COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2024–2025 PIP Validation Report

for

Health Colorado, Inc. Region 4

April 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Acknowledgements and Copyrights

1. Executive Summary

Pursuant to 42 CFR §457.1250, which requires states' Medicaid managed care programs to participate in external quality review (EQR), the State of Colorado, Department of Health Care Policy and Financing (the Department) required its Regional Accountable Entities (RAEs) to conduct and submit performance improvement projects (PIPs) annually for validation by the State's external quality review organization (EQRO). Health Colorado, Inc. Region 4, referred to in this report as HCI R4, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in performance indicator outcomes that focus on clinical or nonclinical areas. For this year's 2024–2025 validation, HCI R4 submitted two PIPs: *Follow-Up After Emergency Department Visits for Substance Use [FUA]* and *Social Determinants of Health (SDOH) Screening*. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *FUA* PIP addresses quality, timeliness and accessibility of healthcare and services for members ages 13 years and older with a diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose. The topic, selected by HCI R4 and approved by the Department, was supported by historical data. The PIP Aim statement is as follow: "Does implementing a deliberate, iterative performance improvement process result in increased rates for members 13 years and older who follow-up after an emergency department visit for Substance Use Disorder (SUD) from 26.06% to 29.19% by June 30, 2025?"

The nonclinical *SDOH Screening* PIP addresses quality and accessibility of healthcare and services for HCI R4 members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP Aim statement is as follows: "Does implementing a deliberate, iterative performance improvement process result in increased rates of screening for SDOH among behavioral health utilizers in RAE 4 from 2.91% to 3.18% by June 30, 2025?"

Table 1-1 outlines the performance indicators for each PIP.

Table 1-1—Performance Indicators

PIP Title	Performance Indicator
FUA	The percentage of emergency department (ED) visits for members ages 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.
SDOH Screening	The percentage of members with at least one behavioral health service who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.

2. Background

Rationale

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 EQR of each contracting health plan. Health plans include primary care case management entities (PCCM entities). The regulations at 42 CFR §438.358 require that the EQR include analysis and evaluation by an EQRO of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for 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 RAEs in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[1] HSAG's evaluation of the PIP includes two key components of the quality improvement (QI) process:

1. HSAG evaluates the technical structure of the PIP to ensure that HCI R4 designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a RAE's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well HCI R4 improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that the RAE executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the RAE during the PIP.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 18, 2025.

Validation Overview

For FY 2024–2025, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), RAE 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 improvement in quality
- Evaluating effectiveness of the interventions
- Planning and initiating of activities for increasing or sustaining improvement

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS EQR Protocol 1. With the Department's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table 2-1—CMS EQR 1 Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG obtains the data needed to conduct the PIP validation from HCI R4's PIP Submission Form. This form provides detailed information about HCI R4's PIP related to the steps completed and evaluated for the 2024–2025 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the RAE adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**

   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

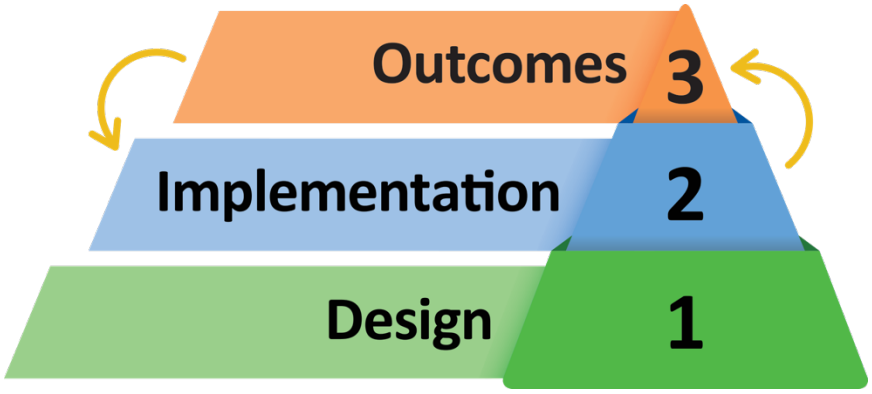
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.

  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

Figure 2-1 illustrates the three stages of the PIP process—Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the PIP topic, Aim statement, population, sampling techniques, performance indicator(s), and data collection processes. To implement successful improvement strategies, a strong methodologically sound design is necessary.

Figure 2-1— Stages of the PIP Process



Once HCI R4 establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, HCI R4 evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when performance indicators demonstrate statistically significant improvement over baseline performance through repeated measurements over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, HCI R4 should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

3. Findings

Validation Findings

HSAG's validation evaluates the technical methods of the PIP (i.e., the design, data analysis, implementation, and outcomes). Based on its review, HSAG determined the overall methodological validity of the PIP. Table 3-1 summarizes the health plan's PIPs validated during the review period with an overall confidence level of *High Confidence*, *Moderate Confidence*, *Low Confidence* or *No Confidence* for the two required confidence levels identified below. In addition, Table 3-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the PIP Validation Tool that HSAG has identified as essential for producing a valid and reliable PIP.

Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2024–2025 PIP Overall Confidence Levels for HCI R4

PIP Title	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
FUA	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*The MCO did not resubmit.*					
SDOH Screening	Initial Submission	94%	89%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission, or resubmission. A resubmission means the MCO resubmitted the PIP with updated documentation to address HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *FUA* PIP was validated through all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. HCI R4 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. HSAG assigned a *High Confidence* level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the first remeasurement.

The *SDOH Screening* PIP was validated through all nine steps of the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology. HCI R4 received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement. HSAG assigned a *High Confidence* level for Validation Rating 2 because the performance indicator results demonstrated a statistically significant improvement over baseline performance at the first remeasurement.

Scores and feedback for individual evaluation elements and steps are provided for each PIP in Appendix B. Final PIP Validation Tools.

Analysis of Results

Table 3-2 displays data for HCI R4's *FUA* PIP.

Table 3-2—Performance Indicator Results for the *FUA* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of ED visits for members ages 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.	N: 410 D: 1,573	26.1%	N: 411 D: 1,376	29.9%			

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, HCI R4 reported that 26.1 percent of ED visits for members ages 13 years and older who had a principal diagnosis of SUD or other diagnosis of drug overdose had a follow-up visit within seven days of an ED visit.

For the first remeasurement period, HCI R4 reported that 29.9 percent of ED visits for members ages 13 years and older who had a principal diagnosis of SUD or other diagnosis of drug overdose had a follow-up visit within seven days of an ED visit. Compared to baseline performance, the Remeasurement 1 results demonstrated a statistically significant increase of 3.8 percentage points in the seven-day follow-up rate among eligible members.

Table 3-3 displays data for HCI R4's *SDOH Screening* PIP.

Table 3-3—Performance Indicator Results for the *SDOH Screening* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (07/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of members with at least one behavioral health service who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	N: 931 D: 31,955	2.9%	N: 1,576 D: 29,604	5.3%			

N–Numerator D– Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, HCI R4 reported that 2.9 percent of members with at least one behavioral health service were screened for the four SDOH domains.

For the first remeasurement period, HCI R4 reported that 5.3 percent of members with at least one behavioral health service were screened for the four SDOH domains. Compared to baseline performance, the Remeasurement 1 results demonstrated a statistically significant increase in the percentage of eligible members who were screened for the four SDOH domains of 2.4 percentage points.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. HCI R4's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

Table 3-4 displays the barriers and interventions documented by HCI R4 for the *FUA* PIP.

Table 3-4—Barriers and Interventions for the *FUA* PIP

Barriers	Interventions
Lack of access to care coordination communication system; previous contract for utilization management software application was not renewed.	Revise behavioral health (BH) referral process for members discharged from the ED with a SUD or drug overdose diagnosis by using mobile early intervention services (MEIS) transmissions through email and fax. The Health Solutions MEIS workflow automated referrals for care coordination services to support BH follow-up appointments for eligible members.
• Competing priorities for care coordination workload • Client not interested in engagement (consent) • Unaddressed social determinant barriers (e.g., transportation)	A Care Coordinator was embedded in the partner ED and a workflow was developed so the embedded Care Coordinator could facilitate referrals for BH follow-up appointments for members diagnosed with a SUD or drug overdose diagnosis while working onsite at the ED.

Table 3-5 displays the barriers and interventions documented by HCI R4 for the *SDOH Screening* PIP.

Table 3-5—Barriers and Interventions for the *SDOH Screening* PIP

Barriers	Interventions
• No explicit productivity threshold • No data on productivity	**Provider performance feedback and education.** Care coordination policy was updated to promote completion of SDOH screenings. Care coordination providers were educated on the new policy and performance dashboards were created to provide feedback on SDOH screening performance.
• Member does not understand potential benefit of care coordination service. • Care coordinator does not understand potential benefit of additional care coordination intake. • Care coordinator does not effectively communicate potential benefit of additional care coordination intake	**Revised care coordination intake process and training for care coordination providers on the new process.** The intake process was revised so that SDOH screening questions were a required step and were asked at the start of the process to facilitate completion of the screening at intake.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, HCI R4 submitted the clinical *FUA* PIP and the nonclinical *SDOH Screening* PIP. HCI R4 reported Remeasurement 1 performance indicator results for both PIPs, and both PIPs were validated through Step 9 (Outcomes stage). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages. In the Outcomes stage, both PIPs received a *High Confidence* level that the PIP achieved significant improvement.

HSAG's PIP validation findings suggest a thorough application of the PIP Design stage (Steps 1 through 6) for both PIPs. A methodologically sound design created the foundation for HCI R4 to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. In the Implementation stage (Steps 7 and 8), HCI R4 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. In the Outcomes stage (Step 9), Remeasurement 1 results for both PIPs demonstrated statistically significant improvement over baseline results. HCI R4 will report results from the second remeasurement period at the end of their contract period in June 2025.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- Revisit causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- Use QI tools such as a key driver diagram, process mapping, and/or failure modes and effects analyses to determine and prioritize barriers and process gaps or weaknesses, as part of the causal/barrier analyses.
- Use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. The RAE should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results frequently throughout each measurement period. The intervention evaluation results should drive next steps for interventions and determine whether they should be continued, expanded, revised, or replaced.

Appendix A. Final PIP Submission Forms

Appendix A contains the final PIP Submission Forms that HCI R4 submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Demographic Information	
Managed Care Organization (MCO) Name: Health Colorado, Inc. (RAE 4)	
Project Leader Name: Edward Arnold	Title: Performance Improvement Analyst
Telephone Number: 719-666-0540	Email Address: edward.arnold@carelon.com
PIP Title: *Follow-Up After Emergency Department (ED) Visit for Substance Use (FUA)*	
Submission Date: 10/31/24	
Resubmission Date (if applicable):	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Follow-Up After Emergency Department Visit for Substance Use: Ages 13 and Older

Provide plan-specific data:
Nationwide, rates of appropriate follow-up within seven days of an Emergency Department (ED) visit for a substance use disorder (SUD) or unintentional drug overdose are poor with reported rates for Medicaid HMO populations as low as 13.4% for CY2021 (www.NCQA.org). Performance on this measure among the Medicaid population in Colorado is slightly better on average, with rates reported as 27.0% for CY22. Despite this higher performance and considering the significant negative outcomes associated with unmanaged substance abuse, substantial opportunity still remains to improve the engagement of this population in the therapeutic environment.

Baseline performance was collected per guidance from the Colorado Department of Health Care Policy & Financing (HCPF) and HSAG for July 1, 2022, through June 30, 2023. 7/1/22-6/30/23. Health Colorado, Inc (HCI/R4) elected to utilize the Center for Medicare & Medicaid Services (CMS) core measure specifications for Follow-Up After Emergency Department Visit for Substance Use: Ages 13 and Older (FUA) to facilitate benchmarking with national averages and align with a Behavioral Health Incentive Program (BHIP) measure.

- HCI members who had a qualifying ED encounter between July 1, 2022, and June 30, 2023: 1,573
- Number of these members with appropriate follow-up within seven days: 410
- Baseline performance for Follow-up After ED Visit for Substance Use (seven days): 26.06%.

Analysis of the age groups for qualifying encounters and follow-ups is consistent with the size of these age ranges. Nearly all qualifying encounters are within the 18-to-64-year age group. To better identify opportunities for improved performance on this measure, this data was reviewed to isolate encounters without qualifying follow-ups. The proportion of this group consisting of children and older adults both increased slightly, but still represents a small portion of the overall group. An additional analysis was conducted to identify whether timely access to follow-up services may be a significant issue. Eligible ED encounters that completed a follow-up within 30 days but not within seven days were reviewed. Reversing the previous observation, the proportion of children and older adults in this group is less than their representation in the overall measure group.

This data was also analyzed to examine what substances are associated with this measure population in the region. Analysis reveals that alcohol-related ED encounters represent the largest portion of qualifying ED encounters with nearly half of all encounters (46.3%). The next most

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Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

common diagnostic groups for ED encounters are stimulants (17.9%) and opioids (14.3%). No other diagnostic groups exceed 10% of the qualifying encounters. This result is consistent with anecdotal report from regional EDs. Again, this data was reviewed to isolate encounters without qualifying follow-ups to identify potential opportunities to improve performance. The same three diagnostic groups remain in the same hierarchy, although there is a slightly greater representation for alcohol diagnoses. An additional analysis to identify whether timely access to follow-up services may be a significant issue relative to the substance-related diagnostic group that was conducted. The review of eligible ED encounters that completed a follow-up within 30 days but not within seven days demonstrated a notable increase in the proportions of stimulant and opioid encounters in this group.

Age Range	Percent of All Encounters (N=1,573)	Percent of Encounters Without Follow-up (N=983)	Percent of Encounters With 30-Day Follow-up (N=418)
Adult (18-64)	94.15%	93.5%	95.8%
Child (13-17)	3.12%	3.2%	2.7%
Older Adult (65+)	2.73%	3.4%	1.5%
Diagnostic Group (Not All Inclusive)			
Alcohol (F10.XX)	46.3%	49.1%	44.4%
Stimulants (F15.XX)	17.9%	16.5%	21.1%
Opioids (F11.XX)	14.3%	11.4%	18.3%

In summary, this analysis suggests that engaging members coping with alcohol-related conditions represents the greatest opportunity to improve performance on this measure, followed by stimulant and opioid-related conditions. In turn, access to treatment services for stimulants and/or opioid-related conditions could be reviewed to determine what may be the cause for delays in this populations engaging in services.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction: Substance use has a significant impact on health outcomes for individuals as well as health system utilization. The CMS established the Follow-up After Emergency Department Visit for Substance Use (FUA) measure as an assessment of an evidence-based outcome for this population. More than one-tenth of ED visits in the USA were related to SUD and these individuals were more likely to return to the ED within 72 hours, more likely to be admitted to the hospital, and more likely to be admitted to the intensive care unit (ICU).[1] Individuals who do not receive follow-up care after ED visits are more likely to return to the ED and experience worsening of their conditions.[2] In addition to this evidence regarding the importance of follow-up after an ED visit for SUD, there is evidence that the problem is growing. From 2014 to 2018, ED visits made by adults with alcohol and SUD increased by 30% and hospitalizations among patients with those disorders increased by 57%.[3] Taking action now has the potential to reverse this trend by impacting HCI members.

[1] Zhang X, Wang N, Hou F, Ali Y, Dora-Laskey A, Dahlem CH, McCabe SE. Emergency Department Visits by Patients with Substance Use Disorder in the United States. West J Emerg Med. 2021 Aug 19;22(5):1076-1085
[2] Croake S, Brown JD, Miller D, Darter N, Patel MM, Liu J, Scholle SH. Follow-Up Care After Emergency Department Visits for Mental and Substance Use Disorders Among Medicaid Beneficiaries. Psychiatr Serv. 2017 Jun 1;68(6):566-572
[3] Suen LW, Makam AN, Snyder HR, Repplinger D, Kushel MB, Martin M, Nguyen OK. National Prevalence of Alcohol and Other Substance Use Disorders Among Emergency Department Visits and Hospitalizations: NHAMCS 2014-2018. J Gen Intern Med. 2022 Aug;37(10): 2420-2428

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):
Does implementing a deliberate, iterative performance improvement process result in increased rates for members 13 years and older who follow-up after an ED visit for SUD from 26.06% to 29.19% by June 30, 2025?

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Follow-Up After ED Visit for Substance Use (FUA)
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Performance Improvement Projects

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition: Members aged 13 and older with an ED visit that includes a principal diagnosis of SUD, or any diagnosis of drug overdose

Enrollment requirements (if applicable):

Length of Enrollment: 31 days minimum

Continuous Enrollment: Date of the ED visit through 30 days after the ED visit (31 total days) with no allowable gaps

Member age criteria (if applicable): Age 13 or older on the date of the ED visit. Anchor date for age is date of ED visit.

Inclusion, exclusion, and diagnosis criteria:

Inclusion: An ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between July 1 of the previous year and May 31 of the following year when the beneficiary was age 13 and older on the date of the visit. Value Sets from 2023 CMS Adult and Child Core Measure (FUA) at Attachment A & B.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Exclusion: ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. (An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay). Exclude beneficiaries in hospice or using hospice services anytime during the measurement year. If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit after applying relevant exclusions.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): Denominator specifications in accordance with 2023 CMS Core Measure: Follow-Up After Emergency Department Visit for Substance Use (FUA-AD, FUA-CH) (Attachment A, B) and Value Sets (Attachment C, D).

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level

Describe in detail the methods used to select the sample: Sampling was not used in this PIP.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	Follow-Up After Emergency Department Visit for Substance Use (FUA)
	This indicator is endorsed by the National Committee for Quality Assurance (NCQA) as a CMS core measure. This illustrates the validity of this indicator as a measure of impact on this at-risk population. Use of this national standard specification also allows comparison with similar insured populations across the nation. (2023 Child and Adult Resource and Technical Specifications will be used).
Numerator Description:	Number of members aged 13 and older with a qualifying follow-up visit within seven days of an ED visit with a principal diagnosis of SUD, or any diagnosis of drug overdose (eight total days).
Denominator Description:	Number of members aged 13 and older with an ED visit that includes a principal diagnosis of SUD or any diagnosis of drug overdose.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ]Manual Data	[X]Administrative Data	[ ]Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [X] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [X] Data completeness assessment attached [ ] Coding verification process attached	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ ___ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Estimated percentage of reported administrative data completeness at the time the data are generated: 98.66 % complete. Data Completeness Calculation (Attachment E): Remeasurement 1 performance was calculated using the monthly claims and encounter data feed available 60 days from the last date of the performance period. Accordingly, data completeness calculation was performed to estimate the average data completeness available at the 60-day point. The 90- day lag is the end point established by HCPF for final performance measure calculations - Claims processed between July 1, 2023, through June 30, 2024, were included in this sample for calculation as it represented a period that all claims would have been resolved at the time of calculation. - Dental claims were excluded as they were the only claim type not included in value sets associated with PIP performance measures. - Denominator: Count of all inclusive claims processed in the time frame above - Numerator at 90 days: Count of all inclusive claims processed in time frame above that were completed in 90 days following the date of submission	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	- Numerator at 60 days: Count of all inclusive claims processed in time frame above that were completed in 60 days following the date of submission - Numerator was divided by Denominator and expressed as a percentage	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected:

- Member ID
- ED Date
- Age
- Denominator Revenue Code
- Denominator Service Code
- Denominator Diagnosis Code
- Denominator Provider Number
- Denominator Rendering Provider
- Follow-up Date
- Follow-up Service Code
- Follow-up Revenue Code
- Follow-up Diagnosis Code
- Follow-up POS Code
- Follow-up NDC Code
- Follow-up Provider Number

Data Collection Process:

Data from submitted claims and encounters will be used in conjunction with the FUA FFY 2023 Child and Adult Resource and Technical Specification as well as the FFY 2023 Adult and Child Core Set HEDIS Value Set Directory to identify qualifying events and exclusions.

1. Denominator: Identify ED visits for members aged 13 and older with a principal diagnosis of SUD or any diagnosis of drug overdose on or between July 1 and June 30.
2. Denominator: Identify exclusions which include ED visits that result in inpatient stays, admission to acute or nonacute inpatient care setting on or within 30 days after the ED visit, or members in or using hospice anytime during the measurement period.
3. Denominator: Identify members who had more than one ED visit in a 31-day period and only include the first eligible visit.
4. Denominator: Identify members who were not continuously enrolled on the date of the ED visit through 30 days after the ED visit (31 days total) with no gaps and exclude these ED visits.
5. Numerator: Identify follow-up visits or pharmacotherapy dispensing events within seven days after the ED visits (eight total days) including visits and pharmacotherapy events that occur on the dates of the ED visit.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
6. Percentage of members who received a follow-up visit within seven days after an ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose: Divide the numerator by denominator to calculate the percentage of members who received a follow-up within seven days of the ED visit.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: Follow-Up After Emergency Department Visit for Substance Use (7-day)

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 to 06/30/2023	Baseline	410	1573	26.1%	N/A for baseline	N/A for baseline
07/01/2023 to 06/30/2024	Remeasurement 1	411	1376	29.87%	29.19%	Chi Square, two-tailed Statistically significant ($p<0.05$) $p=0.02148$
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative: Baseline data was collected in accordance with 2023 CMS Core Measure Specifications for the Follow-up After Emergency Department Visit for Substance Use (FUA) measure for the measurement period July 1, 2022, through June 30, 2023 (SFY22-23) for Medicaid members in RAE 4 (HCI). The total population included 1,573 eligible member ED encounters for substance use or drug overdose. Of this population, 410 completed an appropriate follow-up within seven days of the ED visit, resulting in a completion rate of 26.1%.

The goal established was formulated using a two-tailed normal distribution with a p-value of 0.05 using baseline sample size. Code to calculate measure performance was written by DAR staff to match CMS measure specifications. The reporting period for the baseline (i.e., SFY22-23) does not match the HEDIS specification (i.e., CY22) and a certified HEDIS measure engine could not be utilized. As this measure is a new BHIP measure in SFY23-24, HCI has not had the opportunity to validate member-level data with HCPF and there is potential for minor coding or data source inconsistencies.

Baseline to Remeasurement 1 Narrative: Remeasurement 1 data was collected in accordance with 2023 CMS Core Measure Specifications for the Follow-up After Emergency Department Visit For Substance Use (FUA) measure for the measurement period July 1, 2023, through

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

June 30, 2024 (SFY23-24) for Medicaid members in RAE 4 (HCI) The total population included 1,376 eligible member ED encounters for substance use or drug overdose. Of this population, 411 completed an appropriate follow-up within seven days of the ED visit, resulting in a completion rate of 29.19%.

The goal previously established was formulated using a two-tailed normal distribution with a p-value of 0.05 using baseline sample size. The reported p-value was calculated with a two-tailed, chi-square analysis with comparison to baseline values. The code to calculate measure performance was the same code written by DAR staff to match CMS measure specifications. The reporting period for the baseline (i.e., SFY22-23) does not match the HEDIS specification (i.e., CY22) and a certified HEDIS measure engine still cannot be utilized. As this

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

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- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

measure was a new BHIP measure in SFY23-24 and HCPF does not provide member-level data on performance until early 2025, HCI has not had the opportunity to validate this data with HCPF and there is potential for minor coding or data source inconsistencies.

Data Analysis: Data analysis was performed comparing the Baseline period with Remeasurement Period 1. A chi-square, two-tailed analysis was performed, which produced a p=0.0215.

Variations & Potential Threats to Validity: Starting in May of 2023 through April of 2024, Colorado resumed normal eligibility renewal processes (i.e., termination of continuous eligibility/Public Health Emergency (PHE) unwind). As a result of this process, the number of eligible members began to significantly decline during this period. Total HCI enrollment fell from a peak nearing 160,000 to nearly 110,000 in June of 2024. From June 2023 to June 2024, the absolute count of members with at least one of HCPF's 10 priority conditions changed from 69,861 (2023) to 54,069 (2024). Most relevant to this project is the number of members with a diagnosed SUD condition decreasing from 5,285 in 2023 to 4,797 in 2024. It is unclear whether demographic or utilization variations exist between these populations.

Baseline to Remeasurement 2 Narrative: N/A

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

- **Quality Improvement (QI) Team and Activities Narrative Description**

QI Team Members:
Edward Arnold- Clinical Quality Audit Analyst, Sr
Michaela Smyth- Clinical Quality Audit Analyst, Sr
Jeremy White- Director, Quality Management
Brian Hill- Medical Director
Michael Clark- Data Analytics and Reporting
Melissa Schuchmann- Business Information Analyst II
Teresa Braden- VP of Quality/Chief Quality Officer, Chief of Medicine
Amelia Vigil- Director of Medical Staff Services, Parkview Medical Center
Brad Roberts- Medical Officer, Pueblo Department of Public Health & Environment
LeAnna Pacheco- Vice President of Quality Improvement and Project Management, Health Solutions
Teah Miller- Vice President of Specialty Services, Health Solutions
Kristi Spinuzzi- Clinical Care Coordinator, Parkview Medical Center
Crystal Smith- Director of Complex Care, Health Solutions
Shanalee Ourso- Lead Behavioral Health Evaluator, Parkview Medical Center

QI process and/or tools used to identify and prioritize barriers:

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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   - Intervention Status

One or more of the following process improvement methods/tools may be used during the PIP:

- Identify Aim Statement
- Assemble QI team
- Brainstorm
- Process Mapping
- Key Driver Diagram
- Failure Modes & Effects Analysis (FMEA)
- PDSA Cycle

The process map that was created at the inception of the PIP is available at Attachment F (i.e. as of June 30, 2023). This informed the Key Driver Diagram at Attachment G and FMEA/Priority Matrix available at Attachment H. These informed the intervention testing described in Attachment I.[4]

[4] CO2023-24_Intervention Worksheet_FUA_MEIS

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

Following the intervention testing and further exploration of the process that was informed by the corporate reorganization of Parkview Medical Center to now merge with the UCHealth System, the process map was reviewed. The Key Driver diagram was validated, and the FMEA/Priority Matrix was revised and available at Attachment I (as of February 29, 2024). These were used to inform the subsequent intervention testing found at CO2023-24_Intervention Worksheet_FUA_EmbedCC. The final Key Driver diagram is available at Attachment J.

- **Barriers/Interventions Table:** In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Revise Referral Mechanism	- Failure to renew contract for application
Embedded Care Coordinator	- Client not interested in engagement (consent) - Unaddressed social determinant barriers (e.g. transportation)

- **Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results**
  Intervention worksheets are included for each intervention: Complete a Step 8 Intervention Worksheet for each intervention currently being evaluated. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After ED Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

See the following intervention worksheets:

- CO2023-24_Intervention Worksheet_FUA_MEIS_0624
- CO2023-24_Intervention Worksheet_FUA_ EmbedCC_0624

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Demographic Information
Managed Care Organization (MCO) Name: Health Colorado, Inc. (RAE 4)
Project Leader Name: Edward Arnold Title: Performance Improvement Analyst
Telephone Number: 719-666-0540 Email Address: edward.arnold@carelon.com
PIP Title: *Social Determinants of Health (SDOH) Screening*
Submission Date: 10/31/24
Resubmission Date (if applicable): 1/31/25

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.

PIP Topic: Social Determinants of Health (SDoH) Screening Among Behavioral Health Utilizers

Provide plan-specific data:
Although individual providers certainly identified and addressed SDoH when they impacted an individual plan of care, Health Colorado, Inc (HCI/R4) only comprehensively implemented SDoH screening throughout a specific portion of HCI membership (i.e., members receiving care coordination services as part of a full intake assessment) in SFY22-23. Regarding the calculation of the denominator for this PIP, HCI monitored behavioral health utilization as part of a Key Performance Indicator (KPI) in SFY22-23.

- HCI members who had a behavioral health encounter between July 1, 2022 and June 30, 2023: 31,955
- Number of these members screened for SDoH (housing, food, transportation, utilities): 931
- Baseline performance for SDoH screening: 2.91%.

Within this baseline period, a sizeable portion of the behavioral health utilizing population (27.36%) are also part of a care coordination cohort (care management, care navigation, or low risk care coordination). This group represents a major opportunity to identify social needs as the care coordination staff is uniquely trained to not only connect members with needed resources, but also to facilitate self-management support through motivational interviewing and goal setting. Unfortunately, this baseline data revealed that despite this significant overlapping population, many members in this group did not have the Care Coordination Intake initiated. Of the smaller group that did, more than half had the intake terminated prior to the completion of the full intake that includes the full SDoH screening.

Population	# of Behavioral Health Utilizers	% of Behavioral Health Utilizers
R4 members who had a behavioral health encounter	31,955	----------
R4 members who had a behavioral health encounter AND are in a care coordination cohort	8,742	27.36%
R4 members who had a behavioral health encounter, are in a care coordination cohort, AND care coordination intake is initiated	1,793	5.61%
R4 members who had a behavioral health encounter, are in a care coordination cohort, AND full care coordination intake is completed	931	2.91%

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction: Evidence shows that non-medical factors such as housing instability and food insecurity impact health care utilization and health outcomes.[1][2] Food insecurity has been shown to be more highly correlated with chronic illness than income.[3] Standardized screening tools to identify SDoH needs have been established and tested as part of the Center for Medicare & Medicaid Services (CMS) Accountable Healthcare Communities model. Five years after implementation of this model, early results have reported that over a third of individuals screened identified at least one health-related social need. Although not part of this initial PIP cycle, through increased use of standardized screening tools and workflows it becomes possible to initiate potentially valuable interventions and connections to social supports that may address identified needs. HCI has a unique opportunity to impact our population of members through our diverse connections to community resources, partners, and innovative programs supported through our community reinvestment grants. At a population level, increased screening for SDoH with the aggregation of results will further allow HCI to understand the complex needs across our region and potentially leverage existing partnerships or support new initiatives.

[1] Kushel MB, Vittinghoff E, Haas JS. Factors associated with the health care utilization of homeless persons. JAMA 2001;285(2):200–6
[2] Ma CT, Gee L, Kushel MB. Associations between housing instability and food insecurity with health care access in low-income children. Ambul Pediatr 2008;8(1):50–7.
[3] Gregory, CA & Coleman-Jensen, A. (2017). Food Insecurity, Chronic Disease, and Health Among Working-Age Adults. Economic Research Report No. (ERR-235) 31 pp.

***Appendix A*: State of Colorado 2024-25 PIP Submission Form**
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):
Does implementing a deliberate, iterative performance improvement process result in increased rates of screening for SDoH among behavioral health utilizers in RAE4 from 2.91%.to 3.18% by June 30, 2025?

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition: Distinct RAE 4 members who received at least one behavioral health service delivered in a primary care setting within the 12-month evaluation period or under the Capitated Behavioral Health Benefit within the 12-month evaluation period.

Enrollment requirements (if applicable):

Length of Enrollment: No minimum enrollment.

Continuous Enrollment: No continuous enrollment requirement

Member age criteria (if applicable): No age limitation

Inclusion, exclusion, and diagnosis criteria:

Inclusion: Enrollment in RAE 4 (HCI) on the last day of measurement period

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): Members with either fee-for-service (FFS) claim for behavioral health service (90791, 90832, 90834, 90837, 90846, 90847) or any encounter using the Capitated Behavioral Health Benefit.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level

Describe in detail the methods used to select the sample: Sample was not used in this PIP.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) must track performance or improvement over time. The indicator(s) must be objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research.

The description of the Indicator(s) must:

- Include the complete title of each indicator.
- Include the rationale for selecting the indicator(s).
- Include a narrative description of each numerator and denominator.
- If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the month, day, and year).
- Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."

Indicator 1	SDoH Screening Among Behavioral Health Utilizers
	This internal indicator was created to capture the criteria indicated by the Colorado Department of Health Care Policy and Financing (HCPF) and HSAG during statewide meetings such as the Performance Improvement Advisory Council (PIAC) and Technical Assistance (TA) call with HSAG.
Numerator Description:	Sum of distinct members from the denominator who received a screening for SDoH including all four domains (food insecurity, housing, utilities, transportation) within the 12-month evaluation period
Denominator Description:	Sum of distinct members who received at least one behavioral health service delivered in a primary care setting within the 12-month evaluation period or under the Capitated Behavioral Health Benefit within the 12-month evaluation period.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	No mandated goal exists for this PIP measure. HCI Goal: 3.18%

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology must include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ] Manual Data	[X] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [X] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)-please attach separately [X] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 98.66 % complete.	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Data Completeness Calculation (Attachment E): Baseline performance was calculated using the monthly claims and encounter data feed available 60 days from the last date of the performance period. Accordingly, data completeness calculation was performed to estimate the average data completeness available at the 60-day point. Ninety day lag is the end point established by HCPF for final performance measure calculations. - Claims processed between January 1, 2023 through December 31, 2023 were included in this sample for calculation as it represented a period that all claims would have been resolved at the time of calculation. - Dental claims were excluded as they were the only claim type not included in value sets associated with PIP performance measures - Denominator: Count of all inclusive claims processed in the timeframe above - Numerator at 90 days: Count of all inclusive claims processed in time frame above that were completed in 90 days following the date of submission - Numerator at 60 days: Count of all inclusive claims processed in time frame above that were completed in 60 days following the date of submission - Numerator was divided by denominator and expressed as a percentage	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Data Elements Collected:

- Member ID
- Date of Service
- IPN Behavioral Health Claim Status
- Behavioral Health Encounter Status
- FFS Service Code
- Care Coordination Cohort
- Care Coordination Intake Status
- Care Coordination Intake Status Date

Data Collection Process:

In order to obtain the data for the performance improvement project Andrea Scott from the Data, Analytics & Reporting (DAR) team followed the steps below. A mixture of submitted claims and encounters were used as the source for data during the 12-month measurement period.

1. Denominator – Determine all distinct members who received at least one behavioral health service delivered in a primary care setting. within the 12-month evaluation period or under the Capitated Behavioral Health Benefit within the 12-month evaluation period. All ACC enrollees as of the last day of the measurement period were evaluated for behavioral health visit within the primary care setting within the measurement period billed a FFS (behavioral health in PC Value Set at Attachment L), a behavioral health encounter billed by a physical health managed care entity, or any behavioral health encounter within the measurement period.
2. Numerator – Determine all members from denominator who received a full care coordination intake documented in Essette (HCI care coordination record) within the past 12 months as the PRAPARE is included in this assessment. The PRAPARE questionnaire is a validated SDoH assessment tool at Attachment M. A crosswalk of questions from the PRAPARE to the full care coordination intake is at Attachment N.
3. Join the denominator with the numerator to calculate the follow up percentage.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
The baseline period for the denominator was determined using methodology similar to the Colorado KPI measure specification for Behavioral Health Engagement for the measurement period July 1, 2022 through June 30, 2023. This captured the "behavioral health utilizers" per HCPF/HSAG tasking. Although some assessment for SDoH occurs throughout the RAE within both physical health and behavioral health settings, the only setting where SDoH screening occurred during the baseline period consistently and with data aggregation is the population receiving care coordination services. The standardized HCI care coordination intake tool begins with the What Matters Index (WMI) as a high-level screening tool to identify potential health services needs.[4] If members screen positive on this tool or the care coordinator believes there will be value in completing the full intake assessment, the full intake tool is completed. A validated SDoH screening tool (PRAPARE) is embedded within the full intake assessment. The PRAPARE tool and a crosswalk of questions from the PRAPARE tool to the HCI care coordination intake is found at Attachments M and N. The distinct count of members from the denominator who had the full HCI care coordination intake completed comprised the numerator for the baseline calculation. The goal established was formulated using a two-tailed normal distribution with a p-value of 0.05 using baseline sample size. During Remeasurement 1, the team decided that the structure of the care coordination intake was a failure mode to address for intervention. Data on completed screenings was calculated from the original intake by using a system flag that indicated that the intake proceeded past the initial section (the WMI). This was relevant because the SDoH screening was included in the latter portion of the intake. The restructuring of the intake to place the SDoH screening questions at the beginning made this "Stopped at WMI" flag irrelevant. As a result, the DAR team developed code to capture screenings performed prior to the intake change continuing to use the "Stopped at WMI" flag, and combine this population with screenings completed after the intake change using completions flags that were now relevant to this intake. This process was discussed with HSAG during a TA call on April 24, 2024.

[4] Wasson JH, Ho L, Soloway L, Moore LG. Validation of the What Matters Index: A brief, patient-reported index that guides care for chronic conditions and can substitute for computer-generated risk models. PLoS One. 2018 Feb 22;13(2):e0192475. doi: 10.1371/journal.pone.0192475. PMID: 29470544; PMCID: PMC5823367

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).

Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: Social Determinants of Health (SDoH) Screening Among Behavioral Health Utilizers

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 to 06/30/2023	Baseline	931	31,955	2.91%	N/A for baseline	N/A for baseline
07/01/2023 to 06/30/2024	Remeasurement 1	1,576	29,604	5.32%	3.18%	Chi Square, two-tailed Statistically significant ($p<0.0001$)

Indicator 2 Title: [Enter title of indicator]

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline				N/A for baseline	N/A for baseline
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 1					
MM/DD/YYYY–MM/DD/YYYY	Remeasurement 2					

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results must include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Baseline Narrative: Behavioral health utilizers were identified as the target population for SDoH screening. Behavioral health utilizers were defined as HCI members who had a behavioral health FFS claim (90791, 90832, 90834, 90837, 90846, 90847) or any Capitated Behavioral Health Benefit encounter. A total of 31,955 HCI members utilized behavioral health services during the baseline period (July 1, 2022 – June 30, 2023). During the baseline period, 931 members in the behavioral health utilizer cohort were screened for SDoH needs as part of the full care coordination intake questionnaire for members receiving care coordination services. This resulted in a screening rate of 2.91% for the baseline period. Upon review of the process for data collection, the only threat to validity of the baseline data was the potential for members to have declined to respond to individual questions on the PRAPARE tool (e.g., unwilling to share issues with housing insecurity). HCI is working with our data team to be able to itemize and analyze individual question responses to determine whether this represents a significant factor.

Baseline to Remeasurement 1 Narrative: Remeasurement 1 data was collected in accordance with the hybrid data collection model developed to accommodate the change to the care coordination intake that occurred with the second intervention tested. The total population included 29,604 eligible members who utilized a behavioral health service in the past 12 months. Of this population, 1,576 were screened for SDoH per the methods previously described, resulting in a completion rate of 5.32%.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

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- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

Data Analysis: Data analysis was performed comparing the baseline period with Remeasurement Period 1. A chi-square, two-tailed analysis was performed. The analysis produced a p=0.0000. This result was statistically significant, though there are potential threats to validity described below.

Variations & Potential Threats to Validity: Starting in May of 2023 through April of 2024, Colorado resumed normal eligibility renewal processes, including termination of continuous eligibility/Public Health Emergency (PHE) unwind. As a result of this process, the number of eligible members began to significantly decline during this period. Total HCI enrollment fell from a peak nearing 160,000 in April of 2023 to nearly 110,000 in June of 2024. It is unclear whether there are demographic or comorbidity variations between these populations, though the behavioral health utilizers did drop by more than 2,000 members between baseline and Remeasurement 1. As a result of this notable decrease in denominator, the screening rate and p-value may be exaggerated.

The major threat to the validity is the absence of a full calendar year of Essette data for all members starting on July 1, 2022. The baseline period covered July 1, 2023 through June 30, 2023. Although some care coordination entities were documenting activities in Essette in July 2022, it was not mandated for all entities until November 1, 2022. The data from Remeasurement Year 1 showed a large increase in screenings (i.e.,

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

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- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

intakes) in July that was coincidental with both the start of the PIP intervention and the initiation of a productivity target for all care coordination entities. It is also possible that pressure to ensure compliance with the extended care coordination incentive measure prompted aggressive outreach efforts in July 2023 as the new FY started. A similar surge in outreaches/engagements may have occurred in July 2022 for the same rationale. This would potentially cause a significant number of screenings to have been missed from the baseline calculation if performed by a care coordination entity that had not fully adopted Essette in July. This could have exaggerated the statistical significance of the Remeasurement 1 rate; however, data is not available to substantiate that.

Another potential threat to validity is the hybrid data collection model described above. The shift in the reliance on the "Stopped at WMI" flag to using the "Completed Intake" flag that was selected in consultation with the DAR team could have incorrectly identified member screenings. In response to this potential threat, the HCI PIP team conducted a purposive sampling of members with multiple screenings both before and after the intake intervention date to validate the data. The results were consistent with the intention of the measure. Another potential threat to

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

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- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results must be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing must be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether factors that could threaten (a) the validity of the findings for each measurement period, including the baseline, and (b) the comparability of each remeasurement period to the baseline was identified. If there were no factors identified, this must be documented in Step 7.

the validity of the comparison between baseline and Remeasurement 1 is related to the change in Health First Colorado enrollments during this period.

Baseline to Remeasurement 2 Narrative: N/A

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

The documentation of Step 8 is organized into the following three sections:

A. Quality Improvement (QI) Team and Activities Narrative Description
B. Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

- **Quality Improvement (QI) Team and Activities Narrative Description**

QI Team Members:
Edward Arnold - Clinical Quality Audit Analyst, Sr
Michaela Smyth - Clinical Quality Audit Analyst, Sr
John Mahalik/Jeremy White - Director, Quality Management
Kaylanne Chandler/Matt Wilkins - Director of Care Management Operations
Christine Anderson - Health Promotion Manager
Brian Hill - Medical Director
Michael Clark - Data Analytics and Reporting
Andrea Scott - Data Analytics and Reporting
Melissa Schuchmann - Business Information Analyst II

QI process and/or tools used to identify and prioritize barriers:
During the early years of HCI's contract for RAE 4, the delegated care coordination model was implemented such that local entities that were most informed and connected with both their local population and the resources available in those areas would coordinate care for those members.

While there were standards and policies for the delivery of these services, documentation of care coordination was maintained in individual documentation systems unique to each entity.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

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   - Intervention Status

Prior to the migration of care coordination documentation to the Essette platform, each care coordination entity collected their own data on outreach and engagement of members to HCI for eventual aggregation and reporting to the State. This provided each entity with potential visibility for their own level of effort and performance regarding these activities. The basic workflow for collection and reporting of this data to HCI is included in Attachment O (CC Reporting Prior to Essette). Following the migration to the Essette platform for the documentation of all care coordination activities, HCI now had detailed and aggregated data on outreach attempts and performance. However, care coordination entities no longer had easy access to their individual outreach volume and performance as they no longer calculated and reported their own data (see Attachment P - CC Reporting After Implementation of Essette). These factors, along with the process map created for SDoH Screening (Attachment Q), allowed the team to prioritize the failure modes that were identified (Attachment R).

HCI leadership's review of the data from Essette revealed a broad range of the volume of member outreaches/engagements across the various care coordination entities. HCI leadership hypothesized that more outreach attempts would result in more successful member engagements. As a result, HCI established outreach and productivity targets for each care coordination entity effective July 1, 2023. These were intended to establish uniform standards in documentation and raise the expectations to engage our members. This plan would also include monthly feedback with each care coordination entity with data pulled from Essette, providing the opportunity to discuss potential barriers to performance (Attachment S - CC Entity Scorecard).

The increases in SDoH Screening among behavioral health utilizers from July through October of 2023 were impressive. However, the gains plateaued by December of 2023, which led the PIP team to reexamine the process map and failure modes & effects analysis (FMEA) for potential

Step 8: Improvement Strategies. Interventions are developed to target and address causes/barriers identified through the use of quality improvement (QI) processes and tools.

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   - Intervention Status

adaptations and/or to potentially consider new interventions. The team decided to adopt the Performance Feedback intervention and consider interventions to target other failure modes.

The team was struck by the missed opportunities to screen members when the intake questionnaire was stopped before reaching the SDoH screening questions. Stopping the intake at this point could be appropriate based on responses from the member on the initial portion (e.g., very low WMI score, member declines to proceed). This was identified as a failure mode during the initial PIP team's work; however, the team was drawn to the data reported by care coordination leadership that approximately half of all completed intakes were being stopped prior to the latter portion of the intake where the SDoH screening questions were included. The team updated the Key Driver Diagram (Attachment T) and agreed that mitigating the impact of these abbreviated intakes on SDoH screening rates would require a restructuring of the care coordination intake. This allowed the care coordination leadership to reexamine the intake as a whole. They had built a robust platform for care coordination care planning by this time with care coordinator tasks, member-centric goal setting, and condition-specific management programming triggered by intake responses. They decided that the SDoH screening questions were most relevant to many of the initiatives available to care coordinators and were a priority to include in all intakes. They also deleted some questions from the intake that were not associated with care plan tasks or goal setting. This was the rationale for the second intervention (Revise CC Intake) that moved the SDoH screening questions into the initial section of the intake (Attachment U- CC Intake: Current & Future State).

The intervention and testing of this second intervention is described in CO2023-24_Intervention Worksheet_SDoH_Revise_CC_Intake_0624 and is ongoing. The final Key Driver Diagram as of June 30, 2024 is found at Attachment V.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

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   - Intervention Status

- **Barriers/Interventions Table:** In the table below, list interventions currently being evaluated, and barrier(s) addressed by each intervention. For each intervention, complete a Step 8 Intervention Worksheet. The worksheet must be completed to the point of intervention progression at the time of the annual PIP submission.

Intervention Title	Barrier(s) Addressed
Productivity Targets & Feedback	- No explicit productivity threshold - No data on productivity
Revised Care Coordination Intake	- Member does not understand potential benefit of care coordination service - Care coordinator does not understand potential benefit of additional care coordination intake - Care coordinator does not effectively communicate potential benefit of additional care coordination intake

- **Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results**

See the following intervention worksheets:

- CO2023-24_Intervention Worksheet_ SDoH_PerformanceFeedback_0624_Resubmission
- CO2023-24_Intervention Worksheet_SDoH_Revise_CC_Intake_0624

Appendix A1. Intervention Worksheets

Appendix A1 contains the completed Intervention Worksheets that HCI R4 provided for validation. HSAG made only minor grammatical corrections to these forms and did not alter the content/meaning.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc. (RAE 4)
PIP Title	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*
Intervention Title	Behavioral Health Referral Workflow - Mobile Early Intervention Services (MEIS)

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Behavioral Health Referral Workflow - Mobile Early Intervention Services (MEIS)		
What barrier(s) are addressed?	Absence of data visibility on outreach volume Competing priorities for care coordination workload		
Describe how the intervention is culturally and linguistically appropriate.	All staff receive cultural awareness training as a part of orientation processing. Linguistic support services are available to staff in the ED where the care coordinator will be working, as needed.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Confirm capability for MEIS referral transmissions (email, fax) from Parkview ED		
	2. Train Parkview Behavioral Health ED staff on new workflow		
	3. Create Health Solutions referral workflow to route to appropriate intake staff		
	4. Train Health Solutions referral intake staff on new workflow		
Intervention Start Date (MM/DD/YYYY)	07/12/2023	**Intervention End Date (MM/DD/YYYY)**	01/31/2024

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	Follow-Up After Emergency Department Visit for Substance Use (FUA)		
Numerator description (narrative)	The number of members aged 13 and older with a qualifying follow-up visit within seven days of an ED visit from Parkview Medical Center ED with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, (eight total days).		
Denominator description (narrative)	The number of members aged 13 and older with an ED visit that includes a principal diagnosis of SUD or any diagnosis of drug overdose who were discharged from Parkview Medical Center ED.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
07/01/2022 - 06/30/2023	169	499	33.87%
08/01/2022 - 07/31/2023	185	532	34.77%
09/01/2022 - 08/31/2023	177	570	31.05%
10/01/2022 - 09/30/2023	179	576	31.08%
11/01/2022 - 10/31/2023	164	529	31.00%
12/01/2022 - 11/30/2023	170	539	31.54%
01/01/2023 - 12/31/2023	166	535	31.03%
02/01/2023 - 01/31/2024	174	530	32.83%

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure			
3/01/2023 - 2/29/2024	179	523	34.23%
If qualitative data were collected, provide a narrative summary of results below.			
Qualitative data was not collected.			

***Appendix A1-1*: State of Colorado PIP Intervention Worksheet**
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
HCI learned that the MEIS referral workflow intervention was not associated with any change (increase or decrease) in the performance on the PIP Intervention Effectiveness Measure. This intervention was created based on the process map as of June 30, 2023 (Attachment F), the associated Key Driver diagram (Attachment G), and the Failure Modes & Effects Analysis (FMEA)/Prioritization Matrix (Attachment H). The period of intervention testing also allowed the team to collect additional insights on the priorities for the identified failure modes and afforded increased options once the organizational merger was finalized.
What challenges were encountered?
The major challenge encountered during the initial intervention testing period pertained to the limitations on the team's ability to make more significant changes to workflows due to the announcement of a pending merger of Parkview Medical Center with the UCHealth system. This announcement was received in late May of 2023 with the merger eventually occurring on September 1, 2023. During this interim period, staff priorities at Parkview focused on transition planning and operations. This delayed considerations for other potential interventions identified during earlier process mapping and FMEA work. With the merger pending as of July 1, 2023, but not finalized until September 1, 2023, the contract for use of the PIECES system that was previously used for referrals from Parkview ED to Health Solutions could not be renewed and the service was no longer available. Another challenge identified was the result of feedback received from a new member of the team who served as both a physician within the Parkview ED and the Medical Director for Pueblo County Department of Human Services (PCDHS). He stressed that the volume of members likely qualifying for the denominator of this measure who do not receive a behavioral health referral is more significant than may have been originally described.
How were the challenges resolved?
Due to the restricted list of available options to test interventions and the need to continue to connect patients to Health Solutions for clinical needs, a workflow had to be determined that did not involve the use of the PIECES application. The team researched a resource that was used in the UCHealth system (FindHelp.org) as a potential workflow. It was determined that this was more of a resource list rather than a referral pathway and did not meet the clinical need. The team agreed that the use of the MEIS pathway was the best

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
workflow as it did not require use of encrypted email and because it was a workflow that had been used in the past by many current ED behavioral health team members. Regarding the potential increased significance of members who are not seen by behavioral health, the team updated the FMEA and Prioritization Matrix.
What successes were demonstrated through the intervention testing?
A success of this intervention was the adaptability and engagement shown by the staff on the ED behavioral health team and the Health Solutions intake team. The change in workflow was determined with less advance planning than would be typical; however, staff were trained on the new workflow and adopted the change without significant disruption.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Status
Select one intervention status: ☒ Adopt ☐ Adapt ☐ Abandon ☐ Continue
Rationale for Intervention Status Selected
Performance appeared to have maintained baseline levels on the Intervention Effectiveness Measure without increase or decrease. Without another established workflow for this clinical need, it was determined that the intervention was as effective as the previous workflow. Barring an alternative, it was decided that the new workflow should be adopted.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc. (RAE 4)
PIP Title	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*
Intervention Title	Embedded Care Coordinator (CC)

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Embedded Care Coordinator (CC)		
What barrier(s) are addressed?	Absence of data visibility on outreach volume Competing priorities for care coordination workload		
Describe how the intervention is culturally and linguistically appropriate.	All staff receive cultural awareness training as a part of orientation processing. Linguistic support services are available to staff in the ED where CC will be working, as needed.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Finalize Memorandum of Understanding (MOU) between Health Solutions and Parkview/UCHealth		
	2. Develop workflows for referrals from ED to embedded CC in coordination with physician ED leadership		
	3. Develop documentation standards for embedded CC in Essette to allow data collection on engagements		
	4. Orient embedded CC to ED/In-process for electronic health record (EHR) access		
	5. Train Parkview Behavioral Health ED staff on new workflow a. Email explanation to include program intention and referral mechanism b. In-person introductions to staff		
	6. Schedule embedded CC to attend daily morning report to foster engagement with staff		
Intervention Start Date (MM/DD/YYYY)	03/07/2024	**Intervention End Date (MM/DD/YYYY)**	

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	Embedded Care Coordinator Effectiveness on Follow-Up After Emergency Department Visit for Substance Use		
Numerator description (narrative)	Number of members aged 13 and older with a qualifying follow-up visit within seven days of an ED visit from Parkview Medical Center with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose (eight total days), or any diagnosis of drug overdose per core measure: FUA specifications, but without exclusion of multiple visits within 30 days of each other who also had a face-to-face encounter with the embedded CC on the day of discharge or one day prior to discharge.		
Denominator description (narrative)	Number of members aged 13 and older with an ED visit from Parkview Medical Center that includes a principal diagnosis of SUD, or any diagnosis of drug overdose per core measure: FUA specifications, but without exclusion of multiple visits within 30 days of each other, who also had a face-to-face encounter with the embedded CC on the day of discharge or one day prior to discharge.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
03/01/2024 - 03/31/2024	1	1	100%
04/01/2024 - 04/30/2024	1	1	100%
05/01/2024 - 05/31/2024	2	3	66.66%
06/01/2024 - 06/30/2024	2	3	66.66%
If qualitative data were collected, provide a narrative summary of results below.			
Qualitative data was not collected.			

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
Thus far in the process of this intervention, HCI learned that the placement of an embedded CC on site at Parkview Medical Center ED is a slow intervention to take root for evaluation. Creating workflows to facilitate engagement of the embedded CC with members in the ED was challenging, as this is an atypical service line and not utilized in other facilities within the UCHealth system. This necessitated the creation of less formal notifications to be utilized (i.e. instant messaging) which may cause a longer period for staff to adopt. The low volume of engagements is going to take longer than expected to reach the volume to potentially assess the validity of this intervention. Another lesson learned is the importance of distinguishing the Intervention Effectiveness Measure created here from the actual PIP measure. Due to the 30-day exclusion for multiple member discharges in the PIP measure, it is necessary to capture all discharges to appropriately match the intervention to any potential follow-up. This allows HCI to evaluate the impact of this intervention; however, the eventual impact on the PIP measure could be blunted.
What challenges were encountered?
The major challenge encountered in the early months of intervention testing for the embedded CC intervention was obtaining referrals for members to connect with the CC. After orientation to the ED, introducing the CC to the teams, and providing instructional handouts on workflows, the number of members referred to the CC remained extremely low (i.e., less than three per month). The team met with physician leadership in the ED to identify potential barriers and solicit suggestions for revising the referral workflow to make it less cumbersome. Another challenge was identifying that the original data methodology for the Intervention Effectiveness Measure would need to be modified slightly to appropriately identify ED visits during which the embedded CC intervention was delivered. This was identified when the dates of the face-to-face encounter between the CC and the member in the ED matched with ED discharges from dates greater than a week from the face-to-face encounter. A final challenge encountered during this evaluation period was a workforce challenge for nursing staff that resulted in the use of temporary staff typically assigned at other facilities. Although not specifically identified within our process map, the nursing staff are an integral part of the team to support the physician/provider in delivering all available elements of patient-centered care. The embedded CC shared that nursing staff often prompt the physicians to initiate referrals for members who may benefit from this CC

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
service. However, with nursing staff who are new or only temporarily working at Parkview Medical Center, the role of the embedded CC and how to engage this support may not be accessed as readily. An emerging challenge that the group is going to consider is whether the working hours of the embedded CC are most appropriately matched to the days/times that the members who qualify for this measure are accessing the ED.
How were the challenges resolved?
The major challenge of low referral volume was addressed by meeting with physician leadership within the ED to incorporate recommendations to streamline the referral workflow as much as possible. Since this service is only currently provided at Parkview Medical Center and the corporate structure (UCHealth) was resistant to creating site-specific referral types within the EHR at this time, alternative pathways such as secure instant messaging were utilized. Training materials were created to illustrate step-by-step instructions (Attachment K). In addition to streamlining workflows, the embedded CC adapted her schedule to attend daily report to maximize her visibility as a member of the care team and be present to promote the service she provides and methods to initiate this service. The challenge of generating appropriate data to measure the impact of this intervention was addressed through the active partnership with the Data, Analytics & Reporting (DAR) team at HCI. Although the documentation standards for the CC's use of Essette were established, the team identified that the code used to calculate the measure performance included the exclusion criteria that only one ED discharge per member can qualify within a 30-day period in accordance with the core measure specification. As a result, if a member had more than one discharge within that 30-day period, it was possible that the discharge showing in our performance measure data set was not the same discharge as the day the embedded CC had a face-to-face encounter. The team decided to remove this exclusion criteria and include all discharges for potential matching to face-to-face encounters. The team was aware to use caution when comparing performance on this intervention effectiveness measure with that of the standard measure using the core measure specification. The team will also evaluate whether there are additional intervention effectiveness measures to consider due to the significantly low denominators. The final challenge caused by workforce transitions of nursing staff was address by maintaining a dialogue with the nursing leadership in the ED to promote awareness of this program as well as continuing to attend daily report with staff to promote team cohesion and address any knowledge deficits regarding the program.
What successes were demonstrated through the intervention testing?

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
Although referral volume remains low and actual face-to-face engagements with members are lower, the early data suggests a high rate of qualifying follow-up encounters for the members who worked with the embedded CC prior to discharge. Anecdotal feedback from the team at Parkview also reveals that the CC has been well received as a member of the team.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon ☒ Continue
Rationale for Intervention Status Selected
Due to the extremely low qualifying denominators, it is premature to draw any conclusions on the potential effectiveness of this intervention at this time as this population may not be fully representative of the measure's population utilizing the core measure specifications. Efforts to increase referral volumes must continue and the team should also begin to consider potential additional methods to assess the impact of this intervention.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc. (RAE 4)
PIP Title	*Social Determinants of Health (SDOH) Screening*
Intervention Title	Performance Expectations and Feedback

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Performance Expectations and Feedback		
What barrier(s) are addressed?	No explicit productivity threshold No data on productivity		
Describe how the intervention is culturally and linguistically appropriate.	The intervention focuses on interaction with leadership within HCI delegated care coordination entities. This relationship is contractually established without obvious cultural or linguistic factors.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Create dashboards to display care coordination activity completion (Attachment S)		
	2. Update contract to include productivity expectations		
	3. Update Care Coordination Policy to include productivity expectations (Attachment W; Note highlighted sections on pages 15-16)		
	4. Schedule periodic meetings with individual care management entities to present data		
	5. Meet with care coordination entities to provide data/feedback on outreach efforts/ engagements and address identified barriers to outreach/engagement		
Intervention Start Date (MM/DD/YYYY)	07/01/2023	**Intervention End Date (MM/DD/YYYY)**	03/31/2024

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #1			
Intervention Effectiveness Measure Title	Total Outreach Attempts		
Description (narrative)	Sum of outreach attempts to members in the Complex or Care Navigation care coordination risk cohorts within a calendar month (i.e., Phone- Outbound, Text message, Automated Outreach, Email- Sent, Face-to-Face, Mail)		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Total Outreaches**		
07/01/2023-07/31/2023	13,227		
08/01/2023-08/31/2023	17,379		
9/01/2023-09/30/2023	19,956		
10/01/2023-10/31/2023	19,403		
11/01/2023-11/30/2023	19,104		
12/01/2023-12/31/2023	18,480		
01/01/2023-01/31/2024	18,517		
02/01/2023-2/29/2024	18,238		
03/01/2023-3/31/2024	18,448		
If qualitative data were collected, provide a narrative summary of results below.			

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #1
During the monthly meetings with care coordination entities in July, August, and September, there were questions about the validity of the data on outreaches attempted. This qualitative feedback prompted the DAR team to analyze and revise the code the generate the data originally presented. The result of the corrected code is displayed in this deliverable.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #2			
Intervention Effectiveness Measure Title	Outreaches per Care Coordination Member		
Numerator description (narrative)	Sum of outreach attempts to members in the Complex or Care Navigation care coordination risk cohorts within a calendar month (i.e., Phone- Outbound, Text message, Automated Outreach, Email- Sent, Face-to-Face, Mail)		
Denominator description (narrative)	Count of distinct members in the Complex or Care Navigation care coordination risk cohorts during that calendar month		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Outreaches per Member Ratio**
07/01/2023-07/31/2023	4,645	13,227	2.8
08/01/2023-08/31/2023	4,982	17,379	3.5
9/01/2023-09/30/2023	6,408	19,956	3.1
10/01/2023-10/31/2023	5,731	19,403	3.4
11/01/2023-11/30/2023	5,311	19,104	3.6
12/01/2023-12/31/2023	5,035	18,480	3.7
01/01/2023-01/31/2024	5,645	18,517	3.3
02/01/2023-2/29/2024	5,152	18,238	3.5
03/01/2023-3/31/2024	5,072	18,448	3.6

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #2
If qualitative data were collected, provide a narrative summary of results below.
During the monthly meetings with care coordination entities in July, August, and September, there were questions about the validity of the data on outreaches attempted. This qualitative feedback prompted the DAR team to analyze and revise the code that generates the data originally presented. The result of the corrected code is displayed in this deliverable.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #3			
Intervention Effectiveness Measure Title	Social Determinants of Health (SDoH) Screening Among Behavioral Health Utilizers		
Numerator description (narrative)	Sum of distinct members from the denominator who received a screening for Social Determinants of Health (SDoH) including all four (4) domains: Food insecurity, Housing, Utilities, Transportation within the 12-month evaluation period		
Denominator description (narrative)	Sum of distinct members who received at least one behavioral health service delivered in a primary care setting or under the Capitated Behavioral Health Benefit within the 12-month evaluation period.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
08/01/2022-07/31/2023	1,498	32,293	4.64%
09/01/2022-08/31/2023	1,577	32,407	4.87%
10/01/2022-09/30/2023	1,695	32,538	5.21%
11/01/2022-10/31/2023	1,754	32,664	5.37%
12/01/2022-11/30/2023	1,763	32,502	5.42%
01/01/2023-12/31/2023	1,702	32,369	5.26%
02/01/2023-01/31/2024	1,627	32,442	5.02%
03/01/2023-2/29/2024	1,577	32.334	4.88%

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure #3			
04/01/2023-3/31/2024	1,532	31,729	4.83%
If qualitative data were collected, provide a narrative summary of results below.			
Qualitative data was not used.			

***Appendix A1-3*: State of Colorado PIP Intervention Worksheet**
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
This intervention produced an exceptional impact on the rate of SDoH screening among behavioral health utilizers. The intervention was fortunate to align with a larger initiative within HCI and the contracted care coordination entities. As described in the Remeasurement 1 Narrative, HCI's decision to create productivity targets with clearly aligned incentives and accountability to start in July of 2023 had a large impact on the PIP outcome. Monthly meetings were scheduled for each of the five (5) delegated care coordination entities starting in July. Attendance at the meetings by key leadership personnel was good and the meetings were well-received. As described in the qualitative section above for Intervention Effectiveness Measures #1 & #2, the organizations were engaged and interested in analyzing the data provided. This exploration led to the edits to the code used to calculate outreach volume and ratios. SDoH screening only occurs as part of the Care Coordination Intake performed when a care coordinator is able to engage with a member. Actually, engaging with a member can often require multiple outreach attempts before being successful and SDoH screening can only occur if the care coordinator is able to engage with the member. As many outreaches did not result in member engagement, HCI leadership hypothesized that more outreach attempts would result in more successful member engagements. The intervention sought to address the failure modes of both HCI not sharing productivity data with the care coordination entities, as well as not having productivity targets for those entities. An initial intervention effectiveness measure related to the number of outreach attempts was selected as it was deemed to capture the efforts to contact our members. All methods of outreach (e.g., phone, text, email) were included as our members may choose to communicate through various means. It was also determined to be most appropriate to measure this in monthly intervals rather than a rolling 12-month period to maintain the focus on outreaches in the period the intervention was initiated rather than dilute changes over a 12-month period. The first intervention effectiveness measure was the absolute count of outreach attempts. This was hypothesized to be an indicator of increased outreach efforts. A second intervention effectiveness measure was developed as it was noted that the number of members in the primary care coordination cohorts (i.e., Complex, Care Navigation) could vary by greater than 15% in the early months of the FY. This measure would be the ratio of outreach attempts per member in these primary care coordination cohorts. The PIP team felt this was appropriate as the increasing number of members requiring outreach could potentially explain a significant increase in outreach attempts without necessarily greater efforts to contact each member. The increase in both the absolute count of outreach efforts and the per member outreach ratio that then plateaued

***Appendix A1-3*: State of Colorado PIP Intervention Worksheet**
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
in January through March at approximately 18,500 per month and 3.5 outreaches per member suggests that the intervention produced the desired impact on prompting more member outreach by the care coordination entities throughout the RAE. The third intervention effectiveness measure was the actual PIP outcome measure. Although the initial intervention effectiveness measures would reveal increased efforts to engage with members, it could only be hypothesized to result in increased member engagement and potentially in SDoH screenings of BH utilizers. This third intervention effectiveness measure that mirrored the PIP outcome measure increased along with the other two intervention outcome measures. The increases in all intervention effectiveness measures suggests that the Performance and Expectations Feedback intervention was effective. HCI learned of an additional factor that positively impacted our results, although it was not anticipated. The efforts of the care coordination entities to engage members are largely driven by the performance expectations for the Performance Pool Incentive Measure on Extended Care Coordination. The measure specifications for this are extremely detailed, including the documentation of quarterly outreach/engagement for members and documentation standards for members who do not want to participate with care coordination (i.e. "opt out"). A by product of the reporting period starting in July 2023 is that documentation standards start anew without regard to past engagements. Care coordination entities were informed that they needed to ensure adequate outreach/engagement for all their complex members within the first quarter. This guidance even included members who had recently opted out of services because failing to meet the standard within the first quarter of the fiscal year would prevent that member from ever meeting the measure within the fiscal year. As a result of this explicit guidance and potential significant amount of incentive dollars at risk for failure to initiate and document these outreach/engagements, the response of all entities to outreach members immediately at the start of the FY may also explain the increases in engagements and SDoH screenings among BH utilizers. It is possible that this same response occurred in July of 2022; however, although some care coordination entities were using Essette in July of 2022, Essette documentation was not fully mandated until November of 2022. This initial push to engage members in July of 2023 was tempered in subsequent months, although it appears that the productivity targets and feedback produced a positive trend in screening members through the end of the second quarter of the fiscal year (December 2023).
What challenges were encountered?

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Performance Improvement Projects

Intervention Evaluation Results
An early challenge was the methodology for reporting the outreach efforts. The team initially sought to use the total of outreach attempts as an intervention effectiveness measure as it was the real target of the contractual performance expectations. However, after providing these data in the first couple of months of meetings with the care coordination entities, there were questions raised regarding the accuracy of this data. As the DAR team reviewed the methodologies and reporting, the PIP team began to receive the actual data on SDoH screenings among BH utilizers as the claim lag had passed. This data was promising and the team continued to follow that as the outreach data issue was resolved. The DAR team identified among other irregularities, that members were being counted more than once in early reporting. The data presented above is retrospective recalculation of the outreach ratio. Another challenge experienced was the delay in calculating the intervention effectiveness measure caused by relying on claims data for the behavioral health utilizer population ("claim lag"). The Outreach Total and Outreaches per Member data was available sooner as it did not rely on claims lag to calculate it, but the issues with that early data was described above, The team felt it was important to be certain we were measuring screenings among the target population. This was a reasonable decision, as there is limited data with this relatively new metric. Yet another challenge is the potential threat to the validity caused by the delayed full mandate for Essette documentation until November of 2022. The baseline period covered July 1, 2023 through June 30, 2023. Although some care coordination entities were documenting activities in Essette in July 2022, it was not mandated for all entities until November 1, 2022. The data from Remeasurement Year 1 showed a large increase in screenings (i.e., intakes) in July that was coincidental with both the start of the PIP intervention and the initiation of a productivity target for all care coordination entities. It is also possible that pressure to ensure compliance with the Extended Care Coordination incentive measure prompted aggressive outreach efforts in July 2023 as the new FY started. It is possible that a similar surge in outreaches/engagements occurred in July 2022 for the same rationale. This would potentially cause a significant number of screenings to have been missed from the baseline calculation if performed by a care coordination entity that had not fully adopted Essette in July. This could have exaggerated the statistical significance of Remeasurement 1 rate; however, data is not available to substantiate that. A final challenge experienced was the missed opportunity to screen members when the intake questionnaire was stopped before reaching the SDoH screening questions. Stopping the intake at this point could be appropriate based on responses from the member on the initial portion (e.g., very low WMI score, member declines to proceed). This was identified as a failure mode during the initial PIP team's work (Attachment R). However, when the initial significant improvements in screening rates began to plateau in December

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
of 2023, the team was drawn to the data reported by Care Coordination leadership that approximately half of all completed intakes were being stopped prior to the latter portion of the intake where the SDoH screening questions were included.
How were the challenges resolved?
The challenge related to dealing with claim lag on our intervention effectiveness measure was simply accepted at this time. It is too early to know if the population of behavioral health utilizers receiving care coordination services engages differently than the overall care coordination population. As a result, upon observing increases in the outreach rates, we monitored for the correlation of this with the third intervention effectiveness measure before choosing to adopt the intervention. Regarding the challenge of a potential surge in care coordination engagements that might have occurred in July 2022 but were not captured in baseline calculations, HCI will continue to monitor these efforts at the start of the next FY (July of 2024) to see if there is an annual periodicity to this measure due to the constraints of the Extended Care Coordination measure. (Although not available at the time of original PIP submission, the data for July 2024 was able to be reviewed prior to resubmission. There was a similar step-wise increase in the SDoH screening rate from June 2024 to July 2024. More detailed comparisons are difficult as the number of Complex & Care Navigation members decreased for the June/July 2023 period versus a significant increase for the June/July 2024 period and the second PIP intervention was actively in place during the June/July 2024 period. It is possible that the methodology for the Extended Care Coordination metric may be an independent factor to explain some of this increase.) Regarding the challenge of the missed SDoH screening opportunities for intakes stopped at the WMI, the team explored the original rationale for the construction of the care coordination intake and discussed options for an intervention to impact this gap. The team agreed that mitigating the impact of these abbreviated intakes on SDoH screening rates would require a restructuring of the care coordination intake. This allowed the care coordination leadership to reexamine the intake as a whole. They had built a robust platform for care coordination care planning by this time with care coordinator tasks, member-centric goal setting, and condition-specific management programming triggered off of intake responses. They decided that the SDoH screening questions were most relevant to many of the initiatives available to the care coordinators and were a priority to include in all intakes. They also deleted some questions from the intake that were not associated with care plan tasks or goal setting. This was the rationale for the second intervention (Revised CC Intake) that moved the SDoH screening questions into the initial section of the intake (Attachment T- CC Intake: Current & Future State).

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
What successes were demonstrated through the intervention testing?
This intervention demonstrated exceptional success. The team concluded that the success was most likely related to the operational elements initiated at the start of the FY. The specific feedback sessions and productivity data may have been helpful in sustaining gains, but the timing may not completely justify the initial gain. HCI's expectations for increased accountability across care coordination entities was explicitly communicated prior to the start of the FY along with training/support available if concerns were expressed. The potential to share in financial incentives associated with achieving the Performance Pool target, explicit guidance on the importance of early outreach/engagement of members, and the potential risk for Corrective Action Plans (CAPs) for failure to maintain targets are believed to be responsible for this success.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Status
Select one intervention status: ☒ Adopt ☐ Adapt ☐ Abandon ☐ Continue
Rationale for Intervention Status Selected
The intervention appears to have addressed the targeted failure mode by increasing outreach efforts and also produced an increase in SDoH screening rate among behavioral health utilizers that was exceptional. The rationale for the intervention is solid, care coordination entities shared positive feedback from these reports/sessions, and more HCI members are being engaged with supportive care coordination services. Although it is possible that other influences were coincidental with the timing of the start of this intervention and potential threats to data validity, HCI will continue to provide these feedback sessions while considering additional interventions to target the SDoH screening rate.

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Managed Care Organization (MCO) Information	
MCO Name	Health Colorado, Inc. (RAE 4)
PIP Title	*Social Determinants of Health (SDOH) Screening*
Intervention Title	Revised Care Coordination Intake

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Instructions: Complete a separate worksheet for each intervention.

Intervention Description			
Intervention Title	Revised Care Coordination Intake		
What barrier(s) are addressed?	Needs not identified by What Matters Index (WMI) SDoH screening questions are not required fields		
Describe how the intervention is culturally and linguistically appropriate.	All questions still included in the intake were included in the previous intake, just in a different order. The previous intake was culturally and linguistically appropriate.		
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Review all intake questions for potential associated care coordination interventions		
	2. Generate new intake sequence where SDoH screening questions are in the initial portion of intake and explicitly "required." Also include only questions associated with care coordination tasks/interventions.		
	3. Reprogram intake		
	4. Provide training to care coordination entities on new intake		
	5. Review potential threats to data integrity and schedule Technical Assistance (TA) call with HSAG as appropriate		
Intervention Start Date (MM/DD/YYYY)	03/18/2024	**Intervention End Date (MM/DD/YYYY)**	

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	Social Determinants of Health (SDoH) Screening Among Behavioral Health Utilizers		
Numerator description (narrative)	Sum of distinct members from the denominator who received a screening for Social Determinants of Health (SDoH) including all four domains: food insecurity, housing, utilities, transportation within the 12-month evaluation period		
Denominator description (narrative)	Sum of distinct members who received at least one behavioral health service delivered in a primary care setting or under the Capitated Behavioral Health Benefit within the 12-month evaluation period.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
03/01/2023-02/29/2024	1,577	32.334	4.88%
04/01/2023-03/31/2024	1,532	31,729	4.83%
05/01/2023-04/30/2024	1,563	31,204	5.01%
06/01/2023-05/31/2024	1,574	30,358	5.18%
07/01/2023-06/30/2024	1,576	29,604	5.32%
If qualitative data were collected, provide a narrative summary of results below.			
Qualitative data was not used.			

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
HCI learned that the care coordinators were amenable to the change in the intake as they did not receive any notable negative feedback. Any negative impressions may have been mitigated by the justifications provided during meetings with the care coordination managers at each entity. HCI learned that the response to this intervention appears to be trending in a positive direction, but at a very slow rate. The team assumed that the increases in SDoH screenings would be immediately significant as all intakes initiated would now include the SDoH screening. However, when this was not seen in the data, a detailed analysis was performed. This detailed review of member-level data revealed an unexpected explanation. In April of 2024, all members who had an intake performed qualified for the numerator, yet there were members still qualifying for the denominator who had had a full intake (with SDoH screening) in April 2023 that was no longer in the reporting period. These members had also had an abbreviated intake (without SDoH screening) within the reporting period. Review of several of these individual cases revealed that these intakes were abbreviated because either the care coordinator or the member did not see value in performing the full intake again as it had already been completed recently.
What challenges were encountered?
An initial challenge encountered when developing and implementing this intervention was the result of the non-standard specifications for SDoH screening. The initial intervention testing leveraged the care coordination documentation system (Essette), but as described in the Step 6: Data Collection Process section of the 2024 PIP submission form, significant changes were required to the care coordination intake, and these would impact reporting. Another challenge was then related to timely support from the Data, Analytics, & Reporting (DAR) team. At the time of the implementation of this intervention, the DAR team experienced two significant, unanticipated manpower losses. As a result, the leadership was forced to prioritize reporting tasks and leverage various team members with operational knowledge in certain platforms. While the implementation of the intervention was fairly quick, this significantly delayed the availability of reporting on the intervention effectiveness beyond the end of the SFY.
How were the challenges resolved?
The initial challenge was overcome by the TA call with HSAG. This engaged dialogue acknowledged that standardized measure specifications may not exist yet for SDoH screening and the plan for measuring the impact for the second intervention was academically sound.

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Evaluation Results
In response to the challenge of staffing transitions, this is a typical situation, and key tasks previously completed by those individuals were assigned to other staff members. The team believed this was a well-developed intervention and had to wait until after the end of the SFY to evaluate the results.
What successes were demonstrated through the intervention testing?
The major success of this intervention testing at this point is the creation of a streamlined care coordination intake that prioritizes the collection of data that will add value to the care plan created in collaboration with the member. The revised tool has been well received by the staff performing this work for members. Another success is that the work with the DAR team produced a data collection methodology that appropriately captures the screenings completed before and after the transition date.

Appendix A1-4: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon ☒ Continue
Rationale for Intervention Status Selected
The intervention is showing a very slow positive trend in screenings. Detailed analysis revealed a potential explanation for this effect, and it is presumed that rates should continue to improve as additional members receive an initial or subsequent intake. Additional data must be collected to fully assess the impact of this intervention.

Appendix B. Final PIP Validation Tools

Appendix B contains the final PIP Validation Tools provided by HSAG.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Demographic Information			
MCO Name:	Health Colorado, Inc. (RAE 4)		
Project Leader Name:	Edward Arnold	**Title:**	Performance Improvement Analyst
Telephone Number:	719-666-0540	**Email Address:**	edward.arnold@carelon.com
PIP Title:	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*		
Submission Date:	October 23, 2024		
Resubmission Date:	*Not Applicable*		

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [N/A]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*N/A*	
2. Included the sample size for each indicator.	C*	*N/A*	
3. Included the margin of error and confidence level for each indicator.		*N/A*	
4. Described the method used to select the sample.		*N/A*	
5. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	5	2	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*N/A*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	1	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	7	3	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Met*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Results for Step 7 - 8			
Total Evaluation Elements	**8**	**4**	**Critical Elements**
Met	8	4	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Met*	
2. There was improvement over baseline performance across all performance indicators.		*Met*	
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Met*	
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.

Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

Table B—1 2024-25 PIP Validation Tool Scores
for *Follow-Up After Emergency Department Visit for Substance Use* for Health Colorado, Inc. (RAE 4)

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	1	0	0	1	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	3	0	0	0	1	1	0	0	0
Totals for All Steps	**26**	**18**	**0**	**0**	**7**	**13**	**10**	**0**	**0**	**3**

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Follow-Up After Emergency Department Visit for Substance Use* for Health Colorado, Inc. (RAE 4)	
Percentage Score of Evaluation Elements *Met* *	***100%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***High Confidence***

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Follow-Up After Emergency Department Visit for Substance Use* for Health Colorado, Inc. (RAE 4)	
Percentage Score of Evaluation Elements *Met* *	***100%***
Percentage Score of Critical Elements *Met* **	***100%***
Confidence Level***	***High Confidence***

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.*
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Emergency Department Visit for Substance Use (FUA)
for Health Colorado, Inc. (RAE 4)

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***High Confidence***

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Demographic Information			
MCO Name:	Health Colorado, Inc. (RAE 4)		
Project Leader Name:	Edward Arnold	**Title:**	Performance Improvement Analyst
Telephone Number:	719-666-0540	**Email Address:**	edward.arnold@carelon.com
PIP Title:	*Social Determinants of Health (SDOH) Screening*		
Submission Date:	October 23, 2024		
Resubmission Date:	January 13, 2025		

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *N/A* is not applicable to this element for scoring.	C*	*Met*	

Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *N/A* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [N/A]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*N/A*	
2. Included the sample size for each indicator.	C*	*N/A*	
3. Included the margin of error and confidence level for each indicator.		*N/A*	
4. Described the method used to select the sample.		*N/A*	
5. Allowed for the generalization of results to the population.	C*	*N/A*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	5	2	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements*****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *N/A* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *N/A* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	1	1	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	8	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	6	3	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Met*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Met*	For the Performance Expectations and Feedback intervention, the health plan reported rolling 12-month results for the overall performance indicator for the Intervention Effectiveness Measure in the Intervention Worksheet. The health plan should add quantitative results for an Intervention Effectiveness Measure that is specific to the intervention. For example, data on percentage of providers trained or data from intervention-related meetings with care management entities (Steps 4 and 5 in the Intervention Process Steps). **Resubmission January 2025:** The health plan updated the Intervention Worksheet documentation to reflect results of multiple quantitative measures, as well as qualitative evaluation results, used to evaluate intervention effectiveness. The revised documentation addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
Met	8	4	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 9. Assess the likelihood that Significant and Sustained Improvement Occurred: Improvement in performance is evaluated based on evidence that there was improvement over baseline indicator performance. Sustained improvement is assessed after improvement over baseline indicator performance has been demonstrated. Sustained improvement is achieved when repeated measurements over comparable time periods demonstrate continued improvement over baseline indicator performance.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Met*	
2. There was improvement over baseline performance across all performance indicators.		*Met*	
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Met*	
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	Sustained improvement is not assessed until statistically significant improvement is demonstrated and remeasurement results are reported for a subsequent remeasurement period.

Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

Table B—1 2024-25 PIP Validation Tool Scores
for *Social Determinants of Health Screening* for Health Colorado, Inc. (RAE 4)

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	3	0	0	0	1	1	0	0	0
8. Assess the Improvement Strategies	5	5	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	3	0	0	0	1	1	0	0	0
Totals for All Steps	**26**	**19**	**0**	**0**	**6**	**13**	**10**	**0**	**0**	**3**

Table B—2 2024-25 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8)
for *Social Determinants of Health Screening* for Health Colorado, Inc. (RAE 4)

Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

Table B—3 2024-25 Overall Confidence That the PIP Achieved Significant Improvement (Step 9)
for *Social Determinants of Health Screening* for Health Colorado, Inc. (RAE 4)

Percentage Score of Evaluation Elements *Met**	***100%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***High Confidence***

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.*
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Health Colorado, Inc. (RAE 4)

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS	
HSAG assessed the MCO's PIP based on CMS Protocol 1 to determine whether the MCO adhered to an acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. HSAG's validation of the PIP determined the following:	
High Confidence:	High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
Moderate Confidence:	Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
Low Confidence:	Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
No Confidence:	No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
Confidence Level for Acceptable Methodology:	***High Confidence***

HSAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. HSAG's validation of the PIP determined the following:	
High Confidence:	All performance indicators demonstrated *statistically significant* improvement over the baseline.
Moderate Confidence:	To receive *Moderate Confidence* for significant improvement, one of the three scenarios below occurred: 1. All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline. 2. All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline. 3. Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
Low Confidence:	The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
No Confidence:	The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.
Confidence Level for Significant Improvement:	***High Confidence***