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

Colorado Community Health Alliance Region 6

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

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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). Colorado Community Health Alliance Region 6, referred to in this report as CCHA R6, 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, CCHA R6 submitted two PIPs: *Follow-Up After Hospitalization for Mental Illness (FUH)* 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 *FUH* PIP addresses quality, timeliness and accessibility of healthcare and services by improving follow-up visit rates after hospitalization for mental illness among CCHA R6 members. The topic, selected by CCHA R6 and approved by the Department, was supported by historical data. The PIP Aim statement is as follows: "Do targeted interventions increase the percentage of members who have a follow-up visit with a mental health provider within 7 days after discharge from psychiatric inpatient hospitalization for treatment of selected mental illness or intentional self-harm diagnoses?"

The nonclinical *SDOH Screening* PIP addresses quality and accessibility of healthcare and services for CCHA R6 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: "Do targeted interventions increase the percentage of members enrolled in CCHA's Behavioral Health Transitions of Care (BHTOC) and Specialized Transitions of Care (STOC) who are screened for SDOH (unmet food, housing, utility, and transportation needs)?"

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

Table 1-1—Performance Indicators

PIP Title	Performance Indicator
FUH	The percentage of discharges for CCHA R6 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.
SDOH Screening	The percentage of new BHTOC and STOC cases for members attributed to Region 6 wherein the member was screened for unmet food, housing, utility, and transportation needs.

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 CCHA R6 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 CCHA R6 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

[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.

improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the RAE during the PIP.

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 CCHA R6's PIP Submission Form. This form provides detailed information about CCHA R6'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*.

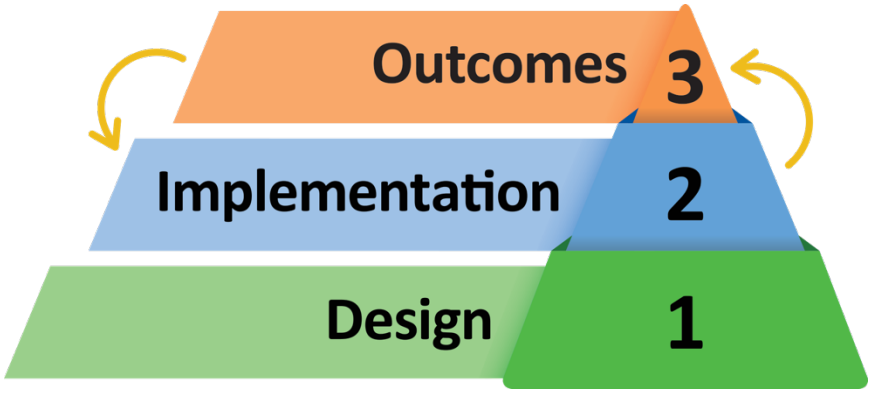
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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 CCHA R6 establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7–8). During this stage, CCHA R6 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, CCHA R6 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 CCHA R6

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]
FUH	Initial Submission	80%	89%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*No Confidence*
SDOH Screening	Initial Submission	81%	89%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	94%	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 *FUH* 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. CCHA R6 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 *No Confidence* level that the PIP achieved significant improvement. HSAG assigned a level of *No Confidence* for Validation Rating 2 because the performance indicator results demonstrated a decline in performance from baseline to 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. CCHA R6 received *Met* scores for 100 percent of applicable evaluation elements in the Design stage (Steps 1–6) and for 88 percent of applicable evaluation elements in the Implementation stage (Steps 7–8) 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 CCHA R6's *FUH* PIP.

Table 3-2—Performance Indicator Results for the *FUH* 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 discharges for CCHA R6 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	N: 751 D: 1,500	50.1%	N: 683 D: 1,399	48.8%			

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

For the baseline measurement period, CCHA R6 reported that the percentage of discharges of CCHA R6 members 6 years of age and older who were hospitalized for treatment of selected mental illness or

intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 50.1 percent.

For the first remeasurement period, CCHA R6 reported that the percentage of discharges of CCHA R6 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 48.8 percent. Compared to baseline, the Remeasurement 1 results demonstrated a decrease in the seven-day follow-up rate among eligible members of 1.3 percentage points.

Table 3-3 displays data for CCHA R6'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 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of new BHTOC and STOC cases for members attributed to Region 6 wherein the member was screened for unmet food, housing, utility, and transportation needs.	N: 794 D: 2,654	29.9%	N: 869 D: 2,505	34.7%			

N–Numerator D– Denominator

For the baseline measurement period, CCHA R6 reported that 29.9 percent of members attributed to Region 6 with new BHTOC and STOC cases were screened for unmet food, housing, utility, and transportation needs. CCHA R6 updated the baseline indicator data for the 2024–2025 validation cycle after identifying and addressing a data collection issue. The RAE discussed the updated indicator results with HSAG and the Department in an October 2024 technical assistance call to ensure appropriate documentation for PIP validation.

For the first remeasurement period, CCHA R6 reported that 34.7 percent of members attributed to Region 6 with new BHTOC and STOC cases were screened for unmet food, housing, utility, and transportation needs. Compared to baseline, the Remeasurement 1 results demonstrated a statistically significant increase in the percentage of eligible members who were screened for SDOH of 4.8 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. CCHA R6'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 CCHA R6 for the *FUH* PIP.

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

Barriers	Interventions
• Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays. • Lack of standardized process to verify and/or obtain up-to-date contact information for all members or to automate appointment reminders for effective outreach and engagement efforts. • Lack of staff training on measure specifications and requirements to ensure that a qualifying follow-up service is scheduled within 7 days from discharge. • Lack of standardized process to mitigate specific process failures identified. • Lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement.	Improve Mental Health Partner's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.
• Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays. • Lack of staff training on measure specifications and requirements. • Lack of standardized process to mitigate specific process failures identified.	Improve Jefferson Center for Mental Health's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.

Table 3-5 displays the barriers and interventions documented by CCHA R6 for the *SDOH Screening* PIP.

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

Barriers	Interventions
Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and Acute Treatment Unit (ATU) for a behavioral health condition, or high levels of care for a substance use disorder (SUD) event.	Standardize requirements for screening CCHA members enrolled in BHTOC and STOC programming for unmet food, housing, utility, and transportation needs.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, CCHA R6 submitted the clinical *FUH* PIP and the nonclinical *SDOH Screening* PIP. CCHA R6 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, the *FUH* PIP received a *No Confidence* level and the *SDOH Screening* PIP 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 CCHA R6 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), CCHA R6 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. For the *SDOH Screening* PIP, CCHA R6's narrative interpretation of Remeasurement 1 results included statements that were unclear. In the Outcomes stage (Step 9), Remeasurement 1 results for the *FUH* PIP did not demonstrate any improvement compared to baseline results. Remeasurement 1 results for the *SDOH Screening* PIP demonstrated statistically significant improvement over baseline results. CCHA R6 will report Remeasurement 2 indicator results for both PIPs and will progress to being evaluated for sustaining significant improvement for one PIP, *SDOH Screening,* in next year's validation.

Recommendations

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

- For the *SDOH Screening* PIP, review the narrative interpretation of the Remeasurement 1 indicator with HSAG's assistance to ensure a clear and accurate understanding of indicator results over time.
- For the *FUH* PIP, identify new or revised interventions, based on updated causal/barrier analyses and intervention evaluation results, to address the lack of improvement in indicator results.
- 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 CCHA R6 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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

Demographic Information	
Managed Care Organization (MCO) Name: Colorado Community Health Alliance (RAE 6)	
Project Leader Name: Camila Joao	Title: Clinical Quality Program Manager
Telephone Number: (303) 817-3791	Email Address: camila.joao@cchacares.com
PIP Title: Follow-Up After Hospitalization for Mental Illness (FUH)	
Submission Date: 10/31/2024	
Resubmission Date (if applicable): 01/22/2025	

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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: As one of the clinical measures determined by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members 6 years of age and older who have a follow-up visit with a mental health provider within 7 days after discharge from hospitalization for treatment of selected mental illness or intentional self-harm diagnoses. In compliance with Federal Medicaid managed care regulations and quality standards outlined in 42 CFR § 438.330, the PIP is designed to achieve and sustain improvement in health outcomes and clinical services administered by Medicaid managed care organizations (MCOs).

Provide plan-specific data:

CCHA's internal service claims data shows 50.07% of the 1,500 acute inpatient discharges for CCHA members 6 years or older with a principal diagnosis of mental illness or intentional self-harm with a triggering event within July 1, 2022, and May 31st, 2023[1] had a qualifying follow-up visit with a mental health provider within 7 days.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:

Healthcare spending per capita in the United States is more than double that of other industrialized nations while ranking comparatively low on key indicators of the quality of care and population health status[i]. Health care quality improvement experts from the Centers for Medicare & Medicaid Services (CMS) consensus-based entity endorse timely follow-up services after hospitalization for mental illness as a key strategy to accelerate efficiency, and ultimately value, of care[ii].

[1] The triggering event period ends 30 days prior to the last day of the measurement cycle to allow sufficient time for the follow-up service to occur. Discharges on or after June 1st, 2023, are not included in the baseline calculation in alignment with 2023 CMS Core Measure Set Technical Specifications and Value Set Directories time frames.

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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.
Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. Individuals in vulnerable circumstances are at the juncture of a complex system with vulnerable connections between multiple actors when transitioning out of acute mental health settings. Lack of coordination and collaboration between treatment providers can result in inadequate and fragmented support, which increase the risk of repeated psychiatric decompensation and inpatient hospital readmissions. The risk of readmission has been found to be higher in the periods immediately after discharge[iii] and may be indicative of a lack of access to adequate community-based aftercare, challenges with psychiatric medication adherence and effective condition management in lower intensity settings. In addition to being disruptive to individuals' stable and independent functioning, readmissions are costly and further restrict the health care system's capacity to effectively manage the demand for services. Timely follow-up service with a mental health provider after discharge from inpatient hospital treatment has the potential to improve member health, functional status, and/or satisfaction in the following ways: • Timely outpatient engagement can help members establish and maintain protective self-care activities to sustain the benefits of inpatient treatment and prevent future hospital readmissions. • Effective treatment in least restrictive settings protects against disruptions to individuals' independent functioning, resulting in improved functional status at school, work, within the family and community. • Care coordination between service providers may improve health outcomes, facilitate condition management in lower acuity settings, and decrease the of risk avoidable utilization of higher levels of care; ultimately, reducing cost. • Containing avoidable hospital readmissions promotes efficiencies in the allocation of health care resources, enhancing availability and systemic capacity to manage psychiatric inpatient beds shortage. • Prompt assistance accessing treatment and overcoming barriers to engagement helps to mitigate the adverse impact of unmet socially determined factors and address disparities in health equity. • Support navigating systems of care and convenience of access may increase member satisfaction.

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

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):

Do targeted interventions increase the percentage of members who have a follow-up visit with a mental health provider within 7 days after discharge from psychiatric inpatient hospitalization for treatment of selected mental illness or intentional self-harm diagnoses?

Appendix A: State of Colorado 2024-25 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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:

Health First Colorado members attributed to Region 6 (Jefferson, Boulder, Broomfield, Gilpin, and Clear Creek counties) who are 6 years of age or older as of the date of discharge from an acute inpatient placement for treatment of selected mental illness or intentional self-harm diagnoses.

Enrollment requirements (if applicable):
Members must be continuously enrolled with CCHA from date of discharge through 30 days after discharge, with no gaps.

Member age criteria (if applicable):
Members must be 6 years or older as of the date of discharge.

Inclusion, exclusion, and diagnosis criteria:

Inclusion:

- Members enrolled in the Accountable Care Collaborative (ACC), attributed to CCHA Region 6.

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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.

- All acute inpatient discharges (Inpatient Stay Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between July 1 and May 31 of the measurement year for CCHA members aged 6 years or older.
- The denominator is based on discharges, not on beneficiaries. All discharges that occur within the measurement period are included.
- Race, ethnicity, age, gender, and language information will be tracked and analyzed to evaluate the impact of demographic disparities and promote equitable outcomes.

Exclusions:

1. Members 5 years and younger.
2. Members who die during the measurement year
3. Members in hospice or using hospice services anytime during the measurement year (Hospice Encounter Value Set and Hospice Intervention Value Set)
4. Nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
5. Nonacute readmission or direct transfer: Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
6. Acute readmission or direct transfer:

Appendix A: State of Colorado 2024-25 PIP Submission Form
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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.

6.1 Exclude the initial discharge if followed by a readmission/direct transfer to an acute inpatient care setting for a principal diagnosis of mental health disorder or intentional self-harm within 30 days.
6.2 Exclude both the original and the readmission/direct transfer discharge if the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis.
6.3 Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after May 31 of the measurement year.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):

Refer to Appendix I for a detailed list of codes included in each of the value sets used to identify the eligible population for Remeasurement 1 and Remeasurement 2, as described above:

- Inpatient Stay Value Set
- Nonacute Inpatient Stay Value Set
- Mental Illness and Intentional Self-Harm Value Set
- Hospice Encounter and Hospice Intervention Value Set

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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
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

The intervention population includes all CCHA members 6 years or older attributed to Region 6 who were hospitalized for treatment of selected mental illness or intentional self-harm during the measurement period.

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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	**BH follow-up within 7 days after discharge from a psychiatric inpatient hospitalization for treatment of mental illness or intentional self-harm.** Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. As one of the clinical measures determined by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members 6 years of age and older who have a follow-up visit with a mental health provider within 7 days after discharge from hospitalization for treatment of selected mental illness or intentional self-harm diagnoses. Performance is calculated in accordance with the 2023 and 2024 CMS Core Measure Set Technical Specifications and Value Set Directories.
Numerator Description:	Denominator events followed by a visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge.
Denominator Description:	All acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm for CCHA members 6 years or older on the day of discharge that occur within the measurement 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

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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."

Mandated Goal/Target, if applicable	Not Applicable.

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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 [ ] 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 [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 90 % 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: _____

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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.		
	Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: Data completeness percentage is assessed by estimated Incurred But Not Reported (IBNR) claims for the measurement period, as calculated by CCHA's Finance Department as of the date of data generation. The IBNR assessment includes known claims in the process of adjudication and/or settlement as well as unknown claims.	

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

Data Elements Collected:
Detailed flagged event files from claims/encounters.

Data Collection Process:

1. Fee-for-service (FFS) claims sent to Health Plan by State monthly.
2. FFS claims are combined with BH Encounters in data warehouse.
3. The NCQA-certified vendor, Cotiviti, retrieves all claims for all acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim, and flags denominator events in accordance with measure specifications[2]:
   - 3.1 Identify acute inpatient discharges (Inpatient Stay Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between June 1 and May 31 of the measurement year.
   - 3.2 Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
   - 3.3 Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:
     - 3.3.1 Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after May 31 of the measurement year.
     - 3.3.2 If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.
     - 3.3.3 Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting (Nonacute Inpatient Stay Value Set) within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
   - 3.4 Exclude members in hospice or using hospice services anytime during the measurement year.
   - 3.5 Exclude members 5 years old or younger.
   - 3.6 Exclude members with gaps in enrollment from date of discharge through 30 days after discharge.
   - 3.7 Exclude members who die during the measurement year.

[2] Refer to Appendix I for a detailed list of codes included in each of Value Set Directory.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
4. Internal HEDIS engine retrieves all claims and flags denominator events with a follow-up visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge, in accordance with measure specifications[2]: 4.1 An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider. 4.2 An outpatient visit (BH Outpatient Value Set) with a mental health provider. 4.3 An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) 4.4 An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). 4.5 A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set). 4.6 Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set). 4.7 A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health provider. 4.8 An observation visit (Observation Value Set) with a mental health provider. 4.9 Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider. 4.10 A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set). 4.11 A telephone visit (Telephone Visits Value Set) with a mental health provider. 4.12 Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set). 5. Final report is generated with eligible denominator and numerator eligible encounters.

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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: BH follow-up within 7 days after discharge from a psychiatric hospitalization for treatment of mental illness or intentional self-harm.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 – 06/30/2023	Baseline	751	1500	50.07%	N/A for baseline	N/A for baseline
07/01/2023 – 06/30/2024	Remeasurement 1	683	1399	48.82%	56.67%	Fisher's exact test. Two-tailed *p* Value=0.5037
07/01/2024 – 06/30/2025	Remeasurement 2					

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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:

Between July 1, 2022, and May 31, 2023, 1,500 discharges from an acute psychiatric inpatient facility for treatment of a principal diagnosis of mental illness or intentional self-harm occurred for members 6 years or older attributed to CCHA in Region 6. 751 discharges were followed by qualifying service with a mental health provider within 7 days, excluding the day of discharge, which corresponds to a 50.07% follow-up rate. Discharges on or after June 1st, 2023, are not included in the baseline calculation in alignment with 2023 CMS Core Measure Set Technical Specifications and Value Set Directories time frames. The triggering event period ends 30 days prior to the last day of the measurement cycle (June 30th) to allow sufficient time for the follow-up service to occur. Data completeness rate of 90% and timely filing limits of up to 365 days for services rendered with CCHA as a secondary payer impact the validity of findings, as unadjudicated claims are not included in calculations.

Baseline to Remeasurement 1 Narrative: Between July 1, 2023, and May 31, 2024, 1,399 discharges from an acute psychiatric inpatient facility for treatment of a principal diagnosis of mental illness or intentional self-harm occurred for members 6 years or older attributed to CCHA in Region 6. 683 discharges were followed by qualifying service with a mental health provider within 7 days, excluding the day of

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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.

discharge, which corresponds to a 48.82% follow-up rate. Discharges on or after June 1st, 2024, are not included in the remeasurement 1 period rate calculation in alignment with 2023 CMS Core Measure Set Technical Specifications and Value Set Directories time frames. The triggering event period ends 30 days prior to the last day of the measurement cycle (June 30th) to allow sufficient time for the follow-up service to occur. Data completeness rate of 90% and timely filing limits of up to 365 days for services rendered with CCHA as a secondary payer impact the validity of findings, as unadjudicated claims are not included in calculations.

The final performance rate during the remeasurement 1 period did not surpass the target of 56.67%. A Fisher's Exact test was conducted to determine the statistical significance of the improvement, yielding a two-tailed *p* value of 0.5037. This result indicates the intervention did not achieve statistically significant improvement over the baseline rate at conclusion of the first remeasurement period. No factors have been identified that threaten the comparability of Remeasurement 1 results to Baseline results; however, indicator measurements are calculated based on fiscal year cycles and are not comparable to validated measurement year results.

Baseline to Remeasurement 2 Narrative:

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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
   - Intervention Status

A. Quality Improvement (QI) Team and Activities Narrative Description

Remeasurement 1 Intervention QI Team Members:

1. Camila Joao, CCHA, Clinical Quality Program Manager
2. Kathryn Morrison, CCHA, Medicaid Quality Management Health Plan Director
3. Vladimir Sevastyanov, Business Information Consultant
4. Wendy Thoreaux, Mental Health Partners, Inpatient Liaison
5. Linda Davis, Mental Health Partners, Boulder Regional Director
6. Jill McFadden, Front Range Health Partners, Director of Operations
7. Alan Girard, Front Range Health Partners, Chief Executive Officer

Remeasurement 2 Intervention QI Team Members:

1. Camila Joao, CCHA, Clinical Quality Program Manager
2. Kathryn Morrison, CCHA, Medicaid Quality Management Health Plan Director
3. Vladimir Sevastyanov, Business Information Consultant
4. Michelle Dyl, Jefferson Center for Mental Health, Hospital Liaison
5. Lauren McMullin, Jefferson Center for Mental Health, Hospital Liaison

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   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

6. Kim Graham, Jefferson Center for Mental Health, Hospital Liaison
7. Andrea Raasch, Jefferson Center for Mental Health, Director of Operations
8. Brandie Keyes, Jefferson Center for Mental Health, Insurance Billing Coordinator
9. Gina Pacheco, Jefferson Center for Mental Health, Business Intelligence and Data Manager

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

Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. To help maintain the positive effects of acute treatment and prevent further disruption to members' stable functioning post-discharge, improvement rates of aftercare engagement is expected to benefit members with recent history of high acuity needs as evidenced by psychiatric hospitalization. Providers expected to have the greatest leverage to impact regional rates of follow-up after hospitalization should serve a large volume of members, offer a comprehensive array of services, and have systems and dedicated personnel in place to engage hospitals and facilitate the discharge process. As safety net providers, Comprehensive Safety Net Providers (CSNPs) meet these standards and are uniquely positioned to implement processes to establish continuity of care and meet members' unique and potentially challenging needs during the period following hospitalization.

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   - Intervention Status

CCHA partnered with two CSNPs to leverage their capacity to impact rates of timely follow-up within 7 days from hospitalization at a regional level. Process mapping[3] was utilized to outline existing steps for notification, coordination, and access to timely follow-up services, and facilitate the identification of gaps associated with failure. The initial intervention will target identified barriers, listed below.

B. 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
Remeasurement 1 Intervention: Improve Mental Health Partner's process to coordinate discharge and aftercare	1. Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays.

[3] Refer to Appendix II for the Process Map document.

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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
   - Intervention Status

	engagement for eligible members transitioning out of psychiatric inpatient hospitalization.	2. Lack of standardized process to verify and/or obtain up-to-date contact information for all members or to automate appointment reminders for effective outreach and engagement efforts. 3. Lack of staff training on measure specifications and requirements to ensure that a qualifying follow-up service is scheduled within 7 days from discharge. 4. Lack of standardized process to mitigate specific process failures identified. 5. Lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement.	
	Remeasurement 2 Intervention: Improve Jefferson Center for Mental Health's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.	1. Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays.	

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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 Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

	2. Lack of staff training on measure specifications and requirements. 3. Lack of standardized process to mitigate specific process failures identified.

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
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.

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1. Appendix

I. Remeasurement 1:

FFY 2023 Adult Core Set HEDIS Value Set Directory: https://www.medicaid.gov/license/form/8196/151206
FFY 2023 Child Core Set HEDIS Value Set Directory: https://www.medicaid.gov/license/form/8191/156246

Remeasurement 2:

FFY 2024 Adult Core Set HEDIS Value Set Directory: https://www.medicaid.gov/license/form/8386/170271
FFY 2024 Child Core Set HEDIS Value Set Directory: https://www.medicaid.gov/license/form/8391/170296

II. QI Tool – Process Maps

Remeasurement 1 Intervention	R6 FUH Intervention 1 Proce
Remeasurement 2 Intervention	R6 FUH Intervention 2 Proce

[i] "Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Patient-Focused Episodes of Care", National Quality Forum, accessed October 4th, 2023, https://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx

[ii] "Follow-Up After Hospitalization for Mental Illness (FUH)", Partnership for Quality Measurement, accessed October 4th, 2023, https://p4qm.org/measures/0576.

[iii] Osborn D.P., Favarato G., Lamb D., Harper T., Johnson S., Lloyd-Evans B., Marston L., Pinfold V., Smith D., Kirkbride J.B., et al. "Readmission after discharge from acute mental healthcare among 231,988 people in England: Cohort study exploring predictors of readmission including availability of acute day units in local areas." BJPsych Open. 2021 Jul;7:e136, https://doi.org/10.1192%2Fbjo.2021.961

Appendix A: State of Colorado 2024-25 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Demographic Information		
Managed Care Organization (MCO) Name: Colorado Community Health Alliance (RAE 6)		
Project Leader Name: Camila Joao	Title: Clinical Quality Program Manager	
Telephone Number: (303) 817-3791	Email Address: camila.joao@cchacares.com	
PIP Title: Social Determinants of Health (SDOH) Screening		
Submission Date: 10/31/2024		
Resubmission Date (if applicable): 01/22/2025		

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Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

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:

As mandated by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members participating in the Behavioral Health (BH) capitated benefit who are screened for unmet food, housing, utility, and transportation needs. In compliance with Federal Medicaid managed care regulations and quality standards, the PIP targets improvement in non-clinical services delivered by CCHA that are expected to mitigate threats to the health or functional status of members experiencing high-risk conditions.

Members' high-risk conditions and participation in BH capitation are identified by an approved authorization for placement in high levels of care for a mental health or substance use disorder diagnosis. These members are served by CCHA's Care Coordinators through the following programs:

1. CCHA's Behavioral Health Transitions of Care (BTOC) supports members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays for a covered behavioral health condition.
2. CCHA's Specialized Transitions of Care (STOC) program provides deliberate care coordination assistance, facilitate effective discharge and aftercare planning for members transitioning from high levels of care (inpatient, residential, and withdrawal management) for a substance use disorder (SUD) event.

Provide plan-specific data:

CCHA's documentation of care coordination activities indicates 2,654 BTOC and STOC cases were opened between 7/1/2022 and 6/30/2023, corresponding to 2,218 unique members, and 446 members associated with 2 to up to 7 treatment episodes. 29.92% of cases received a full screening for unmet food, housing, utility, and transportation needs. 62.53% (1,387) were screened for at least one of these factors, out of which 25.23% identified unmet needs related to these core elements. Transportation was the most frequently reported concern (38.86%), followed by housing (29.43), food (23.14%) and utilities (8.57%).

No screening was administered to 24.66% of members with multiple placements to evaluate the impact of social needs on the repeated utilization of higher levels of care. Consistent assessment of immediate needs may provide insights into the prevalence of resource gaps and its correlation to the risk of higher acuity interventions.

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Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

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:

Health is a product of multiple determinants. A broad body of evidence indicates that social determinants of health (SDOH) affect health outcomes and can be more important than health care or lifestyle choices in influencing health status, according to the World Health Organization.[i] Disparities in quality and outcomes of care often reveal socially determined inequities rooted in the unequal distribution of power and resources. Individuals with unmet social needs are more likely to utilize emergency departments, miss outpatient appointments, and struggle to manage chronic health conditions[ii]. Research has shown that a person's zip code is a better predictor of life expectancy than genetic code, and highest income groups can expect to live six and a half years longer than those living in poverty[iii].

Social, economic, environmental, and structural disparities manifest as uneven health risk that is avoidable and remediable. Identifying and addressing social needs is essential for whole-person care, to enable promotion of health equity and establish conditions in which no one is disadvantaged from achieving their full health potential independently of social position. Correspondently, mitigating the impact of adverse SDOH upstream helps to reduce long-term health care costs[iv]. Assessing social needs as key components of health can provide information that is necessary to begin to address the barriers securing health for members and promote equitable outcomes.

Routine SDOH screening has the potential to improve member health, functional status, and/or satisfaction in the following ways:

- Screening for health and social factors promotes detection of unmet needs and supports access to assistance.
- Determining a person's immediate necessities promotes removal of barriers to effective health management.
- Addressing members' social needs may facilitate engagement in healthcare services, diminish risk of poor health outcomes, reduce ED utilization and inpatient stays, and reduce overall healthcare costs.
- Effective management of socially determined inequities may improve functional status at school, work, within the family and community.
- Whole-person care and collaboration with social services agencies may increase member satisfaction.

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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):

Do targeted interventions increase the percentage of members enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) who are screened for SDOH (unmet food, housing, utility, and transportation needs)?

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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:
Health First Colorado members attributed to Region 6 (Jefferson, Boulder, Broomfield, Gilpin, and Clear Creek counties) enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) or Specialized Transitions of Care (STOC) programming.

Enrollment requirements (if applicable):
No continuous enrollment requirement. Population includes all Health First Colorado members who are attributed to Region 6 at the time of discharge from a Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a Behavioral Health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event.

Member age criteria (if applicable):
None.

Inclusion, exclusion, and diagnosis criteria:

- Members will be included in the denominator if they are enrolled in the Accountable Care Collaborative (ACC), attributed to CCHA Region 6, and enrolled in BTOC or STOC.

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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.

- The denominator for this measure is based on new BTOC/STOC enrollment, not on members. All new BTOC/STOC enrollments initiated during the measurement period are included.
- Readmissions to specified levels of care (LOC) prior to BTOC/STOC termination are considered part of the same treatment episode and do not result in a new enrollment.
- No exclusions.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable):

1. CCHA's Behavioral Health Transitions of Care (BTOC) supports members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays for a covered behavioral health condition.
   1.1 Procedure: CCHA's Census Coordinator receives daily census report from Utilization Management Reviewers with CCHA members attributed to Region 6 with approved authorization for placement and admitted to psychiatric inpatient facilities or Acute Treatment Units (ATU). The Census Coordinator assigns cases to BTOC staff upon receipt. All members with a Psychiatric authorization type are eligible for BTOC support.

2. CCHA's Specialized Transitions of Care (STOC) program provides deliberate care coordination assistance, facilitate effective discharge and aftercare planning for members transitioning from high levels of care (inpatient, residential, and withdrawal management) for a substance use disorder (SUD) event.

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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.
2.1 Procedure: CCHA's Census Coordinator receives a daily census report from Utilization Management Reviewers to identify CCHA members attributed to Region 6 who have a placement authorization for 3.1, 3.3, 3.2WM, 3.5, 3.7, and 3.7WM placement and are admitted to a substance use disorder treatment facility. STOC also supports members who have open authorization for 3.1 or 3.5 levels of care and are pending admission to SUD residential treatment. The Census Coordinator assigns cases to STOC staff upon receipt. All members with a Substance Abuse authorization type are eligible for STOC support. 2.2 American Society of Addiction Medicine (ASAM) Levels of Care: • 3.1 Low Intensity Residential • 3.3 Population-Specific, High Intensity Residential • 3.5 High Intensity Residential • 3.5 High Intensity (or medium intensity for teens) Residential • 3.7 Medically Monitored Intensive Inpatient Services (IP) • 3.2WM Residential Withdrawal Management (Social Detox) • 3.7WM Medically Monitored Inpatient Withdrawal Management

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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:

The intervention population includes all members enrolled in BTOC or STOC programming within all CCHA members attributed to Region 6 who received a capitated behavioral health service during the measurement period. A homogeneous purposive method was used to delineate the target population based on BTOC/STOC enrollment as the specific determining factor. This selection method serves to strategically deploy resources and prioritize members with service utilization patterns indicative of higher risk, which may be socially determined or exacerbated. This is a non-probability method and not intended to be representative or extrapolated to the full CCHA population, however, it may furnish valuable insight into correlations between HLOC utilization and SDOH factors in addition to potential therapeutic benefits.

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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 of BTOC and STOC members.**
	CCHA's BTOC and STOC programs provides care coordination assistance to members transitioning out of inpatient psychiatric placement or high levels of care for a SUD event. Utilization of higher levels of care may signal a lack of access to care or issues with continuity of care. Screening for and addressing resource gaps can support stable functioning, promote recovery, and help mitigate future risk of higher acuity intervention needs.
Numerator Description:	**Number of cases from the denominator that have a screening for unmet food, housing, utility, and transportation needs.**
Denominator Description:	**Number of new CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) cases for members attributed to Region 6.**
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	Not Applicable.

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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.

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- 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."

Use this area to provide additional information.

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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 [ ] 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 [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached Estimated percentage of reported administrative data completeness at the time the data are generated: 99.16 % 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: _____

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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.		
	Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: Data completeness percentage is determined based on the case status according to the clinical documentation. Only cases with "Closed" status or with responses documented for all mandatory SDOH screening questions are considered complete. Information may still be pending for cases with an "Enrolled" status and without responses to the SDOH questions.	

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

Data Elements Collected:

The Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) screening report from CCHA's electronic care management platform (Essette).

Data Collection Process:

1. CCHA's Census Coordinator receives daily census report from Utilization Management Reviewers with information on placement authorizations for Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a Behavioral Health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event.
2. CCHA's Census Coordinator loads cases to the appropriate program queue based on authorization type.
3. BTOC and STOC staff pull all cases daily from the program queue, prioritizing "rapid re-admitters". Rapid re-admitters are defined as members who have been admitted to 3.2WM and 3.7WM levels of care or Psychiatric Inpatient within 30 days, excluding step-downs from inpatient to residential.
4. BTOC and STOC staff attempt to outreach members telephonically within 2 business days of the referral date. At least three (3) telephonic attempts will be made to reach the member within 7 business day period in attempt to engage the member by phone. All possible means of locating the member will be exhausted including, but not limited to – telephonic outreach to natural supports, connecting with any/all affiliated provider(s), and researching claims data, as appropriate.
5. Once successful contact has been made, the BTOC and STOC staff will work to identify unmet food, housing, utility, and transportation needs by asking the following PRAPARE questions embedded in the Health Needs Assessment form[1] in Essette:
    - Housing:
        - What is your housing situation today? Or,
        - Are you worried about losing your housing?
    - Food and Utilities: In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Food, utilities, medicine or any health care (Medical, Dental, Mental Health, Vision), Phone, Clothing, Child Care, or Other.
    - Transportation: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

[1] Refer to Appendix I for a copy of the Health Needs Assessment template.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
6. Information collected will be documented in the member's record in Essette. 7. A report will be automatically generated according to the following guidelines: • Frequency: Quarterly, one calendar month after the end of each fiscal quarter (e.g., SFY24 Q2 report will be generated by January 31st, 2024) • Timeframe: Cases created from the beginning of the measurement period through the last day of the fiscal quarter (e.g., SFY24 Q2 report will include data from July 1st, 2023, through December 31st, 2023). • Denominator: Members attributed to Region 6 enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) or CCHA's Specialized Transitions of Care (STOC) programming during the measurement period. • Numerator: Members in the denominator who are screened for unmet food, housing, utility, and transportation needs, as evidenced by a documented response to all three (3) of the required PRAPARE elements embedded in the Health Needs Assessment. • Numerator exclusion: Partial completion of PRAPARE questions will not be considered compliant. • Performance indicator rates will be calculated based on the number of compliant assessments administered by each program during the measurement period.

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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: SDOH Screening of BTOC and STOC members.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 – 06/30/2023	Baseline	794	2654	29.92%	N/A for baseline	N/A for baseline
07/01/2023 – 06/30/2024	Remeasurement 1	869	2505	34.69%	33.46%	Fisher's exact test. statistically significant increase from Baseline to Remeasurement 1, Two-tailed *p* Value=0.0003
07/01/2024 – 06/30/2025	Remeasurement 2					

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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:

Between July 1, 2022, and June 30, 2023, 2,654 new cases were enrolled in CCHA's BTOC and STOC programming for members attributed to CCHA in Region 6 who were admitted to a Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a behavioral health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event. 794 cases received a full screening for unmet food, housing, utility, and transportation needs, which corresponds to 29.92% screening rate. Electronic Health Record (EHR) function to open cases and assign appropriate assessments is automated, and no evidence of failure or inaccuracies in programming that could impact the validity of baseline results were identified at the time of plan submission. However, intervention testing data analysis indicated a portion of enrolled members were not captured through the original population identification method. A different EHR source was identified to provide a comprehensive enrollment dataset, which was used to recalculate baseline rates and subsequent measurement periods. The rates enclosed in this plan reflect the updated values recalculated with this adjustment.

Baseline to Remeasurement 1 Narrative: Between July 1, 2023, and June 30, 2024, 2,505 new cases were enrolled in CCHA's BTOC and STOC programming for members attributed to CCHA in Region 6 who were admitted to a Psychiatric Inpatient facility or Acute Treatment

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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.

Unit (ATU) for a behavioral health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event. 869 cases received a full screening for unmet food, housing, utility, and transportation needs, which corresponds to 34.69% screening rate.

The higher performance in remeasurement 1 exceeded the target of 33.46%. A Fisher's Exact test was used to determine the statistical significance of the improvement, resulting in a 0.0003 two-tailed *p* value, which indicates the intervention achieved statistically significant improvement over baseline SDOH screening rate at conclusion of the first remeasurement period. Although the percentage of cases with a documented SDOH screening slightly increased by 4.77 percentage points in remeasurement 1 compared to the baseline rate, the target rate was only achieved due to fewer eligible new cases, consistent with a decrease in CCHA's overall membership since the end of the public health emergency. Had denominator values remained unchanged, the number of SDOH screenings administered in remeasurement 1 would not have supported statistical significance.

Additional SDOH screenings were administered for cases opened during the remeasurement 1 period that remained enrolled after the original PIP form submission. Rates and values in the current report reflect updated calculations. Data completeness for remeasurement 1 period is

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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.
93.33% at resubmission and screenings may still occur for enrolled members. No evidence of failure or inaccuracies in methodology that could impact the validity of the remeasurement 1 period results or that threaten its comparability to Baseline results have been identified. **Baseline to Remeasurement 2 Narrative:**

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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

A. Quality Improvement (QI) Team and Activities Narrative Description

QI Team Members:

1. Camila Joao, CCHA, Clinical Quality Program Manager
2. Kathryn Morrison, CCHA, Medicaid Quality Management Health Plan Director
3. Michelle Blady, CCHA, Manager of Behavioral Health Care Coordination
4. Art Chan, Elevance Health, Senior Business Information Consultant
5. Kathryn Stingl, CCHA, Lead Behavioral Health Care Coordinator
6. Christie Cimermancic, CCHA, Lead Outreach Care Specialist
7. Melissa Fisk, CCHA, Lead Behavioral Health Care Coordinator

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

As outlined in the contract with the Colorado Department of Health Care Policy and Financing (HCPF), CCHA is tasked with administering, operating, and managing the delivery of medically necessary covered BH services under the Medicaid Capitated Behavioral Health Benefit in the following categories: Outpatient, Emergency and Post-Stabilization Care Services, Inpatient Psychiatric Hospital Services, and Residential and Inpatient Substance Use Disorder Services.

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   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

A Failure Modes and Effects Analysis was used to assign a priority ranking score for each service category based on detection likelihood, ability to intervene, and risk of detrimental impact to health outcomes caused by lack of screening and access to resources, as follows:

LOC	Detection Likelihood	Ability to reach/intervene	Potential Harm/Damage	TOTAL
Inpatient Psychiatric Hospital	4	4	4	12
Residential and Inpatient Substance Use Disorder	3	3	3	9
Emergency and Post-Stabilization	1	1	2	4
Outpatient	2	2	1	5

Individuals with unmet social needs are more likely to access higher levels of care due to challenges consistently engaging with preventative and lower intensity services[ii]. To help maintain the positive effects of acute treatment and prevent further disruption to members' stable functioning post-discharge, improvement efforts are expected to have highest potential benefit if dedicated to targeting members with recent history of high acuity needs as evidenced by placement in Inpatient Psychiatric Hospitals and Residential/Inpatient SUD service categories.

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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

B. 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
Standardize process and requirements for screening CCHA members enrolled in BTOC and STOC programming for unmet food, housing, utility, and transportation needs.	Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and ATU for a behavioral health condition, or high levels of care for a SUD event.

C. Intervention Worksheet: Intervention Effectiveness Measure and Evaluation Results
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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

1. Appendix

I.	Health Needs Assessment template	Essette v3.10.1 PROD • Modify Asse

[i] "Social determinants of health," World Health Organization, accessed June 6th, 2023, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 .

[ii] "Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations", Center for Health Care Strategies, accessed June 5th, 2023, https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/.

[iii] Risa Lavizzo-Mourey,. Why Health, Poverty and Community Development are Inseparable. In: Investing in What Works for America's Communities: Essays on People, Places, and Purpose. 1st ed. Federal Reserve Bank of San Francisco & Low-Income Investment Fund; 2012:215-225, http://whatworksforamerica.org/pdf/whatworks_fullbook.pdf

[iv] "Social Determinants of Health: Resource Guide", NCQA, accessed June 6th, 2023. https://www.ncqa.org/wp-content/uploads/2020/10/20201009_SDOH-Resource_Guide.pdf

Appendix A1. Intervention Worksheets

Appendix A1 contains the completed Intervention Worksheets that CCHA R6 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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (RAE 6)
PIP Title	*Follow-up After Hospitalization for Mental Illness (FUH)*
Intervention Title	Improve Mental Health Partner's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

Instructions: Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	**Remeasurement 1 Intervention: Improve Mental Health Partner's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.**
What barrier(s) are addressed?	1. Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays. 2. Lack of standardized process to verify and/or obtain up-to-date contact information for all members or to send appointment reminders for effective outreach and engagement efforts 3. Lack of staff training on measure specifications and requirements to ensure that a qualifying follow-up service is scheduled within 7 days from discharge. 4. Lack of standardized process to mitigate specific process failures identified. 5. Lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement.
Describe how the intervention is culturally and linguistically appropriate.	Aftercare services are scheduled in accordance with client's needs and preferences, including cultural and language needs. Liaisons verify treatment recommendations from inpatient facilities and make efforts to speak directly to members to offer services at a convenient time through the preferred mode of delivery. Providers fluent in the member's primary language are prioritized as available, and language interpretation services are offered by phone, virtually, or in person to facilitate services for non-English speaking members.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Review data to identify partner provider with sufficient volume and resources to impact regional performance.
	2. Identify stakeholders, engage PIP team, and schedule recurring process meetings.
	3. Transfer daily inpatient placement census files for provider notification.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Description			
	4. Design process map to identify workflow gaps and opportunities for improvement.		
	5. Align process with measure methodology specifications.		
	6. Design tracking tool to track and monitor process performance.		
	7. Build appointment reminder function prior to follow-up service.		
	8. Train liaisons on workflow and documentation, and ensure needed resources are known and available.		
	9. Retrieve and analyze tracking report to evaluate process effectiveness.		
Intervention Start Date (MM/DD/YYYY)	07/01/2023	**Intervention End Date (MM/DD/YYYY)**	06/30/2024

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**Hospital outreach for aftercare planning and coordination.**		
Numerator description (narrative)	Denominator events followed by a qualifying visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge.		
Denominator description (narrative)	Psychiatric inpatient placement discharges for CCHA members 6 years or older open or referred to Mental Health Partners within the measurement period.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
07/01/2023-09/30/2023	**85**	**130**	**65.38%**
10/01/2023-12/31/2023	**43**	**104**	**41.35%**
01/01/2024-03/31/2024	**53**	**109**	**48.62%**
04/01/2024-06/30/2024	**52**	**103**	**50.49%**
If qualitative data were collected, provide a narrative summary of results below.			
The apparent decline in performance rates after Q2 is attributable to improvements in data capture and tracking structure implemented in October 2023, which allowed for greater accuracy in determining the eligibility of the service rendered according to measure specifications. A calculation methodology equivalent to the one used in the SFY24 Q1 evaluation period results in a 76.23% final overall rate of follow-up services rendered on or within seven days from discharge. A higher percentage compared to Q1 supports that PIP interventions generated increased aftercare connections. Since SFY24 Q1 results include types of service and modalities of delivery that may not qualify as a follow-up contact per measure specifications, initial performance data may not directly correspond to improvements to regional rates of follow-up after hospitalization as measured for this PIP.			

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
Between 7/1/2023 and 6/30/2024, MHP liaisons established connections with 16 facilities to support aftercare planning and coordination for 250 members who were receiving services at the Center at the time of placement and 199 new referrals received from facilities. Rates of qualifying follow-up services was 57.20% for existing members compared to 46.73% for new referrals, indicating active treatment status has no statistical significance in members' probability of engagement. The primary reasons identified for non-compliant events in the remeasurement 1 period were member no show (24.84%), ineligible procedure code or place of service (18.01%), and client cancelation, rescheduling or preference (13.04%). Other reasons include direct transfer to appointments or other levels of care, member refusal, late appointments, and provider cancelation.
What challenges were encountered?
The process was initially designed to establish contact with members on the day of discharge from facilities to establish aftercare plans based on final treatment recommendations, as outlined in the discharge plan. However, coordination did not occur when discharges were AMA, unplanned/modified, or that occurred while liaisons were unavailable, such as weekends/holidays. This resulted in unscheduled follow-up appointments and no up-to-date contact information for members. Without it, appointment reminders are ineffective and the likelihood of successful contact with members greatly diminishes post-discharge. Restrictions imposed by this PIP's measure specifications for the types of service and modalities of delivery that qualify as a follow-up contact also impacted the project's success rate. Data tracking tools were augmented in Q2 to provide service-level details necessary to evaluate the eligibility of clinical events, showing service billing elements corresponded to a large percentage of failures. Although the workflow was adjusted to promote rendering of eligible services, these failures are not expected to be eliminated. Providers have discretion to determine clinically indicated services and selections may not qualify. Delivery modalities may also be adjusted to accommodate member preference or to overcome barriers, such as lack of transportation, which will continue to be prioritized to facilitate access to aftercare in lieu of the PIP's measure standards.
How were the challenges resolved?
To resolve barriers pertaining to contact on the day of discharge and high no show rates, liaisons began care coordination activities prior to the day of discharge to ensure follow-up appointments are scheduled and member's contact information is obtained in advance.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Evaluation Results
The change increased rates of care coordination contact from 56.15% in Q1 to 96.12% in Q4, leading to 99.20% of cases having a follow-up service scheduled after November/2023 and reducing no show rates from 51.11% in Q1 to an average of 14.66% in following quarters. Process tracking tools were augmented in Q2 to provide the service-level details necessary to evaluate the eligibility of clinical events. Guidance on places and types of service was developed and distributed to inform opportunities to prioritize qualifying services and resulted in progressively lower rates of utilization of ineligible CPT and POS codes from 29.17% in Q2 to 12.12% in Q4.
What successes were demonstrated through the intervention testing?
This intervention standardized procedures and established pathways that foster coordination and collaboration between inpatient and outpatient treatment facilities to support transition of care. In addition to securing aftercare services for 52.24% of members, 16 facilities were engaged in this collaboration and 199 new referrals were made for members that may not have secured aftercare otherwise. Offering a designated point of contact who's knowledgeable of needs promotes efficiency, expediting access, and enhancing convenience and satisfaction for members and providers alike. Ongoing collaboration is expected to create an increasingly more seamless transition between care settings. At conclusion, intervention testing results support improvements to Mental Health Partner's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization were effective, as evidenced by increased rates of eligible and timely BH follow-up services.

Appendix A1-1: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Status
Select one intervention status: ☒ Adopt ☐ Adapt ☐ Abandon ☐ Continue
Rationale for Intervention Status Selected
The intervention demonstrated effectiveness improving rates of eligible and timely BH follow-up services for members discharging from psychiatric inpatient placement. The provider's ability to resolve outstanding failure causes is limited and the extensive resources required for ongoing intervention outweigh expected benefits at this time. For these reasons, the process will be adopted to maintain coordination contact with facilities and members prior to the day of discharge from placement to arrange qualifying BH follow-up services. Providers will also leverage CCHA's Healthy Rewards member incentive program to offer financial compensation to members and promote engagement in recommended aftercare activities. Performance will continue to be tracked and monitored for process controls and regular evaluation for improvements.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (RAE 6)
PIP Title	*Follow-up After Hospitalization for Mental Illness (FUH)*
Intervention Title	Improve Jefferson Center for Mental Health's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Performance Improvement Projects

Instructions: Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	**Remeasurement 2 Intervention: Improve Jefferson Center for Mental Health's process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.**
What barrier(s) are addressed?	1. Unreliable process to ensure coordination and scheduling occur when discharges are AMA, unplanned/modified, or that take place while liaisons are unavailable, such as weekends/holidays. 2. Lack of staff training on measure specifications and requirements. 3. Lack of standardized process to mitigate specific process failures identified.
Describe how the intervention is culturally and linguistically appropriate.	Aftercare services are scheduled in accordance with client's needs and preferences, including cultural and language needs. Liaisons verify treatment recommendations from inpatient facilities and make efforts to speak directly to members to offer services at a convenient time through the preferred mode of delivery. Providers fluent in the member's primary language are prioritized as available, and language interpretation services are offered by phone, virtually, or in person to facilitate services for non-English speaking members.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Review data to identify partner provider with sufficient volume and resources to impact regional performance.
	2. Identify stakeholders, engage PIP team, and schedule recurring process meetings.
	3. Transfer daily inpatient placement census files for provider notification.
	4. Design process map to identify workflow gaps and opportunities for improvement.
	5. Align process with measure methodology specifications.
	6. Design tracking tool to track and monitor process performance.
	7. Train liaisons on workflow and documentation, and ensure needed resources are known and available.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Description			
	8. Retrieve and analyze tracking report to evaluate process effectiveness.		
Intervention Start Date (MM/DD/YYYY)	07/01/2024	**Intervention End Date (MM/DD/YYYY)**	06/30/2025

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**Hospital outreach for aftercare planning and coordination.**		
Numerator description (narrative)	Denominator events followed by a visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge.		
Denominator description (narrative)	Psychiatric inpatient placement discharges for CCHA members 6 years or older open or referred to Jefferson Center for Mental Health within the measurement period.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
07/01/2024-09/30/2024	**18**	**66**	**27.27%**
10/01/2024-12/31/2024			
01/01/2025-03/31/2025			
04/01/2025-06/30/2025			
If qualitative data were collected, provide a narrative summary of results below.			
CCHA partnered with Jefferson Center for Mental Health (JCMH) to outreach facilities and members at discharge from psychiatric inpatient placement and arrange aftercare services within 7 days. Between 7/1/2024 and 9/30/2024, JCMH liaisons established connections with 9 facilities to support aftercare planning and coordination for 51 members who were receiving services at the Center at the time of placement and 15 new referrals received from facilities. Rates of qualifying follow-up services is 29.41% for existing members compared to 20.00% for new referrals.			

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
The initial performance rate shows that 27.27% of members who received care coordination support from the JCMH liaisons had a qualifying behavioral health follow-up service within 7 days from discharge. However, this rate's calculation methodology excludes some types of service and modalities of delivery that do not qualify as a follow-up contact, per the PIP's measure specifications. This failure cause is associated with 43.18% of noncompliant events and the rate of general aftercare engagement is substantially higher. The second most frequent failure cause in Q1 was no follow up service scheduled (18.18%). Addressing process gaps associated with these issues is expected to significantly impact outcomes and will be prioritized for intervention.
What challenges were encountered?
Review of process data identified that the place of service was being incorrectly documented in the EHR, leading to claims with wrong and ineligible codes. In addition, the provider's decision to not utilize the Community Mental Health Center place of service code (POS 53) significantly restricts qualifying procedure codes.
How were the challenges resolved?
JCMH leadership was notified of incorrect documentation findings to ensure accuracy and compliance with documentation requirements. The reason why POS 53 is not used has not been discovered.
What successes were demonstrated through the intervention testing?
This intervention standardizes procedures and establishes pathways that foster coordination and collaboration between inpatient and outpatient treatment facilities to support transition of care. In addition to securing aftercare services for 27.27% of members, 9 facilities were engaged in this collaboration and 15 new referrals were made for members that may not have secured aftercare otherwise. Offering a designated point of contact who's knowledgeable of needs promotes efficiency, expediting access, and enhancing convenience and satisfaction for members and providers alike. Ongoing collaboration is expected to create an increasingly more seamless transition between care settings.

Appendix A1-2: State of Colorado PIP Intervention Worksheet
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon ☒ Continue
Rationale for Intervention Status Selected
The intervention will continue as planned to support care coordination, access to timely follow-up care, and accuracy of service documentation.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (RAE 6)
PIP Title	*Social Determinants of Health (SDOH) Screening*
Intervention Title	Standardize process and requirements for screening CCHA members enrolled in BTOC and STOC programming for unmet food, housing, utility, and transportation needs

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Instructions: Complete a separate worksheet for each intervention.

Intervention Description	
Intervention Title	**Standardize process and requirements for screening CCHA members enrolled in BTOC and STOC programming for unmet food, housing, utility, and transportation needs.**
What barrier(s) are addressed?	Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and ATU for a behavioral health condition, or high levels of care for a SUD event.
Describe how the intervention is culturally and linguistically appropriate.	Members are offered local resources to access unmet social factors in accordance with their specific needs and preferences, including cultural and language needs. BTOC and STOC staff fluent in the member's primary language are prioritized, and language interpretation services are available to facilitate services for non-English speaking members.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Identify available resources, stakeholders, engage PIP team, and schedule recurring process meetings.
	2. Select tool for screening for social determinants of health.
	3. Design process map to identify workflow gaps and opportunities to align screening with existing procedures.
	4. Embed SDOH screening tool in Health Needs Assessment (HNA).
	5. Design performance tracking reports.
	6. Review data to determine performance baseline.
	7. Train BTOC and STOC staff on workflow and documentation, and ensure needed resources are known and available.
	8. Retrieve and analyze tracking report to evaluate process effectiveness.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Intervention Description			
Intervention Start Date (MM/DD/YYYY)	07/01/2023	**Intervention End Date (MM/DD/YYYY)**	06/30/2025

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Intervention Effectiveness Measure			
Intervention Effectiveness Measure Title	**SDOH Screening of members enrolled in CCHA's BTOC and STOC programming.**		
Numerator description (narrative)	Number of cases from the denominator that have a documented screening for unmet food, housing, utility, and transportation needs.		
Denominator description (narrative)	Number of CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) cases for members enrolled and reached during the measurement period.		
Intervention Evaluation Period Dates (MM/DD/YYYY-MM/DD/YYYY)	**Numerator**	**Denominator**	**Percentage**
07/01/2023-09/30/2023	**160**	**259**	**61.78%**
10/01/2023-12/31/2023	**146**	**331**	**44.11%**
01/01/2024-03/31/2024	**177**	**330**	**53.64%**
04/01/2024-06/30/2024	**268**	**330**	**81.21%**
If qualitative data were collected, provide a narrative summary of results below.			
N/A			

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Intervention Evaluation Results
What lessons did the MCO learn from the intervention testing and evaluation results?
The intervention was originally designed to correspond to the performance improvement plan's aim of increasing the percentage of members enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) who are screened for Social Determinants of Health (SDOH) needs. However, the inability to reach members for screening emerged as a confounding variable in assessing the team's performance. To mitigate the impact of unreachable members, the intervention was modified to include only those cases where the member or guardian was successfully contacted. This adjustment enabled an independent evaluation of the teams' success in increasing the percentage of screenings each quarter, irrespective of the total number of members reached. After a decline in Q2, adjustments to the PIP workgroup's internal stakeholder communication and engagement strategy have been effective in reestablishing screening rates and are expected to continue contributing to positive outcomes. Quarterly intervention measurements indicate performance is trending upward along with the number of screenings administered to members reached, supporting this strategy has been productive in driving improvements. However, it is important to note that the increase in the number of screenings would not have met the target without the decrease in membership size. Ongoing evaluation is necessary to assess the intervention's effectiveness in increasing and sustaining a higher volume of screenings.
What challenges were encountered?
A challenge in implementing the PIP intervention included conflicting priorities during the initial rollout. This period coincided with numerous structural and procedural changes within the Care Coordination team, thereby restricting the ability to adequately focus on balancing the new process with staff needs.
How were the challenges resolved?
As competing projects concluded or became more established, additional focus was gradually dedicated to this intervention. Increased emphasis on adherence to screening and documentation requirements was regularly communicated to the team, reinforcing the priority and re-educating staff on the significance of assessing SDOH needs.
What successes were demonstrated through the intervention testing?
The increased focus on SDOH screening required reevaluation of available resources, competing requirements and associated benefit to inform adjustments to CCHA's member engagement strategy. Mandatory questions were highlighted on the HNA assessment to

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Intervention Evaluation Results
prompt staff to target priority elements amid extensive general documentation requirements. Care coordination leaders also initiated auditing all HNAs for members reached prior to case closure, promoting corrections, real-time feedback, and identification of knowledge gaps requiring support or clarification. The Quality department participated in team meetings to share updates on the process, outcomes, and impact of these efforts. Staff were invited to provide direct feedback on the workflow and to brainstorm solutions on enhancements to support ongoing improvements. In addition to staff education and focus on value enabling activities, these efforts improved internal collaboration and shared process responsibility, participation, and ownership among stakeholders. Communicating and reviewing performance data with care coordinators has helped to enhance transparency, drive accountability, sustain engagement, and foster a culture of continuous improvement. Adjustments to the PIP workgroup's internal stakeholder communication and engagement strategy have been effective in reestablishing screening rates and are expected to continue supporting improvements. The remeasurement 1 period concluded with the highest screening rate since intervention deployment and statistical significance over Q1 was achieved. This improvement also corresponded to a higher number of screenings administered to all BTOC and STOC members in this period, resulting in a PIP performance rate exceeding the statistically significant target.

Appendix A1-3: State of Colorado PIP Intervention Worksheet
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Intervention Status
Select one intervention status: ☐ Adopt ☐ Adapt ☐ Abandon ☒ Continue
Rationale for Intervention Status Selected
Intervention testing will continue for ongoing evaluation of the intervention's effectiveness increasing the volume of screenings and sustaining outcomes with a stable membership size.

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

Demographic Information			
MCO Name:	Colorado Community Health Alliance (RAE 6)		
Project Leader Name:	Camila Joao	**Title:**	Clinical Quality Program Manager
Telephone Number:	(303) 817-3791	**Email Address:**	camila.joao@cchacares.com
PIP Title:	*Follow-Up After Hospitalization for Mental Illness (FUH)*		
Submission Date:	October 31, 2024		
Resubmission Date:	January 22, 2025		

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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 Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance Region 6

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
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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)*

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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*	The health plan reported accurate indicator data; however, HSAG was unable to replicate the reported p value for the Fisher's Exact test comparing Remeasurement 1 to baseline results. HSAG calculated $p = 0.5037$. If the health plan is using GraphPad or a similar calculator, please ensure that the numerator value is entered for Outcome 1 and the difference between the numerator and denominator is entered for Outcome 2. HSAG is available to provide statistical testing support and technical assistance upon request, if needed. **Resubmission January 2025:** The health plan corrected the Remeasurement 1 statistical testing results and addressed the initial feedback. The validation score for this evaluation element has been change to *Met*.
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	As noted in the feedback for Evaluation Element 1, above, the health plan should correct the p value in the Baseline to Remeasurement 1 Narrative. **Resubmission January 2025:** The health plan corrected the Baseline to Remeasurement 1 Narrative and addressed the initial feedback. The validation score for this evaluation element has been change to *Met*.
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	The health plan included a statement regarding the validity of the Remeasurement 1 results but did not discuss whether any factors were identified that may threaten the ability to compare the Remeasurement 1 results to the baseline results. The health plan should revise the Baseline to Remeasurement 1 Narrative to also discuss whether any factors were identified that threaten comparability of Remeasurement 1 results to baseline results. If no factors were identified, then a statement of this fact should be added to the Baseline to Remeasurement 1 Narrative. This requirement applies to the narrative for each remeasurement period. **Resubmission January 2025:** The health plan corrected the Baseline to Remeasurement 1 Narrative and addressed the initial feedback. The validation score for this evaluation element has been change to *Met*.

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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*
Not Applicable (N/A)	0	0	*Not Applicable (N/A)*

* "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.

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Follow-Up After Hospitalization for Mental Illness (FUH)
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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*	**General Feedback:** To drive greater improvement in overall performance indicator results, the health plan should consider shorter testing periods for future interventions. For example, if meaningful effectiveness data can be collected in 1-3 months to determine intervention effectiveness, the health plan can make a decision to adapt, adopt, or abandon and move onto revising the intervention or starting a new intervention before the end of the measurement period. The health plan should consider collecting more real-time, process-level intervention effectiveness data to support timely decisions about adopting, adapting, or abandoning interventions to support overall improvement.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	**General Feedback**: The health plan should consider if additional interventions are needed to sufficiently address high-impact barriers and drive improvement in overall indicator results.

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.

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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)*

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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.		*Not Met*	The indicator results demonstrated a decline in performance from baseline to Remeasurement 1. **Resubmission January 2025:** The indicator results remained the same; therefore, the validation score for this evaluation element remains *Not Met*.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Met*	The indicator results demonstrated a decline in performance from baseline to Remeasurement 1. **Resubmission January 2025:** The indicator results remained the same; therefore, the validation score for this evaluation element remains *Not 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	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	2	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.

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Table B—1 2024-25 PIP Validation Tool Scores for *Follow-Up After Hospitalization for Mental Illness* for Colorado Community Health Alliance Region 6										
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	1	0	2	0	1	1	0	0	0
Totals for All Steps	**26**	**16**	**0**	**2**	**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 Hospitalization for Mental Illness* for Colorado Community Health Alliance Region 6	
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 Hospitalization for Mental Illness* for Colorado Community Health Alliance Region 6	
Percentage Score of Evaluation Elements *Met**	***33%***
Percentage Score of Critical Elements *Met***	***100%***
Confidence Level***	***No 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.

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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***

IISAG assessed the MCO's PIP based on CMS Protocol 1 and determined whether the MCO produced evidence of significant improvement. IISAG'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:	***No Confidence***

Appendix B: State of Colorado 2024-25 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance Region 6

Demographic Information			
MCO Name:	Colorado Community Health Alliance Region 6		
Project Leader Name:	Camila Joao	**Title:**	Clinical Quality Program Manager
Telephone Number:	(303) 817-3791	**Email Address:**	camila.joao@cchacares.com
PIP Title:	*Social Determinants of Health (SDOH) Screening*		
Submission Date:	October 31, 2024		
Resubmission Date:	January 22, 2025		

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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.

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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.

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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.

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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*	**General Feedback:** The health plan stated in Step 4 that the entire eligible population defined in Step 3 of the PIP Submission Form was included in the PIP; therefore, sampling methods were not applicable.
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.

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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.

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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.

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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)*

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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*	The health plan reported accurate indicator data; however, HSAG was unable to replicate the reported p value for the Fisher's Exact test comparing Remeasurement 1 to baseline results. HSAG calculated $p = 0.3731$. If the health plan is using GraphPad or a similar calculator, please ensure that the numerator value is entered for Outcome 1 and the difference between the numerator and denominator is entered for Outcome 2. HSAG is available to provide statistical testing support and technical assistance upon request, if needed. **Resubmission January 2025:** The health plan updated the Remeasurement 1 indicator results and corrected the statistical testing results. The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.
2. Included a narrative interpretation of results that addressed all requirements.		*Partially Met*	As noted in the feedback for Evaluation Element 1, above, the health plan should correct the p value in the Baseline to Remeasurement 1 Narrative. In addition, when describing the difference between the baseline and Remeasurement 1 indicator rates, the correct units is percentage points, rather than percent. For example, there was an increase of 1.62 percentage points. **Resubmission January 2025:** The health plan addressed the initial feedback; however, some of the revised documentation in the Baseline to Remeasurement 1 Narrative was unclear including the statement, "Data completeness for remeasurement 1 period is 93.33% at resubmission and screenings may still occur for enrolled members". The validation score for this evaluation element remains *Partially Met*. HSAG recommends a technical assistance call to clarify the health plan's Remeasurement 1 narrative interpretation of results.

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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:			
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	The health plan included a statement regarding the validity of the Remeasurement 1 results but did not discuss whether any factors were identified that may threaten the ability to compare the Remeasurement 1 results to the baseline results. The health plan should revise the Baseline to Remeasurement 1 Narrative to also discuss whether any factors were identified that threaten comparability of Remeasurement 1 results to baseline results. If no factors were identified, then a statement of this fact should be added to the Baseline to Remeasurement 1 Narrative. This requirement applies to the narrative for each remeasurement period. **Resubmission January 2025:** The health plan addressed the initial feedback and the validation score for this evaluation element has been changed to *Met*.

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	2	1	*Met*
Partially Met	1	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.

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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*	**General Feedback:** To drive greater improvement in overall performance indicator results, the health plan should consider shorter testing periods for future interventions. For example, if meaningful effectiveness data can be collected in 1-3 months to determine intervention effectiveness, the health plan can make a decision to adapt, adopt, or abandon and move onto revising the intervention or starting a new intervention before the end of the measurement period. The health plan should consider collecting more real-time, process-level intervention effectiveness data to support timely decisions about adopting, adapting, or abandoning interventions to support overall improvement.
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Met*	**General Feedback:** The health plan should consider if additional interventions are needed to sufficiently address high-impact barriers and drive improvement in overall indicator results.
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.

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Results for Step 7 - 8			
Total Evaluation Elements	8	4	Critical Elements
Met	7	4	*Met*
Partially Met	1	0	*Partially Met*
Not Met	0	0	*Not Met*
N/A (Not Applicable)	0	0	*N/A (Not Applicable)*

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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*	The improvement in indicator results from baseline to Remeasurement 1 was not statistically significant. **Resubmission January 2025:** The updated Remeasurement 1 results demonstrated statistically significant improvement over baseline. The validation score for this evaluation element has been changed to *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 Colorado Community Health Alliance Region 6

Table B—1 2024-25 PIP Validation Tool Scores for *Social Determinants of Health Screening* for Colorado Community Health Alliance Region 6										
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	2	1	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**	**1**	**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 Colorado Community Health Alliance Region 6	
Percentage Score of Evaluation Elements *Met**	***94%***
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 Colorado Community Health Alliance Region 6	
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 Colorado Community Health Alliance Region 6

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***