



**COLORADO**

**Department of Health Care  
Policy & Financing**

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

# **Fiscal Year 2021–2022 PIP Validation Report** *for*

## **Northeast Health Partners Region 2**

*April 2022*

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



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## 1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children’s Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado’s Medicaid 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) 2021–2022, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

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

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

(CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.<sup>1-1</sup>

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.<sup>1-2</sup> The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous QI. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. CMS agreed that given the pace of QI science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed and provided HSAG with approval to use this approach in all requesting states.

## PIP Components and Process

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

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

### PIP Terms

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

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

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

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

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

<sup>1-2</sup> 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.ihl.org/resources/Pages/HowtoImprove/default.aspx>. Accessed on: Feb 23, 2022.



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

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

## Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **NHP R2**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **NHP R2**'s PIP and the activities completed in Module 2 and Module 3. (See Appendix A. Module Submission Forms.) Following HSAG's rapid-cycle PIP process, the health plan submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

## Validation Scoring

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

- **High confidence** = The PIP was methodologically sound: the SMART Aim goals, statistically significant, clinically significant, or programmatically significant improvements were achieved for both measures: at least one tested intervention for each measure could reasonably result in the demonstrated improvement: and the MCO accurately summarized the key findings and conclusions.
- **Moderate confidence** = The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:
  - ☐ The SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved *for only one measure*, and the MCO accurately summarized the key findings and conclusions.
  - ☐ Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure*, and the MCO accurately summarized the key findings and conclusions.
  - ☐ The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.
- **Low confidence** = One of the following occurred:
  - ☐ The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.
  - ☐ The PIP was methodologically sound. The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.
  - ☐ The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.
- **No confidence** = The SMART Aim measure methodology and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

## PIP Topic Selection

In FY 2021–2022, **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:

- **Specific**: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **Measurable**: 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?
- **Attainable**: 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)?
- **Relevant**: The goal addresses the problem to be improved.
- **Time-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
<i>Depression Screening</i>	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 years and up, from 84.04% to 85.06%.
<i>Follow-Up After a Positive Depression Screen</i>	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health (BH) follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC ages 12 years 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 BH 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
<i>Depression Screening and Follow-Up After a Positive Depression Screen</i>	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

At the time this FY 2021–2022 PIP validation report was produced, **NHP R2** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **NHP R2** had also passed all validation criteria for the Module 3 submission form submitted for each intervention being tested and was continuing to test interventions. The health plan will conclude all intervention testing on June 30, 2022. Module 4 validation findings will be reported in the FY 2022–2023 PIP validation report.

## 2. Findings

### Validation Findings

In FY 2021–2022, **NHP R2** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan passed Module 2 and Module 3 of the rapid-cycle PIP process during FY 2021–2022. HSAG reviewed Module 2 and Module 3 submission forms and provided feedback and technical assistance to the health plan until all validation criteria were achieved. Below are summaries of the Module 2 and Module 3 validation findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

#### Module 2: Intervention Determination

The objective of Module 2 is to ask and answer the fundamental question, “What changes can we make that will result in improvement?” In this phase, **NHP R2** developed process maps, conducted FMEAs, and updated key driver diagrams to identify potential interventions for the PIP. The detailed process maps, FMEA results, and updated key driver diagrams that **NHP R2** documented in the Module 2 submission form are included in Appendix A. Module Submission Forms. Table 2-1 presents the FY 2021–2022 Module 2 validation findings for **NHP R2**’s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
<b><i>Depression Screening</i></b>	<ul style="list-style-type: none"> <li>Medical assistant (MA) skips PHQ-4<sup>1</sup> during check-in process without medical rationale</li> <li>Failure to transcribe paper-based depression screening form into EHR and results not captured by reporting</li> <li>No depression screening completed</li> <li>MA elects not to perform PHQ-4 at encounter</li> </ul>	<ul style="list-style-type: none"> <li>Documentation of depression screen in the EHR</li> <li>Billing consistency</li> <li>Data accuracy</li> <li>MA awareness of depression screening impact</li> <li>EHR detection of all completed screening forms</li> </ul>	<ul style="list-style-type: none"> <li>Provider education and engagement in appropriate billing strategies to allow accurate and complete depression screen EHR documentation</li> <li>Provider education on correct depression screen coding and reporting</li> <li>Staff training on clinical impact of depression screening and current performance on depression screening metrics</li> <li>Identify alternative methods of capturing paper-based depression screens in EHR</li> </ul>

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
<b>Follow-Up After a Positive Depression Screen</b>	<ul style="list-style-type: none"> <li>Case manager has Red Flag parameters set higher than simply a positive depression screen without scheduled/completed BH follow-up</li> <li>Follow-up BH appointment scheduling conflict: rescheduled outside 30-day window, cancelled appointment, or missed appointment</li> <li>Unable to reach member to schedule follow-up BH visit after two phone calls and mailed letter</li> <li>Provider addresses positive depression screen with a follow-up plan and/or psychopharmacology, without BH provider involvement</li> <li>Coding not aligned with metric specifications</li> <li>Member does not schedule follow-up</li> </ul>	<ul style="list-style-type: none"> <li>Timely communication with BH providers following positive depression screen</li> <li>Coordination of depression screening and follow-up services among primary care offices</li> <li>BH service billed even if follow-up BH visit occurs on the same day as positive depression screen</li> <li>All members receive support to schedule a follow-up BH visit after a positive depression screen</li> </ul>	<ul style="list-style-type: none"> <li>Intervention-case managers or care coordinators coordinate with primary care providers to ensure depression screening and follow-up services are provided</li> <li>Develop process flow for communicating positive depression screens to targeted BH provider</li> <li>Capture BH follow-up service on well visit claim if services occur on the same day</li> <li>Case managers identify members in need of follow-up BH services after a positive depression screen</li> </ul>

<sup>1</sup>PHQ = Patient Health Questionnaire

In Module 2, **NHP R2** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **NHP R2** identified to improve depression screening focused on provider and staff education, EHR documentation, and appropriate coding and billing practices for depression screening. The potential interventions **NHP R2** identified to improve follow-up services focused on care coordination and case management and improved clinic workflow and communication.

### Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **NHP R2** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **NHP R2** submitted testing plans for two interventions. In addition to validating the intervention plan submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **NHP R2** carried out PDSA cycles to evaluate intervention



effectiveness. Table 2-2 summarizes the FY 2021–2022 Module 3 validation findings for **NHP R2**’s two interventions.

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

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
<b>Staff feedback on depression screening performance and training on depression screening procedures</b>	MA skips PHQ-4 during check-in process without medical rationale	MA training/awareness of depression screening impact	Percentage of eligible outpatient encounters at Sunrise Clinic (MFC) during which a depression screen was conducted, as captured in the EHR
<b>Establish a clinical policy for BH referral after a positive depression screen and provide staff training on BH referral policy and procedures following a positive depression screen</b>	Provider addresses positive depression screen with a follow-up plan and/or psychopharmacology without BH provider involvement	Timely communication with BH providers following positive depression screen	Percentage of members with a positive depression screen at Valley-Wide Clinic who have a follow-up BH service within 30 days of the positive screen

In Module 3, **NHP R2** selected two interventions to test for the PIP. The detailed intervention testing plans **NHP R2** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process gaps or failures in staff training and clinical policies and procedures for depression screening and follow-up after a positive depression screen. For each intervention, **NHP R2** defined an intervention effectiveness measure to evaluate the impact of each intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **NHP R2** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

## 3. Conclusions and Recommendations

### Conclusions

The validation findings suggest that **NHP R2** successfully completed Module 2 of the rapid-cycle PIP process, using QI science-based tools to identify process gaps and failures, and to select PIP interventions. **NHP R2** also passed Module 3 for two interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **NHP R2** will continue to test interventions for the PIP through the end of FY 2021–2022. The health plan will submit final intervention testing results, PIP outcomes, and project conclusions for validation in FY 2022–2023.

### Recommendations

- **NHP R2** should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should record intervention testing results and interpretation of results in the PDSA worksheet for each intervention, which will be submitted as part of Module 4—PIP Conclusions in FY 2022–2023.
- **NHP R2** should ensure that the approved SMART Aim data collection methodology defined in Module 1 is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, **NHP R2** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **NHP R2** should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to documenting any improvement achieved through the project, the health plan should document which interventions had the greatest impact, including the evaluation data used to determine intervention effectiveness.



## Appendix A. Module Submission Forms

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



State of Colorado  
 Performance Improvement Project (PIP)  
 Module 2 — Intervention Determination Submission Form  
*Depression Screening and Follow-up After a Positive Depression Screen*  
 for Northeast Health Partners (RAE 2)



Managed Care Organization (MCO) Information	
MCO Name	Northeast Health Partners – RAE 2
PIP Title	<i>Depression Screening and Follow-up After a Positive Depression Screen</i>
Contact Name	Jeremy White
Contact Title	Quality Manager
Email Address	<a href="mailto:Jeremy.White@beaconhealthoptions.com">Jeremy.White@beaconhealthoptions.com</a>
Telephone Number	719-226-7794
Submission Date	May 3, 2021
Resubmission Date (if applicable)	NA



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### Process Map – Depression Screening

#### Instructions:

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

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

NOTE: Process map is attached separately (RAE 2\_CO2020-21\_MCO\_PIP-Val\_Mod 2\_Depression\_Submission Process Maps\_D1\_05-03-2021.pdf). Depression Screening is on first tab. These process maps were constructed by an interdisciplinary PIP team consisting of both clinical and management staff members at Sunrise Community Health and Quality staff within RAE 2. The combination of SME & clinical expertise was used through multiple iterations to create the final product.



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

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

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

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

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
<b>PHQ Readministered</b>	MA electing not to perform PHQ-4 at encounter although it had been performed within last 12 months.	No operational requirement.	Could miss new onset identification of depression &/or failing metric if screening not performed at future encounter.
<b>MA Decides to Complete PHQ4?</b>	MA skips PHQ-4 during check-in process without medical rationale	<ul style="list-style-type: none"> <li>• MA distracted by other business (e.g. member, environment)</li> </ul>	Screening not completed. Metric failure.



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		<ul style="list-style-type: none"> <li>MA doesn't perceive clinical/operational importance of screening</li> </ul>	
<b>MA collects vitals &amp; PHQ4</b>	No screening completed	<ul style="list-style-type: none"> <li>Member autonomy</li> <li>Member doesn't understand clinical importance of depression screening</li> </ul>	Screening not completed. Metric failure.
<b>Records reentered</b>	Failure to transcribe paper-based screening into EHR not captured by reporting.	<ul style="list-style-type: none"> <li>Training deficit on importance of screening result transcription.</li> <li>Operational limitation to volume of records transcribed for prolonged outage.</li> </ul>	Screening not captured for reporting. Metric failure. Uncertain clinical follow-up.



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### Failure Mode Priority Ranking – Depression Screening

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

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

Table 2a—Failure Mode Priority Ranking – Depression Screening	
Priority Ranking	Failure Modes
1	MA skips PHQ-4 during check-in process without medical rationale
2	Failure to transcribe paper-based screening into EHR not captured by reporting.
3	No screening completed
4	MA electing not to perform PHQ-4 at encounter although it had been performed within last 12 months.



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

**Instructions:**

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

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

NOTE: Process map is attached separately (RAE 2\_CO2020-21\_MCO\_PIP-Val\_Mod 2\_Depression\_Submission Process Maps\_D1\_05-03-2021.pdf). Follow-up After a Positive Depression Screen is on second tab. These process maps were constructed by an interdisciplinary PIP team consisting of both clinical and management staff members at Sunrise Community Health and Quality staff within RAE 2. The combination of SME & clinical expertise was used through multiple iterations to create the final product.





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 Performance Improvement Project (PIP)  
 Module 2 — Intervention Determination Submission Form  
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### Failure Modes and Effects Analysis (FMEA) – Follow-up After a Positive Depression Screen

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

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

Table 1b—Failure Modes and Effects Analysis Table – Follow-up After a Positive Depression Screen			
Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
<b>Provider Meets with Member</b>	Provider addresses issue with plan &/or psychopharmacology and no Behavioral Health involvement	<ul style="list-style-type: none"> <li>• Member depression does not require behavioral health intervention at this time</li> <li>• Member perceives that depression is not a behavioral health issue at this time or</li> </ul>	No BH follow-up. Metric failure.



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		does not understand its importance.	
<b>Additional BH follow-up referrals are made if needed</b>	Coding not in line with metric specifications	Provider training deficit	Metric failure.
<b>Member declines BH follow-up</b>	Member doesn't schedule follow-up	<ul style="list-style-type: none"> <li>Denial</li> <li>Prior negative experience with Behavioral Health</li> <li>Alternate therapy/treatment options utilized</li> <li>Pursing spiritual guidance</li> <li>Alternate priorities</li> </ul>	Member doesn't schedule follow-up
<b>Red Flag</b>	Case manager has Red Flag parameters set higher than simply a positive depression screen without scheduled/completed BH follow-up	<ul style="list-style-type: none"> <li>Heavy caseload</li> <li>Training deficiency utilizing Azara reporting</li> </ul>	Member doesn't schedule follow-up
<b>BH contacts member to offer appointment within 7 days</b>	<ul style="list-style-type: none"> <li>Unable to contact member after 2 calls &amp; a letter sent</li> <li>Appointments booked greater than 30 days of positive screening</li> </ul>	<ul style="list-style-type: none"> <li>Incorrect contact information in record</li> <li>Member does not return messages</li> </ul>	No BH follow-up. Metric failure.
<b>Does member attend BH appointment?</b>	<ul style="list-style-type: none"> <li>Scheduling conflict, rescheduled outside 30 day window</li> <li>Cancelled appointment</li> </ul>	<ul style="list-style-type: none"> <li>Competing member priorities</li> </ul>	No BH follow-up in some cases. Metric failure.



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	<ul style="list-style-type: none"> <li>Missed appointment</li> </ul>	<ul style="list-style-type: none"> <li>Booking staff lack of awareness of 30 day window for metric</li> <li>Denial</li> <li>Prior negative experience with Behavioral Health</li> <li>Alternate therapy/treatment options utilized</li> <li>Pursing spiritual guidance</li> <li>Alternate priorities</li> </ul>	
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### Failure Mode Priority Ranking – Follow-up After a Positive Depression Screen

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

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

Table 2b—Failure Mode Priority Ranking – Follow-up After a Positive Depression Screen	
Priority Ranking	Failure Modes
1	Case manager has Red Flag parameters set higher than simply a positive depression screen without scheduled/completed BH follow-up
2	Scheduling conflict, rescheduled outside 30 day window / Cancelled appointment / Missed appointment
3	Unable to contact member after 2 calls & a letter sent / Appointments booked greater than 30 days of positive screening
4	Provider addresses issue with plan &/or psychopharmacology and no Behavioral Health involvement
5	Coding not in line with metric specifications
6	Member doesn't schedule follow-up



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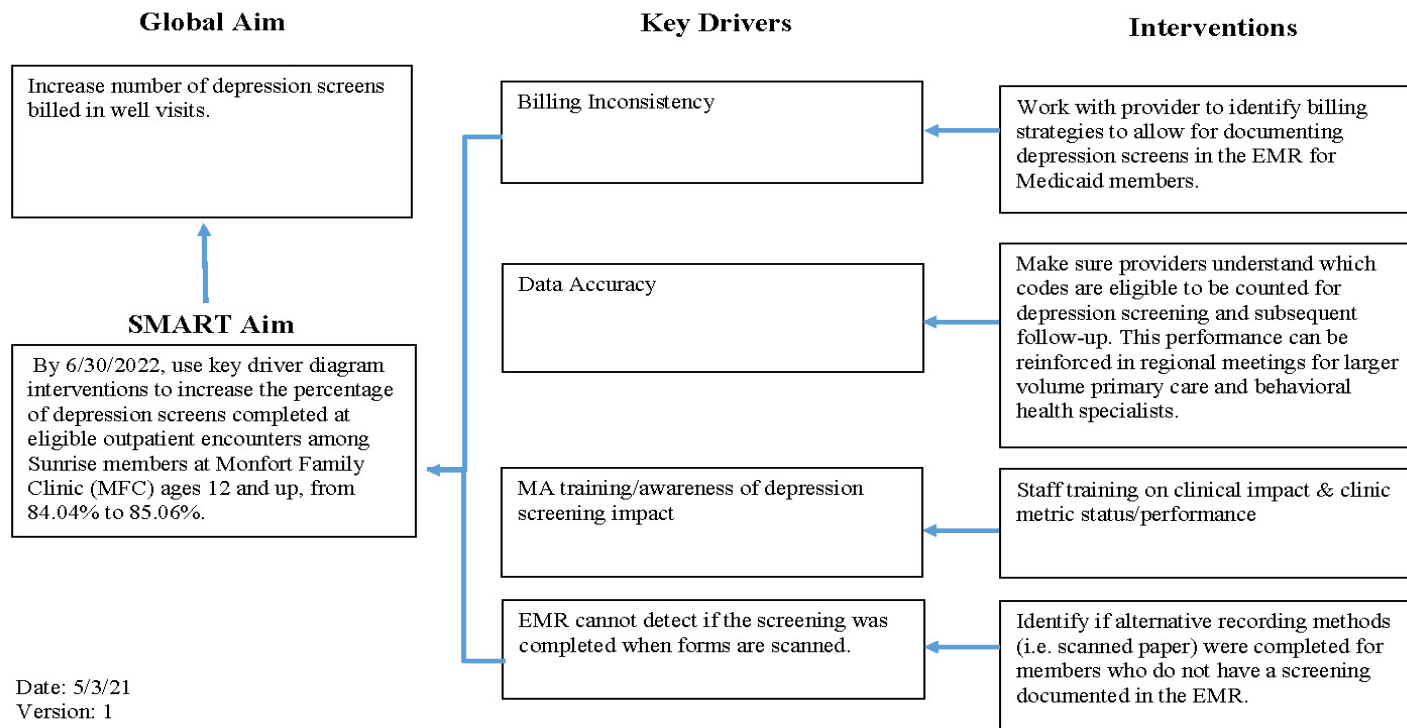
### Key Driver Diagrams

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

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

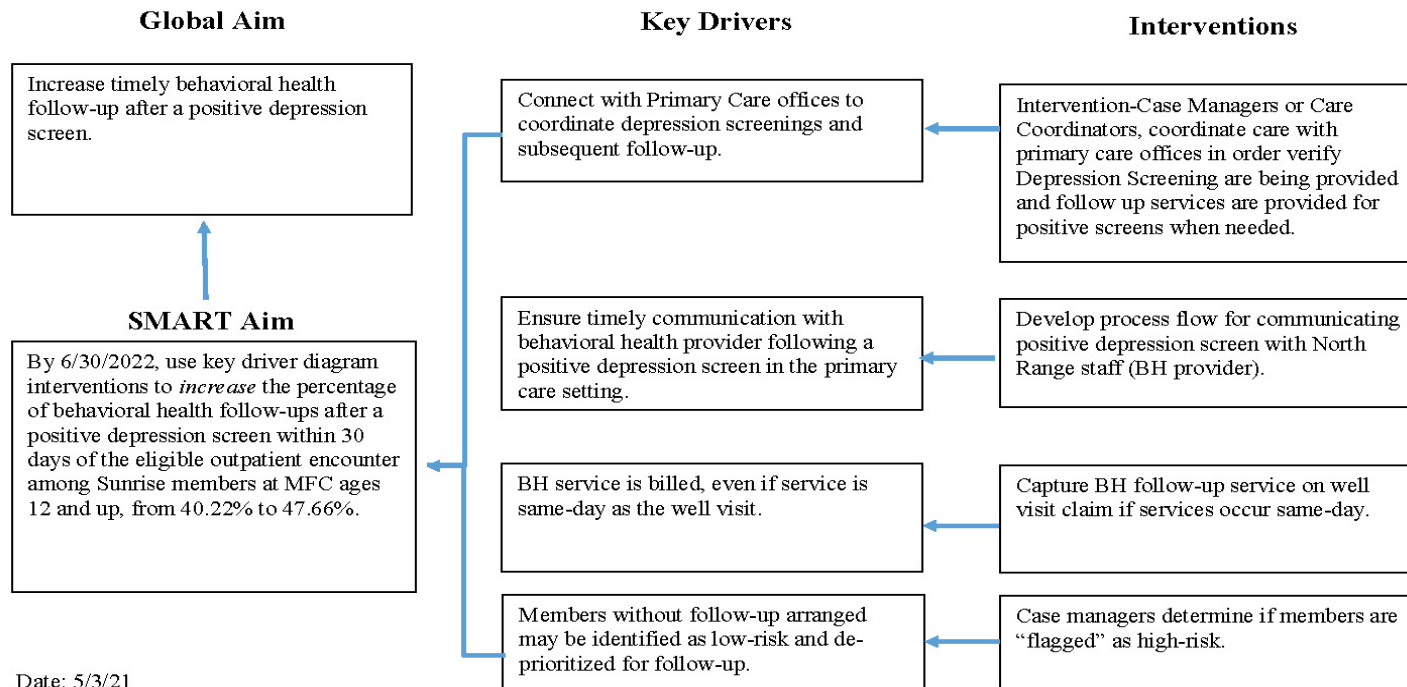
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**Key Driver Diagram– Depression Screening**



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



Date: 5/3/21  
Version: 1





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Managed Care Organization (MCO) Information	
MCO Name	Northeast Health Partners – RAE 2
PIP Title	<i>Depression Screening and Follow-up After a Positive Depression Screen</i>
Intervention Name:	Staff Education and Feedback on Depression Screening Procedures
Contact Name	Jeremy White
Contact Title	Quality Manager
Email Address	<a href="mailto:Jeremy.White@beaconhealthoptions.com">Jeremy.White@beaconhealthoptions.com</a>
Telephone Number	719-226-7794
Submission Date	8/6/2021
Resubmission Date (if applicable)	XXXXXX



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### Intervention Testing Plan

#### Instructions:

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

Table 1b—Intervention Plan	
Intervention Being Tested	Staff Education and Feedback on Depression Screening Procedures
Outcome Addressed	<input type="checkbox"/> <i>Depression Screening</i> <input checked="" type="checkbox"/> <i>Follow-up After a Positive Depression Screen</i>
Failure Mode Addressed	Provider addresses issue with plan &/or psychopharmacology and no Behavioral Health involvement
Key Driver Addressed	Ensure timely communication with behavioral health provider following a positive depression screen in the primary care setting.
Intervention Process Steps ( <i>List the step-by-step process required to carry out this intervention.</i> )	1. Encourage behavioral health (BH) providers to meet with providers during All Staff training to emphasize the clinical value of depression screening, reinforce procedures to BH contact, and outcome evidence. 2. Establish clinical policy that referral to BH is default practice for positive depression screening. 3. Repeat above briefing periodically (e.g., quarterly or when new staff are oriented) and include in orientation checklist materials for new staff and transitional/intern staff.





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**Table 1b—Intervention Plan**

What are the predicted results of this test?	Increased depression screening follow-up percentage
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### Intervention Effectiveness Measure

#### Instructions:

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

**Table 2b—Intervention Effectiveness Measure**

Intervention Measure Title	<b>(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A)</b> <b>Follow-up after positive depression screening at any visit within Valley-Wide Clinic</b>
Numerator Description	The total number of members with a positive depression screen at Valley-Wide Clinic within the measurement period and a follow-up behavioral health service within 30 days of positive depression screen (See Attachment 2)
Denominator Description	The total number of members with a positive depression screen at Valley-Wide Clinic within the measurement period



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**Table 3b—Intervention Effectiveness Measure Data Collection Process**

Describe the Data Elements	<p>Eligible outpatient encounters were calculated by finding all encounters described in CMS 2v8 (Depression Screening and Follow-up). The Value Set OID is “2.16.840.1.113883.3.600.1916”. Screening for depression was met by using an age appropriate standardized tool. The list of CPT and SNOMED codes included in the Value Set can be found at this link: <a href="https://vsac.nlm.nih.gov/valueset/expansions?pr=all&amp;rel=Latest&amp;q=Depression%20Screening%20and%20Follow-up%20encounter">https://vsac.nlm.nih.gov/valueset/expansions?pr=all&amp;rel=Latest&amp;q=Depression%20Screening%20and%20Follow-up%20encounter</a> (Attachment 3-5).</p> <p>Data fields include: Medicaid ID, DOB, Last Name, First Name, Gender, Ethnicity, Age, Age Group, County, Depression Screen Date, Screening Provider, Follow-up Date, Follow-up Provider.</p>
Describe the Data Sources	Valley-Wide Clinic claims data will be pulled from HCPF source file.
Describe how Data will be Collected	<ol style="list-style-type: none"> <li>1. Denominator                             <ol style="list-style-type: none"> <li>a. Find all members in the physical health data table who had a positive depression screening using svccod ‘G8431’ during the measurement period.</li> <li>b. Determine continuous enrollment from date of positive depression screening through 30 days after.</li> </ol> </li> <li>2. BH Numerator                             <ol style="list-style-type: none"> <li>a. Match up the members from the denominator with BH services using the service codes and provider type codes per the Incentive Measure #4 (Attachment 2).</li> </ol> </li> <li>3. Physical Health Numerator                             <ol style="list-style-type: none"> <li>a. Match up the members from the denominator with Physical Health services using the service codes and provider type codes per the Incentive Measure #4 (Attachment 2).</li> <li>b. Combine the BH and PH numerators</li> </ol> </li> <li>4. Join the Denominator with the Numerator to calculate the follow up percentage.</li> </ol>



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**Table 3b—Intervention Effectiveness Measure Data Collection Process**

Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Claims data will be reported monthly. Any data irregularities will be first addressed with the Beacon DMATT team and then elevated to HCPF data POCs for resolution.  The Quality team will partner with Valley-Wide IT staff to generate detailed member-level data on encounters, screening results, and follow-up in order to provide incremental feedback on intervention efficacy.
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Managed Care Organization (MCO) Information	
MCO Name	Northeast Health Partners – RAE 2
PIP Title	<i>Depression Screening and Follow-up After a Positive Depression Screen</i>
Intervention Name:	Medical Assistant Education and Feedback on Depression Screening Procedures
Contact Name	Jeremy White
Contact Title	Quality Manager
Email Address	<a href="mailto:Jeremy.White@beaconhealthoptions.com">Jeremy.White@beaconhealthoptions.com</a>
Telephone Number	719-226-7794
Submission Date	7/21/21
Resubmission Date (if applicable)	9/3/21



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### Intervention Testing Plan

#### Instructions:

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

Table 1a—Intervention Plan	
Intervention Being Tested	Medical Assistant (MA) Education and Feedback on Depression Screening Procedures
Outcome Addressed	<input checked="" type="checkbox"/> <i>Depression Screening</i> <input type="checkbox"/> <i>Follow-up After a Positive Depression Screen</i>
Failure Mode Addressed	MA skips PHQ-4 during check-in process without medical rationale
Key Driver Addressed	MA training/awareness of depression screening impact
Intervention Process Steps ( <i>List the step-by-step process required to carry out this intervention.</i> )	Intervention is a two-pronged approach. A1, and B1 start at same time. A: 1. Generate gap report from Azara from previous two-week period. 2. Manipulate report, if required, with data that can be sorted by provider team. 3. Distribute bi-weekly feedback with each team to provide previous week's results for missed opportunities for the completion of a depression screen. 4. Track performance by team. 5. Post performance results (by team or by pod) on the clinic Quality board (See Attachment 1).





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



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### Intervention Effectiveness Measure

#### Instructions:

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

Table 2a—Intervention Effectiveness Measure	
Intervention Measure Title	(e.g., The number or percentage of eye exams scheduled on Saturday for Provider A) <b>Depression screening completed at any visit within Sunrise Montfort Clinic (MFC)</b>
Numerator Description	The total number of eligible outpatient encounters at one Sunrise Clinic (MFC) where a depression screen was conducted within the measurement period
Denominator Description	The total number of eligible outpatient encounters at one Sunrise Clinic (MFC) within the measurement period

Table 3a—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	We will use data pulled from the Electronic Health Record (EHR) to capture documented depression screens. Eligible outpatient encounters were calculated by finding all encounters described in CMS 2v8 (Depression Screening and Follow-up). The Value Set OID is “2.16.840.1.113883.3.600.1916”. Screening for depression was met by using an age appropriate standardized tool. The list of CPT and SNOMED codes included in the Value Set can be found at this link: <a href="https://vsac.nlm.nih.gov/valueset/expansions?pr=all&amp;rel=Latest&amp;q=Depression%20Screening%20and%20Follow-up%20encounter">https://vsac.nlm.nih.gov/valueset/expansions?pr=all&amp;rel=Latest&amp;q=Depression%20Screening%20and%20Follow-up%20encounter</a> This file is included in the attached file.



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Table 3a—Intervention Effectiveness Measure Data Collection Process	
	Data fields include: Medicaid ID, DOB, Last Name, First Name, Gender, Ethnicity, Age, Age Group, County, Encounter Date of Service, Location, Depression Screen Date, Depression Screen Measure, Depression Screen Score, Excluded, Excluded Date
Describe the Data Sources	Sunrise Clinic (MFC) EHR
Describe how Data will be Collected	Medical assistants will input depression screening responses directly into the EHR when talking with the member while taking vitals. CCMCN will pull data on eligible outpatient visits and depression screening from the Sunrise EHR and provide an Excel file to NHP. Beacon calculate the performance rate for depression screens completed.
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Data will be collected daily during outpatient visits. EHR data will be delivered monthly to NHP and Beacon. Performance rates will be reported monthly to Sunrise.



## Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.



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Criteria	Score	HSAG Feedback and Recommendations
1. The health plan included process maps for <i>Depression Screening and Follow-Up After a Positive Depression Screen</i> that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
5. The health plan prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	The health plan listed steps instead of failure modes in Tables 2a and 2b. In each table, the column titled “Failure Modes” should include failure modes rather than steps. For example, in Table 2a, the step, “MA Decides to Complete PHQ4?” should be replaced by the failure mode, “MA skips PHQ-4 during check-in process without medical rationale.”



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Criteria	Score	HSAG Feedback and Recommendations
		<b>Re-review June 2021:</b> The health plan corrected the failure modes listed in Tables 2a and 2b in the resubmission. The criterion has been changed to <i>Met</i> .
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the health plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Additional Recommendations:</b> None.		

**Intervention Determination (Module 2)**

☒ Pass

Date: June 14, 2021



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***Intervention: Medical Assistant Education and Feedback on Depression Screening Procedures***

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. The health plan included all components for the Intervention Plan.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. The <i>Intervention Effectiveness Measure(s)</i> was appropriate for the intervention.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Additional Recommendations:</b> None.		

**Intervention Testing (Module 3)**

☒ Pass

Date: September 15, 2021



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***Intervention: Staff Education and Feedback on Depression Screening Follow-up Procedures***

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
2. The health plan included all components for the Intervention Plan.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
3. The <i>Intervention Effectiveness Measure(s)</i> was appropriate for the intervention.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Additional Recommendations:</b> The health plan should continue to pursue additional intervention effectiveness measures / data sources as described in the August 31 <sup>st</sup> NHP PIP Module 3 update email. Tracking additional intervention effectiveness measures will support the health plan's ability to obtain meaningful and actionable data that can be used to rapidly refine improvement strategies as the health plan seeks to achieve the SMART Aim goals for the project. The following additional intervention effectiveness data collection strategies should be utilized in testing the intervention, if feasible:		



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Criteria	Score	HSAG Feedback and Recommendations
<ul style="list-style-type: none"> <li>Identification of a data field that captures presence of a BH provider at the encounter when the positive depression screening occurred to allow tracking the percentage of encounters with a positive depression screen that included the involvement of a BH provider.</li> <li>Utilization of EHR data to capture BH encounters that can be matched to positive depression screens that occur with narrowed focus provider clinic.</li> <li>Further evaluation of claims lag impacting the existing intervention effectiveness measure, which tracks completion of a follow-up BH visit within 30 days of the positive depression screen to determine completeness of data being used to evaluate intervention effectiveness.</li> </ul>		

**Intervention Testing (Module 3)**

☒ Pass

Date: September 15, 2021