COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2023–2024 PIP Validation Report

for

Denver Health Medical Plan

April 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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1. Executive Summary

Pursuant to 42 CFR §457.1250, which requires states' Medicaid managed care programs to participate in external quality review (EQR), the State of Colorado, Department of Health Care Policy and Financing (the Department) required its Medicaid health plans to conduct and submit performance improvement projects (PIPs) annually for validation by the State's external quality review organization (EQRO). Denver Health Medical Plan, referred to in this report as DHMP, a managed care organization (MCO), holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, the Department's managed care program.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in performance indicator outcomes that focus on clinical or nonclinical areas. For this year's 2023–2024 validation, DHMP submitted two PIPs: *Improving Well-Care Visit [WCV] Rates for Child and Adolescent DHMP Medicaid Members* and *Improving Social Determinants of Health [SDOH] Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services*. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP addresses quality, timeliness, and accessibility of healthcare and services for child and adolescent members. The topic, selected by DHMP and approved by the Department, was supported by historical data. The targeted population includes DHMP Medicaid members ages 3 to 21 years. The PIP Aim statement is as follows: "By June 30, 2025, use targeted interventions to increase the percentage of DHMP Medicaid members ages 3–21 who attend an annual WCV from 43.29% to 45%."

The nonclinical *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP addresses quality and accessibility of healthcare and services for DHMP Medicaid members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP Aim statement is as follows: "By June 30th, 2025, use targeted interventions to increase the percentage of DHMP Medicaid members empaneled at DHHA [Denver Health and Hospital Authority] who had at least one primary care visit in the past year and who had at least one SDOH screening (defined as at least one HRSN [Health-Related Social Needs] flowsheet question) completed in the past year from 22.25% to 25%."

Table 1-1 outlines the performance indicators for each PIP.

Table 1-1—Performance Indicators

PIP Title	Performance Indicator
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members	The percentage of DHMP Medicaid members ages 3–21 years who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement period.
Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services	The percentage of DHMP Medicaid members who were empaneled at Denver Health, had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least HRSN flowsheet question) completed in the past year.

2. Background

Rationale

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 EQR of each contracting health plan. Health plans include MCOs. The regulations at 42 CFR §438.358 require that the EQR include analysis and evaluation by an EQRO of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the Department—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[1-1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that DHMP in this report, designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, an MCO's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well DHMP improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that the MCO executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the MCO during the PIP.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 27, 2024.

Validation Overview

For FY 2023–2024, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCO 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 improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

Table 2-1—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the data needed to conduct the PIP validation from DHMP's PIP Submission Form. This form provides detailed information about DHMP's PIP related to the steps completed and evaluated for the 2023–2024 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**

   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

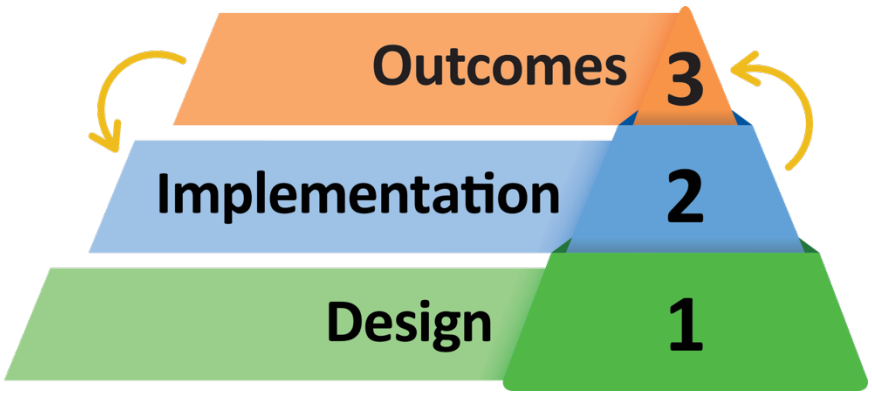
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.

  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Figure 2-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the PIP topic, Aim statement, population, sampling techniques, performance indicator(s), and data collection processes. To implement successful improvement strategies, a strong methodologically sound design is necessary.

Figure 2-1—Stages of the PIP Process



Once DHMP establishes its PIP design, the PIP progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, DHMP evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. If the outcomes do not improve, DHMP should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

3. Findings

Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 3-1 summarizes the health plan's PIPs validated during the review period with an overall confidence level of *High Confidence*, *Moderate Confidence*, *Low Confidence* or *No Confidence* for the two required confidence levels identified below. In addition, Table 3-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

DHMP submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP and the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. DHMP resubmitted both PIPs to address initial validation feedback and received a *High Confidence* level for both PIPs after the resubmission. Table 3-1 illustrates the initial and resubmission validation scores for each PIP.

Table 3-1—2023–2024 PIP Overall Confidence Levels for DHMP

PIP Title	Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members	Initial Submission	67%	63%	*No Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

PIP Title	Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services	Initial Submission	67%	50%	*No Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Populated from the PIP Validation Tool and based on the percentage scores.

The *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP.

The *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP was also validated through the first eight steps in the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. DHMP received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

Scores and feedback for individual evaluation elements and steps are provided for each PIP in Appendix B. Final PIP Validation Tools.

Analysis of Results

Table 3-2 displays data for DHMP's *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP.

Table 3-2—Performance Indicator Results for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of DHMP Medicaid members ages 3–21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.	N: 14,725 D: 34,017	43.29%					

N–Numerator D–Denominator

For the baseline measurement period, DHMP reported that 43.29 percent of MCO members ages 3 to 21 years had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Table 3-3 displays data for DHMP's *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 3-3—Performance Indicator Results for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of DHMP Medicaid members who were empaneled at Denver Health, had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least HRSN flowsheet question) completed in the past year.	N: 7,390 D: 33,217	22.25%					

N–Numerator D–Denominator

For the baseline measurement period, DHMP reported that 22.25 percent of Medicaid members with at least one primary care visit at Denver Health were screened for SDOH during the measurement year.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. DHMP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

Table 3-4 displays the barriers and interventions documented by the health plan for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP.

Table 3-4—Barriers and Interventions for the *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP

Barriers	Interventions
• Lack of member awareness of the need for an annual well visit • Lack of transportation • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment • Lack of motivation to schedule and attend an annual well visit	Population Health outreach to members who are overdue for the annual well visit
• Lack of member awareness of the need for an annual well visit • Challenges in navigating the healthcare system • Forgetting a scheduled well visit appointment	Automated reminder phone calls to members who are overdue for the annual well visit
Lack of motivation to schedule and attend an annual well visit	Member incentive for well visit completion

Table 3-5 displays the barriers and interventions documented by the health plan for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP.

Table 3-5—Barriers and Interventions for the *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP

Barriers	Interventions
Medical assistant (MA) staff turnover	Reviewing clinic workflows with MA staff to ensure SDOH screening occurs during the visit
• MA staff turnover • Competing priorities at visits	MyChart SDOH pre-visit screening offers the member an opportunity to complete the SDOH screening prior to the visit

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, DHMP submitted the clinical *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* PIP and the nonclinical *Improving SDOH Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services* PIP. DHMP reported baseline performance indicator results for both PIPs, and both PIPs were validated through Step 8 (Design and Implementation). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages.

HSAG's PIP validation findings suggest a thorough application of the PIP Design stage (Steps 1 through 6) for both PIPs. A methodologically sound design created the foundation for DHMP to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. In the Implementation stage (Steps 7 and 8), DHMP accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. DHMP will progress to reporting Remeasurement 1 indicator results for both PIPs, and both PIPs will progress to being evaluated for achieving significant improvement for next year's validation.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The MCO should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Appendix A. Final PIP Submission Forms

Appendix A contains the final PIP Submission Forms that DHMP submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Demographic Information	
MCO Name: Denver Health Medical Plan	
Project Leader Name: Beth Flood	Title: Senior Manager of Population Health
Telephone Number: (845) 649-0130	Email Address: elizabeth.flood@dhha.org
PIP Title: **Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members**	
Submission Date: 10.31.2023	
Resubmission Date (if applicable): **02.05.2024**	

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members

Provide plan-specific data:

Denver Health Medical Plan (DHMP) monitors well-care visit rates for child and adolescent Medicaid members using Healthcare Effectiveness Data and Information Set (HEDIS) WCV specifications and validated data. DHMP Medicaid WCV performance for HEDIS MY2022 was 42.90%, a slight increase from previous year rates of 41.93% in MY2021 and 39.31% in MY2020, though this rate remains in the 10th percentile nationwide. As the WCV rate is low compared to similar plans across the country, this topic has been identified as an opportunity for improvement.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

The American Academy of Pediatrics (AAP) recommends that children and adolescents attend an annual well-care visit to help prevent illness through immunizations, screenings, and counseling, as well as track growth and development. Well-care visits also provide children, adolescents, and caregivers an opportunity to ask questions or raise any concerns they may have about their health. Bright Futures, in conjunction with the AAP, developed Recommendations for Preventative Pediatric Health Care which provide specific, evidence-based guidance by age for preventative screenings, measurements, and procedures to be performed at well-care visits. Activities performed at annual well-care visits provide an opportunity for early intervention if physical, social, developmental, or behavioral issues are identified, and early intervention leads to better outcomes in member health, functional status, and satisfaction with care.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

By June 30th, 2025, use **targeted interventions** to increase the percentage of DHMP Medicaid members ages 3-21 who attend an annual well-care visit from 43.29% to **45.00%.**

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition:

The PIP population for Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members is defined as follows:

- DHMP Medicaid members who were continuously enrolled throughout the measurement period, with no more than one gap in enrollment of up to 45 days during the continuous enrollment period; and
- Age 3-21 as of June 30th of the measurement period.

Member race and ethnicity will be identified using DHHA Epic data where available and HCPF enrollment data if DHHA Epic data is not available for the member. While not explicitly an area of focus for this PIP, special attention will be dedicated to identifying disparities and improving health equity should any disparities be noted.

Members with special healthcare needs will not be excluded from the PIP population.

Enrollment requirements (if applicable):

Members must be continuously enrolled with DHMP Medicaid throughout the measurement period, with no more than one gap in enrollment of up to 45 days during the continuous enrollment period to be included in the PIP population.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply. **The population definition must:** ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. ◆ Include the age range and the anchor dates used to identify age criteria, if applicable. ◆ Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3. ◆ Capture all members to whom the statement(s) applies. ◆ Include how race and ethnicity will be identified, if applicable. ◆ If members with special healthcare needs were excluded, provide the rationale for the exclusion.
Member age criteria (if applicable): Members must be age 3-21 as of June 30th of the measurement period to be included in the PIP population. **Inclusion, exclusion, and diagnosis criteria:** To be included in the PIP population, members must be: - Continuously enrolled in DHMP Medicaid throughout the measurement period, with no more than one gap in enrollment of up to 45 days during the continuous enrollment period; and - Age 3-21 as of June 30th of the measurement period. Members will be excluded from the PIP population if they (were): - In hospice or using hospice services any time during the measurement period; and/or - Died during the measurement period. **Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):** N/A

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

Sampling was not used to select members of the population.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the Indicator(s) must:** ◆ Include the complete title of each indicator. ◆ Include the rationale for selecting the indicator(s). ◆ Include a narrative description of each numerator and denominator. ◆ If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. ◆ Include complete dates for all measurement periods (with the month, day, and year). ◆ Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Indicator 1	**Child and Adolescent Well-Care Visits (WCV)**
	This indicator utilizes the HEDIS MY2023 technical specifications for the Child and Adolescent Well-Care Visits (WCV) metric, which tracks the rate of members 3-21 years of age during the measurement period who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement period. We have adjusted the HEDIS measurement period, which runs on the calendar year, to reflect the Colorado State Fiscal Year measurement period as requested by HCPF and HSAG. This indicator was selected because it is a validated and universally recognized metric that tracks our identified area of improvement for this PIP: child and adolescent well-care visits.
Numerator Description:	DHMP Medicaid members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.
Denominator Description:	All DHMP Medicaid members 3–21 years of age.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025

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for Denver Health Medical Plan

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table. The description of the sampling methods must: ◆ Include components identified in the table below. ◆ Be updated annually for each measurement period and for each indicator. ◆ Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.	
Mandated Goal/Target, if applicable	**45.00%**
Indicator 2	**[Enter Indicator title]**
	[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]
Numerator Description:	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	[X] Administrative Data Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the	[ ] Survey Data Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

	time the data are generated: **98.99%** Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: **DHMP utilizes an Income Reported but not Paid (IBNP) methodology to calculate the reported administrative data completeness percentage.** As the measurement period ended more than three months prior to the analysis of baseline data, we anticipate **1.01%** of data is missing due to claims lag.	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected:
DHMP Gaps in Care Dashboard:

- Member Secondary ID
- Member DH MRN
- Measurement Month Year
- Line of Business

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
- Benefit Plan - First Name - Last Name - Date of Birth - Age on Measurement Date - Primary Language - Member Physical Address - Member Physical City Name - Member Physical State - Member Physical Zip Code - Member Phone Number - PCP Last Appointment - PCP Next Appointment - Empanelment Status - Medical Home Name - PCP Provider Name - Measure Description - Numerator Outcome HEDIS Vendor Monthly Standard Data Extract: - Member ID - First Name - Last Name - Member DOB - Age End Report Year - Gender - PCP Provider ID

***Appendix A*: State of Colorado 2023-24 PIP Submission Form**
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
- Provider First Name - Provider Last Name - Employer Number - Latest Span - Product Line - Anchor Date - Age - Continuous Enrollment - Benefit - Event Diagnosis - Deceased - Deceased Exclusion - Exclusions - Required Exclusions - Hospice Exclusion - Race ID - Hispanic Origin - Race Source - Ethnicity Source - Service Date - Well Care Visits Administrative - Well Care Visits Supplemental - QNXT Member ID - Member DWID - Member Employer Identification Number - SSN

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Data Collection Process: 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. Because we only compute HEDIS scores once annually and on a calendar year schedule, we used an internal dashboard that utilizes a monthly standard data extract provided by the HEDIS vendor. These data were then run against validated HMY2022 member-level data to create our baseline submission. The monthly standard data extract utilizes the HEDIS specification criteria to ensure inclusion and exclusion criteria are appropriately accounted for in the measure numerator and denominator. Inclusion criteria for the denominator of the WCV measure are DHMP Medicaid members age 3-21 with continuous enrollment during the defined measurement period. Members are included in WCV numerator if they have at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement period. Additional details on inclusion and exclusion criteria for the measure numerator and denominator can be found in Steps 3 and 5 of this report. The list of HEDIS WCV Value Set OIDs and Codes used to identify numerator compliance is attached.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: Child and Adolescent Well-Care Visits (WCV)

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022–06/30/2023	Baseline	14,725	34,017	43.29%	N/A for baseline	N/A for baseline
07/01/2023–06/30/2024	Remeasurement 1					
07/01/2024–06/30/2025	Remeasurement 2					

Indicator 2 Title: [Enter title of indicator]

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline				N/A for baseline	N/A for baseline
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 1					
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative:

Denver Health Medical Plan (DHMP) monitors well-care visit rates for child and adolescent Medicaid members using Healthcare Effectiveness Data and Information Set (HEDIS) WCV specifications and validated data. DHMP Medicaid WCV performance for HEDIS MY2022 was 42.90%, a slight increase from previous year rates of 41.93% in MY2021 and 39.31% in MY2020, though this rate remains in the 10th percentile nationwide. This PIP utilizes a different measurement period from the validated HEDIS MY2022 WCV rate noted above, as requested by HCPF and HSAG. For the measurement period of July 1, 2022 to June 30, 2023, the percentage of DHMP Medicaid members ages 3-21 who attended an annual well-care visit was 43.29%

To calculate the PIP goal, a Chi-Square Test was utilized to ensure the goal indicated statistically significant improvement over the baseline rate; the goal of increasing the percentage of DHMP Medicaid members ages 3-21 who attend an annual well-care visit from 43.29% to **44.07%** is significant to a p-value of **0.04052; however DHMP has set our goal at 45.00%, above the minimum statistically significant increase for performance.**

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

No factors threatening the validity of these findings have been identified at this time.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

QI Team Members:

- **Beth Flood, Senior Manager of Population Health**
- **Katie Egan, Quality Improvement Manager**
- **Shannon Godbout, Population Health Project Manager**
- **Jonathan Ramirez, Quality Improvement Project Manager**
- **Rene Horton, Data Scientist**

QI process and/or tools used to identify and prioritize barriers:

We completed a literature review and key stakeholder interviews to identify and prioritize barriers to children and adolescents ages 3-21 completing an annual well-child visit. The following barriers were identified: education of well-child visit need; motivation; navigating the healthcare system; remembering a well-child visit is due; and transportation.

Many members and their families are not aware of the importance of an annual well-child visit. Well-child visits provide many benefits, including the opportunity to complete growth, social, and developmental screenings; ensure members are current on their immunizations; and provide a forum for members to ask their provider any health-related questions they may have. Additionally,

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

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attending an annual well-child visit can help establish a trusting relationship with a provider, giving members a resource when new issues arise. By ensuring members and their families are aware of the benefits of receiving regular well-care visits, members will be more likely to complete their annual well-care appointments.

Members may lack the motivation to attend an annual well-care visit. If members or their families think the member is healthy, they may not prioritize scheduling and attending a well-care visit. Further, some members may actively avoid attending well-care visits due to anxiety, particularly around receiving immunizations. Providing members an incentive may motivate members who would otherwise not complete an annual well-care visit to do so.

Navigating the healthcare system can be another barrier to completing annual well-care visits. If it is difficult to schedule an appointment with a provider, whether due to a lack of available appointments with a preferred provider or not knowing how to schedule an appointment, members may give up and opt not to see a provider.

Life is busy, and sometimes members or their families may not remember to schedule an annual well-care visit. A simple reminder may be all that is needed to get them to engage in care.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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C. Intervention Worksheet:
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   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

Finally, transportation is a barrier to attending annual well-care visits. Many DHMP members and their families do not have consistent access to a private vehicle or may not be able to drive. Further, if it is difficult for members to access public transportation, attending appointments can be challenging if not impossible.

Through our consideration of these identified barriers, we have developed interventions designed to mitigate their impact on member well-care visit completion. These interventions are discussed below.

B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Population Health Outreach to Overdue Members	**Education of WCV Need; Transportation; Navigating Healthcare System; Remembering; Motivation**
Robocall Reminders to Overdue Members	**Education of WCV Need; Navigating Healthcare System;**

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Well-Care Visit Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

	Remembering
Incentives for WCV Completion	**Motivation**

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Demographic Information	
MCO Name: Denver Health Medical Plan	
Project Leader Name: Beth Flood	Title: Senior Manager of Population Health
Telephone Number: (845) 649-0130	Email Address: elizabeth.flood@dhha.org
PIP Title: **Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services**	
Submission Date: 10.31.2023	
Resubmission Date (if applicable): **02.05.2024**	

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services

Provide plan-specific data:

To assess Social Determinants of Health (SDOH) needs, Denver Health utilizes a Health-Related Social Needs (HRSN) screening tool, which asks questions about member needs in five domains prioritized by CMS: food insecurity, interpersonal safety, housing, transportation, and utilities. The screening tool is attached to this submission.

Denver Health Ambulatory Care Services (ACS), or services provided on an outpatient basis (including diagnosis, consultation, treatment, intervention, and rehabilitation), has developed a robust series of Tableau dashboards designed to monitor member-reported SDOH needs captured through the HRSN screening tool. These dashboards track and trend member responses and demographic information, allowing users to identify domains, populations, and geographic locations with specific needs.

DH ACS currently tracks SDOH screening rates for empaneled patients who have at least one primary care visit within the past year. This is tracked on a monthly basis and reviews the number of patients within the aforementioned population with visits within the measurement month. Of those patients with a visit in the measurement month, a rate is calculated for the percentage of those patients who have an SDOH screening response on file within the previous twelve months.

As of June 30th, 2023, the DH ACS SDOH screening rate for DHMP Medicaid members over the twelve-month measurement period was **22.25%.** Monthly rates improved throughout the measurement period, beginning at **16.99%** in July 2022 and steadily increasing to **23.69%** in June 2023. Still, there is opportunity for improvement.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction: Social determinants of health are the conditions in which people work, live, and play. Recent research indicates that social determinants of health have a greater impact on personal health and well-being than genetics or clinical care access. By improving SDOH screening rates, we will be better able to identify member SDOH needs and work to address them through referrals and advocating for improved access to needed resources. By connecting members to beneficial SDOH resources, we will subsequently improve member health, functional status, and overall satisfaction. Social determinants of health screening tools can also help us work toward health equity by identifying intervenable needs within specific populations which, when appropriately addressed, can improve conditions reinforced by historical and current systems and policies that perpetuate inequities that lead to poor health outcomes. This topic was required by the State.

***Appendix A*: State of Colorado 2023-24 PIP Submission Form**
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

By June 30th, 2025, use **targeted interventions** to increase the percentage of DHMP Medicaid members empaneled at DHHA who had at least one primary care visit in the past year and who had at least one SDOH screening (defined as at least one HRSN flowsheet question) completed in the past year from **22.25%** to **25.00%.**

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition:

The PIP population for Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services is defined as follows:

- DHMP Medicaid members who were empaneled at Denver Health within the measurement period; and
- Had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period.

Member race and ethnicity will be identified using DHHA Epic data where available and HCPF enrollment data if DHHA Epic data is not available for the member. While not explicitly an area of focus for this PIP, special attention will be dedicated to identifying disparities and improving health equity should any disparities be noted.

Members with special healthcare needs will not be excluded from the PIP population.

Enrollment requirements (if applicable):

There are no length of enrollment, continuous enrollment, new enrollment, or allowable gap requirements for the PIP population.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply. **The population definition must:** ◆ Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. ◆ Include the age range and the anchor dates used to identify age criteria, if applicable. ◆ Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. ◆ Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3. ◆ Capture all members to whom the statement(s) applies. ◆ Include how race and ethnicity will be identified, if applicable. ◆ If members with special healthcare needs were excluded, provide the rationale for the exclusion.
Member age criteria (if applicable): There are no member age criteria for the PIP population. **Inclusion, exclusion, and diagnosis criteria:** To be included in the PIP population, members must be: - Enrolled in DHMP Medicaid within the measurement period; and - Empaneled at Denver Health within the measurement period; and - Have at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period. Members will be excluded from the PIP population if they (were): - Not empaneled at Denver Health within the measurement period; and/or - Did not have at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period. **Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):** We use the DHHA ACS primary care visit codes to identify members who had at least one primary care visit within the past year.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

Sampling was not used to select members of the population.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the Indicator(s) must:** ◆ Include the complete title of each indicator. ◆ Include the rationale for selecting the indicator(s). ◆ Include a narrative description of each numerator and denominator. ◆ If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. ◆ Include complete dates for all measurement periods (with the month, day, and year). ◆ Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Indicator 1	**SDOH Screening Rates for DHMP Medicaid Members Seen at DH ACS**
	DH ACS currently tracks SDOH screening rates for empaneled patients who have at least one primary care visit within the past year. This is tracked on a monthly basis and reviews the number of patients within the aforementioned population with visits within the measurement month. Of those patients with a visit in the measurement month, a rate is calculated for the percentage of those patients who have an SDOH screening response on file within the previous twelve months. **When calculating performance, if a member has more than one visit in the measurement period, the most recent visit is counted toward the measure.** 49.20% of DHMP MCD members were empaneled at Denver Health as of June 30th, 2023.
Numerator Description:	Number of DHMP Medicaid members who were empaneled at Denver Health, had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period, and who had at least one SDOH screening (defined as at least HRSN flowsheet question) completed in the past year.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Denominator Description:	Number of DHMP Medicaid members who were empaneled at Denver Health and had at least one primary care visit at Denver Health Ambulatory Care Services within the measurement period.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	**25.00%**
Indicator 2	**[Enter Indicator title]**
	[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]
Numerator Description:	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the Indicator(s) must:** ◆ Include the complete title of each indicator. ◆ Include the rationale for selecting the indicator(s). ◆ Include a narrative description of each numerator and denominator. ◆ If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. ◆ Include complete dates for all measurement periods (with the month, day, and year). ◆ Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data	[ ] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [X] Data collection tool attached (required for manual record review)	Data Source [ ] Programmed pull from claims/encounters [ ] Supplemental data [X] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)-please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Estimated percentage of reported administrative data completeness at the time the data are generated: N/A% complete. Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: As the HRSN screening process is relatively new, improper documentation within Epic may contribute to inadequate data completeness; however, we have not pulled a sample for medical record review to assess how frequently improper documentation of HRSN screening results occurs. Claims lag did not impact the data reported, as claims data is not utilized for this measure.	

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected:

DH Ambulatory Quality Metric Trending Dashboard:

- Measure Name
- Measure Description
- Report Month
- SDOH Screenings Completed
- SDOH Screenings Opt-Out
- Number of Visits
- Empanelment Status
- Primary Payer
- Division

Data Collection Process:

Screening tool results are documented in Epic by medical assistants (MAs) following member visits. There is a custom Epic build for MAs to ensure standard documentation of screener results and standard work processes around how member screening is conducted and data collected.

DH ACS utilizes a SQL query that joins member payer source data, empanelment, visit information, demographics, and SDOH screening tool completion results from Epic, which is then pulled into the DH Tableau Ambulatory Quality Metric Trending dashboard for analysis.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: SDOH Screening Rates for DHMP Medicaid Members Seen at DH ACS

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022–06/30/2023	Baseline	7390	33,217	22.25%	N/A for baseline	N/A for baseline
07/01/2023–06/30/2024	Remeasurement 1					
07/01/2024–06/30/2025	Remeasurement 2					

Indicator 2 Title: [Enter title of indicator]

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target , if applicable	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline				N/A for baseline	N/A for baseline
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 1					
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative:

DH ACS currently tracks SDOH screening rates for empaneled members who have at least one primary care visit within the past year. This is tracked on a monthly basis and reviews the number of members within the aforementioned population with visits within the measurement month. Of those members with a visit in the measurement month, a rate is calculated for the percentage of those members who have an SDOH screening response on file within the previous twelve months. **When calculating performance, if a member has more than one visit in the measurement period, the most recent visit is counted toward the measure.**

As of June 30th, 2023, the DH ACS SDOH screening rate for DHMP Medicaid members over the twelve-month measurement period was **22.25%.** Monthly rates improved throughout the measurement period, beginning at **16.99%** in July 2022 and steadily increasing to **23.69%** in June 2023.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

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- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

To calculate the PIP goal, a Chi-Square Test was utilized to ensure the goal indicated statistically significant improvement over the baseline rate; the goal of increasing the percentage of DHMP Medicaid members empaneled at DHHA who had at least one primary care visit in the past year and who had at least one SDOH screening (defined as at least one HRSN flowsheet question) completed in the past year from **22.25%** to **22.91%** is significant to a p-value of **0.04120**; **however DHMP has set our goal at 25.00%, above the minimum statistically significant increase for performance.**

No factors threatening the validity of these findings have been identified at this time.

Baseline to Remeasurement 1 Narrative:
Baseline to Remeasurement 2 Narrative:

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

QI Team Members:

- **Beth Flood, Senior Manager of Population Health**
- **Katie Egan, Quality Improvement Manager**
- **Shannon Godbout, Population Health Project Manager**
- **Jonathan Ramirez, Quality Improvement Project Manager**
- **Laura Elliott, Data Scientist**

QI process and/or tools used to identify and prioritize barriers:

We completed a literature review and key stakeholder interviews to identify and prioritize barriers to members completing a Social Determinants of Health screening. The following barriers were identified: competing priorities for medical assistants (MA) at visits; MA staff turnover and training; and members not attending appointments to receive screening.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

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   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

MAs are essential to member care and perform the routine screenings and vital sign measurements at visits. As such, they are key to ensuring SDOH screenings are completed. However, MAs are expected to complete an extensive list of tasks in a short time during these visits; as such, tasks can sometimes be forgotten or omitted, particularly if they are not prioritized.

MAs, though essential to clinic operations and member care, tend to be compensated less than other medical professionals while operating in a high-stress environment. Because of this, clinics within the DHHA system have high rates of MA turnover. This leads to staffing shortages and increased pressure on existing clinic staff, leading some tasks to be temporarily halted due to time constraints. Further, when new MAs are hired, they must receive consistent training on SDOH screening importance so they are aware these need to be completed at visits.

The barriers noted above are relevant once members schedule and attend clinic visits; however, we have identified members not attending visits at all as a barrier to completing SDOH screening. Currently, these screenings are completed when a member has a clinic visit; if members do not schedule a visit, there is not an opportunity for them to complete an SDOH screening. Therefore, by increasing member engagement, the number of members with completed SDOH screenings should also increase.

Appendix A: State of Colorado 2023-24 PIP Submission Form
Improving Social Determinants of Health Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services
for Denver Health Medical Plan

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B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

Through our consideration of these identified barriers, we have developed interventions designed to mitigate their impact on member SDOH screening completion. These interventions are discussed below.

B. Barriers/Interventions Table: In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Reviewing clinic workflows	**MA staff turnover**
MyChart SDOH pre-visit screening	**MA staff turnover, competing priorities at visit**

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Appendix B. Final PIP Validation Tools

The following contains the final PIP Validation Tools for DHMP.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Demographic Information			
MCO Name:	Denver Health Medical Plan - MCO		
Project Leader Name:	Beth Flood	**Title:**	Senior Manager of Population Health
Telephone Number:	(845) 649-0130	**Email Address:**	elizabeth.flood@dhha.org
PIP Title:	*Improving Well-Care Visit (WCV) Rates for Child and Adolescent DHMP Medicaid Members*		
Submission Date:	October 31, 2023		
Resubmission Date:	February 5, 2024		

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *NA* is not applicable to this element for scoring	C*	*Met*	The health plan should revise the Aim statement to refer to using "targeted interventions" or "interventions associated with identified key drivers" to drive improvement. In addition, HSAG's calculations did not identify the goal percentage in the Aim statement as representing statistically significant improvement over the baseline percentage. The health plan is not required to specify a goal in the Aim statement; however, if a goal is specified, HSAG recommends that the goal represent statistically significant improvement over baseline. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
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Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [NA]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	5	2	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	**General Feedback:** The health plan is not required to specify a goal in the Step 5 Performance Indicator table; however, if the health plan identifies a goal, HSAG recommends the goal represent statistically significant improvement over baseline results. **Resubmission February 2024:** The health plan revised the goal and addressed the General Feedback comment in the resubmission.
2. Included the basis on which the indicator(s) was developed, if internally developed.		*N/A*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *NA* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *NA* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	The health plan reported that estimated data completeness could not be reported because a sample review was not conducted. To achieve a *Met* validation score for this evaluation element, the health plan must determine and report the estimated completeness of claims data at the time the data were pulled to generate the baseline indicator results and provide a brief description of the process used to determine the estimate. Typically, health plans use an Incurred But Not Reported (IBNR) report to determine estimated data completeness, which may be obtained from the finance, actuarial, or other department. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	1	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	7	3	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	The health plan did not complete Section A in Step 8. HSAG expected that the health plan would have identified quality improvement (QI) team members and conducted initial barrier analyses by the 10/31/23 submission date to facilitate improvement strategies for the Remeasurement 1 period. The health plan should update this section of the PIP submission form for the resubmission. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	The health plan did not complete Section B in Step 8. HSAG expected that the health plan would have conducted initial barrier analyses and identified barriers to improvement by the 10/31/23 submission date. By the January resubmission date, which is mid-way through the Remeasurement 1 period, interventions should be planned if not initiated. The health plan should update this section of the PIP submission form for the resubmission. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

Table B—1 2023-24 PIP Validation Tool Scores
for *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* for Denver Health Medical Plan - MCO

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	1	0	0	1	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	2	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				1	*Not Assessed*			
Totals for All Steps	**26**	**12**	**0**	**0**	**7**	**13**	**8**	**0**	**0**	**3**

Table B—2 2023-24 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* for Denver Health Medical Plan - MCO

Percentage Score of Evaluation Elements *Met* *	***100%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***High Confidence***

Table B—3 2023-24 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Improving WCV Rates for Child and Adolescent DHMP Medicaid Members* for Denver Health Medical Plan - MCO

Percentage Score of Evaluation Elements *Met* *	***Not Assessed***
Percentage Score of Critical Elements *Met* **	***Not Assessed***
Confidence Level***	***Not Assessed***

* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.* The Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving WCV Rates for Child and Adolescent DHMP Medicaid Members
for Denver Health Medical Plan - MCO

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***Not Assessed***

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Demographic Information			
MCO Name:	Denver Health Medical Plan - MCO		
Project Leader Name:	Beth Flood	**Title:**	Senior Manager of Population Health
Telephone Number:	(845) 649-0130	**Email Address:**	elizabeth.flood@dhha.org
PIP Title:	*Improving Social Determinants of Health (SDOH) Screening Rates for DHMP Medicaid Members Seen at Denver Health Ambulatory Care Services*		
Submission Date:	October 31, 2023		
Resubmission Date:	February 5, 2024		

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *NA* is not applicable to this element for scoring	C*	*Met*	The health plan should revise the Aim statement to refer to using "targeted interventions" or "interventions associated with identified key drivers" to drive improvement. In addition, while the health plan is not required to specify a goal percentage in the Aim statement, if a goal is specified, HSAG recommends that the goal represent statistically significant improvement. HSAG's calculations did not identify the goal percentage as representing statistically significant improvement over the baseline percentage. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [NA]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	5	2	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	As defined, the performance indicator suggests that the health plan expects a member to be screened for SDOH at each primary care visit. HSAG recommends defining the denominator based on the number of members who had at least one primary care visit during the measurement period, and defining the numerator based on the number of members in the denominator that had at least one SDOH screening during the measurement period. HSAG recommends a technical assistance call to further discuss the performance indicator for the PIP, if needed. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *NA* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *NA* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*N/A*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	2	1	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	7	3	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	The health plan did not complete Section A in Step 8. HSAG expected that the health plan would have identified quality improvement (QI) team members and conducted initial barrier analyses by the 10/31/23 submission date to facilitate improvement strategies for the Remeasurement 1 period. The health plan should update this section of the PIP submission form for the resubmission. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	The health plan did not complete Section B in Step 8. HSAG expected that the health plan would have conducted initial barrier analyses and identified barriers to improvement by the 10/31/23 submission date. By the January resubmission date, which is mid-way through the Remeasurement 1 period, interventions should be planned if not initiated. The health plan should update this section of the PIP submission form for the resubmission. **Resubmission February 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Results for Step 7 - 8			
Total Evaluation Elements	**8**	**4**	**Critical Elements**
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Table B—1 2023-24 PIP Validation Tool Scores for *Improving Social Determinants of Health Screening Rates* for Denver Health Medical Plan - MCO

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	2	0	0	2	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	2	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				1	*Not Assessed*			
Totals for All Steps	**26**	**12**	**0**	**0**	**7**	**13**	**8**	**0**	**0**	**3**

Table B—2 2023-24 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Improving Social Determinants of Health Screening Rates* for Denver Health Medical Plan - MCO

Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

Table B—3 2023-24 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Improving Social Determinants of Health Screening Rates* for Denver Health Medical Plan - MCO

Percentage Score of Evaluation Elements *Met**	***Not Assessed***
Percentage Score of Critical Elements *Met***	***Not Assessed***
Confidence Level***	***Not Assessed***

* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.* The Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Improving Social Determinants of Health (SDOH) Screening Rates
for Denver Health Medical Plan - MCO

Performance Improvement Projects

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***Not Assessed***