COLORADO

Department of Health Care Policy & Financing

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

Fiscal Year 2022–2023 PIP Validation Report

for

Northeast Health Partners Region 2

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an external quality review (EQR) of each contracting health plan. Health plans include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), primary care case management entities (PCCM entities), and prepaid ambulatory health plans (PAHPs). The regulations at 42 CFR §438.350 require that the EQR include analysis and evaluation by an external quality review organization (EQRO) of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the State of Colorado, Department of Health Care Policy and Financing (the Department)—the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

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

For fiscal year (FY) 2022–2023, the Department required health plans to conduct PIPs in accordance with 42 CFR §438.330(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

Measuring performance using objective quality indicators

Implementing system interventions to achieve improvement in quality

Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

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

(CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[1-1]

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[1-2] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement (QI). The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. CMS agreed that given the pace of QI science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed and provided HSAG with approval to use this approach in all requesting states.

PIP Components and Process

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

There are four modules with an accompanying reference guide for the MCOs to use to document their PIPs. Prior to issuing each module, HSAG held module-specific trainings with the MCOs to educate them about the documentation requirements and use of specific QI tools for each of the modules. The four modules are defined below:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes building a PIP team, describing the PIP topic, and narrowed focus, and providing the rationale and supporting data for the selected narrowed focus. In Module 1, the narrowed focus baseline data collection specifications and methodology are defined, and the MCO sets aims (Global and SMART), completes a key driver diagram, and sets up the SMART Aim run chart for objectively tracking progress toward improvement for the duration of the project.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 28, 2023.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 28, 2023.

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

PIP Terms

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

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

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

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **NHP R2**'s module submission forms. In FY 2022–2023, these forms provided detailed information about **NHP R2**'s PIP and the activities completed in Module 4. (See Appendix A. Module Submission Form.) Following HSAG's rapid-cycle PIP process, each health plan submitted Module 4 according to the approved timeline. HSAG provided scores and feedback and assigned a level of confidence to the PIP in the Module 4 validation tool. If a PIP received less than *High Confidence* on initial review, the health plan had an opportunity to receive technical assistance from HSAG and to complete a single Module 4 resubmission to address the initial validation findings.

Validation Scoring

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

- ***High confidence*** = The PIP was methodologically sound; the SMART Aim goals, statistically significant, clinically significant, or programmatically significant improvements were achieved for both measures; at least one tested intervention for each measure could reasonably result in the demonstrated improvement; and the MCO accurately summarized the key findings and conclusions.
- ***Moderate confidence*** = The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:

  ☐ The SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved *for only one measure,* and the MCO accurately summarized the key findings and conclusions.

  ☐ Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure,* and the MCO accurately summarized the key findings and conclusions.

  ☐ The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.

- ***Low confidence*** = One of the following occurred:

  ☐ The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.

  ☐ The PIP was methodologically sound. The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.

  ☐ The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.

- ***No confidence*** = The SMART Aim measure methodology and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

PIP Topic Selection

In FY 2022–2023, **NHP R2** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen.*

NHP R2 defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What measure will be used? What current data (i.e., count, percent, or rate) are available for that measure? How much increase or decrease in the indicator will demonstrate improvement?
- **A**ttainable: Rationale for setting the goal: Is the desired achievement based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Table 1-1 includes the SMART Aim statements established by **NHP R2**.

Table 1-1—PIP Measures and SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By 6/30/2022, use key driver diagram interventions to increase the percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC), ages 12 years and up, from 84.04% to 85.06%.
Follow-Up After a Positive Depression Screen	By 6/30/2022, use key driver diagram interventions to increase the percentage of behavioral health (BH) follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC, ages 12 years and up, from 40.22% to 47.66%.

Module 4: PIP Conclusions

In FY 2022–2023, **NHP R2** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed initial Module 4 submission form, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

The health plan's final Module 4 submission met all validation criteria. The PIP was methodologically sound, the PIP results demonstrated significant improvement, at least one of the interventions could reasonably result in the demonstrated improvement, and the health plan accurately summarized key findings and conclusions. Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*. Below are summaries of key Module 4 validation findings. Complete validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

SMART Aim Measure Results

HSAG analyzed **NHP R2**'s PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **NHP R2**'s success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for **NHP R2**'s PIP are presented in Table 2-1. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 2-1—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens completed at eligible outpatient encounters among Sunrise members at Monfort Family Clinic (MFC), ages 12 years and up.	84.04%	85.06%	87.40%	Yes

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of behavioral health (BH) follow-ups after a positive depression screen within 30 days of the eligible outpatient encounter among Sunrise members at MFC, ages 12 years and up.	40.22%	47.66%	49.00%	No

To guide the project, **NHP R2** established goals of increasing the percentage of members 12 years of age and older, attributed to Sunrise Community Health, who received a depression screening during an outpatient visit at MFC, from 84.04 percent to 85.06 percent, and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 40.22 percent to 47.66 percent, through the SMART Aim end date of June 30, 2022. **NHP R2**'s reported SMART Aim measure results demonstrated that the SMART Aim goals were exceeded for both measures. For the *Depression Screening* measure, the highest rate achieved, 87.40 percent, represented a statistically significant increase of 3.36 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 49.00 percent, represented an increase of 8.78 percentage points above the baseline rate, which was not statistically significant. The health plan's final SMART Aim run chart and SMART Aim measure data are provided in Appendix A. Module Submission Form.

Intervention Testing Results

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, **NHP R2** completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 2-2 summarizes **NHP R2**'s interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 2-2—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Staff feedback on depression screening performance and training on depression screening procedures.	Significant *clinical* and *programmatic* improvement for *Depression Screening*	Adopted

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Establish a clinical policy for BH referral after a positive depression screen, and provide staff training on the BH referral policy and procedures following a positive depression screen.	Significant *clinical* and *programmatic* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

NHP R2 tested two provider-focused interventions for the project: One intervention focused on *Depression Screening,* and one intervention focused on *Follow-Up After a Positive Depression Screen*. For the depression screening staff feedback intervention, the health plan reported intervention testing results that demonstrated significant clinical improvement in the percentage of members receiving a depression screen and significant programmatic improvement in provider planning and preparation to consistently offer depression screening to members. The intervention was adopted as a result of the sustained improvement demonstrated by the testing results. For the BH referral policy intervention, the health plan reported intervention testing results that demonstrated significant clinical improvement in the percentage of members who received follow-up BH services within 30 days of a positive depression screen and significant programmatic improvement in the consistency of successful BH service referrals. The intervention testing results demonstrated efficacy and sustainability; therefore, the intervention was adopted.

Lessons Learned

An important part of the QI process is to consider how the information gathered and lessons learned during the PIP can be applied in future improvement efforts. **NHP R2** reported successes, challenges, and lessons learned as part of the Module 4 submission.

NHP R2 documented the following lessons learned from the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP:

- The value of an engaged PIP team and practice leadership, despite shifting roles and responsibilities and the concurrent public health emergency, contributed to the success of the project.
- The benefits and limitations of technology for rapid-cycle data collection. Leveraging information technology (IT) resources within the partner provider practice facilitated automated data collection for the project, which would have otherwise required resource-intensive manual medical record review. However, there were limitations to the accessibility and timeliness of using provider electronic health records for real-time monitoring of performance.

3. Conclusions and Recommendations

Conclusions

NHP R2 developed a methodologically sound improvement project that met both State and federal requirements. The health plan tested two interventions using the required QI processes and tools. At the conclusion of the PIP, the health plan accurately reported results that demonstrated achievement of the SMART Aim goal for both *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures and statistically significant improvement over baseline performance for the *Depression Screening* measure. The health plan's intervention testing results also demonstrated clinically and programmatically significant improvement linked to the tested interventions for both measures. Based on the validation findings, HSAG assigned a level of *High Confidence* to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Recommendations

HSAG has the following recommendations:

- **NHP R2** should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- **NHP R2** should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Appendix A. Module Submission Form

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Managed Care Organization (MCO) Information	
MCO Name	Northeast Health Partners (NHP) – RAE 2
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Edward Arnold
Title	Performance Improvement Analyst
Email Address	Edward.Arnold@beaconhealthoptions.com
Telephone Number	719-244-9758
Submission Date	October 21, 2022
Resubmission Date (if applicable)	January 12, 2023

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets- Uploaded with submission

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Final SMART Aim Run Chart – *Depression Screening*

Instructions: In the space below, insert or attach the final SMART Aim run chart. Include the following:

- SMART Aim goal.
- Narrowed focus baseline percentage.
- Rolling 12-month measure data points for the duration of the PIP.
- Intervention markers to display how the timing of the interventions coincided with changes in the SMART Aim measure.

Run chart for Depression Screening is found at Attachment 1.

To confirm that the MCO used the 12-month methodology as required, check the box below.

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Final Monthly SMART Aim Measure Data – *Depression Screening*

Instructions:

- In Table 1a, provide the monthly numerator, denominator, and percentage for each SMART Aim rolling 12-month measurement period.
- The reporting month is the last month of each rolling 12-month measurement period.
- Add additional rows to the table as needed.

Table 1a—SMART Aim Measure Monthly Data - *Depression Screening*

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
07/01/20 – 06/30/21	June	10256	11741	87.4%
08/01/20 – 07/31/21	July	10057	11559	87.0%
09/01/20 – 08/31/21	August	9941	11446	86.9%
10/01/20 – 09/30/21	September	9974	11539	86.4%
11/01/20 – 10/31/21	October	10012	11541	86.8%
12/01/20 – 11/30/21	November	9837	11339	86.8%
01/01/21 – 12/31/21	December	9583	11074	86.5%
02/01/21 – 01/31/22	January	9368	10878	86.1%
03/01/21 – 02/28/22	February	9341	10897	85.7%
04/01/21 – 03/31/22	March	9179	10677	86.0%
05/01/21 – 04/30/22	April	9111	10526	86.6%
06/01/21 – 05/31/22	May	9214	10566	87.2%
07/01/21 – 06/30/22	June	9056	10370	87.3%

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Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Final SMART Aim Run Chart – *Follow–up After a Positive Depression Screen*

Instructions: In the space below, insert or attach the final SMART Aim run chart. Include the following:

- SMART Aim goal.
- Narrowed focus baseline percentage.
- Rolling 12-month measure data points for the duration of the PIP.
- Intervention markers to display how the timing of the interventions coincided with changes in the SMART Aim measure.

Revised run chart for Follow-up After Positive Depression Screening is found at Attachment 6 (formerly Attachment 2).

To confirm that the MCO used the 12-month methodology as required, check the box below.

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Final Monthly SMART Aim Measure Data – *Follow–up After a Positive Depression Screen*

Instructions:

- In Table 1b, provide the monthly numerator, denominator, and percentage for each SMART Aim rolling 12-month measurement period.
- The reporting month is the last month of each rolling 12-month measurement period.
- Add additional rows to the table as needed.

Table 1b—SMART Aim Measure Monthly Data - *Follow–up After a Positive Depression Screen*

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
07/01/20 – 06/30/21	June	187	496	37.7%
08/01/20 – 07/31/21	July	179	478	37.4%
09/01/20 – 08/31/21	August	175	447	39.1%
10/01/20 – 09/30/21	September	164	415	39.5%
11/01/20 – 10/31/21	October	157	383	41.0%
12/01/20 – 11/30/21	November	154	370	41.6%
01/01/21 – 12/31/21	December	151	351	43.0%
02/01/21 – 01/31/22	January	154	342	45.0%
03/01/21 – 02/28/22	February	146	327	44.6%
04/01/21 – 03/31/22	March	154	334	46.1%
05/01/21 – 04/30/22	April	159	337	47.2%
06/01/21 – 05/31/22	May	170	360	47.2%
07/01/21 – 06/30/22	June	187	382	49.0%

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Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

Depression Screening and Follow–up After a Positive Depression Screen

for **Northeast Health Partners (RAE 2)**

Final Key Driver Diagrams

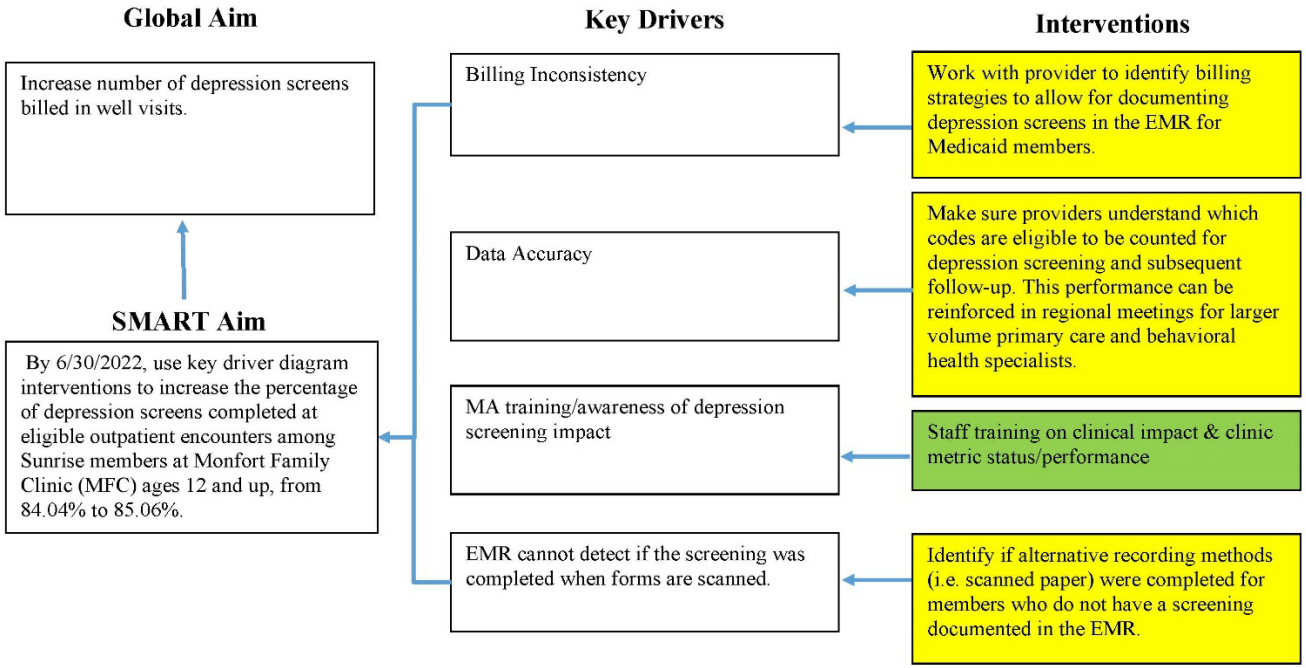
Instructions: In the space below, provide the updated final key driver diagrams. The MCO must use the following color-coding system in the final key driver diagrams. The MCO should ensure that one key driver diagram is provided for each outcome: ***Depression Screening*** and ***Follow–up After a Positive Depression Screen***.

- Green highlight for successful adopted interventions.
- Yellow highlight for interventions that were adapted or not tested.
- Red highlight for interventions that were abandoned.
- Blue highlight for interventions that require continued testing.

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Northeast Health Partners (RAE 2)**

Key Driver Diagram– *Depression Screening*



Date: 10/1/22
Version: 2

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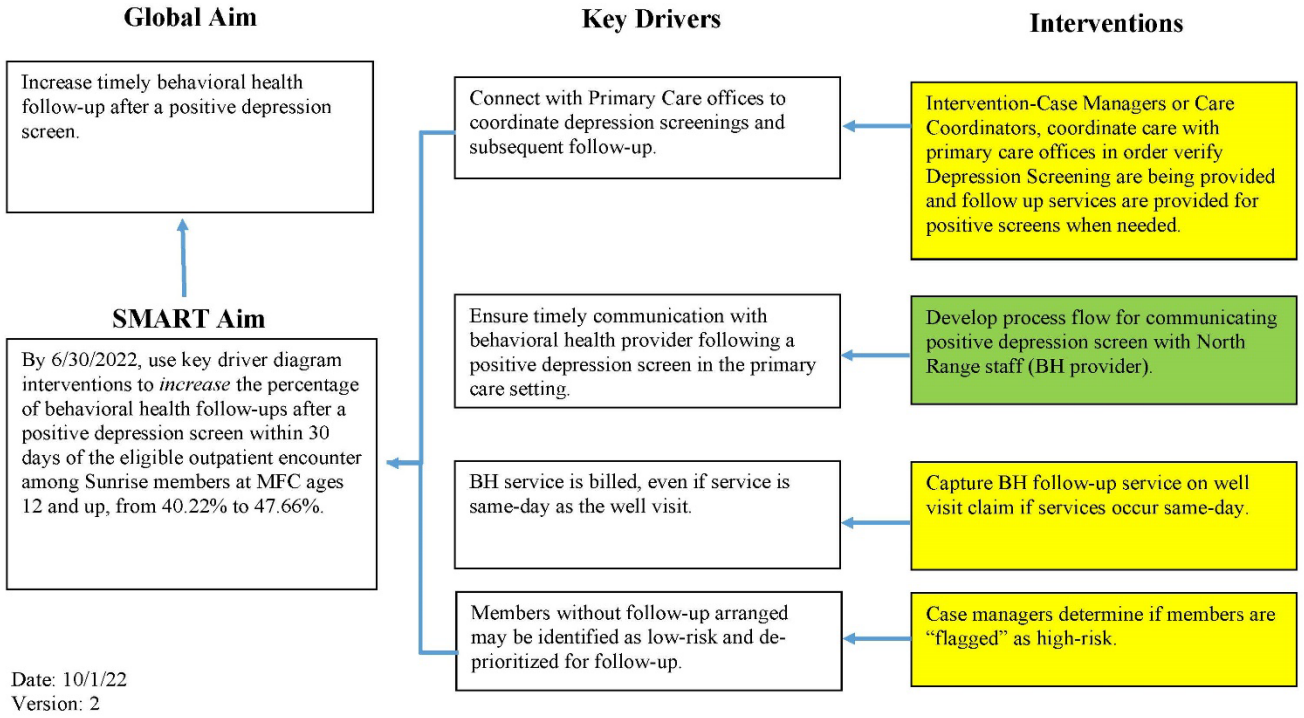
Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Northeast Health Partners (RAE 2)**

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



Date: 10/1/22
Version: 2

State of Colorado
Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Northeast Health Partners (RAE 2)**

Project Conclusions

Instructions: In Table 2a, for ***Depression Screening***, and in Table 2b, for ***Follow–up After a Positive Depression Screen***, provide a description of the following:

- **Project Conclusions**: The narrative should include whether the SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved and what led to the success of the project. If the SMART Aim goal was not achieved and statistically significant improvement in the SMART Aim measure was not achieved, the narrative should describe if there was any non-statistically significant improvement demonstrated by the SMART Aim measure. If the SMART Aim goal or significant improvement was *not* achieved, the narrative should explain why improvement was not achieved and include planned changes to address the lack of improvement in future improvement projects.
- **Intervention Testing Conclusions**: Describe the intervention(s) that had the greatest impact on the SMART Aim, why the MCO came to these conclusions, and how the timing of the intervention(s) related to changes in the SMART Aim measure rate. This narrative should align with the results of the PDSA cycle(s) detailed in the PDSA worksheet(s).
- **Spread of Successful Intervention(s)**: For successful intervention(s), the MCO will describe its plan for spreading the intervention(s) beyond the selected narrowed focus of the PIP.
- **Challenges Encountered**: Describe any challenges or barriers that occurred during the project and the MCO's actions to overcome or address the challenge(s) and/or barrier(s).
- **Lessons Learned/Information Gained**: Describe the knowledge and experience gained from the project. This information can prove to be highly valuable and be applied to future projects.
- **Sustainability of Improvement:** Below each table, provide a narrative description of plans for sustaining any improvement achieved beyond the SMART Aim end date.

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Northeast Health Partners (RAE 2)

Table 2a—Project Conclusions – *Depression Screening*	
Project Conclusions	The SMART Aim goal was achieved by the Sunrise team. This demonstrated statistically significant improvement from baseline performance. Clinically significant improvement was achieved by more depression screens being conducted to identify potential depressive symptoms in a setting where appropriate intervention is available. Programmatic significance was demonstrated by the sustained improvement in performance despite significance workforce challenges impacting Medical Assistant (MA) staffing at the same time that the clinical teams needed to adapt to the Public Health Emergency (PHE).
Intervention Testing Conclusions	The pre-visit planning tool is a valuable decision-support instrument for MAs. The ability of this tool to extract the potential need for depression screening from the Electronic Health Record (EHR) without a manual review of the record is a significant benefit. Performance on the measure was elevated at the time of the intervention. This is most likely due to the prolonged period between the baseline calculation and the implementation of the intervention that was forced by the PHE. The strength of this intervention was demonstrated by the sustained performance gains in the face of MA staffing issues and increased COVID volume between November 2021 and February 2022. The efficacy of the intervention is also supported by the ability to be adopted so quickly as Sunrise initiated an MA training program in response to the work force challenges.
Spread of Successful Interventions	Sunrise Community Health Center will disseminate the workflow for use of the pre-visit planning tool throughout all clinic sites. Cindy McDade was an integral member on the PIP team and continues to serve as the Director of Quality for Sunrise Community Health. She also has recently assumed the role as Director of Operations and can oversee implementation of this workflow across sites outside of Monfort Clinic. The use of pre-visit planning is included at the earliest stages of Medical Assistant (MA) orientation as described in the MA Training Checklist (Attachment 3). The element of the intervention focusing on communication of performance results will be communicated to each clinic

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	for them to incorporate as appropriate at their site. An example of a board that has been constructed to communicate current performance and maintain an open dialog on performance is found at Attachment 4.
Challenges Encountered During Project	Although the PIP project was able to resume when the most critical phases of the PHE had past, the impact of the PHE on clinical operations were immense. The clinic flow to accommodate patients with suspected or confirmed COVID generated a larger than expected volume of walk-in patients. These walk-in patients were processed outside the established workflows to use the pre-visit planning tool and would be less likely to receive depression screening. The explicit COVID impact also impacted staff availability when staff members tested positive and were unable to come to work. This often resulted in available staff covering multiple provider teams at the same time. Finally, the PHE impact on the available workforce was most significant. Leadership implemented innovative strategies to recruit and retain MAs as staffing levels reached critical lows.
Lessons Learned/Information Gained Throughout the Project	Foremost in the lessons learned from this project was the value of an engaged PIP team. While there were a few members who joined the team as staff roles shifted at the clinic, the new members stepped up to actively participate and the existing team members welcomed both their experience and their fresh insights on the process. Another valuable lesson was the leveraging of Information Technology (IT) within the practice. The pre-visit planning tool automated a process that in the past would require a manual review of a medical record and significant man-hours. On a related note, IT resources must be reviewed and utilized with an awareness of the potential limitations of the tools. The depression screening tracked by this PIP was measured from the EHR documentation rather than via claims that were used to trigger the requirement for a follow-up behavioral health encounter discussed elsewhere in this document. This could cause confusion for staff striving to meet performance goals. A potential challenge of these tools was evident as even the reporting pulled from the EHR to provider more real-time performance rates provided a coarse estimate of the actual measure targeted by the PIP and was not necessarily sensitive to predict performance gains or losses.

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Sustainability of Improvement – *Depression Screening*

Instructions: In the space below, describe the MCO's plan for sustaining improvement achieved for ***Depression Screening*** beyond the SMART Aim end date.

Cindy McDade was an integral member on the PIP team and continues to serve as the Director of Quality for Sunrise Community Health. She also has recently assumed the role as Director of Operations and will be able to balance the priorities for each of these areas with an awareness of the efforts involved to produce these gains and the importance in sustaining them. Including the pre-visit planning document explicitly in orientation checklists (Attachment 3) will ensure that new staff members are competent with the use of this tool. Ongoing monthly monitoring of depression screening performance by the Quality team (along with other performance measures) will ensure that potential negative trends catch the attention of clinical managers to address. The use of visual display boards to increase staff awareness of performance (Attachment 4) will also increase awareness of Sunrise's quality priorities and maintain dialog between staff on performance. A final element for sustainment is the annual reporting of Uniform Data Set (UDS) measures that Sunrise must comply with as a Federally Qualified Health Center (FQHC). Depression screening is one of the UDS measures included in these annual reports and visibility for performance is a major factor in maintaining improvements.

The sustainment plan for this measure will also involve the partnership with NHP. Reporting available within Sunrise Health Centers EHR may capture overall performance and may include non-NHP members. While the EHR reporting may capture clinical care, the reporting monitored by the NHP Quality team will capture claims-based reporting of depression screening and may identify trends, as well. Active dialog regarding these slightly different measures provides a collaboration to encourage engagement and accountability.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Project Conclusions	The SMART Aim goal for this measure was ultimately achieved in June 2022 based on data provided 10/27/22. Both clinically and programmatically statistically significant improvement were achieved. As evidenced by steady improvement across the timeline of this project, the team concluded that the intervention was effective and sustainable. The improvement is primarily the product of engaged leadership supporting the full integration of the behavioral health team from North Range Behavioral Health and the primary care medical providers from Sunrise. Actively encouraging collaboration in patient management (e.g., co-visits) and facilitating interpersonal connections (e.g., daily huddles) built trust between these entities for both clinical care and responsiveness. The intervention appears to be sustainable, although potentially vulnerable to workforce challenges. Data for the final month of the PIP evaluation period (June 2022) was not available at the time of original submission to HSAG due to it being a claims-based measure subject to a 90-day claims lag as was discussed during the Technical Assistance (TA) call with HSAG on 7/25/22. Data for June 2022 was subsequently available to support this conclusion and is included in this submission. Results were reported to all PIP team members and organizations when they became available.
Intervention Testing Conclusions	There was a single intervention utilized to impact the Follow-up after a Positive Depression Screen measure. The impact was positive and steady; continuing a positive trend through the last month that data was available for at the time of this submission. The timing of the improvement coincided with the initiation of the intervention further suggesting the impact of this intervention. As performance on the measure continues to improve, it is unclear where performance due to this intervention alone may plateau prior to other failure modes being addressed, if the clinic desires.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	The team learned that early in the timeline for implementing this intervention that there were occasionally "flags" that were not applied to notify behavioral health of a positive screening result. Remedial training appears to have addressed the issue, but appropriate orientation and periodic reinforcement of procedures are likely necessary for any new workflow or procedure. Related to a potential code that was both clinically appropriate and included in the BHIP measure specifications, the team concluded that this disparity was unlikely to impact performance on the SMART Aim and should not be an issue in the future as the disparity was solely the result of comparisons with 2019 performance. Another valuable conclusion from this PIP was understanding the potential value of EHR-based reporting options as proxies for claims-based measures. While the EHR-based reporting is likely capturing the presence of good clinical care, these measures are often not a good proxy for claims-based measures and most importantly, not good proxies for this measure that relies on a completed behavioral health encounter as follow-up. Future PIP efforts should be purposeful in determining if the desired outcome is best assessed by clinical documentation alone (EHR-based) or claims and then valid Intervention Effectiveness Measures should be selected. In a related fashion, this PIP concluded that if a claims-based measure is the preferred outcome and the team would like to cycle through the PDSA more rapidly, that using partial claims (i.e., 60-day claim lag data) may be a useful Intervention Effectiveness measure. It is important to acknowledge the potential limitations of this strategy, but data since December 2021 has shown zero variance.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Spread of Successful Interventions	This PIP focused only on a single clinic site within the Sunrise Health system. Five (5) other clinic sites provide primary care within Sunrise and are the first opportunity for spread of this validated intervention. Each clinic site has access to the same reporting and notification methods to contact behavioral health in the event of a positive depression screen, however three (3) of these sites are children's clinics. This intervention included a portion of the pediatric population as eligibility started at twelve (12) years old, but the data was not analyzed for effectiveness specific to those under twenty-one (21). There are also currently behavioral health staff vacancies at each of these sites which may decrease the effectiveness as same-day interventions may be limited. Aware of these limitations, Sunrise has an organizational structure with a Quality focus that regularly monitors performance. Sunrise has implemented these workflows in conjunction with North Range Behavioral Health at each of the Sunrise sites. Clinical and operational priorities will be considered for to determine if this intervention meets the needs of each site as noted in the Challenges section of this submission. The NHP team will be able to utilize the lessons learned from this PIP when working with other clinical sites, specifically Federally Qualified Health Centers (FQHCs), if they have opportunities for improvement within this measure. NHP currently uses the DMAIC (Define, Measure, Analyze, Improve, Control) framework to prioritize measures with the greatest opportunity for improvement and commit resources to the use of Process Improvement (PI) tools such as were used in this PIP to establish best practices and disseminate those interventions and/or workflows. This framework results in focused partnerships with clinical sites (e.g., FQHCs) to address measures with opportunities for improvement.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	NHP also has initiated a program of Practice Transformation (PT) targeting behavioral health practices. This program specifically works with behavioral health practices to teach them to utilize quality improvement tools and data-driven metrics to achieve individual practice goals. This includes optimizing practice workflows and systems, often through the use of the PDSA process. Through this program, behavioral health practices will have visibility of clinic-level performance data related to the follow-up on positive depression screening and can choose to utilize their transformed Quality Improvement structure to address opportunities.
Challenges Encountered During Project	The most notable challenge during this PIP effort was the ongoing impact of the PHE. The shifting clinical demands as COVID surged and waned caused increases in walk-in encounters that strained available appointments. These same surges also caused unpredictable staff absences that forced available staff to cover additional member appointments. In a larger context, the PHE coincided with significant workforce changes (i.e., "The Great Resignation") that reshaped the manpower available to provide care at all levels. The data revealed that most behavioral health follow-ups that were completed occurred on the same day as the positive screening result. If staff levels resulted in a delay in behavioral health being contacted until after the member departed the clinic or the on-side behavioral health clinician was unavailable, the potential to complete the behavioral health follow-up decreased significantly. The response to the increase in patient volume was primarily in the judgment of the clinicians providing the care as they prioritized clinical needs per their scope of practice (i.e., screenings may be deferred to address pressing presenting complaints.) The impact of episodic staff absences due to COVID that may force cross-coverage of patient loads was addressed similarly, but with active engagement and support from management to adjust available staff. Regarding staff shortages due to position vacancies, leadership increased recruiting efforts. To adapt to Medical Assistant (MA) vacancies, Sunrise created an MA training program to develop individuals new to the role and provide a full training program to maximize staffing. The

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	program has been successful to access a portion of available staff who are able to help meet this clinical demand. Another challenge faced by the PIP team related to the claims-based measure as the SMART Aim measure and Intervention Effectiveness measure. The nature of claims-lag meant that adjustments in the intervention may be delayed by 100-120 days while awaiting performance scores. The use of EHR-based reporting as potential Intervention Effectiveness Measures did not reveal them to be a good proxy of the SMART Aim objective as it did not require a completed behavioral health encounter as follow-up. The team did conclude that the calculation of the measure at the 60-day mark (vs. the 90-day mark) was a fairly accurate proxy and reduced potential cycle times by 30 days. The use of this 60-day proxy correctly anticipated the final month's performance above the SMART Aim goal.
Lessons Learned/Information Gained Throughout the Project	All lessons learned during the period of the PHE must be viewed through the lens of unprecedented challenges. The shifting demands placed on clinicians during this time often forced priorities to be identified to meet the most pressing needs of members' care. Respect and support for those individuals is an important part of the PIP process during this period. Leadership engagement throughout the PIP from project development through ongoing intervention testing is essential. Including the behavioral health lead from North Range Behavioral Health as a key team member was especially valuable given the essential role the BH team has on this measure. Engaged and supportive leadership also likely was a factor in the efficacy of this intervention as it relied heavily on integration of behavioral health clinicians with the primary care teams and communication between these groups.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	Another valuable conclusion from this PIP was understanding the potential value of EHR-based reporting options as proxies for claims-based measures. While the EHR-based reporting is likely capturing the presence of good clinical care, these measures are often not a good proxy for claims-based measures and most importantly, not good proxies for this measure that relies on a completed behavioral health encounter as follow-up. Future PIP efforts should be purposeful in determining if the desired outcome is best assessed by clinical documentation alone (EHR-based) or claims and then valid Intervention Effectiveness Measures should be selected. In a related fashion, this PIP concluded that if a claims-based measure is the preferred outcome and the team would like to cycle through the PDSA more rapidly, that using partial claims (i.e., 60-day lag data) may be a useful Intervention Effectiveness measure. It is important to acknowledge the limitations of this strategy and a review of historic data on claims submission may provide an opportunity to determine if the variance is acceptable for the measure.

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Sustainability of Improvement – *Follow–up after a Positive Depression Screen*

Instructions: In the space below, describe the MCO's plan for sustaining improvement achieved for ***Follow–up After a Positive Depression Screen*** beyond the SMART Aim end date.

Cindy McDade was an integral member on the PIP team and continues to serve as the Director of Quality for Sunrise Community Health. She also has recently assumed the role as Director of Operations and will be able to balance the priorities for each of these areas with an awareness of the efforts involved to produce these gains and the importance in sustaining them. Numerous Quality/performance measures are monitored monthly by the Quality team, and this will ensure that potential negative trends catch the attention of clinical managers to address. The method for MAs to contact Behavioral Health in the event of a positive depression screen (i.e., "flags") is explicitly incorporated into orientation documentation (Attachment 3) and clinic procedures (Attachment 5). The use of visual display boards to increase staff awareness of performance (Attachment 4) will also increase awareness of Sunrise's quality priorities and maintain dialog between staff on performance. A final element for sustainment is the annual reporting of Uniform Data Set (UDS) measures that Sunrise must comply with as a Federally Qualified Health Center (FQHC). Follow-up of Positive Depression Screening is one of the UDS measures included in these annual reports and although the specifications for this measure differ slightly from this PIP, Behavioral Health involvement at the time of the positive screen helps meet this measure due to documentation procedures used by Sunrise and North Range Behavioral Health. Visibility for performance is a major factor in maintaining improvements.

The sustainment plan for this measure will also involve the partnership with NHP. Reporting available within Sunrise Health Centers EHR may capture overall performance and may include non-NHP members. While the EHR reporting may capture clinical care, the reporting monitored by the NHP Quality team will capture claims-based reporting of Follow-up of Positive Depression Screening and may identify trends, as well. Active dialog regarding these slightly different measures provides a collaboration to encourage engagement and accountability.

The Sunrise clinics also have primary care Practice Transformation (PT) coaches that work with them monthly to assist with process improvement (PI) and performance measure issues. These coaches are trained in the methods of PI, including process mapping and Failure Modes and Effects Analysis (FMEA) as was used during this PIP to refine workflows. The primary care PT coaches may focus on the screening and referral workflows, while the behavioral health PT coach may focus more on receipt of referrals and maintaining access to care to accommodate these referrals.

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Sunrise will also continue to partner with NHP as monthly performance is monitored specifically on Follow-up After a Positive Depression Screen as part of the Behavioral Health Incentive Program (BHIP) measures. NHP has data visualization tools available to monitor clinic-level performance on this measure and is available for ongoing consultation if adverse trends are identified.

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The rolling 12-month data collection methodology was followed for the SMART Aim measures for the duration of the PIP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
2. The MCO provided evidence to demonstrate at least one of the following: ☒ The SMART Aim goal was achieved. ☒ Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$.) ☒ Non-statistically significant improvement in the SMART Aim measure. ☒ Significant *clinical* improvement in processes and outcomes. ☒ Significant *programmatic* improvement in processes and outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	For *Depression Screening*: • The SMART Aim goal was achieved. • Statistically significant improvement over baseline was achieved. • Significant *clinical* improvement and *programmatic* improvement were demonstrated for the *Medical Assistant Education and Feedback on Depression Screening Procedures* intervention. For *Follow-up After a Positive Depression Screen*: • Non-statistically significant improvement over baseline was achieved. • Significant *clinical* improvement and *programmatic* improvement were demonstrated for the *Provider Education Integrated Care Delivery Following Positive Depression Screening* intervention. **Resubmission January 2023:** In addition to the improvement identified above, the health plan reported updated SMART Aim

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Criteria	Score	HSAG Feedback and Recommendations
		measure data demonstrating that the SMART Aim goal for *Follow-Up After a Positive Depression Screen* was achieved. The score for this criterion remains *Met*.
3. If improvement, as outlined for Criterion 2, was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
4. The MCO completed the Plan-Do-Study-Act (PDSA) worksheets with accurately reported data and interpretation of testing results.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
5. The narrative summaries of the project conclusions were complete and accurate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	The health plan provided an accurate summary for the *Depression Screening* outcomes but included an inaccurate summary of the *Follow-up After a Positive Depression Screen* outcome. In the project conclusions for *Follow-up After a Positive Depression Screen, the health plan stated*, "The SMART Aim goal was achieved…" This statement was not supported by the reported rolling 12-month SMART Aim measure results; the highest reported rate of 47.2% did not achieve the SMART Aim goal of 47.66%. **Resubmission January 2023:** The health plan updated the SMART Aim measure data and revised the project conclusions to address the

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Criteria	Score	HSAG Feedback and Recommendations
		initial feedback. The score for this criterion was changed from *Partially Met* to *Met*.
6. If improvement, as outlined for Criterion 2, was demonstrated, the MCO documented plans for sustaining improvement beyond the SMART Aim end date.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	

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Based on the validation findings, HSAG determined the following confidence level for this PIP:

☒ **High confidence:** The PIP was methodologically sound, the SMART Aim goals, statistically significant, clinically significant, or programmatically significant improvements were achieved for both measures, at least one tested intervention for each measure could reasonably result in the demonstrated improvement, and the MCO accurately summarized the key findings and conclusions.

☐ **Moderate confidence:** The PIP was methodologically sound, at least one tested intervention could reasonably result in the demonstrated improvement, and at least one of the following occurred:

- ☐ The SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved *for only one measure* and the MCO accurately summarized the key findings and conclusions.
- ☐ Non-statistically significant improvement in the SMART Aim measure was achieved *for at least one measure* and the MCO accurately summarized the key findings and conclusions.
- ☐ The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, the MCO *did not* accurately summarize the key findings and conclusions.

☐ **Low confidence:** One of the following occurred:

- ☐ The PIP was methodologically sound. However, no improvement was achieved for either measure during the PIP. The SMART Aim goals *were not* met, statistically significant improvement *was not* demonstrated, non-statistically significant improvement *was not* demonstrated, significant clinical improvement *was not* demonstrated, and significant programmatic improvement *was not* demonstrated.
- ☐ The PIP was methodologically sound. The SMART Aim goal, statistically significant, non-statistically significant, clinically significant, or programmatically significant improvement was achieved *for at least one measure*; however, *none* of the tested interventions could reasonably result in the demonstrated improvement.
- ☐ The rolling 12-month data collection methodology was followed for only one of two SMART Aim measures for the duration of the PIP.

☐ **No confidence:** The SMART Aim measure methodology and/or approved rapid-cycle PIP methodology/process *was not* followed through the SMART Aim end date.

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Summary of Validation Findings:

HSAG assigned a level of *High Confidence* to the PIP based on the Module 4 submission form and PDSA worksheet documentation. The documentation demonstrated the following:
• Significant improvement achieved for both the *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures:
  ○ Statistically significant improvement was achieved for *Depression Screening*.
  ○ The *Follow-Up After a Positive Depression Screen* SMART Aim goal was achieved.
  ○ The health plan also documented intervention testing results that supported significant *programmatic* and significant *clinical* improvement related to depression screening and follow-up after a positive depression screen.
• Interventions were carried out and evaluated according to the approved Module 3 plan and the health plan provided detailed intervention testing results, clear rationale for intervention or evaluation revisions, and detailed and insightful summaries of lessons learned from intervention testing.
• In the January 2023 resubmission, the health plan reported final, updated SMART Aim measure data for the *Follow-Up After a Positive Depression Screen* measure and updated the project conclusions to clearly document that the SMART Aim goal was achieved. With these revisions, the health plan provided clear and accurate summaries of key findings and conclusions from the PDSA cycles and from the project, overall.