COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2020–2021 PIP Validation Report

for

Rocky Mountain Health Plans Region 1

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

Table of Contents

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) 2018–2019, the Department entered into contracts with Regional Accountable Entities (RAEs) in seven regions throughout Colorado. Each Colorado RAE meets the federal definition of a PCCM entity.

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the state's EQRO. **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 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 R1**'s module submission forms. In FY 2020–2021, these forms provided detailed information about **RMHP R1**'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 R1** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen*.

RMHP R1 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 R1**.

Table 1-1—SMART Aim Statements

PIP Measures	SMART Aim Statements*
Depression Screening	By 06/30/2022, RMHP will partner with St Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE Members attributed to either SMFM or MFHC age 12 and older, from 0.1% to 20%.
Follow-Up After a Positive Depression Screen	By 06/30/2022, RMHP will partner with St Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of follow-ups within 30 days of a positive depression screen among RAE Members attributed to either SMFM or MFHC age 12 and older, from 6.3% to 46.89%.

*The SMART Aim statements are subject to change pending Module 1 resubmission, review, and approval.

The focus of the PIP is to increase the percentage of members 12 years of age and older, attributed to MFHC or SMFM, 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 final approved goals for improvement are pending resubmission by **RMHP R1** and review and approval by HSAG.

Table 1-2 summarizes the progress **RMHP R1** 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	Pending module resubmission, review, and approval.
	2. Intervention Determination	Initial submission targeted for June 2021.
	3. Intervention Testing	Targeted initiation July/August 2021.
	4. PIP Conclusions	Targeted for October 2022.

At the time of the FY 2020–2021 PIP validation report, **RMHP R1** was in the process of resubmitting Module 1 to address HSAG's feedback. Once all Module 1 validation criteria have been achieved for the PIP, **RMHP R1** will progress to Module 2, Intervention Determination. Final Module 1, 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 R1** closed out the *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* PIPs, which were initiated in FY 2018–2019. The health plan submitted a PIP close-out report describing the successes, challenges, and lessons learned from each project.

In FY 2020–2021, **RMHP R1** 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 R1** 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 *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* PIP close-out reports 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 R1** reported in the FY 2019–2020 PIP close-out report for the *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* PIPs.

Table 2-1—PIP Conclusions Summary

Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15–18 PIP	
Interventions	Registry-based automated text outreach system for well-child visits.
Successes	• Established a registry-based automated text outreach system. • Gained information on which members could not be reached, which will be used to explore alternative outreach methods.
Lessons Learned	• Increased understanding and competence in using text platforms for large-scale outreach efforts. • Member response to text outreach was lower than expected, suggesting that additional refinement of outreach methods is needed to best reach the adolescent member population.

Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older PIP	
Interventions	Relatient Health text message outreach campaign targeted toward members due for well care visit, which would include depression screening.
Successes	• Established data-driven tracking mechanism for outreach and scheduling well visits. • Improvement in depression screening rates during the project.
Lessons Learned	Consistent provider partner training on intervention and coding is essential to successful improvement.

Module 1: PIP Initiation

Table 2-2 presents the FY 2020–2021 validation findings for **RMHP R1**'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 06/30/2022, RMHP will partner with St Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE Members attributed to either SMFM or MFHC age 12 and older, from 0.1% to 20%.
Preliminary Key Drivers	• Provider compliance with standardized workflow for depression screening. • 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. • Incorporate accurate coding practices into standard depression screening workflow. • Produce provider education on appropriate depression screening coding and reporting practices.
Measure 2—*Follow-Up After a Positive Depression Screen*	
SMART Aim Statement*	By 06/30/2022, RMHP will partner with St Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) to use key driver diagram interventions to increase the percentage of follow-ups within 30 days of a positive depression screen among RAE Members attributed to either SMFM or MFHC age 12 and older, from 6.3% to 46.89%.
Preliminary Key Drivers	• Established workflow for patient follow-up care following a positive depression screen. • Referral and scheduling of follow-up visit in response to positive depression screen. • Appropriate billing practices for follow-up services.

Measure 2—*Follow-Up After a Positive Depression Screen*	
Potential Interventions	• Establish processes and workflows to define appropriate care when a patient screens positive for depression. • Develop standardized workflow for follow-up service billing and integration of Current Procedural Terminology (CPT) codes. • Track members who screen positive for depression and are in need of follow-up behavioral services.

*The SMART Aim statements are subject to change pending Module 1 resubmission, review, and approval.

In Module 1, **RMHP R1** set two goals to achieve by June 30, 2022:

- Increase the percentage of members 12 years of age and older, attributed to MFHC or SMFM, who receive a depression screening to 20.0 percent.
- Increase the percentage of members 12 years of age and older, attributed to MFHC or SMFM, 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 final goals for the project are pending resubmission, review, and approval. 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 R1**'s identified key drivers focused on provider workflows, provider knowledge, and tracking systems. **RMHP R1** has identified provider-focused and system-focused interventions that may be tested for the PIP. As the health plan progresses to Module 2, **RMHP R1** 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. Final validation findings for Module 1, 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 R1** was successful in building a quality improvement team and identifying potential collaborative partnerships with targeted providers. **RMHP R1** has opportunities for improvement in designing a data-driven, methodologically sound project that must be addressed before the PIP can pass Module 1.

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 R1** should clearly illustrate the step-by-step flow of current processes specific to narrowed focus providers and members.
- **RMHP R1** 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 R1** should assign the highest priority ranking to those failure modes that are believed to have the greatest impact on achieving the SMART Aim.
- **RMHP R1** 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 R1** progresses through determining and testing interventions.
- **RMHP R1** 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 R1** 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for **Rocky Mountain Health Plans**

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	Mary Beckner and Jeremiah Fluke
Contact Title	Quality Improvement Advisor
Email Address	Mary.beckner@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

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for **Rocky Mountain Health Plans**

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
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
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
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

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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, purportedly 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, whom 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), Follow-up after depression if positive and Well-Visits KPI. 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. 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) 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's access to care.(Medicaid.gov)

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

"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

Medicaid.gov (2020). Behavioral Health Services. Retrieved from https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html

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

Narrowed Focus Description

RMHP has identified St. Mary's Family Medicine (SMFM) and Mountain Family Health Centers (MFHC) as candidates for this performance improvement project. 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 SMFM and MFHC 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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	RAE 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	RAE 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 should be continuously enrolled on date of the positive depression screen for 30 days, with no gaps and attributed to SMFM or MFHC.
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)	N/A

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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: 11	Denominator: 1370	Percentage: 0.1%

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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 RAE
  ○ 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		

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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	Number of RMHP RAE Members >12 years of age and attributed to either MFHC or SMFM with a behavioral health visit within 30 days of a primary care visit during the baseline measurement period.
Denominator Description	Number of RAE members >=12 years of age and attributed to either SMFM or MFHC with a primary care visit during the baseline measurement period.
Age Criteria (if applicable)	>= 12 years of age as of 6/30/2020
Continuous Enrollment Specifications (if applicable)	Enrolled during the measurement period and attributed to either SMFM or MFHC.
Allowable Gap in Enrollment (if applicable)	N\A
Anchor Date (if applicable)	Last day of the month

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

Table 4a—Narrowed Focus Baseline Specifications – *Follow–Up After a Positive Depression Screen*	
Denominator Qualifying Event/Diagnosis with Time Frame (if applicable)	Behavioral Health Visit defined from code set found in BHIP follow-up criteria.

Rationale for selecting baseline and calculating specifications:
Practices are not currently using G-Code to identify positive depression screen, therefore calculating how many patients with a positive depression screen who are connected to behavioral health is not possible. Due to the lack of specificity in the reason for the behavioral health visit, the baseline was calculated for any eligible patient who had a behavioral health visit within 30 days of a primary care visit during the measurement period. This rational suggests that patients are connected with behavioral health services after a primary care visit who may be experiencing symptoms of depression captured with a PHQ-9 screen.

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: 29	Denominator: 457	Percentage: 6.3%

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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 RAE
  ○ 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 primary care well visit within the evaluation period
  ○ Exclude Members without continuous enrollment 30 days after well visit 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		

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of depression screenings completed among RAE Members attributed to either SMFM or MFHC age 12 and older, from 0.1% to 20%.

Follow-Up After a Positive Depression Screen:

By 06/30/2022, RMHP will partner with St Mary's Family Medicine and Mountain Family Health Centers to use key driver diagram interventions to increase the percentage of follow ups within 30 days of a positive depression screen among RAE Members attributed to either SMFM or MFHC age 12 and older, from 6.3% 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 RAE PIP is based upon the Region 1 FY 19/20 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

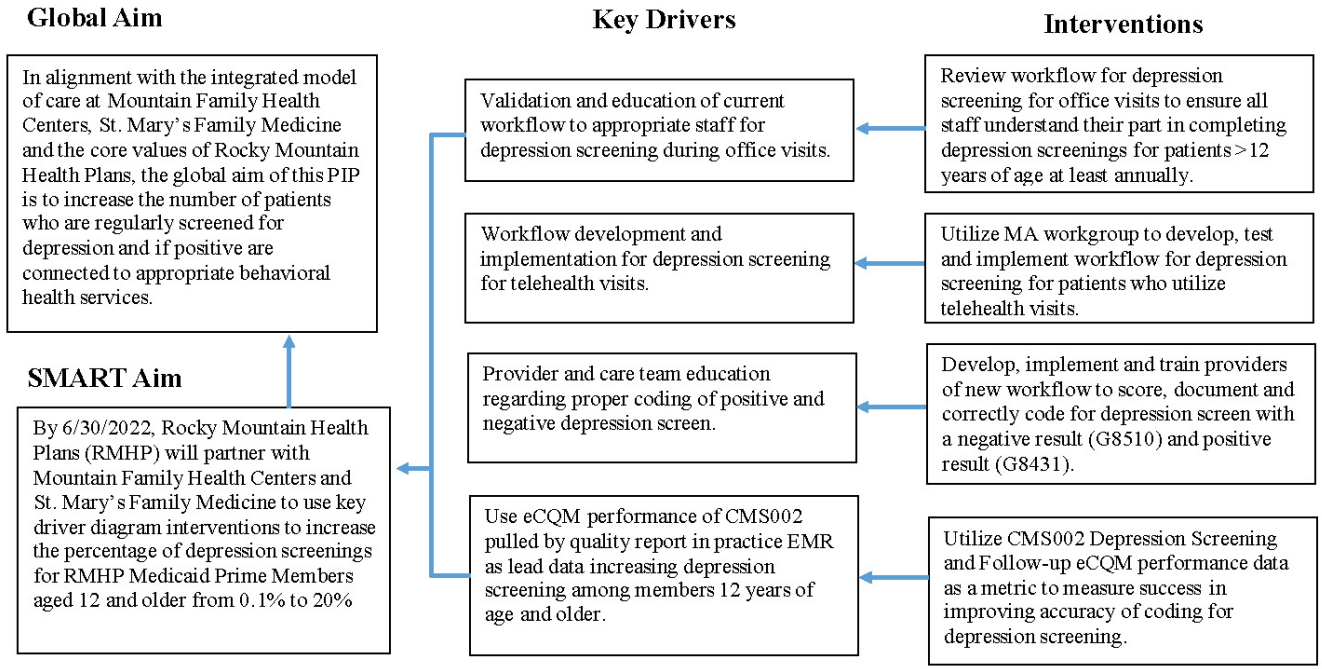
Key Driver Diagrams

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 complet 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 supp 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, Versi 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

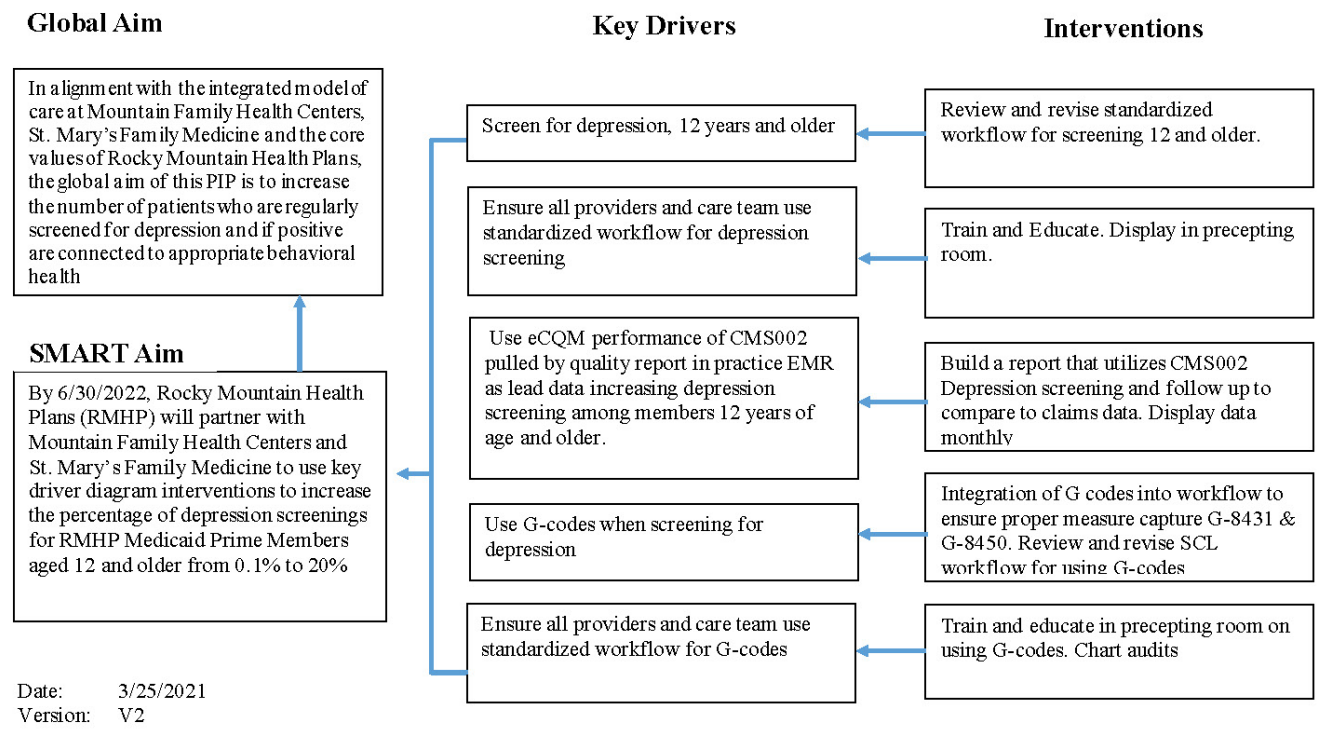
Key Driver Diagram– *Depression Screening Mountain Family Health Centers (MFHC)*



Date: 3/25/2021
Version: V2

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

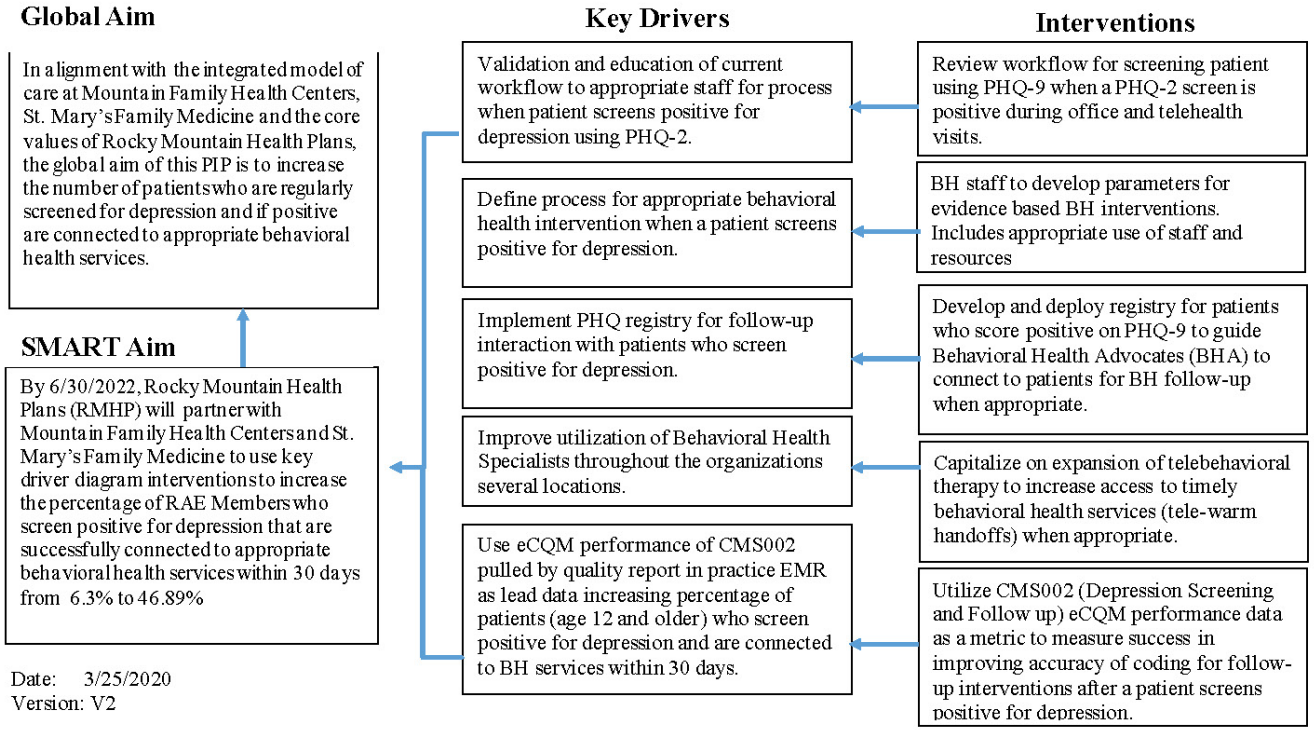
Key Driver Diagram– *Depression Screening St Mary's Family Medicine (SMFM)*



Date: 3/25/2021
Version: V2

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

Key Driver Diagram– *Follow–Up After a Positive Depression Screen Mountain Family Health Center (MFHC)*

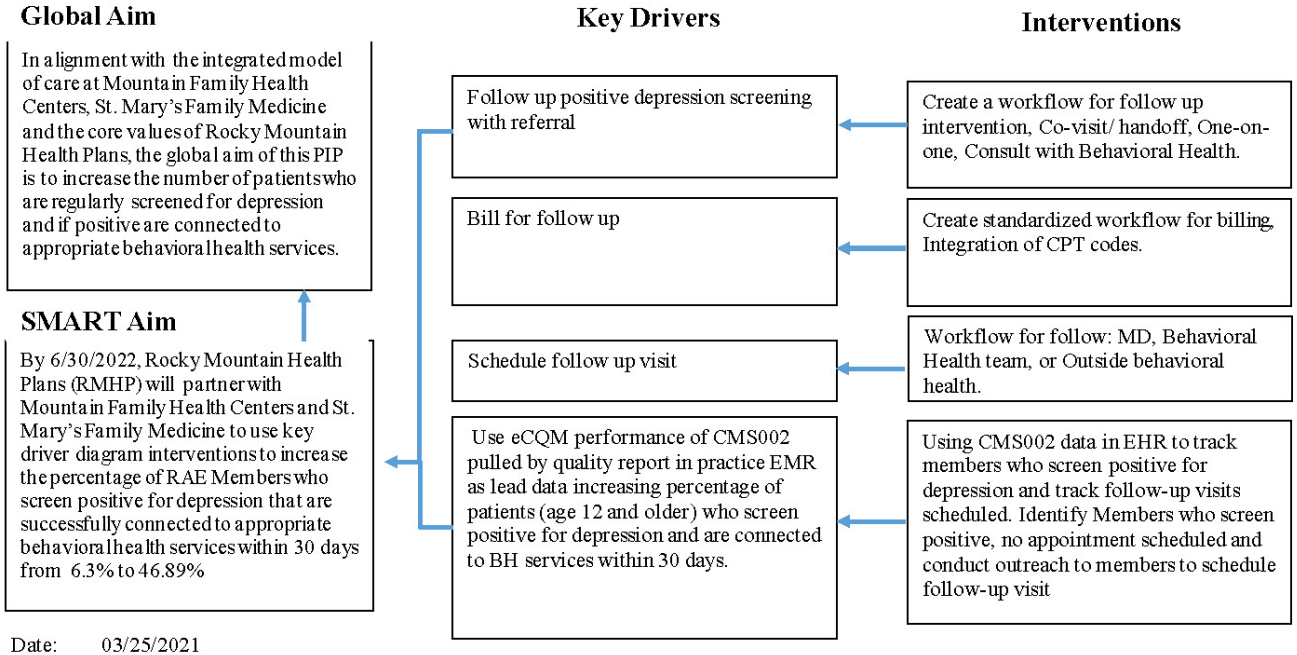


Date: 3/25/2020
Version: V2

Module 1—PIP Initiation Submission Form—State of Colorado—Version 6–2 Page | 15

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

Key Driver Diagram – *Follow–Up After a Positive Depression Screen St Mary's Family Medicine (SMFM)*



Date: 03/25/2021
Version: V2

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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.

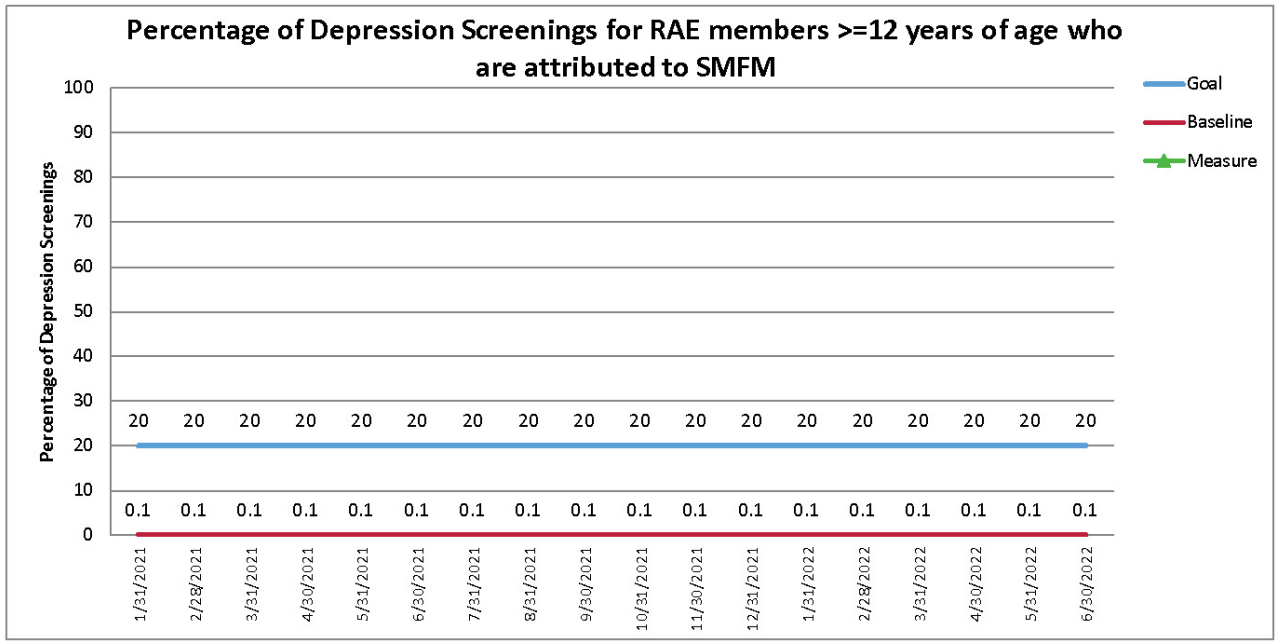
ROLLING 12-MONTH ATTESTATION
☒ **The MCO confirms that the reported SMART Aim run chart data will be based on rolling 12-month measurements.**

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.

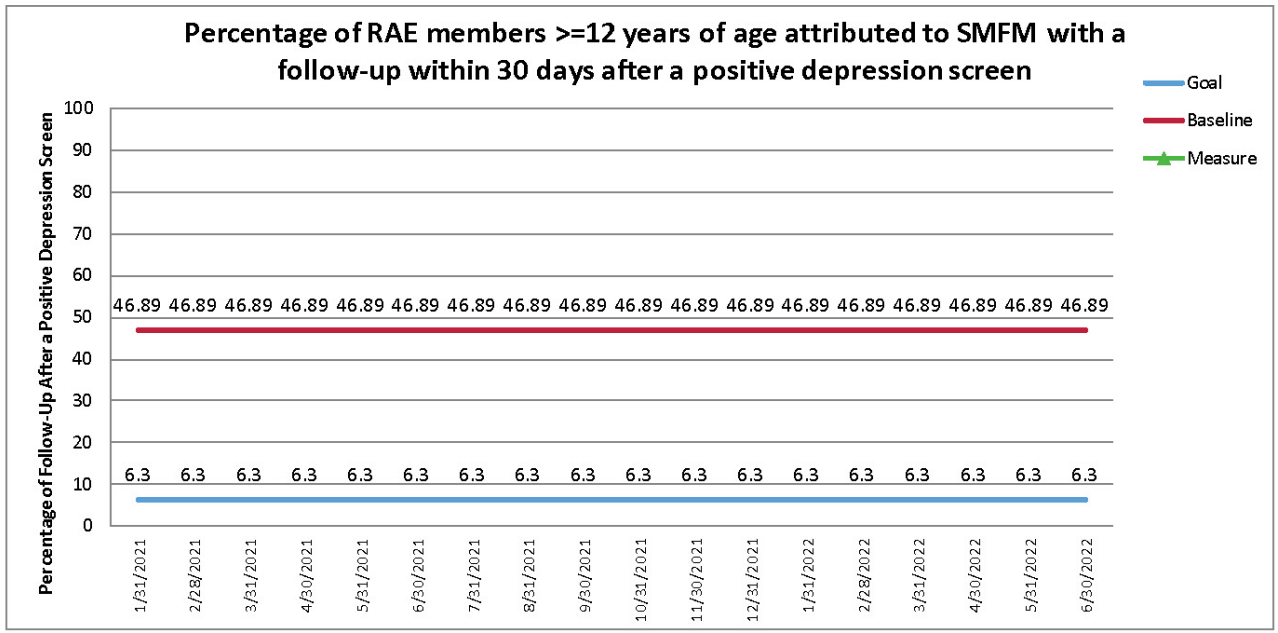
State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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



State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Submission Form
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans

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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

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 110 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:** HSAG identified the following opportunities for improvement: • The *Depression Screening* narrowed focus baseline percentage reported in Table 3b was incorrect, based on the reported baseline numerator and denominator. The health plan should review the data and make corrections.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

Criteria	Score	HSAG Feedback and Recommendations
		• The revised measure description provided for the *Follow-Up After a Positive Depression Screen* measure in Table 4a does not align with the State-mandated PIP topic, which includes improving follow-up care for members with a positive depression screen; therefore, the health plan will need to revise the measure definition and provide updated narrowed focus baseline data for this measure to support the PIP.
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. • 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

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. ***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. • 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.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

Criteria	Score	HSAG Feedback and Recommendations
		Re-review April 2021: The health plan addressed HSAG's initial feedback; however, the health plan made additional revisions to the *Follow-Up* measure description that did not align with the intent of the State-mandated PIP topic, which includes improving follow-up care for members with a positive depression screen. Specifically, HSAG identified the following issues with the revised measure specifications: • For the *Follow-Up After a Positive Depression Screen* measure, the health plan revised the denominator description so that it included all members with a primary care visit and no longer focused on members with a positive depression screen. While the health plan documented that it was not possible to identify members with a positive depression screen through G codes, because the narrowed focus providers do not use these codes, the proposed measure did not appear to measure follow-up care after a positive depression screen and, therefore, did not align with the intent of the State-mandated PIP topic. The health plan must revise the measure specifications to support improvement of follow-up care for members with a positive depression screen. • Based on the health plan-provided rationale for revising the *Follow-Up* measure description, stating that providers did not use G codes for depression screening results, it was unclear how the health plan had identified members to be included in the numerator for the *Depression Screening* measure, which was based on G codes. The health plan should clarify this discrepancy in the next resubmission. • The health plan will need to revise the narrowed focus baseline data provided in Table 4b, once the measure specifications have been revised to address the feedback provided in the first bullet point, above.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

Criteria	Score	HSAG Feedback and Recommendations
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 St Mary's Family Medicine to use key driver diagram interventions…" • The health plan should revise the aim statement removing the reference to "billed." The goal of the PIP is to increase the occurrence of depression screenings among members rather than increase the number of screenings that are billed. ***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 St Mary's Family Medicine 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. • The health plan should revise the SMART Aim to clarify that the follow-up visit must occur *within 30 days* of the positive depression screen. **Re-review April 2021:** The health plan addressed HSAG's initial feedback; however, a new issue was identified in the revised *Follow-Up After a Positive Depression Screen* SMART Aim statement. Because the revised *Follow-Up* measure no longer focused on members with a positive depression screen, the SMART Aim

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

Criteria	Score	HSAG Feedback and Recommendations
		statement does not align with the revised measure description. As currently defined, the *Follow-Up* measure cannot be used to evaluate whether the SMART Aim is achieved during the project. In addition, the health plan will need to update the SMART Aims with revised baseline and goal percentages after addressing HSAG's feedback for Criteria 1 and 2. The revised SMART Aims will also need to be updated in the Module 1 key driver diagrams.
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*. A general comment has been added. **General Comment:** The health plan will need to update the run charts, plotting revised baseline and goal lines, after the health plan has addressed HSAG's feedback for Criteria 1, 2, and 3.

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

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, *Review eCQM reports and performance accountability*, 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). • The health plan should revise the intervention descriptions, *Build a report that utilizes CMS002 depression screening and follow up to compare to claims data.* Additional detail/context should be provided to explain who will carry out the intervention and how the intervention will support the associated driver. ***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, *Review CQM reports and performance accountability*, with additional detail/context to clearly demonstrate how this driver will support achievement of the SMART Aim

State of Colorado
Performance Improvement Project (PIP)
Module 1 — PIP Initiation Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plan – RAE 1

Criteria	Score	HSAG Feedback and Recommendations
		goal (increasing follow-up services within 30 days of a positive depression screen among members 12 years of age and older). • The health plan should revise the intervention description, "*Track follow up visits. Identify members who screen positive, no appointment scheduled*". Additional detail/context should be provided to explain who will carry out this intervention and how the intervention will support the associated driver. **Re-review April 2021:** The health plan addressed HSAG's feedback in the resubmission. The criterion has been *Met*. A general comment has been added. **General Comment:** The health plan will need to update the SMART Aims in the key driver diagrams to align with the revised SMART Aims, after the health plan has addressed HSAG's feedback for Criteria 1, 2, and 3.
Additional Recommendations: None.		

PIP Initiation (Module 1)

☐ Pass

Date: