COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2022–2023 PIP Validation Report

for

Colorado Community Health Alliance Region 7

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Colorado Community Health Alliance Region 7**, referred to in this report as **CCHA R7**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

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

Measuring performance using objective quality indicators

Implementing system interventions to achieve improvement in quality

Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

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

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

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

PIP Components and Process

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

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

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

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

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

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

PIP Terms

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

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

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

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **CCHA R7**'s module submission forms. In FY 2022–2023, these forms provided detailed information about **CCHA R7**'s PIP and the activities completed in Module 4. (See Appendix A. Module Submission Form.) Following HSAG's rapid-cycle PIP process, each health plan submitted Module 4 according to the approved timeline. HSAG provided scores and feedback and assigned a level of confidence to the PIP in the Module 4 validation tool. If a PIP received less than *High Confidence* on initial review, the health plan had an opportunity to receive technical assistance from HSAG and to complete a single Module 4 resubmission to address the initial validation findings.

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2022–2023, **CCHA R7** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen.*

CCHA R7 defined a Global Aim and SMART Aim for the PIP. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the health plan for establishing the SMART Aim for the PIP:

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

Table 1-1 includes the SMART Aim statements established by **CCHA R7**.

Table 1-1—PIP Measures and SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By June 30, 2022, use key driver diagram interventions to increase the percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among unduplicated CCHA members 12 years of age or older from 62.08% to 63.53%.*
Follow-Up After a Positive Depression Screen	By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years of age or older from 72.1% to 75.74%.*

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

2. Findings

Module 4: PIP Conclusions

In FY 2022–2023, **CCHA R7** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed and conducted the final validation on the initial Module 4 submission form.

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

SMART Aim Measure Results

HSAG analyzed **CCHA R7**'s PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP and evaluated **CCHA R7**'s success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for **CCHA R7**'s PIP are presented in Table 2-1. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 2-1—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings provided during an in-person or virtual outpatient primary care visit at Peak Vista Community Health Centers among unduplicated CCHA members 12 years of age or older.	62.08%	63.53%	84.05%	Yes

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of members who receive an in-person or virtual qualifying behavioral health (BH) service by any BH provider on the day of or within 30 days from a positive depression screen provided during an outpatient primary care visit at Peak Vista Community Health Centers among CCHA members 12 years of age or older.	72.10%	75.74%	80.50%	Yes

To guide the project, **CCHA R7** established goals of increasing the percentage of members 12 years of age and older who receive a depression screening during a primary care visit at Peak Vista Community Health Centers from 62.08 percent to 63.53 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 72.10 percent to 75.74 percent, through the SMART Aim end date of June 30, 2022. **CCHA R7**'s reported SMART Aim measure results demonstrated that the SMART Aim goals were exceeded for both measures. For the *Depression Screening* measure, the highest rate achieved, 84.05 percent, represented a statistically significant increase of 21.97 percentage points above the baseline rate. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 80.50 percent, represented a statistically significant increase of 8.40 percentage points above the baseline rate. The health plan's final SMART Aim run chart and SMART Aim measure data are provided in Appendix A. Module Submission Form.

Intervention Testing Results

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, **CCHA R7** completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 2-2 summarizes **CCHA R7**'s interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 2-2—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
Revise Peak Vista's depression screening (Patient Health Questionnaire-9 [PHQ-9]) script to guide providers in educating patients on the benefits of depression screening and help motivate members to complete the screening. The electronic health record (EHR) depression screening forms were also adapted to capture member refusals and medical exclusions more consistently.	Significant *clinical* improvement for *Depression Screening*	Adopted
Revise Peak Vista's depression screen coding protocol to include a category of "Watchful Waiting" for those members whose depression screen score does not warrant immediate follow-up care and adapt the EHR to require a follow-up option is selected (hard stop before exiting form) to ensure that each depression screen entered has a documented follow-up plan.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

CCHA R7 tested two provider-focused interventions for the project: One intervention focused on *Depression Screening,* and one intervention focused on *Follow-Up After a Positive Depression Screen*. For the depression screening provider script intervention, the health plan reported intervention testing results that demonstrated significant clinical improvement for the *Depression Screening* measure by reducing the percentage of members who declined to complete a depression screening. At the conclusion of testing, Peak Vista, the partner provider, chose to adopt the intervention due to the promising testing results and low administrative burden. For the "Watchful Waiting" depression screen coding intervention, the health plan reported intervention testing results that demonstrated significant programmatic improvement in the accuracy of depression screen results coding and significant clinical improvement in the facilitation of appropriate follow-up care. The intervention was adopted at the conclusion of testing as a result of the demonstrated improvement.

Lessons Learned

An important part of the QI process is to consider how the information gathered and lessons learned during the PIP can be applied in future improvement efforts. **CCHA R7** reported successes, challenges, and lessons learned as part of the Module 4 submission.

CCHA R7 documented the following lessons learned from the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP:

- Improving the provider response script for patient depression screening refusal allowed members to receive patient education and improved care for the early detection of depression. These effects were achieved despite the numerous challenges for healthcare providers presented during the coronavirus disease 2019 (COVID-19) pandemic.
- The success of the "Watchful Waiting" coding category for subclinical depression screening results demonstrated the critical role of EHR development and coding practices in measuring and improving quality of care.

3. Conclusions and Recommendations

Conclusions

CCHA R7 developed a methodologically sound improvement project that met both State and federal requirements. The health plan tested two interventions using the required QI processes and tools. At the conclusion of the PIP, the health plan accurately reported results that demonstrated achievement of the SMART Aim goal and statistically significant improvement over baseline performance for both *Depression Screening* and *Follow-Up After a Positive Depression Screen* measures. The health plan's intervention testing results also demonstrated clinically significant improvement in *Depression Screening* and clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions. Based on the validation findings, HSAG assigned a level of *High Confidence* to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Recommendations

HSAG has the following recommendations:

- **CCHA R7** should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- **CCHA R7** should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Appendix A. Module Submission Form

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

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

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets

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Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

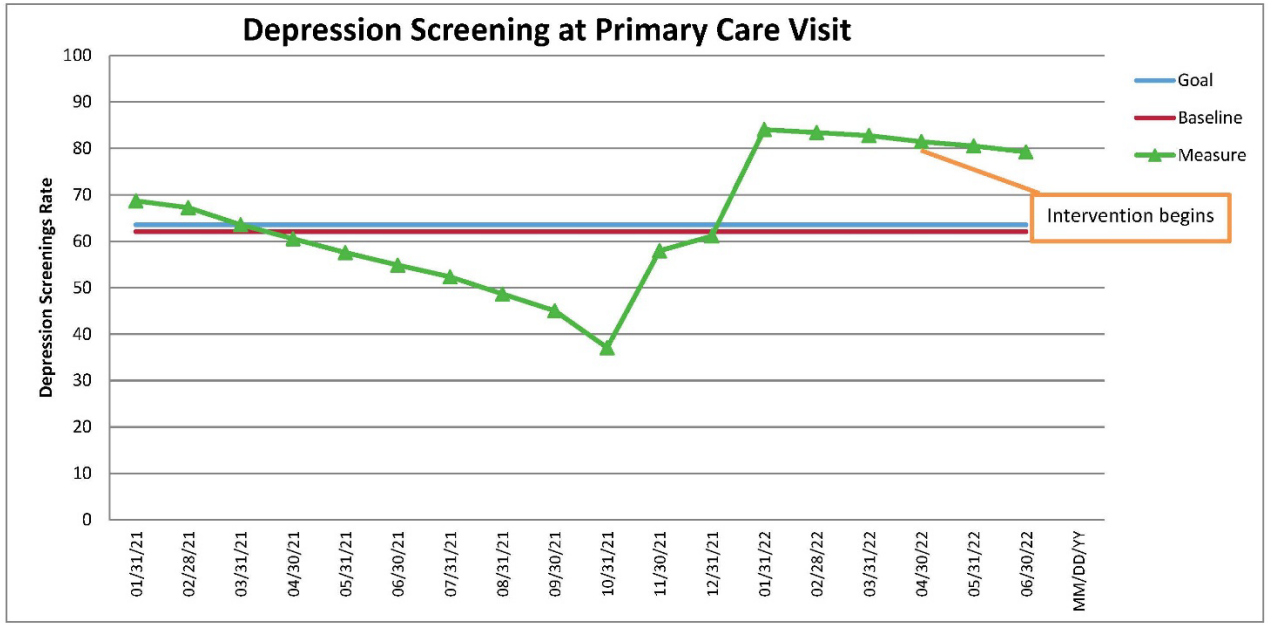
Final SMART Aim Run Chart – *Depression Screening*

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

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance (RAE 7)**



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

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

Final Monthly SMART Aim Measure Data – *Depression Screening*

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020 – 01/31/2021	January-21	5,205	7,577	68.69%
03/01/2020 – 02/28/2021	February-21	5,104	7,592	67.23%
04/01/2020 – 03/31/2021	March-21	5,033	7,920	63.55%
05/01/2020 – 04/30/2021	April-21	5,082	8,393	60.55%
06/01/2020 – 05/31/2021	May-21	4,809	8,355	57.56%
07/01/2020 – 06/30/2021	June-21	4,505	8,211	54.87%
08/01/2020 – 07/31/2021	July-21	4,106	7,843	52.35%
09/01/2020 – 08/31/2021	August-21	3,387	6,962	48.65%
10/01/2020 – 09/30/2021	September-21	2,815	6,251	45.03%
11/01/2020 – 10/31/2021	October-21	2,558	6,767	37.80%
12/01/2020 – 11/30/2021	November-21	4,503	7,771	57.95%
01/01/2021 – 12/31/2022	December-21	4,822	7,890	61.12%

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Performance Improvement Project (PIP)
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for **Colorado Community Health Alliance (RAE 7)**

02/01/2021 – 01/31/2022	January-22	6,617	7,873	84.05%
03/01/2021 – 02/28/2022	February-22	6,492	7,784	83.40%
04/01/2021 – 03/31/2022	March-22	5,799	7,007	82.76%
05/01/2021 – 04/30/2022	April-22	5,545	6,809	81.44%
06/01/2021 – 05/31/2022	May-22	5,453	6,773	80.51%
07/01/2021 – 06/30/2022	June-22	5,464	6,896	79.23%

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

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

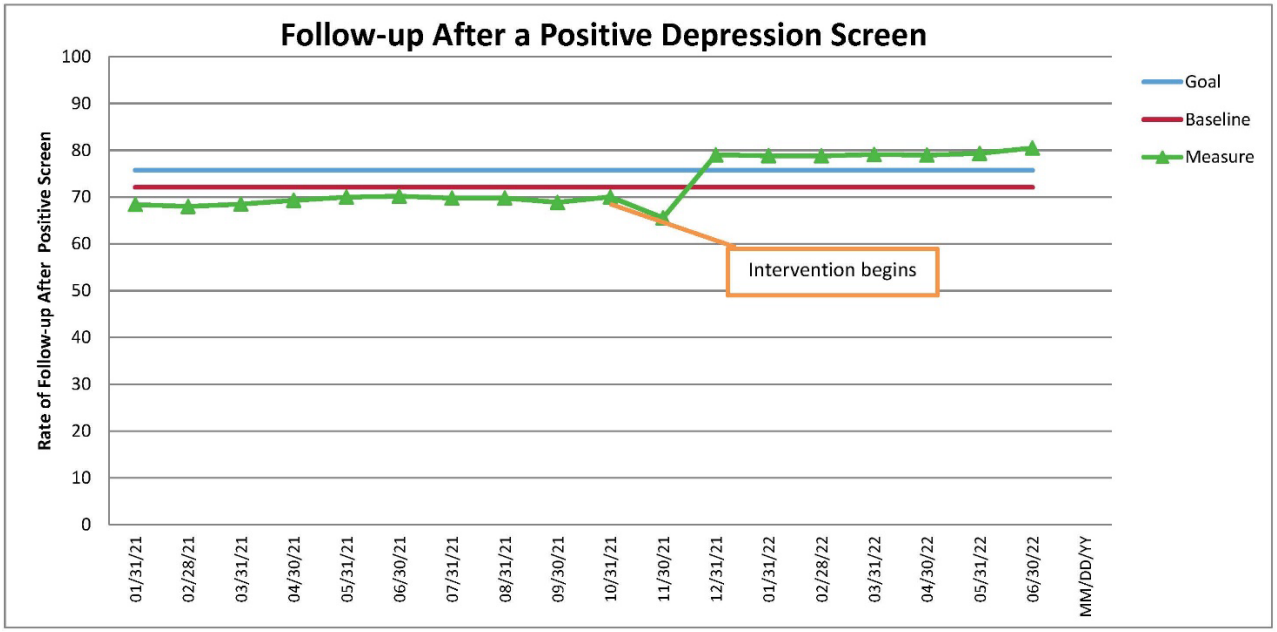
Instructions: In the space below, insert or attach the final SMART Aim run chart. Include the following:

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

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)



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

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

State of Colorado
Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance (RAE 7)**

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

Instructions:

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

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

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020 – 01/31/2021	January-21	1,468	2,145	68.4%
03/01/2020 – 02/28/2021	February-21	1,552	2,282	68.0%
04/01/2020 – 03/31/2021	March-21	1,714	2,503	68.5%
05/01/2020 – 04/30/2021	April-21	1,895	2,733	69.3%
06/01/2020 – 05/31/2021	May-21	1,925	2,750	70.0%
07/01/2020 – 06/30/2021	June-21	1,881	2,680	70.2%
08/01/2020 – 07/31/2021	July-21	1,782	2,552	69.8%
09/01/2020 – 08/31/2021	August-21	1,575	2,256	69.8%
10/01/2020 – 09/30/2021	September-21	1,382	2,007	68.9%
11/01/2020 – 10/31/2021	October-21	722	1,031	70.0%
12/01/2020 – 11/30/2021	November-21	1,457	2,222	65.6%

State of Colorado
Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for **Colorado Community Health Alliance (RAE 7)**

01/01/2021 – 12/31/2022	December-21	1,482	1,875	79.0%
02/01/2021 – 01/31/2022	January-22	1,441	1,828	78.8%
03/01/2021 – 02/28/2022	February-22	1,323	1,679	78.8%
04/01/2021 – 03/31/2022	March-22	1,098	1,388	79.1%
05/01/2021 – 04/30/2022	April-22	958	1,213	79.0%
06/01/2021 – 05/31/2022	May-22	891	1,123	79.3%
07/01/2021 – 06/30/2022	June-22	904	1,123	80.5%

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

Final Key Driver Diagrams

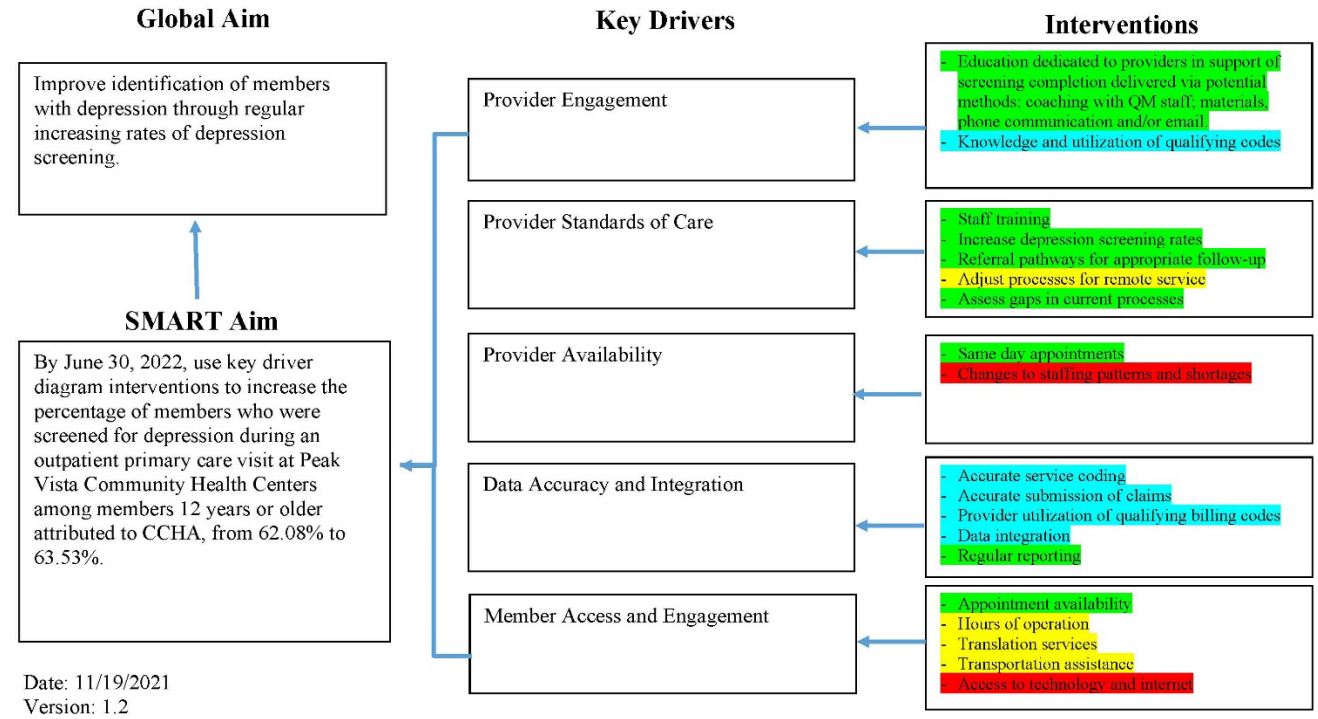
Instructions: In the space below, provide the updated final key driver diagrams. The MCO must use the following color-coding system in the final key driver diagrams. The MCO should ensure that one key driver diagram is provided for each outcome: ***Depression Screening*** and ***Follow–up After a Positive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

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

Key Driver Diagram– *Depression Screening*



Date: 11/19/2021
Version: 1.2

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Colorado Community Health Alliance (RAE 7)

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

Global Aim

Improve health outcomes for members with depression by facilitating timely access to behavioral health services.

SMART Aim

By June 30, 2022, use key driver diagram interventions to increase the percentage of members who receive a qualifying behavioral health service the day of or within 30 days from a positive depression screen conducted at an outpatient primary care visit at Peak Vista Community Health Centers among members 12 years or older attributed to CCHA, from 72.1% to 75.74%.

Date: 1/19/2021
Version: 1.2

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

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Project Conclusions

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

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

Table 2a—Project Conclusions – *Depression Screening*

Project Conclusions	The statistically significant SMART Aim goal for Depression Screening was achieved as well as clinically significant improvements. The implementation of script for patients refusing the screening did decrease the volume of refusals by 0.11%, but this

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	improvement did not ultimately influence an increase in the overall rate of depression screening. The improvement was not programmatically significant due to the low volume of impacted members.
Intervention Testing Conclusions	The new refusal script decreased the rate of refusal for patients during the intervention period. The downward trend indicates continued reduction in refusals should be expected with the continued use of the revised script. The volume of refusals was unlikely to meaningfully impact rates of depression screening at the practice level. Despite the small intervention population, the intervention provides valuable insight into patient engagement and staff's adherence to clinical protocols. In addition, reports are automatically generated and add minimal burden to the administration.
Spread of Successful Interventions	A discussion regarding current clinical practice guidelines for response to patient refusal will be introduced to the Quality Management Committee and evaluated for future practice transformation projects.
Challenges Encountered During Project	The review of depression screening encounters in the PIP report that is pulled directly from the EHR led to the discovery of an issue with the billing software that adjusted off charges for depression screens and disrupted the submission of claims for multiple completed assessments. Changes made to billing protocol were not communicated to the clinical or PIP teams, and different criteria as well as additional procedure codes were utilized that were not captured by the PIP's performance calculation methodology. Further, variation in covered benefits for distinct payer sources and discrepancies in measure specifications between different incentive programs the practice participates in created inefficiencies that enhanced provider burden and led to duplicative work to fulfill documentation requirements. As a result, actual depression screening performance is expected to be higher than the current data reflects. Additionally, the practice reported experiencing unprecedented access barriers due to staffing constraints caused by illness, resignations due to the vaccine mandate, and

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	general labor shortages. Significant stress and strain impaired the practice's ability to be nimble and quickly respond to issues identified by this PIP. Adjustments made to respond to new demands altered the practice's operational landscape compared to the original PIP plan and introduced new confounding variables that had not been previously identified and impacted definitive conclusions.
Lessons Learned/Information Gained Throughout the Project	Improving the script for response to patient refusals for screening allowed members to receive patient education and improved care for the early detection of depression. These effects were achieved despite the numerous changes occurred in the 24 months of this project which impacted the original intervention design, including the seminal healthcare event of the COVID-19 pandemic. The agility of the providers and quality improvement staff made it possible to implement impactful improvements possible amid these circumstances.

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Sustainability of Improvement – *Depression Screening*

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

The standards, protocols and tools developed provide valuable insight into patient engagement and staff's adherence to clinical protocols. In addition, reports are automatically generated and add minimal burden to the administration. Peak Vista's Director of Quality and Patient Safety will continue to generate the PHQ-9 report monthly to track and monitor performance. Data will be reviewed with the Vice president of Behavioral Health for improvements and corrections, as needed. Further action will be determined by and carried out by the practice. An offer for ongoing partnership or assistance has been extended by CCHA to support related endeavors the practice opts to pursue in the future.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Project Conclusions	The statistically significant target originally established for rate 2 was achieved, sustained for 7 months, and exceeded by 4.76 percentage points in the final month of testing. This project demonstrates that discerning negative, subclinical, and positive depression screens has therapeutic and practical benefits that endorse its clinically and programmatically significant improvements.
Intervention Testing Conclusions	The utilization of "Watchful Waiting" category to identify subclinical screens provides valuable insights into population health, expedites patient identification, and facilitates oversight to ensure proper response to patient needs. Further, the ability to verify and monitor adherence to the depression screening guidelines helped demonstrate standards of patient care were sustained despite unprecedented staffing challenges and is expected enhance patient's clinical outcomes. These strategies establish a programmatic structure that reinforces the utilization of empirically supported recommendations for depression management.
Spread of Successful Interventions	A discussion regarding current clinical practice guidelines for identification and response to subclinical screens will be introduced to the Quality Management Committee and evaluated for future practice transformation projects. Different providers have different workflows, use different EHRs with different functions that are tailored to meet specific needs from regulations, scope of service, payer sources and incentive programs. PIP interventions were specifically designed for this project and would need to be tailored to specific provider systems to yield similar results.
Challenges Encountered During Project	Variations in covered benefits for distinct payer sources and discrepancies in measure specifications and calculation methodology between different incentive programs the practice participates in created inefficiencies that enhanced provider burden and led to duplicative work to fulfill documentation requirements. As a result, expectations for

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	activities that qualify as a follow-up after a positive depression screen are different across programs. Additionally, the practice reported experiencing unprecedented access barriers due to staffing constraints caused by illness, resignations due to the vaccine mandate, and general labor shortages. Significant stress and strain impaired the practice's ability to be nimble and quickly respond to issues identified by this PIP. Adjustments made to respond to new demands altered the practice's operational landscape compared to the original PIP plan and introduced new confounding variables that had not been previously identified and impacted definitive conclusions.
Lessons Learned/Information Gained Throughout the Project	Rates of follow-up after a positive depression screening showed a significant improvement following implementation of a "Watchful Waiting" category for subclinical depression screens. This project demonstrated the important role that EHR development, coding and billing play in the measurement of quality clinical practice.

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

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

The "Watchful Waiting" category will be maintained and will continue to be defined as screening scores between 5 and 9 points with a negative response to question 9. As it currently stands, the established workflow and process can fulfill its intended goals of categorizing screens, expediting patient identification, providing insight into population health, and supporting accountability. Peak Vista's Director of Quality and Patient Safety will continue to generate the PHQ-9 report monthly to track and monitor performance. Data will be reviewed with the Vice president of Behavioral Health for improvements and corrections, as needed. Further action will be determined and carried out by the practice. An offer for ongoing partnership or assistance has been extended by CCHA to support related endeavors the practice opts to pursue in the future.

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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

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

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

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

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

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

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

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

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

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Summary of Validation Findings:

HSAG assigned a level of *High Confidence* to the PIP based on the Module 4 submission form and PDSA worksheet documentation. The documentation demonstrated the following:
• Significant improvement achieved for both the *Depression Screening* and *Follow-up After a Positive Depression Screen* measures:
  ○ Both the SMART Aim goal and statistically significant improvement were achieved for *Depression Screening*.
  ○ Both the SMART Aim goal and statistically significant improvement were achieved for *Follow-up After a Positive Depression Screen*.
  ○ Documented intervention testing results demonstrated significant clinical improvement related to depression screening and significant *programmatic* and significant *clinical* improvement related to follow-up care.
• Interventions were carried out and evaluated according to the approved Module 3 plan and the health plan provided accurate intervention testing results, clear rationale for intervention or evaluation revisions, and actionable summaries of lessons learned from intervention testing.
• Clear and accurate summaries of key findings and conclusions from the PDSA cycles and from the project, overall.