COLORADO

Department of Health Care Policy & Financing

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

Fiscal Year 2019–2020 PIP Validation Report

for

Rocky Mountain Health Plans

Region 1

April 2020

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 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) 2019–2020, 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. One RAE, **Rocky Mountain Health Plans Region 1**, referred to in this report as **RMHP R1**, holds a contract with the State of Colorado for provision of healthcare services for Health First Colorado, Colorado's Medicaid program.

For FY 2019–2020, the Department required RAEs to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i-iv), and each PIP must include:

Measurement of performance using objective quality indicators.

- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation 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, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on January 27, 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, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

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 18 months.

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 developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to Validation

HSAG obtained the data needed to conduct the PIP validation from **RMHP R1**'s module submission forms. In FY 2019–2020, these forms provided detailed information about **RMHP R1**'s PIPs and the activities completed in Module 3. (See Appendix A. Module Submission Forms.)

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 *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 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 2019–2020, **RMHP R1** submitted the following PIP topics for validation: *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* and *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older.*

RMHP R1 defined a Global Aim and SMART Aim for each 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 each 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 is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain 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 PIP titles and SMART Aim statements selected by **RMHP R1**.

Table 1-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statements
Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18	By June 30, 2020, increase the percentage of well-child visits among RAE members at Mountain Family Health Center 15–18 years of age, from 36.74% to 40.67%.
Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older	By June 30, 2020, increase the percentage of depression screenings among RAE members attributed to Colorado Mountain Medical ages 11 years and older, from 0.0% to 20.0%.

The focus of the well–child visits PIP is to increase the rate of well–child visits among members 15 through 18 years of age who receive care from the narrowed focus provider group. The focus of the behavioral health PIP is to increase the percentage of members 11 and older who receive a depression screening with the narrowed focus provider group. Table 1-2 summarizes the progress **RMHP R1** has made in completing the five PIP modules for each PIP.

Table 1-2—PIP Title and Module Status

PIP Title	Module	Status
Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in August 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.
Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older	1. PIP Initiation	Completed and achieved all validation criteria.
	2. SMART Aim Data Collection	Completed and achieved all validation criteria.
	3. Intervention Determination	Completed and achieved all validation criteria.
	4. Plan-Do-Study-Act (PDSA)	Initiated in August 2019, with PDSA cycles continuing through SMART Aim end date of June 30, 2020.
	5. PIP Conclusions	Targeted submission for October 2020.

At the time of the FY 2019–2020 PIP validation report, **RMHP R1** had passed Module 1, Module 2, and Module 3, achieving all validation criteria for each PIP. **RMHP R1** has progressed to intervention testing in Module 4—Plan-Do-Study-Act. The final Module 4 and Module 5 submissions are targeted for October 2020; HSAG will report the Module 4 and Module 5 validation findings and the level of confidence assigned to each PIP in the FY 2020–2021 PIP validation report.

Validation Findings

In FY 2019–2020, **RMHP R1** completed and submitted Module 3 for validation for each PIP. Detailed module documentation submitted by the health plan is provided in Appendix A. Module Submission Forms.

The objective of Module 3 is for the MCO to determine potential interventions for the project. In this module, the MCO asks and answers the question, "What changes can we make that will result in improvement?"

The following section outlines the validation findings for each PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

Module 3: Intervention Determination

In Module 3, **RMHP R1** completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions for each PIP.

Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18

Table 2-1 summarizes the potential interventions **RMHP R1** identified for the *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-1—Intervention Determination Summary for the *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* PIP

Failure Modes	Potential Interventions
Member attends an appointment, but the care team does not identify the needed WCV services	Ongoing compliance program including staff education and follow-up to ensure that pre-visit planning (PVP) is consistently performed and communicated to the care team
Dental or behavioral health team does not identify member due for WCV services	• Dental and behavioral health PVP development with a whole-person approach and connection to all service lines • Inclusion in ongoing compliance program (described above)
No registry for tracking WCV services available	• Registry development • Use of registry to track targeted text message WCV reminders, incentives, and education for members

At the time of this FY 2019–2020 PIP validation report, **RMHP R1** had completed Module 3 and initiated the intervention planning phase in Module 4. **RMHP R1** submitted one intervention plan in July 2019 for the WCV PIP. Table 2-2 summarizes the intervention **RMHP R1** selected for testing through PDSA cycles for the *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* PIP.

Table 2-2—Planned Intervention for the *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* PIP

Intervention Description	Key Drivers	Failure Mode
Registry-based outreach campaign to identify members due for well visits, send and track text message WCV reminders, and track scheduled and completed well visits	Ensure member knowledge of recommended annual well visit and the importance of preventative healthcare	No registry currently available to identify members due for a WCV

For the WCV PIP, **RMHP R1** selected one intervention for testing in Module 4. The intervention had a system-focused component and a member-focused component. For the system-focused component, the health plan developed a registry to identify members 15 through 18 years of age who were due for a well visit, initiate automated text message reminders, and track scheduled and completed well visits for members in the registry. For the member-focused component, **RMHP R1** conducted targeted text messaging to members identified in the registry as being due for a well visit. HSAG reviewed the intervention plan and provided written feedback and technical assistance to **RMHP R1**. The health plan is currently in the "Do" stage, testing and evaluating the impact of the intervention. HSAG will report the intervention testing results and final Module 4 and Module 5 validation outcomes in the next annual PIP validation report.

Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older

Table 2-3 summarizes the potential interventions **RMHP R1** identified for the *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older* PIP to address high-priority subprocesses and failure modes determined in Module 3.

Table 2-3—Intervention Determination Summary for the *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older* PIP

Failure Modes	Potential Interventions
Member unaware of the need for a wellness visit, which would provide an opportunity to receive a depression screening	Member outreach campaign using the *Relatient* system, to identify RAE members due for a wellness visit, send reminders, track scheduled and completed wellness visits, and track completed depression screenings for targeted members
Member non-compliance with wellness visit; missed opportunity for depression screening	*Relatient* outreach campaign implementation to send wellness visit reminder alerts to members through text message, email, and phone

Failure Modes	Potential Interventions
Current data collection process for capturing completed depression screens is unreliable and subject to delays	*Relatient* implementation to provide more reliable direct interface with the electronic health record; the system will use newly acquired tablet technology in the provider office; and patients will be able to remotely check-in and complete screenings prior to arriving for the appointment

At the time of this FY 2019–2020 PIP validation report, **RMHP R1** had completed Module 3 and initiated the intervention planning phase in Module 4. **RMHP R1** submitted one intervention plan for the PIP. Table 2-4 summarizes the intervention **RMHP R1** selected for testing through PDSA cycles for the *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older* PIP.

Table 2-4—Planned Intervention for the *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older* PIP

Intervention Description	Key Driver	Failure Modes
Member outreach campaign using the *Relatient* system, to identify RAE members due for a wellness visit, track scheduled and completed wellness visits, and track completed depression screenings for targeted members. The intervention will also include workflow review with providers to reinforce offering depression screenings during wellness visits and proper coding of completed depression screenings.	Member awareness of the importance and benefits of preventive care and services	• Member unaware of the need for a wellness visit, which would provide an opportunity to receive a depression screening • Member noncompliance with annual wellness visit; missed opportunity for depression screening • Current data collection process for capturing completed depression screens is unreliable and subject to delays

For the behavioral health PIP, **RMHP R1** selected one intervention to test using PDSA cycles in Module 4. The intervention included a member-focused outreach component to address member awareness and compliance, a system-focused component to address data access and availability, and a provider-focused component to address depression screening coding issues through workflow. HSAG reviewed the intervention plan for the intervention and provided written feedback and technical assistance to **RMHP R1**. The health plan is currently in the "Do" stage of the PDSA cycles for all interventions, carrying out the intervention and evaluating impact for each PIP. HSAG will report the intervention testing results and final Module 4 and Module 5 validation findings in the next annual PIP validation report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **RMHP R1** successfully completed Module 3 for both PIPs. For the *Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18* PIP, the health plan identified opportunities for improving the process related to obtaining a well visit for members 15 through 18 years of age, and for the *Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older* PIP, the health plan identified opportunities for improving the process related to members receiving a depression screening during a wellness visit. **RMHP R1** further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps and increase the percentage of members who receive a well visit and a depression screening during a wellness visit, when appropriate.

The health plan also successfully initiated Module 4 for both PIPs by selecting interventions to test and documenting a plan for evaluating the impact of each intervention through PDSA cycles. **RMHP R1** will continue testing interventions for the PIPs through June 30, 2020. The health plan will submit complete intervention testing results and PIP conclusions for each PIP for validation in FY 2020–2021. HSAG will report the final validation findings for the PIP in the FY 2020–2021 PIP validation report.

Recommendations

- When planning a test of change, **RMHP R1** should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out.
- To ensure a methodologically sound intervention testing methodology, **RMHP R1** should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- **RMHP R1** should consistently use the approved Module 2 SMART Aim measure data collection and calculation methods for the duration of the PIP so that the final SMART Aim measure run chart provides data for a valid comparison of results to the goal.
- When reporting the final PIP conclusions, **RMHP R1** should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement.
- If improvement is achieved through the PIP, **RMHP R1** should develop a plan for continuing and spreading effective interventions and sustaining improvement in the long term.

Appendix A. Module Submission Forms

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

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Determination Submission
Improving Well–Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18
for Rocky Mountain Health Plans Region 1 (RAE 1)

Managed Care Organization (MCO) Information	
MCO Name:	Rocky Mountain Health Plans
PIP Title:	Improving Well Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15-18
Contact Name:	Jeremiah Fluke
Contact Title:	Community Integration Quality Analyst
E-mail Address:	Jeremiah.Fluke@rmhp.org
Telephone Number:	541-709-6609
Submission Date:	Mary 13, 2019
Resubmission Date:	June 14, 2019

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Process Mapping

Indicate when the process map(s) was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 1—Process Mapping Team	
Development Period	
04/02/2019 to 05/13/2019	
Team Members Involved	**Role/Responsibilities**
Jeremiah Fluke, RMHP	RMHP PIP Lead
Shane Daniels, RMHP	RMHP Data Analyst, data reporting
Alex Vincent, MF	MFHC Quality Manager, MFHC Project Development Lead
Margarito Flores, MFHC	MFHC Director of Operation, Operations Oversight
Eleana Price, MFHC	MFHC Operations Manager, Operations Implementation
Kaitlyn McGovern, MFHC	MFHC Quality Officer, PDSA facilitation and data monitoring

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Failure Modes and Effects Analysis (FMEA)

Indicate when the FMEA was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
04/02/2019 to 05/13/2019	
Team Members Involved	**Role/Responsibilities**
Jeremiah Fluke, RMHP	RMHP PIP Lead
Shane Daniels, RMHP	RMHP Data Analyst, data reporting
Alex Vincent, MF	MFHC Quality Manager, MFHC Project Development Lead
Margarito Flores, MFHC	MFHC Director of Operation, Operations Oversight
Eleana Price, MFHC	MFHC Operations Manager, Operations Implementation
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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Process Map for RAE Members (also attached as additional page):

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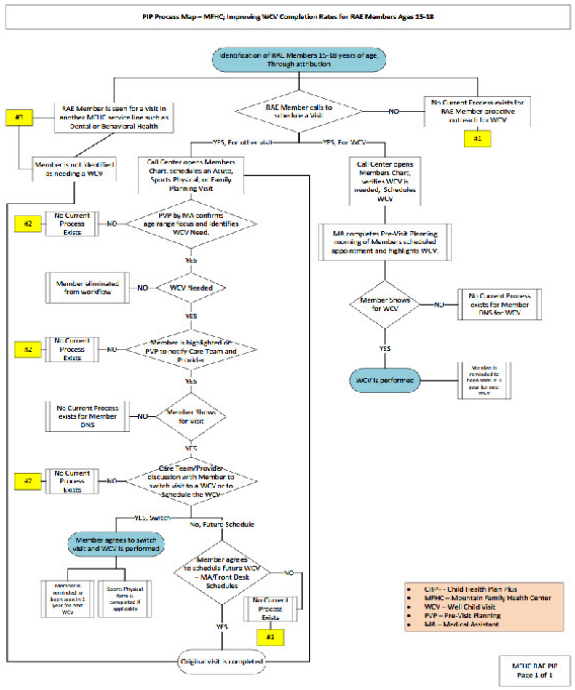

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Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Description of process and rationale for selection of subprocesses:

In developing the process map, MFHC identified the following subprocesses that contain gaps and opportunities (failure modes) for process improvement and increasing completion rates for WCVs.

#1 – No proactive process is in place for outreach to Members who may need a WCV. Evaluations and comparisons have not been completed to determine if internal report development is needed or if using the attribution listing will be sufficient for this outreach. In addition, Members may not be seen in clinic for an acute visit that could be potentially switched to WCV or Member is not a very frequent utilizer of services, so does not contact clinic – this would include Members who may be attributed, but have never been seen by MFHC.

#2 – Member is seen in clinic for an acute visit, not identified initially as a WCV. It was identified that there are multiple steps within the appointment process where the WCV need could be identified, but is often missed. This would include PVP – where age and WCV need is identified, also a potential lack of notification to the Care Team, the discussion by Care Team/Provider does not occur to potential switch current visit to a WCV, and lastly the Member may not agree to schedule a future WCV.

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

#3 – Member is seen in another service line such as Dental or Behavioral Health – it was identified that Members seen in these service lines are not identified for a WCV need. In addition, there is a gap in process to review the electronic medical record to identify appointment history.

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Failure Modes and Effects Analysis

From the completed process map(s), enter up to three subprocesses that have the potential to make the greatest impact on the SMART Aim. The assigned priority number in the process map should align with the subprocess number in the FMEA table. This will help clearly link each opportunity for improvement to an identified subprocess.

Complete the table with the corresponding failure modes, failure causes, and failure effects.
Note: The MCO should ensure that the same language is used consistently to describe the failure modes throughout Modules 3, 4, and 5.

Table 3—Failure Modes and Effects Analysis Table

Subprocesses	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. Member is not identified for WCV	Member does not call for a visit	Lack of education, lack of health need	Member does not receive WCV at this time
	Member does not come in for acute visit	Lack of education, lack of health need	Member does not receive WCV at this time
	No registry available	Lack of development, deciding on listing from RMHP or MFHC E.H.R.	Member does not receive WCV
2. Member is seen in clinic but a WCV is not identified or is not scheduled for future appt.	Member comes in for "visit" but the Care Team does not identify WCV need	Lack PVP, forgetting to address this in the "visit"	Member does not receive WCV at this time
	Member comes in for "visit" but the Care Team does not identify WCV need	Lack PVP, forgetting to address this in the "visit"	More difficulty in engaging and recalling Member due to just being seen otherwise and not proactively identified.
	Member comes in for "visit" but does not agree to switch the current visit to a WCV or schedule a future WCV	Member non-compliance/decline services	Member is not seen for a WCV at this time.

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3. Member is seen in a different MFHC service line such as Dental or BH, and is not identified for	Dental/BH Team does not identify Member for WCV	Not currently running PVP reports	Member is not seen for a WCV at this time.
	Dental/BH Team does not identify Member for WCV	No current process for proactive identification	Member is not seen for a WCV at this time.
	Electronic Health Record (E.H.R.) and Electronic Dental Record (E.D.R.) don't talk well with each other, meaning that the different service line providers may not be aware of the other providers seeing Member within this organization	E.H.R. and E.D.R. don't talk well, lack of current integrated and collaborative communication between service lines.	Member is not identified for WCV and does not receive a WCV at this time.

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Failure Mode Priority Ranking

Based on the results of the priority ranking process, list the numerically ranked failure modes from highest to lowest priority. In the space below the table, please describe the process used to assign the priority ranking.

Table 4—Failure Mode Priority Ranking

Priority Ranking	Failure Modes
1	Member comes in for "visit" but the Care Team does not identify WCV need
2	Dental/BH Team does not identify Member for WCV
3	No Registry available
4	Member does not come in for acute visit
5	Member does not call for a visit
6	E.H.R. and E.D.R. don't talk well with each other, meaning that the different service line providers may not be aware of the other providers seeing Member within this organization.
7	Member comes in for "visit" but does not agree to switch the current visit to a WCV or schedule a future WCV

Description of priority ranking process (i.e., Risk Priority Number (RPN) method). If the RPN method was used, please provide the numeric values from the calculations:

For this FMEA, the priority ranking was completed by the team subjectively. Shown in the priority ranking table as #1, Member comes in for "visit" but the Care Team does not identify WCV need. Impact to the SMART AIM is highest here as the Care Team has clear opportunity to capture the wellness visit for the patient since they are physically being seen in the clinic. Secondarily as #2, the team identified that a Member who is seen in another MFHC service line such as Dental or Behavioral health, may not be identified to

need a WCV. This could impact the SMART AIM with workflow adjustments and developments for PVP to ensure a whole-person approach is taken to ensure connection to all services lines and care needs. Lastly, ranking at #3, The team identified that the highest impact on the WCV PIP Smart AIM would be a proactive approach to increase the completion of WCVs in the CHP+ Member population, thus the gap is identified as needing a registry function and reminder system to outreach patients needing their wellness visits.

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Intervention Determination

In the Intervention Determine table, enter at a minimum, the top three ranked failure modes and the identified intervention to address the failure mode.

Table 5—Intervention Determination Table	
Failure Modes	**Interventions**
Member comes in for "visit" but the Care Team does not identify WCV need	Create ongoing compliance program to include Staff follow up and re-education to ensure that PVP is performed and communicated to the Care Team consistently.
Dental/BH Team does not identify Member for WCV	Dental & BH PVP development to include a whole-person process and ensure connection to all service lines. Once completed, Create ongoing compliance program to include Staff follow up and re-education to ensure that PVP is performed and communicated to the Care Team consistently.
No Registry available	Proactive approaches: Registry Development, Targeted Text Message Reminders for WCV, Gift Card Incentives potential, Education development for Members

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Managed Care Organization (MCO) Information	
MCO Name:	Rocky Mountain Health Plans
PIP Title:	Increase the number of depression screenings completed for RAE Members ages 11 and older
Contact Name:	Jeremiah Fluke
Contact Title:	Community Integration Quality Analyst
E-mail Address:	Jeremiah.Fluke@rmhp.org
Telephone Number:	541-709-6609
Submission Date:	May 15, 2019
Resubmission Date:	June 15, 2019

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Process Mapping

Indicate when the process map(s) was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 1—Process Mapping Team	
Development Period	
04/02/2019 to 05/15/2019	
Team Members Involved	**Role/Responsibilities**
Jeremiah Fluke, RMHP	PIP Lead
Shane Daniels, RMHP	Data Analyst and Reporting
Darren Lacy, CMM	Clinical Application Analyst, Workflow development
Ada Borg, CMM	Chief Strategy Officer, Operations
Sharrie Bindle, CMM	Front Office Manager, Front Desk Operations Implementation

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Failure Modes and Effects Analysis (FMEA)

Indicate when the FMEA was completed and list all team members involved. Describe the role and responsibilities for each individual team member. The team should include a data analyst. The analyst can assist with determining data needed for prioritization of subprocesses and failure modes and proposed interventions.

Table 2—Failure Modes and Effects Analysis Team	
Development Period	
04/02/2019 to 05/15/2019	
Team Members Involved	**Role/Responsibilities**
Jeremiah Fluke, RMHP	PIP Lead
Shane Daniels, RMHP	Data Analyst and Reporting
Darren Lacy, CMM	Clinical Application Analyst, Workflow development
Ada Borg, CMM	Chief Strategy Officer, Operations
Sharrie Bindle, CMM	Front Office Manager

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Process Map for RAE Members (also attached as additional page)**:**

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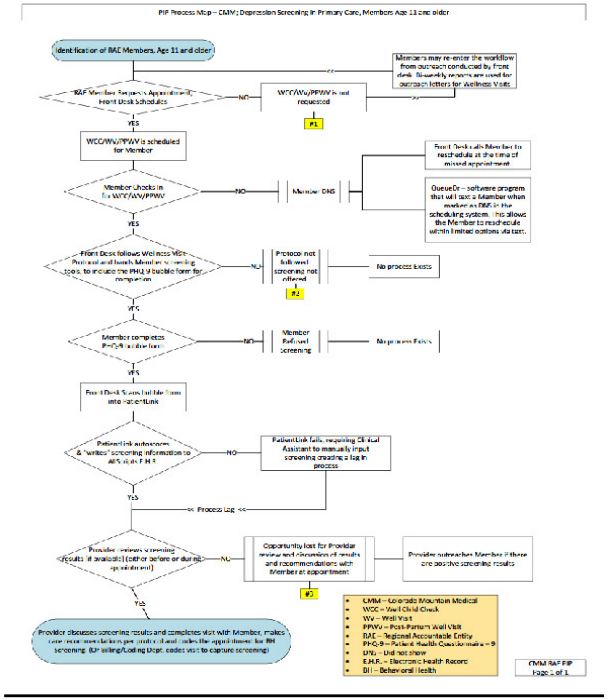

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

Description of process and rationale for selection of subprocesses:

Prior to 2019, CMM did not have a structure process in place for completing depression screening for any patient in their clinic system. Wellness visits were identified by the CMM Quality Improvement Team as the best avenue to complete depression screenings. Upon development of clinic workflows, the following subprocesses had identified gaps (failure modes).

#1 – It was identified that patients, including RAE Members, were not specifically being outreached in a targeted approach for completion of a wellness visit. This wellness visit includes the depression screening in CMM's newer workflow. The gap was identified where patients were not being screened for depression due to not specifically requesting a well visit. Secondarily, upon member request, the Front desk then identifies the well visit need and will schedule the visit. However, there are occasions where the Member does not show (DNS) for the visit. A reschedule may occur by outreach from Front Desk or by text communication from the QueueDr, if the member agrees.

#2 – Once the Member checks in for their visit, the Front desk follows a Wellness Protocol to identify the specific screenings needed for the wellness visit. In this subprocess, the Front Desk may fail to follow that protocol and does not give the Member the screening tool. Alternatively, the Front Desk does follow the protocol, gives the Member the screening tool, however, the Member may refuse to complete the screening.

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Process Mapping

Develop a process map that aligns with the SMART Aim measure from the perspective of the person most impacted by the overall process (typically the member). The MCO may need to complete and submit more than one process map (i.e., member-level, provider-level, MCO-level, new members, existing members, etc.).

Clearly identify subprocesses (opportunities for improvement) within the process map. These subprocesses will be used in the FMEA table. Assign a numerical value to each identified subprocess based on having the greatest potential of impacting the SMART Aim. In addition to providing the process map(s), provide a narrative description of the PIP team's process and rationale for the selection of subprocesses with the greatest impact on the SMART Aim.

#3 – Once the Member completes the screening, the Front Desk scans the form into the software PatientLink. There are occasions where there is a technical failure and the PatientLink software does not interface with the E.H.R. creating a lag in process, whereas the provider may not receive the results timely. In addition, if the results are not readily available, the Provider may forget to request a hard copy of the results to be manually entered into the E.H.R. which also prevents discussion of results and potential recommendation of treatment with Member.

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Failure Modes and Effects Analysis

From the completed process map(s), enter up to three subprocesses that have the potential to make the greatest impact on the SMART Aim. The assigned priority number in the process map should align with the subprocess number in the FMEA table. This will help clearly link each opportunity for improvement to an identified subprocess.

Complete the table with the corresponding failure modes, failure causes, and failure effects.
Note: The MCO should ensure that the same language is used consistently to describe the failure modes throughout Modules 3, 4, and 5.

Table 3—Failure Modes and Effects Analysis Table

Subprocesses	Failure Modes (What could go wrong?)	Failure Causes (Why would the failure happen?)	Failure Effects (What are the consequences?)
1. Well child check (WCC), Well Visit (WV), or Post-Partum Well Visit (PPWV) is not requested	Member unaware need for wellness visit, to include depression screening	Did not receive the Wellness Outreach letter	The Member does not receive a depression screening.
	Member non-compliance with Wellness Visit, to include depression screening	Member declines to complete the Wellness visit to include the depression screening or Member forgot	The Member does not receive a depression screening.
2. Front Desk does not follow protocol, whereas screening is not offered.	Front desk busy and doesn't give the appropriate forms	Lack of following protocol	The Member does not receive a depression screening.
	Member is late and Front Desk rushes to get Member checked in for visit	Member is running late for appt.	The Member does not receive a depression screening.

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3. Opportunity lost for Provider review and discussion of results and recommendations with Member	PatientLink fails, manual entry creating a lag in available results	Software malfunction	The Member does not receive a depression screening.
	Lack of time in appointment	Member was late to the appointment or the screening results were not available.	The Member does not receive a depression screening.
	Provider forgets	Lack of following protocol	The Member does not receive a depression screening.

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Failure Mode Priority Ranking

Based on the results of the priority ranking process, list the numerically ranked failure modes from highest to lowest priority. In the space below the table, please describe the process used to assign the priority ranking.

Table 4—Failure Mode Priority Ranking

Priority Ranking	Failure Modes
1	Member unaware need for wellness visit, to include depression screening
2	Member non-compliance with Wellness Visit, to include depression screening
3	PatientLink fails, manual entry creating a lag in available results
4	Member is late and Front Desk rushes to get Member checked in for visit
5	Provider forgets
6	Front desk busy and doesn't give the appropriate forms
7	Lack of time in appointment

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Description of priority ranking process (i.e., Risk Priority Number (RPN) method). If the RPN method was used, please provide the numeric values from the calculations:

For the FMEA, the Team subjectively ranked the failure modes according to the highest impact on the SMART AIM. The team felt that the highest opportunity, ranked as #1, was to proactively engage or re-engage Members to complete depression screenings in their Wellness Visits through a new campaign using outreach mechanisms to do initial outreach or recall the Member if they are not aware of the need to complete a Wellness Visit. For the 2nd priority ranking, a Member may be non-compliant and not want to complete a wellness visit. To close this gap and impact the SMART AIM, the intent is to use electronic alerts as reminders to increase chances that the member will complete the wellness visit, thus completing the depression screening. Lastly, the Team felt the 3rd highest impact on the SMART AIM related technology improvements. On occasion, the *PatientLink* software fails and manual entry is needed for the depression screening results. This creates a process lag that can lead to not having results available for provider review and discussion with the Member. This also creates an opportunity for the provider to forget and not address the depression screening in the wellness visit.

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Intervention Determination

In the Intervention Determine table, enter at a minimum, the top three ranked failure modes and the identified intervention to address the failure mode.

Table 5—Intervention Determination Table

Failure Modes	Interventions
Member unaware need for wellness visit, to include depression screening	*Relatient* implementation – creating a specific health campaign for RAE Members to outreach for Wellness visits
Member non-compliance with Wellness Visit, to include depression screening	*Relatient* implementation, Alert for reminder of wellness – through text message, email, phone
PatientLink fails, manual entry creating a lag in available results	*Relatient* implementation, more reliable direct interface with E.H.R. This is using newly acquired iPad's. In addition, using the Relatient system, patients are able to check-in and complete screenings for their appointment prior to physically arriving.

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	
2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The health plan did not number the subprocesses on the process map that were identified as opportunities for improvement or gaps in care. • To align with the SMART Aim measure, it appears that the starting point for the process map should be "RAE members 15-18 years of age." • It appears that the following steps in the process map should be decision points with yes/no options. Unless these steps occur 100% of the time in the process, the process map should include steps that follow if they do not occur or note "no process exists." ○ "RAE member calls to schedule Well-Child Visit…" ○ "Pre-Visit Planning (PVP) by MA confirms age range focus and identifies WCV need" ○ "Member is highlighted on PVP to notify Care Team and Provider," ○ "Care Team/Provider discussion with Member to switch to a WCV or to Schedule a WCV" ○ "Member agrees to schedule WCV – MA/Front Desk Schedules."

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		○ It appears the step, "Medical Assistant completes Pre-Visit Planning morning of members scheduled appointment and highlights WCV" should lead directly into "Member shows for WCV." **Re-review June 2019:** The health plan addressed HSAG's feedback. The criterion was achieved.
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	The health plan provided a narrative description of the process map; however, it did not provide a description of the process and rationale for selecting subprocesses from the process map for the FMEA. The health plan should revise the narrative description on pages 6-7 to clearly identify the subprocesses in the process map with greatest opportunity for improvement and explain how the health plan determined that these subprocesses were selected as highest priority. **Re-review June 2019:** The health plan addressed HSAG's feedback. The criterion was achieved.
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The subprocesses in the FMEA should be easily identifiable steps within the process map, i.e., numbered and worded the same. • The third subprocess was missing a failure mode (2nd was left blank).

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		• The health plan should ensure all acronyms in the FMEA table (e.g., E.D.R.) are spelled out to clearly document failure modes and causes. **Re-review June 2019:** The health plan addressed HSAG's feedback. The criterion was achieved.
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	The health plan described a ranking process; however, it appeared that the health plan ranked the subprocesses instead of the failure modes listed in the FMEA table. **Re-review June 2019:** The health plan addressed HSAG's feedback. The criterion was achieved.
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The Intervention Determination table should include ranked **failure modes** in the left side column. The failure mode descriptions should be consistent throughout Tables 3, 4, and 5. • The intervention descriptions were broad and did not include enough detail to be clear what the change is. Each intervention should be clearly linked to a specific failure mode and should be a specific change that could be tested.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		Re-review June 2019: The health plan addressed HSAG's feedback. The criterion was achieved.

Intervention Determination (Module 3)

☒ Pass

Date: June 24, 2019

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
1. The documentation included the team members responsible for completing the process map(s) and failure mode and effects analysis (FMEA).	☒ Yes ☐ No	
2. The documentation included a process map(s) illustrating the step-by-step flow of the current process. The subprocesses identified in the process map(s) as opportunities for improvement were prioritized and assigned a numerical ranking.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The health plan did not number the selected subprocesses on the process map that were identified as opportunities for improvement or gaps in care. • It appears that the starting point for the process map should be "RAE members that are 11 years and older," based on the narrative on page 6 and the SMART Aim measure definition in Module 2. The second step as a decision point would be, "WCC/WV/PPWV is requested" with yes/no. • It appears that the step, "Front desk follows Wellness Visit Protocol and hands member screening tools, to include the PHQ-9 bubble form for completion" should be a decision point with yes/no options. **Re-review June 2019**: The health plan addressed HSAG's feedback; however, the two steps labeled #1 ("WCC/WV/PPWV is not requested" and "Member DNS") and the other step labeled #2 ("Protocol not followed: screening not offered" and "Member refused screening") appeared to be four separate steps that should be labeled as four separate subprocesses, labeled #1

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		through #4. The subprocess labeled #3 should be labeled #5 to distinguish the five different subprocesses identified for improvement in the process map. **Re-review July 2019:** The health plan revised the process map to identify three individual steps as the top three subprocesses in need of improvement. The criterion was achieved.
3. The health plan included a description of the process and rationale used for the selection of subprocesses in the FMEA table.	☒ Yes ☐ No	The health plan provided a narrative description of the process map; however, it did not provide a description of the process and rationale for selecting subprocesses from the process map for the FMEA. The health plan should revise this narrative description to clearly identify the subprocesses in the process map with greatest opportunity for improvement and explain how the health plan determined that these subprocesses were selected as highest priority. **Re-review June 2019**: The health plan addressed HSAG's feedback. The criterion was achieved.
4. Each subprocess in the FMEA table aligned with a numerically ranked opportunity for improvement in the process map(s), and was logically linked to the documented failure modes, causes, and effects.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The subprocesses in the FMEA should be easily identifiable steps within the process map, i.e., numbered and worded the same. • Each subprocess in the FMEA should be one step from the process map. **Re-review June 2019**: As noted in HSAG's initial feedback, each subprocess identified in the process map and FMEA should be a single step in the

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
		process. The health plan should revise the FMEA to examine the two steps labeled as Subprocess #1 as two separate subprocesses and the two steps labeled as Subprocess #2 as two other subprocesses. If the PIP team determines that all five subprocesses have the potential to have a substantial impact on the SMART Aim, the health plan may choose to include all five identified subprocesses in the FMEA table. However, each identified subprocess should be one step from the process map and should be examined separately in the FMEA table. **Re-review July 2019:** The health plan addressed HSAG's feedback. The criterion was achieved.
5. The health plan described the failure mode priority ranking process. If the RPN method was used, the health plan provided the numeric calculations.	☒ Yes ☐ No	The health plan described a ranking process; however, it appeared that the health plan ranked the subprocesses instead of the failure modes listed in the FMEA table. **Re-review June 2019**: The health plan addressed HSAG's feedback. The criterion was achieved. **General Comment:** The health plan may need to revise the ranked failure modes in Table 4, based on HSAG's feedback provided for Criteria 3 and 4, above.

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Criteria	Achieved (Y/N)	HSAG Feedback and Recommendations
6. The interventions listed in the Intervention Determination table were appropriate based on the ranked failure modes.	☒ Yes ☐ No	HSAG identified the following opportunities for improvement: • The Intervention Determination table (Table 5) should include ranked **failure modes** in the left side column. The failure mode descriptions should be consistent throughout Tables 3, 4, and 5. • Some intervention descriptions were broad and did not include enough detail to be clear what the change is. Each intervention should be clearly linked to a specific failure mode and should be a specific change that could be tested. • All three interventions included patient education. How will education be provided to the patient? The health plan should be aware that passive education interventions such as mailers and robocalls are not recommended for the rapid-cycle PIP. • The third intervention included "handouts." The health plan should explain how the handouts would be delivered. For example, face-to-face. **Re-review June 2019**: The health plan addressed HSAG's feedback. The criterion was achieved. **General Comment:** The health plan should ensure that any intervention selected for testing in Module 4 is not passive and can be clearly evaluate for effectiveness and impact on the SMART Aim.

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Intervention Determination (Module 3)

☒ Pass

Date: July 15, 2019