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

Colorado Access Region 5

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). 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.

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, COA R5 submitted two PIPs: *Follow-Up After Hospitalization for Mental Illness (FUH)* and *Social Determinants of Health (SDOH) Screening*. These topics addressed Centers for Medicare & Medicaid Services' (CMS') requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The clinical *FUH* PIP addresses quality, timeliness and accessibility of healthcare and services by improving follow-up visit rates after hospitalization for mental illness among COA R5 members 6 years of age and older. The topic, selected by COA R5 and approved by the Department, was supported by historical data. The PIP has one Aim statement that COA R5 stated as follows: "By June 30, 2025, use targeted *FUH* interventions to increase the percentage of seven-day follow-up visits after hospitalization among Region 5 members six years of age and older from 36.96% to 41.03%."

The nonclinical *SDOH Screening* PIP addresses quality and accessibility of healthcare and services for COA R5 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 has one Aim statement that COA R5 stated as follows: "By June 30, 2025, the Colorado Access CM [Care Management] team will utilize targeted interventions to increase the percentage of SDOH screenings among Region 5 members from 0% to 90%."

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

Table 1-1—Performance Indicators

PIP Title	Performance Indicator
FUH	The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.
SDOH Screening	The percentage of Region 5 members who were screened for SDOH using the Core 5 SDOH screening tool.

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 COA R5 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 COA R5 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 COA R5's PIP Submission Form. This form provides detailed information about COA R5'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*.

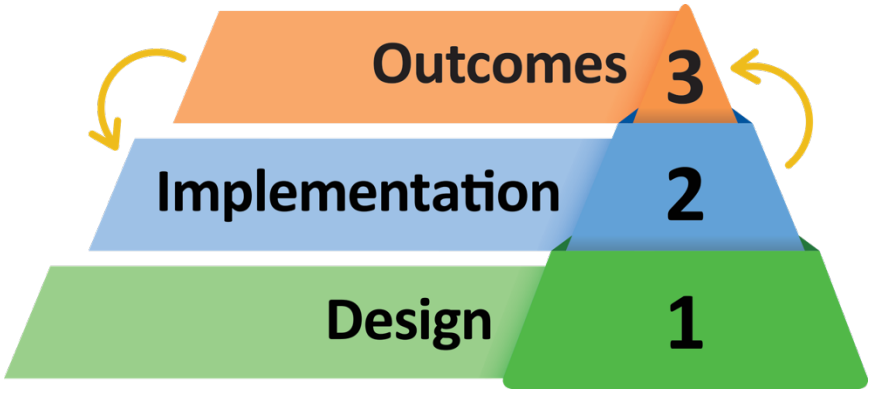
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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 COA R5 establishes its PIP design, the PIP progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, COA R5 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, COA R5 should revise its causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

3. Findings

Validation Findings

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

COA R5 submitted two PIPs for the 2023–2024 validation cycle. For this year's validation, the *FUH* and *SDOH Screening* PIPs 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*. COA R5 resubmitted both PIPs to address initial validation feedback and received *High Confidence* level for both PIPs after the resubmission. Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2023–2024 PIP Overall Confidence Levels for COA R5

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]
FUH	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		
SDOH Screening	Initial Submission	67%	75%	*Low Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*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 *FUH* 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. COA R5 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 *SDOH Screening* 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. COA R5 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 COA R5's *FUH* PIP.

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

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of discharges for Region 5 members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.	N: 476 D: 1,288	36.96%					

N–Numerator D–Denominator

For the baseline measurement period, COA R5 reported that the percentage of members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge was 36.96 percent.

Table 3-3 displays data for COA R5's *SDOH Screening* PIP.

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

Performance Indicator	Baseline (7/1/2022 to 6/30/2023)		Remeasurement 1 (7/1/2023 to 6/30/2024)		Remeasurement 2 (7/1/2024 to 6/30/2025)		Sustained Improvement
The percentage of Region 5 members who were screened for SDOH using the Core 5 SDOH screening tool.	N: 0 D: 2,170	0%					

N–Numerator D– Denominator

For the baseline measurement period, COA R5 reported that 0 percent of Region 5 members were screened for SDOH using the Core 5 SDOH screening tool.

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. COA R5'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 *FUH* PIP.

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

Barriers	Interventions
Care manager challenges with the existing member outreach process due to the following barriers: • Volume of work is too high • Intervention does not feel meaningful • Not enough time to serve members with complex needs • High administrative burden for high volume of members	**Colorado Access care coordination for members with inpatient mental health admissions:** Colorado Access' behavioral health program has been streamlined to improve the member outreach process. Care managers coordinate care with providers, connect members with appropriate outpatient behavioral health services, and mitigate barriers to discharge or engagement in follow-up services. The new approach stratifies members by risk level to reduce overall volume of admissions and to provide an additional touchpoint to members in the seven days following discharge to promote successful follow-up appointment attendance.

Barriers	Interventions
• Community Mental Health Centers (CMHCs) not being notified when a member had an inpatient hospital admission, and having difficulty identifying members who needed a follow-up appointment after discharge. • Hospitals have difficulty identifying members who were already engaged in behavioral health services with a CMHC or other behavioral health provider, so they did not know where to get a member connected for a follow-up appointment.	**Hospital, CMHCs, and Care Management seven-day follow-up dashboard:** Colorado Access worked to build a system that connects hospitals, CMHCs, and our internal care management team to coordinate discharge planning. Colorado Access has implemented a multi-faceted dashboard that hospitals, CMHCs, and the Colorado Access Care Management team can utilize to connect discharged members to behavioral health providers in real-time. CMHCs can now access this dashboard system to see where their members are hospitalized in real-time and preemptively coordinate a follow-up appointment after discharge. They can also see their seven-day follow-up performance rate in real-time. Additionally, hospitals can now see which members are already connected to CMHCs so they can coordinate more targeted discharge and access other behavioral health outpatient options besides CMHCs if appointment availability is limited within the seven-day time frame. This intervention will build community partnerships between hospitals and outpatient behavioral health providers.
CMHCs need for more financial support and incentive to dedicate resources and staffing for 7-day follow-up rate improvement efforts.	**New Value-Based Payment Model for CMHCs:** Colorado Access recently enacted a new value-based payment model for the seven-day follow-up after hospitalization for mental illness metric to all CMHCs. If this *FUH* metric improves, CMHCs will receive additional payment.

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

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

Barriers	Interventions
Existing care management scripts ask members a variety of SDOH questions that do not cover all 5 SDOH core domains.	Standardization of SDOH questions by incorporating the Core 5 Screening Tool into all applicable care management scripts.
The internal Colorado Access HealthEdge GuidingCare system has not been updated since 2021. The older system has impacted the ability to update the care management scripts and workflows within the GuidingCare system in a timely manner.	**Optimization of the collection of SDOH data and reporting within HealthEdge GuidingCare.** The updated and upgraded GuidingCare system incorporates the SDOH Core 5 screening tool into the new and improved system and scripts.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, COA R5 submitted the clinical *FUH* and the nonclinical *SDOH Screening* PIP. COA R5 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 COA R5 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), COA R5 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. COA R5 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 COA R5 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 Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

Demographic Information		
MCO Name: Colorado Access (RAE 5)		
Project Leader Name: Sarah Thomas	Title: Quality Improvement Program Manager	
Telephone Number: 1-800-511-5010	Email Address: sarah.thomas@coaccess.com	
PIP Title: *Follow-Up After Hospitalization for Mental Illness (FUH)*		
Submission Date: 10/31/2023		
Resubmission Date (if applicable): 01/03/2024		

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

Performance Improvement Projects

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

PIP Topic: Follow-Up After Hospitalization for Mental Illness (FUH) – 7 Days: This performance improvement project (PIP) topic was one of the three options for the Region 5 behavioral health PIP mandated by the Colorado Department of Health Care Policy and Financing (the Department). Colorado Access chose FUH because it corresponds with established metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS ®[1]) and the Accountable Care Collaborative(ACC) Key Performance Indicators (KPI) incentive payment program for the RAEs.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provide plan-specific data:
Follow-up after hospitalization for mental illness is a prioritized metric within Colorado Access. The metric gained momentum during the COVID-19 pandemic where the demand for behavioral health care needs drastically increased in almost every healthcare setting, including inpatient hospital settings.[1] The demand for behavioral health care was exacerbated by the ongoing national shortage of behavioral health providers, which further worsened Colorado's mental health resources and put the state into a mental health crisis, with Children's Hospital Colorado declaring a "State of Emergency" for youth mental health in 2021.[2] Colorado continues to display some of the highest prevalence of mental illness and lowest rates of access to care when compared to other states.[3,4]

Colorado Access has observed a relatively steady and flat trend in FUH since 2022, with rates hovering between 35-39% for Region 5 members. As of June 30th, 2023, the baseline rate (July 1st, 2022-June 30th, 2023) for Region 5 FUH was 36.96%. Comparatively, the Region 5 baseline rate was 38.42% as of June 30th, 2022, with slight fluctuations occurring in the year between.

Follow-up after hospitalization for mental illness has been a difficult measure to improve, and there have been many identified barriers that impact this metric:

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

- Behavioral health staffing continues to be an issue with both inpatient and outpatient facilities. The lack of staff in inpatient hospitals limits the facility's ability to go the extra step to schedule a follow-up behavioral health appointment for a member at an outpatient facility within seven days of discharge. Similarly, there is a lack of staff in the outpatient behavioral health clinics, and therefore it is difficult to maintain appointment availability within seven days of discharge.
- Hospitals lack partnerships and connections with outpatient behavioral health facilities, and experience difficulty determining which members are already connected to outpatient behavioral health entities. This creates challenges for the hospitals to assist in scheduling follow-up behavioral health appointments.
- Once members are discharged, this metric relies on a member showing up for their follow-up behavioral health appointment. It is common to see a high number of missed appointments and late cancellations to behavioral health appointments, thus impacting the quick nature and short service completion timeframe required of this metric.
- The FUH denominator has been slowly increasing, with more members being admitted for inpatient mental health services. Many members experience frustration when trying to find outpatient behavioral health services, and the only way to receive timely services is by going to the emergency room, resulting in a subsequent inpatient admission for mental health. The increase in patients requiring inpatient admission causes a greater strain on hospital staff as it becomes challenging to provide adequate behavioral health staffing to provide timely and high-quality services.
- Member readmissions cause hospital staff exhaustion and burnout, therefore reducing the level of investment and priority in establishing follow-up care.
- Some hospitals elect to complete follow-up appointments with patients on the day of discharge to ensure that follow-up appointments are completed prior to the member's discharge. While this improves patient access and leads to fewer missed or canceled follow-up appointments, this type of follow-up appointment completed by the hospitals would not be captured within this metric as follow-up appointments completed on the day of discharge are excluded.

Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:
"In 2019, nearly one in five adults aged 18 and older in the U.S. had a diagnosed mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[5]"

Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Maintaining a focus around increasing follow-up after hospitalization will reduce inequalities associated with access, and improve healthcare outcomes for members by delivering mental health services during the most critical period immediately after hospitalization. Providing follow up care is associated with improved medication adherence, decreased suicide risk, and increased long-term health care engagement, thus preventing readmissions.[6] Colorado Access has placed a large emphasis on behavioral health programming by devoting resources to promoting follow-up visits after hospitalizations for our members. FUH align with NCQA and Centers for Medicare & Medicaid Services (CMS) priorities, which further solidifies Colorado Access' selection of this metric.

Sources:

1. TrendWatch: The impacts of the COVID-19 pandemic on behavioral health | AHA. (2022, May 31). American Hospital Association. https://www.aha.org/guidesreports/2022-05-31-trendwatch-impacts-covid-19-pandemic-behavioral-health
2. Children's Colorado declares 'State of Emergency' for youth mental health. (2021, May). https://www.childrenscolorado.org/about/news/2021/may-2021/youth-mental-health-state-of-emergency/
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Appendix A: State of Colorado 2023-24 PIP Submission Form
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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):

By June 30th, 2025, use targeted FUH interventions to *increase* the percentage of seven day follow-up visits after hospitalization among Region 5 members six years of age and older from 36.96% to 41.03%.

Colorado Access utilized the HEDIS Quality Compass to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal[1]. Colorado Access' current baseline rate of 36.96% is greater than the 50th percentile national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the 66.67th percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the *HSAG Quick Start Guide for Statistical Testing*[2,3] to verify this goal would yield statistically significant (95 percent confidence level, $p < 0.05$) improvement over the baseline performance.

Sources:

1. Quality Compass - NCQA. (2023, January 27). NCQA. https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/
2. Analyze a 2x2 contingency table. (n.d.). https://www.graphpad.com/quickcalcs/contingency1.cfm
3. Quick Start Guide for Statistical Testing (n.d.). https://www.hsag.com/contentassets/3f0180a5a4d84b73bea402165443cf50/pipvalquickstartstattestv1508.pdf

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Follow-Up After Hospitalization for Mental Illness (FUH)
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Step 3: Define the PIP Population. The PIP population must be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition must:

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

*** All population, enrollment inclusion, exclusion and diagnosis criteria are located within the HEDIS MY2023 Specification documents. What is outlined below has been directly taken from these HEDIS specification documents[1].**

1. HEDIS Measures and Technical Resources - NCQA. (2023, October 4). NCQA. https://www.ncqa.org/hedis/measures/

Population definition:

All continuously enrolled Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses from July 1st, 2022 – June 30th, 2025.

Enrollment requirements (if applicable):

Members must have continuous Medicaid enrollment from the date of discharge through 30 days after discharge.

Member age criteria (if applicable):

Ages six years and older as of the date of discharge.

Inclusion, exclusion, and diagnosis criteria:

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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.

Inclusion Criteria: All continuously enrolled Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses from July 1st, 2022 – June 30th, 2025.

- Inpatient discharge inclusion criteria: Members must have an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between the PIP measurement year. PIP measurement years include:
  - Baseline: July 1st, 2022 – June 30th, 2023
  - Remeasurement Year 1: July 1st, 2023 - June 30th, 2024
  - Remeasurement Year 2: July 1st, 2024 - June 30th, 2025

  To identify acute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between the PIP measurement year.

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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.

Exclusion Criteria:

- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
- Exclude members who meet either of the following criteria:
  - Members in hospice or using hospice services anytime during the measurement year. Refer to HEDIS General Guideline 15: Members in Hospice.
  - Members who died any time during the measurement year. Refer to HEDIS General Guideline 16: Deceased Members.

Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): Members must have an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between the PIP measurement year. All diagnosis and billing codes are located in the identified value sets provided by HEDIS.

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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	Sampling was not used.			

Describe in detail the methods used to select the sample:

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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	**The percentage of discharges for Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and had a follow-up visit with a mental health provider within seven days after discharge.** This indicator uses HEDIS methodology (Measurement Year 2023 specifications) published by NCQA. *HEDIS differences: • Specifications will be run with 12 month rolling rates (not calendar year which true HEDIS specifications use) • Due to differences in timeline, we are using internal resources to collect this data (not our certified HEDIS vendor).
	This indicator was selected because it was one of the three options for the Region 5 behavioral health PIP mandated by the Department. Colorado Access chose FUH because the current baseline rate has ample room for improvement, and this metric corresponds with many established metrics, such as HEDIS and the ACC and KPI incentive payment program for the RAE's.
Numerator Description:	Number of Region 5 members who received a follow-up visit with a mental health provider within seven days after discharge. Do not include visits that occur on the date of discharge.

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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."

Denominator Description:	Number of Region 5 members six years of age and older who were discharged after being hospitalized for treatment of selected mental illness or intentional self-harm diagnoses as of the end of the performance period.
Baseline Measurement Period	July 1st, 2022 – June 30th, 2023
Remeasurement 1 Period	July 1st, 2023 – June 30th, 2024
Remeasurement 2 Period	July 1st, 2024 – June 30th, 2025
Mandated Goal/Target, if applicable	41.03% Colorado Access utilized the HEDIS Quality Compass to determine an appropriate SMART Aim goal. Colorado Access' current baseline rate of 36.96% is greater than the 50th percentile national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the 66.67th percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the *HSAG Quick Start Guide for Statistical Testing*[2,3] to verify this goal would yield statistically significant (95 percent confidence level, $p < 0.05$) improvement over the baseline performance.

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

The data collection methodology must include the following:

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

Data Sources (Select all that apply)

[ ]Manual Data	[ ] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [X] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [X] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately – **HEDIS Value Set attached.** [ ] Data completeness assessment attached. [ ] Coding verification process attached. Estimated percentage of reported administrative data completeness at the time the data are generated: **95.01% complete.**	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: **Data was calculated after 09/30/2023, with a 3-month delay to account for claims runout. The Colorado Access internal Incurred But Not Reported (IBNR) model uses historic claims volume and runout to estimate completion factors every month and calculates an estimate to reserve for claims incurred but not yet reported. The October 2023 IBNR report shows a 95.01% completion rate for June 2023 services.**	

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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: Data elements were collected from Colorado Access's internal claims databases (HRP and Truven). There were 62 elements sourced from three sourced data tables:

Truven and HRP Database Collection

16 elements sourced from internal Region 5 enrollment tables:

- Medicaid ID, ACC Enrollment Indicator, Medicaid Number, Member Snapshot Date, Client Eligibility End Date, Enrollment Effective Date, and Enrollment End Date
- Primary Care Medical Providers (PCMP) Business Provider Name (Attributed Provider), PCMP MC Provider ID, and Member Snapshot Provider Name (Clinic Level Detail for Attributed Provider)
- Race Description, Gender Code, Client Date of Birth, Disabled Eligibility Type Indicator, Special Needs Indicator, and Pregnancy Indicator

46 elements sources from HRP and Truven claims tables:

- Denominator Claim ID, Numerator Claim ID, Denominator Claim Line Number, Numerator Claim Line Number, and Numerator Date (Claim First Service Date when record is in Numerator)
- Procedure Code, Procedure Code Description, Diagnosis 1-4 Codes, and Diagnosis 1-4 Descriptions
- Billing Provider Location ID, Billing Provider Location Name, Billing Vendor, Billing Vendor Tax ID, Billing Provider Medicaid ID, Billing Provider NPI, Billing Provider Type, Rendering Provider Location ID, Rendering Provider Location Name, Rendering Provider Type Code, Rendering Provider Type Description, Intake Provider Name
- Medicaid Number, Medicaid ID, Client Home City, Client Home State, Client Home County Name, Client Home Zip Code, Race Description, Gender Code, and Client Date of Birth
- Claims First Service Date, Claim Status Code, Claim Line Status Code, Most Recent Claim Indicator, Revenue Code, Paid Amount, Admission Date, Discharge Date, Bill Type Code, Place of Service Code, Claim Type, Claim Status, Claim Line Status, Service Category, Current Record Indicator, and Aid Code

Colorado Access then conducts additional calculations matched to the listed specification below to produce the FUH rate:

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

- **Numerator Specifications:** The FUH numerator follow the HEDIS methodology (Measurement Year 2023 specifications) published by NCQA[1]. Both paid and denied claims are included. Please reference the HEDIS Value Set excel document for specific diagnosis and CPT codes. This is located on tab 3, "Value Set to Codes", under the Value Set Name column. Numerator specifications include multiple value sets, including:
  - An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.
  - An outpatient visit (BH Outpatient Value Set) with a mental health provider.
  - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
  - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
  - A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).
  - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
  - A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.
  - An observation visit (Observation Value Set) with a mental health provider.
  - Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.
  - A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
  - A telephone visit (Telephone Visits Value Set) with a mental health provider.
  - Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

- **Denominator Specifications:** The FUH denominator follows the HEDIS methodology (Measurement Year 2023 specifications) published by NCQA[1]. Both paid and denied claims are included. Please reference the HEDIS Value Set excel document for specific diagnosis and CPT codes. This is located on tab 3, "Value Set to Codes", under the Value Set Name column. Denominator specifications include multiple value sets, including:
  - Mental Illness Value Set
  - Intentional Self-Harm Value Set
  - Inpatient Stay Value Set

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

- Nonacute Inpatient Stay Value Set

Reference: HEDIS Measures and Technical Resources - NCQA. (2023, October 4). NCQA. https://www.ncqa.org/hedis/measures/

Data Collection Process:

To extract the data, the Colorado Access Business Intelligence (BI) developer wrote a data extraction SQL code to pull claims from Colorado Access's internal claims databases (HRP) and Truven. The data extraction code reflects the baseline measurement period from July 1st, 2022, through June 30th, 2023. The "claims first service date" field, which corresponds to date of service, was used to account for all claims during the measurement period. For claims that have been adjudicated multiple times, claims were also filtered so that only the most recent adjudication was included in the dataset. Claim paid status was ignored; both paid and denied claims were included. For the approximate 62 attributes included in the data set from the two database sources, three tables were used to source the data: enrollment tables and two claims' tables. Matching logic for Medicaid ID and RAE location indicator were applied during all table joins. Depending on database source, different attributes were sourced from different tables.

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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: The percentage of discharges for Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider up within 7 days after discharge.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
July 1st, 2022 – June 30th, 2023	Baseline	476	1,288	36.96%	N/A for baseline	N/A for baseline
July 1st, 2023 – June 30th, 2024	Remeasurement 1					
July 1st, 2024 – June 30th, 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:

The preliminary baseline data analysis revealed that 36.96% of Region 5 members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses had a follow-up visit with a mental health provider up within seven days after discharge from July 1st, 2022-June 30th, 2023. Colorado Access utilized the HEDIS Quality Compass to determine an appropriate SMART Aim goal[1]. Colorado Access' current baseline rate of 36.96% is greater than the 50th percentile national benchmark for the HEDIS Medicaid FUH metric. Therefore, Colorado Access has chosen the 66.67th percentile national benchmark of 41.03% as our goal. Colorado Access further utilized the *HSAG Quick Start Guide for Statistical Testing*[2,3] to verify this goal would yield statistically significant (95 percent confidence level, $p < 0.05$) improvement over the baseline performance and determined that 41.03% would be an appropriate goal (an approximate increase of 53 Region 5 members).

Colorado Access does not foresee any factors affecting the validity of the data due to the use of standardized HEDIS methodology. Colorado Access does however anticipate that the expiration of the COVID-19 Public Health Emergency (PHE) will impact member demographics during the PIP remeasurement period. States began to terminate Medicaid enrollment for individuals who were no longer eligible beginning in

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- 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.

May of 2023. Colorado Access anticipates that the demographic populations of Health First Colorado and CHP+ members will undergo a noticeable shift during PIP remeasurement year 1 due to the absence of continuous eligibility and the movement of members between health insurers and regions. These changes will significantly impact measure denominators throughout the PIP, and Colorado Access expects to see the CHP+ member population increase, and Health First Colorado member population decrease. Colorado Access will continue to monitor demographic population changes and will adjust PIP interventions and programming according to the evolving needs of its members.

Sources:

1. Quality Compass - NCQA. (2023, January 27). NCQA. https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/
2. Analyze a 2x2 contingency table. (n.d.). https://www.graphpad.com/quickcalcs/contingency1.cfm
3. Quick Start Guide for Statistical Testing (n.d.). https://www.hsag.com/contentassets/3f0180a5a4d84b73bea402165443cf50/pipvalquickstartstattestv1508.pdf

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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.

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

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

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

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

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

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

QI Team Members:

- Sarah Thomas, Quality Improvement Program Manager at Colorado Access
- Stacy Stapp, Quality Improvement Program Manager at Colorado Access
- Laura Coleman, Quality Improvement Program Manager at Colorado Access
- Mika Gans, Quality Improvement Director at Colorado Access
- Caleb Menke, Quality Improvement Analyst at Colorado Access
- Krista Anderson, Manager of Behavioral Health at Colorado Access

QI process and/or tools used to identify and prioritize barriers: The quality team used the Six Sigma DMAIC (Define, Measure, Analyze, Improve and Control) model to identify and prioritize barriers and determine improvement opportunities. During the "Define" phase, the quality team determined that the Region 5 baseline measure is slightly higher than the 50th percentile of HEDIS national rankings, and therefore has plenty of room for improvement. The quality team further dove in during the "Measure" phase to identify trends within the FUH measure, and noticed that FUH has not improved since 2021, remaining stagnant the last two years. The "Analyze" phase allowed Colorado Access to identify barriers to improvement and interventions that could potentially target these barriers. Quality tools (including flowcharts) were utilized to determine current state versus future state to guide changes to processes. Barriers to improvement and their associated interventions are listed in more detail in Step B below. The "Improve" phase is currently underway, with all interventions listed below currently in progress.

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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
Colorado Access care coordination for members with inpatient mental health admissions: Colorado Access' behavioral health program is designed to identify and intervene with members utilizing inpatient and residential services and to prevent readmission. Care managers coordinate care with providers, connect members with appropriate outpatient behavioral health services, and mitigate barriers to discharge or engagement in follow-up services.	Care Managers (CM) expressed their top barriers with existing outreach programming to be: • Volume of work is too high. • Intervention does not feel meaningful. • Not enough time to serve members with complex needs. • High administrative burden for high volume of members To address these barriers, the Care Management team has recently streamlined their member outreach program to stratify

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

		members for risk, with the aim to reduce the overall volume of admissions and provide an additional touchpoint to members in the 7 days after discharge to promote appointment attendance.
	Implementation of the Hospital, Community Mental Health Centers (CMHCs) and Care Management seven day follow-up dashboard: Colorado Access has implemented a multi-faceted dashboard that hospitals, Community Mental Health Centers (CMHCs), and the Colorado Access Care Management team can utilize to connect discharged members to behavioral health providers in real-time.	CMHC's reported that they were not being notified if a member was inpatient in the hospital, and therefore had difficulty identifying members who needed a follow-up appointment after they were discharged. On the reverse side, hospitals reported having difficulty identifying members who were already engaged in behavioral health services with a CMHC or other behavioral health provider, so they did not know where to get a member connected for a follow-up appointment. Colorado Access worked to build a system that connects hospitals, CMHC's and our internal care management team to coordinate discharge planning. CMHC's can now access this dashboard system to see where their members are hospitalized in real-time and preemptively coordinate a follow-

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for Colorado Access (RAE 5)

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
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		up appointment after discharge. They can also see their seven day follow-up performance rate in real-time. Additionally, hospitals can now see which members are already connected to CMHC's so they can coordinate more targeted discharge, and access other behavioral health outpatient options besides CMHC's if appointment availability is limited within the seven day time-frame. This intervention will build community partnerships between hospitals and outpatient behavioral health providers.
	New Value Based Payment Model for CMHCs: Colorado Access recently enacted a new value-based payment model for the seven day follow-up after hospitalization for mental illness metric to all CMHCs. If this FUH metric improves, CMHCs will receive additional payment.	CMHCs identified needing more financial support and incentive to dedicate resources to prioritize this metric. Getting a member scheduled for a follow-up behavioral health appointment within seven days is a quick turnaround, and in order for CMHCs to provide this type of appointment availability, they need extra funding for additional behavioral staffing to increase appointment availability. Prior to this

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	incentive, there was no motivation for hospitals or CMHCs to prioritize this metric.

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.

Step C does not need to be completed at this time (08/2023 IQuIC meeting).

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Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

Demographic Information	
MCO Name: Colorado Access (RAE 5)	
Project Leader Name: Sarah Thomas	Title: Quality Improvement Program Manager
Telephone Number: 1-800-511-5010	Email Address: sarah.thomas@coaccess.com
PIP Title: *Social Determinants of Health (SDOH) Screening*	
Submission Date: 10/31/2023	
Resubmission Date (if applicable): 01/03/2024	

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Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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:

Social Determinants of Health (SDOH) Screening**:** this performance improvement project (PIP) topic is mandated from the Colorado Department of Health Care Policy and Financing (the Department).

Provide plan-specific data:

This topic is timely and relevant, as Colorado Access is currently in the process of developing an organization wide comprehensive strategy to address Social Determinants of Health (SDOH) in partnership with communities and members to create an aligned approach and standardized processes for evaluation. Colorado Access reviewed an existing inventory of SDOH initiatives within the organization and determined the opportunity to improve SDOH screenings completed with members internally by the Care Management (CM) team within Colorado Access. The Colorado Access CM Team employs a multi-disciplinary team-based approach to provide care coordination to help members and their support systems in managing needs across physical health, behavioral health, and social determinants of health. CM staff utilize targeted scripts, or intervention and interview templates, based on member diagnosis and/or acuity level to ensure consistent care delivery and to create collaborative care plan goals. Scripts generate a series of questions to aid care managers in identifying barriers to their health care needs and resolve care gaps via telephonic and electronic care coordination. Scripts are completed in the member-centric web-based healthcare management system HealthEdge, also known as GuidingCare. This platform offers health plans easy-to-use, next-generation data integration and workflow management tools that streamline workflows, facilitate coordination and collaboration, accelerate quality improvement, and promote provider and patient engagement. The CM team has been using GuidingCare to record all member interactions since 2018.

A preliminary analysis of CM scripts displayed that current scripts do not contain a standardized SDOH screening tool that encompasses the five HCPF required SDOH core domains: 1) Housing Instability, 2) Food Insecurity, 3) Transportation Problems, 4) Utility Help Needs, 5) Interpersonal Safety. Current scripts display a variety of SDOH related questions that vary based on the script. After review, it was determined that 100% of Region 5 CM scripts contained at least one SDOH question from the five SDOH core domains. **There were no CM scripts (0%) that contained SDOH questions with all five SDOH core domains.** In relation to Region 5 member specific data, there were 2,170 Region 5 members that were in contact with the Care Management team during FY22-23 and had an applicable SDOH script completed. 94% of these members were asked at least one SDOH question from the five SDOH core domains, and **0% of members were asked all five SDOH core domains within one script**. There were 14 applicable SDOH scripts that were utilized during FY22-23, with 11 scripts including a question on food insecurity; 10 scripts including a question around housing; 9 scripts including a question on transportation; 4 scripts including a question on utilities, and 2 scripts that included questions on interpersonal safety.

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Performance Improvement Projects

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Colorado Access has identified the opportunity to improve SDOH screening within the organization by overhauling all SDOH questions within the CM scripts and incorporating the Core 5 Social Determinants of Health Screening Tool within all applicable CM scripts[1]. The Performance Improvement Project (PIP) team evaluated a multitude of SDOH screening tools and determined the Core 5 screening tool was the best tool to use to ask questions to members over the phone; can easily be integrated into pre-established CM scripts and addresses all 5 SDOH core domains. Colorado Access can also build established resource and referral regulations based off SDOH question responses to better serve member needs.

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

"Nonmedical social factors such as food, housing, utilities, transportation, and safety significantly influence the health of Coloradans. Unmet social needs limit people from being active in their communities, diminish their overall well-being, and increase the likelihood that a person will develop a chronic disease and not be able to manage their care. These unmet needs are often disproportionately experienced by Black, Latino, and indigenous populations, and are exacerbated during a crisis, like the COVID-19 pandemic, when people experiencing disparities face even greater barriers to protecting their health[2]." The Social Determinants of Health (SDOH) have shown to have a greater influence on health than either genetic factors or access to healthcare services[3]. Addressing differences in SDOH makes progress toward health equity and improving SDOH screening will ensure members have an opportunity to share their needs, and get connected to resources that improve housing stability, food security, transportation, utility stability, and safety. This PIP focus has potential to improve social factors, reduce health inequities and increase access to resources for our members by addressing their social needs in a timely manner.

Sources:

1. Core Determinants of Health Screening Tool, aka the "Core 5" BECHTEL & JONES. https://cdn.ymaws.com/www.ohioleaguefornursing.org/resource/resmgr/ohio_action_coalition/ph_nurse_leader_project/Attachment_B_CDH_Screening_T.pdf.
2. Interoperable Social Health Information Exchange Ecosystem | Colorado Health Institute. (n.d.). Colorado Health Institute. https://www.coloradohealthinstitute.org/research/interoperable-social-health-information-exchange-SHIE.
3. Social determinants of health. (2022, December 8). Centers for Disease Control and Prevention. https://www.cdc.gov/about/sdoh/addressing-sdoh.html#:~:text=SDOH%20have%20been%20shown%20to,higher%20risk%20of%20premature%20death.

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Social Determinants of Health (SDOH) Screening
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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):

By June 30th, 2025, the Colorado Access CM team will utilize targeted interventions to *increase* the percentage of social determinants of health (SDOH) screenings among Region 5 members from 0% to 90%.

Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound

1. **(SMART) Aim goal. Colorado Access' baseline data shows that** CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05.

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Performance Improvement Projects

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

The population definition must:

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

Population definition:
All actively enrolled Region 5 members from July 1st, 2022 – June 30th, 2025, that the Care Management team comes into contact with via a documented phone call.

Enrollment requirements (if applicable):
All actively enrolled Region 5 members during the PIP (July 1st, 2022 – June 30th, 2025).

Member age criteria (if applicable):
All ages included.

Inclusion, exclusion, and diagnosis criteria:
Exclusion criteria include non-applicable scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).

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

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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	Sampling was not used.			

Describe in detail the methods used to select the sample:

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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	**The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool.**
	This indicator was selected because Region 5 members are currently not being asked SDOH questions in a standardized format during Care Management (CM) calls. The SDOH questions on CM scripts vary, and often only contain 1-2 questions that relate to the 5 SDOH Core Domains. There are no scripts (0%) that contain SDOH questions with all five SDOH core domains. Therefore, 0% of members are currently being asked <u>all five</u> SDOH questions during one phone call/point of contact. This indicator is mandated from the Colorado Department of Health Care Policy and Financing (the Department).
Numerator Description:	Number of Region 5 members that were screened for SDOH using the Core 5 SDOH screening Tool
Denominator Description:	Number of Region 5 members that were in contact with the CM team through a documented interaction via an *applicable CM script in the CM documentation software HealthEdge GuidingCare. *Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).
Baseline Measurement Period	July 1st, 2022 – June 30th, 2023
Remeasurement 1 Period	July 1st, 2023 – June 30th, 2024

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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."

Remeasurement 2 Period	July 1st, 2024 – June 30th, 2025
Mandated Goal/Target, if applicable	90% Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal. Colorado Access' baseline data shows that CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05.

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

The data collection methodology must include the following:

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

Data Sources (Select all that apply)

[ ]Manual Data	[X] Administrative Data	[ ] Survey Data
Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	Data Source [ ] Programmed pull from claims/encounters. [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [X] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately. [ ] Data completeness assessment attached. [ ] Coding verification process attached. Estimated percentage of reported administrative data completeness at the time the data are generated: **100% complete.**	Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other _____ Other Survey Requirements: Number of waves: _____ Response rate: _____ Incentives used: _____

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Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology must include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: N/A – **there is no lag time for call center data. Call center data is live data that is collected and recorded in real time. Incurred But Not Reported (IBNR) only relates to claims data, and this is not claims data.**	

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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: Data elements are collected in the member-centric web-based healthcare management system HealthEdge, also known as GuidingCare. This platform offers health plans easy-to-use, next-generation data integration and workflow management tools that streamline workflows, facilitate coordination and collaboration, accelerate quality improvement, and promote provider and patient engagement. The CM team has been using GuidingCare to record all member interactions since 2018. There were 12 data elements sourced from the HealthEdge GuidingCare system: • Member Identification Number (ID) • Line of Business • Script ID • Script Name • Script Active • Question Number • Question ID • Question • Option ID • Option Value • Suboption ID • Suboption Value **Data Collection Process:**

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
Scripts are completed in the HealthEdge GuidingCare system by all CM staff. Scripts are workflow dependent, and CM has a menu of script options to select from and chosen based on the specific population each CM staff supports. For example, if a CM team member supports the Transitions of Care program, they would utilize the Transitions of Care script that is tailored to the population that is stratified by service unitization into the Transitions of Care population. If a certain member is not in a particular program, the staff has a general script they can use to enter information into. Staff are encouraged to use their expertise to decide on the best script to fit the member's needs. The CM team performs member-centered care, and while they do their best to complete all questions on each script, a member may choose not to answer or complete the script and the CM team respects their decision. Therefore, not all questions may be completed on a given script. The data and answers from all CM scripts are recorded and housed in the HealthEdge GuidingCare data platform. To extract the data, the Colorado Access Business Intelligence (BI) team wrote a data extraction SQL code to pull all recorded CM scripts from the Colorado Access internal HealthEdge data server. The data extraction code reflects the baseline measurement period from July 1st, 2022, through June 30th, 2023. The raw data was sent to the Quality team in a Microsoft Excel file to analyze for the PIP. The Quality team looked at each specific script and member to determine how many SDOH questions were answered during the baseline period. While all scripts were initially pulled, only applicable scripts were included in the SDOH analysis. Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions.

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Performance Improvement Projects

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

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

Indicator 1 Title: The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
July 1st, 2022 – June 30th, 2023	Baseline	0	2,170	0%	N/A for baseline	N/A for baseline
July 1st, 2023 – June 30th, 2024	Remeasurement 1					
July 1st, 2024 – June 30th, 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:

The preliminary baseline data analysis revealed that there were 2,170 Region 5 members that were in contact with the CM team during FY22-23 and had an applicable SDOH script completed. 94% of these members were asked at least one SDOH related question from one of the five SDOH core domains, and 0% of members were asked all five SDOH core domain questions within one script. It was therefore determined that Indicator 1: "The percentage of Region 5 members who were screened for Social Determinants of Health (SDOH) using the Core 5 SDOH screening Tool" is 0%, with 0 out of 2,170 members asked all five SDOH questions from the Core 5 Screening tool during one phone call/point of contact. Colorado Access utilized previous CM call center data to determine an appropriate Specific, Measurable, Attainable, Realistic, Time-bound (SMART) Aim goal. Colorado Access' baseline data shows that CM is completing SDOH questions in >90% of calls (as described in Step 1). Therefore, achieving SDOH screening in over 90% of scripts should be feasible once a standardized SDOH screening tool has been incorporated into all relevant CM scripts. This will also result in a statistically significant improvement over the baseline performance of 0%, with a confidence level of 95% and p-value < 0.05.

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Performance Improvement Projects

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

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

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- 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.

Colorado Access does not foresee any factors affecting the validity of the data due to the use of the standardized data collection and reporting tool, HealthEdge GuidingCare. Colorado Access does however anticipate that the expiration of the COVID-19 Public Health Emergency (PHE) will impact member demographics during the PIP remeasurement period. States began to terminate Medicaid enrollment for individuals who were no longer eligible beginning in May of 2023. Colorado Access anticipates that the demographic populations of Health First Colorado and CHP+ members will undergo a noticeable shift during PIP remeasurement year 1 due to the absence of continuous eligibility and the movement of members between health insurers and regions. These changes will significantly impact measure denominators throughout the PIP, and Colorado Access expects to see the CHP+ member population increase, and Health First Colorado member population decrease. Colorado Access will continue to monitor demographic population changes and will adjust PIP interventions and programming according to the evolving needs of its members.

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

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   - Intervention Evaluation Results
   - Intervention Status

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

QI Team Members:

- Sarah Thomas, Quality Improvement Program Manager at Colorado Access
- Laura Coleman, Quality Improvement Program Manager at Colorado Access
- Mika Gans, Quality Improvement Director at Colorado Access
- Jamie Zajac, Director of Care Management at Colorado Access
- Joy Twesigye, Vice President of Health Systems Integration at Colorado Access
- Brittany Goldstein, Clinical Program Manager at Colorado Access

QI process and/or tools used to identify and prioritize barriers: The Quality team used the Six Sigma DMAIC (Define, Measure, Analyze, Improve and Control) model to identify and prioritize barriers and determine improvement opportunities. During the "Define" phase, the Quality Team reviewed an inventory of SDOH initiatives within the organization and determined the opportunity to improve SDOH screenings completed internally by the Care Management (CM) team within Colorado Access. The team defined the problem as not having a standardized SDOH screener incorporated into CM scripts, with barriers that included an older HealthEdge system with outdated scripts; a variety of current SDOH questions that have not been streamlined or updated; and the need to consolidate resources and referrals if SDOH concerns are present. During the "Measure" phase, the team ran a report of all CM scripts completed by all members from 2018 – 2022 to determine baseline performance, and the "Analyze" phase allowed the team to examine the data and determine there was ample

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opportunity to incorporate the Core 5 SDOH screening tool into all CM scripts. The "Improve" phase is currently underway, with the first step of the improvement strategy upcoming with the HealthEdge GuidingCare upgrade.

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
Standardization of SDOH questions by incorporating the CORE 5 Screening Tool into all applicable CM scripts.	Current state CM scripts ask a variety of SDOH questions that do not cover all 5 SDOH core Domains. The CM team aims to standardize SDOH questions by incorporating the CORE 5 Screening Tool into all *applicable CM scripts used with member interactions. *Nonapplicable scripts include scripts that would not be appropriate to contain SDOH questions. Example: standardized screening tools (PHQ-9, AHQ).

Appendix A: State of Colorado 2023-24 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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

Optimization of the collection of SDOH data and reporting within HealthEdge GuidingCare.	The internal Colorado Access HealthEdge GuidingCare system has not been updated since 2021. The older system has impacted the ability to update the CM scripts and workflows within the GuidingCare system in a timely manner to better serve our members. GuidingCare is being upgraded in December of 2023, and is the perfect opportunity to incorporate the SDOH Core 5 screening tool into the new and improved system and scripts.

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.

Step C does not need to be completed at this time (08/2023 IQuIC meeting).

Appendix B. Final PIP Validation Tools

The following contains the final PIP Validation Tools for COA R5.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

Demographic Information			
MCO Name:	Colorado Access (RAE 5)		
Project Leader Name:	Sarah Thomas	**Title:**	Quality Improvement Program Manager
Telephone Number:	1-800-511-5010	**Email Address:**	sarah.thomas@coaccess.com
PIP Title:	*Follow-Up After Hospitalization for Mental Illness (FUH)*		
Submission Date:	October 31, 2023		
Resubmission Date:	January 3, 2024		

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Colorado Access (RAE 5) 2023-24 PIP Validation Tool
State of Colorado

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COA-R5_CO2023-24_PIP-Val_FUH_Tool_F1_0224

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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*	*NA*	
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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
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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*	The health plan did not include a statement in the baseline narrative section of Step 7 that addressed whether any factors were identified that impacted validity of the baseline indicator results. If the health plan did not identify any factors that may have impacted the validity of the baseline results, a statement of this fact should be added to the baseline narrative in the resubmission. If factors that impacted validity were identified, the health plan should provide a brief description of the identified factors and the steps taken to address those factors. **Resubmission January 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element was changed to *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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 8. Assess the Improvement Strategies: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:			
1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	C*	*Met*	
2. Interventions that were logically linked to identified barriers and have the potential to impact indicator outcomes.	C*	*Met*	
3. Interventions that were implemented in a timely manner to allow for impact of indicator outcomes.		*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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

Table B—1 2023-24 PIP Validation Tool Scores
for *Follow-Up After Hospitalization for Mental Illness* for Colorado Access (RAE 5)

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 Hospitalization for Mental Illness* for Colorado Access (RAE 5)

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 Hospitalization for Mental Illness* for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Access (RAE 5)

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
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

Demographic Information			
MCO Name:	Colorado Access (RAE 5)		
Project Leader Name:	Sarah Thomas	**Title:**	Quality Improvement Program Manager
Telephone Number:	1-800-511-5010	**Email Address:**	sarah.thomas@coaccess.com
PIP Title:	*Social Determinants of Health (SDOH) Screening*		
Submission Date:	October 31, 2023		
Resubmission Date:	January 3, 2024		

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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*	As currently written, the Aim statement focuses only on Indicator 1 and does not align with Indicator 2. In addition, the Aim statement(s) should focus on improving the performance on each indicator. For example, using the X/Y format for Indicator 2, "Do targeted interventions increase the percentage of Region 3 members who were screened for SDOH during the measurement period using the Core 5 SDOH screening tool?" **Resubmission January 2024:** The health plan revised the Aim statement and addressed the initial feedback. The validation score for this evaluation element was changed to *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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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.

Colorado Access (RAE 5) 2023-24 PIP Validation Tool
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Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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*	Indicator 1 focuses on an intervention, increasing the Care Management scripts that include the SDOH screening questions, to improve SDOH screening rates. HSAG recommends the health plan use Indicator 2 as the overall performance indicator for the PIP and include the Care Management script measure as a measure of intervention effectiveness for Step 8. **Resubmission January 2024:** The health plan revised Step 5 to remove the indicator that had previously focused on measuring an intervention, keeping the recommended performance indicator focused on the screening rate. The health plan addressed the initial feedback and the validation score for this evaluation element was changed to *Met*.
2. Included the basis on which the indicator(s) was developed, if internally developed.		*Met*	The rationale for Indicator 1 described an intervention for improving performance on Indicator 2. HSAG recommends the health plan use Indicator 2 as the overall performance indicator for the PIP and include the Care Management script measure as a measure of intervention effectiveness for Step 8. **Resubmission January 2024:** The health plan revised Step 5 to remove the indicator that had previously focused on measuring an intervention, keeping the recommended performance indicator focused on the screening rate. The health plan addressed the initial feedback and the validation score for this evaluation element was changed to *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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Access (RAE 5)

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.		*N/A*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	2	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	2	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*	The health plan did not include a statement in the baseline narrative section of Step 7 that addressed whether any factors were identified that impacted validity of the baseline indicator results. If the health plan did not identify any factors that may have impacted the validity of the baseline results, a statement of this fact should be added to the baseline narrative in the resubmission. If factors that impacted validity were identified, the health plan should provide a brief description of the identified factors and the steps taken to address those factors. **Resubmission January 2024:** The health plan addressed the initial feedback and the validation score for this evaluation element was changed to *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*	**General Feedback:** The health plan noted an intervention focused on improving the referral process for members who report an SDOH concern during screening. While HSAG acknowledges that this strategy is valuable to improving member care and well being, the health plan should ensure that all PIP interventions have the potential to positively impact performance on the PIP indicators, which focus on screening rather than referral.
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 *Social Determinants of Health Screening* for Colorado Access (RAE 5)

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	2	0	0	2	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 *Social Determinants of Health Screening* for Colorado Access (RAE 5)

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 *Social Determinants of Health Screening* for Colorado Access (RAE 5)

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***