Colorado Children's Health Insurance Program

Fiscal Year 2021–2022 PIP Validation Report

for

Denver Health Medical Plan, Inc.

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. **Denver Health Medical Plan, Inc.**, referred to in this report as **DHMP**, 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 **DHMP**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **DHMP**'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, **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 Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health CHP+ members ages 12–21 years assigned to the Westside Pediatrics PCMH, from 62.11% to 70.18%.*
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who completed a BH visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside BH provider among Denver Health CHP+ members ages 12–21 years assigned to the Westside Pediatrics PCMH from 55.56% to 81.48%.*

* HSAG approved revisions to the SMART Aim statements in February 2022.

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 BH services within 30 days of screening positive for depression. In January 2022, **DHMP** communicated to HSAG the need to revise the initial SMART Aim statements and data collection methodology to correct errors identified in the original code used to generate the initial baseline data. After a technical assistance discussion and receiving a written rationale from the health plan, HSAG approved **DHMP** to revise SMART Aims to reflect the corrected baseline data and revised goals. **DHMP** submitted updated Module 1 and Module 2

submission forms with revised documentation to HSAG in January and February 2022. HSAG reviewed the revised data and confirmed that the goals to increase depression screening to 70.18 percent and to increase follow-up within 30 days after a positive depression screen to 81.48 percent represent statistically significant improvement over the revised baseline percentages.

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	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, **DHMP** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **DHMP** 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, **DHMP** 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, **DHMP** 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 **DHMP** 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 **DHMP**'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	• Member not prompted to schedule a well visit • Member does not attend scheduled visits • Member declines well visit • Front desk staff does not give depression screener at check-in • The medical assistant (MA) does not document the depression screen score in EPIC	• Member attends a well visit annually • Transportation to appointment • Correct depression screening documentation in EPIC • Adequate time in visit to address depression screening	• Proactive outreach to schedule well visits for members who have not recently received well visit services • Providing transportation services to members for their appointment • Provider education about standard workflow for depression screening and follow-up services • Expand depression screening to all primary care acute visits in addition to well visits

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• Member does not attend the BH appointment • Provider does not document follow-up plan in EPIC using the correct format • Member declines same-day BH follow-up services	• Member attends a well visit annually • Transportation to appointment • Correct documentation of BH follow-up plan in EPIC • Adequate appointment length to address positive depression screen results • Patient attends BH visit following a positive depression screen	• Proactive outreach to schedule well visits for members who have not recently received well visit services • Providing transportation services to members for their appointment • Provider education about standard workflow for depression screening and follow-up services • Same-day warm handoff to in-clinic BH provider

In Module 2, **DHMP** 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 **DHMP** identified to improve depression screening focused on member outreach, provider education, transportation assistance, and expanding access screening services during acute (sick) visits. The potential interventions **DHMP** identified to improve follow-up services focused on member outreach, provider education, improved clinic workflow, and same-day follow-up services.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **DHMP** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **DHMP** submitted testing plans for two interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **DHMP** carried out PDSA cycles to evaluate intervention effectiveness. Table 2-2 summarizes the FY 2021–2022 Module 3 validation findings for **DHMP**'s two interventions.

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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Expand depression screening services to all primary care acute (sick) visits in addition to well visits	Member declines well visit	Member attends a visit annually (when depression screening services would typically be provided)	The percentage of acute visits attended by adolescent members during which a depression screening was completed and documented in EPIC

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Same-day warm hand-off to in-clinic BH provider when a member screens positive for depression	Member does not attend follow-up BH appointment	Member attends follow-up BH visit after a positive depression screen	The percentage of adolescent members who screen positive for depression and receive a same-day BH visit or have a follow-up plan documented in the electronic health record (EHR) stating that the member is already engaged in BH services

In Module 3, **DHMP** selected two interventions to test for the PIP. The detailed intervention testing plans **DHMP** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process failures related to appointment attendance and access to services. For each intervention, **DHMP** defined an intervention effectiveness measure to evaluate the impact of the intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **DHMP** 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 **DHMP** 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. **DHMP** also passed Module 3 for two interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **DHMP** 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

- **DHMP** 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.
- **DHMP** 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, **DHMP** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **DHMP** 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.

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Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for DHMP CHP+

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 Denver Health Medical Plan CHP+ Members*
Contact Name	Elizabeth Flood
Contact Title	Acting Population Health Manager
Email Address	Elizabeth.Flood@dhha.org
Telephone Number	845-649-0130
Submission Date	4.30.2021
Resubmission Date (if applicable)	2.3.2022

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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.) **See Attachment**

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Table 1a - Failure Modes and Effects Analysis Table - Depression Screening			
Steps from the Process Map	**Failure Mode(s) (What could go wrong?)**	**Failure Cause(s) (Why would the failure happen?)**	**Failure Effect(s) (What are the consequences?)**
Member attends visit where they would receive Depression Screening (1. Member calls appointment center to schedule acute visit, 2. Member does not schedule any visits, 3. Appointment Center sees that member is due for Well-Visit and offers well visit, 4. Member accepts well-visit, 5. Member schedules Acute appointment, 6. Member arrives at clinic for scheduled appointment, 7. Member does not attend scheduled visit, 8. Front desk staff member offers to "flip" visit to well visit, 9. Member accepts flipped visit, 10. Member attends acute visit only)	**Member not prompted to schedule a well-visit**	**Appointment center staff doesn't prompt member calling for acute visit to schedule well visit**	**Member schedules an appointment where they would not be screened for depression**
		Front desk staff doesn't prompt member who has arrived for acute visit to "flip" visit to well visit	**Member attends a visit where they would not be screened for depression**
		Member who is due for well-visit does not call to schedule or attend any visits	**Member does not attend any visits and is not screened for depression**
	Member does not attend scheduled visits	**Member forgets visit**	**Member does not attend a visit and is not screened for depression**
		Member has transportation issues and is unable to attend visit	**Member does not attend a visit and is not screened for depression**

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	Member declines well-visit	**Member has time constraints (needs an acute visit sooner than a well-visit is available, doesn't have time on the day they are attending an acute visit to accept a well-visit)**	**Member attends a visit where they would not be screened for depression**
Member receives Depression screener at visit (11. Front Desk Staff gives depression screener to member, 12. MA notices screener not given by front desk and gives screener, 14. Provider Gives Screener in room)	**Front desk staff does not give depression screener at check-in**	**Lack of training/reminders around clinic standard work**	**Member is not screened for depression**
	MA does not give depression screener (if missed by front desk)	**Lack of training/reminders around clinic standard work**	**Member is not screened for depression**
	Provider does not give depression screener (if missed by both front desk and MA)	**Lack of training/reminders around clinic standard work**	**Member is not screened for depression**
Results from Depression Screen are appropriately documented in EPIC (13. MA documents depression screen score in EPIC, 15. Provider enters Depression Screener Score into EPIC)	**The MA does not document the depression screener score in EPIC**	**Lack of training/reminders around clinic standard work**	**Depression screen not counted as numerator hit**
	The Provider does not document the depression screener score in EPIC	**Lack of training/reminders around clinic standard work**	**Depression screen not counted as numerator hit**

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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*

Priority Ranking	Failure Modes
1	Member not prompted to schedule a well-visit
2	Member does not attend scheduled visits
3	Member declines well-visit
4	Front desk staff does not give depression screener at check-in
5	The MA does not document the depression screener score in EPIC

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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.) **See Attachment**

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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*

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?)
Member attends BH appointment at DH (5. Member attends BH appointment at Denver Health)	**Member does not attend the BH appointment**	**Member does not have time to stay for same day BH appointment**	**The Member would have to schedule a follow-up BH appointment**
		Member forgets visit	**The Member would not receive a BH visit within 30 days of a positive depression screen**
		Member has transportation issues and is unable to attend visit	**The Member would not receive a BH visit within 30 days of a positive depression screen**

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BH Follow-up plan to see outside provider is appropriately documented in Epic (6. Provider documents follow-up plan in EPIC)	**Provider does not document follow-up plan in EPIC using the correct format**	**Lack of training/reminders around clinic standard work**	**If a member is receiving BH services outside the DH system and the provider does not document it in the EPIC drop-down, the member would be counted as numerator-negative even though they should be a numerator hit**
Member agrees to participate in BH services (1. Member accepts same-day BH services at Denver Health, 3. Member agrees to make follow-up appointment)	**The Member declines same day BH services**	**The Member may not have enough time to meet with a BH provider that day.**	**The member would have to schedule a follow-up BH appointment**
	The Member declines follow-up BH services	**The Member may not want BH services.**	**The member would not receive a BH visit within 30 days of a positive depression screen**
There is BH visit availability within 30 days (2. Denver Health BH provider available for same-day appointment, 4. BH follow-up appointment available at Denver Health within 30 days?)	**The BH provider does not have time in their schedule for a same-day appointment**	**The BH provider has a full schedule**	**The member would have to schedule a follow-up BH appointment**
		There is not be a BH provider in-office every day	**The member would have to schedule a follow-up BH appointment**
	There is not a BH follow-up appointment available within 30 days	**High demand for BH services**	**The member would not receive a BH visit within 30 days of a positive depression screen**

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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*

Priority Ranking	Failure Modes
1	**Member does not attend the BH appointment**
2	**Provider does not document follow-up plan in EPIC using the correct format**
3	**The Member declines same day BH services**

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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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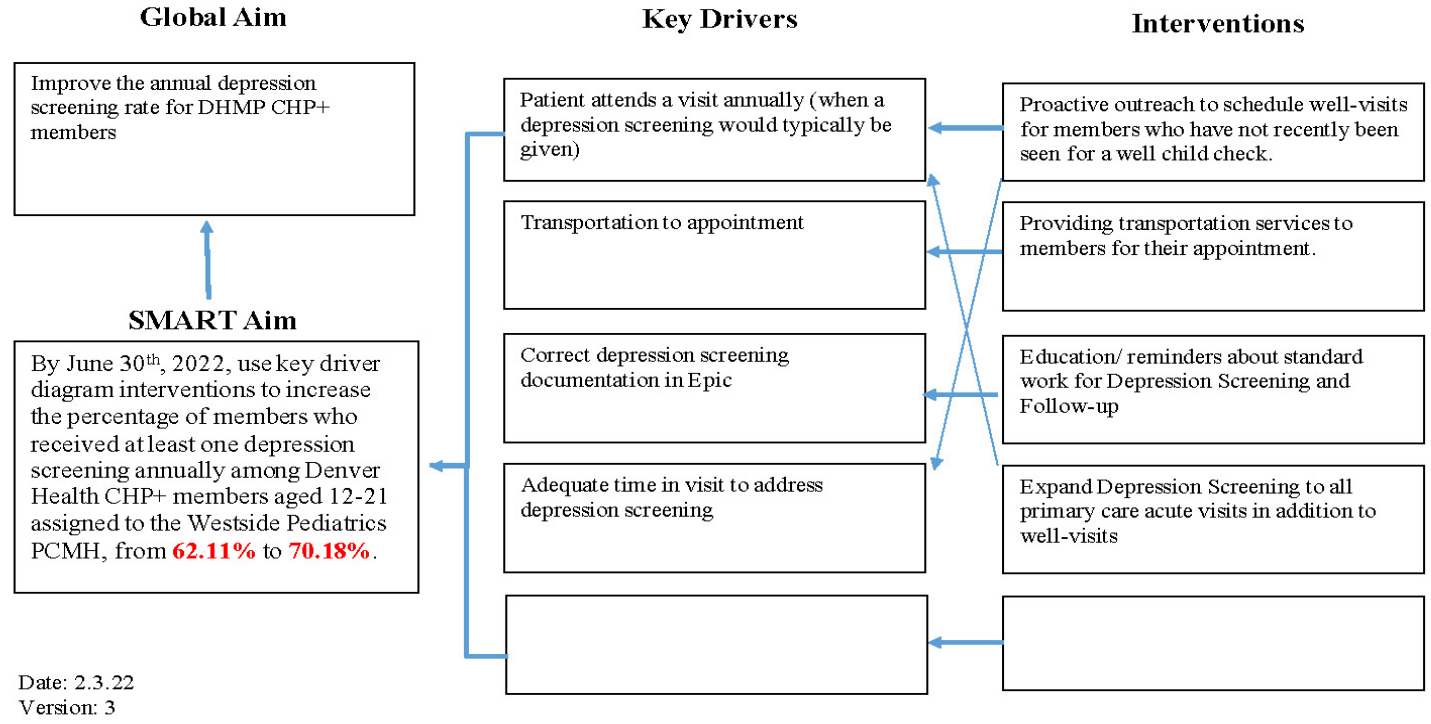
Key Driver Diagram– *Depression Screening*



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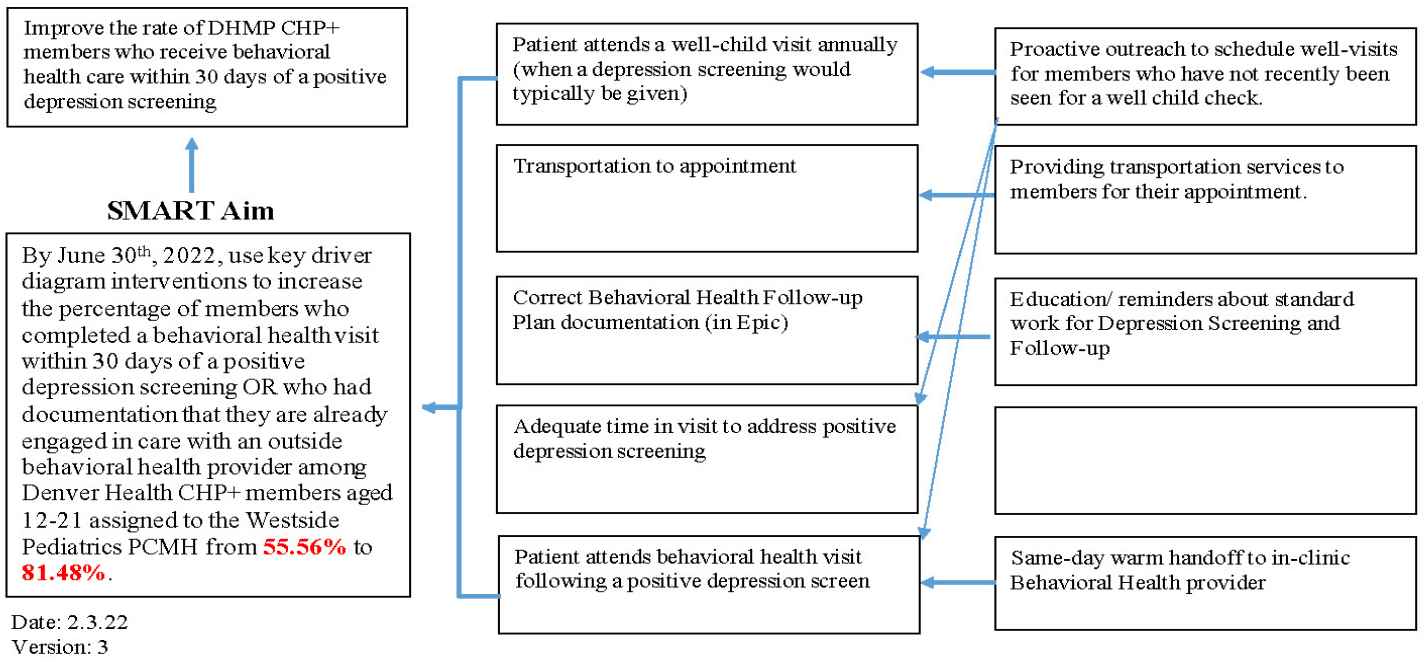
Key Driver Diagram – *Follow–up After a Positive Depression Screen*



Date: 2.3.22
Version: 3

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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 CHP+ Members*
Intervention Name:	Expand Depression Screening to all primary care acute visits in addition to well-visits
Contact Name	Gregg Kamas
Contact Title	Quality Improvement Director
Email Address	Gregg.Kamas@dhha.org
Telephone Number	303-602-2051
Submission Date	**July 9, 2021**
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	Expand Depression Screening to all primary care acute visits in addition to well-visits
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Member declines well-visit
Key Driver Addressed	Patient attends a visit annually (when a depression screening would typically be given)
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Notify all staff of change to standard work (that depression screening will be given at **every acute visit** for members 12+ years of age. The rest of the standard work for the process will remain the same as when a depression screening is given at a well visit). 2. Clinic staff will roll out new screening process 3. Collect data (screening rates at acute visits) 4. Reassess new process – (collect staff feedback, consider data and staff feedback)

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Table 1—Intervention Plan	
What are the predicted results of this test?	Screening for depression at acute visits in addition to well visits should increase overall depression screening rates for two reasons. First, this approach will expand the overall number of visits where a member could be screened. Second, the screening process will no longer be reliant on a member scheduling a well visit or accepting a flipped visit offered by either the appointment center or the front desk.

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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)** **Depression Screening Rate at Adolescent Acute visits**
Numerator Description	The number of acute visits where an adolescent member completed a depression screening (with the depression screening documented in EPIC)
Denominator Description	The number of acute visits attended by adolescent members

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	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 reporting date frame) 2.) DHHA Epic data: 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

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	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.
Describe the Data Sources	Enrollment data file, Epic EMR data
Describe how Data will be Collected	We will write a custom SQL query against the state enrollment files and DHHA's Epic Electronic Medical Record (EMR) data. Our SQL query uses state enrollment files and Epic EMR encounter data to determine how many acute visits members attended and whether members received a depression screen at the acute visit. For the custom SQL query, DHMP enrollment data will be used to determine whether members were enrolled during the reporting period. 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 Westside Pediatrics listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic as of the end of the reporting month, and whether these members had at least one qualifying acute visit during the reporting period. If the member meets the above criteria, they qualify for the denominator. The report will be pulled monthly during the intervention. The reporting period will be the month the data is pulled for (e.g. 6/1/2021-6/30/2021). For the depression screening numerator, the query pulls data from the Epic EMR, to determine whether the members in the denominator have had a

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	documented depression screen (PHQ-2, PHQ-9, EPDS, or RHS 13) at the acute visit they attended.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	As noted above, data will be pulled monthly. Since screening data will be pulled directly from EPIC, there should be very little lag. However, we will pull the data for the previous month no earlier than the 5th of the subsequent month to allow for any charting lag.

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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 CHP+ Members*
Intervention Name:	Same-day warm handoff to in-clinic Behavioral Health (BH) provider
Contact Name	Gregg Kamas
Contact Title	Quality Improvement Director
Email Address	Gregg.Kamas@dhha.org
Telephone Number	303-602-2051
Submission Date	**July 9, 2021**
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	Same-day warm handoff to in-clinic Behavioral Health (BH) provider
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	**Member does not attend the BH appointment**
Key Driver Addressed	Patient attends behavioral health visit following a positive depression screen
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Notify all staff of change to standard work (that a same-day BH visit should be offered to every member with a positive depression screen who is not already engaged in BH services). 2. Clinic staff will roll out same-day warm handoff process 3. Collect data (same day BH visit rate) 4. Reassess new process – (collect staff feedback, consider data and staff feedback)
What are the predicted results of this test?	Offering a same-day BH visit as part of a warm-handoff to the in-clinic BH provider should increase the number of members with a positive depression screen who have a BH follow-up

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Table 1—Intervention Plan	
	within 30 days. A same day BH visit removes obstacles related to scheduling, transportation or time related challenges that may prevent members being able to return to the clinic on a different day.

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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)** **Same Day BH Follow-up rate - The percent of visits where members with a positive depression screening receive a BH visit on the same day as their positive depression screen**
Numerator Description	The number of visits for adolescent members who have a BH visit on the same day as their positive depression screening OR who have a follow-up plan completed in the EMR stating that they are already engaged in BH services
Denominator Description	The number of visits for adolescent members who have a positive depression screening at that visit

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	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)

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	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, whether the member had a documented behavioral health visit (in-person or telehealth) on the same day as the positive depression screen, the contents from the Behavioral Health Follow-up Plan in Epic and the visit type and date of the behavioral health visit if applicable
Describe the Data Sources	DHMP state enrollment files, Epic EMR data
Describe how Data will be Collected	We will write a custom SQL query against the state enrollment files and DHHA's Epic Electronic Medical Record (EMR) data. Our SQL query uses state enrollment files and Epic EMR encounter data to determine how many visits members attended and whether members received a depression screen. For the custom SQL query, DHMP enrollment data will be used to determine whether members were enrolled during the reporting period. 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 Westside Pediatrics

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	listed as their Patient-Centered Medical Home (PCMH) in their medical record in Epic during the month of the data pull, and whether these members had at least one qualifying acute visit during the reporting period. If the member meets the above criteria, then the SQL query pulls the members with a depression screening at the visit with a positive depression screening (PHQ-2≥2, PHQ-9 ≥ 10, EPDS ≥ 10, RHS-13 ≥ 5). These members qualify for the **Same Day BH Follow-up** denominator. For the **Same Day BH Follow-up** numerator, the query pulls data from the Epic EMR, to determine whether the members in the denominator have had a BH visit on the same day as their positive depression screening or the contents from the Behavioral Health Follow-up Plan in Epic indicate that the member is already engaged in BH services. 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 will be pulled monthly during the intervention. The reporting period will be the month the data is pulled for (e.g. 6/1/2021-6/30/2021).
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	As noted above, data will be pulled monthly. Since screening data will be pulled directly from EPIC, there should be very little lag. However, we will pull the data for the previous month no earlier than the 5th of the subsequent month to allow for any charting lag.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The MCO included process maps for *Depression Screening* and *Follow–up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	**General Comment:** The health plan used numbering instead of highlighting to clearly identify the steps in the process maps that were identified as opportunities for improvement.
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 MCO 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 MCO 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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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: May 26, 2021

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Intervention: Expand Depression Screening to All Primary Care Acute Visits in Addition to Well-Visits

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: The health plan should assess effectiveness of the intervention as soon as meaningful intervention effectiveness measure data are available. If meaningful data can be collected more frequently than monthly, the health plan should consider shorter measurement intervals to direct intervention next steps as early as possible and allow maximal time for course corrections that facilitate achievement of the SMART Aim goal.		

Intervention Testing (Module 3)

☒ Pass

Date: July 26, 2021

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Intervention: Same Day Warm Handoff to In-Clinic BH Provider

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: The health plan should assess effectiveness of the intervention as soon as meaningful intervention effectiveness measure data are available. If meaningful data can be collected more frequently than monthly, the health plan should consider shorter measurement intervals to direct intervention next steps as early as possible and allow maximal time for course corrections that facilitate achievement of the SMART Aim goal.		

Intervention Testing (Module 3)

☒ Pass

Date: July 26, 2021