Nearly 3 in 10 middle and high school students in Denver responding to the same survey noted that they were so sad or hopeless during the most recent two week period that they stopped doing some of their usual activities.

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Depression screening is recommended as part of routine care for adolescents. The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years and the American Academy of Pediatrics (AAP) recommends routine depression screening for adolescents starting at 12 years of age. Screening and treatment of depression in adolescents are particularly important given that untreated depression in adolescents is associated with increased risk of suicide and depression in adulthood.

Within the DHMC system, the Uniform Data System (UDS) Depression Screening and Follow-up after a Positive Depression Screening rate is higher for the pediatric clinics than for the system overall. Westside Pediatrics*, has historically performed very well on this metric. However, since the beginning of the COVID-19 pandemic, the clinic has seen their rate for the UDS Depression Screening and Follow-up after a Positive Screen metric (the metric which DHMC tracks internally) decrease from 77.1% in October of 2019 to 70.7% in 2020 for DHMP Medicaid and CHP+ members.

For this PIP, we have chosen adolescent DHMP Medicaid Choice members with Westside Pediatrics as their PCMH as our sub-population. We will collaborate with Westside Pediatrics to improve their rates. By improving the depression screening rate and rate of follow-up after a positive depression screening for adolescents, DHMP may be able to improve behavioral health outcomes for our members. Possible improved outcomes for our adolescent members include recognizing depression early, improving engagement in treatment, and prevention of progression of existing depression. The lessons learned at this clinic may be implemented to help adolescent members across the organization.

** Denver Health Medical Center's Department of Ambulatory Care Services (ACS) is comprised of 10 Patient-Centered Medical Home clinics (PCMHs) at which members receive primary care and preventive wellness services. Pediatric members who access Denver Health's system of care choose one of the PCMHs as a medical home at point of entry into the Denver Health system. The Westside Pediatrics clinic is part of this care delivery system. Additional information detailing the separation between DHMP and ACS can be found as a footnote after the PIP team table.*

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Narrowed Focus Baseline Measurement – *Depression Screening*

Instructions:

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

Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Numerator Description	Denver Health Medicaid Choice members who met the denominator criteria who have at least one depression screening (PHQ-2, PHQ-9, EPDS, or RHS 13) documented in EPIC between 10/1/2019 and 9/30/2020
Denominator Description	Denver Health Medicaid Choice members ages 12-21 who have had at least one outpatient primary care visit between 10/1/2019 and 9/30/2020 and who have Westside Pediatrics listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic at the time of the visit
Age Criteria (if applicable)	12-21 years
Continuous Enrollment Specifications (if applicable)	N/A

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Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Allowable Gap in Enrollment (if applicable)	N/A
Anchor Date (if applicable)	9/30/20
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Members with at least one outpatient primary care visit between 10/1/2019 and 9/30/2020

Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 10/01/2019	End Date: 9/30/2020
Numerator: 1433	Denominator: 2007	Percentage: 71.40%

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

Table 3c—Narrowed Focus Baseline Data Collection Methodology – *Depression Screening*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: DHMP receives validated HEDIS data once a year from a third-party vendor, who computes rates and continuous eligibility from claims and supplemental data source extracts sent by DHMP. Due to the fact that DHMP receives claims data through contract for behavioral health services with Colorado Access and DHMC providers do not code with the G-codes necessary to use the HEDIS metric for this measure, we wrote a custom SQL query against DHMP claims and DHHA's Epic Electronic Medical Record (EMR) data to create our baseline data submission. Our SQL query uses state enrollment files and Epic EMR encounter data to determine whether members received a depression screen, whether a follow-up plan was documented following a positive depression screen, whether the member received behavioral health services in the 30 days following the positive screen, and the contents of the Behavioral Health Follow-up Plan drop down, if applicable. For the custom SQL query, DHMP enrollment data was used to determine individuals who were members between 10/1/2019 and 9/30/2020.		

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Then, members' unique health plan IDs are joined to DHHA medical record numbers to query Epic data in the DHMP data warehouse.

Next, the query pulls medical record data directly from Epic to determine whether the members meeting this enrollment criteria have at least one outpatient primary care visit between 10/1/2019 and 9/30/2020 and whether these members had Westside Pediatrics listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic at the time of the above visit.

If the member meets the above criteria, they qualify for the denominator. The denominator will be determined with a 12-month lookback culminating on the last day of the reporting period. The report can be adjusted for timeframes and will be used for the rolling data collection as well.

For the depression screening numerator, the query pulls data from the Epic EMR, to determine whether the members in the denominator have had a documented depression screen (PHQ-2, PHQ-9, EPDS, or RHS 13) between 10/1/2019 and 9/30/2020 and the score of the screen (if applicable).

We then pull the data from the custom SQL query into a Tableau report that can be accessed by the PIP team. The Tableau report identifies the members who were in the denominator, and which of these members were also numerator compliant. The report can be adjusted for timeframes and will be used for the rolling data collection as well.

The following data elements are included in the SQL query and then pulled into the Tableau report:

1.) DHMP state enrollment files:
   a. Member name, and enrollment status (based on date frame described above)

2.) DHHA Epic data:
   a. Primary Care Provider (PCP), PCMH assignment (will be Westside Pediatrics), the date of the outpatient visit when a depression screening was given OR if no depression screening is documented in EPIC, the date of the most recent outpatient visit, whether the patient had a depression screen, if there is a documented depression screen, the type of screen completed and the score of the screen

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

Instructions:

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

Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Numerator Description	Denver Health Medicaid Choice members who met the denominator criteria who received a behavioral health visit (in-person or telehealth) within 30 days of the positive depression screen OR who had documentation that they are already engaged in care with an outside behavioral health provider
Denominator Description	Denver Health Medicaid Choice members ages 12-21 who have had at least one outpatient primary care visit between 10/1/2019 and 9/30/2020 and who have Westside Pediatrics listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic at the time of the visit who have had at least one positive depression screening (PHQ-2, PHQ-9, EPDS, or RHS 13) between 10/1/19 and 9/30/20
Age Criteria (if applicable)	12-21

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Continuous Enrollment Specifications (if applicable)	N/A
Allowable Gap in Enrollment (if applicable)	N/A
Anchor Date (if applicable)	9/30/20
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Members with a positive depression screening between 10/1/2019 and 9/30/2020

Table 4b—Narrowed Focus Baseline Data – *Follow–Up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 10/01/2019	End Date:9/30/2020 (for screening denominator) 10/31/20 (for behavioral health appointment)
Numerator:92	Denominator: 221	Percentage: 41.63%

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

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: *Please note that the Follow-up After a Positive Depression Screen data is built as a subset of the Depression Screening data. The full process is outlined below. But to jump to where this process deviates from the Depression Screening process to the Follow-up after a Positive Depression screen process, look for the* ** DHMP receives validated HEDIS data once a year from a third-party vendor, who computes rates and continuous eligibility from claims and supplemental data source extracts sent by DHMP. Due to the fact that DHMP receives claims data through contract for behavioral health services with Colorado Access and DHMC providers do not code with the G-codes necessary to use the HEDIS metric for this measure, we wrote a custom SQL query against DHMP claims and DHHA's Epic Electronic Medical Record (EMR) data to create our baseline data submission. Our SQL query uses state enrollment files and Epic EMR encounter data to determine whether members received a depression screen, whether a follow-up plan was documented following a positive depression screen, whether the member received behavioral health services in the 30 days following the positive screen, and the contents of the Behavioral Health Follow-up Plan drop down, if applicable.		

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For the custom SQL query, DHMP enrollment data was used to determine individuals who were members between 10/1/2019 and 9/30/2020.

Then, members' unique health plan IDs are joined to DHHA medical record numbers to query Epic data in the DHMP data warehouse.

Next, the query pulls medical record data directly from Epic to determine whether the members meeting this enrollment criteria have at least one outpatient primary care visit between 10/1/2019 and 9/30/2020 and whether these members had Westside Pediatrics listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic at the time of the above visit.

If the member meets the above criteria, they qualify for the denominator. The denominator will be determined with a 12-month lookback culminating on the last day of the reporting period. The report can be adjusted for timeframes and will be used for the rolling data collection as well.

For the depression screening numerator, the query pulls data from the Epic EMR, to determine whether the members in the denominator have had a documented depression screen (PHQ-2, PHQ-9, EPDS, or RHS 13) between 10/1/2019 and 9/30/2020 and the score of the screen (if applicable).

** For the Follow-up after a Positive Depression Screen data, the SQL query pulls the members from the depression screening numerator with positive depression screening (PHQ-2≥2, PHQ-9 ≥ 10, EPDS ≥ 10, RHS-13 ≥ 5). These members qualify for the Follow-up after a Positive Depression Screening denominator.

For the Follow-up after a Positive Depression Screening numerator, the query pulls data from the Epic EMR, to determine whether the members in the denominator have had a documented behavioral health visit (in-person or telehealth) within 30 days of the positive depression screen. The query also pulls the contents from the Behavioral Health Follow-up Plan data elements (see Appendix 1 for full drop-down contents) if available. Members who received a behavioral health visit (in-person or telehealth) within 30 days of the positive depression screen OR who had documentation that they are already engaged in care with an outside behavioral health provider are considered numerator compliant.

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We then pull the data from the custom SQL query into a Tableau report that can be accessed by the PIP team. The Tableau report identifies the members who were in the denominator, and which of these members were also numerator compliant. The report can be adjusted for timeframes and will be used for the rolling data collection as well.

The following data elements are included in the SQL query and then pulled into the Tableau report:

1.) DHMP state enrollment files:
   a. Member name, and enrollment status (based on date frame described above)

2.) DHHA Epic data:
   a. Primary Care Provider (PCP), PCMH assignment (will be Westside Pediatrics), the date of the outpatient visit when a depression screening was given OR if no depression screening is documented in Epic, the date of the most recent outpatient visit, whether the patient had a depression screen, if there is a documented depression screen, the type of screen completed, the date the screen was completed and the score of the screen. For members with a positive screen, the contents from the Behavioral Health Follow-up Plan data elements (see Appendix 1 for full drop-down contents) if available, whether the member had a documented behavioral health visit (in-person or telehealth) within 30 days of the positive depression screen, and the visit type and date of the behavioral health visit if applicable

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

Instructions:

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

Depression Screening:

By [*insert SMART Aim end date*], use key driver diagram interventions to [*increase/decrease*] the percentage of [*insert topic/issue/service*] among [*insert narrowed focus*], from [*insert narrowed focus baseline rate*] to [*insert SMART Aim goal*].

By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice members aged 12-21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39%.

Baseline data indicates that 1433 members completed a depression screening out of a population of 2007 eligible members for a success rate of 71.40%. Using a chi-square test of statistical significance, we calculated the rate of a statistically significant increase over baseline, assuming a stable population of 2007 members. A total of 1493 members would need to complete a depression screening, for a success rate of 74.39% (increase of 60 depression screens over baseline). This would represent a statistically significant increase at $p<0.05$ ($p=0.0331$) of 2.99% in success rate over the entire eligible Medicaid Choice population, which we believe is feasible by the project end date on 6/30/2022.

Follow-Up After a Positive Depression Screen:

By [*insert SMART Aim end date*], use key driver diagram interventions to [*increase/decrease*] the percentage of [*insert topic/issue/service*] among [*insert narrowed focus*], from [*insert narrowed focus baseline rate*] to [*insert SMART Aim goal*].

By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral

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health provider among Denver Health Medicaid Choice members aged 12-21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58%.

Baseline data indicates that 92 members completed a behavioral health visit within 30 days out of a population of 221 eligible members for a success rate of 41.63%. Using a chi-square test of statistical significance, we calculated the rate of a statistically significant increase over baseline, assuming a stable population of 221 members. A total of 114 members would need to complete behavioral health follow-up visits, for a success rate of 51.58% (increase of 22 members with behavioral health follow-up visits over baseline). This would represent a statistically significant increase at $p < 0.05$ (p=0.0359) of 9.95% in success rate over the entire eligible Medicaid Choice population, which we believe is feasible by the project end date on 6/30/2022.

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

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Key Driver Diagrams

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

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

Key Driver Narrative

During the initial discussions with our clinical partners, it was noted that the clinic processes are different for well-visits and sick visits. It is part of the standard work for depression screenings to be completed at all well-visits, whereas depression screenings are only completed at sick visits on an as-needed basis. It should also be noted that well-visits are usually longer visits than sick-visits, and this expectation is communicated to members when they schedule well-visits.

To improve well-visit rates for adolescents, it is part of the clinic standard work to "flip" a sick visit to a well-visit if the patient is overdue for a well-visit but is at the clinic for a different reason. However, this process of "flipping" visits affects the flow at check-in and increases the duration of the visit (which can be inconvenient for the member).

Through discussion with the clinic lead, we determined that lack of time for screening at non-well-child or flipped well-child visits is an issue that can impact whether a depression screening is completed. Additionally, if there is a positive depression screen at a "flipped" well-visit, members are less likely to stay to meet with a BHC afterward because they have already been at the clinic for longer than they planned. Due

to these factors, depression screenings and same-day follow-up with a BHC are much more likely to occur at well-visits that are scheduled as well-visits (rather than flipped well-visits).

Based on this dynamic, we believe that outreaching to schedule well-visits will increase the number of members who attend a well-visit and reduce the number of "flipped" well-visits. This approach also makes it more likely that there will be sufficient time for the screening and follow-up from both the patient and providers' perspectives. Thus, we believe that this intervention will lead to more members being screened for depression. Additionally, the expectation of a longer visit duration will also increase the likelihood that a member with a positive depression screen will also be willing to meet with a behavioral health provider on the same day. Therefore, increasing the number of scheduled well-visits would be a key-driver for both depression screening and follow-up within 30 days of a positive depression screen.

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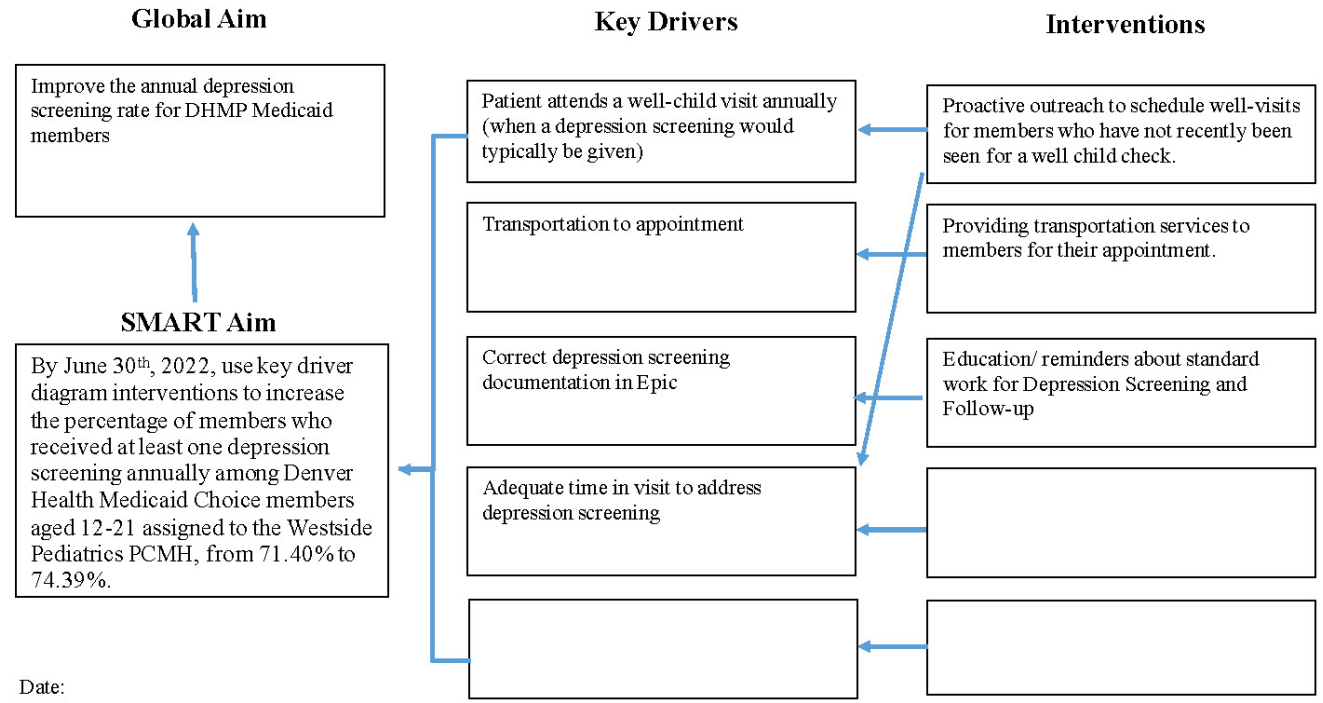
Key Driver Diagram– *Depression Screening*



Date:
Version:

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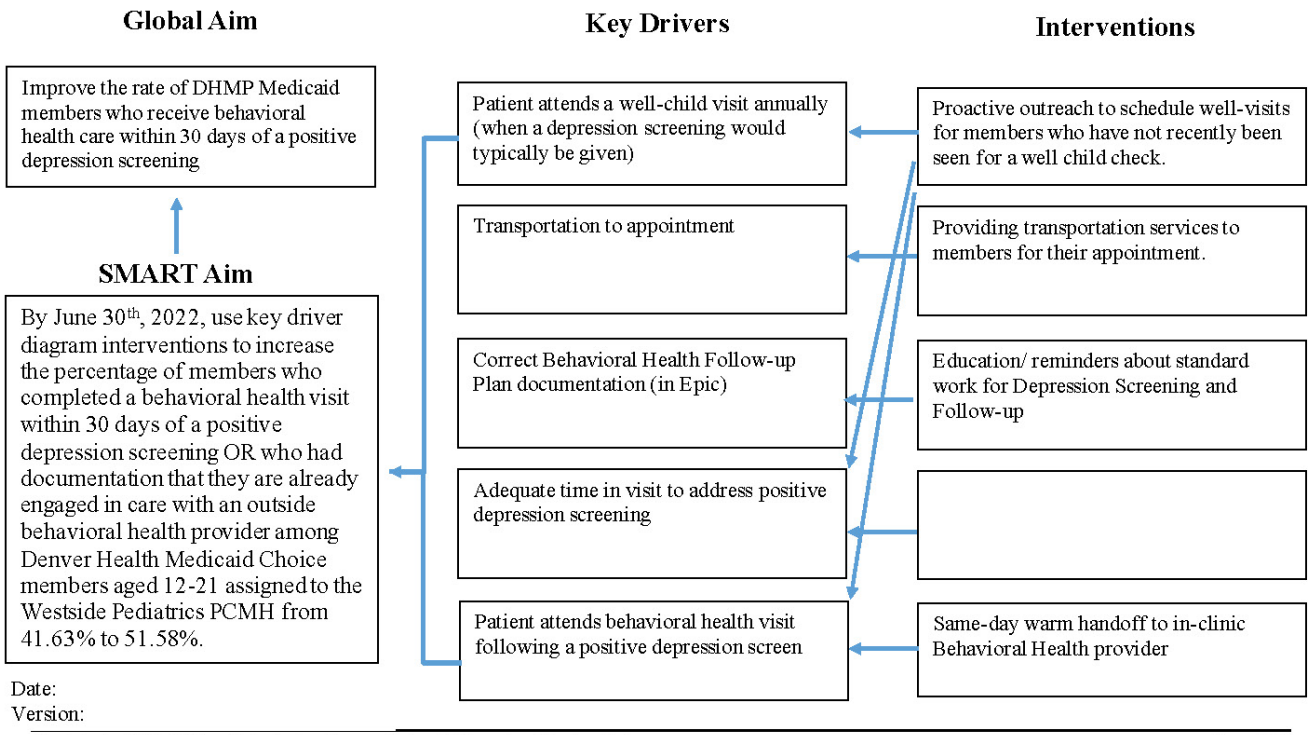
Key Driver Diagram – *Follow–up After a Positive Depression Screen*



Date:
Version:

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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

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

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

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

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

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

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

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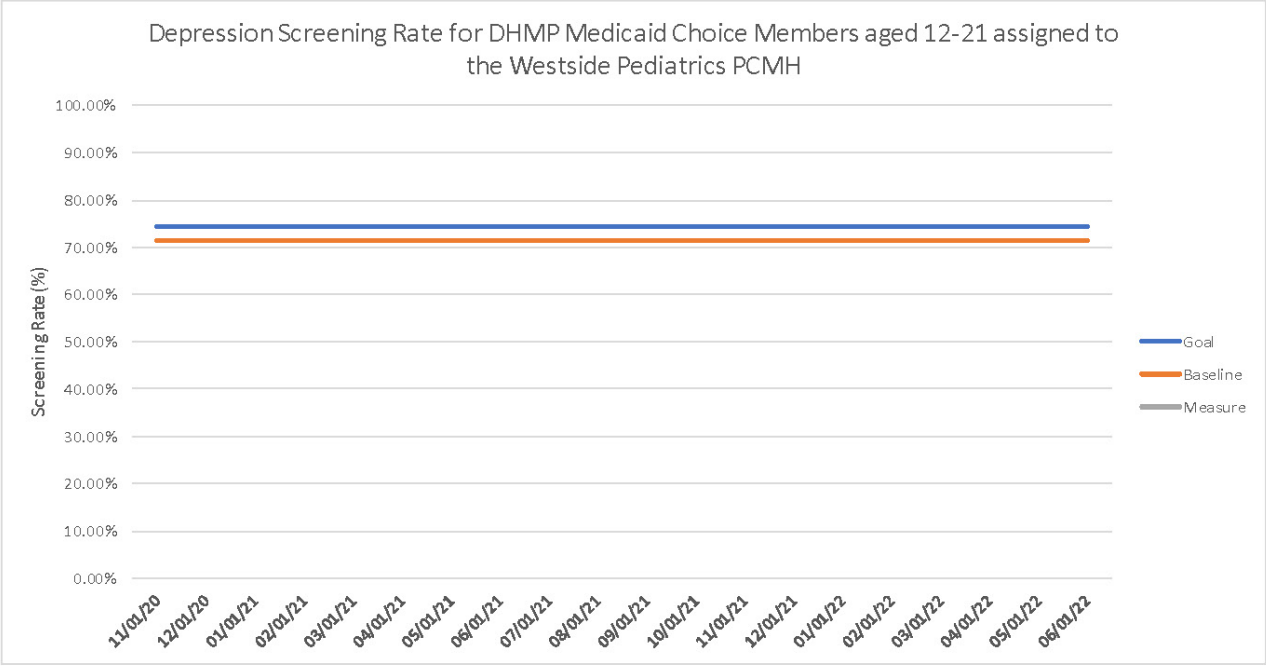
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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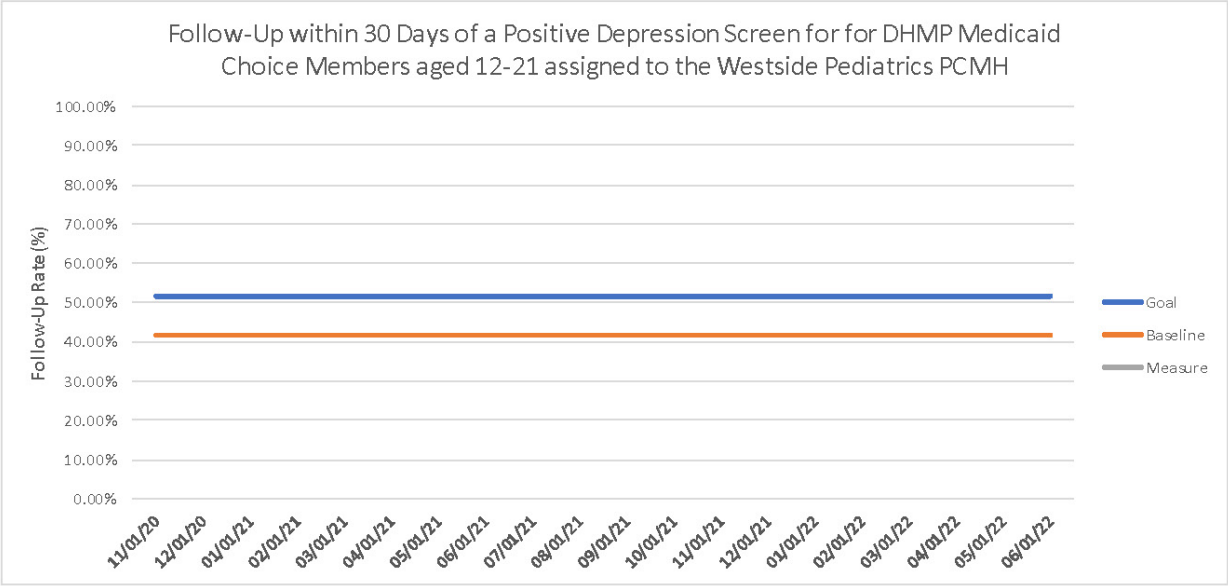
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



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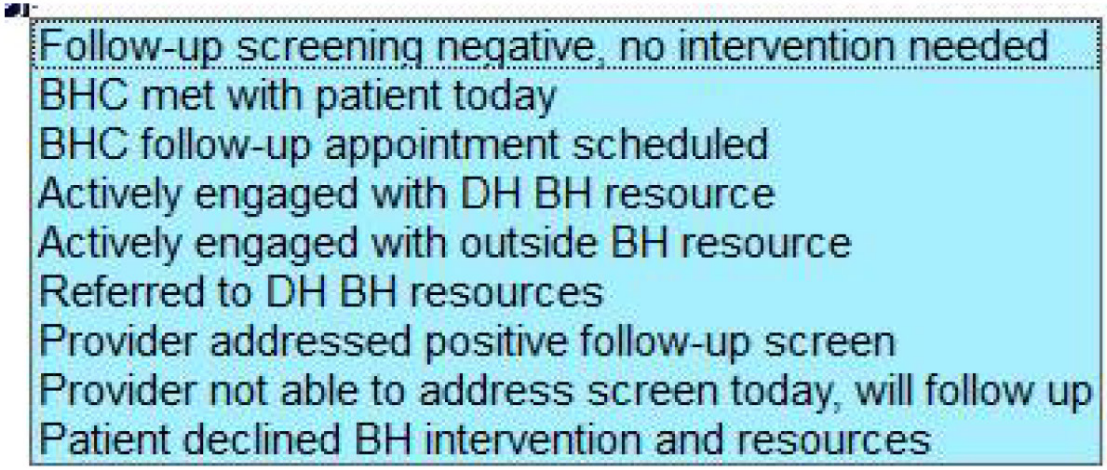
Appendix 1. Behavioral Health Follow-up Plan Drop-Down



The only option from this drop-down that would count toward numerator compliance is "Actively engaged with outside BH resource"

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen*.	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Follow-Up after a Positive Depression Screen*:** • The health plan noted at the bottom of Table 4c that the baseline data was incomplete and will need to be recalculated, along with the goal, at a later date. The health plan should notify HSAG when complete baseline data is anticipated. Module 1 will need to be updated and resubmitted with complete baseline data before HSAG can evaluate whether the baseline data for this measure supports selection of the narrowed focus. • HSAG recommends a technical assistance call to discuss preliminary data for the narrowed focus and when data will be available to complete the baseline percentage for the measure and update the goal for the SMART Aim. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*:** • In the denominator description and in the data collection process description, the health plan should clarify how "qualifying outpatient visits" are defined. What type (code) of outpatient visit qualifies a member to be included in the denominator? Are qualifying visits limited to only well visits or do they include sick visits? • It was unclear why continuous enrollment was required for 30 days prior to 9/30/20 in addition to at least 30 days after the depression

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Criteria	Score	HSAG Feedback and Recommendations
d) Narrowed focus baseline data that considered claims completeness		screen. In addition, if the depression screening must occur on the same date of service as the outpatient visit, it appeared that continuous enrollment may not be required for this measure. ***Follow-Up After a Positive Depression Screen*:** • It was unclear why continuous enrollment was required for 30 days prior to 9/30/20 in addition to at least 30 days after the depression screen. It appeared that the health plan could remove the phrase, "30 days prior to 9/30/20" from the continuous enrollment specifications for this measure. • The health plan noted that complete baseline data for the measure was not available at the time of PIP submission. When the health plan has complete baseline data for the measure, the data collection process should be reviewed and revised, as needed, to accurately reflect the final data collection process used when complete baseline data are obtained. • The health plan should clearly specify which depression screen follow-up plan options from the Appendix 1 drop-down menu are defined as "numerator-positive" for the measure. This clarification may be added to the narrative description of the data collection process or notated on the appendix. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
3. The SMART Aims for *Depression Screening* and *Follow–Up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage e) End date	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*:** To align with the denominator description, the narrowed focus description in the SMART Aim should specify, "…assigned to the Westside Pediatrics PCMH *and had at least one qualifying outpatient visit*, …" ***Follow-Up After a Positive Depression Screen*:** HSAG cannot evaluate the baseline and goal percentages in the SMART Aim since the health plan stated that these percentages are based on incomplete baseline data and will be revised. The health plan should update the SMART Aim with complete baseline data and corresponding goal prior to resubmitting Module 1. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*:** • The run chart title should specify the narrowed focus. ***Follow-Up After a Positive Depression Screen*:** • The run chart title should specify the narrowed focus and should specify that follow-up must occur within 30 days of positive depression screen. • Since the health plan stated that baseline and goal percentages are based on incomplete baseline data, the health plan should update the

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Criteria	Score	HSAG Feedback and Recommendations
		SMART Aim run chart with complete baseline data and corresponding goal prior to resubmitting Module 1. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–Up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal in each key driver diagram.	☒ Met ☐ Not Met	HSAG identified some key drivers and interventions that did not appear to be relevant for the key driver diagrams (KKDs). The health plan should ensure that the drivers and interventions for each KDD are expected to lead to achieving the SMART Aim goal (increasing depression screening and increasing follow-up care following a positive depression screen, respectively). Specific feedback on the drivers and interventions in each KDD is listed below. ***Depression Screening*:** • It appeared that the key driver, *patient attends a well-child visit annually*, and its associated intervention may not be relevant for achieving the SMART Aim. If the member must have a well visit ("qualifying outpatient visit") to be included in the denominator of the Depression Screening measure, increasing attendance of annual well visits will result in an increase in the denominator but not necessarily the numerator and rate. This driver would be relevant, however, if

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Criteria	Score	HSAG Feedback and Recommendations
		members with only a sick visit (and no well visit) are included in the denominator. • The linkage between the intervention, *proactive outreach to members who have not recently been seen for a well child check*, and the key driver, *adequate time in visit to address depression screening*, was unclear. ***Follow-up after a Positive Depression Screen*:** • The key driver, *patient attends a well-child visit annually*, and its associated intervention, did not appear relevant for achieving the SMART Aim. • The linkages between the intervention, *proactive outreach to member who have not recently been seen for a well child check*, and the key drivers, *adequate time in visit to address depression screening* and *patient attends behavioral health visit following a positive depression screen*, were unclear. **Re-review March 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
Additional Recommendations: None.		

PIP Initiation (Module 1)

☒ Pass

Date: March 19, 2021