Colorado Children's Health Insurance Program

Fiscal Year 2021–2022 PIP Validation Report

for

Rocky Mountain Health Plans

April 2022

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

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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 managed care program and Child Health Plan *Plus* (CHP+), Colorado's program to implement CHIP managed care. The Department contracts with five CHP+ MCOs across the State.

Pursuant to 42 CFR §457.1520, which requires states' CHIP managed care programs to participate in EQR, the Department required its CHP+ MCOs to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Rocky Mountain Health Plans**, referred to in this report as **RMHP**, an MCO, holds a contract with the State of Colorado for provision of medical and behavioral health (BH) services for the Department's CHP+ managed care 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**'s module submission forms. In FY 2021–2022, these forms provided detailed information about **RMHP**'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** submitted the following PIP topic for validation: *Depression Screening and Follow-Up After a Positive Depression Screen*.

RMHP 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**.

Table 1-1—SMART Aim Statements

PIP Measures	SMART Aim Statements
Depression Screening	By 6/30/2022, RMHP will partner with Mountain Family Health Centers (MFHC) and Pediatric Partners of the Southwest (PPSW) to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP+ members 12 years of age or older from 3.5% to 25.0%
Follow-Up After a Positive Depression Screen	By 6/30/2022, RMHP will partner with MFHC and PPSW to use key driver diagram interventions to increase the percentage of RMHP CHP+ members 12 years of age or older who screen positive for depression that are successfully connected to appropriate BH services within 30 days to the established benchmark of 46.89%.

The focus of the PIP is to increase the percentage of members 12 years of age and older, attributed to MFHC or PPSW, who receive a depression screening and to increase the percentage of those members who receive BH services within 30 days of screening positive for depression. **RMHP** 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 25.0 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** 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** had passed Module 1 and Module 2, achieving all validation criteria for the PIP. **RMHP** 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** 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** 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** documented in the Module 2 submission form are included in Appendix A. Module Submission Forms. Table 2-1 presents the FY 2021–2022 Module 2 validation findings for **RMHP**'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	• Medical assistant (MA) does not calculate screening score and submit to superbill • Appropriate code for screening results (G8510, G8431) is not attached to screening tool (PHQ9)[1] or added to claim • Screening tool is scored and billed incorrectly • Screening result does not accurately reflect member's level of depression • No process exists in data system to block incorrect depression screening codes (96160, 96161) and replace with correct codes (G8510, G8431)	• Application of correct depression screening workflows for office visits and telehealth visits • Provider and care team use of correct codes for positive and negative depression codes • Practice-level electronic health record (EHR) data on depression screening used to provide feedback and encourage improvement	• Educate clinic staff on correct depression screening workflow during office visits • Develop and roll out depression screening workflow for telehealth visits • Develop and roll out scoring and coding workflow for positive and negative depression screens • Share depression screening electronic clinical quality measure (eCQM) performance data with provider staff as feedback on coding accuracy

PIP Measures	Priority Failure Modes	Key Drivers	Potential Interventions
Follow-Up After a Positive Depression Screen	• BH provider does not document and code positive depression screening as a reason for warm handoff referral • Positive depression screening (PHQ9) report does not accurately capture all members who screen positive on the PHQ9 screening tool • Community BH providers do not schedule follow-up visit within 30 days or communicate referral status to primary care provider • Community BH providers are not accepting eligible members as new patients • Member does not prioritize BH care, is reluctant to engage in care, or has social determinants of health (SDOH) barriers preventing access to care	• Clarification and application of correct depression screening workflows for positive depression screen referral and follow-up care • BH provider application of appropriate coding and billing workflow for positive depression screens • Practice-level EHR data on depression referral and follow-up care used to provide feedback and encourage improvement	• Staff education on positive depression screen documentation • Establish evidence-based BH care practices for positive depression screen follow-up • Develop a registry or other tracking process for members who screen positive for depression • Establish and roll out positive depression screen coding workflow for BH providers • Use expanded telebehavioral therapy to increase access to follow-up BH services • Share BH follow-up eCQM performance data with provider staff as feedback on coding accuracy

[1]PHQ = Patient Health Questionnaire

In Module 2, **RMHP** 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** identified to improve depression screening included provider-focused education, clinical workflow development, and use of electronic clinical performance data for provider feedback. The potential interventions **RMHP** identified to improve follow-up services were including staff training on the appropriate clinical workflow following a positive depression screen, a registry or tracking system for members in need of follow-up BH services, and use of telehealth to expand member access to follow-up BH services.

Module 3: Intervention Testing

Module 3 initiates the intervention testing phase of the PIP process. During this phase, **RMHP** developed the intervention *Plan* component of the PDSA cycle. In FY 2021–2022, **RMHP** 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** carried out PDSA cycles to evaluate intervention

effectiveness. Table 2-2 summarizes the FY 2021–2022 Module 3 validation findings for **RMHP**'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 CHP+	• Percentage of depression screenings completed for CHP+ members by MFHC for which a negative depression screen coded G8510 was submitted for billing • Percentage of depression screenings completed for CHP+ 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 CHP+ 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
Same-day warm hand-off and consultation with a behavioral health clinician (BHC) when member screens positive for depression and BHC follow-up with member/caregiver to ensure BH follow-up visit is scheduled and completed within 30 days	• Community BH providers do not schedule within 30 days or communicate referral status to PPSW • Community BH providers not accepting new patients per payer or age demographic • Patient may not be ready to engage in therapy for depression	• Define process for appropriate BH intervention when a patient screens positive for depression	• Percentage of CHP+ members who were referred by PPSW to a community BH provider for a positive depression screen coded (G8431) and who have referral marked as "complete" within 30 days of positive screen

Intervention Description	Failure Mode(s) Addressed	Key Driver(s) Addressed	Intervention Effectiveness Measure(s)
Develop, implement, and train providers on new workflow to score, document, and correctly code for depression screen with a negative result (G8510) or positive result (G8431)	• No process exists in data system to block incorrect depression screening codes (96160, 96161) • No process exists to replace incorrect depression screening codes (96160, 96161) with correct codes (G8510, G8431)	• Provider and care team use of correct codes for positive and negative depression screening results for CHP+ and Medicaid members/patients	• Percentage of CHP+ members screened for depression with a negative depression screen coded (G8510) and submitted to RMHP • Percentage of CHP+ members screened for depression with a positive depression screen coded (G8431) and submitted to RMHP

In Module 3, **RMHP** selected four interventions to test for the PIP. The detailed intervention testing plans **RMHP** documented in the Module 3 submission forms are included in Appendix A. Module Submission Forms. The interventions addressed process gaps or failures related to clinic workflows, coding of depression screening results, and billing practices for depression screening and follow-up services. For each intervention, **RMHP** 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** 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** 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** also passed Module 3 for four interventions, developing a methodologically sound plan for evaluating effectiveness of the interventions through PDSA cycles. **RMHP** will continue to test the 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** 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** 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** should develop and document a plan for sustaining the improvement beyond the end of the project.
- At the end of the project, **RMHP** 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 CHP

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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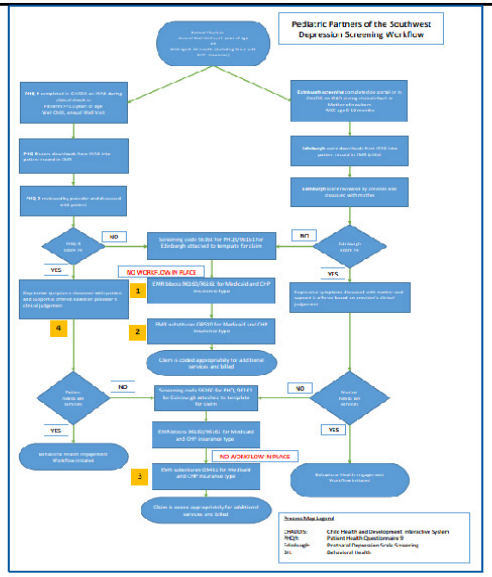
Process Map – *Depression Screening Pediatric Partners of the Southwest (PPSW)*

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.

See attachment:

"6.2021.PPSW Depression Screen Workflow.v2"



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Failure Modes and Effects Analysis (FMEA) – *Depression Screening Pediatric Partners of the Southwest (PPSW)*

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 – *PPSW 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?)
Block 96160/96161 and substitute G8510 for Medicaid and CHP patients with a negative depression screen	• 96160/96161 is not blocked • G8510 not substituted • G8510 substituted for commercial payer •	• New process being tested by IT/Billing department • Only part of the process works and 96160/96161 is blocked but substitution is not made	• Screening code is received but not distinguished as a depression screen • No screening codes are received by payer

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		• Code not accepted and claim is denied	• Practice is not paid for screening using G code by commercial payers
Block 96160/96161 and substitute G8431 for Medicaid and CHP patients with a positive depression screen	• 96160/96161 is not blocked • G8431 not substituted • G8431 substituted for commercial payer	• New process being tested by IT/Billing department • Only part of the process works and 96160/96161 is blocked but substitution is not made • Code not accepted and claim is denied	• Screening code is received but not distinguished as a depression screen • No screening codes are received by payer • Practice is not paid for screening using G code by commercial payers
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 • Patient screen is positive and follow-up other than BH engagement is part of treatment plan • 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 Pediatric Partners of the Southwest (PPSW)*

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.

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

Priority Ranking	Failure Modes
1	96160/96161 is not blocked for Medicaid and CHP patients with a negative or positive depression screening
2	G8510 is not substituted for 96160/96161 for Medicaid and CHP patients with a negative depression screening
3	G8431is not substituted for 96160/96161 for Medicaid and CHP patients with positive depression screening
4	Patient is not experiencing depression but scored positive on screener
5	

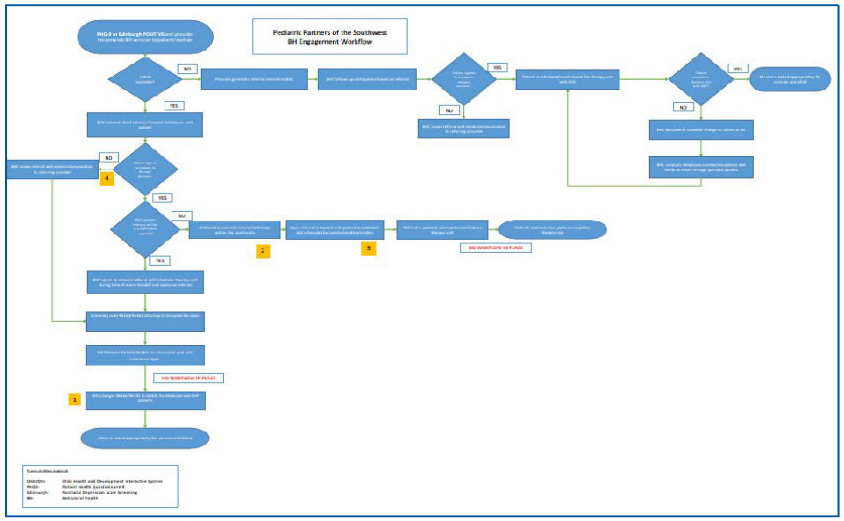
State of Colorado
Performance Improvement Project (PIP)
Module 2 — Intervention Determination Submission Form
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans CHP

Process Map – *Follow–up After a Positive Depression Screen Pediatric Partners of the Southwest (PPSW)*

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.

See attachment:
"6.2021.PPSW Depression Screen Follow Up Workflow.v2"



State of Colorado
Performance Improvement Project (PIP)
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Failure Modes and Effects Analysis (FMEA) – *Follow–up After a Positive Depression Screen Pediatric Partners of the Southwest (PPSW)*

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?)
Patient does not show/cancels for therapy visit with BHC	• Patient may not be ready to engage in therapy for depression • Patient does not prioritize BH visit as part of medical services	• Explanation of BH therapy services is unclear during recommendation from provider • Patient does not understand the benefits of therapy for treating depression	• Patient does not understand the link between physical and behavioral health and continues to experience depression • Patient misses appointment that could

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	• Patient may have SDoH barriers such as transportation	• 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	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 referred to a behavioral health provider in the community	• Community BH provider not accepting new patients or not accepting patient's insurance • Patient does not schedule appointment with community BH provider within 30 days of positive depression screen • Community BH provider does not communicate referral status to PPSW	• Community BH services does not have an adequate workforce of credentialed providers to accommodate demand • Patient decides not to engage in therapy and does not successfully schedule visit as recommended by provider • Community BH provider may not have a standardized referral or communication process with primary care providers.	• Patient is added to waitlist for BH services and does not begin treatment for depression • Patient is forced to pay cash or not engage in therapy services with referred BH provider • Patient continues to experience depression • Referring provider is unable to close the referral loop and follow up if necessary to uncover barriers patient may be facing in scheduling appointment
BHC does not appropriately document and code for positive depression screen after warm handoff	• BH provider does not document and code positive depression	• BH provider is asked to engage with patient for many conditions	• BH provider does not adequately address symptoms of depression outlined in screener

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	screening as one reason for referral/warm handoff • 96160/96161 is not blocked • G8431 not substituted • G8431 substituted for commercial payer	including, but not limited to, depression. • Depression screen not identified as screener used • Positive depression screen not captured in claims data • Code not accepted and claim is denied	• Medicaid and RMHP/CHP claim does not specify depression screen conducted • No data regarding result of screening captured by Medicaid or RMHP/CHP • Practice is not paid for screening by commercial payer

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Failure Mode Priority Ranking – *Follow–up After a Positive Depression Screen Pediatric Partners of the Southwest (PPSW)*

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	BH provider does not document and code positive depression screening as reason for warm handoff
2	Community BH providers does not schedule within 30 days or communicate referral status to PPSW
3	Community BH providers not accepting new patients per payer or age demographic
4	Patient may not be ready to engage in therapy for depression
5	

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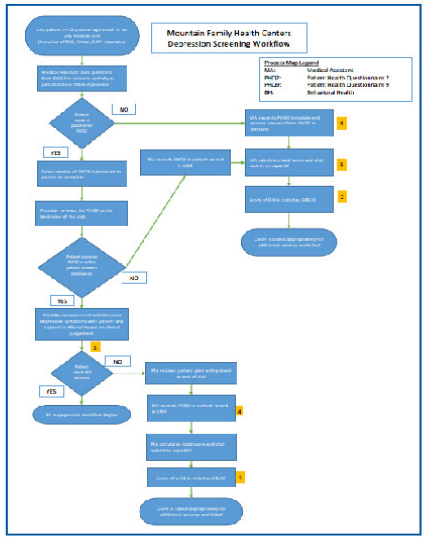
Process Map – *Depression Screening Mountain Family Health Centers (MFHC)*

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.

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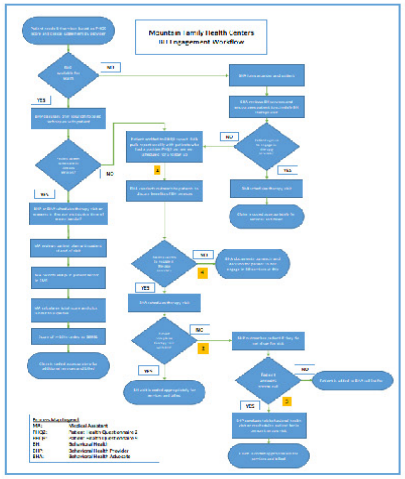
Process Map – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*

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.

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 Mountain Family Health Centers (MFHC)*

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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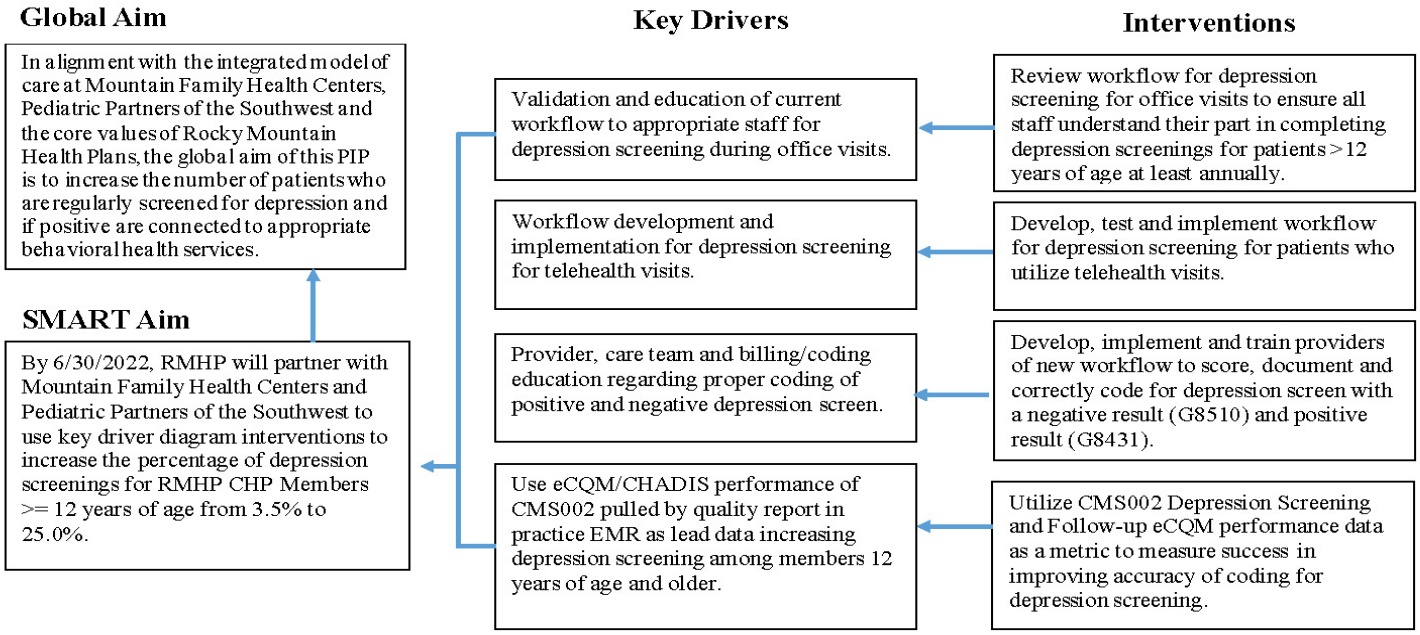
Key Driver Diagram– *Depression Screening Pediatric Partners of the Southwest (PPSW)*



Date: 5/5/2021
Version: V3

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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, Pediatric Partners of the Southwest 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, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP Members >=12 years of age from 3.5% to 25.0%.

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.	Develop, test and implement workflow for depression screening for patients who utilize telehealth visits.
Provider, care team and billing/coding 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/CHADDIS 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 Pediatric Partners of the Southwest (PPSW)*

Global Aim

In alignment with the integrated model of care at Mountain Family Health Centers, Pediatric Partners of the Southwest, 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, RMHP will partner with Mountain Family Health Centers and Pediatric Partners of the Southwest to use key driver diagram interventions to increase the percentage of RMHP CHP Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days to the established benchmark of 46.89%.

Date: 5/5/2021
Version: V3

Key Drivers	Interventions
Validation and education of current workflow to appropriate staff for process when patient screens positive for depression using PHQ-2/ PHQ9	Review workflow for screening patient using PHQ-2/PHQ9 and documenting screen is positive in patient record.
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 strategy for follow-up interaction with patients who screen positive for depression.	Develop and deploy workflow for following up with patients who score positive on PHQ-9 who are not connected to BH with a warm handoff during the visit in which the screening took place.
Behavioral Health Provider billing/coding education and workflow regarding proper coding of positive depression screen.	Develop and implement workflow for BH provider to code positive depression screen with G-code G8431 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	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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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 CHP
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

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Table 1—Intervention Plan	
	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) 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 CHP 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 RMHP CHP 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 RMHP CHP 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 CHP
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**PPSW Intervention 1:** Follow-up after a positive depression screen: BH staff to develop parameters for evidence based BH interventions. Includes appropriate use of staff and resources.
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 parameters for evidence based BH interventions when a patient screens positive for depression and needs connection to community based BH services.
Outcome Addressed	☐ *Depression Screening* ☒ *Follow–up After a Positive Depression Screen*
Failure Mode(s) Addressed	• Community BH providers does not schedule within 30 days or communicate referral status to PPSW • Community BH providers not accepting new patients per payer or age demographic • Patient may not be ready to engage in therapy for depression
Key Driver Addressed	Define process for appropriate behavioral health intervention when a patient screens 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/mother 2. Behavioral Health Clinician (BHC) is introduced to patient during appointment through a warm handoff. 3. BHC and patient discuss the value and benefits of engaging in therapy services as part of treatment for depression – in this visit

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Table 1—Intervention Plan	
	4. BHC and patient determine that patient needs connection with community BH provider to establish long term therapy services. BHC reviews options of therapy services and provides a list to patient. 5. Patient is responsible for connecting to community BH services based on recommendation from BHC 6. BHC records referral to therapy in patient record and referral status is pending 7. BHC tracks pending referrals by following up with patient in 2 weeks to see if therapy appointment has been made a. BHC follows up via phone and/or b. BHC sends a portal message to patient 8. If follow up with patient is successful but no therapy visit has been scheduled, BHC offers to call community BH provider on patient's behalf to assist with connection. 9. BHC updates referral status in patient record when therapy appointment has been scheduled 10. BHC makes 2nd attempt to follow up with patient between 3-4 weeks after initial conversation 11. Referral status is updated to complete. Internal tracking categorizes the referral: a. With Response: connection to patient and BH services made successfully b. Without response: connection to patient or BH services status unknown
What are the predicted results of this test?	PPSW can improve connection of CHP patients/members to community BH services within 30 days of positive depression screening through follow up and referral tracking.

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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	**PPSW Intervention 1:** Follow-up after a positive depression screen: BH staff to develop parameters for evidence based BH interventions. Includes appropriate use of staff and resources.
Numerator Description	Leading data indicator (pulled by PPSW): Number of patients with CHP insurance with a positive depression screen coded (G8431) referred to community BH AND referral marked as complete with response within 30 days of positive screen.
Denominator Description	Leading data indicator (pulled by PPSW): Number of referrals made to community BH providers for patients who also had a positive depression screens coded (G8431) during encounter.

Table 3—Intervention Effectiveness Measure Data Collection Process	
Describe the Data Elements	G8431 documented and coded and linked to a therapy encounter (see BHIP measure set) Referral tracking – internal referrals generated for collection using OP EMR
Describe the Data Sources	PPSW OP claims report

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Table 3—Intervention Effectiveness Measure Data Collection Process	
	PPSW OP referral report
Describe how Data will be Collected	Data will be collected monthly and populated on an excel spreadsheet for tracking
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	PPSW data will be collected monthly

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans CHP
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 CHP members/patients
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, 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 CHP
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 PHQ2/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 RMHP 6. Claim is submitted to RMHP for reimbursement

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Table 1—Intervention Plan	
What are the predicted results of this test?	Claims submitted to RMHP 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 CHP patients/members
Numerator Description	Leading data indicator (pulled by MFHC): • # of negative depression screens coded (G8510) and submitted to RMHP • # of positive depression screens coded (G8431) and submitted to RMHP
Denominator Description	Leading data indicator (pulled by MFHC): • # of depression screenings completed for CHP 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

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Managed Care Organization (MCO) Information	
MCO Name	Rocky Mountain Health Plans CHP
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Intervention Name:	**PPSW Intervention 1:** Depression Screen: Increase accuracy of coding and billing for positive and negative depression screenings provided to CHP+ members/patients
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)	**9/8/2021**

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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 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	• 96160/96161 is not blocked for Medicaid and CHP patients with a negative or positive depression screening • G8510 is not substituted for 96160/96161 for Medicaid and CHP patients with a negative depression screening • G8431is not substituted for 96160/96161 for Medicaid and CHP patients with positive depression screening
Key Driver Addressed	Provider, care team and billing/coding education regarding proper coding of positive and negative depression screen for CHP and Medicaid members/patients.
Intervention Process Steps (*List the step-by-step process required to carry out this intervention.*)	1. Billing director to implement a block for CPT code 96160 and 96161 when a depression screen is imported from CHADDIS into Office Practicum when the insurance demographic field equals RAE Medicaid or CHP.

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Table 1—Intervention Plan	
	2. When the insurance demographic field equals RAE Medicaid or CHP the CPT code G8510 will be substituted. 3. If the insurance demographic field equals RAE Medicaid or CHP AND the depression screen is positive (PHQ >4, Edinburgh >8). Based on clinical judgement, connection with behavioral health provider may occur at that time via a warm handoff. The CPT code G8510 will be replaced with G8431 to reflect the score of the depression screen by the appropriate provider. 4. Billing department reviews all claims from the day before and to double check accuracy of coding for RAE Medicaid and CHP.
What are the predicted results of this test?	Claims submitted to RMHP for CHP members 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	**PPSW Intervention 1:** Increase accuracy of coding and billing for positive and negative depression screenings provided to CHP+ members/patients
Numerator Description	Leading data indicator (pulled by PPSW): # of negative depression screens coded (G8510) and submitted to RMHP for CHP patients # of positive depression screens coded (G8431) and submitted to RMHP for CHP patients
Denominator Description	Leading data indicator (pulled by PPSW): # of depression screens completed for CHP patients

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
Describe the Data Sources	PPSW OP claims report, PPSW CHADDIS depression screen report (PHQ and Edinburgh)
Describe how Data will be Collected	Data will be collected monthly and populated on an excel spreadsheet for tracking
Describe how often Data will be Collected and how data completeness will be addressed (e.g. – real-time data exchange with narrowed focus entity)	PPSW data will be collected monthly

Appendix B. Module Validation Tools

Appendix B contains the Module Validation Tools provided by HSAG.

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

Intervention Determination (Module 2)

☒ Pass

Date: June 30, 2021

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Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (CHP+)

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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Intervention Testing (Module 3)

☒ Pass

Date: September 9, 2021

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Module 3 — Intervention Testing Validation Tool
Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (CHP+)

PPSW Intervention 1: BH Staff to Develop Parameters for Evidence Based BH Interventions. Includes Appropriate Use of Staff and Resources

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
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Module 3 — Intervention Testing Validation Tool
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MFHC Intervention 1: Increase Accuracy of Coding and Billing for Positive and Negative Depression Screenings Provided CHP 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
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Depression Screening and Follow–up After a Positive Depression Screen
for Rocky Mountain Health Plans (CHP+)

PPSW Intervention 1: Increase Accuracy of Coding and Billing for Positive and Negative Depression Screenings Provided CHP 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