COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2021–2022 PIP Validation Report

for

Health Colorado, Inc. Region 4

April 2022

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 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 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) 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 **HCI R4**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **HCI R4**'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, **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 (BH) 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 BH 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	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

At the time this FY 2021–2022 PIP validation report was produced, **HCI R4** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **HCI R4** 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, **HCI R4** 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, **HCI R4** 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 **HCI R4** 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 **HCI R4**'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	• Medical assistant (MA) is unaware that depression screening is due • MA skips depression screen during check-in process without medical rationale • MA does not get information about needed depression screening • Screening into electronic health record (EHR) not captured by reporting • Incorrect code used for screening	• Billing inconsistency • Data accuracy • MA awareness of depression screening impact • EHR detection of all completed screening forms	• Provider education and engagement in appropriate billing strategies to allow accurate and complete depression screen EHR documentation • Provider education on correct depression screen coding and reporting • Staff training on clinical impact of depression screening and current performance on depression screening metrics • Identify alternative methods of capturing paper-based depression screens in EHR

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• Primary care physician (PCP) addresses positive depression screen without BH provider involvement • Same-day BH follow-up services were unavailable when positive depression screen occurs • Member does not attend scheduled BH follow-up appointment	• Timely communication with BH providers following positive depression screen • Coordination of depression screening and follow-up services among primary care offices • BH service billed even if follow-up BH visit occurs on the same day as positive depression screen • All members receive support to schedule a follow-up BH visit after a positive depression screen	• Intervention-case managers or care coordinators coordinate with PCPs to ensure depression screening and follow-up services are provided • Develop process flow for communicating positive depression screens to targeted BH provider • Capture BH follow-up service on well visit claim if services occur on the same day • Case managers identify members in need of follow-up BH services after a positive depression screen

In Module 2, **HCI R4** 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 **HCI R4** identified to improve depression screening focused on provider and staff education, EHR documentation, and appropriate coding and billing practices for depression screening. The potential interventions **HCI R4** identified to improve follow-up services focused on care coordination and case management and improved clinic workflow and communication.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **HCI R4** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **HCI R4** submitted testing plans for three interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **HCI R4** carried out PDSA cycles to evaluate intervention effectiveness. Table 2-2 summarizes the FY 2021–2022 Module 3 validation findings for **HCI R4**'s three interventions.

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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Staff feedback on depression screening performance and training on depression screening procedures	MA skips PHQ-4[1] during check-in process without medical rationale	MA training/awareness of depression screening impact	• Percentage of outpatient visits for eligible members within Valley-Wide Health Systems during which a depression screening was conducted (claims-based) • Percentage of outpatient encounters for eligible members within Valley-Wide Health Systems during which a depression screening was conducted (EHR-based)
Establish a clinical policy for BH referral after a positive depression screen and provide staff training on BH referral policy and procedures following a positive depression screen	Provider addresses positive depression screen with a follow-up plan and/or psychopharmacology, without BH provider involvement	Timely communication with BH providers following positive depression screen	• Percentage of members with a positive depression screen at Valley-Wide Clinic who have a follow-up BH service within 30 days of the positive screen (claims-based) • Percentage of members with a positive depression screening at Valley-Wide Clinic who have a BH encounter following the positive depression screen
Provide training to coding auditors on the correct criteria for entering G-codes for positive and negative depression screening results in the electronic health record (EHR)	Incorrect code used for screening	Data accuracy	• Percentage of encounters reviewed across all Valley-Wide clinics with an appropriate depression screening G-code documented in the EHR

[1]PHQ = Patient Health Questionnaire

In Module 3, **HCI R4** selected three interventions to test for the PIP. The detailed intervention testing plans **HCI R4** documented in the Module 3 submission forms are included in Appendix A. Module

Submission Forms. The interventions addressed process gaps or failures in staff training and clinical policies and procedures for depression screening and follow-up services, and coding practices. For each intervention, **HCI R4** defined one or more intervention effectiveness measures to evaluate the impact of each 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. **HCI R4** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **HCI R4** 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. **HCI R4** also passed Module 3 for three interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **HCI R4** will continue to test interventions for the PIP through the end of FY 2021–2022. The health plan will submit final intervention testing results, PIP outcomes, and project conclusions for validation in FY 2022–2023.

Recommendations

- **HCI R4** should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should record intervention testing results and interpretation of results in the PDSA worksheet for each intervention, which will be submitted as part of Module 4—PIP Conclusions in FY 2022–2023.
- **HCI R4** 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, **HCI R4** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **HCI R4** 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 **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	June 4th, 2021
Resubmission Date (if applicable)	

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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?)
Conv. Care Clinic Visit?	MA is not aware that depression screening is due	Unscheduled visits do not allow for pre-visit planning	Screening not completed. Metric failure.
Patient Visit report from Azara is reviewed daily – by clinical team	MA does not get information about needed depression screening	No one person is responsible to identify need for screening	Could miss new onset identification of depression &/or failing metric if screening not performed at future encounter.

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MA Decides to Complete Screening?	MA skips depression screen during check-in process without medical rationale	MA distracted by other business (e.g. member, environment) MA doesn't perceive clinical/operational importance of screening	Screening not completed. Metric failure.
MA administers screening on paper at convenient care clinics	Screening into EHR not captured by reporting	Training deficit on importance of screening result transcription	Screening not captured for reporting. Metric failure. Uncertain clinical follow-up.
Depression screen coded and billed	Incorrect code used for screening	IT programming deficit	Metric failure

Note: Throughout document, MA describes medical assistant or nursing staff assigned to assist physical health provider.

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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	MA is not aware that depression screening is due
2	MA skips depression screen during check-in process without medical rationale
3	MA does not get information about needed depression screening
4	Screening into EHR not captured by reporting
5	Incorrect code used for screening

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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?)
Is BHP follow-up needed	PCP decides to address depression in primary care without BHP follow-up	PCP does not see need for BHP	Depression symptoms may not be adequately addressed Failure of metric
Member declines BH follow-up	Member does not want to see BHP	Alternate therapy/treatment options are utilized Member does understand importance of BH Denial	Depression symptoms may not be addressed Failure of metric

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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	PCP decides to address depression in primary care without BHP follow-up
2	BH was not immediately available at visit; Follow-up via phone
3	Member misses scheduled appointment
4	Member does not want to see BHP

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Key Driver Diagrams

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

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

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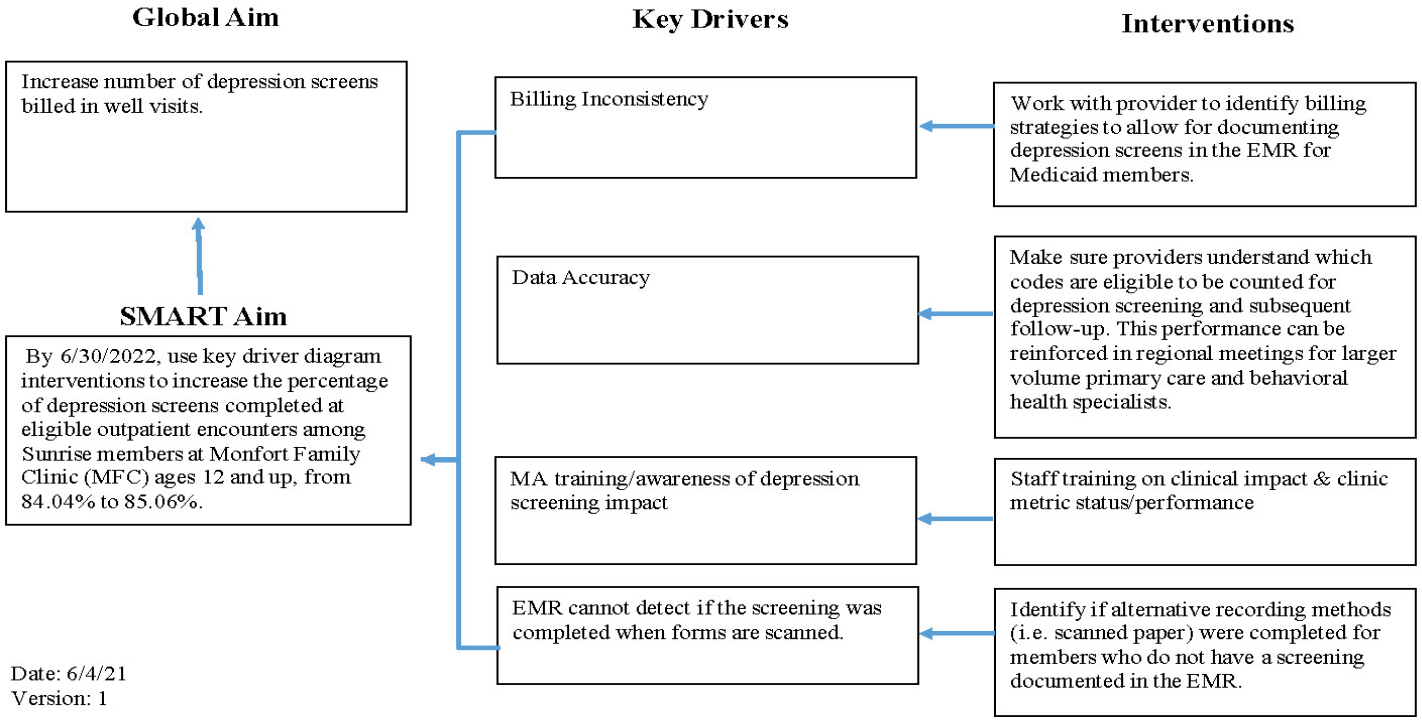
Key Driver Diagram– *Depression Screening*



Date: 6/4/21
Version: 1

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Health Colorado, Inc.

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

Global Aim

Increase timely behavioral health follow-up after a positive depression screen.

SMART Aim

By 6/30/2022, use key driver diagram interventions to *increase* the percentage of behavioral health follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC ages 12 and up, from 40.22% to 47.66%.

Date: 6/4/21
Version: 1

Key Drivers	Interventions
Connect with Primary Care offices to coordinate depression screenings and subsequent follow-up.	Intervention-Case Managers or Care Coordinators, coordinate care with primary care offices in order verify Depression Screening are being provided and follow up services are provided for positive screens when needed.
Ensure timely communication with behavioral health provider following a positive depression screen in the primary care setting.	Develop process flow for communicating positive depression screen with North Range staff (BH provider).
BH service is billed, even if service is same-day as the well visit.	Capture BH follow-up service on well visit claim if services occur same-day.
Members without follow-up arranged may be identified as low-risk and de-prioritized for follow-up.	Case managers determine if members are "flagged" as high-risk.

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Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc. (HCI)
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Staff Education and Feedback on Depression Screening Procedures
Contact Name	Edward Arnold
Contact Title	Performance Improvement Analyst
Email Address	Edward.Arnold@beaconhealthoptions.com
Telephone Number	719-244-9758
Submission Date	8/6/2021
Resubmission Date (if applicable)	9/24/21

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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 1a—Intervention Plan	
Intervention Being Tested	Staff Education and Feedback on Depression Screening Procedures
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	MA skips PHQ-2 during check-in process without medical rationale
Key Driver Addressed	MA training/awareness of depression screening impact
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	Intervention is a two-pronged approach. A1, and B1 start at same time. A: 1. Generate gap report from Azara system of the provider (Valley-Wide Health Systems) prior to all encounters including Convenient Care Clinic appointments (See Attachment 1). 2. Reinforce training for Medical Assistants (MAs) to complete depression screening if due. 3. Post/distribute monthly performance measure rate to all teams at Valley-Wide Health Systems for feedback.

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Table 1a—Intervention Plan	
	B: 1. Encourage behavioral health (BH) providers to meet with Medical Assistants (MAs) during All Staff training to briefly describe the clinical value of depression screening, reinforce procedures to BH contact, and outcome evidence value. 2. Repeat above briefing periodically (e.g., quarterly or when new staff are oriented) and include in orientation checklist materials for new staff.
What are the predicted results of this test?	Increased depression screening percentage

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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 2a—Intervention Effectiveness Measure	
Two (2) different intervention effectiveness measures will be utilized in this setting. Measure #1 will be a claims-based measure and quantitative standard for improvement, yet will be subject to claims-lag and less agile for rapid cycle improvement. Measure #2 will be a quantitative measure pulled from the clinic EHR.	
	(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)
Intervention Measure Title	Effectiveness Measure #1: Claims-based depression screening completed at any visit within Valley-Wide Health Systems. Effectiveness Measure #2: EHR-based depression screening completed at any visit within Valley-Wide Health Systems.
Numerator Description	Effectiveness Measure #1: All members attributed to Valley-Wide Health Systems seen within the measurement period who have a depression screen billed within the last 12 months on the date of service for the well visit using the service codes for documentation of screening and qualified visits per the Incentive Measure #4 (Attachment 2). Effectiveness Measure #2: The total number of outpatient encounters within the measurement period for Medicaid members within Valley-Wide Health Systems where a depression screen was conducted on the date of a qualifying encounter or 14 days prior to the date of a qualifying encounter using an age-appropriate standardized depression screening tool.

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Table 2a—Intervention Effectiveness Measure	
Denominator Description	Effectiveness Measure #1: The total number of members with eligible outpatient encounters at Valley-Wide Health Systems within the measurement period. Effectiveness Measure #2: The total number of outpatient encounters within the measurement period for Medicaid members within Valley-Wide Health Systems.

Table 3a—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Effectiveness Measure #1: Eligible outpatient encounters were calculated by finding all encounters described in CMS 2v8 (Depression Screening and Follow-up). The Value Set OID is "2.16.840.1.113883.3.600.1916". Screening for depression was met by using an age appropriate standardized tool. The list of CPT and SNOMED codes included in the Value Set can be found at this link: https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=Depression%20Screening%20and%20Follow-up%20encounter (Attachment 3-5). Data fields include: Medicaid ID, DOB, Last Name, First Name, Gender, Ethnicity, Age, Age Group, County, Depression Screen Date, Screening Provider, Follow-up Date, and Follow-up Provider. Effectiveness Measure #2: We will use data pulled from the Electronic Health Record (EHR) to capture documented depression screens. Eligible outpatient encounters were calculated by finding all encounters described in CMS 2v8 (Depression Screening and Follow-up). The Value Set OID is "2.16.840.1.113883.3.600.1916". Screening for depression was met by using an age appropriate standardized tool. The list of CPT and SNOMED codes included in the Value Set can be found at this link: https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=Depression%20Screening%20and%20Follow-up%20encounter (Attachment 3-5). Data fields include: DOB, Name, Race, Ethnicity, Most Recent Encounter Date, Most Recent Encounter Location, Depression Screen Date, Depression Screen Source, Depression Screen Results, Exclusion, Depression Screen FollowUp Date, Depression Screen FollowUp Result, Depression Screen FollowUp Type
Describe the Data Sources	Effectiveness Measure #1: Valley-Wide Health Systems claims data will be pulled from HCPF source file.

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Table 3a—Intervention Effectiveness Measure Data Collection Process	
	Effectiveness Measure #2: Valley-Wide Health Systems EHR/Azara record.
Describe how Data will be Collected	Effectiveness Measure #1: MAs will input depression screening responses directly into the EHR when talking with the member while taking vitals. This will populate the appropriate G-code (positive or negative) for depression screening on the claim for that encounter into the EHR. In order to obtain the data for the performance improvement project the steps below will be used to obtain the data set. Submitted claims and encounters will be used as the source for data during each one-month measurement period. 1. Denominator - Find all members attributed to Valley-Wide Health Systems who had a well visit using the service codes per the Incentive Measure #4 (Attachment 3-5) within the measurement month. 2. Numerator - Find all members attributed to Valley-Wide Health Systems who have a depression screen billed on the date of service for the well visit including a twelve (12) month lookback using the service codes of claims per the Incentive Measure #4 (Attachment 2). Join the Denominator with the Numerator to calculate the follow up percentage. Effectiveness Measure #2: Medical assistants will input depression screening responses directly into the EHR when talking with the member while taking vitals. Valley-Wide Health Systems Quality team will filter results for Medicaid members and calculate the performance rate for depression screens completed.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Effectiveness Measure #1: Claims data will be reported monthly. Any data irregularities will be first addressed with the Beacon Data Analytics and Reporting Team (DART) and then elevated to HCPF data POCs for resolution. Effectiveness Measure #2: Data will be collected daily during outpatient visits. EHR rates with numerators and denominators will be calculated and reported monthly to HCI and Beacon Health Options (Beacon).

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Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc.
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	Provider Education on Integrated Care Delivery Following Positive Depression Screening
Contact Name	Edward Arnold
Contact Title	Performance Improvement Analyst
Email Address	Edward.Arnold@beaconhealthoptions.com
Telephone Number	719-244-9758
Submission Date	8/6/2021
Resubmission Date (if applicable)	10/8/2021

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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 1b—Intervention Plan	
Intervention Being Tested	Provider Education on Integrated Care Delivery Following Positive Depression Screening
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Provider addresses issue with plan &/or psychopharmacology and no Behavioral Health involvement
Key Driver Addressed	Ensure timely communication with behavioral health provider following a positive depression screen in the primary care setting.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Encourage behavioral health (BH) providers to meet with providers during All Staff training to emphasize the clinical value of depression screening, reinforce procedures to BH contact, and outcome evidence. Stress the value of the integrated BH model to members receiving care and providers delivering care. 2. Establish clinical policy that referral to BH is default practice for positive depression screening.

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Table 1b—Intervention Plan	
	3. Repeat above briefing periodically (e.g., quarterly or when new staff are oriented) and include in orientation checklist materials for new staff and transitional/intern staff.
What are the predicted results of this test?	Increased depression screening follow-up percentage (Current target: 30%)

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 2b—Intervention Effectiveness Measure	
Two (2) different intervention effectiveness measures will be utilized in this setting. Measure #1 will be a claims-based measure and quantitative standard for improvement, yet will be subject to claims-lag and less agile for rapid cycle improvement. Measure #2 will be a quantitative measure produced audit of results from the Azara analytics tool pulling data from the NextGen electronic health record (EHR).	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)**
	Effectiveness Measure #1: Follow-up after positive depression screening at any visit within Valley-Wide Clinic Effectiveness Measure #2: BH encounter after a positive depression screening at any visit within Valley-Wide Clinic.

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Table 2b—Intervention Effectiveness Measure	
Numerator Description	Effectiveness Measure #1: The total number of members with a positive depression screen at Valley-Wide Clinic within the measurement period and a follow-up behavioral health service within 30 days of positive depression screen (See Attachment 1) Effectiveness Measure #2: The total number of members with a BH encounter following a positive depression screening at Valley-Wide Clinic within the measurement period.
Denominator Description	Effectiveness Measure #1: The total number of members with a positive depression screen at Valley-Wide Clinic within the measurement period Effectiveness Measure #2: The total number of members with a positive depression screening at Valley-Wide Clinic within the measurement period.

Table 3b—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Effectiveness Measure #1: Eligible outpatient encounters were calculated by finding all encounters described in CMS 2v8 (Depression Screening and Follow-up). The Value Set OID is "2.16.840.1.113883.3.600.1916". Screening for depression was met by using an age appropriate standardized tool. The list of CPT and SNOMED codes included in the Value Set can be found at this link: https://vsac.nlm.nih.gov/valueset/expansions?pr=all&rel=Latest&q=Depression%20Screening%20and%20Follow-up%20encounter (Attachment 23-4). Data fields include: Medicaid ID, DOB, Last Name, First Name, Gender, Ethnicity, Age, Age Group, County, Depression Screen Date, Screening Provider, Follow-up Date, Follow-up Provider. Effectiveness Measure #2: Valley-Wide Quality Department will pull the Azara "Screening for Depression and Follow-up Plan" Report that uses NQF 0418e / CMS eCQM 2v10 specs for the previous month. The team will manipulate the detail report to capture members who screened positive for depression and audit each member's appointment history for an encounter with BH following the positive screening (See Attachment 5).

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Table 3b—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Sources	Effectiveness Measure #1: Valley-Wide Clinic claims data will be pulled from HCPF source file. Effectiveness Measure #2: Valley-Wide Clinic EHR/Azara.
Describe how Data will be Collected	Effectiveness Measure #1: 1. Denominator a. Find all members in the physical health data table who had a positive depression screening using svccod 'G8431' during the measurement period. b. Determine continuous enrollment from date of positive depression screening through 30 days after. 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 (Attachment 1). 3. Physical Health Numerator 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 (Attachment 1). b. Combine the BH and PH numerators 4. Join the Denominator with the Numerator to calculate the follow up percentage. Effectiveness Measure #2: 1. Denominator: The total number of members filtered to have Medicaid primary insurance with a positive depression screening at Valley-Wide Clinic within the measurement period. 2. Numerator: The total number of members filtered to have Medicaid primary insurance with a positive depression screening at Valley-Wide Clinic within the measurement period AND if positive, found to have a BH encounter within 30 days of the positive screen.

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Table 3b—Intervention Effectiveness Measure Data Collection Process	
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Effectiveness Measure #1: Claims data will be reported monthly. Any data irregularities will be first addressed with the Beacon DMATT team and then elevated to HCPF data POCs for resolution. The Quality team will partner with Valley-Wide IT staff to generate detailed member-level data on encounters, screening results, and follow-up in order to provide incremental feedback on intervention efficacy. Effectiveness Measure #2: The "Screening for Depression and Follow-up Plan Report" will be generated monthly and manipulated per description above. The results of audited records will be aggregated by the Valley-Wide team and provided to PIP team for review and discussion. Any disparity in the number of audited records versus the number of positive screens on Azara report will be reviewed to identify mitigating strategies for future months.

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Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc.
PIP Title	*Depression Screening*
Intervention Name:	Depression Screening Coding Training
Contact Name	Edward Arnold
Contact Title	Performance Improvement Analyst
Email Address	Edward.Arnold@beaconhealthoptions.com
Telephone Number	719-244-9758
Submission Date	8/6/2021
Resubmission Date (if applicable)	4/15/22

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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 1a—Intervention Plan	
Intervention Being Tested	Depression Screening Coding Training
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	Incorrect code used for screening
Key Driver Addressed	Data Accuracy
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Provide reinforcement training to coding auditors on criteria for the codes associated with Depression Screening and where to find that in clinical notes: - G8510 - Negative Screening for Depression - G8511 - Positive Screening for Depression without follow-up - G8431 - Positive Screening for Depression with follow-up 2. This training will be included with orientation if any coding auditors join the team following the initial intervention training.

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Table 1a—Intervention Plan	
What are the predicted results of this test?	Increased depression screening percentage

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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 2a—Intervention Effectiveness Measure	
Intervention Measure Title	**(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)** **Coding training on depression screening within Valley-Wide Clinic**
Numerator Description	Number of encounters reviewed from the past month with the appropriate application of a depression screening G-code based on review of clinical documentation of the encounter.
Denominator Description	Number of encounters reviewed from the past month across all Valley-Wide clinics for appropriate G-code use.

Table 3a—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Clinical documentation of the encounter to include depression screening questions/responses, assessment, plan, and coding.
Describe the Data Sources	Electronic Health Record from Valley-Wide clinics.
Describe how Data will be Collected	Valley-Wide staff (e.g. Quality Assurance Coordinator) will select a random sample of encounters that Azara reporting indicates that depression screening has occurred. (Half of the sample will be from positive screening results and half from negative screening results.) The sample size will be 10 records from across

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Table 3a—Intervention Effectiveness Measure Data Collection Process	
	all Valley-Wide clinics during April, and 20 records per month once use of tablets at check-in has been implemented across all clinics. Documentation will be compared with the coding manual standards for G8510- Negative Screening for Depression, G8511- Positive Screening for Depression without follow-up, G8431- Positive Screening for Depression without follow-up. This sample size represents between 5-10% of the denominator of PIP outcome measure over the past year.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Data will be provided monthly. If the full sample was not collected, this will be addressed during PIP team meetings.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The MCO included process maps for *Depression Screening* and *Follow–Up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	☒ Met ☐ Not Met	
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	
5. The MCO prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	

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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 MCO included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: June 28, 2021

State of Colorado
Performance Improvement Project (PIP)
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Intervention: Staff Education and Feedback on Depression Screening Procedures

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	HSAG identified the following opportunities for improvement: • The health plan should separate the documentation of the two separate interventions into two separate Module 3 submission forms. One Module 3 submission form should be completed for the intervention targeting *Depression Screening*, which was documented in Tables 1a, 2a, and 3a. The other Module 3 submission form should be completed for the intervention targeting *Follow-Up After a Positive Depression Screen*, which was documented in Tables 1b, 2b, and 3b. • The health plan should update the header in each new Module 3 submission form to reference the correct RAE. • For the intervention targeting *Follow-Up After a Positive Depression Screen*, the health plan should provide more detail in the intervention process steps (Table 2b) to demonstrate the link with the documented predicted results. The predicted results should describe the direct effect expected from the intervention. Based on the current intervention process steps, it appeared that the predicted results may be an increase in screening providers, who received the intervention (training), contacting and involving behavioral health providers when a member screens positive for depression.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review September 2021: The health plan addressed HSAG's feedback in the resubmission. The criterion has been changed to *Met*.
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	As noted above for the intervention targeting *Follow-Up After a Positive Depression Screen*, it appeared that the direct effect of this intervention would be an increase in screening providers contacting and involving behavioral health providers when a member screens positive for depression. Based on the current process steps for this intervention, RAE 4 should consider adding an intervention effectiveness measure that will allow tracking of how many providers who received the intervention (training) contacted and involved behavioral health (BH) providers in the care of members who screened positive for depression. The RAE should revisit, and possibly revise, the intervention effectiveness measure to allow evaluation of the direct effect of the intervention. **Re-review September 2021:** The health plan removed the intervention targeting *Follow-Up After a Positive Depression Screen* and focused the Module 3 submission on the *Depression Screening* intervention only. The criterion has been changed to *Met*.
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	**General Comment:** The health plan documented that claims and encounter data would be used for the intervention effectiveness measures. The health plan should consider if / how claims lag will impact monthly evaluation of intervention effectiveness measure results. Effectiveness data should be evaluated monthly, if not more frequently, to support rapid PDSA testing cycles and support achieving the SMART Aim goals by the SMART Aim end date.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review September 2021: The health plan added a second intervention effectiveness measure in the resubmission, based on EHR data. The General Comment was addressed with the addition of the second intervention effectiveness measure.
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: September 29, 2021

State of Colorado
Performance Improvement Project (PIP)
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for Health Colorado, Inc. (RAE 4)

Intervention: Provider Education on Integrated Care Delivery Following Positive Depression Screening

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 MCO included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: October 14, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for **Health Colorado, Inc. (RAE 4)**

Intervention: Depression Screening Coding Training

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 MCO included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: April 19, 2022