COLORADO

Department of Health Care Policy & Financing

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

Fiscal Year 2020–2021 PIP Validation Report

for

Northeast Health Partners Region 2

April 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for Medicaid programs, with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **Northeast Health Partners Region 2**, referred to in this report as **NHP R2**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

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

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

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

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

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

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

PIP Components and Process

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

PIP Terms

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

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

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

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

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

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

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

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **NHP R2**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **NHP R2**'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, **NHP R2** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen.*

NHP R2 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 **NHP R2**.

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 at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC), ages 12 and up, from 84.04% to 85.06%.
Follow-Up After a Positive Depression Screen	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups 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%

The focus of the PIP is to increase the percentage of members 12 years of age and older, and attributed to Sunrise Community Health, who receive a depression screening during an outpatient visit at MFC and to increase the percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goals to increase depression screening to 85.06 percent and to increase follow-up within 30 days after a positive depression screen to 47.66 percent represent statistically significant improvement over the baseline performance.

Table 1-2 summarizes the progress **NHP R2** 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 due May 4, 2021.
	3. Intervention Testing	Targeted initiation July 2021.
	4. PIP Conclusions	Targeted for October 2022.

At the time of the FY 2020–2021 PIP validation report, **NHP R2** had passed Module 1 achieving all validation criteria for the PIP. **NHP R2** has progressed to Module 2, Intervention Determination. Module 2 and Module 3 validation findings will be reported in the FY 2021–2022 PIP validation report.

2. Findings

Validation Findings

At the end of FY 2019–2020, **NHP R2** closed out the *Increasing Well Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIPs, which were initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from each project.

In FY 2020–2021, **NHP R2** 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, **NHP R2** 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 reviewed Module 1 and provided feedback and technical assistance to the health plan until all Module 1 criteria were achieved.

Below are summaries of PIP conclusions from the *Increasing Well Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIP close-out reports and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **NHP R2** reported in the FY 2019–2020 PIP close-out reports for the *Increasing Well Checks for Members 21–64 Years of Age* and *Increasing Mental Healthcare Services After a Positive Depression Screening* PIPs.

Table 2-1—PIP Conclusions Summary

Increasing Well Checks for Members 21–64 Years of Age PIP	
Interventions	Text-based outreach campaign targeting 21–64-year-old male members who were due for a well visit. Text messages included direct link to phone-based or text-based appointment scheduling with provider partner.
Successes	Well visit rates increased during the project.
Lessons Learned	• Real-time data needs for the PIP should be communicated clearly and in detail with the partner provider; roles and responsibilities should be established prior to intervention initiation. • Provider and member buy-in for interventions would be enhanced if PIP topics and target populations can be aligned with the provider partner's population health initiatives.

Increasing Mental Healthcare Services After a Positive Depression Screening PIP	
Interventions	Communication with providers regarding knowledge and practices related to appropriate depression screening coding and reporting; development of related provider training materials.
Successes	Provider training materials on documenting and billing for a depression screen were developed and are available for future training and improvement efforts.
Lessons Learned	• Without accurate and timely data (removal of substance use disorder [SUD] and limited claims submission), it is impossible to understand where performance deficits exist, and which interventions should be implemented. • Billing procedures and requirements highly impact provider interest in submitting data for coding completed depression screens.

Module 1: PIP Initiation

Table 2-2 presents the FY 2020–2021 validation findings for **NHP R2**'s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

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

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC) ages 12 and up, from 84.04% to 85.06%.
Preliminary Key Drivers	• Documentation of depression screen in the electronic medical record (EMR) • Screening completion
Potential Interventions	• Provider education and engagement in accurate and complete depression screen EMR documentation • Collaboration with provider on depression screening strategies
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health follow-ups 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%
Preliminary Key Drivers	• Timely communication with behavioral health providers • Closing behavioral health referral communication loop
Potential Interventions	• Develop process flow for communicating positive depression screens to targeted behavioral health provider • Develop process flow for referral loop communication between targeted primary care and behavioral health providers

In Module 1, **NHP R2** set two goals to achieve by June 30, 2022:

- Increase the percentage of members 12 years of age and older who receive a depression screening during an outpatient visit at MFC 85.06 percent.
- Increase the percentage of members 12 years of age and older who screened positive for depression at MFC and that receive follow-up behavioral health services within 30 days of the positive depression screen to 47.66 percent.

The health plan completed key driver diagrams in Module 1 that identified evidence-based key drivers and potential interventions to support achievement of these goals. **NHP R2**'s identified key drivers focused on provider service reporting, provider communication, and effective provider process flows. **NHP R2** has identified provider-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **NHP R2** 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 **NHP R2** successfully completed Module 1 and designed a methodologically sound project. **NHP R2** was successful in identifying an appropriate narrowed focus, building internal and external quality improvement teams, and developing collaborative partnerships with targeted providers and facilities.

Recommendations

- When mapping and analyzing the process(es) related to depression screening and follow-up care after a positive depression screen for the PIP, **NHP R2** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **NHP R2** 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, **NHP R2** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **NHP R2** 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 **NHP R2** progresses through determining and testing interventions.
- **NHP R2** 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, **NHP R2** 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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Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for **Northeast Health Partners (RAE 2)**

Managed Care Organization (MCO) Information	
MCO Name	Northeast Health Partners – RAE 2
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	January 8, 2021
Resubmission Date (if applicable)	March 19, 2020

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PIP Team

Instructions:

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

Table 1—Team Members

Name	Title	Role and Responsibilities
Brian Robertson	Director, Quality Improvement, Northeast Health Partners (NHP)	Quality Improvement, NHP
Melissa Schuchman	Performance and Outcomes Analyst, Beacon Health Options	Data and Reporting
Jeremy White	Quality Manager, Beacon Health Options	PIP Lead
Andrea Scott	SQL Developer II, Beacon Health Options	Data and Reporting
Kat Fitzgerald	Quality Management Specialist II, Beacon Health Options	Billing and Claims
John Mahalik	Director, Quality Improvement, Beacon Health Options	Quality Improvement, Beacon Health Options (ASO)
Dr. Mark Wallace	Chief Clinical Officer, NHP	Executive Sponsor
Cindy McDade	Sunrise Community Health	PCMP Partner
TBD	North Range Behavioral Health	BH Follow-up Partner

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PIP Topic and Narrowed Focus

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

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

Table 2—PIP Topic and Narrowed Focus

PIP Topic Description
To improve access to behavioral health care, Northeast Health Partners (NHP) will target depression screening in primary care and subsequent behavioral health follow-up as its Performance Improvement Project (PIP). The effort will aim to increase the rate in which a provider in NHPs' region completes a depression screen at eligible outpatient visits, as well as ensure any positive depression screen has a timely (within 30 days) mental health service. This topic was also mandated by the state. There are multiple factors that have created complications in identifying individual providers for a narrowed focus on this measure. First, depression screen claims data for NHP can be limited due to the removal of all screens that are SUD-related. Second, overall volume for depression screens in NHPs' region is low; data for services for FY20 shows 762 depression screens billed for the entire region. Third, depression screen volume remains low due to practices choosing to not itemize depression screens on a claims line, and instead billing for a well visit or other service, ultimately driving an underreported number of screens that leads to a low count of follow-up services. With a low number of depression screens billed, which serve as the denominator event for this measure, assessment of the region's true follow-up rate for mental health services also remains nuanced. Depression screen completion is often tracked in provider's Electronic Health Record (EHR) data. With claims data being so sparse due to billing issues identified above, in order to understand the rates of depression screens completed we will use EHR data for this measure. NHP will identify a provider that has adequate EHR data available and IT support resources to provide data for baselines and tracking of progress throughout the project. Providers with adequate EHR data and IT support resources for this project are larger practices with multiple locations and we will need to further limit to a smaller number of members and providers to one or two specific clinic locations in order to have a manageable project for this rapid cycle PIP.

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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.

Narrowed Focus Description
NHP will work with a provider to increase the rate in which depression screens are completed for Medicaid members. Northeast Health Partners selected Sunrise Community Health ("Sunrise") as a narrowed focus provider. Sunrise is a Federally Qualified Health Center (FQHC) and attribution to this provider is centered mostly in Weld County and spans across child and adult populations. Sunrise also partners with North Range Behavioral Health ("North Range"), a Community Mental Health Center (CMHC), for behavioral health services. Assessment of processes and performance specific to the follow-up for positive depression screens will therefore include this partner. Sunrise has six locations with over 24,000 members attributed. Sunrise locations complete depression screens with each office visit for all members age 12 years and older. Exceptions to this include members with active bipolar or active depression disorder diagnosis, those who refuse, urgent or emergent situations, or those who lack cognitive capacity. They do not currently bill for depression screens at any of their locations so claims data cannot be used for this PIP, though they do conduct and track depression screens internally in their electronic medical record (EMR) for UDS reporting, which shows that across all their locations for FY19-20 they had 18,874 eligible encounters (denominator) with Region 2 Medicaid members. We have elected to focus on one clinic location (Monfort Family Clinic "MFC") to narrow the focus of this project to 9,731 members with eligible encounters. Of these encounters, 8,180 members completed a depression screen (numerator) resulting in a .84.04% depression screen rate for all eligible visits.

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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	The total number of eligible outpatient encounters at one Sunrise Clinic (MFC) where a depression screen was conducted
Denominator Description	The total number of eligible outpatient encounters at one Sunrise Clinic (MFC)
Age Criteria (if applicable)	12 years and older at the date of the eligible encounter
Continuous Enrollment Specifications (if applicable)	N/A
Allowable Gap in Enrollment (if applicable)	None
Anchor Date (if applicable)	First day of the month
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Eligible outpatient encounter

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Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 07/01/2019	End Date: 06/30/2020
Numerator: 8,180	Denominator: 9,734	Percentage: 84.04%

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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: Because Sunrise does not bill for depression screens currently, we used EHR to capture documented depression screens for baselines and goal setting. The same data sources will be used for baseline and subsequent rolling 12-month measurement periods. NUMERATOR: Encounters for members screened for depression during the measurement period between July 1, 2019 and June 30, 2020. Screened for depression using an age appropriate standardized tool. DENOMINATOR: Encounters for members aged 12 years and older at time of the encounter with at least one outpatient encounter at one Sunrise clinic (MFC) during the baseline measurement period between July 1, 2019 and June 30, 2020. 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". 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 This file is included in the attached file. EXCLUSIONS:		

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Any of the following diagnoses active before and during qualifying encounter in the period: Active bipolar disorder diagnosis Active depression diagnosis
EXCEPTIONS: Patient refused screening in the past year.
Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
These exceptions follow CMS guidelines (CMS2v10) for Preventive Care and Screening: Screening for Depression and Follow-up Plan for the 2021 performance period as noted by CMS: https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10.
PERFORMANCE RATE:
The performance rate is calculated by dividing the numerator by the denominator to create a percentage.

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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	The total number positive depression screens with a follow-up behavioral health service within 30 days of positive depression screen at one Sunrise clinic (MFC)
Denominator Description	The total number of positive depression screens for members at one Sunrise clinic (MFC) between July 1, 2019 and May 31, 2020
Age Criteria (if applicable)	12 years and older at the date of depression screen
Continuous Enrollment Specifications (if applicable)	30 days from the date of the depression screen
Allowable Gap in Enrollment (if applicable)	None
Anchor Date (if applicable)	First day of the month

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

Table 4b—Narrowed Focus Baseline Data – *Follow–Up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 07/01/2019	End Date: 06/30/2020
Numerator: 146	Denominator: 363	Percentage: 40.22%

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Instructions: **For Table 4c, check the applicable data source and describe the step-by-step process for how the *Follow-up After a Positive Depression Screen***

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: Combination of Sunrise EHR for the denominator and FFS and encounter data for the numerator. NUMERATOR: Data from the clm_lne_fact (RAE claims data/FFS), DW_Claim (Beacon paid claims/encounters), and RPT_Encounter_data (services provided by Beacon partners/encounters). Match up members using Medicaid ID number from the denominator with behavioral health follow-up services using the service codes and provider type codes per the Incentive Measure #4: Depression Screen (see scope document page 22). The follow-up service must include a covered mental health diagnosis (see scope document page 31) as a primary diagnosis. Follow-up services were included for services provided between July 1, 2019 and June 30, 2020. DENOMINATOR: EHR data provided by Sunrise.		

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All patients aged 12 years and older with a positive depression screen at the date of the depression screen with at least one eligible encounter one Sunrise clinic (MFC) between July 1, 2019 and May 31, 2020. We excluded June 1, 2020 to June 30, 2020 to allow for the full 30 day follow-up period to be included for the follow-up data from depression screens prior to June 1, 2020.

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". 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

Positive depression screen using the PHQ2 (score >=3) or PHQ9 (score >=10).

Age >=12 at the date of the depression screen.

EXCLUSIONS:

Depression screens repeated within 30 day follow-up period of the previous depression screen were excluded from the denominator.

Any of the following diagnoses active before and during qualifying encounter in the period:
Active bipolar disorder diagnosis.
Active depression diagnosis.

EXCEPTIONS:

Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).

These exceptions follow CMS guidelines (CMS2v10) for Preventive Care and Screening: Screening for Depression and Follow-up Plan for the 2021 performance period as noted by CMS: https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10.

PERFORMANCE RATE: The performance rate is calculated by dividing the numerator into the denominator to create a percentage.

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

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

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

Depression Screening:

By 6/30/2022, use key driver diagram interventions to *increase* the percentage of depression screens completed at eligible outpatient encounters among Sunrise members at MFC ages 12 and up, from 84.04% to 85.06%.

The aim goal of 85.06% represents a statistically significant improvement with 9,734 eligible outpatient encounters and 8,180 depression screens completed at a baseline rate of 84.04%.

Follow-Up After a Positive Depression Screen:

By 6/30/2022, use key driver diagram interventions to *increase* the percentage of behavioral health follow-ups 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%.

The aim goal of 47.66% represents a statistically significant improvement over the baseline of 146 follow-ups within 30 days from 363 positive depression screens (40.22%) to 173 follow-ups within 30 days out of 363 positive depression screens (47.66%)

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

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Key Driver Diagrams

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

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

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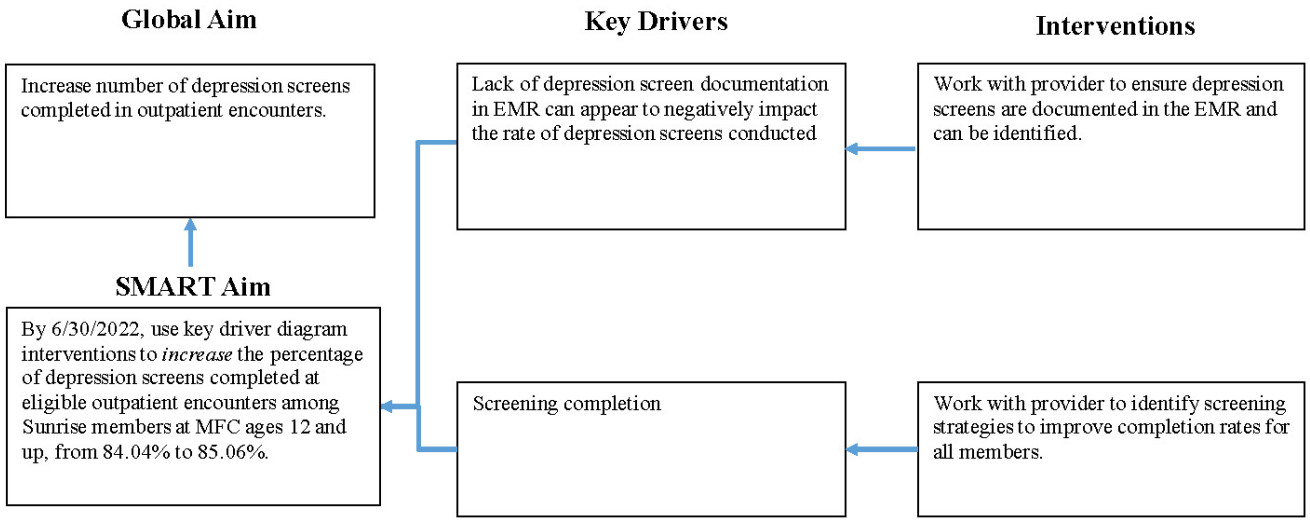
Key Driver Diagram– *Depression Screening*



Date: 3/12/2021
Version: 3

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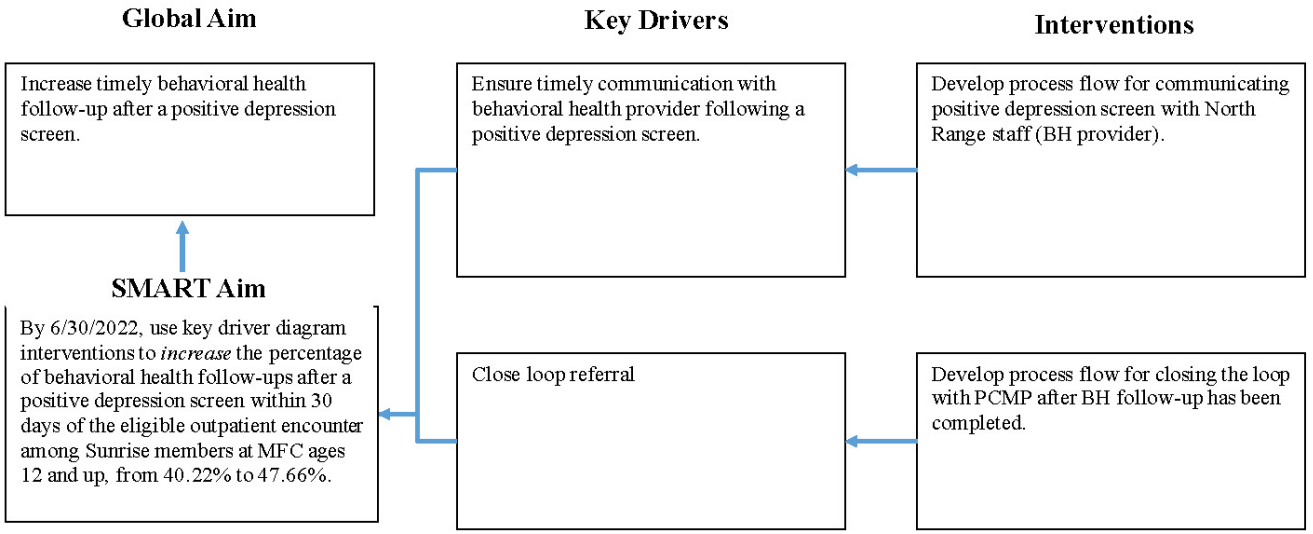
Key Driver Diagram – *Follow–Up After a Positive Depression Screen*



Date: 3/12/2021
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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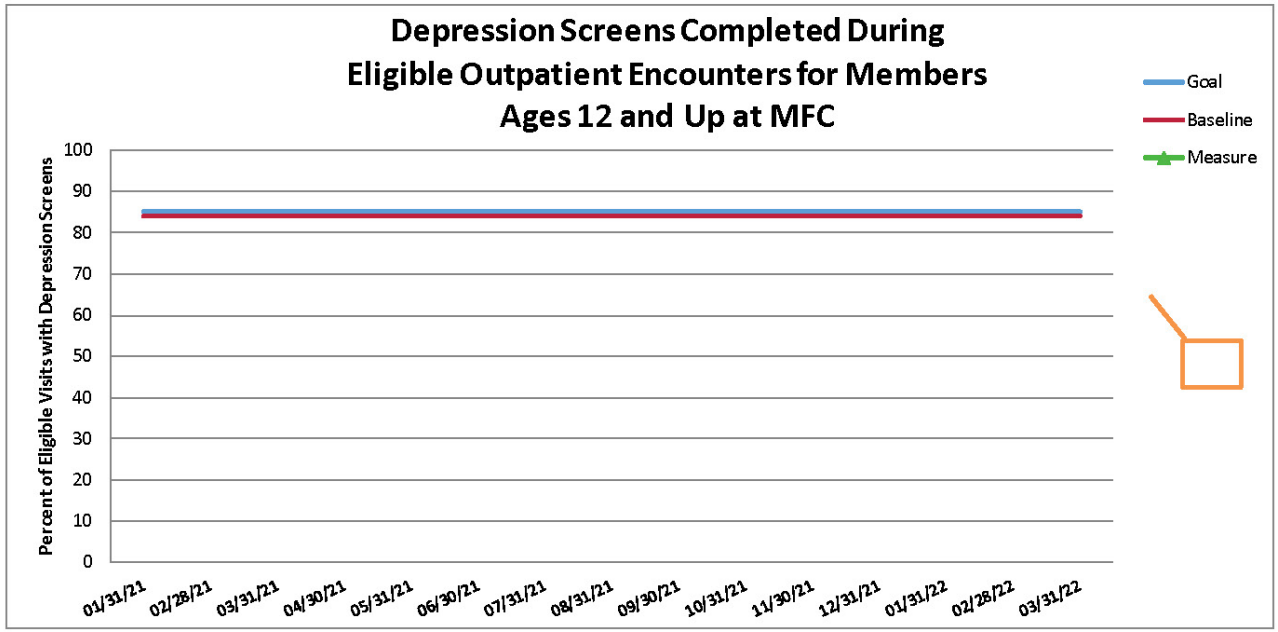
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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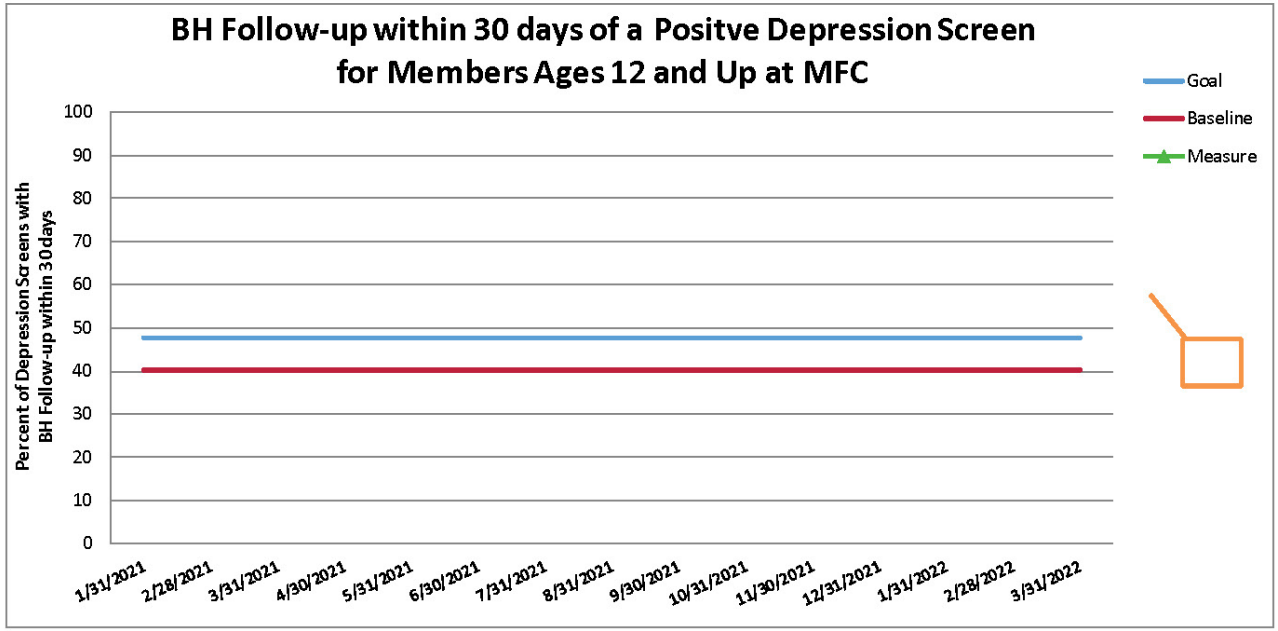
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



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: • In the PIP topic description, the health plan included the phrase, "The effort will aim to increase the rate in which a provider in NHP's region complete and bill for a depression screen at eligible outpatient visits…" In the narrowed focus description, the health plan stated, "NHP will work with a provider to increase the rate in which depression screens are completed and subsequently submit claims for the depression screens…" It was unclear how the health plan would evaluate progress toward improving billing or claims submission for depression screens since the PIP measures are based on electronic health record (EHR) data from the narrowed focus provider. The health plan should revise the PIP topic description and the narrowed focus description to align with the measure descriptions, which are based on EHR data and focus on improving the percentage of eligible members who receive a depression screen and receive follow-up services within 30 days of a positive depression screen. • The narrowed focus baseline denominator size for the *Depression Screening* measure is quite large for a rapid-cycle PIP. Although not a cause for the *Not Met* score for Criterion #1, the health plan should ensure the following is feasible for the selected narrowed focus: ○ Timely data collection to identify members/providers eligible for interventions.

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Criteria	Score	HSAG Feedback and Recommendations
		○ Enough members/providers in the narrowed focus can be reached with interventions to support achievement of the SMART Aim goals. • If the health plan is confident in conducting intervention testing with the current narrowed focus, the health plan should include this information as part of the rationale provided in the Narrowed Focus Description section of Table 2. **Re-review March 2021:** The health plan addressed HSAG's feedback. The criterion has been *Met*.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process 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 total number of members…" • For the denominator description and the denominator qualifying event, the health plan should define "eligible" and "encounter." The health plan should revise the documentation to clearly define how the health plan will identify members to be included in the denominator using EHR data, as described in the data collection process. • For the denominator description, the health plan should clarify how members with multiple "eligible outpatient encounters" were handled. Based on the data collection process description, it appeared that the numerator and denominator descriptions should be revised to include, "Members with at least one

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Criteria	Score	HSAG Feedback and Recommendations
		outpatient encounter at Sunrise during the baseline measurement period." • For the age criteria, the health plan should define "service." • The health plan should clarify the continuous enrollment criteria. Continuous enrollment was defined as 30 days from the date of the depression screen. Not all members in the denominator will have a depression screen. • The health plan should address the following issues identified in the data collection process description: ○ The following statement was unclear: "Because Sunrise does not bill for depression screens currently, we used EHR for baselines and goal setting." The health plan should revise this statement to clarify that the same data sources will be used for baseline and subsequent rolling 12-month measurements. ○ It was unclear why at least one eligible outpatient encounter must occur between July 1, 2019 and May 31, 2020. Why were outpatient encounters between June 1 and June 30, 2020 excluded from the denominator for this measure? ○ The health plan should clarify the statement, "Age >=12 at the date of the depression screen." This statement appeared incorrect. Since not all members in the denominator received a depression screen, age criteria for

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Criteria	Score	HSAG Feedback and Recommendations
		inclusion in the denominator cannot be based on date of depression screen. ○ The health plan should describe all criteria used in situations of patients' cognitive capacity, functional capacity, or motivation to improve. ***Follow-Up After a Positive Depression Screen*** • The numerator and denominator descriptions should specify, "The total number of members…" • For the denominator description and denominator qualifying event, the health plan should specify the date range for positive depression screens. Based on the step-by-step data collection process, it appeared that members with a positive depression screen between July 1, 2019 and May 31, 2020 were included in the denominator. • The step-by step data collection description excludes patients who refused a screening in the past year. For the follow-up measure a positive depression screen is required for inclusion, therefore this exclusion does not appear to be appropriate. • In the data collection process description, the health plan should describe all criteria used in situations of patients' cognitive capacity, functional capacity, or motivation to improve. **Re-review March 2021:** The health plan addressed some but not all HSAG's feedback. The following revisions, to address the highlighted feedback above, are still required:

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Criteria	Score	HSAG Feedback and Recommendations
		• In Table 3a, for the *Depression Screening* Age Criteria, the health plan should revise, "…at the date of depression screen" to "…at the date of the outpatient encounter," to align with the updated data collection process description. • In the *Depression Screening* data collection process description of exceptions, the health plan should add how impaired cognitive capacity, functional capacity, or motivation to improve is determined from EHR. This was documented for the *Follow-Up* measure data collection process but should also be reflected for the *Depression Screening* measure. **2nd Re-review March 2021:** The health plan addressed HSAG's feedback. The criterion has been *Met*.
3. The SMART Aims for *Depression Screening* and *Follow–Up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage e) End date	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • For each SMART Aim, the health plan should add the member age range as part of the narrowed focus description. • For each SMART Aim, the health plan referenced two different goals – one goal in the SMART Aim statement and a different goal in the confidence interval description. The health plan should specify only one goal for each SMART Aim. • For the *Depression Screening* SMART Aim, the health plan should specify, "…members with an eligible outpatient encounter at Sunrise" to align with the measure definition. • For the *Follow–Up After a Positive Depression Screen* SMART Aim, the health plan reported that the goal of 44.00%

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Criteria	Score	HSAG Feedback and Recommendations
		represented statistically significant improvement, based on the reported confidence interval. Using results of statistical testing, HSAG determined that this goal did not represent statistically significant improvement. HSAG recommends that the health plan use a statistical test (Chi-square) and plug in values for the goal, assuming a constant denominator, to identify a goal that represents statistically significant improvement. The goal should be revised based on the results of statistical testing. **Re-review March 2021:** The health plan addressed some but not all of HSAG's feedback. The following revisions, to address the highlighted feedback above, are still required: • Using the updated narrowed focus baseline data for the *Follow-Up After a Positive Depression Screen* measure and a Chi-square test for proportions, HSAG determined that the health plan's goal of 43.24 percent did not represent statistically significant improvement ($p = 0.4562$). HSAG determined that the minimum percentage needed to represent statistically significant improvement over the narrowed focus baseline performance was 47.84 percent ($p = 0.0456$). The health plan should revise the SMART Aim goal to represent statistically significant improvement. • The health plan should update the *Follow-Up After a Positive Depression Screen* key driver diagram on page 15 and the *Follow-Up After a Positive Depression Screen* run chart on page

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Criteria	Score	HSAG Feedback and Recommendations
		18 with the revised SMART Aim goal representing statistically significant improvement. **2nd Re-review March 2021:** The health plan addressed HSAG's feedback. The criterion has been *Met*.
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening*** • The run chart title should align with the measure defined in Table 3a, which was focused on screening, not billing, and is based on EHR data. The reference to billing should be removed from the title. In addition, the run chart title should specify the member age range. • The goal percentage line plotted on the run chart did not align with the goal percentage specified in the SMART Aim on page 11 of the submission form. The goal line in the run chart should represent the same percentage specified as the goal in the SMART Aim statement. • The dates labelled on the x-axis of each run chart should be the last day of the last month for each rolling 12-month measurement period. For example, 1/31/2021 instead of 1/01/2021. ***Follow-Up After a Positive Depression Screen*** • The run chart title should specify the member age range.

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Criteria	Score	HSAG Feedback and Recommendations
		• The health plan should revise the goal percentage plotted on the run chart to address HSAG's feedback provided for Criterion #3. • The goal percentage line plotted on the run chart did not align with the goal percentage specified in the SMART Aim statement. The goal line in the run chart should represent the same percentage specified as the goal in the SMART Aim statement on page 11 of the submission form. • The dates labelled on the x-axis of each run chart should be the last day of the last month for each rolling 12-month measurement period. For example, 1/31/2021 instead of 1/01/2021. **Re-review March 2021:** The health plan addressed HSAG's feedback. The criterion has been *Met* with a General Comment. **General Comment:** The health plan will need to revise the *Follow-Up After a Positive Depression Screen* run chart with the updated SMART Aim goal based on HSAG's feedback for Criterion #3. **2nd Re-review March 2021:** The health plan addressed HSAG's General Comment in the second resubmission.
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	HSAG identified the following opportunities for improvement: ***Depression Screening*** • It was unclear why the health plan referenced, "well visits" in the global aim for the key driver diagram (KDD). Throughout Module 1, the health plan referred to "eligible outpatient encounters" and not, "well visits." The health plan should revise the documentation to consistently describe the specific type of visit or encounter that is the focus for improving depression screening rates. • The SMART Aim goal reported in the KDD did not align with the goal specified in the SMART Aim statement on page 11 of the Module 1 submission form. The SMART Aim goal should be documented consistently throughout Module 1 and for all subsequent modules. • It was unclear how billing consistency would lead to achieving the SMART Aim goal, which focuses on increasing depression screens identified through EHR data. The key driver description, "Billing Inconsistency," appeared to be a barrier, not a driver. The health plan should revise or remove this key driver description. All key drivers listed in the KDD should be factors that will support achieving the SMART Aim goal, which is based on the percentage of members receiving a depression screen as identified through EHR data. • Two of the three interventions in the KDD focused on billing strategies and coding; however, the data for this measure is

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Criteria	Score	HSAG Feedback and Recommendations
		generated from EHR data rather than claims and encounters. It was unclear how improving coding and billing practices would increase the total number of depression screenings occurring for members at Sunrise. All interventions in the KDD should have the potential to directly impact related drivers and support achieving the SMART Aim goal. The health plan should revise the PIP documentation to explain how interventions focused on billing and coding can support achieving the SMART Aim goal. ***Follow-Up After a Positive Depression Screen*** • The SMART Aim goal reported in the KDD did not align with the goal specified in the SMART Aim statement on page 11 of the Module 1 submission form. The SMART Aim goal should be documented consistently throughout Module 1 and for all subsequent modules. • The health plan will need to revise the SMART Aim goal, based on HSAG's feedback for Criterion #3. **Re-review March 2021:** The health plan addressed HSAG's feedback. The criterion has been *Met* with a General Comment. **General Comment:** The health plan will need to revise the *Follow-Up After a Positive Depression Screen* KDD with the updated SMART Aim goal based on HSAG's feedback for Criterion #3.

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Criteria	Score	HSAG Feedback and Recommendations
		2nd Re-review March 2021: The health plan addressed HSAG's General Comment in the second resubmission.
Additional Recommendations: None.		

PIP Initiation (Module 1)

☒ Pass

Date: March 23, 2021