COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2022–2023 PIP Validation Report

for

Colorado Access Region 5

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Colorado Access Region 5**, referred to in this report as **COA R5**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

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

Measuring performance using objective quality indicators

Implementing system interventions to achieve improvement in quality

Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

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

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

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

PIP Components and Process

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

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

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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2023.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Mar 16, 2023.

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

PIP Terms

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

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

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

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **COA R5**'s module submission forms. In FY 2022–2023, these forms provided detailed information about **COA R5**'s PIP and the activities completed in Module 4. (See Appendix A. Module Submission Form.)
Following HSAG's rapid-cycle PIP process, each health plan submitted Module 4 according to the approved timeline. HSAG provided scores and feedback and assigned a level of confidence to the PIP in the Module 4 validation tool. If a PIP received less than *High Confidence* on initial review, the health plan had an opportunity to receive technical assistance from HSAG and to complete a single Module 4 resubmission to address the initial validation findings.

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2022–2023, **COA R5** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen.*

COA R5 defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

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

Table 1-1 includes the SMART Aim statements established by **COA R5**.

Table 1-1—PIP Measures and SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in well visits among members ages 12 years and older who receive care at Every Child Pediatrics and Inner-City Health Center from 56.39% to 61.99%.
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits completed among members ages 12 years and older within 30 days of a positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Inner-City Health Center from 44.18% to 70.59%.

2. Findings

Module 4: PIP Conclusions

In FY 2022–2023, **COA R5** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

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

SMART Aim Measure Results

HSAG analyzed **COA R5**'s PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated **COA R5**'s success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for **COA R5**'s PIP are presented in Table 2-1. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 2-1—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screens in well visits among members ages 12 years and older who receive care at Every Child Pediatrics and Inner-City Health Center.	56.39%	61.99%	88.83%	*Yes*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of *Follow-Up After a Positive Depression Screen* visits completed among members ages 12 years and older within 30 days of a positive depression screen occurring by June 30, 2022, at Every Child Pediatrics and Inner-City Health Center.	44.18%	70.59%	54.29%	*No*

To guide the project, **COA R5** established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during a well visit at Every Child Pediatrics or Inner-City Health Center from 56.39 percent to 61.99 percent and increasing the percentage of those members who receive behavioral health (BH) services within 30 days of screening positive for depression from 44.18 percent to 70.59 percent, through the SMART Aim end date of June 30, 2022. **COA R5**'s reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 88.83 percent, representing a statistically significant increase of 32.44 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 54.29 percent, representing an improvement of 10.11 percentage points over the baseline rate, which was not statistically significant. The health plan's final SMART Aim run chart and SMART Aim measure data are provided in Appendix A. Module Submission Form.

Intervention Testing Results

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, **COA R5** completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 2-2 summarizes **COA R5**'s interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 2-2—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Inner-City Health Center workflow and coding changes: capture all depression screening services for members more accurately and better monitor depression screening performance.	Significant *programmatic* improvement for *Depression Screening*	Adopted
Every Child Pediatrics workflow and coding practices optimization: educate providers on coding best practices and use of electronic health record (EHR) to support protocol and coding standardization, using automation where possible.	*Evaluation results were inconclusive*	Adopted
A two-pronged approach to expanding BH services access by: (1) providing funding to Every Child Pediatrics for BH staff hiring and retention through an incentive grant and (2) facilitating use of the Virtual Care Collaboration and Integration (VCCI) program for follow-up BH services via telehealth.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
Revise patient educational materials, medical assistant (MA) scripting, and screening tool format at Inner-City Health Center to promote depression screening and follow-up BH services and reduce member hesitancy to receiving services.	*Programmatic* and *clinical* improvement for *Depression Screening*	Adopted

COA R5 tested four interventions for the project: Two interventions focused on *Depression Screening*, and two interventions focused on *Follow-Up After a Positive Depression Screen*. For the Inner-City Health Center workflow and coding changes intervention, the health plan reported testing results that demonstrated significant programmatic improvement in the partner practice's coding practices for depression screening. The partner practice, Inner-City Health Center, has adopted the intervention in response to the promising testing results. For the Every Child Pediatrics coding workflow intervention, the health plan reported that the intervention testing results were inconclusive; however, the partner practice chose to adopt the intervention. The health plan expects that the coding workflow will demonstrate programmatic improvement in the future in conjunction with a new credentialing pilot for unlicensed BH providers, which would allow these providers to bill for BH services. For the two-pronged BH services access intervention, the health plan reported testing results that demonstrated significant programmatic and clinical improvement in follow-up BH care. The partner provider, Every Child Pediatrics, adopted the intervention and will continue recruiting for an additional BH provider as well as continue to utilize the virtual BH care program, VCCI, to provide follow-up services when appropriate. For the Inner-City Health Center patient education and MA script intervention, the health plan reported programmatic improvement in promoting BH awareness for members at Inner-City Health Center and clinical improvement in the percentage of members who completed a depression screening. The partner provider, Inner-City Health Center, has adopted the intervention and will continue to use the

treatment hesitancy educational materials for members who are hesitant to complete depression screenings or behavioral health follow-up services in the future.

Lessons Learned

An important part of the QI process is to consider how the information gathered and lessons learned during the PIP can be applied in future improvement efforts. **COA R5** reported successes, challenges, and lessons learned as part of the Module 4 submission.

COA R5 documented the following lessons learned from the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP:

- Claims data did not always accurately reflect practice operations and services delivered. Discrepancies between claims data and practice operations were more apparent for the *Follow-Up After a Positive Depression Screen* measure, which had greater variability in results.
- The importance of working with each practice on a case-by-case basis to identify and understand the root causes of current performance and indicator results. Success was achieved by addressing challenges and barriers individually at the practice level, rather than using a one-size-fits-all approach across practices.

3. Conclusions and Recommendations

Conclusions

COA R5 developed a methodologically sound improvement project that met both State and federal requirements. The health plan tested four interventions using the required QI processes and tools. At the conclusion of the PIP, the health plan accurately reported results that demonstrated achievement of the SMART Aim goal, statistically significant improvement over baseline performance for the *Depression Screening* measure, and non-statistically significant improvement over baseline performance for the *Follow-Up After a Positive Depression Screen* measure. The health plan's intervention testing results also demonstrated programmatically significant improvement in *Depression Screening* and *Follow-Up After a Positive Depression Screen*, and clinically significant improvement in *Follow-Up After a Positive Depression Screen,* linked to the tested interventions. Based on the validation findings, HSAG assigned a level of *High Confidence* to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Recommendations

HSAG has the following recommendations:

- **COA R5** should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- **COA R5** should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Appendix A. Module Submission Form

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Access RAE 5

Managed Care Organization (MCO) Information	
MCO Name	Colorado Access
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Sarah Thomas
Title	Quality Improvement Program Manager
Email Address	Sarah.Thomas@coaccess.com
Telephone Number	970-556-4781
Submission Date	10/19/22
Resubmission Date (if applicable)	

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets

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for **Colorado Access RAE 5**

Final SMART Aim Run Chart – *Depression Screening*

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

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

[Insert or attach completed and final *Depression Screening* run chart from Module 1 here.]

State of Colorado

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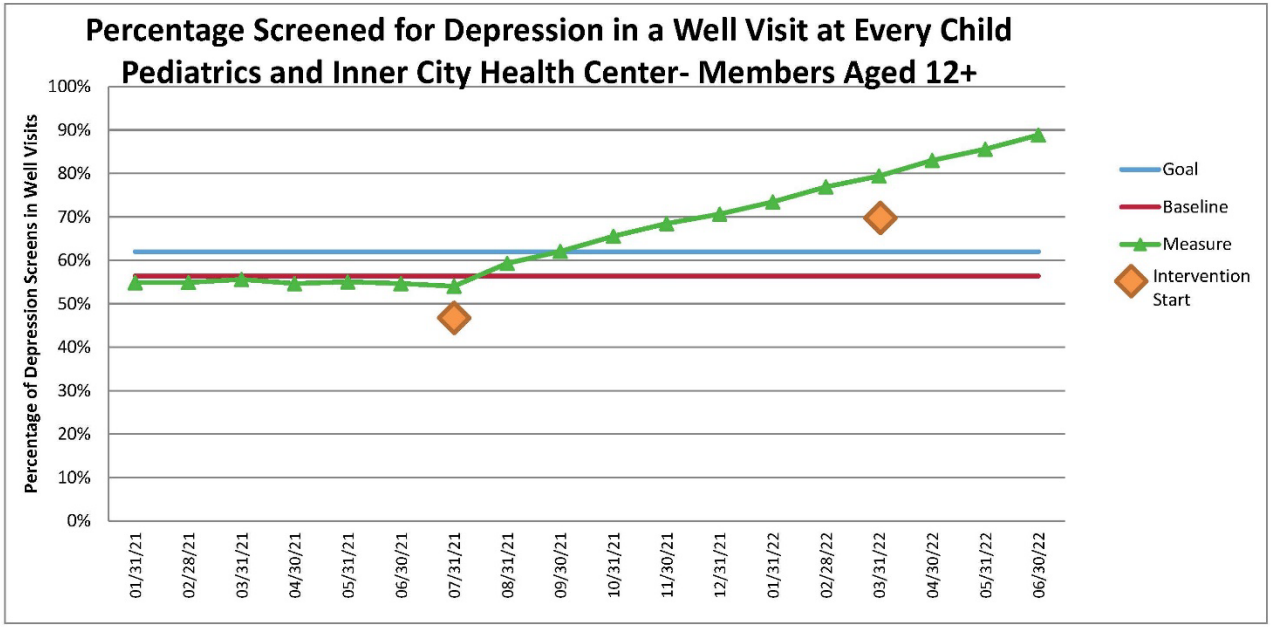
for **Colorado Access RAE 5**



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

State of Colorado
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for **Colorado Access RAE 5**

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

Final Monthly SMART Aim Measure Data – *Depression Screening*

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020-01/31/2021	January 2021	378	689	54.86%
03/01/2020-02/28/2021	February 2021	387	705	54.89%
04/01/2020-03/31/2021	March 2021	416	748	55.61%
05/01/2020-04/30/2021	April 2021	441	807	54.65%
06/01/2020-05/31/2021	May 2021	474	861	55.05%
07/01/2020-06/30/2021	June 2021	470	860	54.65%
08/01/2020-07/31/2021	July 2021	482	892	54.04%
09/01/2020-08/31/2021	August 2021	555	936	59.29%

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10/01/2020-09/30/2021	September 2021	569	917	62.05%
11/01/2020-10/31/2021	October 2021	609	929	65.55%
12/01/2020-11/30/2021	November 2021	649	948	68.46%
01/01/2021-12/31/2021	December 2021	681	964	70.64%
02/01/2021-01/31/2022	January 2022	708	964	73.44%
03/01/2021-02/28/2022	February 2022	749	974	76.90%
04/01/2021-03/31/2022	March 2022	775	976	79.41%
05/01/2021-04/30/2022	April 2022	820	988	83.00%
06/01/2021-05/31/2022	May 2022	843	985	85.58%
07/01/2021-06/30/2022	June 2022	867	976	88.83%

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

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

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

[Insert or attach completed and final *Follow–up After a Positive Depression Screen* run chart from Module 1 here.]

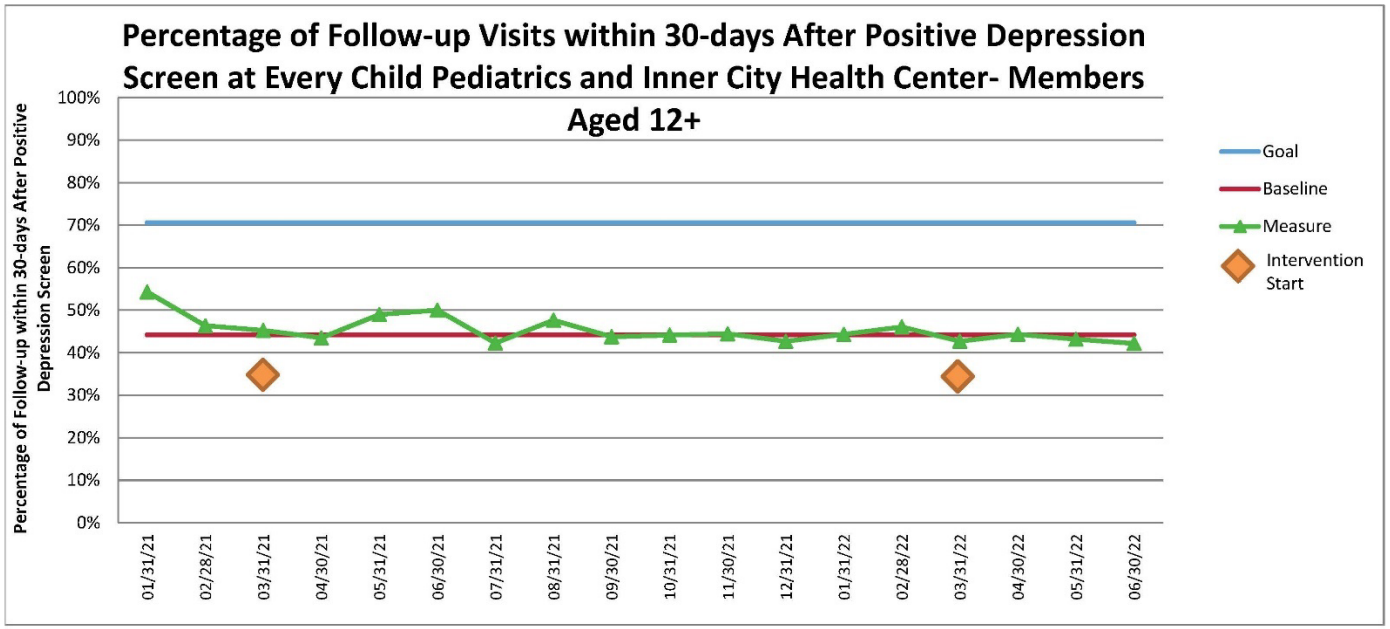
State of Colorado

Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

Depression Screening and Follow–up After a Positive Depression Screen

for **Colorado Access RAE 5**



State of Colorado

Performance Improvement Project (PIP)
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Depression Screening and Follow–up After a Positive Depression Screen
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To confirm that the MCO used the 12-month methodology as required, check the box below.

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

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

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020-03/02/2021	January 2021	19	35	54.29%
03/01/2020-03/30/2021	February 2021	19	41	46.34%
04/01/2020-04/30/2021	March 2021	19	42	45.24%
05/01/2020-05/30/2021	April 2021	20	46	43.48%
06/01/2020-06/30/2021	May 2021	24	49	48.98%
07/01/2020-07/30/2021	June 2021	25	50	50.00%
08/01/2020-08/30/2021	July 2021	26	55	47.27%
09/01/2020-09/30/2021	August 2021	30	63	47.62%

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Performance Improvement Project (PIP)
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10/01/2020-10/30/2021	September 2021	28	64	43.75%
11/01/2020-11/30/2021	October 2021	30	68	44.12%
12/01/2020-12/30/2021	November 2021	32	72	44.44%
01/01/2021-01/30/2022	December 2021	32	75	42.67%
02/01/2021-03/02/2022	January 2022	35	79	44.30%
03/01/2021-03/30/2022	February 2022	35	76	46.05%
04/01/2021-04/30/2022	March 2022	35	82	42.68%
05/01/2021-05/30/2022	April 2022	39	88	44.32%
06/01/2021-06/30/2022	May 2022	41	95	43.16%
07/01/2021-07/30/2022	June 2022	43	102	42.16%

Final Key Driver Diagrams

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

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

[Attach the final Key Driver Diagram for *Depression Screening*]

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Access RAE 5

Global Aim

Improve depression screening in Well Visits to improve member health and align with the Department's 2020 Quality Strategy.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screens in outpatient primary care Well Visits among members aged 12 and older who receive care at Every Child Pediatrics and Inner City Health Center, from 56.39% to 61.99%.

Date: 06/01/22
Version: 5

Key Drivers

- Standards of care: consistency at clinic and provider level on coding, provider education, and training.
- Financial stability and billing accuracy
- Members are screened for depression at Well and Sick Visits and have at least one Well Visit annually
- Members are educated about treatment options and engaged
- Clinic offers scheduling flexibility and hours and provides appropriate social determinants of health resources.

Interventions

- Standardization of depression screening scoring as positive or negative based on industry analysis of best practice.[1]
- Analyze at provider and clinic levels to identify and evaluate differences
- Standardize Sick Visit screening protocols
- EHR optimization and support for ordering and coding
- Standardize processes and targeted clinic and provider education.
- Promote telehealth Well Visit options and initiate member outreach campaign on telehealth options, safety protocols from COVID-19 and importance of Well Visits.
- Understand and identify outreach barriers and assist in improving member contact information for sequential/automatic Well Visit scheduling and reminder protocols.[2]
- Engage members to learn about common clinical and non-clinical barriers, and develop educational materials to address them (i.e. transportation needs in rural area)[3]

[1]Mulvaney-Day, N., Marshall, T., Piscopo, K. D., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for behavioral health conditions in primary care settings: A systematic review of the literature. *Journal of General Internal Medicine, 33*(3), 335-346. doi: 10.1007/s11606-017-4181-0
[2]Regents of the University of Michigan. (2017). Adolescent Well-Child Exams. *Adolescent Health Initiative.* https://www.umhs-adolescenthealth.org/wp-content/uploads/2018/07/adolescent-well-child-exam-starter-guide.pdf
[3]CipherHealth. (2020). *Taking a deep dive into closing HEDIS gaps: Adolescent well-care visits (W15, W34, AWC).* https://cipherhealth.com/blog/taking-a-deep-dive-into-closing-hedis-gaps-adolescent-well-care-visits-w15-w34-awc/

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Global Aim

Improve Follow-up After a Positive Depression Screen to improve member health, outcomes and align with the Department's 2020 Quality Strategy.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of Follow-up After a Positive Depression Screen visits among members aged 12 and older completed within 30 days of positive depression screen occurring by June 30, 2022 at Every Child Pediatrics and Inner City Health Center, from 44.18% to 70.59%.

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Key Drivers

- Standards of care: efficient referral processes between Every Child Pediatrics, Inner City Health Center, and internal and external behavioral health
- Standards of care: provider education, follow-up coding, and training.
- Internal and external provider availability with scheduling flexibility to provide follow-up visits.
- Financial stability and billing accuracy
- Member access, knowledge, and engagement.

Interventions

- Analysis at clinic and provider level to identify external partners for opportunities of improvement→ targeted education and intervention after process standardization.
- Analyze records for follow-up that occurred > 30 days after positive screen and develop targeted interventions to reduce follow-up time.
- Analysis of internal tracking processes, workflows, and outreach protocols → EHR efficiency & optimization improvement support for protocol and coding standardization that utilize automation when possible.
- Leverage COA Secret Shopper program for additional insight and determine if problematic referral patterns with external BH partners exist.
- Gap analysis on current coding practices, encounter rate specs, PIP specs, and literature review. Develop educational materials on best practices as toolkit for providers. [1, 2]
- Expand Colorado Access's free Virtual Care Collaboration and Integration (VCCI) Program to all integrated clinics to expand telehealth follow-up options by PCMP's.
- Educate members about BH benefit free costs and importance of follow-up. Safety protocols in place for COVID-19
- Literature review to understand follow-up barriers.[3] Engage members to learn about common clinical and non-clinical barriers and develop educational materials to address these barriers → Develop member facing resource for Behavioral Health FAQ and referral, community, and rural resources.
- Utilize the Colorado Access (COA) Behavioral Health (BH) Incentive Funding grant to promote the hiring of new BH staff.

[1] Pickens, E., Wright, J., Bristol, T., Seashore, C., Perry, M., Nazworth, A., & Reed, R. (2019). *Adolescent depression screening and initial treatment toolkit for primary care clinicians.* https://www.med.unc.edu/ihqi/files/2019/03/Adolescent-Depression-Screening-and-Initial-Treatment-Toolkit.pdf
[2] AmeriHealth Caritas District of Columbia. (2014). *Depression toolkit for primary care clinicians: The patient health questionnaire (PHQ-9) adolescent toolkit.* https://www.amerihealthcaritasdc.com/pdf/provider/resources/clinical/depression-toolkit-adolescents.pdf
[3] Szymanski, B. R., Bohnert, K. M., Zivin, K., & McCarthy, J. F. (2013). Integrated care: Treatment initiation following positive depression screens. *Journal of General internal Medicine, 28* (3), 346-352.

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Project Conclusions

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

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

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Table 2a—Project Conclusions – *Depression Screening*	
Project Conclusions	At the conclusion of the PIP, the depression screening rate for the Region 5 PIP narrowed focus population was 88.83%. This rate showed improvement over the baseline PIP rate of 56.39% and surpassed the SMART Aim Region 5 goal of 61.99%, displaying statistically significant improvement. The success of this project was most influenced by programmatic interventions targeting depression screening coding changes. One clinic discovered that their billing department was manually removing G codes from their depression screening claims. Once the programmatic intervention was implemented to educate the billing team on including G codes in claims, Colorado Access witnessed a significant improvement in the SMART Aim Region 5 depression screening rates.
Intervention Testing Conclusions	The interventions that had the greatest impact on the Region 5 Depression Screening SMART Aim measure included: • EHR optimization and support for ordering and coding • Standardize processes and targeted clinic and provider education These interventions targeted improving practice consistency around billing and coding and providing education to the providers at each practice. One Region 5 practice discovered that after doing extensive claims research comparing the Z13.31 diagnosis code (encounter for depression screening) with the G8510/G8431 procedure codes, their billing staff was manually removing G codes from claims. The practice met with the billing team to educate them on the importance of including G codes on depression screening claims. However, following the inclusion of G codes on claims, it was found that the electronic health record (EHR) had begun to auto-delete G codes due to a $0 cost association. This was resolved by the practice deciding to add costs based on the

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	Medicaid fee schedule to use chargemaster rates for each code. Once these changes were implemented, the monthly depression screening rate from January to June 2021 was 3.09% and jumped to 15.91% in July of 2021 during the month the intervention was implemented. Rates further increased to 90.91% in August-December 2021, which displayed that depression screening rates immediately improved once this coding change was made. This intervention achieved significant programmatic improvement in processes and outcomes. (Reference: RAE 5 Inner City Depression Screen Coding Change PDSA Form) Specific to Region 5, one practice was very focused on coding terminology, as they had discovered they had been incorrectly coding their depression screenings for CHP+ members (Reference: CHP+ Module 4 Submission Form). Thus, depression screenings were at the forefront of their mind, and activities surrounding improved coding and increasing screenings for CHP+ members likely also impacted improved coding and screenings for Region 5 members. (Reference: CHP+ Every Child Pediatrics Depression Screen Coding Change PDSA Form) The intervention that had a lesser impact on the Region 5 Depression Screening SMART Aim measure included: • Engage members to learn about common clinical and non-clinical barriers, and develop educational materials to address them One practice developed a specific intervention targeting barriers to patients completing depression screening or follow-up. Process steps included hanging English and Spanish psychoeducation posters in treatment rooms to encourage mental health and wellness throughout the clinic; creating "treatment hesitancy" flyers to give to patients who expressed resistance to depression screening or follow-up after screening; creating more formalized medical assistant scripting to standardize the introduction of depression screenings to patients; and reformatting the depression screening assessment to make it

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	more patient friendly. This intervention displayed clinical significance, as the rate of patients refusing depression screenings decreased from 0.6% before intervention start, to 0.2% after the intervention start. Programmatic improvements were also made, as the practice committed to hanging all posters, changing the medial assistant verbiage, and handing out treatment hesitancy flyers at an average of 45 flyers per month to patients who expressed resistance to completing a screening. These interventions were implemented towards the end of the PIP and thus it was difficult to determine the impact of the interventions based on the SMART Aim rates alone, however intervention data proved that they achieved significant clinical and programmatic improvement in processes and outcomes. (Reference: RAE 5 Inner City Depression Screen Patient Psychoeducation and Treatment Hesitancy Reduction PDSA Form)
Spread of Successful Interventions	The plan to spread this intervention beyond the selected narrow focus of the PIP is to ensure that practices are aware of the correct coding procedures for depression screenings. Colorado Access recognized that some of the practices thought they were coding correctly, but claims data did not reflect their operations. Colorado Access investigated this by auditing claims and sending clinics a list of patients who showed they had not completed a depression screening. The clinic would look up the patient in their EHR and see why the record appeared to not have a completed depression screening. Upon further review it was discovered (depending on the practice) that either the wrong codes were getting submitted for claims, or that G codes were getting unintentionally removed before the claim was processed by Colorado Access. Colorado Access believed that the case review format was a valuable tool in identifying the root cause for why there was an incongruence between data and practice operations. This intervention was beneficial because better claims data improved the financial stability of the practice, and increased consistency around standards of care.

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Challenges Encountered During Project	Challenges experienced during this project included:
	• The SMART Aim depression screening measure was claims based, and therefore could take months to be accurate due to delayed claims run out. This made it more difficult to pinpoint the root cause of an issue and suggest improvement strategies in real-time.
	  ○ Colorado Access utilized the practice's internal data/EHR system within interventions to help address this barrier and create a faster data source. Data discrepancies, however, were still observed between claims data and practice level internal data and was often hard to connect why.
	• One Region 5 practice experienced resource challenges and could not print or acquire additional resources to complete the intervention.
	  ○ Colorado Access addressed this barrier by printing all posters and flyers and delivering them to their office.
	• Lastly, all practices experienced challenges related to burnout throughout the PIP. Feedback included:
	  ○ Multiple clinic locations closed due to the COVID-19 pandemic and financial constraints.
	  ○ Practices were understaffed and had a lack of new applicants.
	  ○ Both Colorado Access and PIP practices experienced staff turnover, resulting in a challenge to re-establishing project goals and continue PIP motivation.
	  ○ Some practices had an inability to incentivize new applicants and could not offer as high of a salary as other larger entities like UCHealth.
	  ○ Practices experienced difficulty making EHR button changes, as many practices partner with third party vendors for their EHR and are limited to making requests and changes in a timely manner.

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	○ Providers felt burnout in regard to the length of the 18-month long PIP cycle, especially because there was no incentive to mitigate that burnout (i.e. financial). Practices were doing the bulk of the PIP work, which took many additional hours of time they were not getting reimbursed for. Clinic buy-in became more challenging throughout the PIP. Colorado Access addressed these challenges by finding funding sources to help support the hiring of new behavioral staff, retain current staff, and combat other financial barriers for the practices.
Lessons Learned/Information Gained Throughout the Project	Colorado Access learned many valuable lessons from this project. Colorado Access found that practice operations did not always reflect claims data, and it was important to investigate on a case-by-case basis to identify the root cause of why the data was reflected a certain way. Colorado Access also learned that what may seemingly be an easy and straight-forward intervention may have confounding variables that can easily alter both the implementation and the success/measurement of the intervention. It was important to recognize that each practice was struggling with many different types of challenges, and the best way to support them was to devise solutions targeting each barrier individually. Each practice was very appreciative of the challenges navigated together, and the PIP project allowed improved access to behavioral health care for members.

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Sustainability of Improvement – *Depression Screening*

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

[Insert narrative here]

Throughout the PIP process, Colorado Access employed many quality improvement techniques and strategies to set the project up for success. PIP practices were involved in learning and practicing these strategies in partnership with Colorado Access. Strategies included: determining baseline data, building process maps, performing root cause analyses, conducting a failure modes and effects analysis, identifying gaps and opportunities for improvement, and building interventions to target these metrics. These practices became well versed in quality improvement methodology and are equipped to sustain improvement beyond the SMART Aim end date.

Colorado Access has built a wonderful relationship with each PIP practice during this project, and remains in contact with practices for questions, assistance, and help beyond the SMART aim end date. Many PIP practices are involved in the Pay for Performance metrics and therefore tracking the Behavioral Health Incentive Measure 4, which is Follow-Up after a Positive Depression Screen. Colorado Access will therefore be able to continue working with these clinics to ensure that the depression screenings and follow-up measures remain consistent, and continue to brainstorm opportunities for improvement.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Project Conclusions	At the conclusion of the PIP, the follow-up within 30 days after a positive screen rate for the Region 5 PIP narrowed focus population was 42.16%. This rate did not improve from the baseline PIP rate of 44.18% and did not meet the SMART Aim Region 5 goal of 70.59%, and therefore did not display statistically significant improvement. The two practices involved in this PIP performed significantly different for follow-up rates (Practice A – 51.02% compared to Practice B –33.96%). The billing team for Practice A was manually removing G codes (as mentioned in the depression screen section above), followed by the EHR auto-deleting G codes. This greatly impacted not only depression screening rates, but also follow-up rates, and was not addressed until March of 2021. While the coding resolution resulted in significant improvement of the monthly follow-up rates, it took longer to observe these improvements in the rolling 12-month follow-up rates. Small sample sizes continue to impact this measure, with the combined clinics totaling 102 positive depression screenings for Region 5 members during the last 12 months. In addition, it was found that Practice B primarily uses unlicensed providers for behavioral health follow-up visits, which are not captured through claims data at this time and contributes greatly to the reduction in rates. Colorado Access is currently in the process of enrolling this practice into a new credentialing pilot program, which would allow them to begin billing for Behavioral Health services completed by unlicensed providers (more details is listed in the "Challenges" section below).

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	While the SMART Aim Region 5 goal was not achieved, clinical and programmatic interventions made significant improvement in targeting this metric. These included: promoting the utilization of the telehealth Virtual Care Collaboration and Integration (VCCI) Program; providing behavioral health incentive funding to hire and retain current behavioral health staff; provider education on follow-up codes; and EHR optimization and automation. Additional descriptions as to why the SMART Aim measure was not achieved are described in the "Challenges" section below and includes how Colorado Access plans to address the lack of improvement in the future.
Intervention Testing Conclusions	The interventions that had the greatest impact on the RAE 5 follow-up after a positive depression screen SMART Aim measure included: • Utilize the Colorado Access (COA) Behavioral Health (BH) Incentive Funding grant to promote the hiring of new BH staff. • Expand Colorado Access's free Virtual Care Collaboration and Integration (VCCI) Program to all integrated clinics to expand telehealth follow-up options by Primary Care Medical Providers (PCMP's). The behavioral health incentive funding grant supported the hiring of more behavioral health providers to increase the quantity of staff available to conduct follow-ups after a positive depression screening. The VCCI program was utilized as an external resource for behavioral health providers to refer patients for follow-up services when internal behavioral health providers were either unavailable to conduct follow-up services, or not comfortable with the type of service needing to be rendered (example: psychiatry services). These interventions directly impacted follow-up rates, as it allowed the practice to have a greater capacity to conduct follow-ups after a positive depression

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	screening. These interventions were implemented towards the end of the PIP and thus it was difficult to determine the impact of the interventions based on the SMART Aim rates alone, however intervention data proved that they achieved significant clinical and programmatic improvement in processes and outcomes. (Reference: RAE 5 Every Child Pediatrics BH Access Improvements PDSA Form) The interventions that had a lesser impact on the RAE 5 follow-up after a positive depression screen SMART Aim measure included: • Analysis of internal tracking processes, workflows, and outreach protocols; EHR efficiency & optimization improvement support for protocol and coding standardization that utilize automation when possible. • Gap analysis on current coding practices, encounter rate specs, PIP specs, and literature review. Develop educational materials on best practices as toolkit for providers. While the education surrounding additional follow-up codes (such as the promotion of the H0002 code) was helpful for practices, it was not always applicable due to many practices not having enough behavioral health staffing to see their patients, and therefore utilize these codes. (Reference: RAE 5 Every Child Pediatrics Follow-up H0002 Clarification PDSA Form) • Literature review to understand follow-up barriers.[3] Engage members to learn about common clinical and non-clinical barriers and develop educational materials to address these barriers à Develop member facing resource for Behavioral Health FAQ and referral, community, and rural resources.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	One practice created treatment hesitancy flyers to give to patients who expressed resistance to depression screening or follow-up after screening. While this intervention displayed clinical significance in reducing patients refusing depression screenings, it did not achieve clinical significance in reducing the rate of patients refusing a referral for follow-up. They did, however, make significant programmatic improvements by handing out treatment hesitancy flyers at an average of 45 flyers per month to patients who expressed resistance to a behavioral health referral, and promoting mental health and wellness throughout the clinic by hanging English and Spanish psychoeducation posters in treatment rooms. These interventions were implemented towards the end of the PIP and thus it was difficult to determine the impact of the interventions based on the SMART Aim rates alone, however intervention data proved that they achieved significant clinical and programmatic improvement in processes and outcomes. (Reference: RAE 5 Inner City Depression Screen Patient Psychoeducation and Treatment Hesitancy Reduction PDSA Form)
Spread of Successful Interventions	The plan to spread these interventions beyond the selected narrow focus of the PIP is to continue promoting the Virtual Care Collaboration and Integration (VCCI) Program to all practices contracted with Colorado Access, and to continuously assess struggles with staffing and barriers to providing services. Colorado Access has been an integral advocate for AccessCare Services to recruit practices to utilize the VCCI Program. This program is a free tele-behavioral health services program available to providers and members, and a great resource to use when practices are lacking access to external behavioral health sources for care. It was important for Colorado Access and AccessCare Services to develop targeted provider

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	education and information about the program; create a customized practice workflow; and schedule time to train the practice on how to use VCCI, in order be successful in the adoption of this program. In the future, Colorado Access will continue to utilize these methods when promoting this program. It was also imperative for Colorado Access to continuously assess the practices' barriers and struggles to providing the appropriate services for members during the PIP. When Colorado Access recognized that many practices were understaffed and having difficulty in hiring behavioral health providers, Colorado Access searched for ways to overcome this barrier and provide the practice with adequate funding for hiring and retention bonuses. Colorado Access has continued to utilize this grant for other practices to ensure adequate staffing and funding is available for routine practice operations.
Challenges Encountered During Project	Challenges experienced during this project included: • A root cause analysis of claims data revealed that the follow-up within 30 days measure is not always accurately represented through claims data, and does not consistently reflect clinic operations. Barriers to achieving the SMART Aim goal have included, but are not limited to: One practice was unable to bill with unlicensed providers due to credentialing issues, and a significant portion of unlicensed providers complete their behavioral health follow-up visits; a patient may already be in therapy and is not counted in claims data as currently receiving treatment; members utilize school-based therapy programs for follow-up, which is not accurately represented in claims data; members may be seen after the 30 day mark due to rescheduling or no shows; and members may decline a follow-up appointment, even if the practice successfully encouraged a referral for treatment.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	○ Colorado Access navigated these challenges by enrolling the practice with unlicensed providers into an internal Colorado Access credentialing pilot program. This would allow this practice to begin billing for Behavioral Health services completed by unlicensed providers. This would not only benefit future PIP metrics but also help the clinic receive financial compensation for the services they are rendering.
Lessons Learned/Information Gained Throughout the Project	Colorado Access learned many valuable lessons from this project. Colorado Access found that practice operations did not always reflect claims data, and it was important to investigate on a case-by-case basis to identify the root cause of why the data was reflected a certain way. The discrepancies between claims data and clinic operations were much more apparent in the follow-up after positive depression screening in 30 days measure, which had greater variability and thus was a much harder measure to impact. Colorado Access also learned that what may seemingly be an easy and straight-forward intervention may have confounding variables that can easily alter both the implementation and the success/measurement of the intervention. It was important to recognize that each practice was struggling with many different types of challenges, and the best way to support them was to devise solutions targeting each barrier individually. Each practice was very appreciative of the challenges navigated together, and the PIP project allowed improved access to behavioral health care for members.

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

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

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[Insert narrative here]

Throughout the PIP process, Colorado Access employed many quality improvement techniques and strategies to set the project up for success. PIP practices were involved in learning and practicing these strategies in partnership with Colorado Access. Strategies included: determining baseline data, building process maps, performing root cause analyses, conducting a failure modes and effects analysis, identifying gaps and opportunities for improvement, and building interventions to target these metrics. These practices became well versed in quality improvement methodology and are equipped to sustain improvement beyond the SMART Aim end date.

Colorado Access has built a wonderful relationship with each PIP practice during this project, and remains in contact with practices for questions, assistance, and help beyond the SMART aim end date. In relation to the credentialing pilot mentioned above, Colorado Access has continued to work with that practice in processing their paperwork so that they can be credentialed to bill using unlicensed providers (the goal was to have this completed by September 2022). Many PIP practices are involved in the Pay for Performance metrics and therefore tracking the Behavioral Health Incentive Measure 4, which is Follow-Up after a Positive Depression Screen. While the Behavioral Health Incentive Measure 4 metric specifications slightly differ from the Performance Improvement Project specifications, it will allow us to continue working with these practices to ensure that the depression screenings and follow-up measures remain consistent and brainstorm opportunities for improvement.

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The rolling 12-month data collection methodology was followed for the SMART Aim measures for the duration of the PIP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
2. The MCO provided evidence to demonstrate at least one of the following: ☒ The SMART Aim goal was achieved. ☒ Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$.) ☒ Non-statistically significant improvement in the SMART Aim measure. ☒ Significant *clinical* improvement in processes and outcomes. ☒ Significant *programmatic* improvement in processes and outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	For *Depression Screening*: • The SMART Aim goal was achieved. • Statistically significant improvement over baseline was achieved. • Significant *programmatic* improvement was demonstrated for the *Inner-City Depression Screening Coding Changes* intervention. For *Follow-up After a Positive Depression Screen*: • Non-statistically significant improvement over baseline was achieved. • Significant *programmatic* and significant *clinical* improvement were demonstrated for the *Every Child Pediatrics Behavioral Health (BH) Access Improvements* intervention.

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Criteria	Score	HSAG Feedback and Recommendations
3. If improvement, as outlined for Criterion 2, was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
4. The MCO completed the Plan-Do-Study-Act (PDSA) worksheets with accurately reported data and interpretation of testing results.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
5. The narrative summaries of the project conclusions were complete and accurate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
6. If improvement, as outlined for Criterion 2, was demonstrated, the MCO documented plans for sustaining improvement beyond the SMART Aim end date.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	

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

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

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

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

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

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

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

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Summary of Validation Findings:

HSAG assigned a level of *High Confidence* to the PIP based on the Module 4 submission form and PDSA worksheet documentation. The documentation demonstrated the following:

- Significant improvement achieved for both the *Depression Screening* and *Follow-up After a Positive Depression Screen* measures:
  - Both the SMART Aim goal and statistically significant improvement were achieved for *Depression Screening*. In addition, the health plan documented intervention testing results that supported significant *programmatic* improvement related to depression screening.
  - While only non-statistically significant improvement was achieved for *Follow-up After a Positive Depression Screening*, the health plan documented intervention testing results that supported significant *programmatic* and significant *clinical* improvement related to follow-up care.
- Interventions were carried out and evaluated according to the approved Module 3 plan and the health plan provided detailed intervention testing results, clear rationale for intervention or evaluation revisions, and detailed and insightful summaries of lessons learned from intervention testing.
- Clear, comprehensive, and accurate summaries of key findings and conclusions from the PDSA cycles and from the project, overall.