COLORADO

Department of Health Care Policy & Financing

Regional Accountable Entities (RAEs)
For the Colorado Accountable Care Collaborative

Fiscal Year 2020–2021 PIP Validation Report

for

Health Colorado, Inc. Region 4

April 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for Medicaid programs, with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include 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 program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **Health Colorado, Inc. Region 4**, referred to in this report as **HCI R4**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid 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: 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 **HCI R4**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **HCI R4**'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, **HCI R4** submitted the following PIP topic for validation: *Depression Screening and Follow–Up After a Positive Depression Screen.*

HCI R4 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 **HCI R4**.

Table 1-1—SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older, from 11.21% to 15%.
Follow–Up After a Positive Depression Screen	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from 25.15% to 30%.

The focus of the PIP is to increase the percentage of members 12 years of age and older who receive a depression screening during a well visit at Valley-Wide Health Systems and to increase the percentage of members attributed to Valley-Wide who receive behavioral health services within 30 days of screening positive for depression at any visit. The goals to increase depression screening to 15 percent and to increase follow-up within 30 days after a positive depression screen to 30 percent represent statistically significant improvement over the baseline performance.

Table 1-2 summarizes the progress **HCI R4** 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, **HCI R4** had passed Module 1 achieving all validation criteria for the PIP. **HCI R4** 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.

2. Findings

Validation Findings

At the end of FY 2019–2020, **HCI R4** closed out the *Increasing Well–Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIPs, which were initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from each project.

In FY 2020–2021, **HCI R4** 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, **HCI R4** 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 *Increasing Well–Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP close-out reports 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 **HCI R4** reported in the FY 2019–2020 PIP close-out report for the *Increasing Well Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIPs.

Table 2-1—PIP Conclusions Summary

Increasing Well–Checks for Members 21–64 Years of Age PIP	
Interventions	Telephone outreach by care coordinators to 21–64-year-old male members due for a well visit; outreach calls included reminder and assistance with appointment scheduling.
Successes	Well visit rates increased during the project.
Lessons Learned	• Live, personal phone outreach by care coordinators was resource-intensive and limited the number of members who could be targeted for outreach each month. • Revisions for the intervention considered by the health plan include increasing the scope of outreach (more members per month) and focusing on members who had previously been seen by the partner provider (established patients).

Increasing Mental Healthcare Services After a Positive Depression Screening PIP	
Interventions	Use of real-time electronic health record (EHR) data dashboard to identify members with positive depression screens and member outreach by a behavioral health clinician to schedule follow-up appointment and offer resources (transportation); behavioral health clinician also conducted phone outreach for missed appointments.
Successes	Enhanced EHR dashboard to enable real-time tracking of positive depression screens and follow-up appointments.
Lessons Learned	Without accurate and timely data (removal of substance use disorder [SUD] and limited claims submission), it is impossible to understand where performance deficits exist, and which interventions should be implemented.

Module 1: PIP Initiation

Table 2-2 presents the FY 2020–2021 validation findings for **HCI R4**'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 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older, from 11.21% to 15%.
Preliminary Key Drivers	• Primary care provider education and knowledge. • Data accuracy.
Potential Interventions	• Implement provider townhalls and/or learning collaboratives to discuss depression screening services and reduce stigma. • Ensure provider understanding and use of correct depression screening codes.
Measure 2—*Follow–Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow–ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from 25.15% to 30%.
Preliminary Key Drivers	• Member education and awareness. • Provider collaboration.
Potential Interventions	• Provide member outreach and education by care coordinators following a positive depression screen. • Coordinate depression screening and follow-up services at primary care offices by case managers or care coordinators.

In Module 1, **HCI R4** set two goals to achieve by June 30, 2022:

- Increase the percentage of members 12 years of age and older who receive a depression screening during a well visit at Valley-Wide Health Systems to 15 percent.
- Increase the percentage of members 12 years of age and older, attributed to Valley-Wide Health Systems, who screened positive for depression that receive follow-up behavioral health services within 30 days of the positive depression screen to 30 percent.

The health plan completed key driver diagrams in Module 1 that identified evidence-based key drivers and potential interventions to support achievement of these goals. **HCI R4**'s identified key drivers focused on provider knowledge and collaboration, data accuracy, and member awareness. **HCI R4** has identified provider-focused and member-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **HCI R4** 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 **HCI R4** successfully completed Module 1 and designed a methodologically sound project. **HCI R4** was successful in identifying an appropriate narrowed focus, 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, **HCI R4** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **HCI R4** 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, **HCI R4** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **HCI R4** 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 **HCI R4** progresses through determining and testing interventions.
- **HCI R4** 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, **HCI R4** 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for **Health Colorado, Inc.**

Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc.
PIP Title	Depression Screening and Follow–up After a Positive Depression Screen
Contact Name	Jeremy White
Contact Title	Quality Manager
Email Address	Jeremy.White@beaconhealthoptions.com
Telephone Number	719-226-7794
Submission Date	December 5, 2020
Resubmission Date (if applicable)	April 2, 2021

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PIP Team

Instructions:

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

Table 1—Team Members

Name	Title	Role and Responsibilities
Melissa Schuchman	Performance and Outcomes Analyst, Beacon Health Options	Data and Reporting
Jeremy White	Quality Manager, Beacon Health Options	PIP Lead
Andrea Scott	SQL Developer II, Beacon Health Options	Data and Reporting
Kat Fitzgerald	Quality Management Specialist II, Beacon Health Options	Billing and Claims
John Mahalik	Director, Quality Improvement, Beacon Health Options	Quality Improvement, Beacon Health Options (ASO)
Dr. Brian Hill	Chief Clinical Officer, Health Colorado, Inc.	Executive Sponsor
Cathy Michopoulos	Chief Operating Officer, Health Colorado, Inc.	Executive Sponsor
Tina McCrory	Chief Strategy Officer, Health Colorado, Inc.	Behavioral Health Strategy
Kelly Bowman	Health Colorado, Inc.	Behavioral Health Strategy
Charles Boston	Valley-Wide Health Systems	PCMP Partner
Lorraine Madrid	Valley-Wide Health Systems	PCMP Partner
James Martinez	Valley-Wide Health Systems	PCMP Partner

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Larry Helms	Valley-Wide Health Systems	PCMP Partner
Marisa Atencio	Valley-Wide Health Systems	PCMP Partner
Kristina Daniels	Valley-Wide Health Systems	PCMP Partner
Rajan Mohan	Network Support Consultant, Beacon Health Options	PIP Consultant

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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
To improve access to behavioral health care, Health Colorado, Inc. (HCI) will target depression screening in primary care and subsequent behavioral health follow-up as its Performance Improvement Project (PIP) focusing on members who are diagnosed with diabetes. With this focus on members with diabetes, the project will have greater alignment with HCI's condition management efforts and Population Health strategic goals. The effort will aim to increase the rate in which a provider in HCIs' region complete and bill for a depression screen at members' annual well visit, as well as ensure any positive depression screen has a timely mental health service. This topic was also mandated by the state.
Narrowed Focus Description
HCI has identified Valley-Wide Health Systems ("Valley-Wide") as the narrowed focus provider for this PIP. Primary Care Medical Provider (PCMP) attribution was evaluated to identify volume of members by providers. Valley-Wide has 15 locations with 14,196 members 12 years and older attributed with 1,856 members with a well visit between July 1, 2019 and June 30, 2020, and only 208 of those members had a depression screen completed during the well visit. Looking more broadly at members 12 years and older, with a positive depression screen completed at any visit between July 1, 2019 and June 30, 2020, and BH follow-up rates for Valley-Wide, there were 843 members who had positive depression screens, and 212 of those members with BH follow-up within 30 days after the positive depression screen.

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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	Members with depression screen at Valley-Wide
Denominator Description	Members with a well visit at Valley-Wide
Age Criteria (if applicable)	12 years of age and older at date of well visit
Continuous Enrollment Specifications (if applicable)	
Allowable Gap in Enrollment (if applicable)	None
Anchor Date (if applicable)	First day of the month
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: 07/01/2019	End Date: 06/30/2020
Numerator: 208	Denominator: 1,856	Percentage: 11.21%

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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: In order to obtain the data for the performance improvement project Andrea Scott followed the steps below to obtain the data set. A mixture of submitted claims and encounters were used as the source for data during the 12 month measurement period, July 1, 2019 to June 30, 2020. 1. Denominator - Find all members attributed to Valley-Wide who had a well visit using KPI Well Visit table provided through Truven Data Analytics Portal. 2. Numerator - Find all members attributed to Valley-Wide who have a depression screen completed at the time of the well visit using the service codes G8510 & G8431. 3. Melissa Schuchman, Data Analyst, will review the data, divide the Numerator by the Denominator to calculate the follow up percentage rate and track ongoing progress.		

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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 with a follow-up behavioral health service within 30 days of positive depression screen.
Denominator Description	Members with a positive depression screen at Valley-Wide.
Age Criteria (if applicable)	12 years of age and older at date of depression screen
Continuous Enrollment Specifications (if applicable)	30 days
Allowable Gap in Enrollment (if applicable)	None
Anchor Date (if applicable)	First day of the month

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	

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: 07/01/2019	End Date: 06/30/2020
Numerator: 212	Denominator: 843	Percentage: 25.15%

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

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:
Describe the step-by-step data collection process and data elements collected: In order to obtain the data for the performance improvement project Andrea Scott followed the steps below to obtain the data set. A mixture of submitted claims and encounters were used as the source for data during the 12 month measurement period July 1, 2019 to June 30, 2020. 1. Denominator a. Find all members attributed to Valley-Wide who had a positive depression screening using svccod 'G8431'. b. Determine continuous enrollment from date of positive depression screening through 30 days after the depression screening. 2. BH Numerator a. Match up the members from the denominator with BH services using the service codes and provider type codes per the Incentive Measure #4 (scope document – see attached). 3. Physical Health Numerator		

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a. Match up the members from the denominator with Physical Health services using the service codes and provider type codes per the Incentive Measure #4 (scope document – see attached).
b. Combine the BH and PH numerators

Melissa Schuchman, Data Analyst, will review the data, divide the Numerator by the Denominator to calculate the follow up percentage rate and track ongoing progress.

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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 6/30/2022, use key driver diagram interventions to *increase* the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older, from 11.21% to 15%.

Follow-Up After a Positive Depression Screen:

By 6/30/2022, use key driver diagram interventions to *increase* the percentage of behavioral health follow-ups within 30 days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from 25.15% to 30%.

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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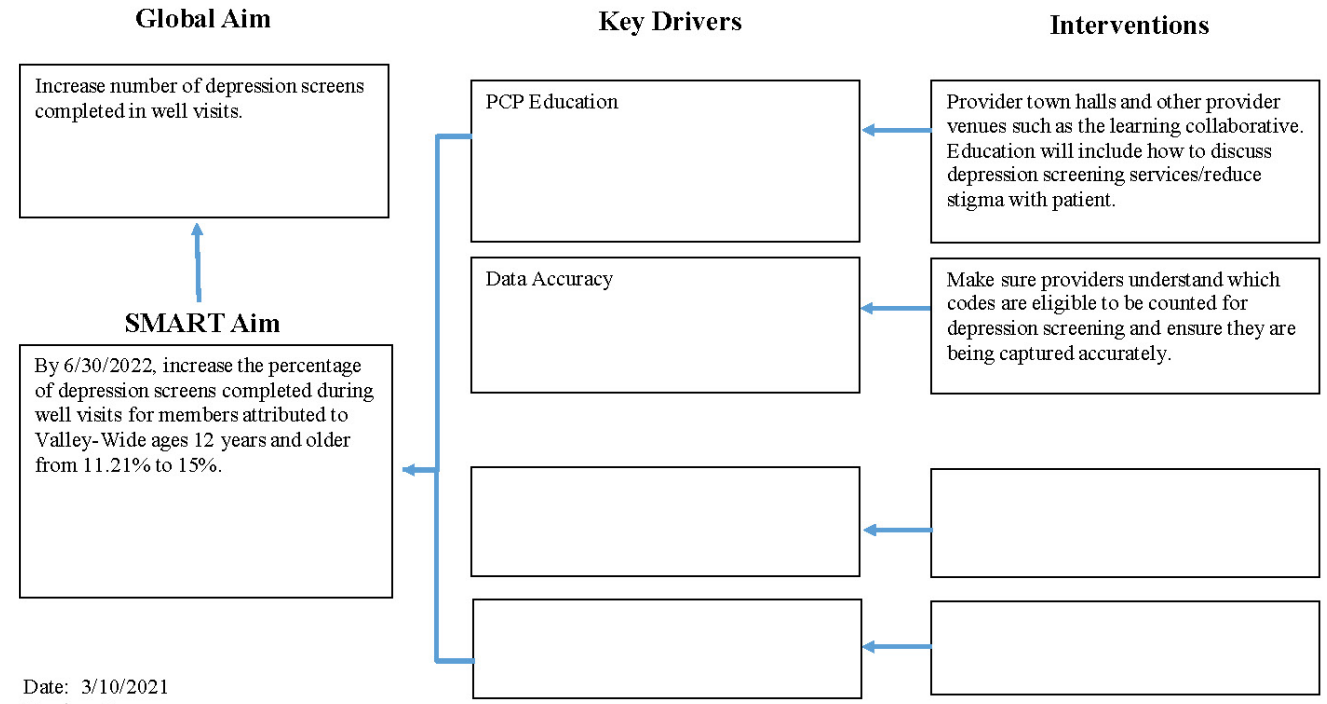
Key Driver Diagram– *Depression Screening*



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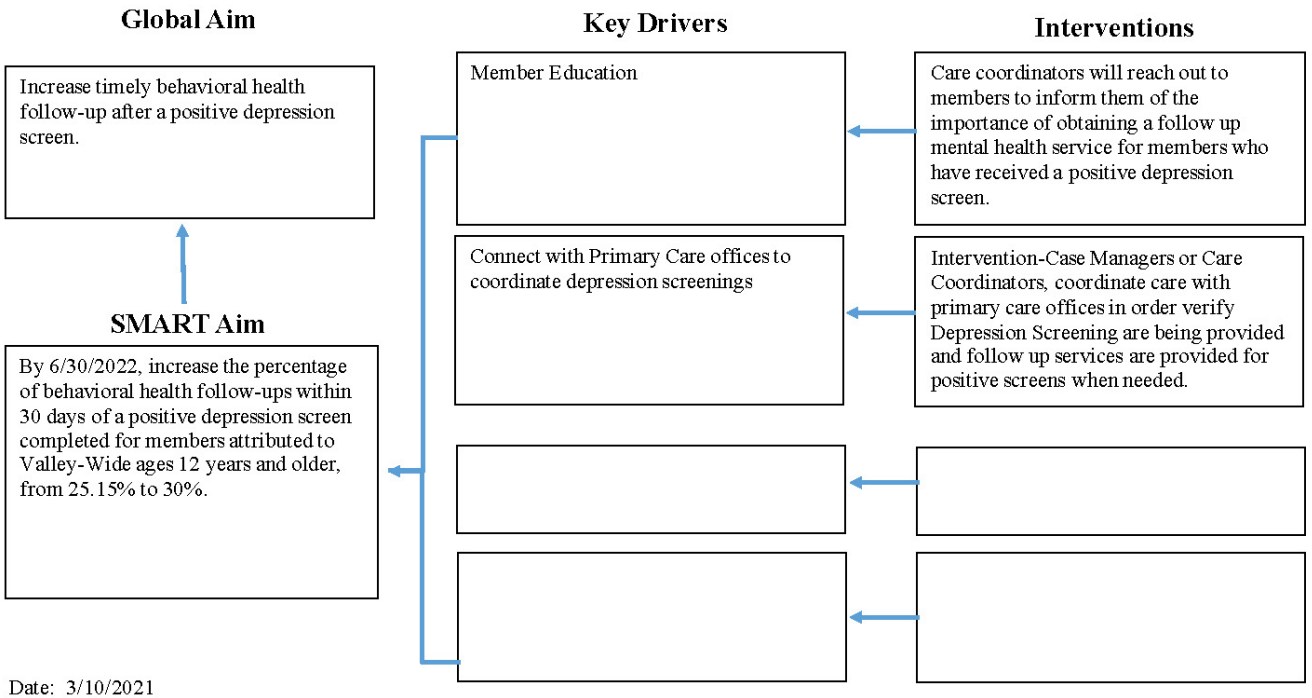
Key Driver Diagram – *Follow–Up After a Positive Depression Screen*



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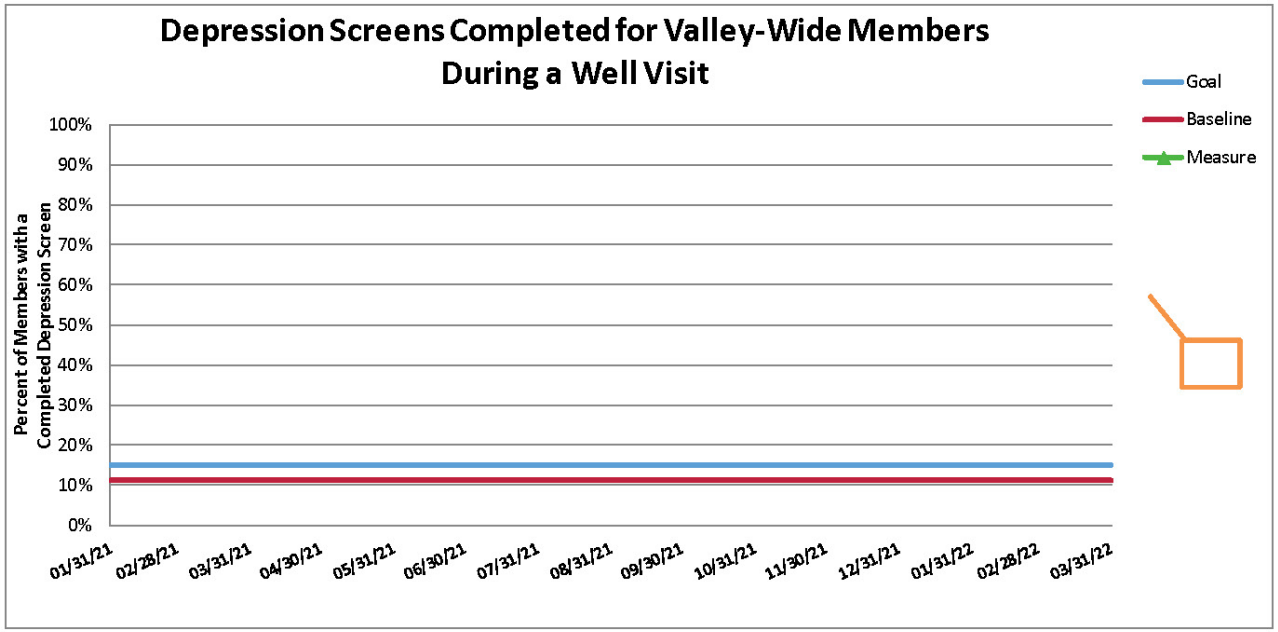
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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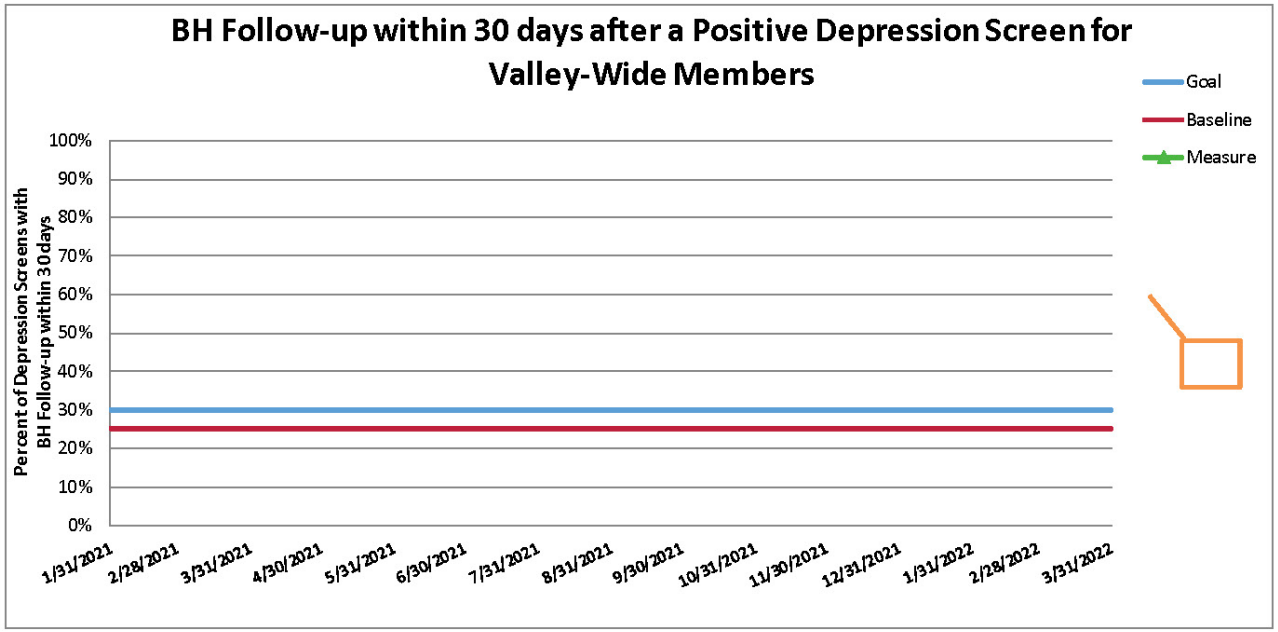
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



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 opportunity for improvement: • The baseline denominator (88 members) for the *Follow-Up After a Positive Depression Screen* measure was low for a rapid-cycle PIP. The small number of members in the denominator may cause issues with the length of time required to test interventions. The health plan should consider expanding the narrowed focus or revising the inclusion criteria for the eligible population to increase the denominator size. • HSAG recommends a technical assistance call to discuss the baseline denominator size for the *Follow-Up After a Positive Depression Screen* measure and potential alternative narrowed focus options. **Re-review March 2021:** In the resubmission, the health plan expanded the narrowed focus selected for the PIP and the baseline denominator size for the *Follow-Up After a Positive Depression Screen* measure increased from 88 to 843 members. The criterion has been *Met*.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*** • The numerator and denominator descriptions should specify, "The total number of members…" • The numerator description should clarify that the depression screening must occur during the measurement period.

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Criteria	Score	HSAG Feedback and Recommendations
d) Narrowed focus baseline data that considered claims completeness		• The health plan should confirm if the depression screening must occur with the narrowed focus provider to be deemed numerator compliant. • The denominator description should specify, "during the measurement period." • For age criteria, the health plan should specify the exact date or timeframe used for member age determination. • It was unclear why 60 days of continuous enrollment was required. Additionally, it was unclear when continuous enrollment was required in relation to the denominator qualifying event and measurement period. Was it 60 days at any point during the baseline measurement period? • For the denominator qualifying event, the health plan should document the rationale for using the Department's All file to determine diagnosis of diabetes. In addition, the health plan should specify if the diagnosis of diabetes must occur within a specific timeframe within the baseline measurement period. • The step-by-step data collection process did not appear to align with the continuous enrollment requirements reported in Table 3a. The data collection process did not refer to determining continuous enrollment for members in the denominator. ***Follow-Up After a Positive Depression Screen*** • The numerator and denominator descriptions should specify, "The total number of members…"

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Criteria	Score	HSAG Feedback and Recommendations
		• The numerator description should specify the narrowed focus: "…within 30 days of positive depression screen at Valley-Wide." • For the denominator qualifying event, the health plan should document the rationale for using the Department's All file to determine diagnosis of diabetes. In addition, the health plan should specify if the diagnosis of diabetes must occur within a specific timeframe within the baseline measurement period. • The denominator description should specify the timeframe when the positive depression screen occurred in relation to the baseline measurement period. Could the positive depression screen occur anytime within the baseline measurement period, which would require the follow-up visit to be tracked beyond of the measurement period? Were members with a positive depression screen less than 30 days before the end of the measurement period included or excluded? • For age criteria, the health plan should specify the exact date used for member age determination. • The health plan should clarify the rationale for requiring 60 days of continuous enrollment and the timeframe when continuous enrollment was required. Based on the numerator description, only 30 days after the positive depression screen are required to determine if a follow-up visit occurred. • The step-by-step data collection process referenced "Incentive Measure #4 (scope document – see attached.)" However, the attachment was not received with the Module 1 submission.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review March 2021: The health plan addressed some but not all of HSAG's initial feedback in the resubmission. The unaddressed feedback is highlighted above. To clarify, the following must be addressed in the next resubmission to achieve a *Met* score for this criterion: • For the *Depression Screening* measure, the health plan removed the continuous enrollment requirements, which had been specified as 60 days, and left this row blank in Table 3a. If the health plan will not be applying continuous enrollment requirements for this measure, the row should be labelled *None* or *Not Applicable*. • For both *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures, the health plan should clarify how a member's age was determined for inclusion in each measure. The revised documentation should clarify what date or time frame was used to determine if the member was 12 years of age or older. For example, was age determined at the start of the baseline measurement period or at the end of the baseline measurement period.? Or, if age was determined on the date of service, did a member have to be 12 years or older on the date of the well visit, for the *Depression Screening* measure and, 12 years or older on the date of the positive depression screen, for the *Follow-Up* measure? The health plan should clearly document how member age was determined for inclusion in each measure.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review April 2021: The health plan addressed the remaining feedback in the second resubmission. 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 e) End date	☒ Met ☐ Not Met	
4. The SMART Aim run charts for *Depression Screening* and *Follow–up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement: • The dates labelled on the x-axis of each run chart should be the last day of the last month for each rolling 12-month measurement period. For example, 1/31/2021 instead of 1/01/2021. **Re-review March 2021:** The health plan did not address HSAG's initial feedback (highlighted above); therefore, the criterion remains *Not Met*. The health plan must revise the dates on the x-axis to reflect the *last* day of the month to address the initial feedback. The dates should represent the last day of the last month of each rolling 12-month measurement period.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review April 2021: The health plan addressed the remaining feedback in the second resubmission. The criterion has been *Met*.
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal in each key driver diagram.	☒ Met ☐ Not Met	HSAG identified the following opportunity for improvement: • The health plan should revise the SMART Aim in the key driver diagram to specify that the follow-up visit must occur within 30 days of the positive depression screen. The SMART Aim statement in the *Follow–up After a Positive Depression Screen* key driver diagram should be the same as the SMART Aim statement on page 10 of the Module 1 submission form. **Re-review March 2021:** In the resubmission, HSAG identified the following opportunities for improvement that must be addressed: • The health plan did not address HSAG's initial feedback (highlighted above). • In addition, the health plan did not update the SMART Aim in the *Depression Screening* key driver diagram (KDD) to align with the revised SMART Aim on page 10. **Re-review April 2021:** The health plan addressed the remaining feedback in the second resubmission. The criterion has been *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

PIP Initiation (Module 1)

☒ Pass

Date: April 19, 2021