Colorado Children's Health Insurance Program

Fiscal Year 2021–2022 PIP Validation Report

for

Friday Health Plans of Colorado

April 2022

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

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1. Executive Summary

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

Pursuant to 42 CFR §457.1520, which requires states' CHIP managed care programs to participate in EQR, the Department required its CHP+ MCOs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Friday Health Plans of Colorado**, referred to in this report as **FHP**, an MCO, holds a contract with the State of Colorado for provision of medical and behavioral health (BH) services for the Department's CHP+ managed care program.

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

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

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

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

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

PIP Components and Process

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

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

PIP Terms

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

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

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

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

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

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

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

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

Approach to Validation

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

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2021–2022, **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 Measures	SMART Aim Statements
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 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 who receive a follow-up visit at 90% or higher.

The focus of the PIP is to increase the percentage of members ages 12–17 years who receive a depression screening and to maintain a high percentage of those members who receive BH 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 rate 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	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

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

Validation Findings

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

Module 2: Intervention Determination

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

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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Depression Screening	• Provider's office does not administer depression screening • Provider does not enter the billing code or enters an incorrect code	• Provider engagement in proper coding for depression screening services • Consistent depression screening coding practices among providers and staff	• Provider and staff education on proper coding and offer ideas for process improvement efforts • Member/Caregiver education on the clinical importance of depression screening for adolescent members during outpatient visits • Develop educational tools for providers and staff • Develop information packet for child and caregiver that includes contact information for BH services

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• Provider does not refer the child member for follow-up services after a positive depression screen • Provider does not enter the billing code or enters an incorrect code	• Provider support in capturing depression screening and follow-up services through appropriate coding practices • Periodic record reviews to ensure that providers' offices are entering appropriate depression screening and follow-up codes • Consistent use of G8431 as documentation of the depression screening and follow-up plan	• Provider education on correct depression screening codes (G8431 and G8510) and why it is important to have those codes on the claims • Develop education tools for providers and their staff • Develop a tracking tool to monitor members who participate in follow-up BH services

In Module 2, **FHP** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **FHP** identified to improve depression screening focused on provider education on appropriate coding practices and member/caregiver education on the importance of adolescent depression screening. The potential interventions **FHP** identified to improve follow-up services included provider education on appropriate coding practices and tracking tools to assist providers in monitoring follow-up BH service completion.

Module 3: Intervention Testing

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

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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Provider and staff educational email describing appropriate codes to capture depression screening and follow-up BH services, and questionnaire on provider's current depression screening and follow-up process	• Provider does not enter the billing code or enters an incorrect code	• Provider engagement in proper coding for depression screening services • Consistent depression screening coding practices among providers and staff • Provider support in capturing depression screening and follow-up services through appropriate coding practices	• Percentage of members 12–17 years of age who had an outpatient visit and received a depression screening during the visit • Percentage of providers who were sent the educational email and opened/read the email • Percentage of providers who were sent the educational email and returned the depression screening and follow-up workflow questionnaire

In Module 3, **FHP** selected one intervention to test for the PIP. The detailed intervention testing plan **FHP** documented in the Module 3 submission form is included in Appendix A. Module Submission Forms. The intervention addressed process failures in provider awareness and consistent use of appropriate coding practices for depression screening and follow-up services. **FHP** defined three intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **FHP** will report final intervention testing results and conclusions in a PIP close-out form at the end of the fiscal year.

3. Conclusions and Recommendations

Conclusions

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

Recommendations

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

Appendix A. Module Submission Forms

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

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
For Friday Health Plans

Managed Care Organization (MCO) Information	
MCO Name	
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 ext. 1122
Submission Date	7/9/21
Resubmission Date (if applicable)	8/2/21

State of Colorado
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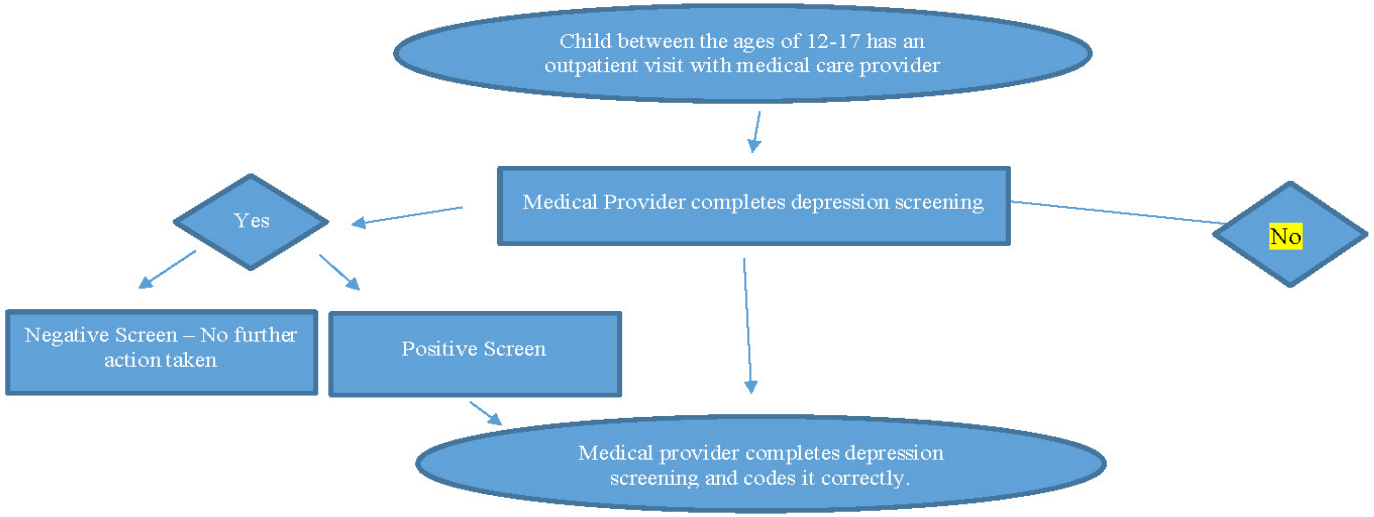
Process Map – *Depression Screening*

Instructions:

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

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



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

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

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

Table 1a—Failure Modes and Effects Analysis Table – *Depression Screening*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
Medical Provider completes depression screening.	Provider's office does not administer depression screening.	Provider's office has not operationalized the expected practices for depression screening.	The provider may miss an opportunity to explore the possibility that the child has depression.
Medical provider completes depression screening and codes it correctly.	Provider does not enter the billing code or enters an incorrect code.	Provider or their staff does not know which code to enter.	Friday Health Plans is unable to determine if depression screening was completed via claims analysis.

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Failure Mode Priority Ranking – *Depression Screening*

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

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

Table 2a—Failure Mode Priority Ranking – *Depression Screening*

Priority Ranking	Failure Modes
1	Provider's office does not administer depression screening.
2	Provider does not enter the billing code or enters an incorrect code.

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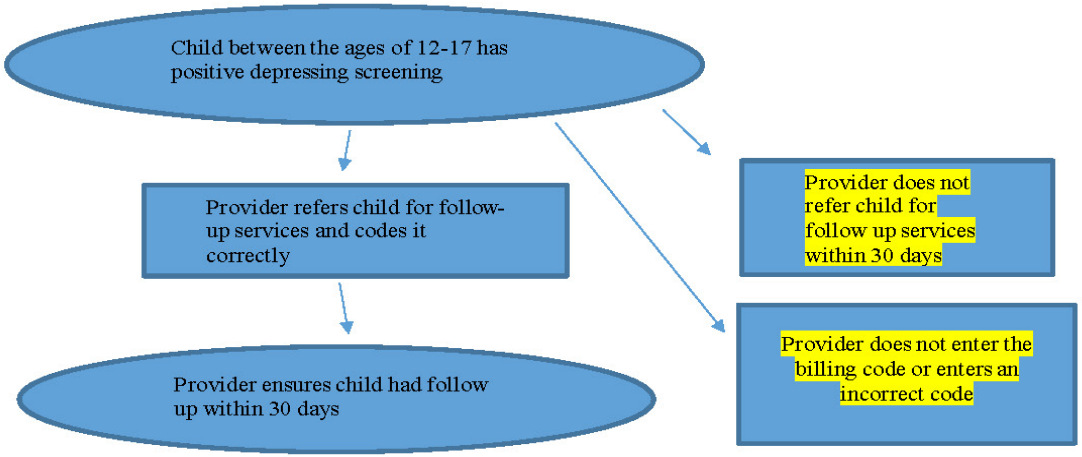
Process Map – *Follow–up After a Positive Depression Screen*

Instructions:

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

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



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

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

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

Table 1b—Failure Modes and Effects Analysis Table – *Follow–up After a Positive Depression Screen*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
Child between the ages of 12-17 has positive depressing screening	Provider does not refer the child for follow up services.	Provider does not know that they need to refer the child for follow up services.	The child may not receive needed mental health treatment and may be at risk to harm themselves or others.
Provider refers child for follow up services and codes it correctly.	Provider does not enter the billing code or enters an incorrect code.	Provider or their staff do not know which code to use.	Friday Health Plans is unable to determine if visit was made within 30 days via claims analysis.

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

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

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

Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Priority Ranking	Failure Modes
1	Provider does not refer the child for follow up services.
2	Provider does not enter the billing code or enters an incorrect code.

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Key Driver Diagrams

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

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

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
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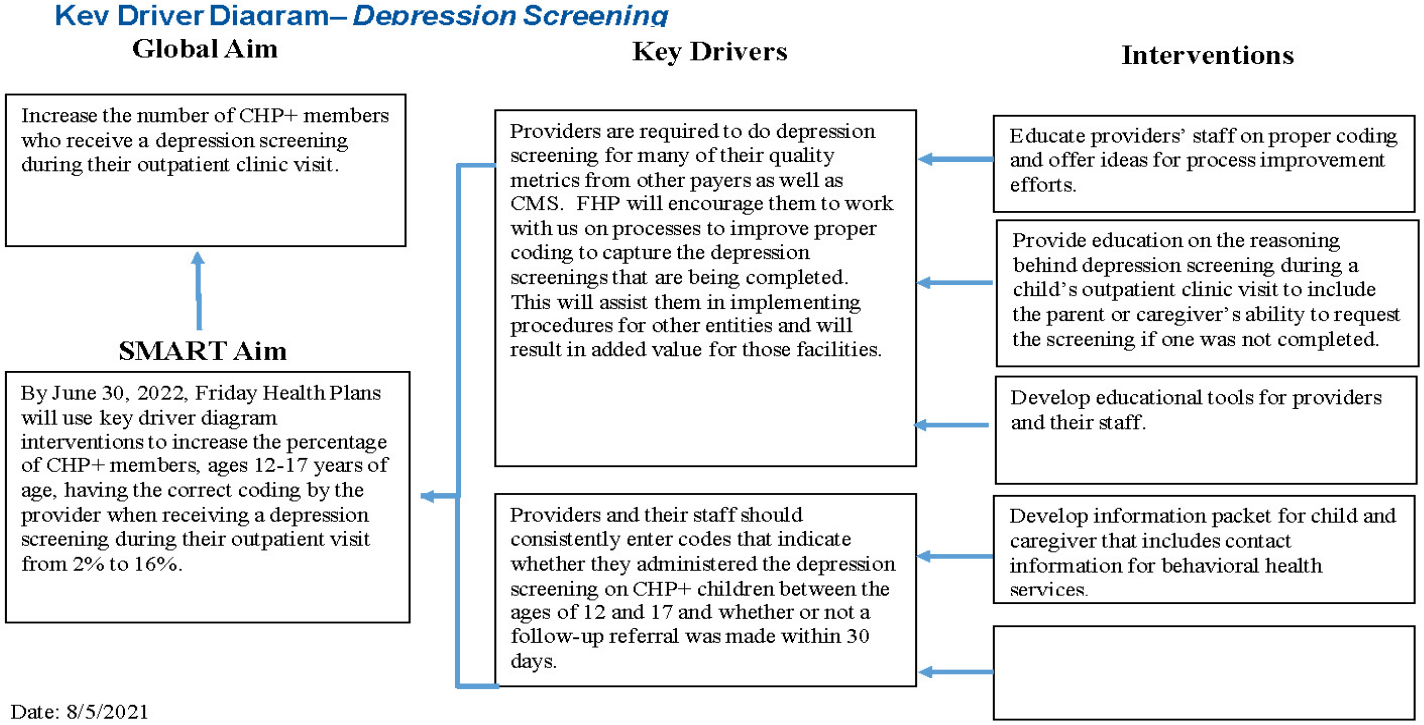
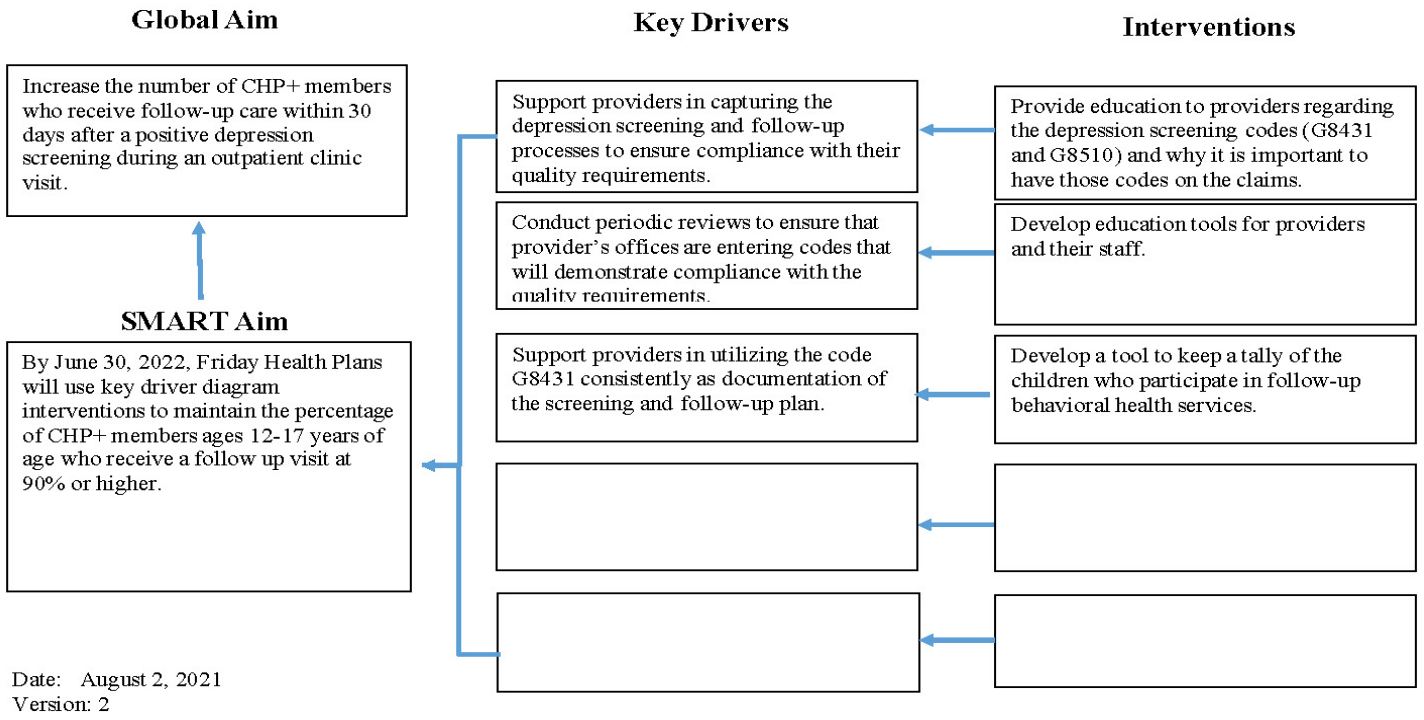
Key Driver Diagram– *Depression Screening*



Date: 8/5/2021
Version: 2

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
For Friday Health Plans

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



Date: August 2, 2021
Version: 2

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for FRIDAY HEALTH PLANS

Managed Care Organization (MCO) Information	
MCO Name	Friday Health Plans
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Provider Education Regarding Coding
Contact Name	Patricia Lara
Contact Title	Quality Specialist
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Intervention Testing Plan

Instructions:

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

Table 1—Intervention Plan	
Intervention Being Tested	Education to medical providers' staff regarding proper coding.
Outcome Addressed	☒ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Provider does not enter the billing code or enters an incorrect code.
Key Driver Addressed	Support providers in utilizing the appropriate billing codes, (listed in Module 1, Table 4a) consistently as documentation of the screening and follow-up plan.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1 Have IT run a report that identifies providers whose patients include CHP+ members between the ages of 12 and 17. 2. Send a letter through email to providers and/or their staff regarding the use of screening and follow-up codes as well as a questionnaire regarding their depression screening and follow-up process. 3. Approximately four weeks after the letter is sent, call the providers who have not responded to the letter to determine if they received the letter, answer questions and provide guidance.

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Table 1—Intervention Plan	
	1. Develop a system for tracking responses to the questionnaire such as an Excel spreadsheet for quantitative data and a list in Word to track qualitative responses (such as information gathered during follow-up phone calls to providers). 2. Develop a system to track data that includes: a) Percentage of providers who were emailed the intervention letter and questionnaire and opened/read the email (determined by automatic tracking of email read receipts). b) Percentage of providers who returned the questionnaire and their responses to the questions. c) Percentage of providers who were contacted for follow-up by phone and who were successfully reached. d) Percentage of providers who were reached for follow-up that reported they were likely to use the proper coding procedures for depression screening and follow-up, as a result of the letter.
What are the predicted results of this test?	Providers and/or their staff will properly document depression screening, and follow-up after a positive screen, within 30 days.

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Intervention Effectiveness Measure

Instructions:

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

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**The use of proper codes to document depression screening and follow-up after a positive screen.**
Numerator Description	Patients screened for depression and those who test positive.
Denominator Description	All members age 12-17 who had an outpatient visit during the measurement year.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	CHP+ members between the ages of 12 and 17 who have appropriate billing codes on their claims following a depression screen and follow-up as indicated by a positive screen.
Describe the Data Sources	Queried electronic data report that includes a list of CHP+ members ages 12 to 17 and a Claims report that shows appropriate depression screening and follow-up codes (listed in Module 1, Table 4a), or lack thereof.

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how Data will be Collected	The FHP IT Department will run data reports that show how many claims for CHP+ members between the ages of 12 and 17 have codes that indicate completion of a depression screening and follow up (if indicated by a positive result.)
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	The IT department will run a monthly claims report that will include data as of the 15th of each month to allow for two weeks of claims lag and provide the most current real time data. The data will be reviewed on an ongoing basis to measure the percentage of providers who are using correct codes with the goal of an increase that is reflective of our intervention and educational efforts.

Table 2a—Intervention Effectiveness Measure	
Intervention Measure Title	**Percentage of providers who were emailed the intervention letter and questionnaire and opened/read the email (determined by automatic tracking of email read receipts).**
Numerator Description	Total number of providers who opened/read the email.
Denominator Description	Total number of providers who were sent the intervention letter and questionnaire via email.

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Table 3a—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Providers and/or their staff who received the email containing a questionnaire from FHP
Describe the Data Sources	FHP's email system, "Outlook", which will provide a notice via read receipt when/if the provider elects to send the notice.
Describe how Data will be Collected	The Quality Specialist will keep track of the opened/read emails using an Excel spreadsheet.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	The read receipts will be counted on a daily basis for two weeks which allows the provider or their staff time to open/read the email.

Table 2b—Intervention Effectiveness Measure	
Intervention Measure Title	**Percentage of providers who returned the questionnaire.**
Numerator Description	Total number of providers who returned the questionnaire
Denominator Description	Total number of providers who were sent the intervention letter and questionnaire via email

Table 3b—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Providers and/or their staff who returned the questionnaire.

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Table 3b—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Sources	Providers and/or their staff will be able to return the questionnaire via FHP's email system, "Outlook," FHP's fax system, or the US Postal Service mail.
Describe how Data will be Collected	The Quality Specialist will check each of the return options and will keep track of the following information in an Excel spreadsheet: a) Name of Provider b) Date Questionnaire was received at FHP c) Responses to the questions in the questionnaire d) Date FHP responded to questions from Providers
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	The data will be collected on a daily basis (Monday-Friday) for four weeks. At that time, the Quality Specialist will follow through via telephone to providers who did not open/read the email and those who did not return the questionnaire. Data collection will be considered complete after all questionnaires have been returned or, for those that are not returned, FHP has made follow-up phone contact with the provider.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan included process maps for *Depression Screening* and *Follow–Up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement: • The process maps for *Depression Screening* and *Follow-Up after a Positive Depression Screen* did not reflect the process for a member in the eligible PIP population to obtain the services. Instead, it appeared that the health plan mapped the process the health plan used to identify gaps/flaws/barriers related to depression screening and follow-up after a positive depression screen. As stated in the Module 2 submission form instructions, the process maps should reflect the existing process for members in the eligible PIP population (12-17 years of age) to receive a depression screening (page 2) and the existing process for members in the eligible population to receive a follow-up behavioral health service after receiving a positive depression screen (page 6). For example, in the *Depression Screening* process map, the first step in the process could be that the 12-17-year-old member attends an outpatient visit and the last step in the process could be the depression screening is completed for the 12-17-year-old member during the outpatient visit. For the *Follow-Up After a Positive Depression Screen* process map, the first step could be that the member screens positive for depression and the last step would be the member receives a follow-up behavioral health service within 30 days of the positive screen. For each process map, the health plan should include all steps that currently occur between the first and the last steps in the process and identify any gaps or failures that may occur.

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Criteria	Score	HSAG Feedback and Recommendations
		For additional guidance on correcting the process maps, **the health plan should review pages 16-18 in HSAG's *Rapid-Cycle PIP Reference Guide, Version 6-2***, which provides a step-by-step guide for completing process maps and an example of the structure/layout of a completed process map. **Re-review August 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement: • The health plan did not highlight in yellow, or otherwise identify, any steps in the process maps as gaps or opportunities for improvement. Once the health plan has revised the process maps to reflect the current processes that occur for a member to receive a depression screening at an outpatient visit and for a member to receive a follow-up behavioral health service within 30 days after a positive depression screen, the health plan should identify specific steps in the process maps that are gaps, flaws, or opportunities for improvement. These identified steps should be highlighted in yellow so that they are clearly identified. **Re-review August 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The health plan did not highlight in yellow, or otherwise identify, any steps in the process maps as gaps or opportunities for improvement;

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Criteria	Score	HSAG Feedback and Recommendations
highlighted in yellow as gaps or opportunities for improvement.		therefore, the steps in the FMEA tables could not align with the steps in the process maps. • The steps listed in the FMEA tables did not align with specific steps in the process maps. The health plan should use the same language (copy/paste) to describe the steps included into the FMEA tables as was used to describe the highlighted steps in the process maps that were identified as gaps, flaws, or opportunities for improvement. Once the health plan has revised the process maps to reflect the current processes that occur for eligible members to receive services, and highlighted specific steps in the process maps that are gaps or opportunities for improvement, the health plan should use the same language (copy/paste) to describe those steps in the "Steps from the Process Map" columns of the FMEA tables. For additional guidance on correcting the FMEA tables, **the health plan should review pages 20-21 in HSAG's *Rapid-Cycle PIP Reference Guide, Version 6-2*,** which provides a step-by-step guide for completing a FMEA table and a simple example of a completed row in a FMEA table. **Re-review August 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	*Not Assessed*. HSAG did not assess the linkage of steps to failure modes, causes, and effects because the steps listed in the FMEA tables were not based on steps in the current processes for eligible members to receive depression screening and follow-up services.

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Criteria	Score	HSAG Feedback and Recommendations
		Once the health plan has revised the process maps to reflect the current processes that occur for eligible members to receive services, and highlighted specific steps in the process maps that are gaps or opportunities for improvement, the health plan should update the failure modes, failure causes, and failure effects listed in the FMEA tables, **following the instructions on pages 20-21 in HSAG's *Rapid-Cycle PIP Reference Guide, Version 6-2*,** which provides a step-by-step guide for completing a FMEA table and a simple example of a completed row in a FMEA table. **Re-review August 2021:** The health plan addressed HSAG's feedback on the process maps and FMEA tables in the resubmission. The criterion has been *Met*.
5. The health plan prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The health plan did not rank the listed failure modes in order of priority. As stated in the Module 2 submission form instructions (bullet points at top of page 5), the health plan should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on the FMEA results. **Re-review August 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the health plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	*Not Assessed*. HSAG did not assess the Module 2 key driver diagrams because the process maps, FMEA tables, and failure mode rankings were not completed as outlined in the Module 2 submission form instructions and HSAG's *Rapid-Cycle PIP Reference Guide, Version 6-2*. The health plan should revisit the key driver diagrams, and update as appropriate, based on the corrected process maps and results of the revised FMEA tables and failure mode rankings. **Re-review August 2021:** The health plan addressed HSAG's feedback on the FMEA tables and the failure mode rankings in the resubmission. The criterion has been *Met*.
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: August 4, 2021

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Intervention: Provider Education Regarding Coding

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	The health plan should provide more detail for Step 3 of the intervention process to clearly specify how the "follow-up with clinic staff" will be carried out. For example, the health plan should document if this follow-up will occur by telephone, face-to-face meetings, or using some other specific method of communication. **Re-review November 2021:** The health plan revised the intervention plan and addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	The health plan based the intervention effectiveness measure on the percentage of eligible members who were screened for depression. HSAG identified the following opportunities for improving the intervention effectiveness measure: • The effectiveness measure focused specifically on depression screening and did not provide a method for tracking correct coding of follow-up visits. If the intervention will target both outcome measures (depression screening and follow-up after a positive depression screen) as documented in Table 1, the health plan should evaluate intervention effectiveness in impacting both outcomes. • The effectiveness measure was based on claims, while the intervention appeared to be targeting earlier steps in the process through educational

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Criteria	Score	HSAG Feedback and Recommendations
		outreach to providers. HSAG recommends the health plan include an intervention effectiveness measure(s) that assesses the direct impact of the intervention. For example, the percentage of clinics who were sent a letter that confirmed receipt of the letter during the follow-up (Step 3) and/or the percentage of clinics who were sent a letter and were successfully reached for follow-up (Step 3). **Re-review November 2021:** The health plan included additional intervention effectiveness measures in the resubmission and addressed HSAG's feedback. The criterion has been *Met*.
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	**General Comments:** • The health plan will need to update the data collection process after addressing HSAG's feedback on the intervention effectiveness measure provided for Criterion 3. • The health plan documented that claims data would be used for the intervention effectiveness measure. If the health plan will be using claims data for the revised intervention effectiveness measure(s), after addressing HSAG's feedback for Criterion 3, the health plan should determine if claims lag will inhibit efforts to obtain timely and meaningful data to support rapid PDSA testing cycles. If claims lag will be an issue, the health plan should consider alternative data sources for the intervention effectiveness measure(s). **Re-review November 2021:** The health plan addressed the General Comments in the resubmission.

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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: November 10, 2021