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 Community Health Alliance Region 6

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 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.

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, CCHA R6 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 CCHA R6 members. The topic, selected by CCHA R6 and approved by the Department, was supported by historical data. The PIP Aim statement is as follows: "Do targeted interventions increase the percentage of members who have a follow-up visit with a mental health provider within 7 days after discharge from psychiatric inpatient hospitalization for treatment of selected mental illness or intentional self-harm diagnoses?"

The nonclinical *SDOH Screening* PIP addresses quality and accessibility of healthcare and services for CCHA R6 members by increasing awareness of social factors that may impact member access to needed care and services. The nonclinical topic was mandated by the Department. The PIP Aim statement is as follows: "Do targeted interventions increase the percentage of members enrolled in CCHA's Behavioral Health Transitions of Care (BHTOC) and Specialized Transitions of Care (STOC) who are screened for SDOH (unmet food, housing, utility, and transportation needs)?"

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 CCHA R6 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 new BHTOC and STOC cases for members attributed to Region 6 wherein the member was screened for unmet food, housing, utility, and transportation needs.

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 CCHA R6 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 CCHA R6 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

[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.

improvement is related to, and can be reasonably linked to, the QI strategies and activities conducted by the RAE during the PIP.

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 CCHA R6's PIP Submission Form. This form provides detailed information about CCHA R6'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*.

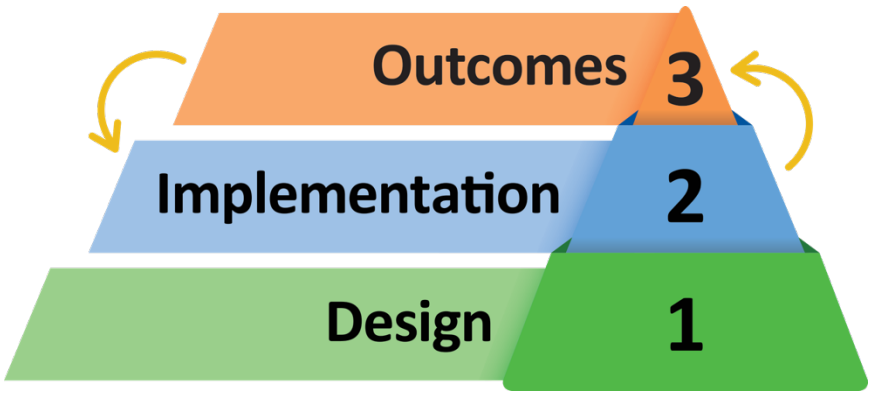
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**

   - *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 CCHA R6 establishes its PIP design, the PIP progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, CCHA R6 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, CCHA R6 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.

CCHA R6 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*. CCHA R6 resubmitted both PIPs and received an overall *High Confidence* level for the final validation. Table 3-1 illustrates the initial submission and resubmission validation scores for each PIP.

Table 3-1—2023–2024 PIP Overall Confidence Levels for CCHA R6

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%	88%	*Low Confidence*	*Not Assessed*		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*		
SDOH Screening	Initial Submission	92%	100%	*High 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. CCHA R6 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. CCHA R6 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 CCHA R6'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 CCHA R6 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: 751 D: 1,500	50.07%					

N–Numerator D–Denominator

For the baseline measurement period, CCHA R6 reported that the percentage of discharges of CCHA R6 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 50.07 percent.

Table 3-3 displays data for CCHA R6'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 new BHTOC and STOC cases for members attributed to Region 6 wherein the member was screened for unmet food, housing, utility, and transportation needs.	N: 708 D: 2,227	31.79%					

N–Numerator D– Denominator

For the baseline measurement period, CCHA R6 reported that 31.79 percent of members attributed to Region 6 with new BHTOC and STOC cases were screened for unmet food, housing, utility, and transportation needs.

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. CCHA R6'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
• Manual verification of the member's treatment status with mental health provider at the time of hospitalization can lead to attribution errors. • Lack of a standardized process to verify and/or obtain up-to-date contact information for all members for effective outreach and engagement efforts. • Manual tracking of coordination efforts and lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement. • No process to reconcile inconsistencies between manual tracking and claims data.	Improve process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.

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
Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and Acute Treatment Unit (ATU) for a behavioral health condition, or high levels of care for a substance use disorder (SUD) event.	Standardize requirements for screening CCHA members enrolled in BHTOC and STOC programming for unmet food, housing, utility, and transportation needs.

4. Conclusions and Recommendations

Conclusions

For this year's validation cycle, CCHA R6 submitted the clinical *FUH* PIP and the nonclinical *SDOH Screening* PIP. CCHA R6 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 CCHA R6 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), CCHA R6 accurately reported performance indicator data and initiated methodologically sound improvement strategies for both PIPs. CCHA R6 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 CCHA R6 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 Community Health Alliance (RAE 6)

Performance Improvement Projects

Demographic Information			
MCO Name: Colorado Community Health Alliance (RAE 6)			
Project Leader Name: Camila Joao		Title: Clinical Quality Program Manager	
Telephone Number: (303) 817-3791		Email Address: camila.joao@cchacares.com	
PIP Title: *Follow-Up After Hospitalization for Mental Illness (FUH)*			
Submission Date: 10/31/2023			
Resubmission Date (if applicable): 01/22/2024			

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Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance (RAE 6)

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: As one of the clinical measures determined by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members 6 years of age and older who have a follow-up visit with a mental health provider within 7 days after discharge from hospitalization for treatment of selected mental illness or intentional self-harm diagnoses. In compliance with Federal Medicaid managed care regulations and quality standards outlined in 42 CFR § 438.330, the PIP is designed to achieve and sustain improvement in health outcomes and clinical services administered by Medicaid managed care organizations (MCOs).

Provide plan-specific data:

CCHA's internal service claims data shows 50.07% of the 1,500 acute inpatient discharges for CCHA members 6 years or older with a principal diagnosis of mental illness or intentional self-harm with a triggering event within July 1, 2022, and May 31st, 2023[1] had a qualifying follow-up visit with a mental health provider within 7 days.

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

Healthcare spending per capita in the United States is more than double that of other industrialized nations while ranking comparatively low on key indicators of the quality of care and population health status[i]. Health care quality improvement experts from the Centers for Medicare & Medicaid Services (CMS) consensus-based entity endorse timely follow-up services after hospitalization for mental illness as a key strategy to accelerate efficiency, and ultimately value, of care[ii].

[1] The triggering event period ends 30 days prior to the last day of the measurement cycle to allow sufficient time for the follow-up service to occur. Discharges on or after June 1st, 2023, are not included in the baseline calculation in alignment with 2023 CMS Core Measure Set Technical Specifications and Value Set Directories time frames.

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Performance Improvement Projects

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

Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. Individuals in vulnerable circumstances are at the juncture of a complex system with vulnerable connections between multiple actors when transitioning out of acute mental health settings. Lack of coordination and collaboration between treatment providers can result in inadequate and fragmented support, which increase the risk of repeated psychiatric decompensation and inpatient hospital readmissions. The risk of readmission has been found to be higher in the periods immediately after discharge[iii] and may be indicative of a lack of access to adequate community-based aftercare, challenges with psychiatric medication adherence and effective condition management in lower intensity settings. In addition to being disruptive to individuals' stable and independent functioning, readmissions are costly and further restrict the health care system's capacity to effectively manage the demand for services.

Timely follow-up service with a mental health provider after discharge from inpatient hospital treatment has the potential to improve member health, functional status, and/or satisfaction in the following ways:

- Timely outpatient engagement can help members establish and maintain protective self-care activities to sustain the benefits of inpatient treatment and prevent future hospital readmissions.
- Effective treatment in least restrictive settings protects against disruptions to individuals' independent functioning, resulting in improved functional status at school, work, within the family and community.
- Care coordination between service providers may improve health outcomes, facilitate condition management in lower acuity settings, and decrease the of risk avoidable utilization of higher levels of care; ultimately, reducing cost.
- Containing avoidable hospital readmissions promotes efficiencies in the allocation of health care resources, enhancing availability and systemic capacity to manage psychiatric inpatient beds shortage.
- Prompt assistance accessing treatment and overcoming barriers to engagement helps to mitigate the adverse impact of unmet socially determined factors and address disparities in health equity.
- Support navigating systems of care and convenience of access may increase member satisfaction.

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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):

Do targeted interventions increase the percentage of members who have a follow-up visit with a mental health provider within 7 days after discharge from psychiatric inpatient hospitalization for treatment of selected mental illness or intentional self-harm diagnoses?

1.

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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:

Health First Colorado members attributed to Region 6 (Jefferson, Boulder, Broomfield, Gilpin, and Clear Creek counties) who are 6 years of age or older as of the date of discharge from an acute inpatient placement for treatment of selected mental illness or intentional self-harm diagnoses.

Enrollment requirements (if applicable):
Members must be continuously enrolled with CCHA from date of discharge through 30 days after discharge, with no gaps.

Member age criteria (if applicable):
Members must be 6 years or older as of the date of discharge.

Inclusion, exclusion, and diagnosis criteria:

Inclusion:

- Members enrolled in the Accountable Care Collaborative (ACC), attributed to CCHA Region 6.

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Follow-Up After Hospitalization for Mental Illness (FUH)
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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.

- All acute inpatient discharges (Inpatient Stay Value Set) 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 July 1 and May 31 of the measurement year for CCHA members aged 6 years or older.
- The denominator is based on discharges, not on beneficiaries. All discharges that occur within the measurement period are included.
- Race, ethnicity, age, gender, and language information will be tracked and analyzed to evaluate the impact of demographic disparities and promote equitable outcomes.

Exclusions:

1. Members 5 years and younger.
2. Members who die during the measurement year
3. Members in hospice or using hospice services anytime during the measurement year (Hospice Encounter Value Set and Hospice Intervention Value Set)
4. Nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
5. Nonacute readmission or direct transfer: Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
6. Acute readmission or direct transfer:

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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.

6.1 Exclude the initial discharge if followed by a readmission/direct transfer to an acute inpatient care setting for a principal diagnosis of mental health disorder or intentional self-harm within 30 days.
6.2 Exclude both the original and the readmission/direct transfer discharge if the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis.
6.3 Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after May 31 of the measurement year.

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

Refer to Appendix I for a detailed list of codes included in each of the value sets used to identify the eligible population, as described above:

- Inpatient Stay Value Set
- Nonacute Inpatient Stay Value Set
- Mental Illness and Intentional Self-Harm Value Set
- Hospice Encounter and Hospice Intervention Value Set

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Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods must be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.

The description of the sampling methods must:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

The intervention population includes all CCHA members 6 years or older attributed to Region 6 who were hospitalized for treatment of selected mental illness or intentional self-harm during the measurement period.

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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	**BH follow-up within 7 days after discharge from a psychiatric inpatient hospitalization for treatment of mental illness or intentional self-harm.**
	Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. As one of the clinical measures determined by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members 6 years of age and older who have a follow-up visit with a mental health provider within 7 days after discharge from hospitalization for treatment of selected mental illness or intentional self-harm diagnoses. Performance is calculated in accordance with the 2023 CMS Core Measure Set Technical Specifications and Value Set Directories.
Numerator Description:	Denominator events followed by a visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge.
Denominator Description:	All acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm for CCHA members 6 years or older on the day of discharge that occur within the measurement period.
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2023 to 06/30/2024

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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."

Mandated Goal/Target, if applicable	Not Applicable.

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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 [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. [ ] Data completeness assessment attached. [ ] Coding verification process attached. Estimated percentage of reported administrative data completeness at the time the data are generated: __90__ % 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 completeness percentage is assessed by estimated Incurred But Not Reported (IBNR) claims for the measurement period, as calculated by CCHA's Finance Department as of the date of data generation. The IBNR assessment includes known claims in the process of adjudication and/or settlement as well as unknown claims.	

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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:
Detailed flagged event files from claims/encounters.

Data Collection Process:

1. Fee-for-service (FFS) claims sent to Health Plan by State monthly.
2. FFS claims are combined with BH Encounters in data warehouse.
3. The NCQA-certified vendor, Inovalon, Inc., retrieves all claims for all acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim, and flags denominator events in accordance with measure specifications[2]:
   - 3.1 Identify acute inpatient discharges (Inpatient Stay Value Set) 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 June 1 and May 31 of the measurement year.
   - 3.2 Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
   - 3.3 Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:
     - 3.3.1 Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after May 31 of the measurement year.
     - 3.3.2 If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.
     - 3.3.3 Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting (Nonacute Inpatient Stay Value Set) within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
   - 3.4 Exclude members in hospice or using hospice services anytime during the measurement year.
   - 3.5 Exclude members 5 years old or younger.
   - 3.6 Exclude members with gaps in enrollment from date of discharge through 30 days after discharge.
   - 3.7 Exclude members who die during the measurement year.
4. Internal HEDIS engine retrieves all claims and flags denominator events with a follow-up visit with a mental health provider within 7 days after discharge, excluding visits that occur on the date of discharge, in accordance with measure specifications[2]:

[2] Refer to Appendix I for a detailed list of codes included in each of Value Set Directory.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
4.1 An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider. 4.2 An outpatient visit (BH Outpatient Value Set) with a mental health provider. 4.3 An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) 4.4 An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). 4.5 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). 4.6 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). 4.7 A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health provider. 4.8 An observation visit (Observation Value Set) with a mental health provider. 4.9 Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider. 4.10 A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set). 4.11 A telephone visit (Telephone Visits Value Set) with a mental health provider. 4.12 Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set). 5. Final report is generated with eligible denominator and numerator eligible encounters.

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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: BH follow-up within 7 days after discharge from a psychiatric hospitalization for treatment of mental illness or intentional self-harm.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 – 06/30/2023	Baseline	751	1500	50.07%	N/A for baseline	N/A for baseline
07/01/2023 – 06/30/2024	Remeasurement 1					
07/01/2024 – 06/30/2025	Remeasurement 2					

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

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

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

Baseline Narrative:

Between July 1, 2022, and May 31, 2023, 1,500 discharges from an acute psychiatric inpatient facility for treatment of a principal diagnosis of mental illness or intentional self-harm occurred for members 6 years or older attributed to CCHA in Region 6. 751 discharges were followed by qualifying service with a mental health provider within 7 days, excluding the day of discharge, which corresponds to a 50.07% follow-up rate. Discharges on or after June 1st, 2023, are not included in the baseline calculation in alignment with 2023 CMS Core Measure Set Technical Specifications and Value Set Directories time frames. The triggering event period ends 30 days prior to the last day of the measurement cycle (June 30th) to allow sufficient time for the follow-up service to occur. Data completeness rate of 90% and timely filing limits of up to 365 days for services rendered with CCHA as a secondary payer impact the validity of findings, as unadjudicated claims are not included in calculations.

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:

1. Camila Joao, CCHA, Clinical Quality Program Manager
2. Kathryn Morrison, CCHA, Medicaid Quality Management Health Plan Director
3. Vladimir Sevastyanov, Business Information Consultant
4. Wendy Thoreaux, Mental Health Partners, Inpatient Liaison
5. Linda Davis, Mental Health Partners, Boulder Regional Director
6. Jill McFadden, Front Range Health Partners, Director of Operations
7. Alan Girard, Front Range Health Partners, Chief Executive Officer

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

Poor transition between inpatient mental health settings and the community may have detrimental effects on members' health outcomes and functional status. To help maintain the positive effects of acute treatment and prevent further disruption to members' stable functioning post-discharge, improvement rates of aftercare engagement is expected to benefit members with recent history of high acuity needs as evidenced by psychiatric hospitalization. Providers expected to have the greatest leverage to impact regional rates of follow-up after hospitalization should serve a large volume of members, offer a comprehensive array of services, and have systems

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   - Intervention Status

and dedicated personnel in place to engage hospitals and facilitate the discharge process. As safety net providers, Community Mental Health Centers (CMHCs) meet these standards and are uniquely positioned to implement processes to establish continuity of care and meet members' unique and potentially challenging needs during the period following hospitalization.

CCHA partnered with the CMHC to leverage their capacity to impact rates of timely follow-up within 7 days from hospitalization at a regional level. Process mapping[3] was utilized to outline existing steps for notification, coordination, and access to timely follow-up services, and facilitate the identification of gaps associated with failure. The initial intervention will target identified barriers, listed below.

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.

[3] Refer to Appendix II for the Process Map document.

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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

Intervention Title	Barrier(s) Addressed
Improve process to coordinate discharge and aftercare engagement for eligible members transitioning out of psychiatric inpatient hospitalization.	1. Manual verification of member's treatment status with MHP at the time of hospitalization can lead to attribution errors. 2. Lack of standardized process to verify and/or obtain up-to-date contact information for all members for effective outreach and engagement efforts. 3. Manual tracking of coordination efforts and lack of follow-up service level details can lead to unreliable process controls and inaccurate performance measurement. 4. No process to reconcile inconsistencies between manual tracking and claims data.

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.

2. Appendix

I. FFY 2023 Adult Core Set HEDIS Value Set Directory: **https://www.medicaid.gov/license/form/8196/151206**
FFY 2023 Child Core Set HEDIS Value Set Directory: **https://www.medicaid.gov/license/form/8191/156246**

II. QI Tool – Process Map

R6 FUH Intervention Process Map.pdf

[i] "Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care, Patient-Focused Episodes of Care", National Quality Forum, accessed October 4th, 2023, https://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx

[ii] "Follow-Up After Hospitalization for Mental Illness (FUH)", Partnership for Quality Measurement, accessed October 4th, 2023, https://p4qm.org/measures/0576.

[iii] Osborn D.P., Favarato G., Lamb D., Harper T., Johnson S., Lloyd-Evans B., Marston L., Pinfold V., Smith D., Kirkbride J.B., et al. "Readmission after discharge from acute mental healthcare among 231,988 people in England: Cohort study exploring predictors of readmission including availability of acute day units in local areas." BJPsych Open. 2021 Jul;7:e136, https://doi.org/10.1192%2Fbjo.2021.961

Appendix A: State of Colorado 2023-24 PIP Submission Form
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

Demographic Information	
MCO Name: Colorado Community Health Alliance (RAE 6)	
Project Leader Name: Camila Joao	Title: Clinical Quality Program Manager
Telephone Number: (303) 817-3791	Email Address: camila.joao@cchacares.com
PIP Title: ***Social Determinants of Health (SDOH) Screening***	
Submission Date: 10/31/2023	
Resubmission Date (if applicable): 01/22/2024	

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Performance Improvement Projects

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

PIP Topic:

As mandated by the Colorado Department of Health Care Policy and Financing (HCPF), this PIP aims to increase the percentage of CCHA members participating in the Behavioral Health (BH) capitated benefit who are screened for unmet food, housing, utility, and transportation needs. In compliance with Federal Medicaid managed care regulations and quality standards, the PIP targets improvement in non-clinical services delivered by CCHA that are expected to mitigate threats to the health or functional status of members experiencing high-risk conditions.

Members' high-risk conditions and participation in BH capitation are identified by an approved authorization for placement in high levels of care for a mental health or substance use disorder diagnosis. These members are served by CCHA's Care Coordinators through the following programs:

1. CCHA's Behavioral Health Transitions of Care (BTOC) supports members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays for a covered behavioral health condition.
2. CCHA's Specialized Transitions of Care (STOC) program provides deliberate care coordination assistance, facilitate effective discharge and aftercare planning for members transitioning from high levels of care (inpatient, residential, and withdrawal management) for a substance use disorder (SUD) event.

Provide plan-specific data:

CCHA's documentation of care coordination activities indicates 2,227 BTOC and STOC cases were opened between 7/1/2022 and 6/30/2023, corresponding to 1,839 unique members, and 293 members associated with 2 to up to 6 treatment episodes. 31.79% of cases received a full screening for unmet food, housing, utility, and transportation needs. 64.26% (1,431) were screened for at least one of these factors, out of which 38.36% identified unmet needs related to these core elements; with housing being the most frequently reported concern (32.56%), followed by transportation (7.62%), food (4.05%) and utilities (1.19%).

No screening was administered to 23.21% of members with multiple placements to evaluate the impact of social needs on the repeated utilization of higher levels of care. Consistent assessment of immediate needs may provide insights into the prevalence of resource gaps and its correlation to the risk of higher acuity interventions.

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Performance Improvement Projects

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction: Health is a product of multiple determinants. A broad body of evidence indicates that social determinants of health (SDOH) affect health outcomes and can be more important than health care or lifestyle choices in influencing health status, according to the World Health Organization.[i] Disparities in quality and outcomes of care often reveal socially determined inequities rooted in the unequal distribution of power and resources. Individuals with unmet social needs are more likely to utilize emergency departments, miss outpatient appointments, and struggle to manage chronic health conditions[ii]. Research has shown that a person's zip code is a better predictor of life expectancy than genetic code, and highest income groups can expect to live six and a half years longer than those living in poverty[iii]. Social, economic, environmental, and structural disparities manifest as uneven health risk that is avoidable and remediable. Identifying and addressing social needs is essential for whole-person care, to enable promotion of health equity and establish conditions in which no one is disadvantaged from achieving their full health potential independently of social position. Correspondently, mitigating the impact of adverse SDOH upstream helps to reduce long-term health care costs[iv]. Assessing social needs as key components of health can provide information that is necessary to begin to address the barriers securing health for patients and individuals and promote equitable outcomes. Routine SDOH screening has the potential to improve member health, functional status, and/or satisfaction in the following ways: • Screening for health and social factors promotes detection of unmet needs and supports access to assistance. • Determining a person's immediate necessities promotes removal of barriers to effective health management. • Addressing members' social needs may facilitate engagement in healthcare services, diminish risk of poor health outcomes, reduce ED utilization and inpatient stays, and reduce overall healthcare costs. • Effective management of socially determined inequities may improve functional status at school, work, within the family and community. • Whole-person care and collaboration with social services agencies may increase member satisfaction.

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Step 2: Define the PIP Aim Statement(s). Defining the Aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The statement(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- The statement(s) must be documented in clear, concise, and measurable terms.
- Be answerable based on the data collection methodology and indicator(s) of performance.

Statement(s):

Do targeted interventions increase the percentage of members enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) who are screened for SDOH (unmet food, housing, utility, and transportation needs)?

1.

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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:
Health First Colorado members attributed to Region 6 (Jefferson, Boulder, Broomfield, Gilpin, and Clear Creek counties) enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) or Specialized Transitions of Care (STOC) programming.

Enrollment requirements (if applicable):
No continuous enrollment requirement. Population includes all Health First Colorado members who are attributed to Region 6 at the time of discharge from a Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a Behavioral Health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event.

Member age criteria (if applicable):
None.

Inclusion, exclusion, and diagnosis criteria:

- Members will be included in the denominator if they are enrolled in the Accountable Care Collaborative (ACC), attributed to CCHA Region 6, and enrolled in BTOC or STOC.

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for Colorado Community Health Alliance (RAE 6)

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.

- The denominator for this measure is based on new BTOC/STOC enrollment, not on members. All new BTOC/STOC enrollments initiated during the measurement period are included.
- Readmissions to specified levels of care (LOC) prior to BTOC/STOC termination are considered part of the same treatment episode and do not result in a new enrollment.
- No exclusions.

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

1. CCHA's Behavioral Health Transitions of Care (BTOC) supports members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays for a covered behavioral health condition.
   1.1 Procedure: CCHA's Census Coordinator receives daily census report from Utilization Management Reviewers with CCHA members attributed to Region 6 with approved authorization for placement and admitted to psychiatric inpatient facilities or Acute Treatment Units (ATU). The Census Coordinator assigns cases to BTOC staff upon receipt. All members with a Psychiatric authorization type are eligible for BTOC support.

2. CCHA's Specialized Transitions of Care (STOC) program provides deliberate care coordination assistance, facilitate effective discharge and aftercare planning for members transitioning from high levels of care (inpatient, residential, and withdrawal management) for a substance use disorder (SUD) event.

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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.

2.1 Procedure: CCHA's Census Coordinator receives a daily census report from Utilization Management Reviewers to identify CCHA members attributed to Region 6 who have a placement authorization for 3.1, 3.3, 3.2WM, 3.5, 3.7, and 3.7WM placement and are admitted to a substance use disorder treatment facility. STOC also supports members who have open authorization for 3.1 or 3.5 levels of care and are pending admission to SUD residential treatment. The Census Coordinator assigns cases to STOC staff upon receipt. All members with a Substance Abuse authorization type are eligible for STOC support.

2.2 American Society of Addiction Medicine (ASAM) Levels of Care:

- 3.1 Low Intensity Residential
- 3.3 Population-Specific, High Intensity Residential
- 3.5 High Intensity Residential
- 3.5 High Intensity (or medium intensity for teens) Residential
- 3.7 Medically Monitored Intensive Inpatient Services (IP)
- 3.2WM Residential Withdrawal Management (Social Detox)
- 3.7WM Medically Monitored Inpatient Withdrawal Management

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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

Describe in detail the methods used to select the sample:

The intervention population includes all members enrolled in BTOC or STOC programming within all CCHA members attributed to Region 6 who received a capitated behavioral health service during the measurement period. A homogeneous purposive method was used to delineate the target population based on BTOC/STOC enrollment as the specific determining factor. This selection method serves to strategically deploy resources and prioritize members with service utilization patterns indicative of higher risk, which may be socially determined or exacerbated. This is a non-probability method and not intended to be representative or extrapolated to the full CCHA population, however, it may furnish valuable insight into correlations between HLOC utilization and SDOH factors in addition to potential therapeutic benefits.

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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	**SDOH Screening of BTOC and STOC members.**
	CCHA's BTOC and STOC programs provides care coordination assistance to members transitioning out of inpatient psychiatric placement high levels of care for a SUD event. Utilization of higher levels of care may signal a lack of access to care or issues with continuity of care. Screening for and addressing resource gaps can support stable functioning, promote recovery, and help mitigate future risk of higher acuity intervention needs.
Numerator Description:	**Number of cases from the denominator that have a screening for unmet food, housing, utility, and transportation needs.**
Denominator Description:	**Number of new CCHA's Behavioral Health Transitions of Care (BTOC) and Specialized Transitions of Care (STOC) cases for members attributed to Region 6.**
Baseline Measurement Period	07/01/2022 to 06/30/2023
Remeasurement 1 Period	07/01/2023 to 06/30/2024
Remeasurement 2 Period	07/01/2024 to 06/30/2025
Mandated Goal/Target, if applicable	Not Applicable.

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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."

Use this area to provide additional information.

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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 [X] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _____ [ ] Other _____ Other Requirements [ ] 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: 99.87 % 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 completeness percentage is determined based on the case status according to the clinical documentation. Only cases with "Closed" status or with responses documented for all mandatory SDOH screening questions are considered complete. Information may still be pending for cases with an "Enrolled" status and without responses to the SDOH questions.	

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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:

The Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) screening report from CCHA's electronic care management platform (Essette).

Data Collection Process:

1. CCHA's Census Coordinator receives daily census report from Utilization Management Reviewers with information on placement authorizations for Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a Behavioral Health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event.
2. CCHA's Census Coordinator loads cases to the appropriate program queue based on authorization type.
3. BTOC and STOC staff pull all cases daily from the program queue, prioritizing "rapid re-admitters". Rapid re-admitters are defined as members who have been admitted to 3.2WM and 3.7WM levels of care or Psychiatric Inpatient within 30 days, excluding step-downs from inpatient to residential.
4. BTOC and STOC staff attempt to outreach members telephonically within 2 business days of the referral date. At least three (3) telephonic attempts will be made to reach the member within 7 business day period in attempt to engage the member by phone. All possible means of locating the member will be exhausted including, but not limited to – telephonic outreach to natural supports, connecting with any/all affiliated provider(s), and researching claims data, as appropriate.
5. Once successful contact has been made, the BTOC and STOC staff will work to identify unmet food, housing, utility, and transportation needs by asking the following PRAPARE questions embedded in the Health Needs Assessment form[1] in Essette:
   - Housing:
     - What is your housing situation today? Or,
     - Are you worried about losing your housing?
   - Food and Utilities: In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Food, utilities, medicine or any health care (Medical, Dental, Mental Health, Vision), Phone, Clothing, Child Care, or Other.
   - Transportation: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
6. Information collected will be documented in the member's record in Essette.

[1] Refer to Appendix I for a copy of the Health Needs Assessment template.

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In the space below, describe the step-by-step data collection process used in the production of the indicator results:
7. A report will be automatically generated according to the following guidelines: • Frequency: Quarterly, one calendar month after the end of each fiscal quarter (e.g., SFY24 Q2 report will be generated by January 31st, 2024) • Timeframe: Cases created from the beginning of the measurement period through the last day of the fiscal quarter (e.g., SFY24 Q2 report will include data from July 1st, 2023, through December 31st, 2023). • Denominator: Members attributed to Region 6 enrolled in CCHA's Behavioral Health Transitions of Care (BTOC) or CCHA's Specialized Transitions of Care (STOC) programming during the measurement period. • Numerator: Members in the denominator who are screened for unmet food, housing, utility, and transportation needs, as evidenced by a documented response to all three (3) of the required PRAPARE elements embedded in the Health Needs Assessment. • Numerator exclusion: Partial completion of PRAPARE questions will not be considered compliant. • Performance indicator rates will be calculated based on the number of compliant assessments administered by each program during the measurement period.

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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: SDOH Screening of BTOC and STOC members.

Measurement Period	Indicator Measurement	Numerator	Denominator	Percentage	Mandated Goal or Target, if applicable	Statistical Test Used, Statistical Significance, and *p* Value
07/01/2022 – 06/30/2023	Baseline	708	2227	31.79%	N/A for baseline	N/A for baseline
07/01/2023 – 06/30/2024	Remeasurement 1					
07/01/2024 – 06/30/2025	Remeasurement 2					

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

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

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

Baseline Narrative:

Between July 1, 2022, and June 30, 2023, 2,227 new cases were enrolled in CCHA's BTOC and STOC programming for members attributed to CCHA in Region 6 who were admitted to a Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a behavioral health condition, or high levels of care (inpatient, residential, and withdrawal management) for a SUD event. 708 cases received a full screening for unmet food, housing, utility, and transportation needs, which corresponds to 31.79% screening rate. Electronic Health Record (EHR) function to open cases and assign appropriate assessments is automated, and no evidence of failure or inaccuracies in programming that could impact the validity of baseline results have been identified at this time.

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 - Clinical and Programmatic Improvement
   - Intervention Status

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

QI Team Members:

1. Camila Joao, CCHA, Clinical Quality Program Manager
2. Kathryn Morrison, CCHA, Medicaid Quality Management Health Plan Director
3. Michelle Blady, CCHA, Manager of Behavioral Health Care Coordination
4. Caleb Odenbach, CCHA, Supervisor of Member Support Services

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

As outlined in the contract with the Colorado Department of Health Care Policy and Financing (HCPF), CCHA is tasked with administering, operating, and managing the delivery of medically necessary covered BH services under the Medicaid Capitated Behavioral Health Benefit in the following categories: Outpatient, Emergency and Post-Stabilization Care Services, Inpatient Psychiatric Hospital Services, and Residential and Inpatient Substance Use Disorder Services.

A Failure Modes and Effects Analysis was used to assign a priority ranking score for each service category based on detection likelihood, ability to intervene, and risk of detrimental impact to health outcomes caused by lack of screening and access to resources, as follows:

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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:

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C. Intervention Worksheet:
   - Intervention Description
   - Intervention Effectiveness Measure
   - Intervention Evaluation Results - Clinical and Programmatic Improvement
   - Intervention Status

LOC	Detection Likelihood	Ability to reach/intervene	Potential Harm/Damage	TOTAL
Inpatient Psychiatric Hospital	4	4	4	12
Residential and Inpatient Substance Use Disorder	3	3	3	9
Emergency and Post-Stabilization	1	1	2	4
Outpatient	2	2	1	5

Individuals with unmet social needs are more likely to access higher levels of care due to challenges consistently engaging with preventative and lower intensity services[ii]. To help maintain the positive effects of acute treatment and prevent further disruption to members' stable functioning post-discharge, improvement efforts are expected to have highest potential benefit if dedicated to targeting members with recent history of high acuity needs as evidenced by placement in Inpatient Psychiatric Hospitals and Residential/Inpatient SUD service categories.

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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 - Clinical and Programmatic Improvement
   - 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
Standardize requirements for screening CCHA members enrolled in BTOC and STOC programming for unmet food, housing, utility, and transportation needs.	Lack of standardized expectations requiring consistent screening for socially determined factors as standard protocol for health needs assessment of members transitioning out of Psychiatric Inpatient and ATU for a behavioral health condition, or high levels of care for a SUD event.

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.

2. Appendix

I.	Health Needs Assessment template	Essette v3.10.1 PROD • Modify Asse

[i] "Social determinants of health," World Health Organization, accessed June 6th, 2023, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 .

[ii] "Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations", Center for Health Care Strategies, accessed June 5th, 2023, https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/.

[iii] Risa Lavizzo-Mourey,. Why Health, Poverty and Community Development are Inseparable. In: Investing in What Works for America's Communities: Essays on People, Places, and Purpose. 1st ed. Federal Reserve Bank of San Francisco & Low-Income Investment Fund; 2012:215-225, http://whatworksforamerica.org/pdf/whatworks_fullbook.pdf

[iv] "Social Determinants of Health: Resource Guide", NCQA, accessed June 6th, 2023. https://www.ncqa.org/wp-content/uploads/2020/10/20201009_SDOH-Resource_Guide.pdf

Appendix B. Final PIP Validation Tools

The following contains the final PIP Validation Tools for CCHA R6.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Follow-Up After Hospitalization for Mental Illness (FUH)
for Colorado Community Health Alliance (RAE 6)

Demographic Information			
MCO Name:	Colorado Community Health Alliance (RAE 6)		
Project Leader Name:	Camila Joao	**Title:**	Clinical Quality Program Manager
Telephone Number:	(303) 817-3791	**Email Address:**	camila.joao@cchacares.com
PIP Title:	*Follow-Up After Hospitalization for Mental Illness (FUH)*		
Submission Date:	October 31, 2023		
Resubmission Date:	January 19, 2024		

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 1. Review the Selected PIP Topic: The PIP topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. The PIP topic:			
1. Was selected following collection and analysis of data. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 1			
Total Evaluation Elements**	**1**	**1**	**Critical Elements*****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 2. Review the PIP Aim Statement(s): Defining the statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The statement:			
1. Stated the area in need of improvement in clear, concise, and measurable terms. *NA* is not applicable to this element for scoring	C*	*Met*	
Results for Step 2			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 3. Review the Identified PIP Population: The PIP population should be clearly defined to represent the population to which the PIP Aim statement and indicator(s) apply, without excluding members with special healthcare needs. The PIP population:			
1. Was accurately and completely defined and captured all members to whom the PIP Aim statement(s) applied. *NA* is not applicable to this element for scoring.	C*	*Met*	
Results for Step 3			
Total Evaluation Elements**	**1**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	0	0	*NA*

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 4. Review the Sampling Method: (If sampling was not used, each evaluation element will be scored *Not Applicable [NA]*). If sampling was used to select members in the population, proper sampling methods are necessary to provide valid and reliable results. Sampling methods:			
1. Included the sampling frame size for each indicator.		*NA*	
2. Included the sample size for each indicator.	C*	*NA*	
3. Included the margin of error and confidence level for each indicator.		*NA*	
4. Described the method used to select the sample.		*NA*	
5. Allowed for the generalization of results to the population.	C*	*NA*	
Results for Step 4			
Total Evaluation Elements**	**5**	**2**	**Critical Elements****
Met	0	0	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	5	2	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 5. Review the Selected Performance Indicator(s): A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The indicator(s) of performance:			
1. Were well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	C*	*Met*	
2. Included the basis on which the indicator(s) was developed, if internally developed.		*N/A*	

Results for Step 5			
Total Evaluation Elements**	**2**	**1**	**Critical Elements****
Met	1	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	0	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *NA* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *NA* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	1	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	7	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	7	3	*NA*

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Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 7. Review Data Analysis and Interpretation of Results: Clearly present the results for each indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the indicator outcomes:			
1. Included accurate, clear, consistent, and easily understood information in the data table.	C*	*Met*	
2. Included a narrative interpretation of results that addressed all requirements.		*Met*	
3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.		*Met*	

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

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

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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*	The health plan documented the quality improvement (QI) team and a summary of the QI team's conclusions but the documentation did not include a description of the QI processes and tools used to identify barriers. For example, did the QI team use brainstorming, a fishbone diagram, or process mapping to identify the documented barriers? In the resubmission, the health plan should provide a specific description of the QI processes or tools used to identify the documented barriers and any completed QI tools should be submitted as attachments. **Resubmission January 2024:** The health plan outlined the QI processes and tools used and provided a completed process map to address the initial feedback. The validation score for this evaluation element was changed to *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 Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

Table B—1 2023-24 PIP Validation Tool Scores for *Follow-Up After Hospitalization for Mental Illness* for Colorado Community Health Alliance (RAE 6)										
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 Community Health Alliance (RAE 6)	
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 Community Health Alliance (RAE 6)	
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 Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

Demographic Information			
MCO Name:	Colorado Community Health Alliance (RAE 6)		
Project Leader Name:	Camila Joao	**Title:**	Clinical Quality Program Manager
Telephone Number:	(303) 817-3791	**Email Address:**	camila.joao@cchacares.com
PIP Title:	*Social Determinants of Health (SDOH) Screening*		
Submission Date:	October 31, 2023		
Resubmission Date:	January 19, 2024		

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

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*	**General Feedback:** The health plan stated in Step 4 that the entire eligible population defined in Step 3 of the PIP submission form was included in the PIP; therefore, sampling methods were not applicable.
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.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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.		*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 Community Health Alliance (RAE 6)

Evaluation Elements	Critical	Scoring	Comments/Recommendations
Performance Improvement Project Validation			
Step 6. Review the Data Collection Procedures: The data collection process must ensure that the data collected on the indicator(s) were valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures included:			
1. Clearly defined sources of data and data elements collected for the indicator(s). *NA* is not applicable to this element for scoring.		*Met*	
2. A clearly defined and systematic process for collecting baseline and remeasurement data for the indicator(s). *NA* is not applicable to this element for scoring.	C*	*Met*	
3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	C*	*N/A*	
4. The percentage of reported administrative data completeness at the time the data are generated, and the process used to calculate the percentage.		*Met*	

Results for Step 6			
Total Evaluation Elements**	**4**	**2**	**Critical Elements****
Met	3	1	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	1	1	*NA*

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

Results for Step 1 - 6			
Total Evaluation Elements	**14**	**8**	**Critical Elements**
Met	8	5	*Met*
Partially Met	0	0	*Partially Met*
Not Met	0	0	*Not Met*
NA	6	3	*NA*

Appendix B: State of Colorado 2023-24 PIP Validation Tool
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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*	**Validation Feedback:** The health plan documented in the intervention worksheet that the intervention would be tested throughout the Remeasurement 1 period and intervention evaluation period dates were not documented. HSAG recommends that interventions be evaluated throughout the measurement year using shorter intervention evaluation periods, such as monthly or quarterly, to determine intervention effectiveness and to allow for mid-year intervention refinements. The health plan should document intervention evaluation periods that occur more frequently than annually and provide evaluation results of those more frequent evaluation periods in next year's annual submission.
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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

Table B—1 2023-24 PIP Validation Tool Scores
for *Social Determinants of Health Screening* for Colorado Community Health Alliance (RAE 6)

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

Table B—2 2023-24 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8)
for *Social Determinants of Health Screening* for Colorado Community Health Alliance (RAE 6)

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 Community Health Alliance (RAE 6)

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
Social Determinants of Health (SDOH) Screening
for Colorado Community Health Alliance (RAE 6)

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***