COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 PIP Validation Report

for

Rocky Mountain Health Plans Medicaid Prime

April 2021

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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1. Executive Summary

The Code of Federal Regulations at 42 CFR Part 438—managed care regulations for Medicaid programs, with revisions released May 6, 2016, and effective July 1, 2017, for Medicaid managed care 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, conducted by an external quality review organization (EQRO), analysis and evaluation of aggregated information on 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 managed care program.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its Medicaid health plans to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **Rocky Mountain Health Plans Medicaid Prime** (**RMHP Prime),** an MCO, holds a contract with the State of Colorado for provision of medical and behavioral health services for the Department's managed care program.

For fiscal year (FY) 2020–2021, 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 quality improvement
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

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]

[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 June 8, 2020.

Over time, HSAG and some of its contracted states identified that while the MCOs had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs had achieved real and sustained improvement. 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. 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. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that given the pace of quality improvement 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.

PIP Components and Process

The key concepts of the new 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 new 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.

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.

[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 February 6, 2020.

For this PIP framework, HSAG uses four modules with an accompanying reference guide to assist MCOs in documenting PIP activities for validation. Prior to issuing each module, HSAG holds technical assistance sessions with the MCOs to educate about application of the modules. The four modules are defined as:

- **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.
- **Module 2—Intervention Determination:** In Module 2, there is increased focus on the quality improvement 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.

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **RMHP Prime**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **RMHP Prime**'s PIP and the activities completed in Module 1. (See Appendix A. Module Submission Form.)

Following HSAG's rapid-cycle PIP process, the health plan submits each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted by the health plan during the PIP. HSAG's scoring methodology evaluates whether the health plan executed a methodologically sound improvement project and confirms that any improvement achieved could be clearly linked to the quality improvement strategies implemented by the health plan.

Validation Scoring

During validation, HSAG determines if criteria for each module are *Met.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 4, HSAG will use the validation findings from modules 1 through 4 for each PIP 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 and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

PIP Topic Selection

In FY 2020–2021, **RMHP Prime** submitted the following PIP topic for validation: *Depression Screening and Follow–Up After a Positive Depression Screen.*

RMHP Prime 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 **RMHP Prime**.

Table 1-1—SMART Aim Statements

PIP Measure	SMART Aim Statement
Depression Screening	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.3% to 20.0%.
Follow–Up After a Positive Depression Screen	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 33.3% to 46.89%.

The focus of the PIP is to increase the percentage of members 12 years of age and older, attributed to Mountain Family Health Centers or St. Mary's Family Medicine, who receive a depression screening and to increase the percentage of those members who receive behavioral health services within 30 days of screening positive for depression. The goal to increase depression screening to 20.0 percent represents statistically significant improvement over the baseline performance. The goal to increase follow-up within 30 days of a positive depression screen to 46.89 percent is based on a benchmark identified by the health plan. Using the *Follow–Up after a Positive Depression Screen* narrowed focus baseline data, it was impossible for the health plan to determine a goal that represented statistically significant improvement. Therefore, the Department and HSAG approved the health plan setting a goal based on a benchmark rather than statistical significance.

Table 1-2 summarizes the progress **RMHP Prime** has made in completing the four PIP modules.

Table 1-2—PIP Topic and Module Status

PIP Topic	Module	Status
Depression Screening and Follow–Up After a Positive Depression Screen	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Initial submission targeted for May 2021.
	3. Intervention Testing	Targeted initiation July 2021.
	4. PIP Conclusions	Targeted for October 2022.

At the time of the FY 2020–2021 PIP validation report, **RMHP Prime** had passed Module 1, achieving all validation criteria for the PIP. **RMHP Prime** has progressed to Module 2, Intervention Determination. Module 2 and Module 3 validation findings will be reported in the FY 2021–2022 PIP validation report.

2. Findings

Validation Findings

At the end of FY 2019–2020, **RMHP Prime** closed out the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP, which was initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from the project.

In FY 2020–2021, **RMHP Prime** initiated a new PIP, *Depression Screening and Follow–Up After a Positive Depression Screen*. The health plan submitted Module 1 for validation in December 2020. The objective of Module 1 is for the health plan to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, **RMHP Prime** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. HSAG reviews Module 1 and provides feedback and technical assistance to the health plan until all Module 1 criteria are achieved.

Below are summaries of PIP conclusions from the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP close-out report and the Module 1 validation findings for the new PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

PIP Close-Out Summary

Table 2-1 presents the interventions, successes, and lessons learned **RMHP Prime** reported in the FY 2019–2020 PIP close-out report for the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP.

Table 2-1—PIP Conclusions Summary for the *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older* PIP

Interventions	In-house care management and referral to therapist.
Successes	Increased medication-assisted substance use disorder (SUD) treatment initiation rates and medication adherence during the project.
Lessons Learned	• The intake/initiation process requires more structure. • Members should receive access to peer support immediately upon intake/initiation. • Coronavirus disease 2019 (COVID-19) prevented testing completion and impeded plans to sustain improvement or spread interventions.

Module 1: PIP Initiation

Table 2-2 presents the FY 2020–2021 validation findings for **RMHP Prime**'s *Depression Screening and Follow–Up After a Positive Depression Screen* PIP.

Table 2-2—Module 1 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Measure 1—*Depression Screening*	
SMART Aim Statement	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.3% to 20.0%.
Preliminary Key Drivers	• Established workflow for depression screening during office visits. • Established workflow for depression screening during telehealth visits. • Provider awareness and understanding of appropriate depression screening coding practices.
Potential Interventions	• Implement provider and office staff education on depression screening workflow for office visits. • Establish a workflow for depression screening during telehealth visits. • Implement provider training on depression screening scoring, documentation, and reporting.
Measure 2—*Follow–Up After a Positive Depression Screen*	
SMART Aim Statement	By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 33.3% to 46.89%.
Preliminary Key Drivers	• Established workflow for patient follow-up care following a positive depression screen. • Registry of patients who screen positive for depression. • Effective utilization of behavioral health specialists.
Potential Interventions	• Establish processes and workflows to define appropriate care when a patient screens positive for depression. • Develop registry of patients who screen positive for depression to support appropriate behavioral health follow-up. • Expand utilization of telehealth services to provide follow-up behavioral services.

In Module 1, **RMHP Prime** set two goals to achieve by June 30, 2022:

- Increase the percentage of members 12 years of age and older, attributed to Mountain Family Health Centers or St. Mary's Family Medicine, who receive a depression screening to 20.0 percent.

- Increase the percentage of members 12 years of age and older, attributed to Mountain Family Health Centers or St. Mary's Family Medicine, who screened positive for depression that receive follow-up behavioral health services within 30 days of the positive depression screen to 46.89 percent.

The health plan completed key driver diagrams in Module 1 that identified evidence-based key drivers and potential interventions to support achievement of these goals. **RMHP Prime**'s identified key drivers focused on provider workflows, provider knowledge, and tracking systems. **RMHP Prime** has identified provider-focused and system-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **RMHP Prime** will use process mapping and FMEA to further analyze the processes related to depression screening and follow-up after a positive depression screen for members served by the narrowed focus provider. The health plan will have the opportunity to update key drivers and interventions in the key driver diagram at the conclusion of Module 2, prior to selecting interventions to test through PDSA cycles in Module 3. Validation findings for Module 2 and Module 3 will be described in the FY 2021–2022 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **RMHP Prime** successfully completed Module 1 and designed a methodologically sound project. **RMHP Prime** was also successful in building internal and external quality improvement teams and developing collaborative partnerships with targeted providers and facilities.

Recommendations

- When mapping and analyzing the process(es) related to depression screening and follow-up care after a positive depression screen for the PIP, **RMHP Prime** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **RMHP Prime** should clearly identify the steps in the process map(s) that represent the greatest opportunities for improvement and further analyze those process steps through an FMEA. For each process step included in the FMEA, the health plan should identify failure modes, causes, and effects that can be logically linked to each step.
- When ranking failure modes identified through the FMEA, **RMHP Prime** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **RMHP Prime** should review and update the key driver diagram after completing the process map(s), FMEA, and failure mode ranking to include any newly identified interventions and/or drivers. The key driver diagram should be updated regularly to incorporate knowledge gained and lessons learned as **RMHP Prime** progresses through determining and testing interventions.
- **RMHP Prime** should identify or develop interventions to test for the PIP that are likely to address high-priority failure mode(s) and leverage key drivers in support of achieving the SMART Aim goal.
- For each intervention that will be tested for the PIP, **RMHP Prime** should develop a methodologically sound testing plan including steps for carrying out the intervention, collecting timely and meaningful intervention effectiveness data, and analyzing the results of intervention effectiveness measures.

Appendix A. Module Submission Form

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

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Heather Steele and Jeremiah Fluke
Contact Title	Quality Improvement Advisor/ Prime Contract manager
Email Address	heather.steele@rmhp.org/jeremiah.fluke@rmhp.org
Telephone Number	425-753-9312/541-709-6609
Submission Date	12/07/2020
Resubmission Date (if applicable)	3/25/2021

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PIP Team

Instructions:

- In Table 1, list the project team members, including their titles and roles and responsibilities.
- The team should include an executive-level sponsor and data analyst.
- If applicable, a representative from the selected narrowed focus should be included on the team.

Table 1—Team Members

Name	Title	Role and Responsibilities
Will Covington	Quality Director	MFHC Quality Lead
Kaitlyn McGovern	Quality Officer	MFHC Quality Officer
Marija Weeden	Director of Operations	MFHC Executive Sponsor
Lance Friesen	Quality Officer	MFHC Quality Department
Becky Bachert	Quality Project Coordinator	SMFM Data Analyst
Randall Reitz	Director of Behavioral Medicine	SMFM Executive Sponsor
Doug McPhee	Family Medicine Education Fellow	SMFM Data support
Mary Beckner	Quality Improvement Advisor	RMHP PIP Lead
Jeremiah Fluke	Prime Contract Manager	RMHP PIP Support
Heather Steele	Quality Improvement Advisor	RMHP PIP Support
Meg Taylor	VP Community Integration	RMHP PIP Executive Sponsor
Todd Lessley	VP Clinical Services	RMHP PIP Executive Sponsor
Shane Daniels	Data Analyst	RMHP Data Analyst

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PIP Topic and Narrowed Focus

Instructions: In Table 2, document the rationale for selecting the topic and narrowed focus.

- The topic should be selected through a comprehensive analysis of MCO member needs and services.
- The narrative should describe how the topic has the potential to improve member health, functional status, and/or satisfaction.
- If the topic was mandated by the state, indicate this in the documentation.

Table 2—PIP Topic and Narrowed Focus

PIP Topic Description
This PIP is a provider centric metric, where the Member population characteristics are not as significant as Provider engagement. While Primary Care Medical Providers (PCMPs) serve as the first line of defense in the detection of depression, studies show that PCMPs fail to recognize up to 50% of depressed patients, reportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments" (Borner, 2010, p. 948). "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). Disparities due to income have also been observed, as those with lower income (below the federal poverty line) in the 18-39 and 40-59 age brackets, who experience higher depression rates than those with higher income. (Pratt & Brody, 2008, p. 2). Per state mandate for focus on depression screening and follow up, the Behavioral Health Incentive Program (BHIP) specifications are being used to establish a Performance Improvement Project using analysis of the following categories: Population, Billing for 96127, BH Engagement KPI, Depression Screening Measure (G codes), and Follow-up after depression if positive and Well-Visits KPI. Part one of the study topic has the potential to improve Member health outcomes by ensuring that the Member receives a depression screening on, at least, an annual basis. If a Member screens positive for depression a timely connection to behavioral health services has been shown as an effective treatment option. All Marketplace plans and other health plans must cover depression screening for adults without charging a copay or coinsurance. This is true even if the patient has not met their yearly deductible. This allows Member access to care. (Medicaid.gov). In 2018 the Colorado Department of Healthcare and Finance (HCPF) included short term behavioral health services in primary care in its fee schedule (Medicaid.gov). These changes removed several barriers for Members to receive behavioral health services in the primary care setting. Members are eligible to receive

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up to six (6) visits per year in the primary care or community mental health setting without having to complete a formal intake or receive prior authorization (Health First Colorado.com).

Congress enacted several laws designed to improve access to mental health and substance use disorder services under health insurance or benefit plans that provide medical/surgical benefits. The most recent law, the Mental Health Parity and Addiction Equity Act (MHPAEA), impacts the millions of Medicaid beneficiaries participating in Managed Care Organizations, State alternative benefit plans (as described in Section 1937 of the Social Security Act) and the Children's Health Insurance Program. This allows Member access to care. (Mediaid.gov)

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360). "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 380).

References

Borner I, Braunstein JW, St. Victor, R, Pollack J (2010). Evaluation of a 2-question screening tool for detecting depression in adolescents in Primary Care. Clinical Pediatrics, 49, 947-995. doi: 10.1177/0009922810370203

Coyle J T, Pine D.S, Charney D S, Lewis L, Nemeroff C B, Carlson G A, Joshi P T (2003). Depression and bipolar support alliance consensus development panel. Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 42, 1494-1503.
Health First Colorado (2020). Benefits and Services: Mental Health, Substance Use Disorder, or Behavioral Health Services. Retrieved from https://www.healthfirstcolorado.com/benefits-services/#mental-behavioral

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Pratt L.A, Brody DJ.(2008). Depression in the United States household population, 2005-2006. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Health Statistics. NCHS Data Brief No.7, 1-8.
Sui, A (2016). Screening for Depression in Children and Adolescents: U.S. Preventative Services Task Force Recommendation Statement. *Annals of Internal Medicine*. Vol 164(5). Retrieved from https://www.uspreventiveservicestaskforce.org/home/getfilebytoken/kAg43FLUnTjCU5ZNaaHQtW

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Narrowed Focus Description
RMHP has identified Mountain Family Health Centers (MFHC) and St. Mary's Family Medicine (SMFM) as candidates for this performance improvement project (PIP). Through a comprehensive analysis of the Population, Billing for 96127, BH Engagement KPI, Depression Screening Measure (G codes), Follow-up after depression if positive and Well-Visits KPI, the RMHP data shows that MFHC and SMFM have opportunity to improve their screening workflow, billing workflow and outcomes for Members in an effort to improve Member health, functional status and/or satisfaction.

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Narrowed Focus Baseline Measurement – *Depression Screening*

Instructions:

- **For Table 3a:**
  - The information should represent the ***Depression Screening*** baseline measurement period specifications used for baseline data collection and not the rolling 12-month SMART Aim measure methodology that is attested to below.
  - The baseline should represent the most recent 12-month fixed time period based on the module submission due date to HSAG and take into consideration claims completeness for the 12-month measurement period.
- **For Table 3b:**
  - If two or more entities are selected as the narrowed focus, only one combined percentage should be entered in the table.
  - The summed numerators are divided by the summed denominators and multiplied by 100 to arrive at the combined percentage.
  - The information should represent the narrowed focus ***Depression Screening*** baseline measurement information and include the dates, numerator value, denominator value, and percentage.

Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Numerator Description	RMHP Prime Members 12 years of age or older and attributed to either SMFM or MFHC during the baseline measurement period who had a depression screening identified by the screening G-Code G8510 or G8431.
Denominator Description	RMHP Prime Members 12 years of age or older and attributed to either SMFM or MFHC during the baseline measurement period.
Age Criteria (if applicable)	>= 12 years as of end of measurement period (6/30/2020)
Continuous Enrollment Specifications (if applicable)	Enrolled during the measurement period. Members are continuously enrolled on the date of the positive depression screen for 30 days, with no gaps and attributed to MFHC or SMFM.
Allowable Gap in Enrollment (if applicable)	N\A
Anchor Date (if applicable)	Last day of the month

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Table 3a—Narrowed Focus Baseline Specifications – *Depression Screening*	
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	N/A

Table 3b—Narrowed Focus Baseline Data – *Depression Screening*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 07/01/2019	End Date: 06/30/2020
Numerator: 5	Denominator: 1600	Percentage: 0.3%

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Instructions: **For Table 3c**, check the applicable data source and describe the step-by-step process for how the ***Depression Screening*** baseline data were collected for the selected narrowed focus.

Table 3c—Narrowed Focus Baseline Data Collection Methodology – *Depression Screening*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:

Describe the step-by-step data collection process and data elements collected:
After the monthly and weekly data load processes finish, run the SQL program which does the following:
- Pull eligible Members from Facets eligibility where
  ○ The member is an eligible member of a plan with Rocky Mountain Health Plans during the evaluation period of 7/1/2019 to 6/30/2020
  ○ Member age at the end of the evaluation period is >=12
  ○ Member line of business is Prime
  ○ Find Member's attribution as of the end of the evaluation period
  ▪ Facets enrollment
- Pull paid final claims where one or more of the applicable code sets matches the referenced value sets
  ○ Identify Members with a positive depression screening ('Depression Screening – Positive' Value set) or negative depression screening ('Depression Screening – Negative' Value set)
- Numerator Compliant Members are those with a depression screening
- Calculate numerator compliance at the Plan level for each line of business
- Calculate numerator compliance at the practice level for each line of business
- Provide aggregate list to PIP Committee
- Provide Member-level list to appropriate PHI-approved committee members for outreach		

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Narrowed Focus Baseline Measurement – *Follow–Up After a Positive Depression Screen*

Instructions:

- **For Table 4a:**
  - The information should represent the ***Follow–Up After a Positive Depression Screen*** baseline measurement period specifications used for baseline data collection and not the rolling 12-month SMART Aim measure methodology that is attested to below.
  - The baseline should represent the most recent 12-month fixed time period based on the module submission due date to HSAG and take into consideration claims completeness for the 12-month measurement period.
- **For Table 4b:**
  - If two or more entities are selected as the narrowed focus, only one combined percentage is entered in the table.
  - The summed numerators are divided by the summed denominators and multiplied by 100 to arrive at the combined percentage.
  - The information should represent the narrowed focus ***Follow–Up After a Positive Depression Screen*** baseline measurement information and include the dates, numerator value, denominator value, and percentage.

Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Numerator Description	Prime Members attributed to either MFHC or SMFM who were engaged in mental health services on or within 30 days of a positive depression screening during the baseline measurement period. Members with a positive depression screen occurring less than 30 days before the end of the measurement period are excluded from the numerator.
Denominator Description	Prime Members attributed to either MFHC or SMFM with a positive depression screening identified by procedure code G8431 during the baseline measurement period. Members with a positive depression screen occurring less than 30 days before the end of the measurement period are excluded from the denominator.
Age Criteria (if applicable)	>= 12 years as of end of measurement period (6/30/2020)
Continuous Enrollment Specifications (if applicable)	Enrolled during the measurement period. Members are continuously enrolled on the date of the positive depression screen for 30 days, with no gaps and attributed to MFHC or SMFM.

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Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Allowable Gap in Enrollment (if applicable)	N\A
Anchor Date (if applicable)	Last day of the month
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Positive depression screening identified by procedure code G8431 during the baseline measurement period. Members with a positive depression screen occurring less than 30 days before the end of the measurement period are excluded from the denominator.

Table 4b—Narrowed Focus Baseline Data – *Follow–up After a Positive Depression Screen*		
Measurement Period (recent 12 months) (use MM/DD/YYYY format)	Start Date: 07/01/2019	End Date: 06/30/2020
Numerator: 1	Denominator: 3	Percentage: 33.3%

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Instructions: **For Table 4c**, check the applicable data source and describe the step-by-step process for how the *Follow-Up After a Positive Depression Screen* baseline data were collected for the selected narrowed focus.

Table 4c—Narrowed Focus Baseline Data Collection Methodology – *Follow–Up After a Positive Depression Screen*		
Data Sources		
☒ Administrative (Queried electronic data. For example, claims/encounters/pharmacy/electronic health record/registry, etc.)	☐ Hybrid (Combination of administrative and medical record review data. Include a blank example of the data collection tool used for medical record review [e.g., log, spreadsheet])	☐ Other—specify:

Describe the step-by-step data collection process and data elements collected:

After the monthly and weekly data load processes finish, run the SQL program which does the following:

- Pull eligible Members from Facets eligibility where
  - The member is an eligible member of a plan with Rocky Mountain Health Plans during the evaluation period of 7/1/2019 to 6/30/2020
  - Member age at the end of the evaluation period is >= 12
  - Member line of business is Prime
  - Find Member's attribution as of the end of the evaluation period
    - Facets enrollment
- Pull paid final claims where one or more of the applicable code sets matches the referenced value sets
  - Identify Members with a positive depression screening ('Depression Screening – Positive' Value set)
  - Exclude Members without continuous enrollment 30 days after the positive depression screen date of service (looks at all lines of business the Member was enrolled in during lookback)
- Numerator Compliant Members are those with a service listed below within 30 days of the positive depression screening
  - Members with a 'Follow-up Assessment Any Setting' billed on the same claim with a 'Any Setting Provider' Provider Type
  - Members with a 'Follow-up Assessment BH Setting' billed on the same claim with a 'Mental Health Provider' Provider Type
- Calculate numerator compliance at the Plan level for each line of business
- Calculate numerator compliance at the practice level for each line of business
- Provide aggregate list to PIP Committee
- Provide Member-level list to appropriate PHI-approved committee members for outreach

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SMART Aims (Specific, Measurable, Attainable, Relevant, and Time-bound)

Instructions: In the space below, complete the SMART Aim statement for each outcome. NOTE:

- Each SMART Aim must be specific, measurable, attainable, relevant, and time-bound.
- Each SMART Aim goal should represent statistically significant (95 percent confidence level, $p < 0.05$) improvement over the baseline performance for the narrowed focus.
- At the end of the project, HSAG will use the SMART Aims to evaluate the outcomes of the PIP and assign a level of confidence as part of the final validation.

Global Aim:

In alignment with the integrated model of care at Mountain Family Health Centers, St. Mary's Family Medicine and the core values of Rocky Mountain Health Plans, the global aim of this PIP is to increase the number of patients who are regularly screened for depression and if positive are connected to appropriate behavioral health services.

Depression Screening:

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.3% to 20.0%.

Follow-up After a Positive Depression Screen:

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 33.3% to 46.89%.

**Due to the sample size being so low, a statistically significant goal cannot be calculated. The 46.89% goal set for this Prime PIP is based upon the Region 1 FY19/20 BHIP target of Indicator 4: Follow-Up after a Positive Depression Screen for the RAE population.

Note: Once Module 1 has passed, the SMART Aim statements should never be modified. If changes need to occur, the MCO must contact HSAG prior to making any changes to the approved methodology.

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Key Driver Diagrams

Instructions: Complete the key driver diagram templates on the following pages.

- The first key driver diagram should be completed for ***Depression Screening*** and the second key driver diagram should be completed for ***Follow–Up After a Positive Depression Screen*** as specified in the key driver diagram template headers on the following pages.
- The key drivers and interventions listed at this stage of the PIP process should be based on the MCO's knowledge, experience, and research and literature review.
- Drivers are factors that contribute directly to achieving the SMART Aim and "drive" improvement. Key drivers are written in support of achieving the improvement outlined in the SMART Aim. For example, "Member transportation to appointment" would support achieving a SMART Aim. Refer to Section 3 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* "Key Driver Diagram" for additional instructions for completing the key driver diagram.
- The identified interventions should be culturally and linguistically appropriate for the narrowed focus population.
- Single interventions can address more than one key driver. Add additional arrows as needed.

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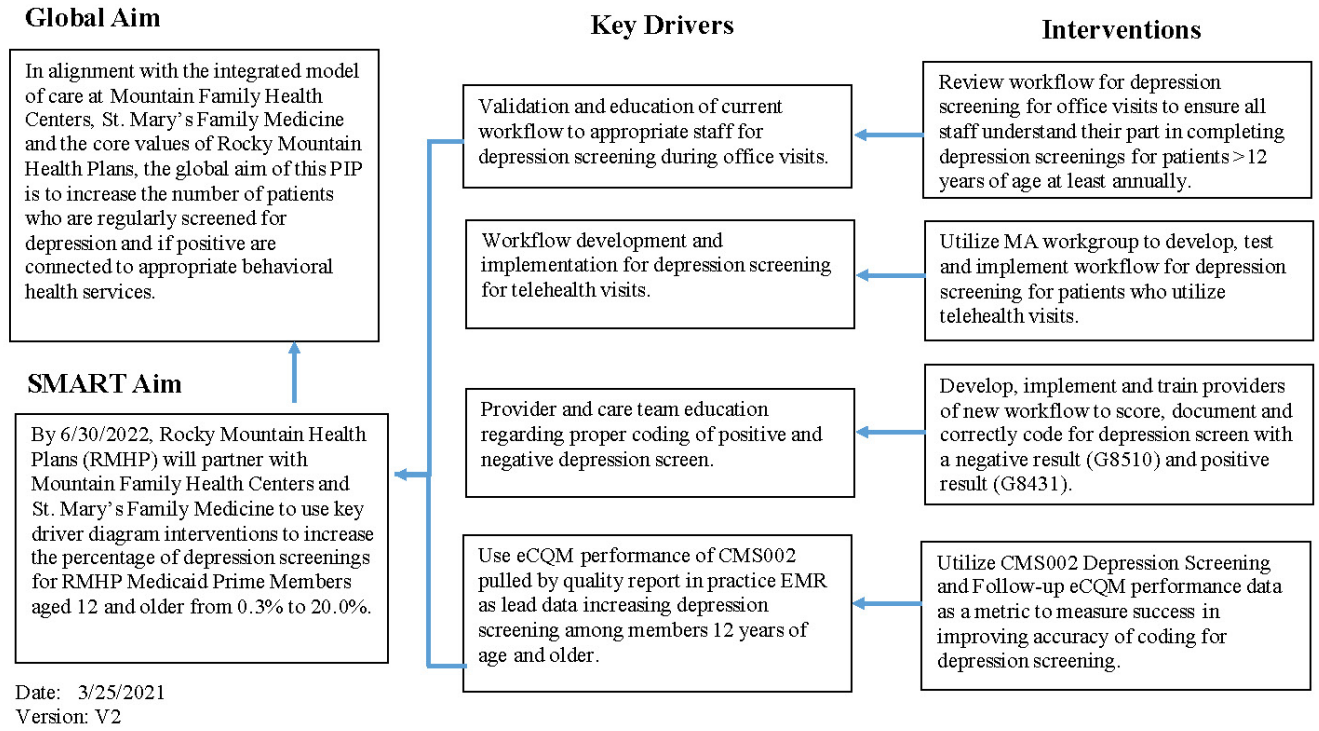
Key Driver Diagram– *Depression Screening Mountain Family Health Center (MFHC)*



Date: 3/25/2021
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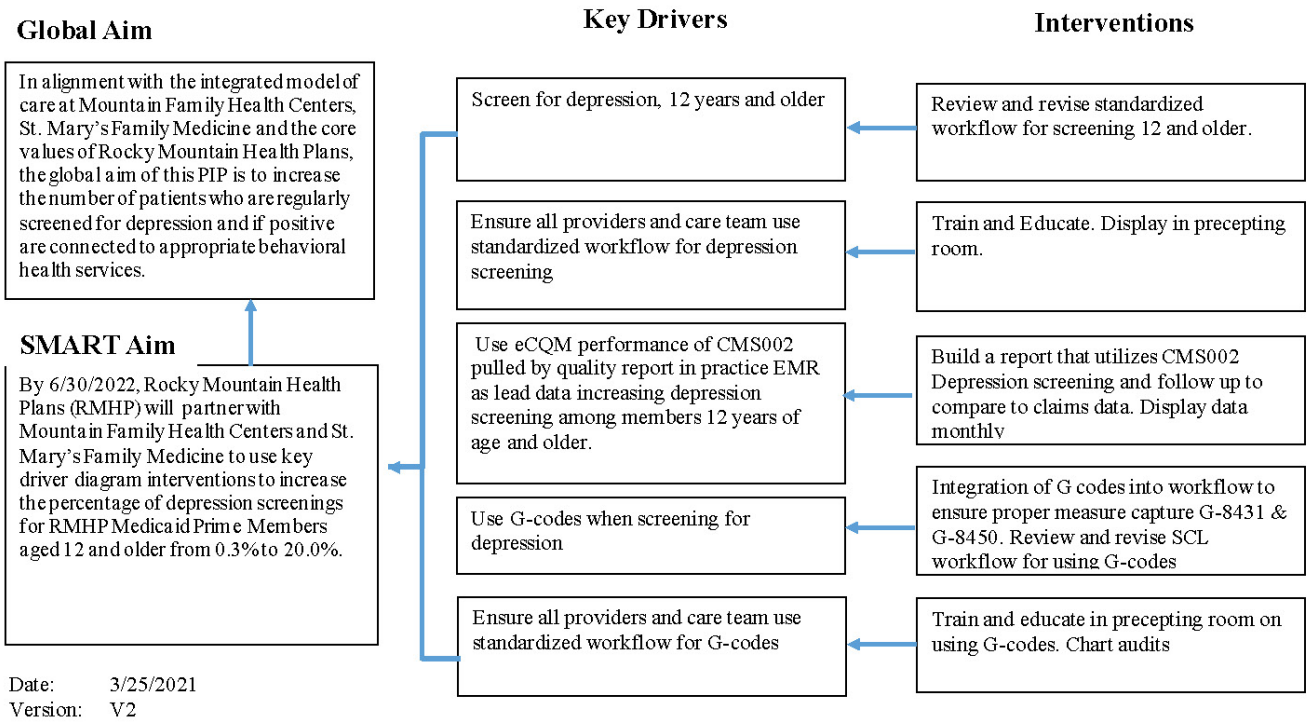
Key Driver Diagram– *Depression Screening St. Mary's Family Medicine (SMFM)*



Date: 3/25/2021
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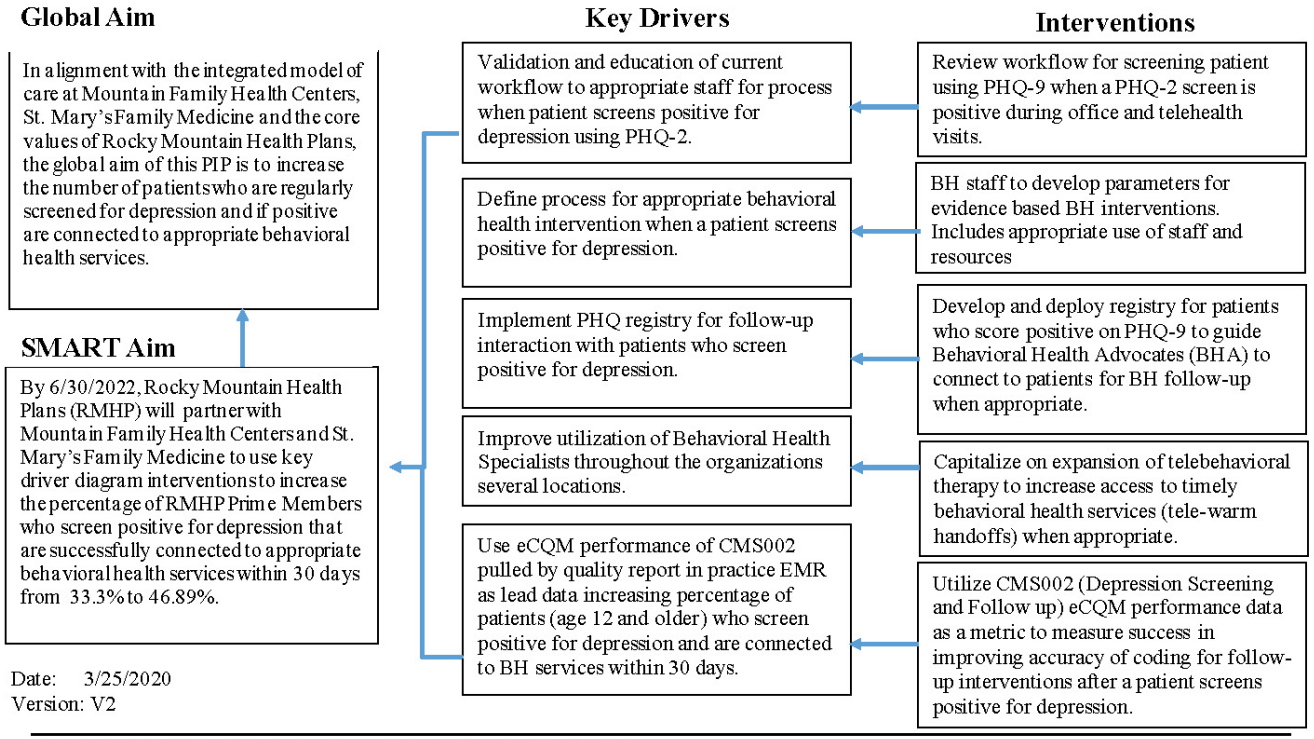
Key Driver Diagram 1 – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*



Date: 3/25/2020
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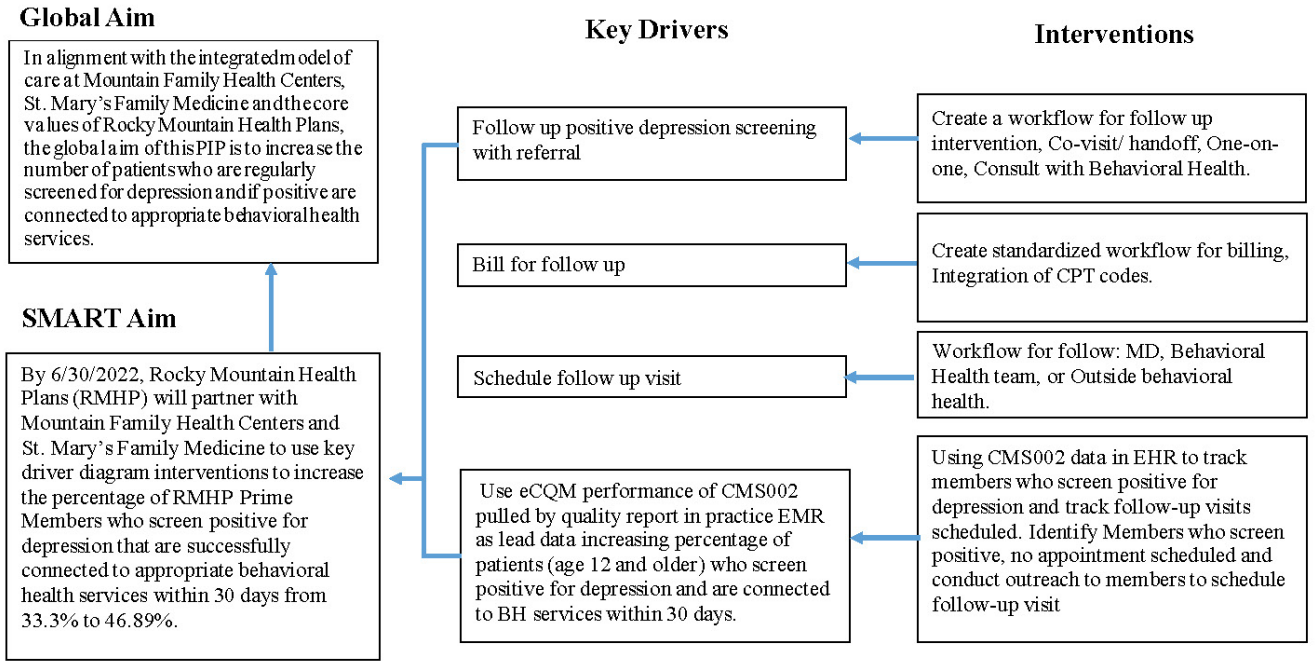
Key Driver Diagram 2 – *Follow–Up After a Positive Depression Screen St. Mary's Family Medicine (SMFM)*



Date: 3/25/2021
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SMART Aim Rolling 12-Month Measure Methodology and Run Charts

Rolling 12-Month Measure Methodology

The MCO will use a rolling 12-month measurement data collection methodology to determine if each SMART Aim goal was achieved.

Data collection for the rolling 12-month measurements should align with the baseline data collection method. For example, if the baseline data were collected administratively, then the rolling 12-month measurement data should be collected administratively. The MCO will compare each rolling 12-month data point with the SMART Aim goal to determine if the goal was achieved. The MCO should start the rolling 12-month calculations following HSAG's approval of Module 1.

Refer to Section 8 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Rolling 12-Month SMART Aim Measure Methodology") for a description of how to calculate rolling 12-month measurements. To confirm understanding of the rolling 12-month methodology requirement, check the box below.

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

Run Chart Instructions: The first run chart template below should be completed for *Depression Screening*, and the second run chart template should be completed for *Follow–Up After a Positive Depression Screen*, as specified in the run chart template headers on the following pages. Edit each run chart template below to include:

- Enter the run chart's title (e.g., The Percentage of Diabetic Eye Exams for Provider A).
- Enter the y-axis title (e.g., The Percentage of Diabetic Eye Exams).
- Enter x-axis dates with monthly intervals through the SMART Aim end date.
- Enter the narrowed focus baseline and SMART Aim goal percentages.
- The y-axis should be scaled 0 to 100 percent.

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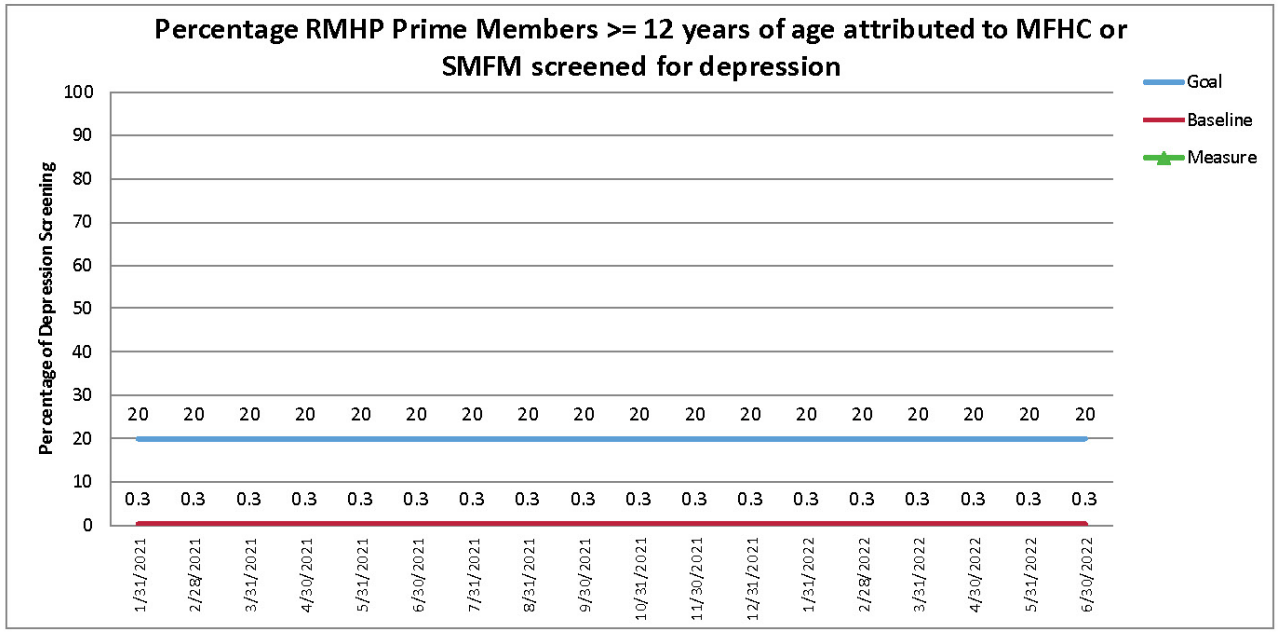
SMART Aim Rolling 12-Month Measure Run Chart – *Depression Screening*



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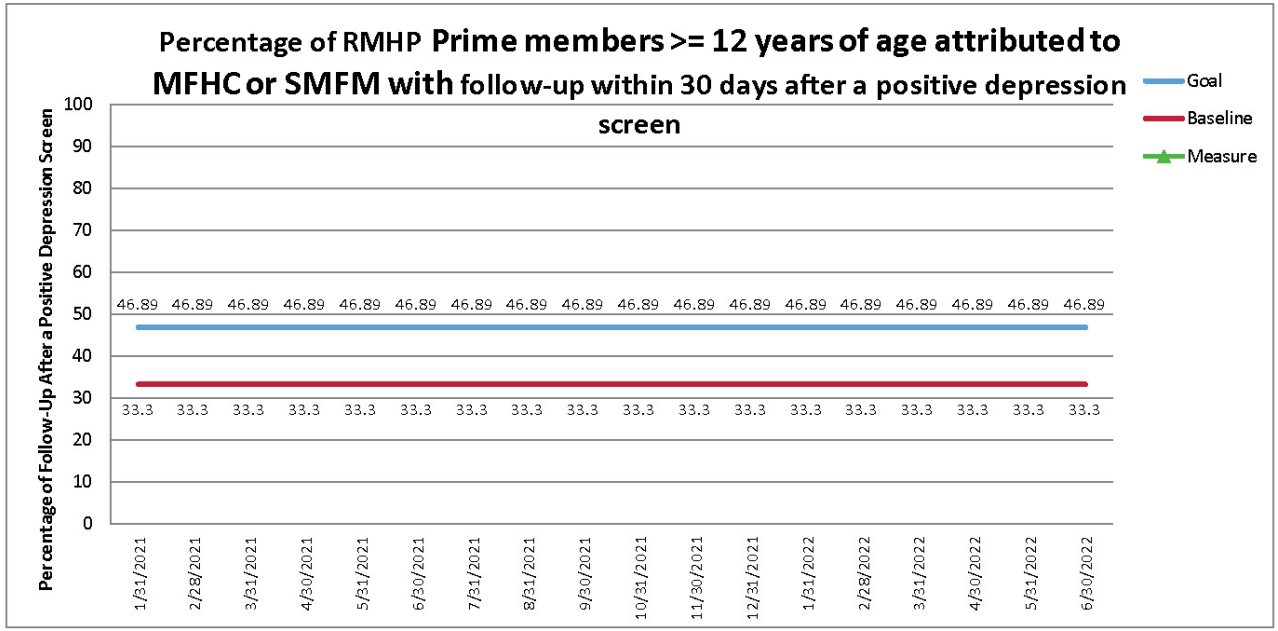
SMART Aim Rolling 12-Month Measure Run Chart – *Follow–Up After a Positive Depression Screen*



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 health plan provided the description and rationale for the selected narrowed focus, and the reported baseline data support opportunities for improvement for *Depression Screening* and *Follow–Up After a Positive Depression Screen.*	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: • The baseline *Depression Screening* data provided in Table 3b included a denominator size of 256 which is low for a rapid-cycle PIP. HSAG recommends identifying a narrowed focus with a larger baseline denominator size or adding a second provider to the narrowed focus. If the health plan uses the same narrowed focus for both measures, the denominator size of this measure will impact the denominator size of the follow-up measure because it is based on a subset (members with a positive depression screen) of this measure's numerator. • The baseline *Follow-Up After a Positive Depression Screen* data provided in Table 4b did not support selection of the narrowed focus. The health plan reported that there were no positive depression screens identified for members attributed to the narrowed focus provider during the baseline measurement period. The rapid-cycle PIP process requires a baseline rate for each measure; however, the health plan cannot report a baseline rate with zero members in the denominator. • HSAG recommends a technical assistance call to discuss the baseline denominator sizes for the PIP and potential alternative narrowed focus options. **Re-review April 2021:** The health plan revised the narrowed focus selection and addressed HSAG's feedback in the resubmission. The criterion has been *Met*. A general comment was added.

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Criteria	Score	HSAG Feedback and Recommendations
		General Comment: The health plan explained the existing challenges in obtaining complete and accurate administrative depression screening data during the March 4, 2021 technical assistance call with HSAG and the Department. The selected narrowed focus and accompanying narrowed focus baseline data represents the best option for the health plan to move forward with the PIP despite the low baseline denominator size for the *Follow-Up* measure.
2. The narrowed focus baseline specifications and data collection methodology for *Depression Screening* and *Follow–Up After a Positive Depression Screen* supported the rapid-cycle process and included: a) Complete and accurate specifications b) Data source(s) c) Step-by-step data collection process d) Narrowed focus baseline data that considered claims completeness	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening:*** • The numerator and denominator descriptions should specify "…during the baseline measurement period." • For age criteria, the health plan should specify the specific date for age determination for the baseline measurement period. Based on the documented baseline measurement period dates, it appeared age was determined as of 6/30/20. • The health plan should revise the continuous enrollment specifications to clarify. Do members have to be continuously enrolled during the entire measurement period? If the health plan is following the Department-defined measure specifications, members should be continuously enrolled on the date of the positive depression screen for 30 days, with no gaps. The health plan should also consider the impact of the enrollment requirements on denominator size for the measure.

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Criteria	Score	HSAG Feedback and Recommendations
		• The health plan should clarify that the denominator qualifying event, "outpatient primary care visit," must occur during the baseline measurement period. • In the step-by-step data collection description, the health plan should clearly define the terms, "effective date," "termination date," and, "evaluation period end date," with respect to the baseline measurement period. ***Follow-Up After a Positive Depression Screen:*** • The denominator description should specify "…during the baseline measurement period." • For age criteria, the health plan should specify the specific date for age determination for the baseline measurement period. Based on the documented baseline measurement period dates, it appeared age was determined as of 6/30/20. • The continuous enrollment requirements should specify that members must be enrolled for at least 30 days following the positive depression screen, with no gaps, in alignment with the Department-defined measure specifications. • The baseline data in Table 4b was reported incorrectly. If no members were identified for inclusion in the numerator and denominator, these values should be reported as zero and the percentage should be reported as N/A or NR, since a percentage cannot be calculated when the denominator is zero.

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Criteria	Score	HSAG Feedback and Recommendations
		• The health plan should clarify that the denominator qualifying event, "positive depression screening," must occur during the baseline measurement period. In addition, the health plan should describe how members with a positive depression screen occurring less than 30 days before the end of the measurement period are handled for the measure. **Re-review April 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*.
3. The SMART Aims for *Depression Screening* and *Follow–up After a Positive Depression Screen* were stated accurately and included all required components: a) Narrowed focus b) Intervention(s) c) Baseline percentage d) Goal percentage e) End date	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening:*** • The SMART Aim should reference the health plan, not just the narrowed focus provider, in the SMART Aim. For example, "By 6/30/2022, RMHP will partner with Mountain Family Health Centers to use key driver diagram interventions…" ***Follow-Up After a Positive Depression Screen:*** • The SMART Aim should reference the health plan, not just the narrowed focus provider, in the SMART Aim. For example, "By 6/30/2022, RMHP will partner with Mountain Family Health Centers to use key driver diagram interventions…" • The baseline percentage of 0% was incorrect, based on the data reported in Table 4b. The health plan will need to revise the baseline and goal percentages in the SMART Aim, once a baseline rate can be calculated.

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Criteria	Score	HSAG Feedback and Recommendations
		Re-review April 2021: The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met.* A general comment was added. **General Comment:** Using the narrowed focus baseline data for the *Follow-Up* measure, it was impossible for the health plan to determine a goal that represented statistically significant improvement. Therefore, it was acceptable for the health plan to set a goal for the *Follow-Up* SMART Aim that was based on a benchmark instead.
4. The SMART Aim run charts for *Depression Screening* and *Follow–Up After a Positive Depression Screen* included all required components: a) Run chart title b) Y-axis title c) SMART Aim goal percentage line d) Narrowed focus baseline percentage line e) X-axis months	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening:*** • The run chart title should include the age range for members in the narrowed focus. ***Follow-Up After a Positive Depression Screen:*** • The run chart title should include the age range for members in the narrowed focus and specify follow-up *within 30 days*. • The health plan will need to revise the baseline and goal percentage lines plotted on the run chart to address the feedback provided for Criteria #3 and #4. **Re-review April 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met.*

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Criteria	Score	HSAG Feedback and Recommendations
5. The health plan completed the attestation and confirmed the SMART Aim run chart measurement data will be based on the rolling 12-month methodology.	☒ Met ☐ Not Met	
6. The health plan accurately completed all required components of the key driver diagrams for *Depression Screening* and *Follow–Up After a Positive Depression Screen*. The drivers and interventions were logically linked and have the potential to impact the SMART Aim goal in each key driver diagram.	☒ Met ☐ Not Met	HSAG identified the following opportunities for improvement: ***Depression Screening:*** • The SMART Aim should be revised to address feedback for Criterion #3. • The health plan should revise the key driver description, *Leverage current eCQM performance…*, with additional detail/context to clearly demonstrate how this driver will support achievement of the SMART Aim goal (increasing depression screening among members 12 years of age and older). ***Follow-Up After a Positive Depression Screen:*** • The SMART Aim should be revised to address feedback for Criterion #3. • The health plan should revise the key driver description, *Leverage current eCQM performance…*, with additional detail/context to clearly demonstrate how this driver will support achievement of the SMART Aim goal (increasing depression screening among members 12 years of age and older). **Re-review April 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has *Met*.

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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

PIP Initiation (Module 1)

☒ Pass

Date: April 13, 2021