COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2022–2023 PIP Validation Report

for

Rocky Mountain Health Plans Medicaid Prime

April 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

Pursuant to 42 CFR §438.350, which requires states' Medicaid managed care programs to participate in EQR, the Department required its Medicaid health plans to conduct and submit performance improvement projects (PIPs) annually for validation by the State's EQRO. **Rocky Mountain Health Plans Medicaid Prime**, referred to in this report as **RMHP**, an MCO, holds a contract with the State of Colorado for provision of healthcare services for the Department's 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 Form.) 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 St. Mary's Family Medicine (SMFM) to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime members ages 12 and older from 0.55% to 20.00%.*
Follow-Up After a Positive Depression Screen	By 6/30/2022, RMHP will partner with MFHC and SMFM to use key driver diagram interventions to increase the percentage of RMHP Prime members who screen positive for depression that are successfully connected to appropriate BH services within 30 days from 37.50% to 46.89%.*

* HSAG approved revisions to the SMART Aim statements in June 2022.

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 five of six validation criteria. The PIP was methodologically sound, the PIP results demonstrated significant improvement, and at least one of the interventions could reasonably result in the demonstrated improvement; however, the health plan did not accurately summarize all 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 *Moderate 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 Medicaid Prime members ages 12 and older attributed to MFHC or SMFM.	0.55%	20.00%	5.77%	*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 Prime members ages 12 and older attributed to MFHC or SMFM who screen positive for depression that are successfully connected to appropriate BH services within 30 days.	37.50%	46.89%	81.82%	*No*

To guide the project, **RMHP** established goals of increasing the percentage of members 12 years of age and older, attributed to SMFM or MFHC, who received a depression screening from 0.55 percent to 20.00 percent and increasing the percentage of those members who receive BH services within 30 days of screening positive for depression from 37.50 percent to 46.89 percent, through the SMART Aim end date of June 30, 2022. **RMHP**'s reported SMART Aim measure results demonstrated a statistically significant improvement of 5.22 percentage points from baseline to the highest rate achieved, 5.77 percent; however, the SMART Aim goal was not achieved. For the *Follow-Up After a Positive Depression Screen* measure, the highest rate achieved, 81.82 percent, exceeded the goal and represented an improvement of 44.32 percentage points over the baseline rate, which was not statistically significant. 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

Intervention Description	Type of Improvement Demonstrated by Intervention Evaluation Results	Final Intervention Status
SMFM Intervention 1: Integrate G-codes into workflow to ensure proper measurement capture of G8431 and G8450. Review and revise SMFM workflow for using G-codes.	*None*	Abandoned
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
SMFM Intervention 2: Create a standardized depression screening billing and Current Procedural Terminology (CPT) coding workflow for the partner provider.	*None*	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, 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. The intervention was 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 SMFM Intervention 1, the second intervention focused on *Depression Screening*, the health plan reported that intervention testing results did not demonstrate programmatic or clinical improvement; therefore, the intervention was abandoned. For MFHC Intervention 2, focused on *Follow-Up After a Positive Depression Screen*, the health plan reported testing results that demonstrated significant programmatic and clinical improvement. The health plan adopted the intervention and is expanding the PHQ-9 reporting to all BHAs across the organization. For SMFM Intervention 2, focused on *Follow-Up After a Positive Depression Screen*, the health plan reported that testing results did not demonstrate improvement due to practice-level G-code billing barriers; however, the intervention will be adopted by the health plan and a workflow for billing for positive depression screens is being rolled out for all providers.

Lessons Learned

An important part of the quality improvement 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.
- Stigma surrounding BH conditions and lack of member interest in obtaining BH care are challenging barriers to ensuring members obtain follow-up BH services after a positive depression 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 reported SMART Aim measure results that demonstrated 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 in *Depression Screening* and clinically and programmatically significant improvement in *Follow-Up After a Positive Depression Screen* linked to the tested interventions. The health plan provided an accurate narrative summary of key findings for the *Depression Screening* measure but documented an inaccurate summary of key findings for the *Follow-Up After a Positive Depression Screen* measure. Based on the validation findings, HSAG assigned a level of *Moderate 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 ensure that all documented interpretation of results, key findings, and conclusions for the PIP are accurate and supported by reported data.
- **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 – PRIME)

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, Mary Beckner and Jeremiah Fluke
Title	Quality Improvement Advisor/ Prime Contract manager
Email Address	heather.steele1@uhc.com/mary.beckner@uhc.com/jeremiah.fluke@uhc.com
Telephone Number	425-753-9312/541-709-6609
Submission Date	10/21/22
Resubmission Date (if applicable)	1/25/23

Provide the following final documents with the Module 4 Submission

- Completed PDSA Worksheets

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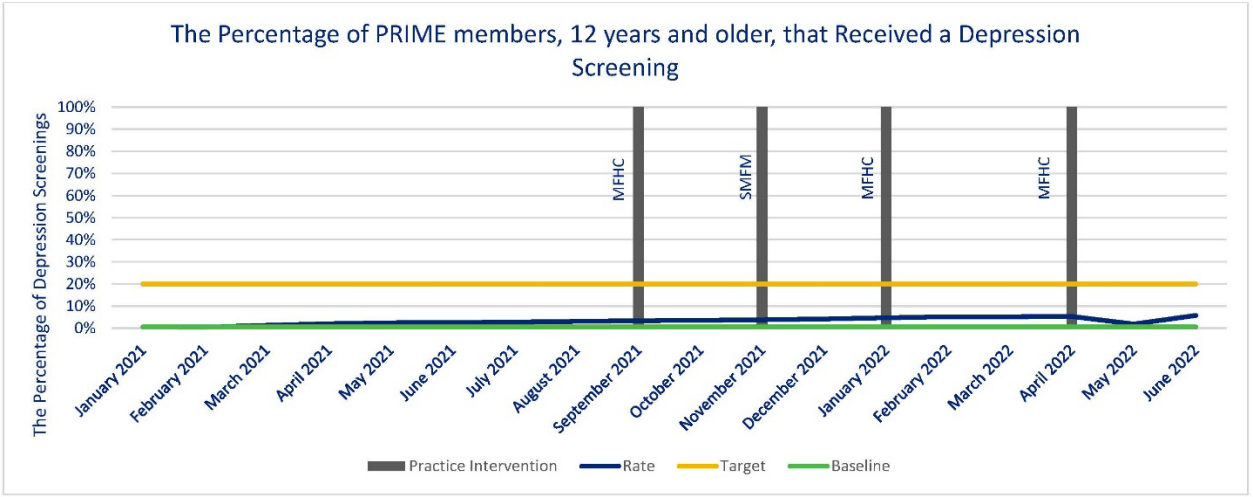
Final SMART Aim Run Chart – *Depression Screening*

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	18	3013	0.60%
03/01/2020-02/28/2021	February 2021	15	3041	0.49%
04/01/2020-03/31/2021	March 2021	41	3084	1.33%
05/01/2020-04/30/2021	April 2021	64	3124	2.05%
06/01/2020-05/31/2021	May 2021	77	3151	2.44%
07/01/2020-06/30/2021	June 2021	81	3168	2.56%

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08/01/2020-07/31/2021	July 2021	88	3195	2.75%
09/01/2020-08/31/2021	August 2021	100	3231	3.10%
10/01/2020-09/30/2021	September 2021	110	3255	3.38%
11/01/2020-10/31/2021	October 2021	116	3241	3.58%
12/01/2020-11/30/2021	November 2021	123	3236	3.80%
01/01/2021-12/31/2021	December 2021	136	3246	4.19%
02/01/2021-01/31/2022	January 2022	154	3269	4.71%
03/01/2021-02/28/2022	February 2022	168	3233	5.20%
04/01/2021-03/31/2022	March 2022	169	3248	5.20%
05/01/2021-04/30/2022	April 2022	176	3310	5.32%
06/01/2021-05/31/2022	May 2022	62	3324	1.87%
07/01/2021-06/30/2022	June 2022	190	3291	5.77%

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.

State of Colorado

Performance Improvement Project (PIP)

Module 4 — PIP Conclusions Submission Form

Depression Screening and Follow–up After a Positive Depression Screen

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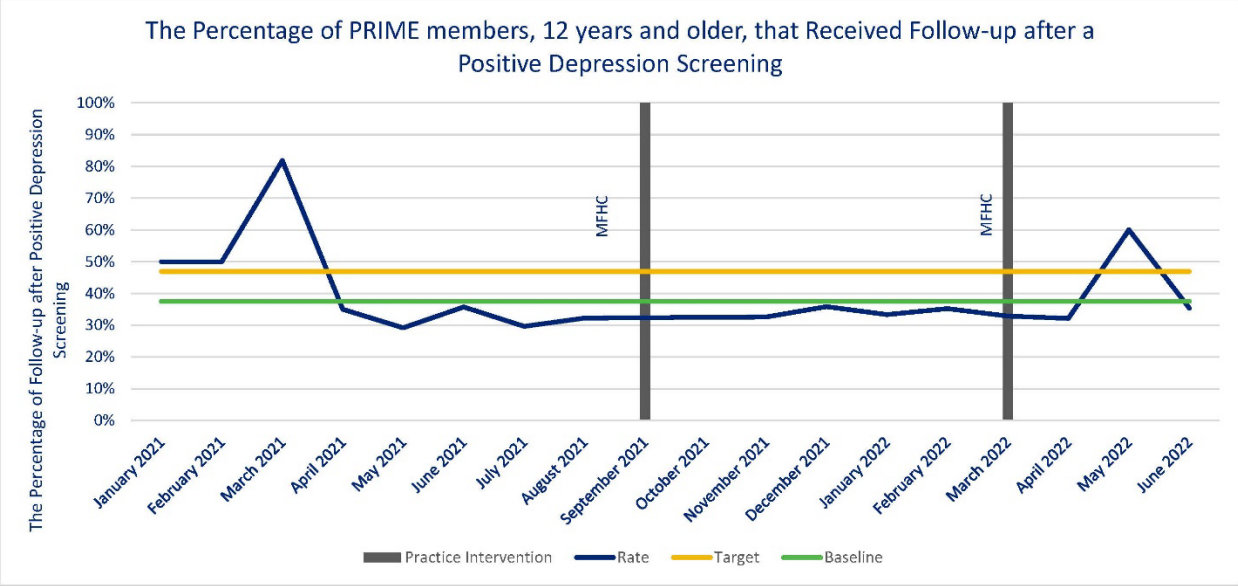

To confirm that the MCO used the 12-month methodology as required, check the box below.

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	4	8	50.00%
03/01/2020-02/28/2021	February 2021	3	6	50.00%
04/01/2020-03/31/2021	March 2021	9	11	81.82%
05/01/2020-04/30/2021	April 2021	7	20	35.00%
06/01/2020-05/31/2021	May 2021	7	24	29.17%
07/01/2020-06/30/2021	June 2021	10	28	35.71%
08/01/2020-07/31/2021	July 2021	8	27	29.63%
09/01/2020-08/31/2021	August 2021	10	31	32.26%
10/01/2020-09/30/2021	September 2021	11	34	32.35%
11/01/2020-10/31/2021	October 2021	13	40	32.50%
12/01/2020-11/30/2021	November 2021	14	43	32.56%
01/01/2021-12/31/2021	December 2021	19	53	35.85%

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02/01/2021-01/31/2022	January 2022	21	63	33.33%
03/01/2021-02/28/2022	February 2022	25	71	35.21%
04/01/2021-03/31/2022	March 2022	24	73	32.88%
05/01/2021-04/30/2022	April 2022	27	84	32.14%
06/01/2021-05/31/2022	May 2022	15	25	60.00%
07/01/2021-06/30/2022	June 2022	29	82	35.37%

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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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 – PRIME)

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

Global Aim

In alignment with the integrated model of care at Mountain Family Health Centers, St. Mary's Family Medicine and the core values of Rocky Mountain Health Plans, the global aim of this PIP is to increase the number of patients who are regularly screened for depression and if positive are connected to appropriate behavioral health services.

SMART Aim

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.55% to 20.0%.

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: 6/24/22
Version: V4

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

Global Aim

In alignment with the integrated model of care at Mountain Family Health Centers, St. Mary's Family Medicine and the core values of Rocky Mountain Health Plans, the global aim of this PIP is to increase the number of patients who are regularly screened for depression and if positive are connected to appropriate behavioral health services.

SMART Aim

By 6/30/2022, Rocky Mountain Health Plans (RMHP) will partner with Mountain Family Health Centers and St. Mary's Family Medicine to use key driver diagram interventions to increase the percentage of depression screenings for RMHP Medicaid Prime Members aged 12 and older from 0.55% to 20.0%.

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

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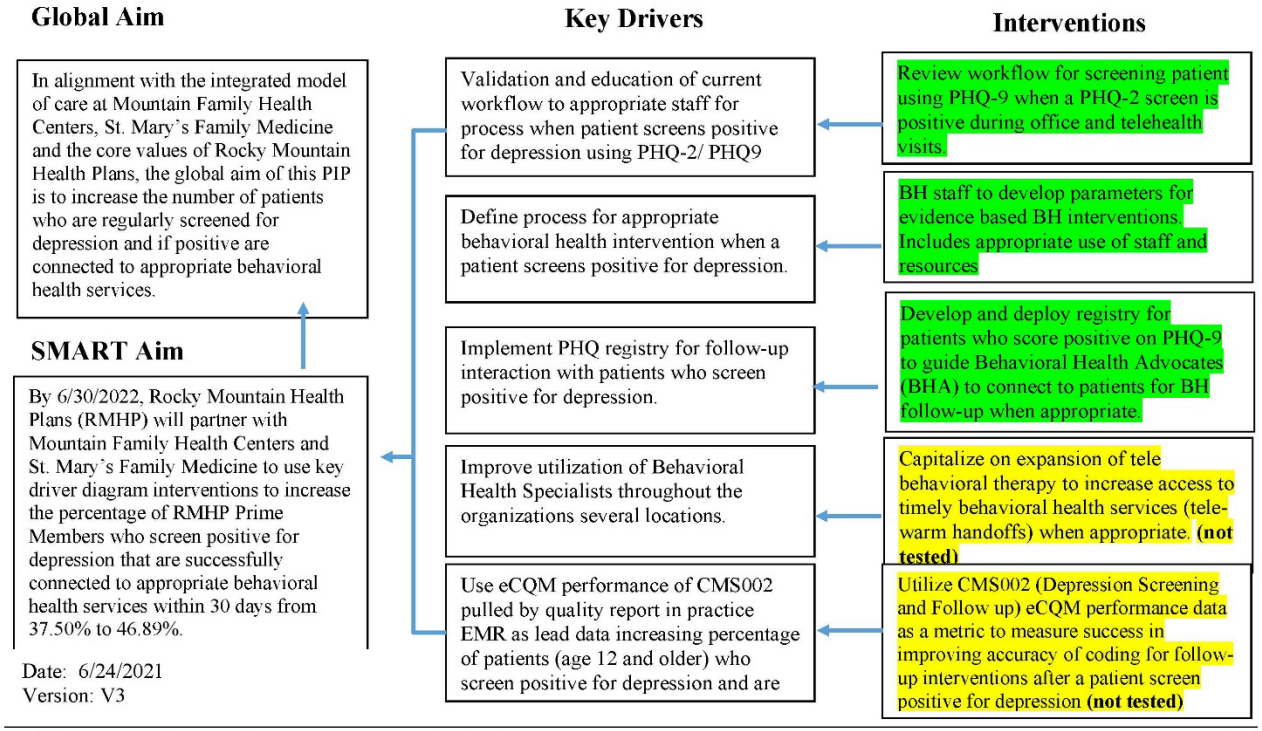
Key Driver Diagram – *Follow–up After a Positive Depression Screen Mountain Family Health Centers (MFHC)*



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

Global Aim

In alignment with the integrated model of care at Mountain Family Health Centers, St. Mary's Family Medicine and the core values of Rocky Mountain Health Plans, the global aim of this PIP is to increase the number of patients who are regularly screened for depression and if positive are connected to appropriate behavioral

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 RMHP Prime Members who screen positive for depression that are successfully connected to appropriate behavioral health services within 30 days from 37.50% to 46.89%.

Key Drivers	Interventions
Follow up positive depression screening with referral	Create a workflow for follow up intervention, Co-visit/ handoff, One-on-one, Consult with Behavioral Health.
Bill for follow up	Create standardized workflow for billing, Integration of CPT codes.
Schedule follow up visit	Workflow for follow up: MD, Behavioral Health team, or Outside behavioral health
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.	Using CMS002 data in EHR to track members who screen positive for depression and track follow-up visits scheduled. Identify Members who screen positive, no appointment scheduled and conduct outreach to members to schedule follow-up visit

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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	The SMART Aim goal of 20.0% was not achieved but a statistically significant improvement in the SMART Aim measure was achieved. Both MFHC and SMFM 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 practice in lessening identified gaps in the screening process. Screenings that were occurring within the practice were not adequately communicated to RMHP for PRIME patients via claims. The PIP project provided an opportunity for MFHC to develop and implement a new workflow to score, document and correctly code for depression screens with a negative result (G8510) and positive result (G8431). This workflow resulted in an improvement in claims-based submissions for depression screenings and results. The PIP project provided an opportunity for SMFM 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 ultimately resulted in an improvement in electronic medical record tracking for the process, but unfortunately SMFM leadership halted the use of claims-based submissions for PRIME Member depression screenings and results, due to the inability to bill depression screening for ALL patients (i.e., all payers).
Intervention Testing Conclusions	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 claims submissions of depression screening results for attributed PRIME members. MFHC is a Federally Qualified Health Center (FQHC) and they 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. SMFM developed a strong workflow for identifying patients in need of a depression screening. They piloted the project with 2 providers successfully. When it came time to spread the process clinic wide, it was stopped at the St. Mary's leadership level due to the inability to bill for ALL

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	patients – which goes against the mission of SCL Health (ownership of the primary care practice SMFM). Although the testing was a success and the workflow improved the process for identification of patients who may need a PHQ-9, results are not reflected in claims data, rather the results are only captured in the electronic medical record of the practice.
Spread of Successful Interventions	MFHC will continue to spread this workflow across all locations to ensure standardized use of a 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. As identified, SMFM is unable to bill for depression screenings, which results in a lack of successful spread of the use of G-codes. However, the workflow improvement to identify patients who need the screening has been successfully rolled out to all providers in the practice. This spread was communicated through a documented workflow and setting of expectations, and in updates to all staff via meetings and other forms of organizational communication.
Challenges Encountered During Project	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 in order to calculate score and submit to superbill. This created extra steps in the workflow when a patient scored 0 on the PHQ-2, which was 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. For SMFM, the barrier of being unable to bill the G-codes for screening is a challenge, but it is demonstrative of a larger barrier that system owned practices often face. In the case of SMFM, they are owned by a system that primarily operates specialty clinics and those specialty clinics have remained the primary focus of the organization. When it comes to the ability to change workflows and billing practices at the primary care practice level, it is evident that the larger organization is slow to understand the importance of billing practices that support quality care reporting.

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Lessons Learned/Information Gained Throughout the Project	RMHP successfully received claims from MFHC with G-codes attached (G8510 or G8431) for PRIME 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. SMFM is set up to begin billing for the screenings once the larger organization will allow it, but ultimately the practice has no influence over this organizational decision.

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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 PRIME 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. Additionally, RMHP has included a requirement to use the identified depression screening G-codes in many of the Community Integration Agreements offered to providers, beginning in 2023. These agreements are a type of value-based contract that allows an organization to earn additional funding for meeting the objectives written into the agreement.

RMHP will continue to monitor G-codes submitted through claims for PRIME 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 MFHC and SMFM 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 hospital system practice (SMFM), RMHP will prioritize our focus to educate and train FQHCs within the PRIME 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	The SMART Aim goal of 46.89% was not achieved and statistically significant improvement was not achieved by the SMART Aim end date. Of note, the improvement in the practice's ability to screen and accurately code and bill for depression screening contributed to a numerical increase in follow up for patients who screen positive for depression. The baseline data showed only 3 members out of 8 had follow-up after a positive depression screen, while the last data point showed us that 29 patients out of 82 had follow-up after a positive depression screen. This shows an improvement to identify and connect patients who screen positive for depression to behavioral health services. Both MFHC and SMFM 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 and the interventions tested by both practices resulted in clinically significant improvements in connecting patients to behavioral health services provided in the clinic.
Intervention Testing Conclusions	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. Using a registry to outreach patients for connection to services help patients get into a behavioral health provider in a timelier manner. With the increase in patients who were connected to a behavioral health provider as an outcome of the registry outreach, the practice learned that many patients had already established care with MFHC behavioral health providers or with other community behavioral health providers. Intervention testing period 3/1/22-5/31/22 resulted in 3/14 patients being successfully connected to behavioral health services. These are patients who, without outreach efforts by a Behavioral Health Advocate (BHA), would not have connected to a behavioral health provider after scoring positive on a depression screen during a recent visit. SMFM has created a standardized workflow for both screening of depression and for follow up after a positive screen throughout the clinic. They have alerted leadership to the importance of being able to bill for these activities to inform quality initiatives among the opportunities for reimbursement. Although the billing for screening was discontinued during the PIP, leadership is now aware of the importance of billing the G-codes. They are also aware that the primary care

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
	clinic is ready to submit the G-codes on claims once allowed, as well as billing for the follow up after a positive depression screening.
Spread of Successful Interventions	MFHC decided to expand the PHQ-9 report registry outreach to all BHA's within the organization. This process shares responsibility across the BHA's and will result in improved timeliness for outreach to patients. The SMFM standardized workflow for depression screening and follow up created for all providers has been successfully rolled out clinic wide. However, the use of G-codes has been halted for the time being and could potentially be reassessed in the future.
Challenges Encountered During Project	MFHC completed two (2) rounds of PDSA cycles for intervention testing and noted the following challenges: • Documenting actions from outreach by a BHA in the PHQ-9 registry adds additional manual work outside of the patient record. • Only one BHA has been testing this intervention which poses an issue to timely outreach after a positive depression screen is obtained. • PHQ-9 registry report is not being run for the BHA team as often as needed. This results in follow up by a BHA that may be happening outside of the 30-day window. The organization may need to spread this work if this intervention is adopted as a practice workflow. SMFM completed two (2) rounds of PDSA cycles for the intervention testing and noted the following challenges: • The stigma around behavioral health services is certainly a challenge. SMFM works hard to do warm hand-offs when possible so that the patient has the opportunity to meet the behavioral health provider and feel reassured about the services they are eligible for. • Another challenge was understanding the requirements needed to be able to implement the billing, coding and workflow for submission of the CPT codes 90791, 90832, 90834, 90837 and have them reimbursed. SMFM is unable to bill for depression screenings, thus the 30 day follow up is not able to be tracked via claims.

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Table 2b—Project Conclusions – *Follow-up after a Positive Depression Screen*	
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 patients on the follow up list are already connected to community behavioral health services (or MFHC behavioral health services) and many were unable to be reached. The proactive process of creating and working the PHQ-9 registry may help to decrease the stigma around behavioral health/therapy as a successful treatment for depression. SMFM was able to successfully standardize the workflow for billing and introduction of the CPT codes 90791, 90832, 90834, 90837 for follow up after a depression screening, but this is not reflected in claims due to the inability to bill for the screenings. A lesson learned was how difficult it is to schedule patients within 30 days, especially if they are not interested in behavioral health intervention. This is an ongoing difficulty as SMFM continues to try to educate and decrease the stigma around behavioral health services.

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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 follow-up after a positive depression screening for PRIME 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 positive 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 the use of the *Short-term Behavioral Health services in Primary Care* benefit as an effort for tracking and connecting patients to behavioral health services, if the 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 for PRIME Members. The follow up connection to behavioral health services will also be monitored through the submission of claims therapy codes for PRIME members. This data will be reviewed and used to inform intervention work at the health plan, practice, and Member level. This data review will occur regularly through the RMHP Integrated Quality Workgroup. RMHP will share workflows adopted by MFHC and SMFM with our network partners to demonstrate a successful process for completion of a follow up service after a positive depression screening for RMHP Members.

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 PRIME Members/Patients* intervention. For *Follow-up After a Positive Depression Screen*: • The SMART Aim goal was achieved. • Non-statistically significant improvement over baseline 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	The health plan's summary of conclusions was accurate for the *Depression Screening* measure but was inaccurate for the *Follow-up After a Positive Depression Screen* measure. Specifically, the health plan included the following statement in the *Follow-up* summary: "The SMART Aim goal of 46.89%% was not achieved but a statistically significant improvement in the SMART Aim measure was achieved." The reported SMART Aim measure data for *Follow-up After a Positive Depression Screen* measure did not support this statement. Based on the reported data, HSAG determined that the reverse was true: the SMART Aim goal was achieved but statistically significant data was not achieved.

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Criteria	Score	HSAG Feedback and Recommendations
		Resubmission January 2023: The health plan revised the project conclusions for the *Follow-up After a Positive Depression Screen* measure and addressed some but not all HSAG's initial feedback. Although the health plan corrected the statement regarding statistically significant improvement, the project conclusions continued to include the statement, "The SMART Aim goal was not achieved…" at the top of page 17. This statement was not supported by the reported *Follow-up* SMART Aim measure data reported on pages 6 and 7, which included the May 2022 result of 60.00% that exceeded the goal of 46.89%. Due to the remaining inaccuracy in the project conclusions, the score for this criterion remains *Partially 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 *Moderate 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 conducted 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 some but not all key project conclusions for the *Follow-up After a Positive Depression Screen* measure. The revised documentation correctly reported conclusions related to statistically significant improvement but did not accurately report that the SMART Aim goal was achieved, as demonstrated by the reported May 2022 *Follow-up* SMART Aim measure results of 60.00%.