COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2023–2024 PIP Validation Report

for

Northeast Health Partners Region 2

April 2024

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). 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.

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 2023–2024 validation, NHP R2 submitted two PIPs: *Follow-Up After Emergency Department Visits for Substance Use [FUA]: Ages 13 and Older* and *Screening for Social Determinants of Health (SDOH)*. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *FUA: Ages 13 and Older* PIP addresses quality, timeliness, and accessibility of healthcare and services for members ages 13 years and older with a diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose. The topic, selected by NHP R2 and approved by the Department, was supported by historical data. The PIP Aim statement is as follows: "Does implementing focused interventions on discharge, care coordination and utilization management processes result in increased 7-day follow-up rates for members aged 13 and older after an emergency department visit for substance use disorder from 26.8% to 30.5% by June 30. 2025?"

The nonclinical *Screening for SDOH* PIP addresses quality and accessibility of healthcare and services for NHP R2 members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP Aim statement is as follows: "Does implementing a standardized screening process result in an increased screening rate of Social Determinants of Health for members who utilize behavioral health services by June 30, 2025?"

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

Table 1-1—Performance Indicators

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

2. Background

Rationale

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for the Medicaid program and Children's Health Insurance Program (CHIP), with revisions released May 6, 2016, effective July 1, 2017, and further revised on November 13, 2020, with an effective date of December 14, 2020—require states that contract with managed care health plans (health plans) to conduct an EQR of each contracting health plan. Health plans include primary care case management entities (PCCM entities). The regulations at 42 CFR §438.358 require that the EQR include analysis and evaluation by an EQRO of aggregated information related to healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the Department —the agency responsible for the overall administration and monitoring of Colorado's Medicaid program. Beginning in fiscal year (FY) 2018–2019, the Department entered into contracts with RAEs in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[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 NHP R2 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 NHP R2 improves its rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

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

[1-1] 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, 2024.

Validation Overview

For FY 2023–2024, 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 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 Protocol 1 steps:

Table 2-1—CMS 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 NHP R2's PIP Submission Form. This form provides detailed information about NHP R2's PIP related to the steps completed and evaluated for the 2023–2024 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 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*.

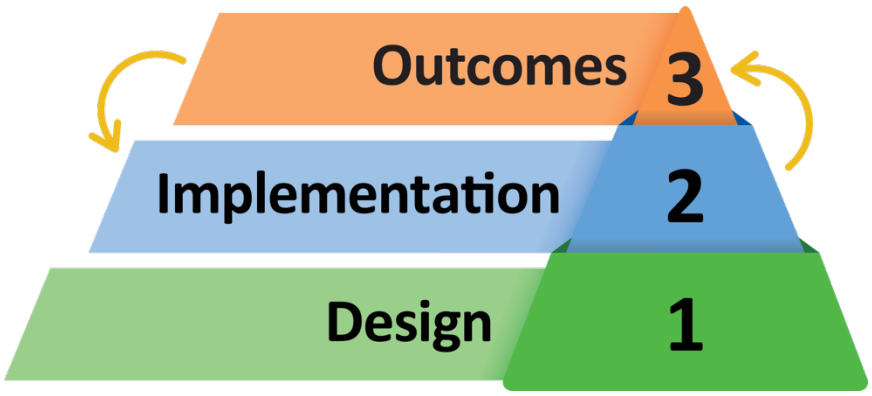
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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—i.e., 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 NHP R2 establishes its PIP design, the PIP progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, NHP R2 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 is the final stage, which involves the evaluation of statistically, clinically, or programmatically 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. If the outcomes do not improve, NHP R2 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 3-1summarizes 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.

NHP R2 submitted two PIPs for the 2023–2024 validation cycle. The *FUA* PIP and the *SDOH Screening* PIP were evaluated for adhering to acceptable PIP methodology. The PIPs had not progressed to being evaluated for achieving significant improvement; therefore, the second validation rating was *Not Assessed*. NHP R2 resubmitted one of the two PIPs and received a final overall *High Confidence* level for both PIPs. Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2023–2024 PIP Overall Confidence Levels for NHP R2

PIP Title	Type of Review[1]	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
FUA: Ages 13 and Older	Initial Submission	92%	88%	*Low Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		
Screening for SDOH	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*		
	Resubmission	*Not Applicable*			*Not Assessed*		

[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**—Populated from the PIP Validation Tool and based on the percentage scores.

The *FUA: Ages 13 and Older* PIP was validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. NHP R2 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.

The *Screening for SDOH* PIP was also validated through the first eight steps of the PIP Validation Tool and received a *High Confidence* level for adhering to acceptable PIP methodology. NHP R2 received *Met* scores for all applicable evaluation elements in the Design and Implementation stages of the PIP.

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 NHP R2's *FUA: Ages 13 and Older* PIP.

Table 3-2—Performance Indicator Results for the *FUA: Ages 13 and Older* PIP

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of ED visits for members ages 13 years and older with a principal diagnosis of SUD or any diagnosis of drug overdose for which a follow-up visit occurred within 7 days of an ED visit.	N: 306 D: 1,142	26.8%					

N–Numerator D–Denominator

For the baseline measurement period, NHP R2 reported that 26.8 percent of members ages 13 years and older who visited the ED with a principal diagnosis of SUD or other diagnosis of drug overdose had a follow-up visit within seven days.

Table 3-3 displays data for NHP R2's *Screening for SDOH* PIP.

Table 3-3—Performance Indicator Results for the *Screening for SDOH* 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 members with at least one behavioral health visit who were screened for the four SDOH domains: food insecurity, housing instability, transportation needs, and utility difficulties.	N: 0 D: 20,498	0%					

N–Numerator D– Denominator

For the baseline measurement period, NHP R2 reported that 0 percent of members with at least one behavioral health visit were screened for the four SDOH domains.

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. NHP R2'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 the health plan for the *FUA: Ages 13 and Older* PIP.

Table 3-4—Barriers and Interventions for the *FUA: Ages 13 and Older* PIP

Barriers	Interventions
Unclear understanding of services, codes, and timeliness required to meet the measure.	Provider and case management education.

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

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

Barriers	Interventions
No standardized process to identify who needs to be screened, the frequency of screening members, questions to address SDOH, or method to track screening statistics.	Standardized screening process.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, NHP R2 submitted the clinical *FUA: Ages 13 and Older* PIP and the nonclinical *Screening for SDOH* PIP. NHP R2 reported baseline performance indicator results for both PIPs, and both PIPs were validated through Step 8 (Design and Implementation). Both PIPs received a *High Confidence* level for adherence to acceptable PIP methodology in the Design and Implementation stages.

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 NHP R2 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), NHP R2 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. NHP R2 will progress to reporting Remeasurement 1 indicator results for both PIPs, and both PIPs will progress to being evaluated for achieving significant improvement for next year's validation.

Recommendations

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

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

Appendix A. Final PIP Submission Forms

Appendix A contains the final PIP Submission Forms that NHP R2 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 2023-24 PIP Submission Form
Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

Demographic Information	
MCO Name: Northeast Health Partners (RAE 2)	
Project Leader Name: Brian Robertson, PhD	Title: Chief Operating Officer
Telephone Number: (970) 237-2917	Email Address: brian@nhpllc.org
PIP Title: *Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older*	
Submission Date: 10/31/23	
Resubmission Date (if applicable): 1/17/24	

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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.

PIP Topic: Increase the percentage of emergency department (ED) visits for members aged 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 7 days of the ED visit. This topic was selected as it aligns with Colorado's Department of Health Care and Financing (HCPF) Behavioral Health Incentive Program (BHIP) performance measures for FY23/24.

Provide plan-specific data: From July 1st, 2022, to June 30th, 2023, NHP had 1,142 members aged 13 and older who had an ED visit for substance use or drug overdose. Out of the 1,142 members only 26.8% or 306 members, had a follow up within 7 days of the ED visit. The following trends were identified from the baseline data:

- Members aged 18-64 were the biggest population in the denominator (94%), followed by 13-17 (4%), and lastly 65+ (2%).
- Members aged 65+ were most likely to receive a follow up visit within 7 days of the ED visits (30%), followed by 18-64 (27%) and lastly 13-17 (18%).
- The most common diagnoses treated in the ED were alcohol (50.26%), stimulants (19.44%), and opioids (9.81%).
- 76.83% of alcohol, 66.67% of stimulants, and 46.43% of opioid diagnosis treated in the ED did not have a follow up visit within 7 days.

Baseline data suggests interventions should be focused on members aged 18-64 with a diagnosis of alcohol, stimulants, or opioids with alcohol being the priority diagnosis to intervene on.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:
Reporting by the CDC revealed increases in the rate of drug overdose in all US states, with an overall increase in drug overdose deaths of 26.8% between August 2019 and August 2020 (Hawk et al, 2021). In a study of over 14,500 Emergency Department (ED) patients by Sanjuan et al. (2014) 45% of patients reported at-risk alcohol use in the past year, 22% has used drugs in the past 30 days, and 17% had moderate to severe drug problems. Substance use-related diagnosis and overdoses are increasingly prevalent in the ED (Ware et al, 2022). Patients with substance use disorder (SUD) frequently seek emergency care, making up half of the more than 4.9 million ED visits for drug related complaints (Hawk et al., 2019). The ED visit has been identified as an opportunity for intervention and linkage to treatment for patients who are at risk for or currently have SUD. It should also be noted that the ED may be the only point of contact with the healthcare system for some patients with SUD (Hawk et al., 2019). Existing research suggests that brief intervention in the ED setting among patients who use alcohol or drugs can result in reduced substance use, decreased future medical costs, and decreased ED utilization (Ware et al, 2022).

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
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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.

1. Hawk, K., Hoppe, J., Ketcham, E., LaPietra, A., Moulin, A., Nelson, L., Schwarz, E., Shahid, S., Stader, D., Wilson, M. P., & D'Onofrio, G. (2021). Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Annals of Emergency Medicine. https://doi.org/10.1016/j.annemergmed.2021.04.023
2. Sanjuan, P.M., Rice, S.L., Witkiewitz, K., Mandler, R.N., Crandall, C., Bogenschutz, M.P., 2014. Alcohol, tobacco, and drug use among emergency department patients. Drug Alcohol Depend. 138, 32–38. doi: 10.1016/j.drugalcdep.2014.01.025
3. Ware, O. D., Buresh, M. E., Irvin, N. A., Stitzer, M. L., & Sweeney, M. M. (2022). Factors related to substance use treatment attendance after peer recovery coach intervention in the emergency department. Drug and Alcohol Dependence Reports, 5, 100093. https://doi.org/10.1016/j.dadr.2022.100093
4. Hawk, K., Glick, R., Jey, A., Gaylor, S., Doucet, J., Wilson, M., & Rozel, J. (2019). Emergency Medicine Research Priorities for Early Intervention for Substance Use Disorders. Western Journal of Emergency Medicine, 20(2), 386–392. https://doi.org/10.5811/westjem.2019.1.39261

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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):

Does implementing focused interventions on discharge, care coordination and utilization management processes result in increased 7-day follow up rates for members aged 13 and older after an emergency department visit for substance use disorder from 26.8% to 30.5% by June 30th, 2025?

*The goal established was formulated using a 2-tailed normal distribution with a p-value of 0.05 using baseline sample size.

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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: Members aged 13 and older who had an ED visit with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose.

Enrollment requirements (if applicable): Date of the ED visit through 30 days after the ED visit (31 total days) with no allowable gaps.

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

Inclusion, exclusion, and diagnosis criteria: An ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between July 1st of the previous year and May 31st of the following year where the member was aged 13 or older on the date of the visit will be included. Value Sets from 2023 CMS Core Measure (FUA) will be used to identify the ED visits, SUD, and overdose diagnosis.

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

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

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
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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: Sampling was not used.

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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	Follow -Up After Emergency Department Visits for Substance Use: Ages 13 and Older
	This indicator is endorsed by the National Committee for Quality Assurance as a CMS core measure. The FFY 2023 Adult and Child Resource and Technical Specification as well as the FFY 2023 Adult and Child Core Set HEDIS Value Set Directory will be used. This depicts the validity of this measure to impact the defined population and allows comparison with similar populations.
Numerator Description:	Number of members aged 13 and older with a follow-up visit within 7 days of an ED visit with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, (8 total days).
Denominator Description:	Number of members aged 13 and older with an ED visit that includes a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	30.5% *The goal established was formulated using a 2-tailed normal distribution with a p-value of 0.05 using baseline sample size.
Indicator 2	
Numerator Description:	
Denominator Description:	

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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."	
Baseline Measurement Period	
Remeasurement 1 Period	
Remeasurement 2 Period	
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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 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)	[X] Administrative Data Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [X] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- Attachments A-E [X] Data completeness assessment attached. Attachment F [ ] Coding verification process attached.	[] Survey Data 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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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Estimated percentage of reported administrative data completeness at the time the data are generated: 96.91% complete at 60 days following the date of service and 97.29% complete at 90 days following the date of service. 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 Calculation (Attachment F): Baseline performance was calculated using the monthly claims & encounter data feed available 60 days from the last date of the performance period. Accordingly, data completeness calculation was performed to estimate the average data completeness available at the 60-day point. 90-day lag is the end point established by the Department for final performance measure calculations. • Claims processed between 1/1/22 and 12/31/22 were included in this sample for calculation as it represented a period that all claims would have been resolved at the time of calculation. • Dental claims were excluded as they were the only claim type not included in value sets associated with PIP performance measures.	

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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.		
	• Denominator: count of all-inclusive claims processed in the timeframe above. • Numerator at 90 days: count of all-inclusive claims processed in time frame above that were completed in 90 days following the date of submission. • Numerator at 60 days: count of all-inclusive claims processed in time frame above that were completed in 60 days following the date of submission. • Numerator was divided by Denominator and expressed as a percentage	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Data Elements Collected: • Member ID • ED Date • Age • Denominator Revenue Code • Denominator Service Code • Denominator Diagnosis Code • Denominator Provider Number • Denominator Rendering Provider

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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

- Follow-up Date
- Follow-up Service Code
- Follow-up Revenue Code
- Follow-up Diagnosis Code
- Follow-up POS Code
- Follow-up NDC Code
- Follow-up Provider Number

Data Collection Process:

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

1. Denominator: Identify ED visits for members aged 13 and older with a principal diagnosis of SUD or any diagnosis of drug overdose on or between July 1st and May 31st.
2. Denominator: Identify exclusions which include ED visits that result in inpatient stays, admission to acute or nonacute inpatient care setting on or within 30 days after the ED visit, or members in or using hospice anytime during the measurement period.
3. Denominator: Identify members who were not continuously enrolled on the date of the ED visit through 30 days after the ED visit (31 days total) with no gaps and exclude these ED visits.
4. Denominator: Identify members who had more than one ED visit in a 31-day period and only include the first eligible visit.
5. Numerator: Identify follow-up visits or pharmacotherapy dispensing events within 7 days after the ED visits (8 total days) include visits and pharmacotherapy events that occur on the dates of the ED visit.
6. Percentage of members who received a follow-up visit within 7 days after an ED visit with a principal diagnosis of substance use or any diagnosis of drug overdose: Divide the numerator by denominator to calculate the percentage of members who received a follow up within 7 days of the ED visit.

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).
Enter results for each indicator by completing the table below. *P* values must be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: Follow -Up After Emergency Department Visits for Substance Use: Ages 13 and Older

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 to 06/30/2023	**Baseline**	306	1,142	26.8%	N/A for baseline	N/A for baseline
07/01/2023 to 06/30/2024	**Remeasurement 1**					
07/01/2024 to 06/30/2025	**Remeasurement 2**					

Indicator 2 Title:

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

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for Northeast Health Partners (RAE 2)

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

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

- **Baseline Narrative:** Baseline data collected from July 1, 2022, through June 30th, 2023, indicated that out of a total population of 1,142 members who had an Emergency Department (ED) visit for substance use or drug overdose, the numerator, or the number of members who received a follow up visit within 7 days of the ED visit, stands at 306, or 26.8%. To determine the eligible population and qualifying follow up visits for baseline, we used the specifications in accordance with the 2023 CMS Core Measure: Follow-Up After Emergency Department Visit for Substance Use for individuals 13 and older (attachment A, B, C, D, and E). While analyzing baseline data we reviewed the various data elements that were collected (as outlined above in step 6) to identify trends and possible areas of improvement. Elements such as most common diagnoses being treated in the ED, diagnoses with the greatest noncompliance rate for follow up visits within 7 days, age of members being treated in the ED for substance use or drug overdose, and which age group has the greatest noncompliance rate for follow up visits within 7 days (see step 1 for more detailed data).We were also able to analyze follow up rates by providers. Through this analysis we were able to identify potential areas of improvement.

  The code to calculate measure performance was written by internal Data, Analytics & Reporting (DAR) staff to match CMS measure specifications. The reporting period for the baseline (i.e., SFY22-23) does not match the HEDIS specification (i.e., CY22) and a certified HEDIS measure engine was not able to be utilized. As this measure is a new measure in SFY23-24, NHP has not had the

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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.

opportunity to validate member-level data with the Department and there is potential for minor coding or data source inconsistencies. This could be a potential threat to validity.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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

QI Team Members:

- Brian Robertson, COO, NHP
- Jennifer Hale-Coulson, Clinical Director, NHP
- Michaela Smyth, Senior Clinical Quality Analyst, Carelon
- Edward Arnold, Senior Clinical Quality Analyst, Carelon
- Melissa Schuchmann- Business Information Analyst II
- Michael Clark, Manager Data Analysis, Carelon
- Andrea Scott, Business Information Developer Senior, Carelon
- Steve Thiboutot, Systems Analyst Advisor, Carelon
- Steve Coen, Director Behavioral Health Services, Carelon
- Tiffany Jenkins, Manager Behavioral Health Services, Carelon
- Nancy Musso, Behavioral Health Provider Quality Manager, Carelon
- Victoria Garcia, Manager of Care Management, NCHA
- MJ Jorgenson, Director of Addiction Response, NCHA
- Lesley Brooks, Assistant Medical Director, NCHA

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

One or more of the following process improvement methods/tools may be used during the PIP. The key driver diagram created by the PIP team is found at Attachment G.

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Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older
for Northeast Health Partners (RAE 2)

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:

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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

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

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
Provider and Case Management Education	Unclear understanding of services, codes, and timelines required to meet the measure

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 2023-24 PIP Submission Form
Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

Demographic Information			
MCO Name: Northeast Health Partners (RAE 2)			
Project Leader Name: Brian Robertson, PhD		Title: Chief Operating Officer	
Telephone Number: (970) 237-2917		Email Address: brian@nhpllc.org	
PIP Title: *Screening for Social Determinants of Health (SDOH)*			
Submission Date: 10/31/23			
Resubmission Date (if applicable): Not Applicable			

Appendix A: State of Colorado 2023-24 PIP Submission Form
Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

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: Increase screening for social determinants of health (SDOH) using a standardized tool amongst behavioral health utilizers. This topic was assigned by the State.

Provide plan-specific data: From July 1st, 2022, to June 30th, 2023, NHP had 15,443 members who utilized behavioral health services. While trying to identify behavioral health utilizers who had been screened for social determinants of health (SDOH), it was discovered that although some entities within RAE2 were collecting information pertaining to SDOH, there were no standardized processes in place that allowed for this data to be communicated to the RAE or to be analyzed to identify member's needs. Therefore, it was deemed necessary to put processes in place that allowed this data to be collected, communicated, aggregated, and analyzed on an ongoing basis.

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

"Studies estimate that clinical care impacts only 20 percent of county-level variation in health outcomes, while social determinants of health (SDOH) affect as much as 50 percent" (Whitman et al.,2022, p.1). Most efforts around reducing health disparities have been geared towards improving access and quality of healthcare. However, greater attention to addressing social determinants of health within and outside of the healthcare system is fundamental for improving health and reducing health inequities (Williams et al., 2008). Taylor et al. (2016) reviewed 39 peer reviewed articles that examined the impact of investments in social services or investments in integrated models of health care and social services on health outcomes and health care spending and 32 (82%) reported some significant positive effects on either health outcomes (N=20), health care costs (N=5), or both (N=7). Increased screening for SDOH will provide NHP greater insight to disparities within the region and be able to leverage existing connections or build new collaborations to address the identified needs of its members.

1. Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. (n.d.). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved September 19, 2023, from https://www.aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf#:~:text=This%20brief%20provides%20a%20high-level%20overview%20of%20select
2. Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving Upstream: How Interventions That Address the Social Determinants of Health Can Improve Health and Reduce Disparities. Journal of Public Health Management and Practice, 14(Supplement), S8–S17. https://doi.org/10.1097/01.phh.0000338382.36695.42

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Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

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.
3. Taylor, L. A., Tan, A. X., Coyle, C. E., Ndumele, C., Rogan, E., Canavan, M., Curry, L. A., & Bradley, E. H. (2016). Leveraging the Social Determinants of Health: What Works? PLOS ONE, 11(8), e0160217. https://doi.org/10.1371/journal.pone.0160217

Appendix A: State of Colorado 2023-24 PIP Submission Form
Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

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):

Does implementing a standardized screening process result in an increased screening rate of Social Determinants of Health for members who utilize behavioral health services by June 30th, 2025?

1.

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Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

Performance Improvement Projects

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

The population definition must:

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

Population definition: Members who have had at least 1 behavioral health visit billed in a primary care setting or under the capitated behavioral health benefit within the rolling 12-month evaluation period.

Enrollment requirements (if applicable): N/A

Member age criteria (if applicable): N/A

Inclusion, exclusion, and diagnosis criteria: Members who had at least 1 behavioral health visit billed in a primary care setting or under the capitated behavioral health benefit will be included in the eligible population. Members must be enrolled in RAE 2 (Northeast Health Partners) on the last day of the measurement period. Diagnosis criteria is not applicable.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): All capitated behavioral health encounters and fee for service (FFS) behavioral health claims were used to identify the eligible population. The codes used for the FFS behavioral health claims were as follows: 90791, 90832, 90834, 90837, 90846, 90847.

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Screening for Social Determinants of Health (SDOH)
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Performance Improvement Projects

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: Sampling was not used.

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Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

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	Percentage of behavioral health utilizers screened for Social Determinants of Health (SDOH)
	This internal indicator was created to meet HCPF requirements to increase screening for SDOH amongst behavioral health utilizers.
Numerator Description:	The number of unique members who were screened for Social Determinants of Health in the following four domains: Food insecurity, housing instability, transportation needs, and utility difficulties.
Denominator Description:	The number of unique members who have had at least 1 behavioral health visit billed in a primary care setting or under the capitated behavioral health benefit within the rolling 12-month evaluation period.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	NA
Indicator 2	
Numerator Description:	

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Performance Improvement Projects

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

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- 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."

Denominator Description:	
Baseline Measurement Period	
Remeasurement 1 Period	
Remeasurement 2 Period	
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

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Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

Performance Improvement Projects

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

The data collection methodology must include the following:

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

Data Sources (Select all that apply)

[ ] Manual Data 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)	[X] Administrative Data Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [X] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- Attachment A [X] Data completeness assessment attached. Attachment E [ ] Coding verification process attached.	[ ] Survey Data 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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Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

Performance Improvement Projects

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Estimated percentage of reported administrative data completeness at the time the data are generated: 96.91% complete at 60 days following the date of service. 97.29% complete at 90 days following the date of service. 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 Calculation (Attachment E): Baseline performance was calculated using the monthly claims & encounter data feed available 60 days from the last date of the performance period. Accordingly, data completeness calculation was performed to estimate the average data completeness available at the 60-day point. 90-day lag is the end point established by the Department for final performance measure calculations. • Claims processed between 1/1/22 and 12/31/22 were included in this sample for calculation as it represented a period that all claims would have been resolved at the time of calculation. • Dental claims were excluded.	

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for Northeast Health Partners (RAE 2)

Performance Improvement Projects

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	• Denominator: count of all-inclusive claims processed in the timeframe above • Numerator at 90 days: count of all-inclusive claims processed in time frame above that were completed in 90 days following the date of submission. • Numerator at 60 days: count of all-inclusive claims processed in time frame above that were completed in 60 days following the date of submission. • Numerator was divided by Denominator and expressed as a percentage	

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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:

- Medicaid ID
- Date of Service
- IPN BH Claims Status
- BH Encounter Status
- FFS Service Code
- Date of SDOH Screening

Data Collection Process:

- Denominator: Identify the number of unique members who have had at least 1 behavioral health visit billed in a primary care setting or under the capitated behavioral health benefit within the rolling 12-month evaluation period using all capitated behavioral health encounters and fee for service (FFS) behavioral health claims. The codes used for the FFS behavioral health claims are as follows: 90791, 90832, 90834, 90837, 90846, 90847.
- Numerator: Identify the number of unique members who were screened for Social Determinants of Health (SDOH) via date of SDOH screening data submitted through MoveIt or Provider Connect. MoveIt and Provider Connect are portals in which providers within the region can securely transmit sensitive data from their EHR.
- Percentage of Members Screened for SDOH: Divide denominator by numerator to calculate the percentage of behavioral health utilizers who were screened for SDOH.

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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: Percentage of behavioral health utilizers screened for Social Determinants of Health (SDOH)

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 to 06/30/2023	**Baseline**	0	20,498	0	N/A for baseline	N/A for baseline
07/01/2023 to 06/30/2024	**Remeasurement 1**					
07/01/2024 to 06/30/2025	**Remeasurement 2**					

Indicator 2 Title: Percentage of behavioral health utilizers who screened positive for any of the 4-health related social needs

Time Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test, Statistical Significance, and *p* Value
07/01/2022 to 06/30/2023	**Baseline**				N/A for baseline	N/A for baseline
07/01/2023 to 06/30/2024	**Remeasurement 1**					
07/01/2024 to 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: Data during the baseline period July 1, 2022, through June 30th, 2023, indicated that out of a total population of 20,498 members who utilized behavioral health services, the numerator, or the number of members screened for social determinants of health, stands at 0, or 0%. All capitated behavioral health encounters and fee for service (FFS) behavioral health claims were used to identify the eligible population. The codes used for the FFS behavioral health claims were as follows: 90791, 90832, 90834, 90837, 90846, 90847. After further investigation it was discovered that some screening for SDOH is occurring amongst providers within the RAE, however, this data was not being documented in a manner that allowed it to be reported nor was it being collected in a way that enabled the data to be aggregated. These findings highlighted a lack of systematic SDOH screening processes in place among healthcare providers. Additionally, the absence of clear reporting mechanisms hinders the ability to track and monitor SDOH screening efforts and outcomes effectively. The baseline data demonstrates the need for a coordinated and standardized approach to SDOH screening in our region's healthcare system. Addressing these challenges and implementing the outlined interventions will be essential in ensuring that all members who receive behavioral health services receive equal attention to their social determinants of health. There were no factors identified that threatened the validity of baseline results.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

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Performance Improvement Projects

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

QI Team Members:

- Brian Robertson, COO, NHP
- Jennifer Hale-Coulson, Clinical Director, NHP
- Wayne Watkins, Chief Information Officer, NHP
- Michaela Smyth, Senior Clinical Quality Analyst, Carelon
- Edward Arnold, Senior Clinical Quality Analyst, Carelon
- Melissa Schuchman, Business Information Analyst II, Carelon
- Steve Thiboutot, Systems Analyst Advisor, Carelon
- Sahar Hadaeghi, Advanced Analytics Analyst, Carelon
- Victoria Garcia, Manager of Care Management, NCHA
- Silvia Gallegos, Care Management Supervisor, NCHA
- Pam Craig, Chief Clinical Officer, Centennial Mental Health Center
- Tiffany Roberts, EHR Technician III, Centennial Mental Health Center
- Devin Houchin, Report Writer, Centennial Mental Health Center
- Tamara McCoy, Administrative Director, North Range Behavioral Health
- Elizabeth Faris, EMR and Data Services Director, North Range Behavioral Health

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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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A. Quality Improvement (QI) Team and Activities Narrative Description
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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results
   - Intervention Status

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

One or more of the following process improvement methods/tools may be used during the PIP. The key driver diagram created by the PIP team is found at Attachment F.

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

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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

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
Standardized Screening Process	No standardized process to identify who needs to be screened, the frequency of screening members, questions to address SDOH, or method to track screening statistics. See Attachments B, C, D, for screening tools

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 B. Final PIP Validation Tools

The following contains the final PIP Validation Tools for NHP R2.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Emergency Department Visits for Substance Use (FUA)
for Northeast Health Partners (RAE 2)

Performance Improvement Projects

Demographic Information			
MCO Name:	Northeast Health Partners (RAE 2)		
Project Leader Name:	Brian Robertson, PhD	**Title:**	Chief Operating Officer
Telephone Number:	(970) 237-2917	**Email Address:**	brian@nhpllc.org
PIP Title:	*Follow-Up After Emergency Department Visits for Substance Use: Ages 13 and Older (FUA)*		
Submission Date:	October 31, 2023		
Resubmission Date:	January 17, 2024		

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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. *NA* 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*
NA	0	0	*NA*

* "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. *NA* 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*
NA	0	0	*NA*

* "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. *NA* 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*
NA	0	0	*NA*

* "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 [NA]*). 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.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
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*
NA	5	2	*NA*

* "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.		*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*
NA	1	0	*NA*

* "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 Emergency Department Visits for Substance Use (FUA)
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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). *NA* 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). *NA* 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*
NA	1	1	*NA*

* "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	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	7	3	*NA*

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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*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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*	In the Step 8 Barriers/Interventions Table, in the Barrier(s) Addressed column, the health plan documented, "Enhance education through engagement activities and materials to increase knowledge around SUD and SAMHSA best practices as well as using appropriate codes." This language provided a description of the intervention but did not describe the barrier that the intervention would address. In the resubmission, the health plan should revise the documentation in the Barrier(s) Addressed column to clearly state what barrier to improving follow-up rates would be addressed by the "Provider and Case Management Education" intervention. **Resubmission January 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element was changed to *Met*.
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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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. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. 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. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool Scores
for *Follow-Up After Emergency Department Visits for Substance Use* for Northeast Health Partners (RAE 2)

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	2	0	0	0	3	2	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				1	*Not Assessed*			
Totals for All Steps	**26**	**12**	**0**	**0**	**7**	**13**	**8**	**0**	**0**	**3**

Table B—2 2023-24 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Follow-Up After Emergency Department Visits for Substance Use* for Northeast Health Partners (RAE 2)

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

Table B—3 2023-24 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Follow-Up After Emergency Department Visits for Substance Use* for Northeast Health Partners (RAE 2)

Percentage Score of Evaluation Elements *Met**	***Not Assessed***
Percentage Score of Critical Elements *Met* **	***Not Assessed***
Confidence Level***	***Not Assessed***

* 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 Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** 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***

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:	***Not Assessed***

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Screening for Social Determinants of Health (SDOH)
for Northeast Health Partners (RAE 2)

Demographic Information			
MCO Name:	Northeast Health Partners (RAE 2)		
Project Leader Name:	Brian Robertson, PhD	**Title:**	Chief Operating Officer
Telephone Number:	(970) 237-2917	**Email Address:**	brian@nhpllc.org
PIP Title:	*Screening for Social Determinants of Health (SDOH)*		
Submission Date:	October 31, 2023		
Resubmission Date:	Not Applicable		

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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. *NA* 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*
NA	0	0	*NA*

* "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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for Northeast Health Partners (RAE 2)

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. *NA* 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*
NA	0	0	*NA*

* "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. *NA* is not applicable to this element for scoring.	C*	*Met*	**General Feedback:** The health plan referred to "the rolling 12-month evaluation period" in the population definintion. Since the PIP is using distinct 12-month baseline and remeasurement periods to compare indicator performance over time, HSAG recommends revising this language to "the 12-month measurement period."

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*
NA	0	0	*NA*

* "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 [NA]*). 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.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
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*
NA	5	2	*NA*

* "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*	**General Feedback:** The health plan referred to "the rolling 12-month evaluation period." Since the PIP is using distinct 12-month baseline and remeasurement periods to compare indicator performance over time, HSAG recommends revising this language to "the 12-month measurement period."
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*
NA	0	0	*NA*

* "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). *NA* 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). *NA* 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*
NA	1	1	*NA*

* "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*
NA	6	3	*NA*

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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*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

Results for Step 7			
Total Evaluation Elements**	**3**	**1**	**Critical Elements*****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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.		*Not Assessed*	
4. An evaluation of effectiveness for each individual intervention.	C*	*Not Assessed*	
5. Interventions that were adopted, adapted, abandoned, or continued based on evaluation data.		*Not Assessed*	

Results for Step 8			
Total Elements**	**5**	**3**	**Critical Elements*****
Met	2	2	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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	5	3	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

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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. Significant clinical improvement in processes and outcomes OR significant programmatic improvement in processes and outcomes is evaluated based on reported intervention evaluation data and the supporting documentation. 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. For significant clinical or programmatic improvement, the MCO must include how it plans to sustain the improvement achieved beyond the current measurement period.			
1. The remeasurement methodology was the same as the baseline methodology.	C*	*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
2. There was improvement over baseline performance across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
3. There was statistically significant improvement (95 percent confidence level, $p < 0.05$) over the baseline across all performance indicators.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
4. Sustained statistically significant improvement over baseline indicator performance across all indicators was demonstrated through repeated measurements over comparable time periods.		*Not Assessed*	The PIP had not progressed to the point of being assessed for improvement.
Results for Step 9			
Total Evaluation Elements**	**4**	**1**	**Critical Elements*****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "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 2023-24 PIP Validation Tool Scores for *Screening for Social Determinants of Health* for Northeast Health Partners (RAE 2)

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

Table B—2 2023-24 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8) for *Screening for Social Determinants of Health* for Northeast Health Partners (RAE 2)

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

Table B—3 2023-24 Overall Confidence That the PIP Achieved Significant Improvement (Step 9) for *Screening for Social Determinants of Health* for Northeast Health Partners (RAE 2)

Percentage Score of Evaluation Elements *Met**	***Not Assessed***
Percentage Score of Critical Elements *Met***	***Not Assessed***
Confidence Level***	***Not Assessed***

* 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 Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** 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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Performance Improvement Projects

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:	***Not Assessed***