COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2022–2023 PIP Validation Report

for

Colorado Community Health Alliance Region 6

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Colorado Community Health Alliance Region 6**, referred to in this report as **CCHA R6**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

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

Measuring performance using objective quality indicators

Implementing system interventions to achieve improvement in quality

Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

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

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

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

PIP Components and Process

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

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

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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 27, 2023.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 27, 2023.

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

PIP Terms

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

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

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

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **CCHA R6**'s module submission forms. In FY 2022–2023, these forms provided detailed information about **CCHA R6**'s PIP and the activities completed in Module 4. (See Appendix A. Module Submission Form.) Following HSAG's rapid-cycle PIP process, each health plan submitted Module 4 according to the approved timeline. HSAG provided scores and feedback and assigned a level of confidence to the PIP in the Module 4 validation tool. If a PIP received less than *High Confidence* on initial review, the health plan had an opportunity to receive technical assistance from HSAG and to complete a single Module 4 resubmission to address the initial validation findings.

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2022–2023, **CCHA R6** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen.*

CCHA R6 defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

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

Table 1-1 includes the SMART Aim statements established by **CCHA R6**.

Table 1-1—PIP Measures and SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older from 49.27% to 53.01%.*
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen administered during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older from 75% to 93.75%.*

* HSAG approved revisions to the SMART Aim statements in November 2021.

2. Findings

Module 4: PIP Conclusions

In FY 2022–2023, **CCHA R6** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

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

SMART Aim Measure Results

HSAG analyzed **CCHA R6**'s PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **CCHA R6**'s success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for **CCHA R6**'s PIP are presented in Table 2-1. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 2-1—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older.	49.27%	53.01%	58.77%	Yes

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen administered during an outpatient primary care visit at Clinica Family Health among unduplicated CCHA members 12 years of age or older.	75.00%	93.75%	88.70%	Yes

To guide the project, **CCHA R6** established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during an in-person or virtual outpatient primary care visit at Clinica Family Health from 49.27 percent to 53.01 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 75.00 percent to 93.75 percent, through the SMART Aim end date of June 30, 2022. **CCHA R6**'s reported SMART Aim measure results demonstrated that the *Depression Screening* goal was exceeded, with the highest rate achieved, 58.77 percent, representing a statistically significant increase of 9.5 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved was 88.70 percent, representing a statistically significant improvement of 13.70 percentage points over the baseline rate. The health plan's final SMART Aim run chart and SMART Aim measure data are provided in Appendix A. Module Submission Form.

Intervention Testing Results

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, **CCHA R6** completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 2-2 summarizes **CCHA R6**'s interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 2-2—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Identify a virtual depression screening tool (Patient Health Questionnaire for Adolescents [PHQ-A]) for minors ages 12–17 years at Clinica Family Health, build an electronic PHQ-A form, and train Clinica staff to integrate the electronic screening tool into the virtual visit workflow.	Significant *clinical* improvement for *Depression Screening*	Adapted
Develop a workflow for BH referral after a positive depression screen and train Clinica staff to consistently and successfully apply the workflow to ensure members receive appropriate referral and follow-up.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

CCHA R6 tested two provider-focused interventions for the project: One intervention focused on *Depression Screening,* and one intervention focused on *Follow-Up After a Positive Depression Screen*. For the virtual depression screening tool intervention, the health plan reported testing results that demonstrated clinically significant improvement in the percentage of members who received a depression screen during a virtual visit. At the conclusion of testing for the PIP, **CCHA R6** reported that the virtual depression screening tool intervention will be adapted and used for both in-person and virtual visits in the future. For the BH referral workflow intervention, the health plan reported testing results that demonstrated clinically significant improvement in the percentage of members who received timely follow-up services after a positive depression screen and programmatically significant improvement in establishing a standardized, consistent process for BH service referral after a positive depression screen. Based on the strong intervention testing results, **CCHA R6** reported that Clinica, the partner provider, has chosen to adopt the BH referral workflow intervention as standard practice at the conclusion of the PIP.

Lessons Learned

An important part of the QI process is to consider how the information gathered and lessons learned during the PIP can be applied in future improvement efforts. **CCHA R6** reported successes, challenges, and lessons learned as part of the Module 4 submission.

CCHA R6 documented the following lessons learned from the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP:

- Administering the depression screening during virtual services was expected to have had a much larger impact on consistency of screening processes. Although technology is a helpful tool to augment processes and increase flexibility in screening methods, additional improvement strategies are needed to resolve all aspects of screening compliance.
- Provider and staff training was effective in improving rates of follow-up after a positive depression screen. Training effects were continued but decreased over time, suggesting that routine trainings and refreshers for providers and staff are an effective method to promote adherence to follow-up protocols.

3. Conclusions and Recommendations

Conclusions

CCHA R6 developed a methodologically sound improvement project that met both State and federal requirements. The health plan tested two interventions using the required QI processes and tools. At the conclusion of the PIP, the health plan accurately reported results that demonstrated achievement of the SMART Aim goal for *Depression Screening* and statistically significant improvement over baseline performance in *Depression Screening and Follow-Up After a Positive Depression Screen.* The health plan's intervention testing results also demonstrated clinically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-up After a Positive Depression Screen* linked to the tested interventions. Based on the validation findings, HSAG assigned a level of *High Confidence* to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Recommendations

HSAG has the following recommendations:

- **CCHA R6** should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- **CCHA R6** should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Appendix A. Module Submission Form

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

Managed Care Organization (MCO) Information	
MCO Name	Colorado Community Health Alliance (CCHA) Regional Accountable Entity, Region 7
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Kathryn Morrison
Title	Medicaid Quality Management Health Plan Director
Email Address	kathryn.morrison2@anthem.com
Telephone Number	(719) 318-5494
Submission Date	10/21/2022
Resubmission Date (if applicable)	N/A

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

Final SMART Aim Run Chart – *Depression Screening*

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

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

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

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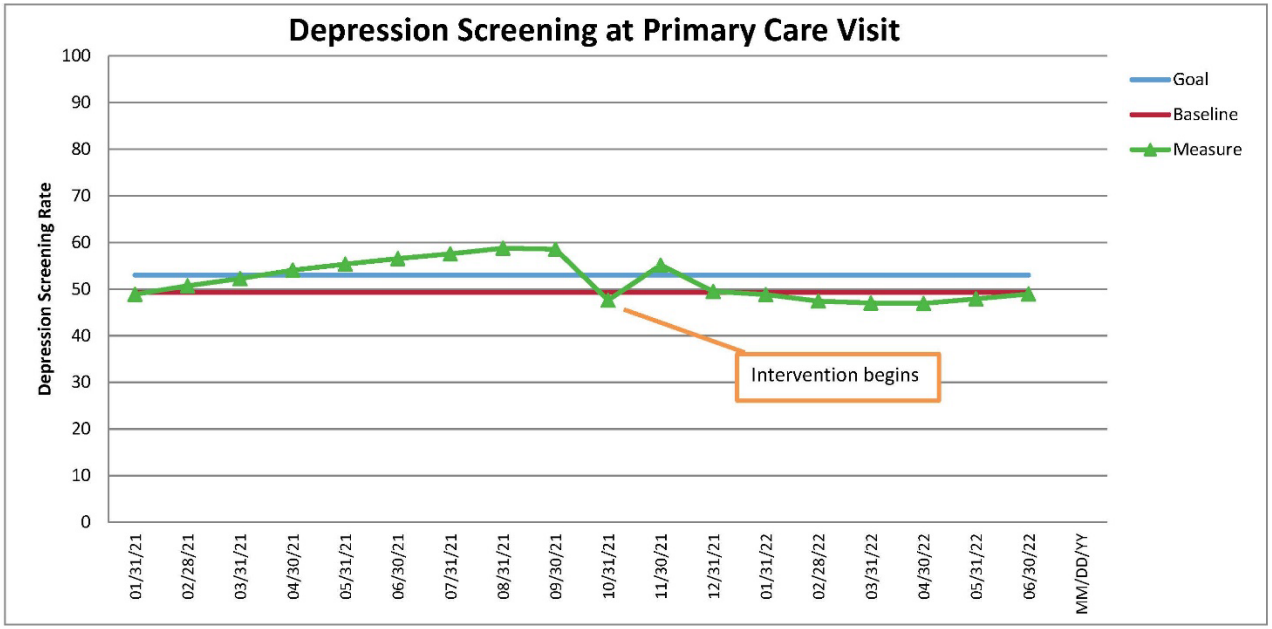
Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

Depression Screening and Follow–up After a Positive Depression Screen

for **Colorado Community Health Alliance (RAE 6)**



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

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

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Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
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for Colorado Community Health Alliance (RAE 6)

Final Monthly SMART Aim Measure Data – *Depression Screening*

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020 – 01/31/2021	January-21	548	1121	48.88%
03/01/2020 – 02/28/2021	February-21	541	1067	50.70%
04/01/2020 – 03/31/2021	March-21	579	1108	52.26%
05/01/2020 – 04/30/2021	April-21	666	1232	54.06%
06/01/2020 – 05/31/2021	May-21	749	1353	55.36%
07/01/2020 – 06/30/2021	June-21	803	1420	56.55%
08/01/2020 – 07/31/2021	July-21	811	1409	57.56%
09/01/2020 – 08/31/2021	August-21	724	1232	58.77%
10/01/2020 – 09/30/2021	September-21	643	1098	58.56%
11/01/2020 – 10/31/2021	October-21	717	1506	47.61%
12/01/2020 – 11/30/2021	November-21	858	1556	55.14%
01/01/2021 – 12/31/2022	December-21	739	1493	49.50%

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Performance Improvement Project (PIP)

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Depression Screening and Follow–up After a Positive Depression Screen

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02/01/2021 – 01/31/2022	January-22	709	1452	48.83%
03/01/2021 – 02/28/2022	February-22	690	1446	47.72%
04/01/2021 – 03/31/2022	March-22	639	1359	47.02%
05/01/2021 – 04/30/2022	April-22	618	1317	46.92%
06/01/2021 – 05/31/2022	May-22	623	1300	47.92%
07/01/2021 – 06/30/2022	June-22	600	1226	48.94%

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Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

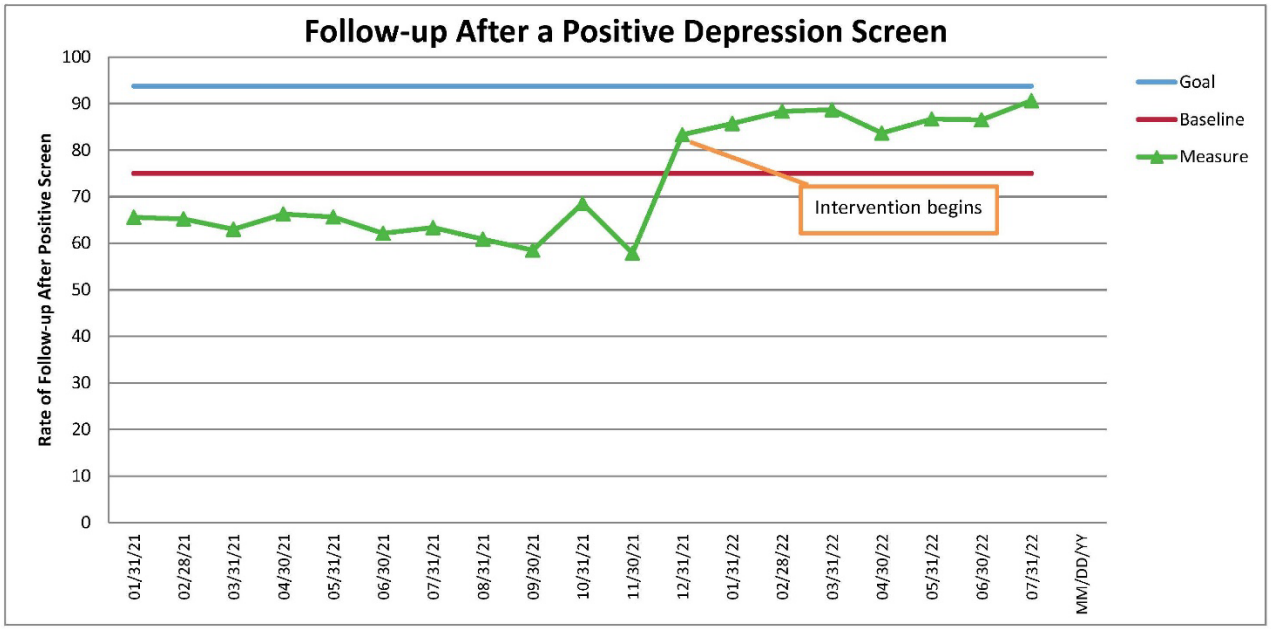
Final SMART Aim Run Chart – *Follow–up After a Positive Depression Screen*

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

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

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

State of Colorado
Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance (RAE 6)**



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

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

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

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020 – 01/31/2021	January-21	40	61	65.6%
03/01/2020 – 02/28/2021	February-21	45	69	65.2%
04/01/2020 – 03/31/2021	March-21	46	73	63.0%
05/01/2020 – 04/30/2021	April-21	55	83	66.3%
06/01/2020 – 05/31/2021	May-21	63	96	65.6%
07/01/2020 – 06/30/2021	June-21	64	103	62.1%
08/01/2020 – 07/31/2021	July-21	64	101	63.4%
09/01/2020 – 08/31/2021	August-21	56	92	60.9%
10/01/2020 – 09/30/2021	September-21	50	85	58.8%
11/01/2020 – 10/31/2021	October-21	48	70	68.6%
12/01/2020 – 11/30/2021	November-21	55	95	57.9%

State of Colorado

Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

Depression Screening and Follow–up After a Positive Depression Screen

for **Colorado Community Health Alliance (RAE 6)**

01/01/2021 – 12/31/2022	December-21	60	72	83.3%
02/01/2021 – 01/31/2022	January-22	54	63	85.7%
03/01/2021 – 02/28/2022	February-22	53	60	88.3%
04/01/2021 – 03/31/2022	March-22	47	53	88.7%
05/01/2021 – 04/30/2022	April-22	41	49	83.7%
06/01/2021 – 05/31/2022	May-22	39	45	86.7%
07/01/2021 – 06/30/2022	June-22	32	37	86.5%
08/01/2021 – 07/31/2022	July-22	29	32	90.6%

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

Final Key Driver Diagrams

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

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

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

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Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 6)

Key Driver Diagram –*Depression Screening*

Global Aim

Improve identification of members with depression through regular increasing rates of depression screening.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of members who were screened for depression during an outpatient primary care visit at Clinica Family Health among members 12 years or older attributed to CCHA, from 49.27% to 53.01%.

Date: 11/19/2021
Version: 1.2

Key Drivers	Interventions
Provider Engagement	- Education dedicated to providers in support of screening completion delivered via potential methods: coaching with QM staff; materials, phone communication and/or email. - Knowledge and utilization of qualifying codes
Provider Standards of Care	- Staff training - Increase depression screening rates - Referral pathways for appropriate follow-up - Adjust processes for remote service - Assess gaps in current processes
Provider Availability	- Same day appointments - Changes to staffing patterns and shortages
Data Accuracy and Integration	- Accurate service coding - Accurate submission of claims - Provider utilization of qualifying billing codes - Data integration - Regular reporting
Member Access and Engagement	- Appointment availability - Hours of operation - Translation services - Transportation assistance - Access to technology and internet

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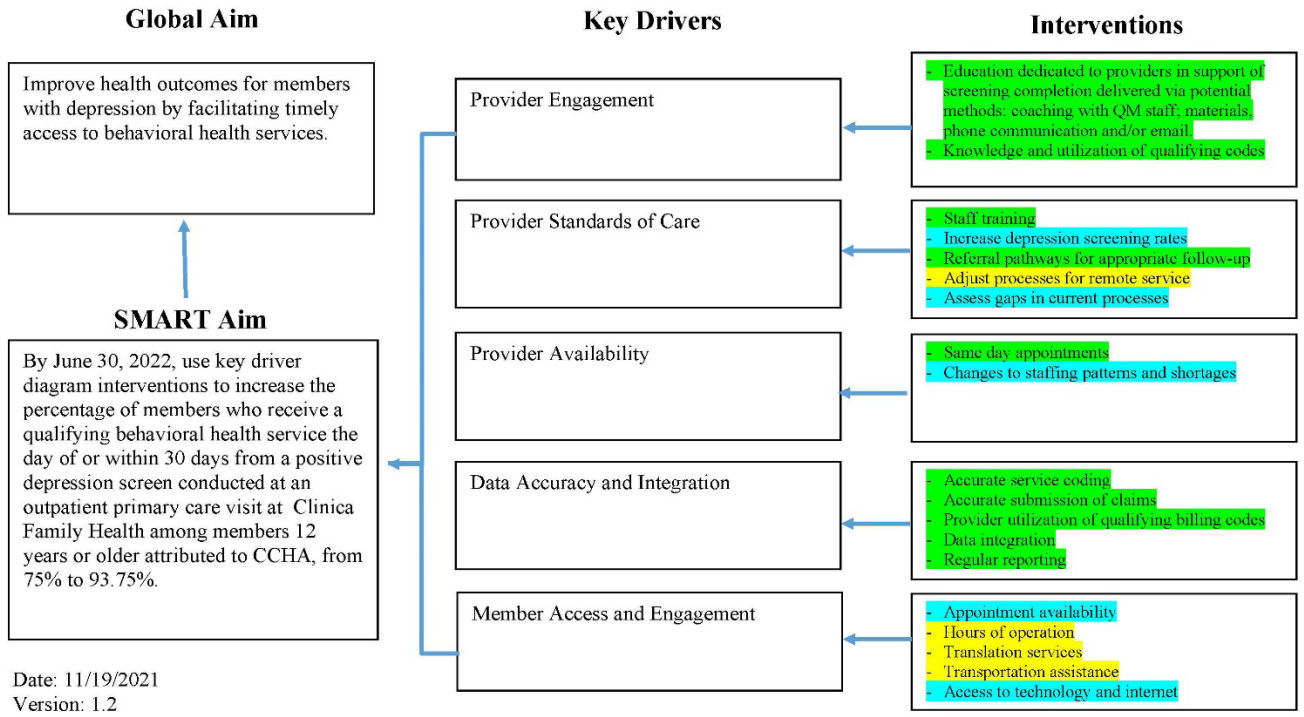
for Colorado Community Health Alliance (RAE 6)

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



Date: 11/19/2021
Version: 1.2

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Project Conclusions

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

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

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Table 2a—Project Conclusions – *Depression Screening*	
Project Conclusions	Depression screening rates were above the 49.27% baseline during 10 of the 18 months of tracking. In 7 of these 18 months, performance exceeded the 53.01% statistically significant SMART Aim goal for Depression Screening rates. However, the positive trend was not sustained, and the project was concluded with rates below performance targets. Internal tracking tools the practice uses to gauge compliance with the depression screening requirements showed a higher compliance rate compared to the claims-based PIP outputs. One hypothesis for this variation is that the practice flags members who have a known Depression diagnosis and/or who have not received a depression screening in the 12 months prior to the any service being rendered. The PIP logic does not match these denominator exclusions, and the qualifying events are limited to primary care visits as defined by the RAE ACC Well Visit KPI Specification and Value Set. Therefore, while a depression screening could occur during any service, the PIP methodology only captures screenings administered on the same day as well visits. Had duplicate members without Depression been excluded and more services been included to match the practice's actual workflow, depression screening performance would likely have been higher. Despite variations, clinically significant improvement was achieved by promoting the establishment of structures that reinforce the utilization of evidence-based strategies for the early identification of depressive symptoms that can enhance patient's clinical outcomes. Since rates of depression screening observed at the practice level overtime remained relatively consistent without noteworthy improvements, outcomes do not support that programmatically significant improvement was achieved through this project.
Intervention Testing Conclusions	Developing and implementing an electronic depression screening form for members 12-17 years old was the intervention designed to improve rates of depression screening. The flexibility provided by the electronic version of the depression screening form establishes greater opportunities to maintain equitable standards of care regardless of mode of service

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	delivery, expands the practice's ability to adhere to clinical practice guidelines, and facilitates members' access to evidence-based care. The electronic form also allows members to fill out the form independently, expediting the process and reducing reliance on staff, which is particularly important during staff shortages and high turnover. As a result, this process allowed additional members to be screened during a virtual service that may not have been screened otherwise. However, the actual number of members impacted by this intervention was not large enough to establish a meaningful impact in overall rates of Depression screening at the practice level.
Spread of Successful Interventions	A discussion regarding utilizing technology to deploy self-administered screening tools will be introduced to the Quality Management Committee and evaluated for future practice transformation projects.
Challenges Encountered During Project	This PIP further highlights the benefits of standardizing programs and establishing consistent practices to accurately measure desired performance that effectively reflect the quality of services. Due to discrepancies between the PIP performance calculation methodology and the provider's standard workflow, outcomes may not accurately reflect the provider's performance in the provision of targeted services. The calculation methodology for this project was similar, but not exact, to additional quality metrics and provider incentive programs this provider participates in. This created completing objectives for process improvement and limited the feasibility of altering workflows.
Lessons Learned/Information Gained Throughout the Project	The ability to administer the depression screening form to adolescents during virtual services was expected to have had a much larger impact on consistent administration. Although technology is a helpful tool to augment processes and allows for greater flexibility in the methods available to reach members, it isn't necessarily the solution to resolve all aspects of compliance.

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Sustainability of Improvement – *Depression Screening*

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

The depression screening process originally established for virtual services will be expanded to include in person services in addition to telehealth for continuous process improvement. CCHA will conclude its participation in this PIP and future testing cycles at the end of SFY22. Moving forward, CCHA will continue to distribute earned behavioral health incentive dollars based and offer incentive payments to reward providers for their contributions in meeting or exceeding performance benchmarks on pre-established metrics for depression screening and follow-up after positive screen. CCHA will remain available to support related endeavors or other transformation efforts the practice opts to pursue in the future.

Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Project Conclusions	Rates of follow-up after a positive depression screen were above the 75% baseline during 8 of the 19 months of tracking. A significant improvement in rates was observed in December/2021 and continued to trend positively until the highest performance rate of 90.60% was achieved in the final month of testing. Despite the substantial progress, the project did not achieve the statistically significant improvement target of 93.75%. It is important to note that the numerator specification for this rate is narrow compared to performance calculation standards of other improvement programs the practice participates in. As a result, different treatment strategies and the most used behavioral health procedure codes did not qualify for the follow-up service performance calculation. Taking into account the additional services that aren't captured, the ambitious performance goal and evident high-performance at closure, we speculate the practice's performance on this measure is likely even more remarkable.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	Clinically and programmatically significant improvement were achieved, as evidenced by the practice's outstanding and growing ability to respond to identified behavioral health needs. Enhancing the practice's integrated on-site service model promotes adherence to recommended follow-up, facilitating timely access to further assessment and short-term behavioral health support that can enhance patient's clinical outcomes.
Intervention Testing Conclusions	The goal of the intervention was to achieve a statistically significant improvement over the baseline rate of 56.63% by having 73.49% of patients 12 years or older receive a behavioral health follow-up service within 30 days of a positive depression screen. The strategy focused on enhancing workflows, reviewing coding guidelines and internal audit protocols, and conducting staff straining. By the final month of testing, follow-up after a positive depression screen achieved its highest success rate with 79.55%. Claims-based rates of follow-up during the testing cycle seem to confirm its correlation to the intervention and endorse the strategy's contribution to the unprecedented systemic performance.
Spread of Successful Interventions	Different providers have different workflows, use different EHRs with different functions that are tailored to meet specific needs from regulations, scope of service, payer sources and incentive programs. PIP interventions were specifically designed for this project and would need to be tailored to specific provider systems to yield similar results.
Challenges Encountered During Project	This PIP further highlights the need to standardize programs, and establish consistent and reliable practices to accurately measure desired performance that reflects the quality of services. Discrepancies between qualifying procedure codes and actual practice demonstrate baselines and progress may not accurately reflect the provider's performance in the provision of targeted services. Variation in specifications and methodology between different incentive programs the practice participates in creates duplication and burdens providers to demonstrate the same performance according to each specific set of standards. As a result, expectations for activities that qualify as a follow-up after a positive depression screen are different across programs.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Lessons Learned/Information Gained Throughout the Project	Rates of follow-up after a positive depression screening showed a significant improvement following training and reminders to staff. Effects were maintained although decreased overtime, which indicates that routine trainings and refreshers are an effective method to promote adherence to follow-up protocols.

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

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

Changes to service coding, staff training on follow-up expectations, and internal audit processes will be maintained. Data will continue to be generated monthly to track and monitor performance and will be reviewed by the Vice President of Behavioral Health for improvements and corrections, as needed. CCHA will conclude its participation in this PIP and future testing cycles at the end of SFY22. Moving forward, CCHA will continue to distribute earned behavioral health incentive dollars based and offer incentive payments to reward providers for their contributions in meeting or exceeding performance benchmarks on pre-established metrics for depression screening and follow-up after positive screen. CCHA will remain available to support related endeavors or other transformation efforts the practice opts to pursue in the future.

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The rolling 12-month data collection methodology was followed for the SMART Aim measures for the duration of the PIP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
2. The MCO provided evidence to demonstrate at least one of the following: ☒ The SMART Aim goal was achieved. ☒ Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$.) ☐ Non-statistically significant improvement in the SMART Aim measure. ☒ Significant *clinical* improvement in processes and outcomes. ☒ Significant *programmatic* improvement in processes and outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	For *Depression Screening*: • The SMART Aim goal was achieved. • Statistically significant improvement over baseline was achieved. • Significant *clinical* improvement was demonstrated for the *Virtual Screening of Minors 12-17 Years Old* intervention. For *Follow-up After a Positive Depression Screen*: • Statistically significant improvement over baseline was achieved. • Significant *clinical* and significant *programmatic* improvement were demonstrated for the *Behavioral Health Referral and Follow-up After a Positive Depression Screen* intervention.

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

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

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

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

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

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

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

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

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Summary of Validation Findings:

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

- Significant improvement achieved for both the *Depression Screening* and *Follow-up After a Positive Depression Screen* measures:
  - Both the SMART Aim goal and statistically significant improvement were achieved for *Depression Screening*.
  - Statistically significant improvement was achieved for *Follow-up After a Positive Depression Screen*.
  - Documented intervention testing results demonstrated significant clinical improvement related to depression screening and significant *programmatic* and significant *clinical* improvement related to follow-up care.
- Interventions were carried out and evaluated according to the approved Module 3 plan and the health plan provided accurate intervention testing results, clear rationale for intervention or evaluation revisions, and actionable summaries of lessons learned from intervention testing.
- Intervention testing results reported in the PDSA worksheets demonstrated a clear link between the *Virtual Screening of Minors 12-17 Years Old* intervention and significant clinical improvement and a clear link between the *Behavioral Health Referral and Follow-up After a Positive Depression Screen* intervention and statistically, clinically, and programmatically significant improvement.
- Clear and accurate summaries of key findings and conclusions from the PDSA cycles and from the project, overall.