COLORADO
Department of Health Care Policy & Financing

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

Fiscal Year 2021–2022 PIP Validation Report

for

Rocky Mountain Health Plans Region 1

April 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its RAEs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **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) 2021–2022, 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 (QI)
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

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

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

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

PIP Components and Process

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

There are four modules with an accompanying reference guide for the MCOs to use to document their PIPs. Prior to issuing each module, HSAG held module-specific trainings with the

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.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 23, 2022.

[1-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 23, 2022.

MCOs to educate them about the documentation requirements and use of specific QI tools for each of the modules. The four modules are defined below:

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

Approach to Validation

The goal of HSAG's PIP validation and scoring methodology is to ensure that the Department and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement can be reasonably linked to the QI strategies and activities conducted by the health plan during the PIP. HSAG obtained the data needed to conduct the PIP validation from **RMHP R1**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **RMHP R1**'s PIP and the activities completed in Module 2 and 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.

Validation Scoring

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

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

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

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

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

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

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

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

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

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

PIP Topic Selection

In FY 2021–2022, **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 ages 12 years and older, from 0.8% to 20%.
Follow-Up After a Positive Depression Screen	By 06/30/2022, RMHP will partner with SMFM and 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 ages 12 years and older, from 0% to 46.89%.

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 (BH) services within 30 days of screening positive for depression. **RMHP R1** submitted the final approved SMART Aim statements and data collection methodology for the project in May 2021. The SMART Aim goal to increase depression screening to 20 percent represents statistically significant improvement over the baseline percentage. The SMART Aim goal to increase the percentage of eligible members who receive timely follow-up BH services to 46.89 percent was selected based on an established benchmark due to the small baseline denominator size.

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	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. Module 3 submission forms submitted to date have achieved all validation criteria. The MCO will test interventions until June 30, 2022, and submit a new Module 3 submission form when a new intervention is initiated.
	4. PIP Conclusions	Targeted for October 2022.

At the time this FY 2021–2022 PIP validation report was produced, **RMHP R1** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **RMHP R1** had also passed all validation criteria for the Module 3 submission form submitted for each intervention being tested and was continuing to test interventions. The health plan will conclude all intervention testing on June 30, 2022. Module 4 validation findings will be reported in the FY 2022–2023 PIP validation report.

Validation Findings

In FY 2021–2022, **RMHP R1** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan passed Module 2 and Module 3 of the rapid-cycle PIP process during FY 2021–2022. HSAG reviewed Module 2 and Module 3 submission forms and provided feedback and technical assistance to the health plan until all validation criteria were achieved. Below are summaries of the Module 2 and Module 3 validation findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. Detailed validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tools.

Module 2: Intervention Determination

The objective of Module 2 is to ask and answer the fundamental question, "What changes can we make that will result in improvement?" In this phase, **RMHP R1** developed process maps, conducted FMEAs, and updated key driver diagrams to identify potential interventions for the PIP. The detailed process maps, FMEA results, and updated key driver diagrams that **RMHP R1** documented in the Module 2 submission form are included in Appendix A. Module Submission Forms. Table 2-1 summarizes the FY 2021–2022 Module 2 validation findings for **RMHP R1**'s *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Depression Screening	• Physician is unable to correctly code depression screening results (positive or negative screen) • Medical assistant (MA) does not calculate score and submit to superbill • MA does not enter completed PHQ[1] into electronic health record • Correct screening result code (G8510 or G8431) is not attached to PHQ9 or added to claim • PHQ2/PHQ9 is scored and billed incorrectly • Patient is not experiencing depression but scored positive on screen	• Screen all members for depression, ages 12 years and older • Provider compliance with standardized workflow for depression screening • Provider awareness and understanding of appropriate depression screening coding practices	• 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

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• Patient has positive PHQ9 but PHQ9 report does not accurately capture all patients • Patient does not prioritize BH visit as part of medical services • Patient may have barriers related to social determinants of health (SDOH) such as transportation • Patient may not be ready to engage in therapy for depression	• 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	• 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 need follow-up behavioral services

[1]PHQ = Patient Health Questionnaire

In Module 2, **RMHP R1** identified potential interventions that can reasonably be expected to support achievement of the SMART Aim goals by addressing priority failure modes and leveraging key drivers. The potential interventions **RMHP R1** identified to improve depression screening were provider-focused education strategies The potential interventions **RMHP R1** identified to improve follow-up services were provider-focused strategies to establish and improve clinic workflows facilitating appropriate care for members who screen positive for depression.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **RMHP R1** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **RMHP R1** submitted testing plans for four interventions. In addition to validating the intervention plans submitted for Module 3, HSAG also conducted an intervention testing check-in with the health plan to provide support and technical assistance, if needed, as **RMHP R1** carried out PDSA cycles to evaluate intervention effectiveness. Table 2-2 presents the FY 2021–2022 Module 3 validation findings for **RMHP R1**'s four interventions.

Table 2-2—Module 3 Validation Findings for the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Develop, implement, and train MAs and providers on a new workflow to score, document, and correctly code depression screens with a negative result (G8510) and positive result (G8431)	• MA does not calculate score and submit to superbill • PHQ2/PHQ9 is scored and billed incorrectly	• Provider, care team, and billing/coding education regarding proper coding of positive and negative depression screen for RAE	• Percentage of depression screenings completed for RAE members by MFHC for which a negative depression screen coded G8510 was submitted for billing • Percentage of depression screenings completed for RAE members by MFHC for which a positive depression screen coded G8431 was submitted for billing
Develop and deploy a registry for patients who score positive on PHQ-9 to guide behavioral health advocates (BHAs) to connect to patients for BH follow-up when appropriate	• Patient has a positive PHQ9 but PHQ9 report does not accurately capture all patients • Community BH providers not accepting new patients • Patient does not prioritize BH visit as part of medical services	• Implement PHQ strategy for follow-up interaction with patients who screen positive for depression.	• Percentage of RAE members with a positive depression screen coded G8431, referred to BH services using the PHQ9 report, who scheduled a follow-up visit with BHA within 30 days of positive screen
Integrate G-codes into workflow to ensure proper measurement capture of G8431 and G8450. Review and revise SMFM workflow for using G-codes	• Depression screening occurred but was not billed for • Providers could not code	• Use G-codes when screening for depression	• Percentage of RAE members seen by the partner provider who were screened for depression and had the appropriate G-code entered in the data system • Percentage of positive depression screen (G8431) claims for RAE members submitted by the partner provider that were paid • Percentage of negative depression screen (G8510) claims for RAE members submitted by the partner provider that were paid

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Create a standardized depression screening billing and CPT coding workflow for the partner provider	• Code is not entered	• Bill for follow-up	• Percentage of RAE members seen by the partner provider who received a PHQ score of 8 or higher and for whom at least one BH intervention code was billed

In Module 3, **RMHP R1** selected four interventions to test for the PIP. The detailed intervention testing plans **RMHP R1** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process gaps or failures in clinic workflows, coding, and billing practices for depression screening and follow-up services. For each intervention, **RMHP R1** defined one or more intervention effectiveness measures to evaluate the impact of the intervention and provide data to guide intervention revisions. The health plan was continuing to test the interventions at the time this FY 2021–2022 PIP validation report was produced. **RMHP R1** will report final intervention testing results and conclusions as part of the Module 4 submission in FY 2022–2023, and the final Module 4 validation findings will be included in the FY 2022–2023 PIP report.

3. Conclusions and Recommendations

Conclusions

The validation findings suggest that **RMHP R1** successfully completed Module 2 of the rapid-cycle PIP process, using QI science-based tools to identify process gaps and failures, and to select PIP interventions. **RMHP R1** also passed Module 3 for four interventions, developing a methodologically sound plan for evaluating effectiveness of each intervention through PDSA cycles. **RMHP R1** will continue to test interventions for the PIP through the end of FY 2021–2022. The health plan will submit final intervention testing results, PIP outcomes, and project conclusions for validation in FY 2022–2023.

Recommendations

- **RMHP R1** should collect complete and accurate intervention effectiveness data for each tested intervention. The health plan should record intervention testing results and interpretation of results in the PDSA worksheet for each intervention, which will be submitted as part of Module 4—PIP Conclusions in FY 2022–2023.
- **RMHP R1** should ensure that the approved SMART Aim data collection methodology defined in Module 1 is used consistently to calculate SMART Aim measure results throughout the project. Using consistent data collection methodology will allow valid comparisons of SMART Aim measure results over time.
- For any demonstrated improvement in outcomes or programmatic or clinical processes, **RMHP R1** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **RMHP R1** should synthesize conclusions and lessons learned to support and inform future improvement efforts. In addition to documenting any improvement achieved through the project, the health plan should document which interventions had the greatest impact, including the evaluation data used to determine intervention effectiveness.

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 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans RAE

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, Heather Steele and Jeremiah Fluke
Contact Title	Quality Improvement Advisor
Email Address	Mary.beckner@rmhp.org/heather.steele@rmhp.org/jeremiah.fluke@rmhp.org
Telephone Number	425-753-9312/541-709-6609
Submission Date	6/14/2021
Resubmission Date (if applicable)	

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Process Map – *Depression Screening St. Mary's Family Medicine (SMFM)*

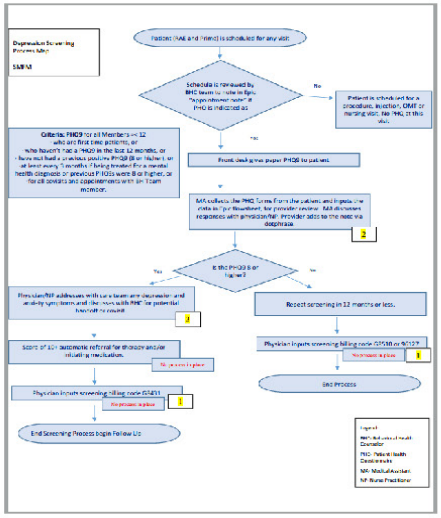
Instructions:

- Map the current process for members to receive ***Depression Screening*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)

See attachment:

"6.2021. SMFM_Depression Screen Workflow"



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Failure Modes and Effects Analysis (FMEA) – *Depression Screening SMFM*

Instructions: In Table 1a, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Depression Screening*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1a—Failure Modes and Effects Analysis Table – *Depression Screening*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
MA collects the PHQ forms from the patient and inputs the data in Epic flowsheet, for provider review. MA discusses responses with physician/NP.	• Patient could leave form in waiting room • PHQ could be handed back to front desk • MA doesn't see PHQ and doesn't input info into Epic	• Patient not understanding what the PHQ is for • Front desk too busy • MA doesn't know to ask for the PHQ	• Potential positive PHQ is missed
Physician/NP addresses depression and anxiety symptoms and discusses with	• Providers could bypass the BHC	• Standard process not in place for all Providers	• Positive PHQ not addressed

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BHC for potential handoff or co-visit.	• BHC could be busy and not available for handoff or co-visit • If patient visit is for illness the illness takes priority, PHQ often overlooked		
Physician inputs screening billing code G8510 or 96127 (negative)Physician inputs screening billing code 8431 (positive)	• Providers could not code • Wrong code could be used	• Standard process not in place for all Providers	• Screening would not be billed

Failure Mode Priority Ranking – *Depression Screening St. Mary's Family Medicine (SMFM)*

Instructions: In Table 2a, list from highest- to lowest-priority at least two failure modes identified in the ***Depression Screening*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.

Use the same language for the listed failure mode that was used in the FMEA table.

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Table 2a—Failure Mode Priority Ranking – *Depression Screening*	
Priority Ranking	**Failure Modes**
1	**Physician inputs screening billing code G8510 or 96127 (negative)Physician inputs screening billing code 8431 (positive)** • Providers could not code • Wrong code could be used
2	**MA collects the PHQ forms from the patient and inputs the data in Epic flowsheet, for provider review. MA discusses responses with physician/NP.** • Patient could leave form in waiting room • PHQ could be handed back to front desk • MA doesn't see PHQ and doesn't input info into Epic
3	**Physician/NP addresses depression and anxiety symptoms and discusses with BHC for potential handoff or co-visit.** • Providers could bypass the BHC • BHC could be busy and not available for handoff or co-visit • If patient visit is for illness the illness takes priority, PHQ often overlooked

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Process Map – *Follow–up After a Positive Depression Screen St. Mary's Family Medicine (SMFM)*

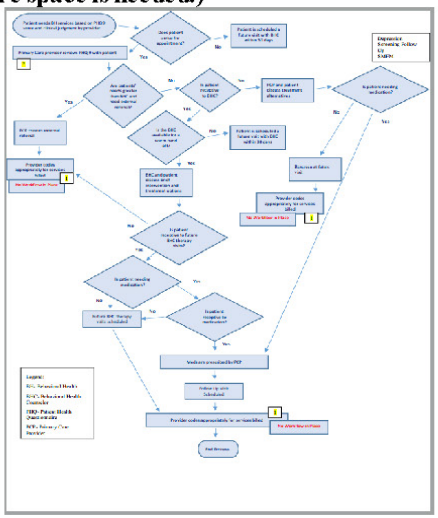
Instructions:

- Map the current process for members to receive ***Follow–up After a Positive Depression Screen*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)

See attachment:

"6.2021.SMFM_BH Follow-up after a Positive Depression Screen Workflow"



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Failure Modes and Effects Analysis (FMEA) – *Follow–up After a Positive Depression Screen*
St. Mary's Family Medicine (SMFM)

Instructions: In Table 1b, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Follow–up After a Positive Depression Screen*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1b—Failure Modes and Effects Analysis Table – *Follow–up After a Positive Depression Screen*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
Provider codes appropriately for services billed	• Code is not entered • Code is entered incorrectly	• Provider doesn't understand process • Provider uses incorrect code	• Behavioral Health Services are not billed
Primary Care provider reviews PHQ9 with patient	• Primary Care Provider does not review with patient	• Provider was not alerted to PHQ9 • Process was unclear	• Patient does not receive critical Behavioral Health services

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for Rocky Mountain Health Plans RAE

Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen St. Mary's Family Medicine (SMFM)*

Instructions: In Table 2b, list from highest- to lowest-priority at least two failure modes identified in the ***Follow–up After a Positive Depression Screen*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.
- Use the same language for the listed failure mode that was used in the FMEA table.

Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Priority Ranking	Failure Modes
1	**Provider codes appropriately for services billed** • Code is not entered • Code is entered incorrectly
2	**Primary Care provider reviews PHQ9 with patient** • Primary Care Provider does not review with patient

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Process Map – *Depression Screening Mountain Family Health Centers (MFHC)*

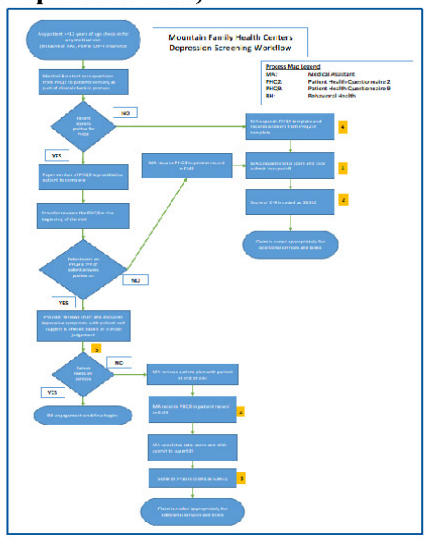
Instructions:

- Map the current process for members to receive *Depression Screening* at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is needed.)

See attachment:

"5.2021.MFHC_Depression Screen Workflow v2"



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Failure Modes and Effects Analysis (FMEA) – *Depression Screening Mountain Family Health Centers (MFHC)*

Instructions: In Table 1a, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Depression Screening*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1a—Failure Modes and Effects Analysis Table – *MFHC Depression Screening*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
MA calculates PHQ score and score of 0-9 is coded as G8510	• MA does not calculate score and submit to superbill • G8510 does not attached to PHQ9 or added to claim • G8510 is billed incorrectly if PHQ9 is positive	• New workflow for MA staff, submit to superbill button at bottom of screen and may be overlooked • New process being tested by IT/Billing department • MA does not transcribe patient answers correctly	• Medicaid and RMHP/CHP claim does not specify depression screen conducted • No data regarding result of screening captured by Medicaid or RMHP/CHP

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		from paper to patient record	• Result of depression screen is inaccurate in internal and claims data
MA calculates PHQ score and score of >=10 is coded as G8431	• MA does not calculate score and submit to superbill • G8431 is not attached to PHQ9 or added to claim • G8431 is billed incorrectly if PHQ9 is negative	• New workflow for MA staff, submit to superbill button at bottom of screen and may be overlooked • New process being tested by IT/Billing department • MA does not transcribe patient answers correctly from paper to patient record	• Medicaid and RMHP/CHP claim does not specify depression screen conducted • No data regarding result of screening captured by Medicaid or RMHP/CHP • Result of depression screen is inaccurate in internal and claims data
Based on clinical judgement during visit, provider does not recommend connection to BH services	• Patient is not experiencing depression but scored positive on screener • Patient's screener is documented as positive for depression • Patient does not take steps advised by provider to treat depressive symptoms •	• Discussion during visit uncovers that answers to PHQ9 did not indicate depression • Positive depression screen billed using G8431 code for Medicaid and CHP patients • Patient engagement or understanding of condition and treatment recommendations are unclear	• Positive screening does not constitute diagnosis of depression. Discussion about answers to specific screening questions are an important part of the clinical visit. • Medicaid and CHP patients have a documented positive depression screen that may be unwarranted • Patient may continue to experience symptoms of depression

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Failure Mode Priority Ranking – *Depression Screening Mountain Family Health Centers (MFHC)*

Instructions: In Table 2a, list from highest- to lowest-priority at least two failure modes identified in the ***Depression Screening*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.

Table 2a—Failure Mode Priority Ranking – *Depression Screening*

Priority Ranking	Failure Modes
1	MA does not calculate score and submit to superbill
2	G8510 is not attached to PHQ9 or added to claim
3	G8431 is not attached to PHQ9 or added to claim
4	PHQ2/PHQ9 is scored and billed incorrectly
5	Patient is not experiencing depression but scored positive on screener

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Process Map – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*

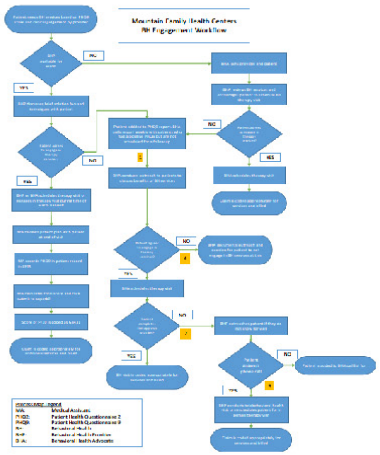
Instructions:

- Map the current process for members to receive ***Follow–up After a Positive Depression Screen*** at the narrowed focus level.
- Document each step of the process and highlight in yellow the steps within the process that have been identified as gaps or opportunities for improvement.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete a process map.

(Insert Process Map Here—Use an attachment or additional pages if more space is r

See attachment:

" 5.2021.MFHC_BH Follow-up after a Positive Depression Screen Workflow v2"



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Failure Modes and Effects Analysis (FMEA) – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*

Instructions: In Table 1b, document the Failure Mode(s), Failure Cause(s), and Failure Effects(s) for the steps from the ***Follow–up After a Positive Depression Screen*** process map that were identified as a gap or opportunity for improvement.

- The steps in this table should be listed based on their potential for impacting the SMART Aim (i.e., the step having the greatest potential for impacting the SMART Aim should be listed first and the step having the lowest priority would be listed last.
- List at least two steps from the process map in the FMEA table.
- Use the same process map language for each step documented in the FMEA table.
- If multiple failure modes/causes/effects are entered for a step, use bullets to identify each one. Add additional rows to the table, if needed.
- Refer to Section 4 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* (Module 2—Intervention Determination) for information on how to complete the FMEA.

Table 1b—Failure Modes and Effects Analysis Table – *MFHC Follow–up After a Positive Depression Screen*

Steps from the Process Map	Failure Mode(s) (What could go wrong?)	Failure Cause(s) (Why would the failure happen?)	Failure Effect(s) (What are the consequences?)
Patient added to PHQ9 report for follow up	• Patient has a positive PHQ9 but report is not accurate • BHA is too busy to follow-up with patients on PHQ9 report	• Depression screen is scored incorrectly • IT/EMR capability – accuracy of PHQ9 report • Staffing levels and multiple priorities by BHA	• Patient does not receive follow-up call • Patient does not engage in therapy services within 30 days of positive PHQ9 • Report is inaccurate so not all patients with a positive PHQ without therapy visit are captured.

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Patient schedules a therapy visit with BH provider but does not complete visit	• Patient does not prioritize BH visit as part of medical services • Patient may have SDoH barriers such as transportation • Patient decides not to show to visit for unknown reason	• Explanation of BH therapy services is unclear during recommendation from provider • Patient has not been screened for SDoH or asked about transportation barrier during scheduling • Patients do not have any consequences (e.g. no show fee etc.) for missing an appointment	• Patient does not understand the link between physical and behavioral health and continues to experience depression • Patient misses appointment that could have been adapted to telebehavioral health to remove transportation barrier • Patient continues to experience depression • BH provider time is not captured and billed
Patient is not receptive to therapy to treat depression	• Patient may not be ready to engage in therapy for depression	• Patient does not understand the benefits of therapy for treating depression	• Patient continues to experience depression

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Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen St. Mary's Family Medicine (SMFM)*

Instructions: In Table 2b, list from highest- to lowest-priority at least two failure modes identified in the ***Follow–up After a Positive Depression Screen*** FMEA.

- The MCO should assign a numeric ranking to the failure modes from the highest-priority level (number one) to the lowest-priority level (last failure mode selected) based on FMEA results.
- The failure modes with the highest priority should take precedence when determining interventions to test.
- The MCO should rank the failure modes based on their potential to impact the SMART Aim rather than ranking failure modes based on which may be easiest to change.
- The highest-priority failure modes are those with the most leverage for impacting the SMART Aim.

Use the same language for the listed failure mode that was used in the FMEA table.

Table 2b—Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen*

Priority Ranking	Failure Modes
1	Patient has a positive PHQ9 but PHQ9 report does not accurately capture all patients
2	Patient does not prioritize BH visit as part of medical services
3	Patient may have SDoH barriers such as transportation
4	Patient may not be ready to engage in therapy for depression

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Key Driver Diagrams

Instructions: Update the ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams from Module 1.

- At this stage of the PIP process, the MCO should use the findings from the process map, FMEA, and failure mode ranking to update drivers and interventions in each key driver diagram, as necessary. The MCO should ensure that the interventions are culturally and linguistically appropriate for the targeted population.
- Single interventions can address more than one key driver. Add additional arrows as needed.
- After passing Module 3 for each planned intervention and completing the testing of each intervention, the MCO should update the appropriate key driver diagram to reflect the status of each tested intervention (adapted, adopted, abandoned, or continue testing). The MCO should use the following color coding to distinguish the intervention status:
  - Green highlight for successful adopted interventions.
  - Yellow highlight for interventions that were adapted or not tested.
  - Red highlight for interventions that were abandoned.
  - Blue highlight for interventions that require continued testing.
- The finalized ***Depression Screening*** and ***Follow–up After a Positive Depression Screen*** key driver diagrams will be submitted at the end of the PIP with Module 4.

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

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

SMART Aim

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP RAE Members >=12 from 0.8% to 20%

Key Drivers	Interventions
Screen for depression, 12 years and older	Review and revise standardized workflow for screening 12 and older.
Ensure all providers and care team use standardized workflow for depression screening	Train and Educate. Display in precepting room.
Use eCQM performance of CMS002 pulled by quality report in practice EMR as lead data increasing depression screening among members 12 years of age and older.	Build a report that utilizes CMS002 Depression screening and follow up to compare to claims data. Display data monthly
Use G-codes when screening for depression	Integration of G codes into workflow to ensure proper measure capture G-8431 & G-8450. Review and revise SCL workflow for using G-codes
Ensure all providers and care team use standardized workflow for G-codes	Train and educate in precepting room on using G-codes. Chart audits

Date: 6/14/2021
Version: V1

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

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.

SMART Aim

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP RAE Members >=12 from 0.8% to 20%

Date: 6/14/2021
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Key Drivers	Interventions
Validation and education of current workflow to appropriate staff for depression screening during office visits.	Review workflow for depression screening for office visits to ensure all staff understand their part in completing depression screenings for patients >12 years of age at least annually.
Workflow development and implementation for depression screening for telehealth visits.	Utilize MA workgroup to develop, test and implement workflow for depression screening for patients who utilize telehealth visits.
Provider and care team education regarding proper coding of positive and negative depression screen.	Develop, implement and train providers of new workflow to score, document and correctly code for depression screen with a negative result (G8510) and positive result (G8431).
Use eCQM performance of CMS002 pulled by quality report in practice EMR as lead data increasing depression screening among members 12 years of age and older.	Utilize CMS002 Depression Screening and Follow-up eCQM performance data as a metric to measure success in improving accuracy of coding for depression screening.

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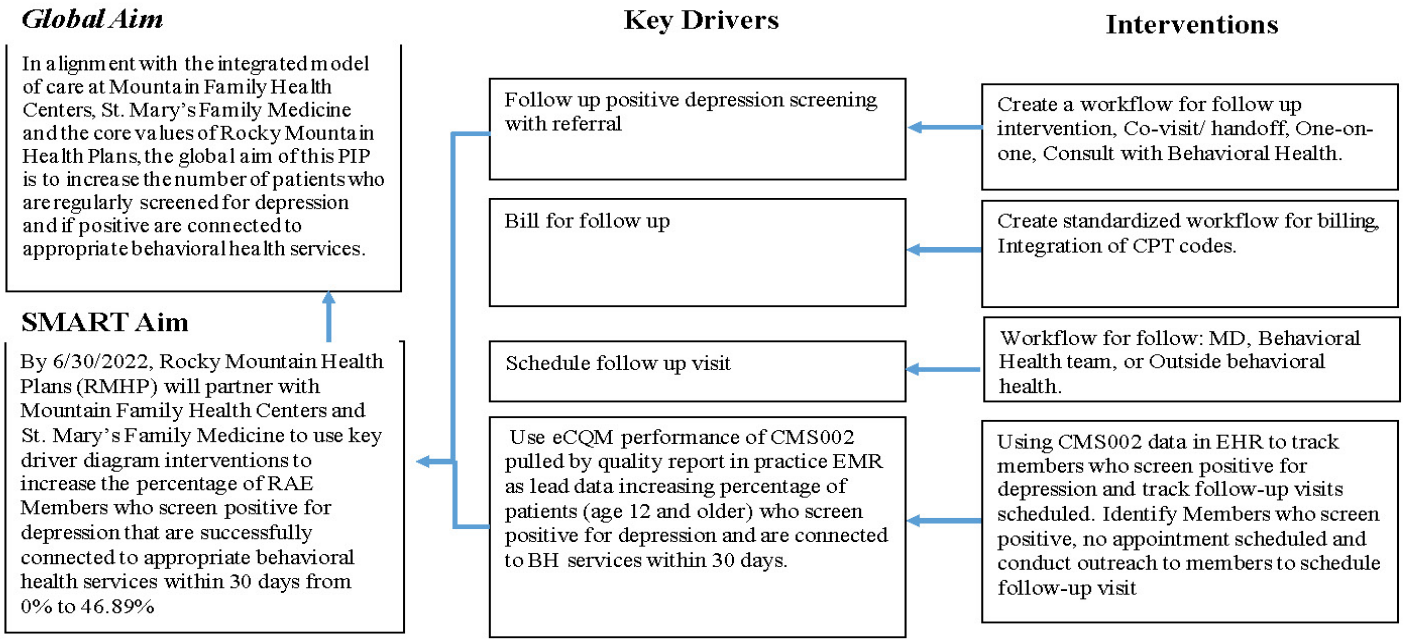
Key Driver Diagram – *Follow–up After a Positive Depression Screen St Mary's Family Medicine (SMFM)*



Date: 6/14/2021
Version: V1

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

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.

SMART Aim

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of RAE Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 0% to 46.89%

Date: 6/14/2021
Version: V1

Key Drivers	Interventions
Validation and education of current workflow to appropriate staff for process when patient screens positive for depression using PHQ-2.	Review workflow for screening patient using PHQ-9 when a PHQ-2 screen is positive during office and telehealth visits.
Define process for appropriate behavioral health intervention when a patient screens positive for depression.	BH staff to develop parameters for evidence based BH interventions. Includes appropriate use of staff and resources
Implement PHQ registry for follow-up interaction with patients who screen positive for depression.	Develop and deploy registry for patients who score positive on PHQ-9 to guide Behavioral Health Advocates (BHA) to connect to patients for BH follow-up when appropriate.
Improve utilization of Behavioral Health Specialists throughout the organizations several locations.	Capitalize on expansion of telebehavioral therapy to increase access to timely behavioral health services (tele-warm handoffs) when appropriate.
Use eCQM performance of CMS002 pulled by quality report in practice EMR as lead data increasing percentage of patients (age 12 and older) who screen positive for depression and are connected to BH services within 30 days.	Utilize CMS002 (Depression Screening and Follow up) eCQM performance data as a metric to measure success in improving accuracy of coding for follow-up interventions after a patient screens positive for depression.

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans RAE
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**SMFM Intervention 1:** Follow Up After a Positive Depression Screen: Increase accuracy of coding and billing for behavioral health services provided to RAE members/patients
Contact Name	Mary Beckner, Heather Steele, Jeremiah Fluke
Contact Title	Quality Improvement Advisors
Email Address	Mary.beckner@rmhp.org/heather.steele@rmhp.org/jeremiah.fluke@rmhp.org
Telephone Number	425-753-9312/541-709-6609
Submission Date	8/13/2021
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan		
Intervention Being Tested	Create standardized workflow for billing, Integration of CPT codes.	
Outcome Addressed	☐ *Depression Screening*	☒ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	• Code is not entered	• Code is entered incorrectly
Key Driver Addressed	Bill for follow up	
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Research on correct RAE covered procedure codes: short term BH services 90791 (diagnostic evaluation without medical service), 90832 (30 minutes psychotherapy), 90834 (45 minutes psychotherapy), 90837 (60 minutes psychotherapy), H0033 2. Create procedure codes cheat sheets for Pilot providers Clinic Lead and Family Nurse Practitioner 3. Pilot providers Clinic Lead and Family Nurse Practitioner to use selected RAE codes to bill appropriately for services 4. Follow RAE patients seen by Pilot Providers in EMR and claim through process for accuracy and completeness	
What are the predicted results of this test?	Pilot providers will code properly for behavioral health services provided based on payer guidelines	

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Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	RAE patients seen by pilot providers Clinic Lead and Family Nurse Practitioner who have a PHQ >=8 and provider adds behavioral health intervention code
Numerator Description	Leading data indicator (pulled by SMFM): RAE patients who were billed at least one Behavioral Health intervention code Final data indicator (pulled by RMHP): Number of 90791, 90832, 90834, 90837 and H0033 claims paid to SMFM for RMHP for RAE members
Denominator Description	Leading data indicator (pulled by SMFM): RAE patients seen by pilot providers Clinic Lead and Family Nurse Practitioner with a PHQ >=8 Final data indicator (pulled by RMHP): Number of 90791, 90832, 90834, 90837 claims paid to SMFM for RMHP for RAE members

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Set codes: 90791, 90832, 90834, 90837 Number of set codes paid by RMHP for RAE members
Describe the Data Sources	SMFM EMR: Epic RMHP submitted and paid claims report
Describe how Data will be Collected	Report run on specifics of numerator and denominator in Epic Report run on specifics of claims paid to RMHP in Tableau
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Monthly report run by SMFM RMHP data will be collected monthly

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans RAE
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**MFHC Intervention 1:** Follow-up after a positive depression screen: Develop and deploy registry for patients who score positive on PHQ-9 to guide Behavioral Health Advocates (BHA) to connect to patients for BH follow-up when appropriate.
Contact Name	Heather Steele, Mary Beckner, Jeremiah Fluke
Contact Title	Quality Improvement Advisors
Email Address	Mary.beckner@rmhp.org/heather.steele@rmhp.org/jeremiah.fluke@rmhp.org
Telephone Number	425-753-9312/541-709-6609
Submission Date	8/13/2021
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan

Intervention Being Tested	Develop and deploy registry for patients who score positive on PHQ-9 to guide Behavioral Health Advocates (BHA) to connect to patients for BH follow-up when appropriate.
Outcome Addressed	☒ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode(s) Addressed	• Patient has a positive PHQ9 but PHQ9 report does not accurately capture all patients Community BH providers not accepting new patients per payer or age demographic • Patient does not prioritize BH visit as part of medical services
Key Driver Addressed	Implement PHQ strategy for follow-up interaction with patients who screen positive for depression.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Primary Care Provider (PCP) recommends BH services to patient 2. Behavioral Health Provider (BHP) is not available for warm handoff 3. Behavioral Health Advocate (BHA) joins PCP with patient for introduction to BH services 4. Behavioral Health Advocate attempts to schedule patient for therapy visit with BHP 5. BHA pulls PHQ9 report weekly from EMR to assess need for follow up 6. BHA updates PHQ9 report to include appointments made for therapy services during warm handoff 7. BHA conducts outreach to patients who had a positive depression screen during visit but did not schedule a therapy visit (or are not currently engaged in therapy services)

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Table 1—Intervention Plan	
	8. BHA schedules patients for follow-up visit with BHP based on positive depression screen at last visit with PCP 9. PHQ9 report reviewed monthly with care team a. # of patients scheduled for therapy visit/engaged in therapy b. # of patients unavailable c. # of patients not interested in therapy at this time
What are the predicted results of this test?	Mountain Family Health Centers can improve connection of RAE patients/members to BH services within 30 days of positive depression screening through follow up by BHA using PHQ9 report

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Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**MFHC Intervention 1:** Follow-up after positive depression screen: Develop and deploy registry for patients who score positive on PHQ-9 to guide Behavioral Health Advocates (BHA) to connect to patients for BH follow-up when appropriate.
Numerator Description	Leading data indicator (pulled by MFHC): Number of RAE patients/members with a positive depression screen coded (G8431) referred to BH services AND scheduled therapy visit with BHC within 30 days of positive screen.
Denominator Description	Leading data indicator (pulled by MFHC): Number of RAE patients/members with a positive depression screen coded (G8431) referred to BH services using PHQ9 report.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	G8431 generated and coded and linked to a therapy encounter (see BHIP measure set) G8431 code is inclusion criteria for PHQ9 report generated in Next Gen EMR
Describe the Data Sources	MFHC claims report, PHQ9 report

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how Data will be Collected	PHQ9 report will be pulled weekly from Next Gen EMR and populated on an excel spreadsheet for tracking MFHC claims report generated through EMR
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	MFHC data will be reviewed monthly for analysis

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans RAE
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**SMFM Intervention 1:** Depression Screen: Increase accuracy of coding and billing for positive and negative depression screenings provided to RAE members/patients
Contact Name	Mary Beckner, Heather Steele, Jeremiah Fluke
Contact Title	Quality Improvement Advisors
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Submission Date	8/13/2021
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Integration of G codes into workflow to ensure proper measurement capture of G-8431 & G-8450. Review and revise SMFM workflow for using G-codes
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode Addressed	• Depression screening occurred but was not billed for • Providers could not code
Key Driver Addressed	Use G-codes when screening for depression
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Research on appropriate and correct RAE covered codes: G-8431 and G-8450 2. Training Clinic Lead, Family Nurse Practitioner and staff on codes and current baseline of depression metric performance. 3. Pilot Providers Clinic Lead and Family Nurse Practitioner use codes 4. Follow RAE patients seen by Pilot Providers in EMR and claim through process for accuracy and completeness
What are the predicted results of this test?	Pilot providers will code properly for depression screening based on payer guidelines

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Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	RAE patients seen by pilot providers Clinic Lead and Family Nurse Practitioner who get a depression screening and provider adds depression screen code
Numerator Description	Leading data indicator (pulled by SMFM): RAE Patients who were screened for depression and where the provider added a code Final data indicator (pulled by RMHP) : # of G8510 claims paid to SMFM for RMHP for RAE members # of G8431 claims paid to SMFM for RMHP for RAE members
Denominator Description	Leading data indicator (pulled by SMFM): RAE Patients seen by pilot providers Clinic Lead and Family Nurse Practitioner Final data indicator (pulled by RMHP) : # of G8510 claims submitted by SMFM to RMHP for RAE members # of G8431 claims paid to SMFM for RMHP for RAE members

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Set codes: G-8431 and G-8510 # of set codes paid by RMHP for RAE members
Describe the Data Sources	SMFM EMR: Epic RMHP submitted and paid claims report
Describe how Data will be Collected	Report run on specifics of numerator and denominator in Epic Report run on specifics of claims paid to RMHP in Tableau
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	Monthly report run by SMFM RMHP data will be collected monthly

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans RAE
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**MFHC Intervention 1:** Depression Screen: Increase accuracy of coding and billing for positive and negative depression screenings provided to RAE members/patients
Contact Name	Heather Steele, Mary Beckner, Jeremiah Fluke
Contact Title	Quality Improvement Advisors
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Submission Date	8/13/2021
Resubmission Date (if applicable)	

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Intervention Testing Plan

Instructions:

- In Table 1, provide the specific details about the intervention including the intervention being tested; outcome (***Depression Screening*** or ***Follow–up After a Positive Depression Screen***), failure mode, and key driver addressed; step-by-step process to conduct the intervention test; and the predicted results.
- If the intervention was documented in the Module 2 submission form, use the same language to describe the key driver, failure mode, and intervention.
- If the intervention was not included the Module 2 submission form, the intervention should be added to the final key driver diagram in Module 4.

Table 1—Intervention Plan	
Intervention Being Tested	Develop, implement and train medical assistants and providers of new workflow to score, document and correctly code for depression screen with a negative result (G8510) and positive result (G8431).
Outcome Addressed	☒ *Depression Screening* ☐ *Follow–up After a Positive Depression Screen*
Failure Mode(s) Addressed	• MA does not calculate score and submit to superbill • PHQ2/PHQ9 is scored and billed incorrectly
Key Driver Addressed	Provider, care team and billing/coding education regarding proper coding of positive and negative depression screen for RAE
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Medical Assistant (MA) conducts PHQ2 verbally with patient during clinical check in, if positive PHQ9 is provided on paper for patient to complete and discuss during visit. 2. MA records PHQ 2/PHQ9 results in patient record (PHQ9 template) 3. MA selects "calculate" and "submit to superbill" at the bottom of PHQ9 template 4. G8510 added to claim if score on PHQ9 0-8/ G8431 added to claim if score on PHQ 9 >9 5. Billing reviews encounter for accuracy before claim is submitted to HCPF 6. Claim is submitted to HCPF for reimbursement

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Table 1—Intervention Plan	
What are the predicted results of this test?	Claims submitted to HCPF will more accurately reflect the practice's dedication to screening patients for depression and conducting appropriate follow-up with patients when they screen positive.

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Intervention Effectiveness Measure

Instructions:

- In Table 2, provide the intervention measure title, numerator description, and denominator description. This measure should specifically measure the intervention's effectiveness.
- In Table 3, complete the information for how data will be collected for the intervention test. If applicable, include a blank copy of the data collection tool (e.g., spreadsheets, tracking log).
- Refer to Section 5 of the *Rapid-Cycle Performance Improvement Project (PIP) Reference Guide, Version 6–2* ("Module 3—Intervention Testing").

Table 2—Intervention Effectiveness Measure	
Intervention Measure Title	**MFHC Intervention 1:** Increase accuracy of coding and billing for positive and negative depression screenings provided to RAE patients/members
Numerator Description	Leading data indicator (pulled by MFHC): • # of negative depression screens coded (G8510) and submitted to HCPF • # of positive depression screens coded (G8431) and submitted to HCPF
Denominator Description	Leading data indicator (pulled by MFHC): • # of depression screenings completed for RAE patients/members

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	Depression screen claims generated and coded G8510 and G8431 linked to an E/M encounter Next Gen Quality Tab data CMS 002
Describe the Data Sources	MFHC claims report, CMS 002 eCQM depression screen and follow up report
Describe how Data will be Collected	Data will be collected monthly and populated on an excel spreadsheet for tracking

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Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	MFHC data will be collected monthly

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Validation Tool
Depression Screening and Follow–Up After a Positive Depression Screen
for Rocky Mountain Health Plans (RAE 1)

Criteria	Score	HSAG Feedback and Recommendations
1. The health plan included process maps for *Depression Screening* and *Follow–Up After a Positive Depression Screen* that clearly illustrate the step-by-step flow of the current processes for the narrowed focus.	☒ Met ☐ Not Met	
2. The prioritized steps in the process maps identified as gaps or opportunities for improvement were highlighted in yellow.	☒ Met ☐ Not Met	
3. The steps documented in each FMEA table aligned with the steps in the corresponding process map that were highlighted in yellow as gaps or opportunities for improvement.	☒ Met ☐ Not Met	
4. The failure modes, failure causes, and failure effects were logically linked to the steps in each FMEA table.	☒ Met ☐ Not Met	
5. The health plan prioritized the listed failure modes and ranked them from highest to lowest in each Failure Mode Priority Ranking table.	☒ Met ☐ Not Met	
6. The key drivers and interventions in each key driver diagram were updated according to the results of the corresponding process map and FMEA. In each key driver diagram, the health plan included interventions that were culturally and linguistically appropriate and have the potential for impacting the SMART Aim goal.	☒ Met ☐ Not Met	

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Depression Screening and Follow–Up After a Positive Depression Screen
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Criteria	Score	HSAG Feedback and Recommendations
Additional Recommendations: None.		

Intervention Determination (Module 2)

☒ Pass

Date: June 30, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (RAE 1)

SMFM Intervention 1: Increase Accuracy of Coding and Billing for Behavioral Health Services Provided to RAE Members/Patients

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: September 9, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (RAE 1)

MFHC Intervention 1: Develop and Deploy Registry for Patients Who Score Positive on PHQ-9 to Guide Behavioral Health Advocates (BHA) to Connect to Patients for BH Follow-Up When Appropriate

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: The health plan should consider tracking additional intervention effectiveness measures such as: • The percentage of members who met with the behavioral health advocate (BHA) and agreed to schedule a behavioral health (BH) appointment (Step 4). • The percentage of members who required outreach by the BHA and who were successfully contacted (Step 7). • The percentage of members who were successfully outreached by the BHA and scheduled a follow-up BH appointment (Step 8).		

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Depression Screening and Follow–up After a Positive Depression Screen
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Intervention Testing (Module 3)

☒ Pass

Date: September 9, 2021

State of Colorado
Performance Improvement Project (PIP)
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for Rocky Mountain Health Plans (RAE 1)

SMFM Intervention 1: Increase Accuracy of Coding and Billing for Positive and Negative Depression Screenings Provided to RAE Members/Patients

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: September 9, 2021

State of Colorado
Performance Improvement Project (PIP)
Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (RAE 1)

MFHC Intervention 1: Increase Accuracy of Coding and Billing for Positive and Negative Depression Screenings Provided to RAE Members/Patients

Criteria	Score	HSAG Feedback and Recommendations
1. The Intervention Plan specified the outcome to be addressed and included at least one corresponding key driver and one failure mode from Module 2.	☒ Met ☐ Not Met	
2. The health plan included all components for the Intervention Plan.	☒ Met ☐ Not Met	
3. The *Intervention Effectiveness Measure(s)* was appropriate for the intervention.	☒ Met ☐ Not Met	
4. The data collection process was appropriate for the intervention effectiveness measure(s) and addressed data completeness.	☒ Met ☐ Not Met	
Additional Recommendations: None.		

Intervention Testing (Module 3)

☒ Pass

Date: September 9, 2021