Colorado Children's Health Insurance Program

Fiscal Year 2020–2021 PIP Validation Report

for

Kaiser Permanente Colorado

April 2021

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

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1. Executive Summary

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

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

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

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

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

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

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

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

PIP Components and Process

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

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **Kaiser**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **Kaiser**'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, **Kaiser** submitted the following PIP topic for validation: *Depression Screening and Follow–Up After a Positive Depression Screen.*

Kaiser 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 **Kaiser**.

Table 1-1—SMART Aim Statements

PIP Measure	SMART Aim Statement
Depression Screening	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who are screened for depression annually from 9.93% to 20%. This will be achieved by utilizing key driver diagram interventions.
Follow–Up After a Positive Depression Screen	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12-17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.

The focus of the PIP is to increase the percentage of members 12 through 17 years of age who receive a depression screening during a well visit at the Englewood and Westminster Medical Office Buildings and to maintain a high percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goal to increase depression screening to 20 percent represents statistically significant improvement over the baseline performance. Because the baseline performance on the *Follow-Up After a Positive Depression Screen* measure was 100 percent, it is not possible for the PIP to demonstrate statistically significant improvement in this measure. The Department and HSAG approved the health plan's goal to maintain performance on follow-up care at 90 percent or higher while also working to increase the percentage of members who are screened for depression.

Table 1-2 summarizes the progress **Kaiser** 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, **Kaiser** had passed Module 1, achieving all validation criteria for the PIP. **Kaiser** has progressed to Module 2, Intervention Determination. Module 2 and Module 3 validation findings will be reported in the FY 2021–2022 PIP validation report.

Validation Findings

At the end of FY 2019–2020, **Kaiser** closed out the *Improving CHP+ Adolescent Well–Visit Adherence for Members 15–18 Years of Age* PIP, which was initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from the project.

In FY 2020–2021, **Kaiser** 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, **Kaiser** 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 *Improving CHP+ Adolescent Well–Visit Adherence for Members 15–18 Years of Age* PIP close-out report and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **Kaiser** reported in the FY 2019–2020 PIP close-out report for the *Improving CHP+ Adolescent Well–Visit Adherence for Members 15–18 Years of Age* PIP.

Table 2-1—PIP Conclusions Summary for the *Improving CHP+ Adolescent Well–Visit Adherence for Members 15–18 Years of Age* PIP

Interventions	Real-time appointment scheduling during outreach calls.
Successes	Improvement of adolescent well-care rates during the project.
Lessons Learned	• Phone calls were successful while mailers were not successful at getting adolescent well visits scheduled. • Adding weekend and evening well-visit appointment options allowed flexibility for busy members and supported an increase in completed visits

Module 1: PIP Initiation

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

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

Measure 1—*Depression Screening*	
SMART Aim Statement	By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who are screened for depression annually from 9.93% to 20%. This will be achieved by utilizing key driver diagram interventions.
Preliminary Key Drivers	• Ensure appropriate depression screening questionnaire is administered and recorded in the electronic health record (EHR) • Increase annual well visits among 12- to 17-year-olds
Potential Interventions	• Text message well-visit reminders • Include depression screening questionnaire in pre-visit forms on KP.org • Pre-load depression screening questionnaire in member's EHR profile • Provide opportunities to complete the depression screening questionnaire in the waiting room and during the well-visit exam, if not previously completed
Measure 2—*Follow–Up After a Positive Depression Screen*	
SMART Aim Statement	By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12-17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.
Preliminary Key Drivers	• Ensure behavioral medicine specialists are available to meet with member at the time of the positive depression screen • Provide medication support to primary care providers via integrated e-consult system with child psychiatry
Potential Interventions	• Ensure a licensed clinical social worker (LCSW) is on staff to provide behavioral health support to the provider and member at the time of positive depression screen • Ensure the primary care provider uses the e-consult system for guidance from the child psychiatrist on behavioral health medication options

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

- Increase the percentage of members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who are screened for depression annually to 20 percent.

- Maintain the percentage of members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who screen positive for depression and receive follow-up care within 30 days at 90 percent or higher.

The health plan completed key driver diagrams in Module 1 that identified evidence-based key drivers and potential interventions to support achievement of these goals. **Kaiser**'s identified key drivers focused on depression screening and follow-up provider workflows, member well-visit attendance, and access to behavioral health support for primary care providers. **Kaiser** has identified member-focused and provider-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **Kaiser** 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 **Kaiser** successfully completed Module 1 and designed a methodologically sound project. **Kaiser** was also successful in building internal and external quality improvement teams and developing collaborative partnerships with targeted providers and facilities.

Recommendations

- When mapping and analyzing the process(es) related to depression screening and follow-up care after a positive depression screen for the PIP, **Kaiser** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **Kaiser** 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, **Kaiser** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **Kaiser** 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 **Kaiser** progresses through determining and testing interventions.
- **Kaiser** 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, **Kaiser** should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Appendix A. Module Submission Form

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

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Managed Care Organization (MCO) Information	
MCO Name	Kaiser Founds Health Plan of Colorado
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Cathy Johnson/ Jo Anne Doherty
Contact Title	Regulatory Consultant/ Senior Consultant Medicaid & Charitable Programs
Email Address	Catherine.m.johnson@kp.org/Joanne.T.Doherty@kp.org
Telephone Number	303-358-3469/303-681-5082
Submission Date	December 7, 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
Kathleen Westcoat	Senior Director, Medicaid, and Charitable Programs	Executive Sponsor
Lauren Galpin, MD	Medical Director, Medicaid, and Charitable Programs	Strategy, Program Design
Hector de Leon, MD	Assistant Regional Medical Director of Pediatrics	Strategy, Program Design, Operational Resource Allocation
Carlos Madrid	Senior Manager, Medicaid, and Charitable Programs	Program/Data Advisor
Jo Anne Doherty	Senior Consultant, Medicaid, and Charitable Programs	BH Project Lead
Cathy Johnson	Regulatory Consultant Medicaid and Charitable Programs	Project Lead
Adam Stauthamer	Data/Information Analyst	Data Analyst & Reporting
Brenda Gallagher	Clinical Quality Oversight Program Specialist	BH HEDIS/Quality
Amy Conley	Interim Director, BH Behavioral Medicine & BH Crisis, Depression Care Management	Behavior Health
Alice Alexander	BH Senior Technical Development Specialist	Behavior Health

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Table 1—Team Partners		
Name	**Title**	**Role and Responsibilities**
Danna Gunderson	Pediatrics Chief – Westminster	Strategy, Program Design Westminster
Alan Kroll	Medical Office Director – Westminster	Strategy, Program Design Westminster
Felipe Hernandez	Family Medicine Chief – Englewood	Strategy, Program Design Englewood
Wendy Weber	Medical Office Director – Englewood	Strategy, Program Design Englewood

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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
Depression Screening and Follow-Up after a Positive Depression Screen
Narrowed Focus Description
As mandated by the state, Kaiser Permanente will focus on pediatric, ages 12-17 depression screening and the follow-up provided after a positive screen at our Englewood and Westminster Medical Office Buildings (MOB). Englewood & Westminster MOBs were chosen as Westminster has one of the highest CHP+ populations and Dr. Galpin (who is Medical Director of Medicaid and Charitable Programs is also a Pediatrician and Internist at Englewood) enabling her to be both a champion of the project and a participant at the Englewood MOB.

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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	CHP+ Members 12 -17 years of age, assigned to Westminster or Englewood Medical Office who had a well-visit and were screened for clinical depression using an age-appropriate standardized questionnaire (PHQ2) between January 1 and December 1, 2020.
Denominator Description	All CHP+ Members 12 -17 years of age, assigned to Westminster or Englewood Medical Office who had a well-visit between Jan 1 and December 1, 2020, excluding any members with any of the following: •Bipolar disorder during the year prior to the Measurement Period •Depression during the year prior to the Measurement Period •In hospice or using hospice services during the Measurement Period.
Age Criteria (if applicable)	CHP+ Members age 12-17 as of January 1, 2020.

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Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Continuous Enrollment Specifications (if applicable)	No Continuous Enrollment criteria was applied
Allowable Gap in Enrollment (if applicable)	N/A
Anchor Date (if applicable)	N/A
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	N/A

Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 01/01/2020	End Date: 12/01/2020
Numerator: 27	Denominator: 272	Percentage: 9.93%

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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: 1. SQL Query of Electronic Medical Record (EMR) and membership system 2. Query considers the HEDIS DSF specifications **3.** Depression screening tools are administered and collected by EMR discreetly		

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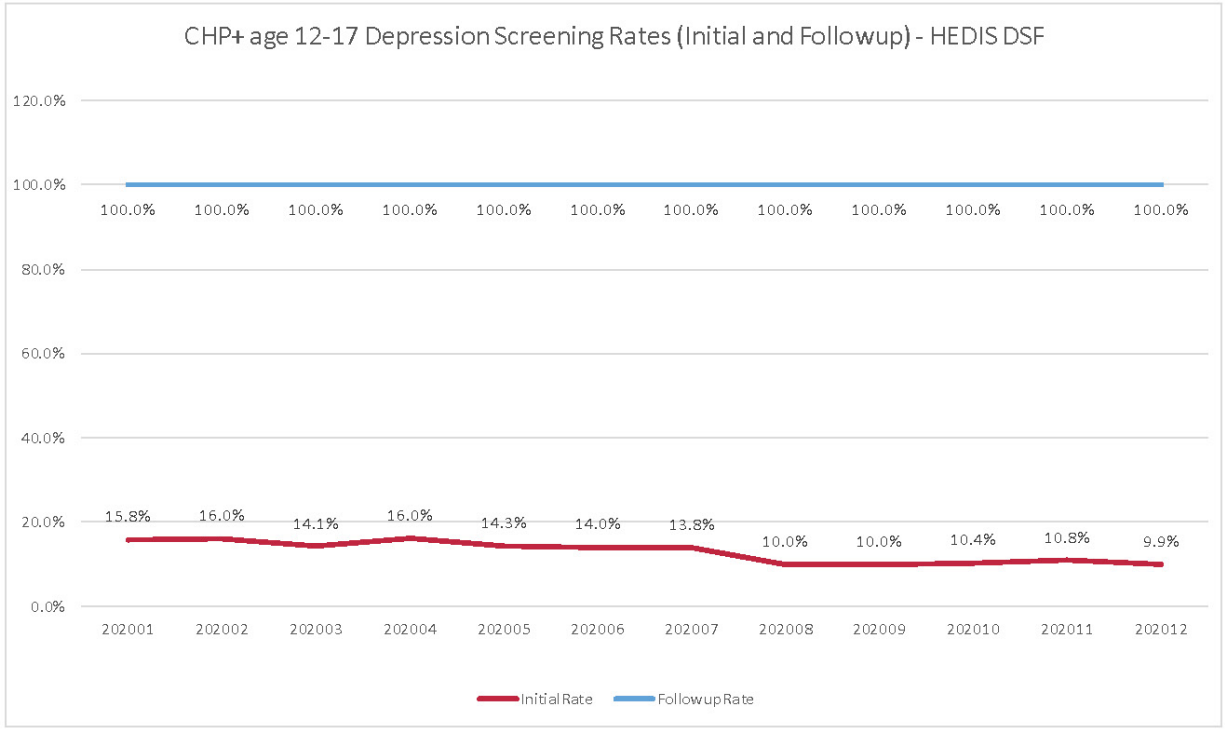

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Narrowed Focus Baseline Measurement – *Follow–Up After a Positive Depression Screen*

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	CHP+ Members 12 -17 years of age, assigned to Westminster or Englewood Medical Office who had a well-visit and had a positive screen for clinical depression using an age-appropriate standardized questionnaire (PHQ2) between January 1 and December 1, 2020 and received any of the following follow-up protocols on or up to 30 days after the first positive screen. · An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. · A depression care management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. · A behavioral health encounter, including assessment, therapy, collaborative care, or medication management.

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
	· A dispensed antidepressant medication. OR · Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
Denominator Description	All CHP+ Members 12 -17 years of age, assigned to Westminster or Englewood Medical Office who had a well-visit and screened positive for clinical depression using an age-appropriate standardized questionnaire (PHQ2) between January 1 and December 1, 2020.
Age Criteria (if applicable)	CHP+ Members age 12-17 as of January 1, 2020
Continuous Enrollment Specifications (if applicable)	No Continuous Enrollment criteria were applied
Allowable Gap in Enrollment (if applicable)	N/A
Anchor Date (if applicable)	N/A
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	N/A

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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: 01/01/2020	End Date: 12/1/2020
Numerator: 9	Denominator: 9	Percentage: 100%

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: 1. SQL Query of Electronic Medical Record (EMR) and membership system 2. Query considers the HEDIS DSF specifications **3.** Follow-up treatment (Rx, Appt) documented in EMR discreetly		

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

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

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

Depression Screening:

By June 30, 2022, we will increase the percentage of all CHP+ members assigned to Westminster and Englewood MOBs between the ages 12 and 17 who are screened for depression annually from 9.93% to 20%. This will be achieved by utilizing key driver diagram interventions.

Follow-Up After a Positive Depression Screen:

By utilizing key driver diagram interventions within 30 days of a positive screen, KP will maintain performance at 90% or higher follow-up rates of all CHP+ members aged 12-17 years who screen positive for depression as we increase our rates of case identification through improved screening rates by June 30, 2022.

Note: Once Module 1 has passed, the SMART Aim statements should never be modified. If changes need to occur, the MCO must contact HSAG before 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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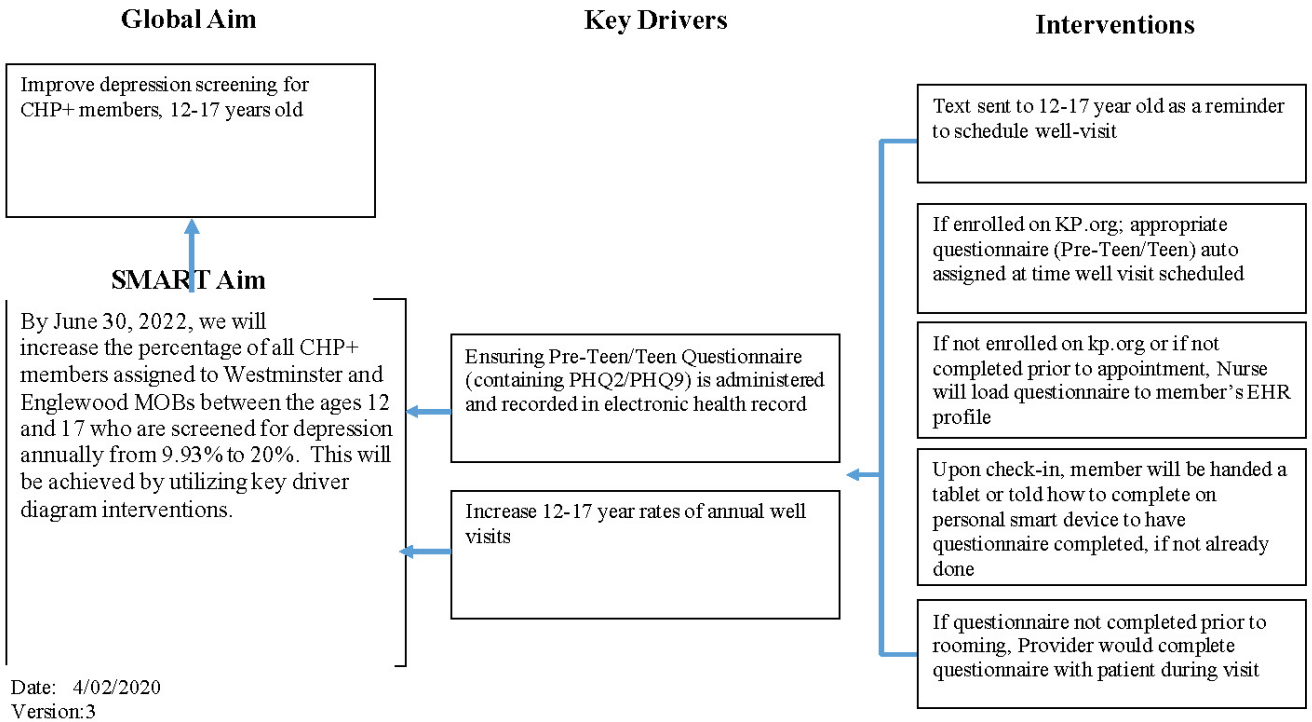
Key Driver Diagram– *Depression Screening*



Date: 4/02/2020
Version:3

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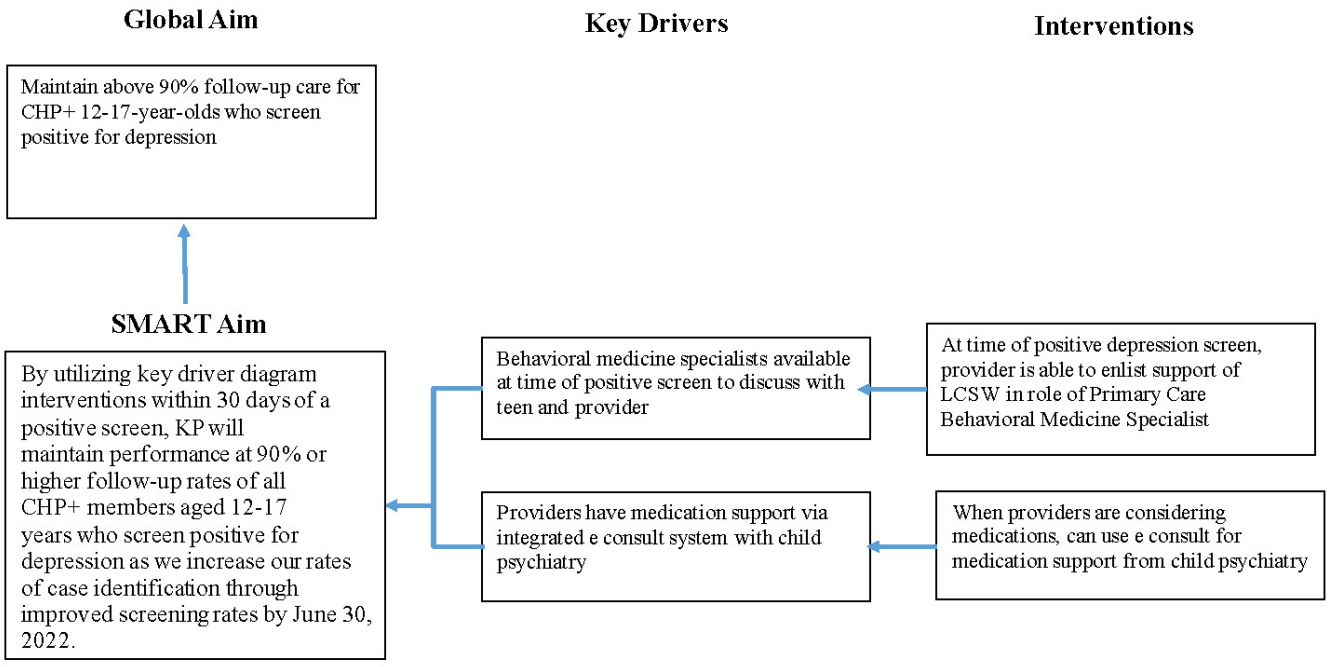
Key Driver Diagram – *Follow–up After a Positive Depression Screen*



Date: 4/02/2020
Version: 3

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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

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

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

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

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

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

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

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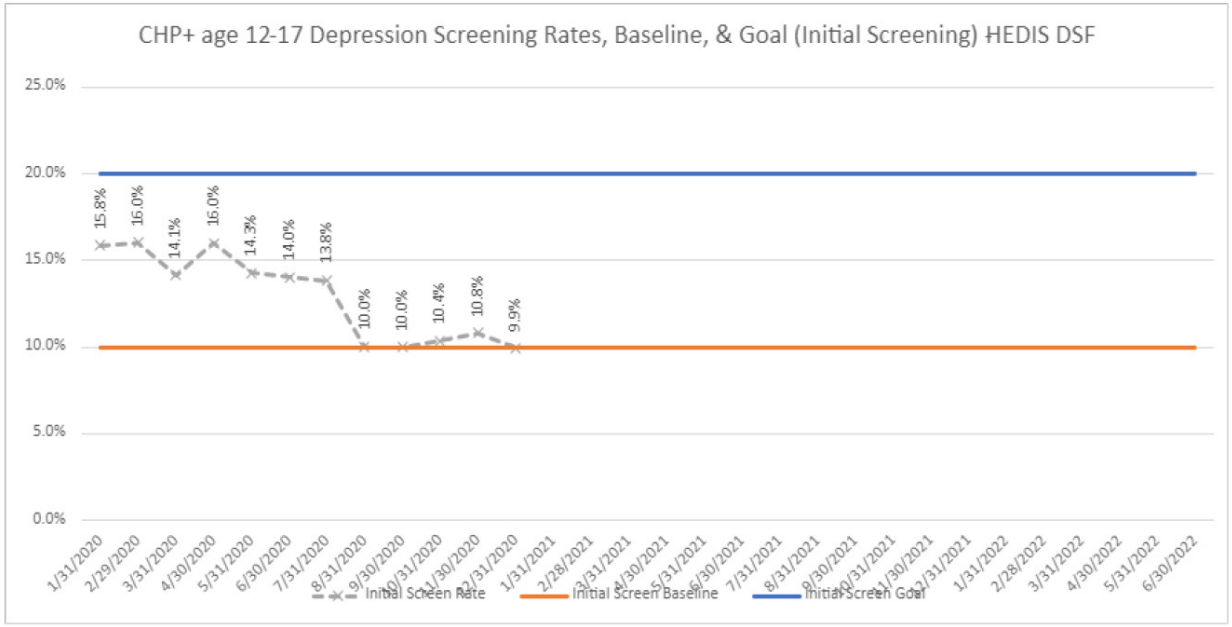
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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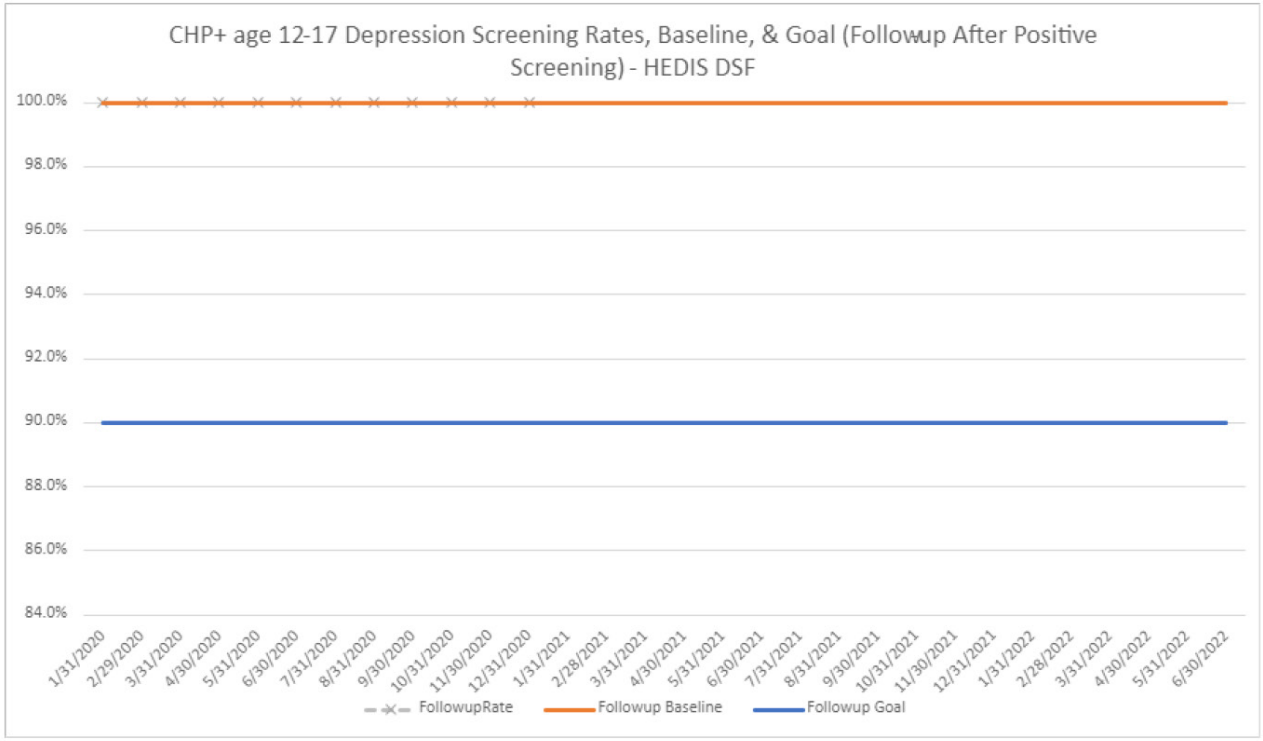
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen.*	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The health plan did not provide the rationale for selecting Englewood and Westminster medical office buildings as the narrowed focus. The health plan's rationale should be added to the narrowed focus description in Table 2. • The health plan should revise the baseline data provided to support selection of the narrowed focus. It appeared that the health plan reported baseline data for each measure at the plan wide level and for each of two provider offices (Englewood and Westminster). The baseline data reported in Tables 3b and 4b should be aggregated across the two office buildings, to create a single narrowed focus baseline numerator, denominator, and percentage for each measure. It is not necessary to report plan wide data in Module 1. • The baseline percentage for the *Follow–up After a Positive Depression Screen* measure for each provider office included in the narrowed focus was 100%. These percentages do not demonstrate a need for improvement; however, it appeared that the plan wide percentage for this measure was 98%. • HSAG recommends a technical assistance call to determine if there is an option to work with a narrowed focus that has room for improvement in both measures. **Re-review March 2021:** The health plan addressed all of HSAG's initial feedback. The criterion has been *Met* and a general comment has been added.

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Criteria	Score	HSAG Feedback and Recommendations
		General Comments: • During a February 4, 2021 technical assistance call, Kaiser confirmed that the plan wide baseline percentage for the *Follow–Up After a Positive Depression Screen* measure was 98%. Following the call, HSAG and the Department agreed that the health plan could proceed with the selected narrowed focus, given the rationale provided by the health plan and the lack of an alternative narrowed focus with a greater need for improvement. • While the health plan's rationale for the narrowed focus is reasonable, the baseline denominator size reported for the *Follow-Up* measure (9) is low for a rapid-cycle PIP and may be problematic for rapid-cycle intervention testing. The health plan may proceed with the proposed narrowed focus but should be aware of potential intervention testing challenges.
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 d) Narrowed focus baseline data that considered claims completeness	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*** • The numerator and denominator descriptions should specify the member age range and narrowed focus providers. • To align with the HEDIS DSF measure specifications the numerator and denominator descriptions should include, "The total number of members…" • In the numerator description, the date range "between January 1 and December 31 of the measurement period" did not align with the baseline measurement period dates, 8/1/2019 through 7/31/2020. Additionally, the numerator description in the HEDIS

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Criteria	Score	HSAG Feedback and Recommendations
		DSF measure specifications only includes members with a depression screening through December 1, cutting off 30 days before the end of the measurement period. To align with these specifications, the numerator should only include members with a depression screen up to 30 days prior to the end of the measurement period. • It was unclear how members would be identified for inclusion in the narrowed focus denominator. The denominator description should be revised to clarify how members were identified for inclusion in the narrowed focus. For example, members assigned to Englewood and Westminster medical office buildings. • For the denominator description, the health plan should define the "criteria for participation." • It was unclear why the health plan reported the numerator and denominator values as member months in Table 3b. Based on the DSE measure specifications, the numerator and denominator values should be number of members. • The health plan should report a single narrowed focus baseline numerator, denominator, and percentage in Table 3b, aggregated across the two provider offices. ***Follow–Up After a Positive Depression Screen*** • For the numerator description, the health plan should define "follow-up care." HSAG would expect the follow-up care definition to align with the HEDIS-DSF measure specifications, based on the documented data collection process.

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Criteria	Score	HSAG Feedback and Recommendations
		• For the denominator description, the positive depression screen should occur no later than July 1, 2020 to align with the HEDIS DSF measure specifications and the health plan's reported baseline measurement period. • To align with the HEDIS DSF measure specifications the numerator and denominator descriptions should include, "The total number of members…" • Although the HEDIS DSF specifications do not require continuous enrollment, the health plan should consider requiring continuous enrollment for 30 days following the positive depression screen to allow follow-up care to occur. • The denominator qualifying event should be specified as a positive depression screen occurring between August 1, 2019 through July 1, 2020. • It was unclear why the health plan reported the numerator and denominator values as member months in Table 4b. Based on the DSF measure specifications, the numerator and denominator values should be number of members. • The health plan should report a single narrowed focus baseline numerator, denominator, and percentage in Table 4b, aggregated across the two provider offices selected for the narrowed focus. **Re-review March 2021:** The health plan addressed HSAG's initial feedback; however, the updated numerator description for the *Follow-Up After a Positive Depression Screen* measure included in the numerator; members who were dispensed antidepressant medication on

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Criteria	Score	HSAG Feedback and Recommendations
		or up to 30 days after the first positive depression screen. On February 15, 2021, HSAG received guidance from the Department stating that a prescription being provided by the physician as part of an initial encounter should not count as a follow-up to a positive depression screening for the purposes of the PIP. Kaiser should revise the *Follow-Up After a Positive Depression Screen* numerator description and data to address the Department's guidance. **Re-review April 2021:** During a March 25, 2021 technical assistance call, the health plan received approval from the Department to use the HEDIS DSF measure specifications for the PIP. 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	HSAG identified the following opportunities for improvement: • The health plan should provide one SMART Aim statement for the *Depression Screening* measure and one SMART Aim statement for the *Follow-Up After a Positive Depression Screen* measure. The baseline percentage and goal percentage included in the SMART Aim should be aggregated across the two provider offices selected in the narrowed focus. It is not necessary to include a plan-level SMART Aim. • The *Follow-Up After a Positive Depression Screen* SMART Aim statement should include that the follow-up visit must occur within 30 days of a positive depression screen. • The health plan should use the phrase, "key driver diagram interventions" in each SMART Aim, rather than specifying interventions in Module 1 of the rapid-cycle PIP process. The

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Criteria	Score	HSAG Feedback and Recommendations
		health plan should complete the process maps and failure modes and effects analyses (FMEAs) in Module 2 before selecting specific interventions to test for the PIP. Using the broader language, "key driver diagram interventions," in the SMART Aims allows the health plan flexibility to identify and revise interventions as part of the rapid-cycle process throughout the project. • The health plan should specify the exact SMART Aim end date, June 30, 2022, in each SMART Aim. **Re-review March 2021:** In the Module 1 resubmission, the health plan did not address the highlighted portions of HSAG's feedback, above. **Re-review April 2021:** The health plan addressed the outstanding feedback in the second resubmission. The criterion has been *Met*.
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The health plan should provide a total of two run charts for the PIP. One run chart for the *Depression Screening* rolling 12-month measurements and one for the *Follow-Up After a Positive Depression Screen* rolling 12-month measurements. The baseline percentage and goal percentage included in the SMART Aim run chart should be aggregated across the two provider offices selected in the narrowed focus.

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Criteria	Score	HSAG Feedback and Recommendations
		• For each run chart, the health plan should use the run chart provided in the Module 1 submission form template provided by HSAG: ○ Each Module 1 run chart should include only the fixed narrowed focus baseline percentage based on the fixed 12-month baseline measurement period, aggregated across the two selected provider offices. The only other data provided in the Module 1 run chart should be the fixed goal percentage specified in the SMART Aim for each measure. The health plan will submit an updated run chart in Module 4, at the end of the project, that will include the results of each subsequent rolling 12-month measurement period. ○ Each run chart title should specify the narrowed focus. For the *Follow-Up After a Positive Depression Screen* run chart, the title should also specify follow-up *within 30 days*. ○ The y-axis should be labelled from 0% to 100%, as provided in the run chart template. ○ The date labels on the x-axis should be the full date of the last day of the last month for each rolling 12-month measurement period. The first date listed is for the month when Module 1 is expected to be approved (1/31/2021). ○ The Module 1 submission form (and all subsequent submission forms) should be submitted as a Word document to allow HSAG to view the excel data behind the run charts and validate the values plotted in the charts.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review March 2021: In the Module 1 resubmission, the health plan did not fully address the highlighted portions of HSAG's feedback, above. Regarding the final highlighted bullet point above, while the health plan provided a Word document for the resubmission, HSAG was unable to view the run chart data in excel. It appeared that the run charts were linked to an external excel file which was not included in the resubmission, rather than using the embedded excel file in the Module 1 submission form template. The health plan may address this feedback by providing the separate excel file with the run chart data displayed (dates, baseline percentages, and goal percentages) as part of the next Module 1 resubmission. **Re-review April 2021:** The health plan addressed the critical outstanding feedback. The criterion has been *Met*.
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	

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Criteria	Score	HSAG Feedback and Recommendations
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	**General Comment:** The health plan will need to revise the SMART Aim included in each key driver diagram, based on the feedback provided for Criteria #2 and #3. **Re-review April 2021:** The health plan addressed the General Comment in the resubmission. The criterion remains *Met*.
Additional Recommendations: For each final run chart provided in the Module 4 submission form at the end of the project, the health plan should scale the y-axis from 0% to 100% for consistency and clarity.		

PIP Initiation (Module 1)

☒ Pass

Date: April 21, 2021