Colorado Children's Health Insurance Program

Fiscal Year 2022–2023 PIP Validation Report

for

Rocky Mountain Health Plans

April 2023

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) 2022–2023, 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 improvement in quality

Evaluating effectiveness of the interventions

Planning and initiating of activities for increasing or sustaining improvement

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

(CMS) publication, *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 quality improvement (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 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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2023.

[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: Mar 16, 2023.

- **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.

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.

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 2022–2023, these forms provided detailed information about **RMHP**'s PIP and the activities completed in Module 4. (See Appendix A. Module Submission Forms.) Following HSAG's rapid-cycle PIP process, each health plan submitted Module 4 according to the approved timeline. HSAG provided scores and feedback and assigned a level of confidence to the PIP in the Module 4 validation tool. If a PIP received less than *High Confidence* on initial review, the health plan had an opportunity to receive technical assistance from HSAG and to complete a single Module 4 resubmission to address the initial validation findings.

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 2022–2023, **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—PIP Measures and 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 2.0% 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%.

* RMHP corrected the baseline percentage for the SMART Aim statement in January 2023.

2. Findings

Module 4: PIP Conclusions

In FY 2022–2023, **RMHP** continued the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP. The health plan completed Module 4, the final module of the rapid-cycle PIP process, during FY 2022–2023. HSAG reviewed the initial Module 4 submission form, provided initial feedback and technical assistance to the health plan, and conducted the final validation on the resubmitted Module 4 submission form.

The health plan's final Module 4 submission met all validation criteria. The PIP was methodologically sound, the PIP results demonstrated significant improvement, at least one of the interventions could reasonably result in the demonstrated improvement, and the health plan accurately summarized key findings and conclusions. Based on the validation findings, HSAG assigned the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP a level of *High Confidence*. Below are summaries of key Module 4 validation findings. Complete validation criteria, scores, and feedback from HSAG are provided in Appendix B. Module Validation Tool.

SMART Aim Measure Results

HSAG analyzed **RMHP**'s PIP data to draw conclusions about the health plan's QI efforts. Based on its review, HSAG determined the methodological validity of the PIP, and evaluated **RMHP**'s success in achieving the SMART Aim goal and in demonstrating statistically, clinically, or programmatically significant improvement.

The final SMART Aim measure results for **RMHP**'s PIP are presented in Table 2-1. HSAG used the reported SMART Aim measure data to determine whether the SMART Aim goal was achieved and whether statistically significant improvement over baseline results was demonstrated.

Table 2-1—SMART Aim Measure Results

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Depression Screening				
The percentage of depression screenings for RMHP CHP+ members 12 years of age and older who received care at MFHC or PPSW.	2.0%	25.0%	24.78%	*Yes*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved (Y/N)
Follow-Up After a Positive Depression Screen				
The percentage of RMHP CHP+ members 12 years of age and older who screen positive for depression at MFHC or PPSW that are successfully connected to the appropriate BH services within 30 days.	100%*	46.89%	50.00%	*Not Applicable*

* The baseline percentage was based on a denominator size of "1." Due to the extremely low baseline denominator size, the Department and HSAG approved a SMART Aim goal based on an established benchmark rather than a goal representing statistically significant improvement.

To guide the project, **RMHP** established goals of increasing the percentage of members 12 years of age and older who receive a depression screening from 2.0 percent to 25.0 percent and ensuring 46.89 percent or greater of those members receive BH services within 30 days of screening positive for depression, through the SMART Aim end date of June 30, 2022. **RMHP**'s reported SMART Aim measure results for *Depression Screening* demonstrated that the highest rate achieved, 24.78 percent, was a statistically significant increase of 22.78 percentage points above the baseline rate but fell just short of achieving the goal. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 50.00 percent, exceeded the goal; however, it was not possible to achieve statistically significant improvement over the baseline percentage of 100 percent. The health plan's final SMART Aim run chart and SMART Aim measure data are provided in Appendix A. Module Submission Form.

Intervention Testing Results

In addition to evaluating the SMART Aim measure results, HSAG also evaluated the PIP intervention testing results for demonstrating significant clinical and programmatic improvement. In Module 4, **RMHP** completed and submitted PDSA worksheets to report final intervention testing results for the PIP. HSAG evaluated PDSA worksheet documentation for each intervention to determine whether the intervention evaluation results demonstrated significant clinical or programmatic improvement. Table 2-2 summarizes **RMHP**'s interventions described in the Module 4 PDSA worksheets, any improvement demonstrated by the intervention evaluation results, and the final status of the intervention at the end of the project.

Table 2-2—Final Intervention Testing Results

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
MFHC Intervention 1: Develop, implement, and train medical assistants (MAs) and providers on a new workflow to score, document, and accurately code depression screens with a negative result (G8510) and positive result (G8431).	Significant *programmatic* improvement for *Depression Screening*	Adopted
PPSW Intervention 1: 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).	Significant *programmatic* improvement for *Depression Screening*	Adopted
MFHC Intervention 2: Develop and deploy a registry for patients who score positive on the Patient Health Questionnaire (PHQ-9) to guide behavioral health advocates (BHAs) to connect to patients for BH follow-up when appropriate.	Significant *programmatic* and *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted
PPSW Intervention 2: Same-day warm handoff and consultation with a behavioral health clinician (BHC) when a 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.	Significant *clinical* improvement for *Follow-Up After a Positive Depression Screen*	Adopted

RMHP tested four provider-focused and practice-specific interventions for the project: Two interventions focused on *Depression Screening*, and two interventions focused on *Follow-Up After a Positive Depression Screen*. For MFHC Intervention 1 and PPSW Intervention 1, focused on *Depression Screening*, the health plan reported intervention testing results that demonstrated significant programmatic improvement in the percentage of positive and negative depression screen results that were accurately coded. Both interventions were adopted, and the health plan is developing best practice guidance on depression screening coding and billing for providers based on the intervention testing results. For MFHC Intervention 2, focused on *Follow-Up After a Positive Depression Screen*, the health plan reported significant programmatic and clinical improvement, based on testing results, and chose to adopt the intervention, expanding the PHQ-9 reporting to all BHAs across the organization. For PPSW Intervention 2, focused on *Follow-Up After a Positive Depression Screen*, the health plan reported significant clinical improvement, with plans to adopt the intervention and share the improvement strategy with other network providers, beyond the provider partner.

Lessons Learned

An important part of the QI process is to consider how the information gathered and lessons learned during the PIP can be applied in future improvement efforts. **RMHP** reported successes, challenges, and lessons learned as part of the Module 4 submission.

RMHP documented the following lessons learned from the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP:

- Training providers on appropriate depression screening coding and billing practices successfully improved the accuracy of claims data, which, in turn, provided a more accurate picture of the providers' depression screening performance.
- Lack of availability of community behavioral health providers in the southwest corner of the state was a primary barrier to ensuring members who screened positive for depression received follow-up BH services within 30 days of the positive screen.

3. Conclusions and Recommendations

Conclusions

RMHP developed a methodologically sound improvement project that met both State and federal requirements. The health plan tested four interventions using the required QI processes and tools. At the conclusion of the PIP, the health plan accurately reported results that demonstrated achievement of statistically significant improvement over baseline performance for the *Depression Screening* measure and achievement of the SMART Aim goal for the *Follow-Up After a Positive Depression Screen* measure. The health plan's intervention testing results also demonstrated programmatically significant improvement for both measures and clinically significant improvement for *Depression Screening* linked to the tested interventions. Based on the validation findings, HSAG assigned a level of *High Confidence* to the *Depression Screening and Follow-Up After a Positive Depression Screen* PIP.

Recommendations

HSAG has the following recommendations:

- **RMHP** should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other QI activities.
- **RMHP** should continue improvement efforts in the PIP topic areas, and for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Appendix A. Module Submission Form

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

State of Colorado

Performance Improvement Project (PIP)
Module 4 — PIP Conclusions 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 (RMHP)
PIP Title	*Depression Screening and Follow–up After a Positive Depression Screen*
Contact Name	Heather Steele and Jeremiah Fluke
Title	Quality Improvement Advisor/ PRIME Contract manager
Email Address	heather.steele1@uhc.com/jeremiah.fluke@uhc.com
Telephone Number	425-753-9312/541-709-6609
Submission Date	10/21/22
Resubmission Date (if applicable)	01/20/2023

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets

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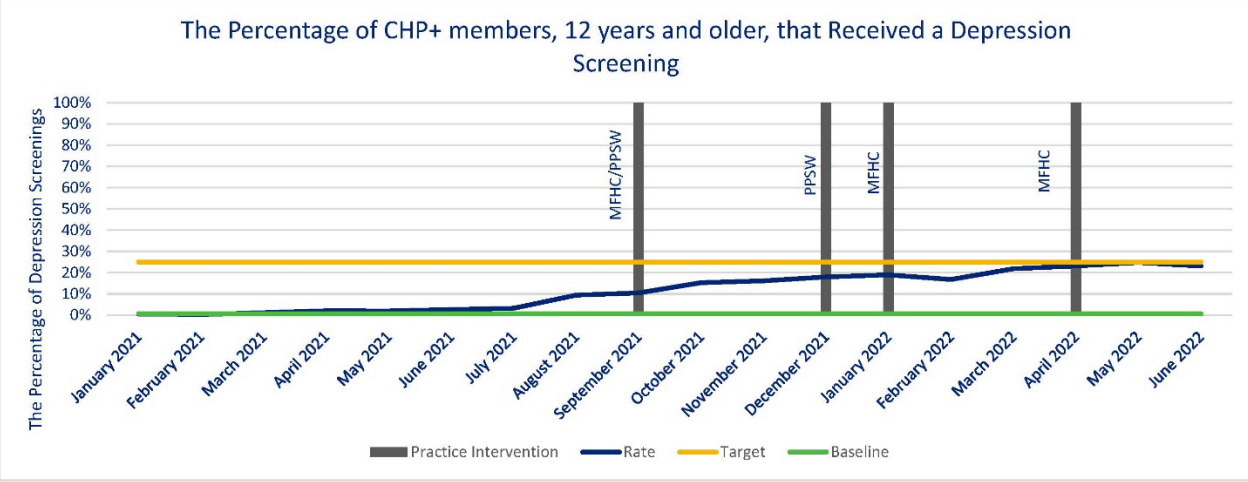
Final SMART Aim Run Chart – *Depression Screening*

Instructions: In the space below, insert or attach the final SMART Aim run chart. Include the following:

- SMART Aim goal.
- Narrowed focus baseline percentage.
- Rolling 12-month measure data points for the duration of the PIP.
- Intervention markers to display how the timing of the interventions coincided with changes in the SMART Aim measure.



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To confirm that the MCO used the 12-month methodology as required, check the box below.

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

Final Monthly SMART Aim Measure Data – *Depression Screening*

Instructions:

- In Table 1a, provide the monthly numerator, denominator, and percentage for each SMART Aim rolling 12-month measurement period.
- The reporting month is the last month of each rolling 12-month measurement period.
- Add additional rows to the table as needed.

Table 1a—SMART Aim Measure Monthly Data - *Depression Screening*

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020-01/31/2021	January 2021	2	347	0.58%
03/01/2020-02/28/2021	February 2021	1	348	0.29%
04/01/2020-03/31/2021	March 2021	4	347	1.15%
05/01/2020-04/30/2021	April 2021	7	349	2.01%
06/01/2020-05/31/2021	May 2021	7	350	2.00%
07/01/2020-06/30/2021	June 2021	9	344	2.62%

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08/01/2020-07/31/2021	July 2021	11	342	3.22%
09/01/2020-08/31/2021	August 2021	32	340	9.41%
10/01/2020-09/30/2021	September 2021	41	393	10.43%
11/01/2020-10/31/2021	October 2021	51	334	16.12%
12/01/2020-11/30/2021	November 2021	54	335	16.12%
01/01/2021-12/31/2021	December 2021	61	339	17.99%
02/01/2021-01/31/2022	January 2022	65	343	18.95%
03/01/2021-02/28/2022	February 2022	77	458	16.81%
04/01/2021-03/31/2022	March 2022	76	348	21.84%
05/01/2021-04/30/2022	April 2022	77	333	23.12%
06/01/2021-05/31/2022	May 2022	83	335	24.78%
07/01/2021-06/30/2022	June 2022*	75	325	23.08%

Final SMART Aim Run Chart – *Follow–up After a Positive Depression Screen*

Instructions: In the space below, insert or attach the final SMART Aim run chart. Include the following:

- SMART Aim goal.
- Narrowed focus baseline percentage.
- Rolling 12-month measure data points for the duration of the PIP.
- Intervention markers to display how the timing of the interventions coincided with changes in the SMART Aim measure.

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Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

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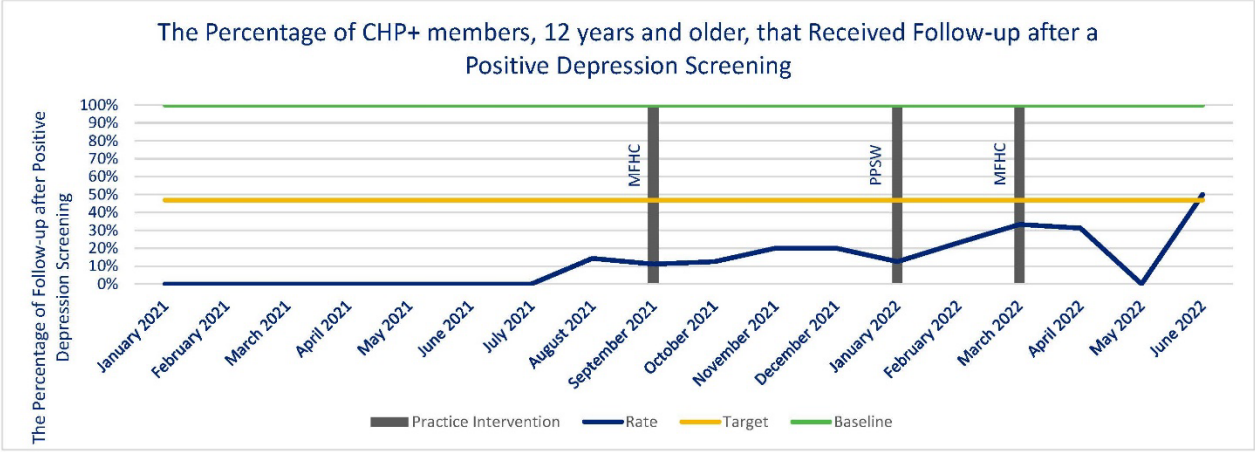

To confirm that the MCO used the 12-month methodology as required, check the box below.

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

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Final Monthly SMART Aim Measure Data – *Follow–up After a Positive Depression Screen*

Instructions:

- In Table 1b, provide the monthly numerator, denominator, and percentage for each SMART Aim rolling 12-month measurement period.
- The reporting month is the last month of each rolling 12-month measurement period.
- Add additional rows to the table as needed.

Table 1b—SMART Aim Measure Monthly Data - *Follow–up After a Positive Depression Screen*

SMART Aim rolling 12-Month Measurement Period (MM/DD/YYYY-MM/DD/YYYY)	Reporting Month	Numerator	Denominator	Percentage
02/01/2020-01/31/2021	January 2021	0	0	N/A
03/01/2020-02/28/2021	February 2021	0	0	N/A
04/01/2020-03/31/2021	March 2021	0	0	N/A
05/01/2020-04/30/2021	April 2021	0	0	N/A
06/01/2020-05/31/2021	May 2021	0	3	0%
07/01/2020-06/30/2021	June 2021	0	4	0%
08/01/2020-07/31/2021	July 2021	0	5	0%
09/01/2020-08/31/2021	August 2021	1	7	14.29%
10/01/2020-09/30/2021	September 2021	1	9	11.11%
11/01/2020-10/31/2021	October 2021	1	8	12.50%
12/01/2020-11/30/2021	November 2021	1	5	20.00%
01/01/2021-12/31/2021	December 2021	1	5	20.00%

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02/01/2021-01/31/2022	January 2022	1	8	12.50%
03/01/2021-02/28/2022	February 2022	3	13	23.08%
04/01/2021-03/31/2022	March 2022	5	15	33.33%
05/01/2021-04/30/2022	April 2022	5	16	31.25%
06/01/2021-05/31/2022	May 2022	0	2	0.00%
07/01/2021-06/30/2022	June 2022	7	14	50.00%

Final Key Driver Diagrams

Instructions: In the space below, provide the updated final key driver diagrams. The MCO must use the following color-coding system in the final key driver diagrams. The MCO should ensure that one key driver diagram is provided for each outcome: ***Depression Screening*** and ***Follow–up After a Positive Depression Screen***.

- 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.

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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 2.0% 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 **(not tested)**.
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. **(not tested)**

Date: 1/20/23
Version: V5

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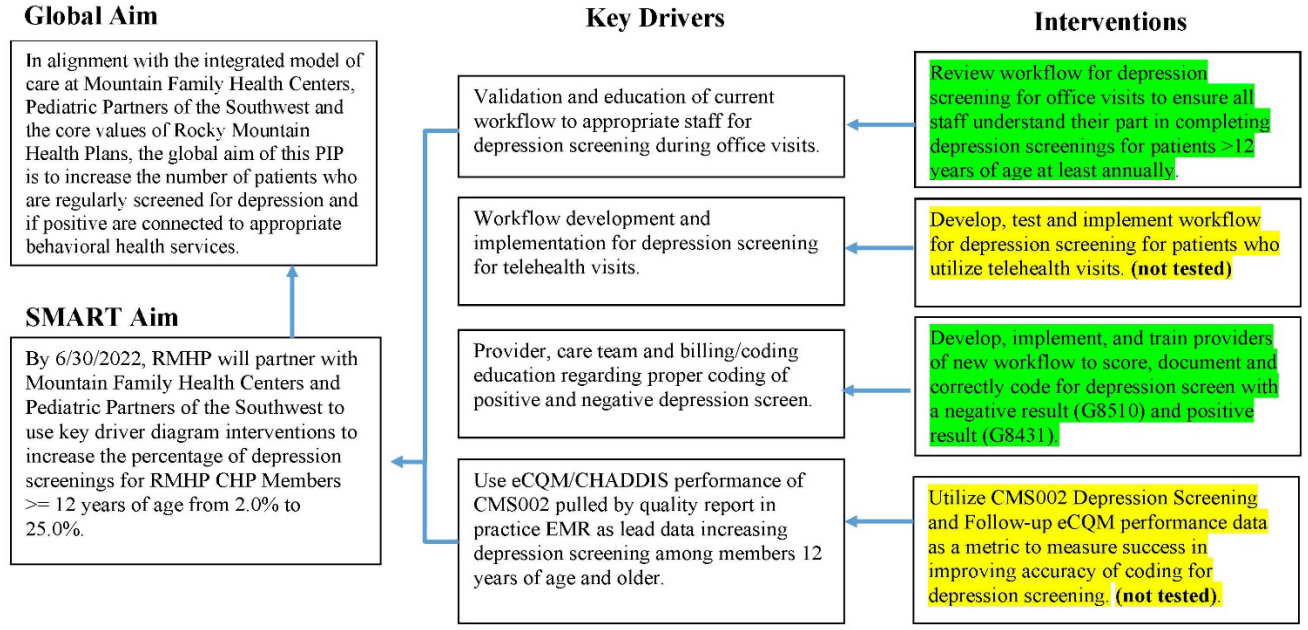
Key Driver Diagram– *Depression Screening Pediatric Partners of the Southwest (PPSW)*



Date: 1/20/23
Version: V5

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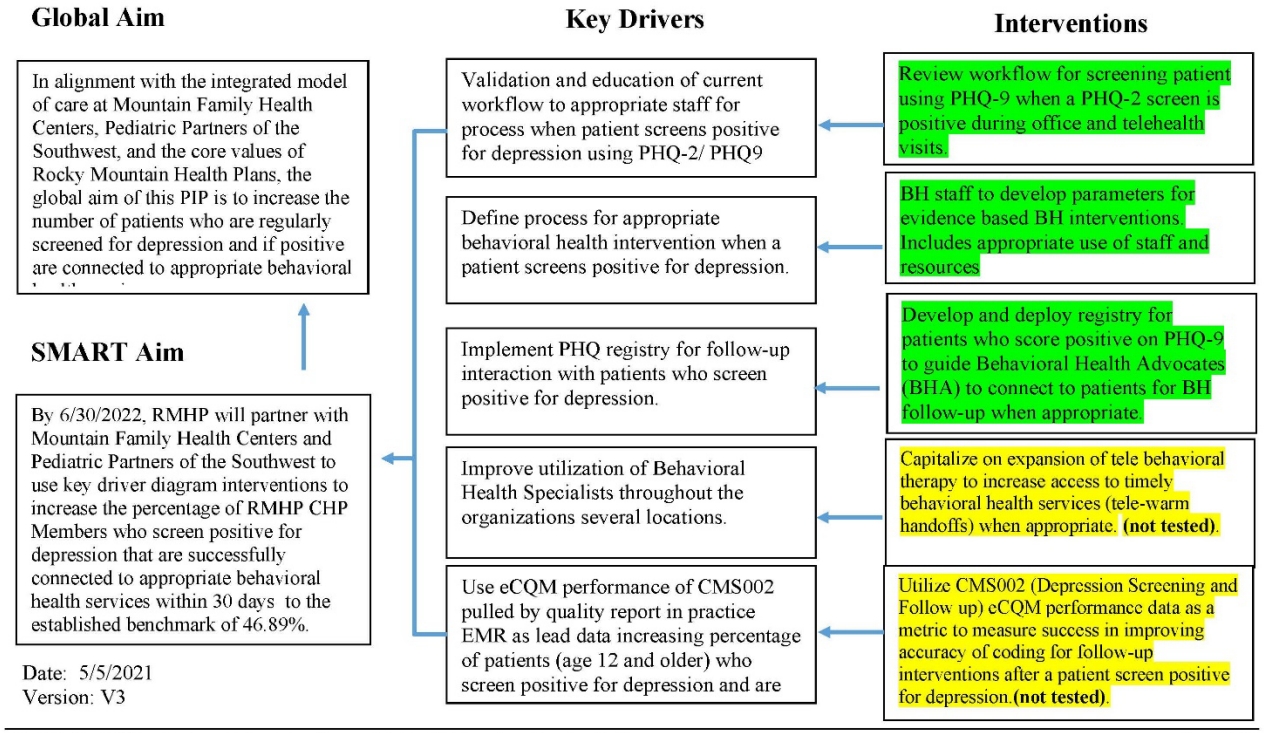
Key Driver Diagram – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*



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Key Driver Diagram – *Follow–up After a Positive Depression Screen and 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	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 screen positive for depression. **(not tested)**

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Project Conclusions

Instructions: In Table 2a, for ***Depression Screening***, and in Table 2b, for ***Follow–up After a Positive Depression Screen***, provide a description of the following:

- **Project Conclusions**: The narrative should include whether the SMART Aim goal, statistically significant, clinically significant, or programmatically significant improvement was achieved and what led to the success of the project. If the SMART Aim goal was not achieved and statistically significant improvement in the SMART Aim measure was not achieved, the narrative should describe if there was any non-statistically significant improvement demonstrated by the SMART Aim measure. If the SMART Aim goal or significant improvement was *not* achieved, the narrative should explain why improvement was not achieved and include planned changes to address the lack of improvement in future improvement projects.
- **Intervention Testing Conclusions**: Describe the intervention(s) that had the greatest impact on the SMART Aim, why the MCO came to these conclusions, and how the timing of the intervention(s) related to changes in the SMART Aim measure rate. This narrative should align with the results of the PDSA cycle(s) detailed in the PDSA worksheet(s).
- **Spread of Successful Intervention(s)**: For successful intervention(s), the MCO will describe its plan for spreading the intervention(s) beyond the selected narrowed focus of the PIP.
- **Challenges Encountered**: Describe any challenges or barriers that occurred during the project and the MCO's actions to overcome or address the challenge(s) and/or barrier(s).
- **Lessons Learned/Information Gained**: Describe the knowledge and experience gained from the project. This information can prove to be highly valuable and be applied to future projects.
- **Sustainability of Improvement:** Below each table, provide a narrative description of plans for sustaining any improvement achieved beyond the SMART Aim end date.

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Table 2a—Project Conclusions – *Depression Screening*	
Project Conclusions	SMART AIM: By 6/30/2022, RMHP will partner with MFHC and PPSW to use key driver diagram interventions to increase the percentage of depression screenings for RMHP CHP Members >= 12 years of age from 2.0% to 25.0%. The SMART Aim goal of 25.0% was not achieved, but a statistically significant improvement in the SMART Aim measure was achieved. Though the Aim goal was not achieved, the practices saw notable improvement with a final rate of 23.08%. Both MFHC and PPSW had a workflow in place to ensure patients 12 years of age and older are being screened for depression using the PHQ-2/PHQ-9. Upon reviewing the workflow for depression screening within office visits (to ensure all staff understand their part in completing depression screenings for patients >12 years of age at least annually) an opportunity was identified to support the practices in lessening identified gaps in the screening process. Screenings that were occurring within the practice were not adequately communicated to RMHP for CHP+ patients via claims. The PIP project provided an opportunity for MFHC and PPSW to develop and implement a new workflow to score, document and correctly code for depression screen with a negative result (G8510) and positive result (G8431). This workflow resulted in a statistically significant improvement in claims-based submissions for depression screenings and results. The CHP+ reported baseline in Module 1 of 896 was incorrect. Upon reviewing the data, it was discovered that the age criteria (members 12 and older) were not applied; thus, the 896 includes all members, regardless of age. The baseline data has been corrected with the appropriate denominator of 340. Though the underlying attribution methodology is the same, the CHP+ population requires the use of a separate report to be used and the age criteria was not initially applied when identifying the baseline denominator. The numerator remained the same at 7 but the new calculation of 7/340 changed the baseline from 0.78% to 2.0%. This correction was made in the SMART Aim goal in the Key Driver Diagram (page 8-9) and this correction was also

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	documented in the Module 1 document. The module 1 document will be sent to HSAG with the Module 4 resubmission to reflect the correction. This was not addressed, due to the Module 4 documentation requiring only the rate to be submitted, and the denominator from the Module 1 documentation was not reviewed. Though HSAG did notice this discrepancy for the CHP+ population, both the RAE and PRIME population baselines were reviewed and confirmed the age criteria was applied to the baseline denominators.
Intervention Testing Conclusions	Prior to participation in the PIP, PPSW used CPT codes 96160, 96161 or 96127 to report behavioral screening and testing to RMHP for CHP+ members. The interventions to test the *block and substitute* of these CPT codes with G-codes (G8510 and G8431) more accurately communicated depression screenings and results to RMHP for CHP+ members via claims, however, this change resulted in a $0 reimbursement for these services. The practice changed its billing workflows again for CHP+ members to include both the appropriate CPT code AND the appropriate G-code to the claim which were then successfully paid at the contracted rate for the CPT code and $0 for the G code. This workflow change resulted in a statistically significant improvement in successful claim submissions for depression screening results for CHP+ members attributed to PPSW. MFHC developed and implemented a new workflow to score, document and correctly code for depression screen with a negative result (G8510) and positive result (G8431). This intervention went through three (3) PDSA cycles and resulted in a statistically significant improvement in successful claim submissions of depression screening results for attributed CHP+ members. MFHC is a Federally Qualified Health Center (FQHC), which are reimbursed for services differently than non-FQHC practices. Due to the differences in billing practices, submission of depression screening codes G8510 and G8431 are reimbursed at $0, regardless of payer.
Spread of Successful Interventions	PPSW will continue the established workflow for coding and billing of depression screenings using G-Codes (G8510, G8431) for CHP+ members. This process has also been expanded for

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	RAE Medicaid members, successfully spreading the intervention to effectively communicate depression screening and results to another payer. MFHC will continue to spread this workflow across all locations to ensure standardized use of the PHQ-9 template to accurately identify, score and bill for depression screenings. The clinic will continue to monitor G8510 and G8431 claims for all attributed patients and will share this performance during monthly QI meetings.
Challenges Encountered During Project	PPSW challenges encountered: The practice billed 75 G-codes for depression screens (68 G8510, 7 G8431) to RMHP for CHP+ members from 6/1/21-11/9/21. Since the G-codes are reimbursed at a $0 rate, this became a disincentive to the practice as they were previously successfully billing and being reimbursed for depression screens using 96160, 96161 or 96127 codes. Cycle 2 of the PDSA uncovered the need to change to the billing/coding process for Medicaid RAE vs CHP+. This workflow requires additional attention and involves an extra step for the billing department. MFHC attached G-codes to the PHQ-9 template within their electronic medical record. At the bottom of the template the Medical Assistant was instructed to calculate the score and submit the PHQ-9 to the superbill with the appropriate G-code attached. Upon testing, it was noted that the buttons needed to *calculate* and *submit* could not be seen when the computer was in laptop mode. It took several months for this to be fixed and slowed success of the intervention. Another challenge noted in the new workflow was the requirement to expand the PHQ-2 template to PHQ-9 to calculate score and submit to superbill. This created extra steps in the workflow when a patient scored 0 on the PHQ-2, which were often missed. The practice will prioritize the addition of the *score* and *submit* buttons (attaching G8510) to the PHQ-2 template, removing the need for the Medical Assistant to record a negative screen in the PHQ-9 template.
Lessons Learned/Information Gained Throughout the Project	RMHP successfully received claims from PPSW and MFHC with G-codes attached (G8510 or G8431) for CHP+ members. This change in coding and billing practices more accurately reflects the practices' dedication to screening patients for depression and conducting appropriate follow-up when they screen positive.

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Sustainability of Improvement – *Depression Screening*

Instructions: In the space below, describe the MCO's plan for sustaining improvement achieved for ***Depression Screening*** beyond the SMART Aim end date.

RMHP has a robust plan for sustaining improvements achieved through the PIP regarding Depression Screening for CHP+ members. This includes the development and deployment of information outlining the importance of screening for depression, coding, and billing best practices by line of business (Medicaid, Commercial, Medicare, CHP+). This information will be shared with our network partners through the health plan's monthly *Provider Insider Plus* newsletter and the *Clinical Quality Improvement Newsroom.*

The learnings from the PIP project have been added to the *2022 Improving Depression Screening and Follow-up Care, an Action Planning Guide for Primary Care*. This resource will be used by the Clinical Quality Improvement team when working with practices on quality improvement projects.

RMHP will continue to monitor G-codes submitted through claims for CHP+ members. The data review will help inform quality improvement activity at the health plan, practice, and Member level. This data review will occur regularly though the RMHP Integrated Quality Workgroup. RMHP will share workflows adopted by PPSW and MFHC with network providers to promote the use of G-codes to demonstrate a successful process for completing depression screenings for RMHP members.

The lessons learned in this round of PIPs will inform the next PIP cycle if the topic remains focused on depression screening and follow-up after a positive depression screen. Based on the challenges experienced by the private practice in billing and coding for depression screens (PPSW), RMHP will prioritize our focus to educate and train FQHCs within the CHP+ region in improving billing and coding for depression screens.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
Project Conclusions	SMART AIM: 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 who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days to the established benchmark of 46.89%. The SMART Aim goal of 46.89%% was achieved with a final rate of 50.00% but a statistically significant improvement from the baseline was not achieved. The baseline data rate was 100% based on only 1 member (1/1), therefore it is not possible to demonstrate statistical significance over baseline. It is important to note that the final data point reflected a denominator size of 14, this is an increase from 1 in the baseline data and reflects an improvement in identifying patients who screen positive for depression and connecting more patients to follow-up. Both MFHC and PPSW had a workflow in place to ensure patients 12 years of age and older are being screened for depression using the PHQ-2/PHQ-9. The interventions tested by both practices resulted in clinically significant improvements in tracking patients referred to behavioral health services and the completion of those behavioral health services either in the practice and by referral to another community behavioral health provider.
Intervention Testing Conclusions	PPSW's intervention testing resulted in a clinically significant improvement in tracking patients referred to community behavioral health services for those who screened positive for depression during an office visit. The behavioral health staff successfully connected patients to community behavioral health services for CHP+ members during the testing phase of this PDSA. Internal data collected by the practice from 1/1/22 – 5/31/22 showed 11/25 patients were successfully connected to community behavioral health services within 30 days after a positive depression screening. MFHC intervention testing resulted in a clinically significant improvement in tracking patients who scored positive on the PHQ-9 and needed follow-up by a Behavioral Health Advocate (BHA). Using a registry to outreach patients for connection to services has shown to help patients who were connected to a behavioral health provider in a timely manner. In addition to the increase in patients who were connected to a behavioral health provider due to this outreach, the practice

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	learned that many patients had already established care with MFHC Behavioral Health Clinicians or with other community behavioral health providers. Intervention testing period 3/1/22-5/31/22 resulted in 3/14 patients successfully connected to behavioral health services. These are patients who, without outreach efforts by BHA, would not have connected to a behavioral health provider after scoring positive on depression screen during a recent visit.
Spread of Successful Interventions	PPSW improved its follow up for patients who have been referred to community behavioral health services when depressive symptoms are recognized and require long term therapy. Adding a two-week follow up flag to the patient chart and documenting the follow-up interaction with the patient increased the confidence of PPSW providers that referred patients were connecting with community behavioral health providers in a timely manner. This workflow will be sustained by the behavioral health team at PPSW. MFHC decided to expand the PHQ9 report outreach to all BHA's within the organization. This shared responsibility across the BHA's and will result in improved timeliness for outreach to patients.
Challenges Encountered During Project	PPSW noted the most impactful challenge is the lack of access and availability of community behavioral health providers in the southwest corner of the state. Many of the behavioral health providers, who are accepting new patients, do not have availability within 30 days of a positive depression screen that was completed at the primary care providers office. The practice does have integrated behavioral health services; however, the practice does not have the capacity to provide behavioral health services to all patients attributed to the practice. The practice workflow does not dictate that all patients who score positive on a PHQ-9 need behavioral health services. Rather, a referral to a community behavioral health provider or warm handoff is conducted based on clinical judgement by the provider. MFHC completed two (2) rounds of PDSA cycles for intervention testing and noted the following challenges: • Documenting actions from outreach by BHA in the PHQ-9 registry adds additional manual work outside of the patient record.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	• Only 1 BHA is working the PHQ-9 registry – may need to spread this work if PDSA is adopted as a workflow. • PHQ-9 report is not being run for BHA team as often as needed. Follow up by the BHA may be happening outside of the 30-day window.
Lessons Learned/Information Gained Throughout the Project	MFHC noted that data shows a lower number of gaps for patients who are interested in connecting to behavioral health services upon outreach. Most on follow up list are already connected to behavioral health services (within the clinic or in the broader community) or are unable to be reached. This proactive process may help to decrease the stigma around behavioral health/therapy as a successful treatment for depression.

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Sustainability of Improvement – *Follow–up after a Positive Depression Screen*

Instructions: In the space below, describe the MCO's plan for sustaining improvement achieved for ***Follow–up After a Positive Depression Screen*** beyond the SMART Aim end date.

RMHP has a robust plan for sustaining improvements achieved through the PIP regarding Depression Screening for CHP+ members. This includes the development and deployment of information outlining the importance of screening for depression, coding and billing best practices by line of business (Medicaid, Commercial, Medicare, CHP+). This information will be shared with our network partners through the health plan's monthly *Provider Insider Plus* newsletter and the *Clinical Quality Improvement Newsroom.*

Accurate coding for depression screening (G8431) is the first step in tracking the connection to behavioral health services when patients screen positive for depression. When behavioral health services are integrated or co-located, RMHP will encourage tracking and connecting patients to behavioral health services for at least one therapy visit if practice has capacity for this intervention.

The learnings from the PIP project have been added to the *2022 Improving Depression Screening and Follow-up Care, an Action Planning Guide for Primary Care*. This resource will be used by the Clinical Quality Improvement team when working with practices on quality improvement projects.

RMHP will continue to monitor positive depression screenings through claims-based billings and will look at connection to behavioral health services through the submission of claims-based therapy codes for CHP+ members. Workflows tested and implemented by PPSW and MFHC will be shared with our network partners.

Appendix B. Module Validation Tool

Appendix B contains the Module Validation Tool provided by HSAG.

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Criteria	Score	HSAG Feedback and Recommendations
1. The rolling 12-month data collection methodology was followed for the SMART Aim measures for the duration of the PIP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
2. The MCO provided evidence to demonstrate at least one of the following: ☒ The SMART Aim goal was achieved. ☒ Statistically significant improvement over the narrowed focus baseline percentage was achieved (95 percent confidence level, $p < 0.05$.) ☐ Non-statistically significant improvement in the SMART Aim measure. ☒ Significant *clinical* improvement in processes and outcomes. ☒ Significant *programmatic* improvement in processes and outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	For *Depression Screening*: • Statistically significant improvement over baseline was achieved. • Significant *programmatic* improvement was demonstrated for the *MFHC Increase Accuracy of Coding and Billing for Positive and Negative Depression Screenings Provided CHP Members/Patients* intervention. For *Follow-up After a Positive Depression Screen*: • The SMART Aim goal was achieved. • Significant *programmatic* improvement and *clinical* improvement were demonstrated for the *MFHC Develop and Deploy Registry for Patients Who Score Positive on PHQ-9 to Guide Behavioral Health Advocates to Connect Patients for BH Follow-up When Appropriate* intervention.

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Criteria	Score	HSAG Feedback and Recommendations
3. If improvement, as outlined for Criterion 2, was demonstrated, at least one of the tested interventions could reasonably result in the demonstrated improvement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
4. The MCO completed the Plan-Do-Study-Act (PDSA) worksheets with accurately reported data and interpretation of testing results.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	
5. The narrative summaries of the project conclusions were complete and accurate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	HSAG identified the following errors and omissions in the narrative summaries of project conclusions for both measures: • The health plan did not address the substantial shift in the denominator size from baseline to the rolling 12-month measurements or provide an explanation of this shift in the narrative summary of project outcomes for the *Depression Screening* measure. The reported denominators for the rolling 12-month *Depression Screening* results in Table 1a ranged from 325 to 458 while the reported baseline denominator from Module 1 was 896. The summary of project conclusions was incomplete without addressing this data issue. • The health plan included the following statement in the project conclusions for the *Follow-up After a Positive Depression Screen* measure: "The SMART Aim goal of 46.89% was achieved with a final rate of 50.00% and a statistically

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Criteria	Score	HSAG Feedback and Recommendations
		significant improvement in the SMART Aim measure was achieved." Based on the reported rolling 12-month *Follow-up* measure results, there was no evidence of statistically significant improvement over baseline. Because the baseline percentage for the *Follow-up* measure was 100%, it was not possible to demonstrate statistically significant improvement over baseline performance and the SMART Aim goal was based on an external benchmark. **Resubmission January 2023:** The health plan corrected the baseline *Depression Screening* denominator and percentage, which eliminated the substantial shift in denominator size from baseline to the rolling 12-month measurements. The *Depression Screening* SMART Aim goal continued to represent statistically significant improvement over the corrected baseline percentage. The health plan also corrected the project conclusions for the *Follow-up After a Positive Depression Screen* measure to address HSAG's initial feedback. The score for this criterion has been changed from *Not Met* to *Met*.
6. If improvement, as outlined for Criterion 2, was demonstrated, the MCO documented plans for sustaining improvement beyond the SMART Aim end date.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	

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Based on the validation findings, HSAG determined the following confidence level for this PIP:

☒ **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.

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Summary of Validation Findings:

HSAG assigned a level of *High Confidence* to the PIP based on the Module 4 submission form and PDSA worksheet documentation. The documentation demonstrated the following:

- Significant improvement achieved for both the *Depression Screening* and *Follow-up After a Positive Depression Screen* measures:
  - Statistically significant improvement was achieved for *Depression Screening*.
  - The SMART Aim goal was achieved for *Follow-up After a Positive Depression Screening*.
  - The health plan documented intervention testing results that supported significant *programmatic* improvement related to depression screening and significant *programmatic* and *clinical* improvement related to follow-up care.
- Interventions were carried out and evaluated according to the approved Module 3 plan and the health plan provided detailed intervention testing results, clear rationale for intervention or evaluation revisions, and detailed and insightful summaries of lessons learned from intervention testing.
- In the January 2023 resubmission, the health plan corrected the baseline *Depression Screening* denominator and percentage, which eliminated the substantial shift in denominator size from baseline to the rolling 12-month measurements. The *Depression Screening* SMART Aim goal continued to represent statistically significant improvement over the corrected baseline percentage. The health plan also corrected the project conclusions for the *Follow-up After a Positive Depression Screen* to correctly identify that the goal was achieved but that statistically significant improvement was not achieved due to the baseline percentage of 100 percent. With these revisions, the health plan provided clear and accurate summaries of key findings and conclusions from the PDSA cycles and from the project, overall.