Colorado Children's Health Insurance Program

Fiscal Year 2020–2021 PIP Validation Report

for

Friday Health Plans of Colorado

April 2021

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

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Parts 438 and 457—managed care regulations for Medicaid and the Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care and July 1, 2018, for CHIP managed care require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include, conducted by an external quality review organization (EQRO), analysis and evaluation of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid managed care program and Child Health Plan *Plus* (CHP+), Colorado's program to implement CHIP managed care.

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

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

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

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

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

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

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

PIP Components and Process

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

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

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

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

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

Validation Scoring

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

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

PIP Topic Selection

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

FHP defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What measure will be used? What current data (i.e., count, percent, or rate) are available for that measure? How much increase or decrease in the indicator will demonstrate improvement?
- **A**ttainable: Rationale for setting the goal: Is the desired achievement based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Table 1-1 includes the SMART Aim statements established by **FHP**.

Table 1-1—SMART Aim Statements

PIP Measure	SMART Aim Statement
Depression Screening	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to increase the percentage of CHP+ members ages 12 – 17 years of age to have the correct coding by the provider when receiving a depression screening during their outpatient visit from 2% to 16%.
Follow-Up After a Positive Depression Screen	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to maintain the percentage of CHP+ members ages 12 – 17 years of age who receive a follow-up visit within 30 days of the positive depression screening at 90% or higher.

The focus of the PIP is to increase the percentage of members ages 12 – 17 years of age who receive a depression screening and to maintain a high percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goal to increase depression screening to 16 percent represents statistically significant improvement over the baseline performance. Because the baseline performance on the *Follow–Up After a Positive Depression Screen* measure was 100 percent, it is not possible for the PIP to demonstrate statistically significant improvement in this measure. The Department and HSAG approved the health plan's goal to maintain performance on follow-up care at 90 percent or higher while also working to increase the percentage of members who are screened for depression.

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

Table 1-2—PIP Topic and Module Status

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

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

Validation Findings

At the end of FY 2019–2020, **FHP** closed out the *Well–Child Visits in the 6–14 Years of Life* PIP, which was initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from the project.

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

Below are summaries of PIP conclusions from the *Well–Child Visits in the 6–14 Years of Life* PIP close-out report and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **FHP** reported in the FY 2019–2020 PIP close-out report for the *Well–Child Visits in the 6–14 Years of Life* PIP.

Table 2-1—PIP Conclusions Summary for the *Well–Child Visits in the 6–14 Years of Life* PIP

Interventions	Member outreach calls.
Successes	Improvement of child well visit rates during the project.
Lessons Learned	Identified the need for additional quality staff members to support improvement efforts and expanded staffing.

Module 1: PIP Initiation

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

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

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to increase the percentage of CHP+ members ages 12 – 17 years of age to have the correct coding by the provider when receiving a depression screening during their outpatient visit from 2% to 16%.
Preliminary Key Drivers	• Quality metrics require providers to complete depression screening and follow-up. • Parent awareness and engagement in child's healthcare. • Integrated physical and behavioral health services.
Potential Interventions	• Provider education. • Member/caregiver education. • Targeted education on appropriate coding for facilities that offer integrated physical and behavioral healthcare .
Measure 2—*Follow–Up After a Positive Depression Screen*	
SMART Aim Statement	By June 30, 2022, Friday Health Plans will use key driver diagram interventions to maintain the percentage of CHP+ members ages 12 – 17 years of age who receive a follow-up visit within 30 days of the positive depression screening at 90% or higher.
Preliminary Key Drivers	Provider compliance with quality metric reporting.
Potential Interventions	Provider education on appropriate depression screening and follow-up coding practices.

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

- Increase the percentage of members 12 to 17 years of age who receive a depression screening to 16 percent.
- Maintain the percentage of members 12 to 17 years of age who screened positive for depression that receive follow-up behavioral health services within 30 days of the positive depression screen at 90 percent or higher.

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

3. Conclusions and Recommendations

Conclusions

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

Recommendations

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

Appendix A. Module Submission Form

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

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Managed Care Organization (MCO) Information	
MCO Name	Friday Health Plans
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Patricia Lara
Contact Title	Quality Specialist
Email Address	patricia.lara@fridayhealthplans.com
Telephone Number	719-589-3696
Submission Date	
Resubmission Date (if applicable)/	04/21/2020

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PIP Team

Instructions:

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

Table 1—Team Members

Name	Title	Role and Responsibilities
Patricia Lara	Quality Specialist	PIP lead, Data Analyst
DeeAnn Sierra	Director of Regulatory Operations	Co-Lead
Jennifer Mueller	Chief Operating Officer	Executive Sponsor
Jesse Myers	Programmer	Provides data reports

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PIP Topic and Narrowed Focus

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

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

Table 2—PIP Topic and Narrowed Focus
PIP Topic Description
Members ages 12-17 who had a primary care visit and screened for depression identified as positive or negative screening code (G8431 or G8510) – In addition any member age 12-17 who had a positive depression screening had the appropriate follow-up within 30 days.
Narrowed Focus Description
Friday Health Plans selected a narrow focused group of ages 12-17 after speaking with several clinicians as to what age they started depression screenings in children. They informed us that they really start looking at depression as a possible diagnosis between the ages of 12-19 rather than the younger ages. We elected to select age 17 as the stopping point as clinics move the member to an adult at age of 18 rather than 19 as is the definition from CHP+. We attempted to partner with 3 local health care facilities in the project and were not successful obtaining a partnership. The larger one at the time was in contract negotiations and we were unsure if they would remain in network. The second facility of choice has behavioral health integrated into the majority of their clinics and felt that they did a good job on this measure already and declined. The third facility didn't have enough CHP+ children in this age group to participate. Due to the issues with finding a narrow focused provider we will be using our narrow focused group to include all eligible members plan-wide ages 12-17.

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Narrowed Focus Baseline Measurement – *Depression Screening*

Instructions:

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

Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Numerator Description	Patients screened for depression on the date of encounter
Denominator Description	All members age 12 – 17 who had a an out- patient visit during the measurement year
Age Criteria (if applicable)	12-17 years of age at the date of service in which the member received an outpatient visit. r
Continuous Enrollment Specifications (if applicable)	At least 30 days following the outpatient visit to allow for the 30 day follow-up appointment.
Allowable Gap in Enrollment (if applicable)	
Anchor Date (if applicable)	
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	

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Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 10/01/2019	End Date: 09/30/2020
Numerator: 1	Denominator: 50	Percentage: 2%

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

Table 3c—Narrowed Focus Baseline Data Collection Methodology – *Depression Screening*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: We had our IT department run a report which included the appropriate membership requirements for the PIP project as well as all members who had a claim for an outpatient visit in the measurement year in addition to depression screening codes G8431 and G8510 for our CHP+ members age 0-17. Once we had the report we filtered by facility location and had hoped to be able to use our local clinics again. However, the denominator was either too low or the facility denied participation in the project. Therefore, we opted to focus on a certain age group and just reach out to facilities and members across our service area. After a few phone calls to provider offices to see what age they focus on, or would possibly diagnosis a child with depression the consensus was age 12-17 since they consider a member an adult at age 18 and over clinically as well. With that information we filtered out the members on the report who fit into the age 12-17 age group and were still active members. The result was 111 children. If the child had more than one outpatient visit we then looked to see if a depression screening code was attached to any of the visits. If so we counted that visit. If not we only counted 1 visit rather than more than one for the denominator.		

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

Instructions:

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

Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Numerator Description	Members who had a positive depression screen who have also received one of the following codes the same day or within 30 days of the encounter: 90791,90832,90834,90837,90846,90847,90791,90792,90832,90834,90837,90846,90847. The Following codes identify follow-up assessment in a Behavioral Health setting: H0002,90833,90835,90838,99201,99205,99211-99215,99217-9926,99231-99236,99238,99239,99304-99310,99315,99316,99318,99324-99328,9934-99337,99341-99345,99347-99350,99366,99637,99368,99441-99443,99281-99285,99241-99245,99251-99255 UB revenue Code 0529 or 09000 with the following: H0002,90791,90792,90832,90833,90834,90836,90837,90838,90846,90847,99201-99205,99211-99215,99205,99211-99215,99217-99226,99231-99236,99238,99239,99304-

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
	99310,99315,99316,99318,99324-99328,99334-99337,9341-99345,99347-99350,99366,99367,99368,99441-99443,99281-99285,99241-99245,99251-99255
Denominator Description	The total number of eligible members who screened positive for depression within the measurement period and received the appropriate follow-up care within 30 days of the positive depression screening. These were identified using CPT the codes listed above.
Age Criteria (if applicable)	12-17 years of age at the date of service in which the member received a positive depression screening.
Continuous Enrollment Specifications (if applicable)	At least 30 days following the positive depression screening to allow for the 30-day follow-up appointment.
Allowable Gap in Enrollment (if applicable)	
Anchor Date (if applicable)	
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	FHP will exclude members who screen positive for depression less than 30 days before the end of the baseline measurement period to allow for the follow-up to be received within the 30 days.

Table 4b—Narrowed Focus Baseline Data – *Follow–Up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 10/01/2019	End Date: 09/30/2020
Numerator: 1	1	Percentage: 100%

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

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Once we had the worked through the initial report of CHP+ children in our service area we were able to narrow down those in the 12-17 age group. IT ran a claims report for all CHP+ children ages 12-17 who had a claim with any of the codes mentioned above from 10/01/2019 to 09/30/2020. We then reviewed the data and looked for claims within 30 days from an outpatient clinic visit in which we found a positive depression screening as well as for any duplicate visits in the same 30 days. Once we had filtered through the data we came up with a denominator for the follow-up after a positive depression screening.		

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

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

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

Depression Screening:

By June 30, 2022, Friday Health Plans will use key driver diagram interventions to increase the percentage of CHP+ members ages 12 – 17 years of age to have the correct coding by the provider when receiving a depression screening during their outpatient visit from 2% to 16%.

Follow-up After a Positive Depression Screen:

By June 30, 2022, Friday Health Plans will use key driver diagram interventions to maintain the percentage of CHP+ members ages 12 – 17 years of age who receive a follow-up visit within 30 days of the positive depression screening at 90% or higher.

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

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Key Driver Diagrams

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

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

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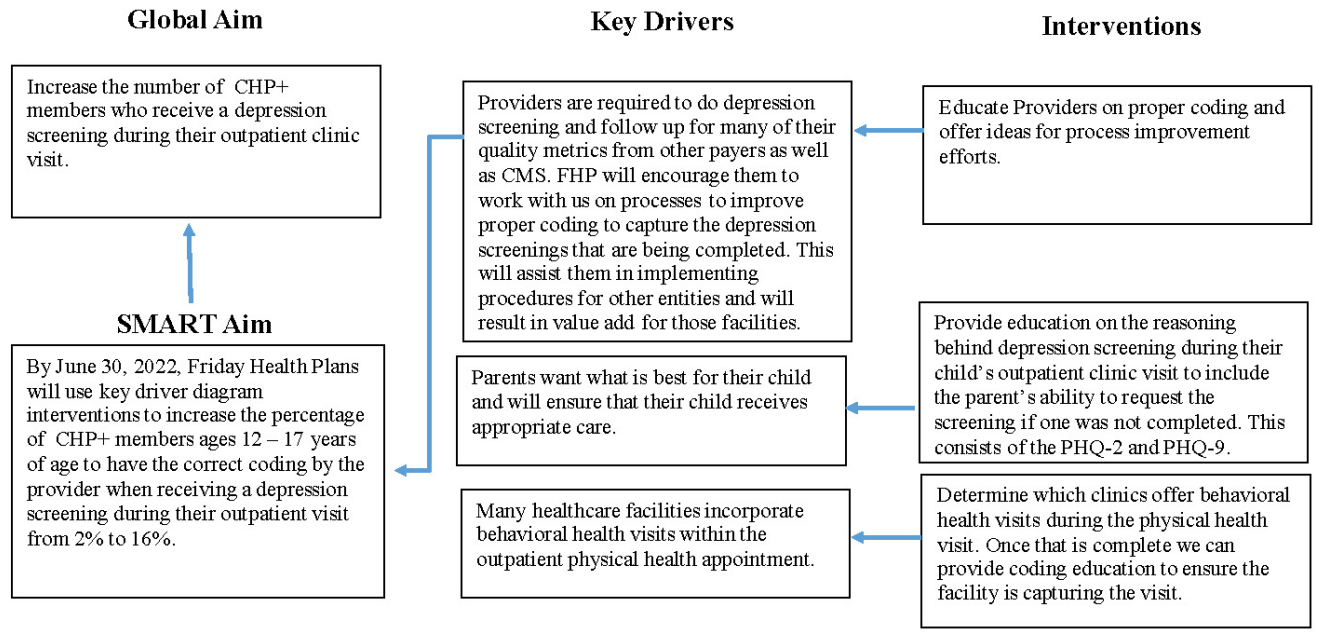
Key Driver Diagram– *Depression Screening*



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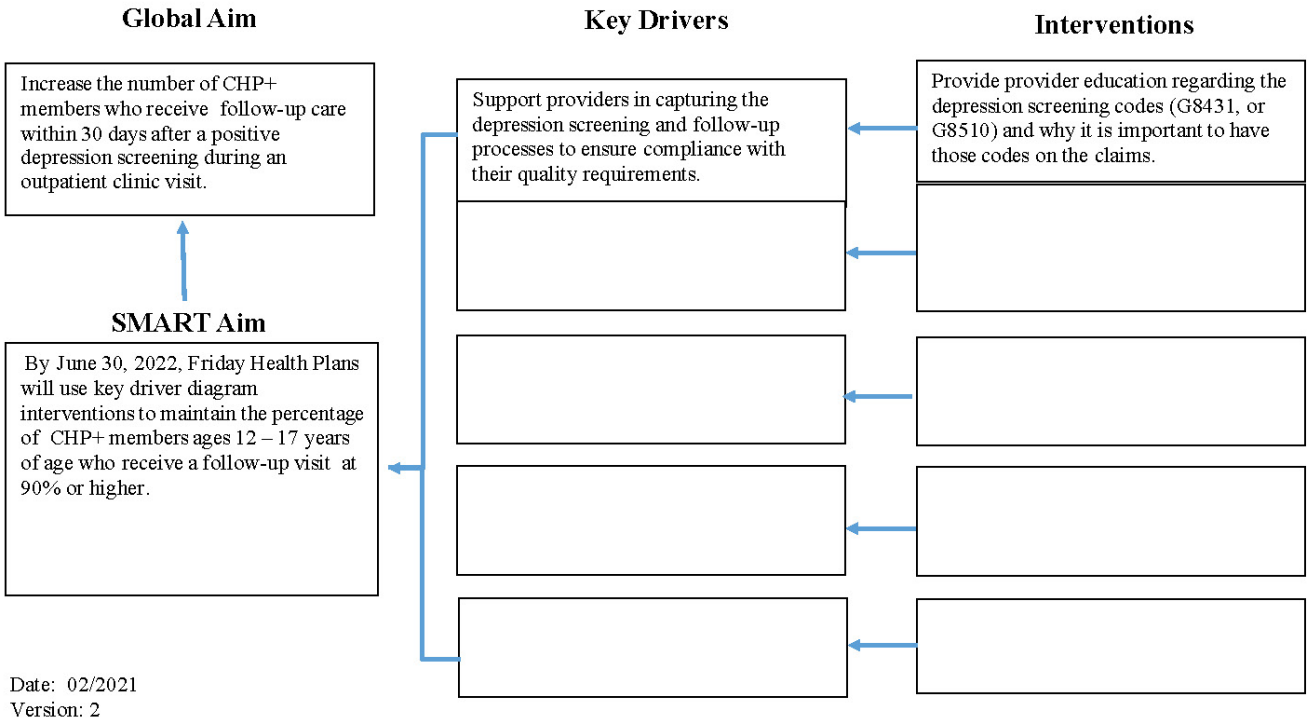
Key Driver Diagram – *Follow–Up After a Positive Depression Screen*



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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

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

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

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

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

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

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

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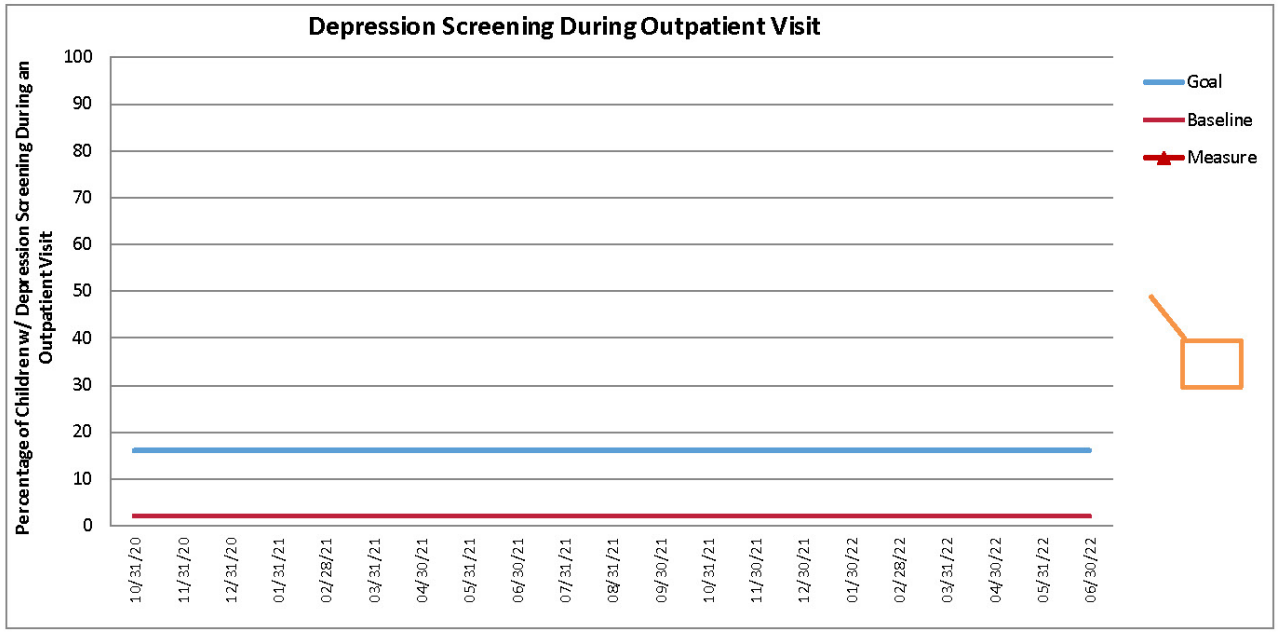
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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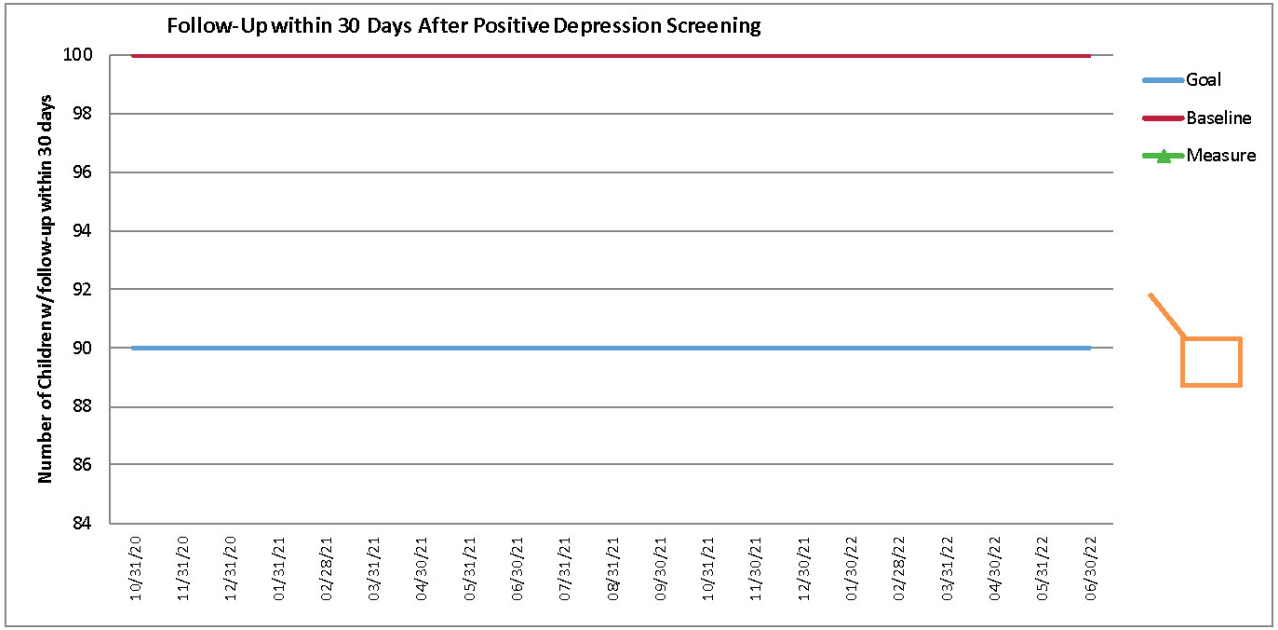
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen.*	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The topic description appeared to focus only on depression screening and did not include follow-up after a positive depression screen. In addition, the age range of 12-17 years included in the topic description was not mandated by the state. If the health plan is selecting this age group as a narrowed focus for the PIP, a rationale should be provided. • The health plan did not provide a description of the narrowed focus in the Narrowed Focus Description section of Table 2 on page 3. In this section, the health plan should describe the narrowed focus group that will be included in the PIP. The purpose of the narrowed focus is to support effective and manageable intervention testing and data collection. Typically, the narrowed focus is defined by a provider practice, geographic area, age group, or other demographic group. If the health plan chooses not to select a narrowed focus for the PIP, the health plan should provide a rationale for including the entire eligible member population. For example, if the eligible population for the PIP topic is very small. • For the *Follow–up After a Positive Depression Screen* baseline data, the health plan reported a denominator of zero and, therefore, no baseline rate could be calculated for this measure. The rapid-cycle PIP process requires a baseline rate to evaluate progress and improvement during the project. The health plan should explore other options for the narrowed focus that will

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Criteria	Score	HSAG Feedback and Recommendations
		allow calculation of a baseline rate for both measures. HSAG recommends a technical assistance call to discuss this issue. • The age range included in the Narrowed Focus Description (12 years and older) differed from the age range of 12-17 years reported in the denominator descriptions for each measure. **Re-review March 2021:** The health plan addressed HSAG's initial feedback in the resubmission; however, the revised narrowed focus baseline data for the two measures in Tables 3b and 4b appeared incorrect. The health plan reported the same numerator (1), denominator (52), and percentage (2%), for the *Depression Screening* measure and the *Follow-Up* measure. Based on the narrowed focus description and the measure descriptions, the denominator value for the *Follow-Up* measure denominator should be less than the denominator value for the *Depression Screening* measure. The health plan should correct the narrowed focus baseline numerator, denominator, and percentage reported for the two measures in Tables 3b and 4b. **Re-review April 2021:** The health plan addressed HSAG's additional feedback and corrected the narrowed focus baseline data. The criterion has been *Met*.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included:	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*** • In the numerator description, the health plan should clarify the phrase, "…on the date of encounter." Is "encounter" the same as

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Criteria	Score	HSAG Feedback and Recommendations
a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process d) Narrowed focus baseline data that considered claims completeness		"outpatient visit" referenced in the denominator? Does this phrase mean that members with multiple outpatient visits in the measurement year must be screened for depression at each visit to be included in the numerator? • In the denominator description, the health plan should clarify how members with more than one outpatient visit in the measurement year were counted. • The health plan must report the date within the measurement period that was used for determining whether members meet the age criteria for the measure. • The denominator qualifying event should be listed as an outpatient visit during the measurement year. • The baseline measurement period dates reported in Table 3b were incorrect. The health plan should report the start and end dates for the 12-month measurement period that was used for collecting the baseline data reported in the table. • The health plan did not provide a narrative description of the data collection process and data elements used for the baseline data. In the bottom row of Table 3c, the health plan should provide a narrative description of the step-by-step process used to collect data to calculate the baseline numerator, denominator, and percentage reported in Table 3b. ***Follow-Up After a Positive Depression Screen*** • The denominator description was incorrect. The denominator description should be the total number of eligible members who screened positive for depression within the measurement period.

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Criteria	Score	HSAG Feedback and Recommendations
		The code(s) to identify the positive depression screen should be included. • The health plan must report the date within the measurement period that was used for determining whether members meet the age criteria for the measure. • The denominator qualifying event should be a positive depression screen during the measurement period. In addition, the health plan should describe how members with a positive depression screen occurring less than 30 days before the end of the measurement period are handled for the measure. • The baseline measurement period dates reported in Table 4b were incorrect. The health plan should report the start and end dates for the 12-month measurement period that was used for collecting the baseline data reported in the table. • The health plan did not provide a narrative description of the data collection process and data elements used for the baseline data. In the bottom row of Table 4c, the health plan should provide a narrative description of the step-by-step process used to collect data to calculate the baseline numerator, denominator, and percentage reported in Table 4b. **Re-review March 2021:** The health plan addressed some but not all of HSAG's initial feedback in the resubmission. The following remaining issues must be addressed to fulfill the requirements for Criterion 2: • The revised continuous enrollment criteria for both measures were unclear.

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Criteria	Score	HSAG Feedback and Recommendations
		• The health plan did not specify the date used to determine member age for inclusion in the measures. The documentation of age criteria should include the specific date or event when a member's age was determined for inclusion in the PIP. • The health plan reported a baseline measurement period of 13 months, from 10/1/12019 to 10/31/2020. The baseline measurement period should be exactly 12 months long. • The health plan did not document how members screening positive for depression less than 30 days prior to the end of the measurement period were handled. HSAG recommends a technical assistance call to better understand the narrowed focus baseline measure specifications and assist the health plan in correcting the documentation. **Re-review April 2021:** The health plan addressed HSAG's additional feedback. The criterion has been *Met*.
3. The SMART Aims for *Depression Screening* and *Follow–Up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage	☒ Met ☐ Not Met	The health plan did not complete the SMART Aims on page 9 of the submission form. HSAG recommends a technical assistance call to review the required components of the SMART Aims for the PIP. **Re-review March 2021:** The health plan included SMART Aims in the resubmission; however, the SMART Aims were not in the correct format. Each SMART Aim must align with the measures defined for the PIP and must include the narrowed focus baseline percentage and a goal

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Criteria	Score	HSAG Feedback and Recommendations
e) End date		percentage. The goal percentage must represent a statistically significant improvement over the baseline percentage. The SMART Aims will need to be revised after the health plan has addressed HSAG's feedback for Criteria 1 and 2 to ensure that accurate narrowed focus baseline data are used. HSAG recommends that the health plan review pages 10-11 in the Rapid-Cycle PIP Reference Guide, Version 6-2, which provides a SMART Aim example in the correct format. **Re-review April 2021:** The health plan corrected the narrowed focus baseline data and addressed HSAG's additional feedback. The criterion has been *Met.*
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	The health plan did not complete the SMART Aim run charts on pages 14-15 of the submission form. HSAG recommends a technical assistance call to review the required components of the SMART Aim run charts for Module 1 of the PIP. **Re-review March 2021:** The health plan populated the SMART Aim run charts in the resubmission; however, the run charts were not in the correct format and the data plotted in the charts appeared incorrect. The SMART Aim run charts should be revised after the health plan addresses HSAG's feedback for Criteria 1, 2, and 3. HSAG recommends that the health plan review pages 13-15 in the Rapid-Cycle PIP Reference Guide, Version 6-2, which provides detailed step-by-step guidance for completing the run charts. The health plan should request additional technical assistance from HSAG, if needed.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review April 2021: The health plan addressed the remaining critical feedback. The criterion has been *Met*.
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	The health plan did not complete the rolling 12-month attestation on page 13 of the submission form. HSAG recommends a technical assistance call to review the rolling 12-month methodology required for the PIP. **Re-review March 2021:** The health plan addressed HSAG's initial feedback in the resubmission. The criterion has been *Met*.
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–Up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal in each key driver diagram.	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The SMART Aim included in each key driver diagram (KDD) was incorrect. HSAG recommends a technical assistance call to review the required components of the SMART Aims for the PIP. • It was unclear how the key drivers, *Parents want what is best for their child and don't want to see their kids going through depression*" and "*Run claims reports…*", would directly contribute to achieving the SMART Aim goals. Key driver descriptions should explain what factors the health plan will leverage to achieve the SMART Aim goal. The health plan should revise the key driver descriptions to more clearly illustrate how each will support achieving the corresponding SMART Aim goal. • In the *Depression Screening* KDD, it was unclear how the intervention, *Educate Providers on proper coding intervention*,

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Criteria	Score	HSAG Feedback and Recommendations
		would impact the driver, *Providers are required to do depression screening and follow up*. The health plan should revise the documentation to demonstrate a clear link between each intervention and driver. • In the *Follow-Up After a Positive Depression Screen* KDD, two intervention descriptions were unclear. The intervention description related to filtering the claims report appeared to be a step in the data collection process, not an intervention. Also, it was unclear how the intervention related to adding information to the provider portal would impact the key driver related to providers being required to have a follow-up plan. The health plan should revise the intervention descriptions to clearly state what changes the health plan is considering testing through PDSA cycles to achieve the SMART Aim goal for the PIP. **Re-review March 2021:** The health plan addressed some but not all of HSAG's initial feedback in the resubmission. The following feedback must be addressed to fulfill the requirements for Criterion 6: • In each KDD, the SMART Aim must be updated to align with the corrected SMART Aims addressing HSAG's feedback for Criterion 3. • In the *Depression Screening* KDD, the health plan should revise the documentation to demonstrate a clear link between the intervention, *Educate Providers on proper coding intervention*, and the driver, *Providers are required to do depression screening and follow-up*. The documentation should explain how

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Criteria	Score	HSAG Feedback and Recommendations
		the intervention will support the driver and support achieving the SMART Aim. **Re-review April 2021:** The health plan addressed HSAG's additional feedback in the resubmission. The criterion has been *Met*.
Additional Recommendations: For each final run chart provided in the Module 4 submission form at the end of the project, the health plan should scale the y-axis from 0% to 100% for consistency and clarity. In addition, the y-axis title for each final run chart should refer to *percentage* of members, not *number* of members.		

PIP Initiation (Module 1)

☒ Pass

Date: April 21, 2021