Denver Health Medical Plan, Inc.

Quality Improvement Program Evaluation 2017

Commercial & Medicare Products

Contents

I. Executive Summary

Denver Health Medical Plan, Inc. (DHMP) is a licensed Health Maintenance Organization (HMO), effective 1/1/97, with responsibility for managing the following DHMP member groups and their health care:

Commercial Large Group:

- City and County of Denver (CSA)
- Denver Health and Hospital Authority (DHHA)
- Denver Employees' Retirement Program (DERP)
- Denver Police Protective Association (DPPA)
- Denver Public Schools

Commercial Exchange;

- Elevate Health Plans

The DHMP Medicare Advantage health plan includes:

- Medicare Select HMO
- Medicare Choice HMO SNP

Medicare Choice and Select both fall under the DHMP HMO plan for health care services. Our Medicare Choice members are covered by both Medicare and Medicaid insurance benefit plans with enrollment in our special needs (SNP) plan.

DHMP established and maintains a comprehensive Quality Improvement (QI) program to systemically define, evaluate and monitor continuous quality improvement, ensuring high-quality; cost-effective care and services are provided to DMHP and Medicare members. The Quality Improvement program incorporates evaluation of key indicators of care and service to identify improvement opportunities, resulting in development and implementation of interventions to increase defined quality metrics. A multidimensional approach is utilized to measure effectiveness. Dimensions evaluated include: appropriateness, efficiency, effectiveness, availability, timeliness, continuity and cost of care and services, as well as member satisfaction, health outcomes and provider satisfaction.

Annually, we review ongoing and completed QI activities, complete analysis of our results and evaluate the overall value of our program. From this evaluation process, we develop recommendations for the upcoming year, which are incorporated into the quality improvement program description and work plan. The Medical plan is able to assess the strengths of the program and identify opportunities for improvement, incorporating learning from the ongoing activities.

In this report, DMHP QI program activities are summarized and evaluated, including program accomplishments and opportunities, with tracking and trending of results and data over time. Data is systematically collected prospectively, concurrently, and/or retrospectively on clinical, safety, preventive and service performance. This data is analyzed, summarized, and presented as information, with recommendations to Quality Management Committee (QMC). QI actively collaborates with other health plan departments, as well as our network providers to develop, implement and evaluates QI initiatives. QI activities are coordinated and implemented with case management, care management, pharmacy, member services, provider/network services, health management services, marketing and product line managers for Commercial and Medicare.

Our provider network includes the Ambulatory Care Services of Denver Health, known as Community Health Services (CHS) for our health maintenance organization (HMO) membership. For the POS (point of service members), we offer the Cofinity Network, including University and Children's Hospital, under more expansive

health plan offerings of expanded and POS (point of service) benefits. We collaborate with Denver Health Community Health Services on QI initiatives through the Ambulatory Quality Improvement and Design Committee (ADQIC), disease and prevention specific work groups and the patient experience work group. In these committees and groups, we join quality resources and actively work together to increase the health and well-being of our members.

For DHMP HMO and Medicare Select and Choice members affiliated with Ambulatory Care Services/Community Health Services, Denver Health is promoted as their medical home (PCMH). A patient centered medical home is responsible for care coordination and provides health maintenance preventive care, anticipatory guidance and health education, acute and chronic illness care, and with coordination of medications, specialists and treatment planning. It is patient centric, encouraging the member to be a partner in their health care decision making. CHS pursued National Committee on Quality Assurance Accreditation (NCQA) for their Patient Centered Medical Home (PCMH) care services in calendar year 2014, achieving a Level II PCMH accreditation.

Randomized provider and clinician CAHPS surveys are done at CHS clinics to measure patient satisfaction with their provider and their care. The information is monitored monthly by the patient experience workgroup for analysis and action planning targeting identification of best practices within clinics.

The Cofinity provider network is an expanded and essential part of our ongoing commercial benefit structure. Providers compromising this network serve our point of service (POS) members for our Commercial plan. Our quality improvement initiatives support collaboration with these practices and facilities in working together to improve the quality and patient experience for our members. Together, the Medical Plan and ACS focus on raising the overall quality of services to achieve measurable outcomes and more productively use resources.

II. Quality Improvement Program Evaluation and Work Plan

Overview

The QI Program Description and QI Work Plan provide guidance to the program structure and activities for a period of one calendar year. Input is obtained from a variety of sources, including the DHMP operations management team, medical management department staff, QI staff, data sources, HEDIS reporting and CAHPS surveys. CMS and contractual requirements for our Medicare Advantage and SNP plans and Commercial groups are reviewed annually, with inclusion in our development and evaluation of quality program indicators.

A QI work plan is prepared annually for the upcoming year for submission to the QMC and the Medical Plan Board of Directors for approval. The work plan includes the following elements:

- Written, measurable objectives for the year
- Quality clinical, preventive and services interventions and initiatives
- Overall scope of the QI program including clinical, safety and service indicators, responsible parties, implementation, review and timeframe of initiatives
- Schedule of reports and planned activities
- Evaluation of the effectiveness of the QI program
- Member Experiences

Quality Improvement Objectives for 2017

- Deliver quality care that meets community standards and offer customer focused service to our members and practitioners/ providers
- Continuously measure, analyze, evaluate and improve the clinical care and administrative services of the plan and health care services delivered by contracted practitioners/providers, using Healthcare Effectiveness Data and Information Set (HEDIS) measures, QI projects and activities, and Consumer

Assessment of Health Providers & System (CAHPS) member surveys

- Implement internal quality improvement activities as necessary
- Adopt national, regional and/or local public health goals and industry performance as benchmarks, evaluating available resources for QI to make sustainable decisions
- Promote medical and preventive care delivered by practitioners/providers that meets or exceeds the accepted standards/benchmarks of quality in the community
- Empower members to lead a healthy lifestyle through health promotion activities, community outreach efforts and coordination with public and private community resources
- Encourage safe and effective clinical practice through established care standards and applying appropriate practice guidelines
- Monitor and evaluate high volume and/or high risk services to identify opportunities for improvement.
- Coordinate delegated activities on behalf of contractual organizations
- Address special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate
- Maintain the health information system to comply professional standards of health information management, including HIPAA privacy and security laws and state privacy standards
- Acquire collaborative feedback from members of the QMC on quality initiatives

QI Program Scope

The QI program includes all administrative departments and services rendered to members by participating providers and practitioners, including:

- Inpatient and outpatient care
- Durable medical equipment
- Physical therapy
- Imaging
- Laboratory pharmacy services
- Behavioral health services
- Ancillary services
- Skilled nursing care
- Home health
- Infusion therapy
- Hospice

The program is comprehensive in scope, is ongoing and includes strategies to monitor, identify, evaluate and resolve problems that affect the accessibility, availability, continuity and quality of care and service provided to DHMP members. The QI program is integrative and designed to link structure, process, and knowledge throughout the Plan to assess and improve quality of health care services.

The QI team is responsible to implement the following:

- Identify and prioritize quality activities based on NCQA and regulatory requirements
- Review data annually to determine QI activities that will have a significant impact on our population
- Work collaboratively with ACS, Denver Public Health and other health plan partners to address healthcare quality initiatives
- Utilize national goals as well as NCQA, HEDIS, and regional benchmarks to establish goals for the Plan
- Employ the use of geo-access software to analyze access and availability of providers and pharmacies

for the membership. Annually, an access report is finalized with geo-access results for member access, panel sizes, telephone responsiveness, referral turnaround timeframes, and monitoring of appointment standards. Language competencies of providers are also evaluated

Recommendations for QI initiatives are reviewed by the QMC. The initiatives are designed to improve performance on selected aspects of clinical care and safety, continuity and coordination of care, preventive care and services to members. QI activities are conducted utilizing the following processes:

- Prioritize specific indicators of performance
- Collect appropriate data
- Analyze data
- Identify opportunities to improve performance
- Implement interventions with objectives, goals, timelines and ownership
- Measure effectiveness of interventions and /or conformance to guidelines
- Re-evaluate for further potential performance improvements

The primary source of information for QI initiatives are from HEDIS and CAHPS. HEDIS clinical outcomes measures data are reviewed for diabetes, cardiovascular conditions, musculoskeletal conditions, prenatal and postpartum care, respiratory conditions, medication management, behavioral health care and preventive health screenings and other quality of care indicators for children and adults. For quality of service, multiple sets of data are reviewed: (i) CAHPS member satisfaction survey data; (ii) HEDIS use of services and access and availability measures; (iii) Grievance and appeal data; and (iv) Quality of Care Concerns (QOCC) and service complaints.

Quality Improvement Program Accomplishments and Strengths

In the past year, the QI program team members have been instrumental in the planning, assessment, implementation and review of various QI activities, highlighted below:

- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention
- Continued to identify and develop training to assist in appropriate provider documentation and coding to support improvement of HEDIS scores
- Increased member outreach to encourage preventive health screenings and to support members with chronic disease conditions, such as diabetic eye exams and mammograms
- Developed, implemented and evaluated incentives for members to engage in evidence based prenatal and postpartum care
- Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase number of adolescent well-child visits and immunizations within Denver Public Schools, including development of an incentive program to increase well child visits to those ages 12 and above
- Continued refinement of member outreach efforts, utilizing EPIC implementation for ACS and QNXT member portal for DHMP
- Collaborated with health management to increase comprehensive contact with members, increase scope in health coaching disease management and evaluate reach and effectiveness of services.
- Developed and implemented enhanced patient education materials, focused on health literacy and cultural competency
- Conducted an annual provider satisfaction survey to evaluate satisfaction DHMP departments and services, including knowledge of DHMP offerings to support patient care
- Conducted an annual medical interpretation survey to evaluate scope and responsiveness of services

- Conducted an annual open shopper survey to evaluate access and availability in both the ACS and Cofinity provider networks, including behavioral healthcare providers
- Collaborated with patient experience workgroup on increasing provider participation with patients in shared decision making and understanding treatment options more fully
- Participated as a member of the Denver Health diversity steering committee to increase health literacy/cultural competency, and reduce health disparities, through services in Denver Health
- Supported development of CLAS training in required annual training for Denver Health providers and staff to support the delivery of culturally sensitive care and engage fully in participation of a diverse workforce
- Maintained the NCQA accreditation for Multicultural Healthcare distinction
- Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting
- Maintained over sight and follow-up of delegated and facility credentialing relationships
- Increased outreach to DHMP members through ACS clinic staff and targeted member outreach at high volume point of service offices
- Facilitated physician involvement in the development of clinical guidelines, including the streamlining process of guideline development
- Conducted development, review and revision of policies and procedures annually through electronic tracking process
- Maintained physician involvement within the QMC structure from both ACS and Cofinity networks

The overall effectiveness of the QI program continues to be evaluated critically. Success in achieving NCQA accreditation for Medicare, and commercial/exchange line of business renewal of full accreditation over the past year has provided a dedicated focus on opportunities for improvement. Meeting NCQA standards will align the QI department of DHMP with improvement in HEDIS and CAHPS metrics more fully, as improvement in scores will be required for Plan re-accreditation in 2020.

Challenges and Opportunities

The adequacy of resources for the QI program continues to be challenging, needing consistent refinement throughout 2017.Significant progress has been made in staffing stability and full time positions were staffed in October 2017. Significant progress and engagement with ACS partners for QI has also been recognized in 2017.. We continue to evaluate our need for more resources, especially in HEDIS data collection and analysis, along with access to and accuracy of data. The IS (Information Systems) conversion from our Dell claims platform to a Cognizant QNXT product has continued to be challenging in terms of IS resources needed for HEDIS and CAHPS. In addition, the DHHA migration to EPIC has posed challenges for data completeness, accuracy and extraction. Increasing our HEDIS scores requires looking at the data results more than once a year to be effective and to give timely feedback to our providers on performance. In addition, ongoing analysis or key drivers of rate includes coding, documentation and claims system configuration for key data elements associated with HEDIS rate production is needed. The creation of a DHMP data warehouse for medical and pharmacy claims data in 2017, along with emerging efforts at adding EPIC based encounter data in 2018 will enhance the foundation of improved data quality, completeness and timeliness to support QI intervention efforts.

DMHP will need to strategize and continuously evaluate how to best use QI resources. Alignment and collaboration with other QI initiatives being done by ACS and providers in the Cofinity network will help maximize our limited resource availability. In addition, we continue to elicit the support of leadership to help move QI activities forward.

Our committee structure continued to be evaluated over 2017. The QMC evolved with regular attendance of

physicians and practitioners. The director of QI for ACS was a regular attendee, along with Cofinity providers, ACS clinic providers, UPI providers and specialty care providers as QMC members. The structure change, done in late 2013, has proven to be significantly better. The QMC has evolved to be a body reflecting on reach and effectiveness of our studies and interventions, servicing as an "advisory board" to DHMP through the QMC process. With changes in some of the medical management departments occurring, case/utilization and care management will be working on the former utilization management committee structure, and it's restructure as the Medical Management Committee (MMC) and their reporting up through the QMC in 2018. Continuous evaluation of the QMC process will continue throughout 2018, with a focus on increasing communication and collaboration of quality improvement efforts organization wide.

Practitioner participation improved over 2017, achieving one of our key metrics for evaluation. We have increased our practitioner involvement with QMC, which allows practitioner input into all aspects of health plan operations and services. Our Provider Survey was expanded to include other specialties to increase valuable information about improving continuity and coordination of care. Increased involvement of QI team members in ACS work groups; clinical design work groups and disease and prevention work groups within CHS will need to continue with targeted focus in 2018.

Leadership involvement, defined as the operations teams from DHMP, the management and operations teams from CHS and provider involvement from our Cofinity network, has continued to increase over the past year. A defined focus and contribution of the QMC has given DHMP a valuable sounding board and feedback mechanism for all departments that present up through the committee. The involvement of the director of QI for ACS, several ACS and School Based Health Center (SBHC) providers and practitioners, along with Cofinity network and UPI providers has provided a rich mix of differing insight and feedback to departments and the QI team in assisting in evaluating reports and interventions. The director of QI is involved on several quality committees and workgroups within ACS, including the AQIDC, which combines the previously separate ambulatory quality improvement and the clinical design work group committees. Members of the QI team staff attend and interact in a variety of ways with chronic disease and prevention work groups, led by senior medical leadership of ACS including the patient experience workgroup (designed to focus on increasing metrics of patient experience, including CAHPS and customer service). .

Future Opportunities for Improvement

- Develop a data validation plan for HEDIS measures, confirming that data and counts are accurate, while continuing to increase supplemental sources of data information for HEDIS measures.
- Evolve the real-time quality data availability and usability through the 2016 launch of the DHMP data warehouse and the 2018 effort to integrate EPIC based encounter data
- Increase engagement and training of providers in HEDIS metrics and provide meaningful, provider-centric education and training to increase HEDIS scores through appropriate medical record documentation and coding and claims submission.
- Work with ACS and DH leadership in the Studer patient experience initiatives throughout Denver Health, focusing on customer service metrics and rounding of staff to improve CAHPS scores.
- Develop a plan with ACS QI leadership to address gaps in care with year around interventions and activities.
- Conduct evaluation of member engagement strategy to increase member buy-in and involvement in self-management goals. Evaluate effective platforms for communication with members.
- Align and partner quality improvement initiatives and interventions with ACS leadership and provider networks to avoid duplication of effort and to utilize resources more effectively.
- Continue to develop the use of LEAN framework within quality initiatives to develop A3 problem solving aligned with our PDSA (plan, do, study, and act) format. Utilize LEAN framework to develop and evolve standard work for QI team.

- Develop REL data collection that will lead to accurate assessments of health disparities for identification of improvement opportunities, where this had been previously addressed by DHHA's participation in the AHA 123 Pledge for Equity
- Develop and implement quarterly review of HEDIS to ensure more timely measures and interventions
- Expand and support QI opportunities for growth and enhancement of skills
- Address known opportunities for NCQA standard improvement and an organizational plan for NCQA standard compliance and accreditation renewal

Clinical Guidelines

Annually reviewed the following Clinical Care Guidelines in 2017 for any nationally recognized updates:

- Diabetes Management Standards
- Management of Asthma in Adults and Children
- Treatment of Depression in Adults in Primary Care
- Treatment of ADHD in Children and Adolescents

Preventive Guidelines

Annually reviewed the following Preventive Care Guidelines in 2017 for any nationally recognized updates:

- Care of Well Newborn
- Perinatal Care
- Fall Prevention Guideline for 65+ & Above
- Routine Cervical Cancer Screening

Both Clinical and Preventive Guidelines guide the QI team in their clinical care quality activities and interventions with providers and members. Each guideline is developed to reflect nationally recognized sources, as well as community healthcare standards. Additionally, QI partners with content experts (Physicians) to review and modify the guidelines to meet member needs with the best practices.

III. Quality of Clinical Care Activities

Indicators for clinical care are based on HEDIS outcome measures and include: diabetes, cardiovascular conditions, asthma, prenatal and postpartum care, behavioral healthcare and preventive health screening measures. Review of these measures is conducted once a year. The results are available after successfully passing the HEDIS audit in June. Results are compared to the previous year and trended over several years. In 2017, HEDIS rates for the Exchange members were reported in the overall Commercial rates, due to small population size.

2017 HEDIS rates are based on measurement year 2016 data, the previous year rate, and the 90th percentile benchmark, which is our target goal. The following QI initiatives are focused on these clinical indicators with the purpose of improving the quality of clinical care and health outcomes for our members.

2017 QI Activities/Interventions

Diabetes

2017 HEDIS Diabetes Results for Commercial Line

Diabetes Indicators	Commercial			
	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90th Percentile
HbA1c Testing	88.38%	89.43%	89.16%	94.83%
HbA1c Poor Control >9.0% (lower=better performance)	30.89%	37.46%	34.98%	20.98%
HbA1c Control <8.0%	57.19%	47.73%	50.77%	66.39%
Eye Exam	45.87%	41.39%	47.37%	72.04%
Medical Attention for Nephropathy	76.15%	83.99%	87.12%	92.71%
Blood Pressure Controlled <140/90	74.92%	75.53%	69.97%	78.35%

2017 HEDIS Diabetes Results for Medicare Line

Comprehensive Diabetes Care (CDC)	Medicare			
	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90th Percentile
HbA1c Testing	94.40%	94.40%	90.02%	97.08%
HbA1c Poor Control >9.0% (lower=better performance)	21.65%	24.09%	26.03%	12.71%
HbA1c Control <8.0%	60.83%	58.88%	58.88%	76.05%
Eye Exam	64.48%	67.88%	67.88%	83.54%
Medical Attention for Nephropathy	86.13%	89.78%	93.43%	98.38%
Blood Pressure Control <140/90	75.91%	71.29%	65.69%	80.12%

HEDIS 2017 Changes for Diabetes Measures

- Added bilateral eye enucleation to the Eye exam (retinal) performed indicator
- Revised the language in step 1 of the BP control <140/90 mm Hg Numerator and added Notes clarifying the intent when excluding BP readings from the numerator
- Clarified the medical record requirements for evidence of ACE inhibitor/ARB therapy (for the Medical Attention for Nephropathy indicator)
- Replaced medication table references with references to medication lists
- Added “sacubitril-valsartan” to the description of Antihypertensive combinations in the ACE Inhibitor/ARB Medications List
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology

Summary of 2017 HEDIS Diabetes Commercial Results

Although some of the comprehensive diabetes care measures improved in 2017 all of the diabetes measures are still below the 90th percentile.

DHMP Diabetes Collaborative Quality Improvement Workgroup

DHMP QI staff members, as well as representatives from DHHA and Denver Health's Ambulatory Care Services (ACS), participate in the Denver Health Diabetes Collaborative QI Workgroup. Participants provide regular updates on diabetes related initiatives and engage in discussions related to diabetes quality measures.. The DHMP QI staff members provide regular updates on an intervention to improve the rate of completed diabetic retinal exams. The collaborative regularly tracks patient outcomes for diabetes management.

Summary of 2017 HEDIS Diabetes Results

In comparing 2017 HEDIS results against national benchmarks, reveals that the 2017 HEDIS results are below 90th percentile benchmark for all comprehensive diabetes care measures. Although the measures fall below the 90th percentile, Commercial rates improved for the HBA1C Control <8.0%, Eye Exams, and Medical Attention for Nephropathy measures. The Medicare rate for Medical Attention for Nephropathy improved in 2017.

2017 Interventions

In 2017, QI continued the diabetic eye exam outreach project, which started in 2015. This project is collaboration between DHMP QI staff and Care Navigators from the Denver Health Eye Clinic. The project involves the Care Navigators conducting outreach calls to Medicare, Commercial and Medicaid patients who have been identified through claims data as needing either a dilated retinal exam or an eye camera screening. Once contacted, members are scheduled for an appointment with One Hour Optical or the Denver Health Eye Clinic.

The intervention initially focused on the Commercial, Medicare and Medicaid lines of business but was later amended to devote more focus on the Commercial and Medicare plans. A "successful call" is defined as a call completed by a Care Navigator which resulted in a member being scheduled for an eye exam.
As a result of this intervention, the number of completed diabetic retinal exams in 2017 for Medicare members exceeded both the goal and stretch goal for 2017. The goal for completed exams was 830 and the stretch goal was 1,038; the final number of completed eye exams for DHMP Medicare members was 1,091. The goal for Commercial members was not met.

2017 DM Eye Exam Outcomes	
LOB	**Total # of Completed appointments**
Medicare	1,091
Commercial	235
Total (Medicare & Commercial)	1,326

Action Plan for 2018

QI will continue to participate in the Diabetes workgroup and monitor the activities related to diabetic retinal exams. Quality Improvement will continue to focus on increasing the Diabetic Eye Exams measure for 2018, which still sits well below the 90th percentile ranking. The Commercial Diabetic Eye Exam component of the Comprehensive Diabetes Care (CDC) HEDIS measure increased from 41.39% to 47.37% while the same component for Medicare stayed the same at 67.88%. We have applied LEAN methodology to this issue to identify root causes and issues leading to low HEDIS rates for diabetic eye exams.

An ongoing barrier to this intervention is limited appointment availability at the Denver Health Eye Clinic. This issue is being addressed. As an organization, Denver Health has made the commitment to improve access for optometry and ophthalmology services. Care Navigators located in the Ambulatory Care Services clinics will continue to conduct outreach calls to members with diabetes due for their eye exam. In 2018, the project will continue to focus on the Commercial and Medicare Plan members. The Care Navigators will also identify barriers

around members getting to their appointment in an effort to address the issue of patient no-shows to the clinic.

Cardiovascular Conditions

2017 HEDIS Cardiovascular Conditions Measures Results

Cardiovascular Indicators	DHMP Medicare				
	2014 HEDIS Results	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2016 HEDIS 90th Percentile
Controlling High Blood Pressure (CBP)	70.07%	78.59%	69.34%	74.94%	84.67%

HEDIS 2017 Changes

No major changes to the CBP Measure for H2017.

Summary of 2017 HEDIS CBP

The rate for Controlling High Blood Pressure (CBP) measure remains below the 90th percentile although there was an improvement in HEDIS results from 2016 – 2017, with the rate increasing from 69.34% to 74.94%. In terms of national percentiles DHMP Medicare is in the 50th percentile, which is an improvement from the 25th percentile in 2016. There are currently no active, ongoing interventions targeting this particular measure, though ongoing discussions for future interventions will feature CBP monitoring.

2017 HEDIS Prevention and Screening Measures Results

HEDIS Measure	DHMP Medicare				
	2014 HEDIS Results	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90TH Percentile
Adult BMI Assessment (ABA)	93.92%	92.7%	96.11%	98.05%	99.09%
Breast Cancer Screening (BCS)	76.80%	73.7%	70.83%	71.25%	83.14%

HEDIS Measure	DHMP Commercial		
	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90TH Percentile
Adult BMI Assessment (ABA)	97.08%	92.21%	91.85%
Breast Cancer Screening (BCS)	65.81%	69.91%	80.63%

There are no active ongoing interventions designed to improve the ABA measure in the DHMP Medicare

population as a result of a 90th %tile performance for this measure.

Breast Cancer Screenings (BCS)

All women 50-74 years old, who are in need of a mammogram, are sent a mailer reminding them to schedule an appointment. The mailer also includes the DH ACS & HEDIS screening recommendations for cervical and colon cancer screening. The QI department uses HEDIS technical specifications and claims data to identify members due for a mammogram. Lists of eligible members are generated on a monthly basis. Members have the option to either get their mammogram from the radiology clinic on the main Denver Health campus or utilize the Denver Health Women's Mobile Clinic. The Women's Mobile Clinic provides a private, comfortable and convenient setting to receive a mammogram.

HEDIS 2017 Changes for Breast Cancer Screenings

NCQA Clarified that diagnostic screenings are not included in the measure.

Breast Cancer Screening Analysis

The results for Breast Cancer Screenings between HEDIS 2014 and HEDIS 2017 are consistently below the HEDIS 90th percentile for this measure.

In 2015, a total of 796 Medicare members that were due for a mammogram received a Mammogram reminder mailer. Of those that received a mailing, 339 (42.59%) obtained a mammogram. Of members in the Commercial plan that received mailers, 386 completed a mammogram.

In 2016, a total of 1211 Medicare members due for a mammogram received a reminder mailer. Of those that received a mailing, 680 (56%) obtained a mammogram. A total of 819 Commercial members due for a mammogram received a reminder mailer. Of those that received a mailing, 436 (53%) completed a mammogram.
This is a vast improvement and we are estimating that our HEDIS 2017 numbers for this category will increase due to this increase in members receiving their exams.

In 2017, a total of 1226 Medicare members due for a mammogram received a reminder mailer. There were 601 completed mammograms during the calendar year 2017 for the Medicare population. During this same timeframe, 1044 Commercial members also received a Mammogram mailer. There were 673 completed mammograms for the commercial population during this timeframe. The number of completed BCS exams as a whole is increasing, in alignment with an increased number of mailings being sent to the Commercial & Medicare populations.

LOB	Completed BCS Exam
COMM	673
MCR	601
Total	1274

Breast Cancer Screening Action Plan for FY2018

All Medicare and Commercial female members 50-74 years old, who are due for a mammogram, will continue to receive a mailer reminding them to schedule an appointment. The QI Intervention Manager will continue to monitor the progress of this intervention. The DHMP QI department maintains a consistent presence at the ambulatory care cancer screening workgroup. This group provides an open forum for discussion surrounding

collaboration with ambulatory care providers and the Women's Mobile Clinic. The QI department will continue this mailing intervention and discussions regarding telephonic outreach for members overdue for screenings are in place with the Women's Mobile Clinic.

Colorectal Cancer Screenings (COL)

HEDIS 2017 Changes for Colorectal Cancer Screening Measures

NCQA provided clarification concerning when pathology reports may be used for numerator hits during medical record review, described below:

Pathology reports need to indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed in order to meet criteria.

For pathology reports that do not indicate the type of screening, or for incomplete procedures:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy

Colorectal Cancer Screening Analysis

HEDIS Measure	DHMP Medicare				
	2014 HEDIS Results	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90TH Percentile
Colorectal Cancer Screening(COL)	62.04%	66.42%	67.40%	60.58%	81.48%

The COL rates for Medicare increased overall from 2014 through 2016 but took a downturn per HEDIS 2017. DHMP remains in the 25th percentile for Medicare members in this measure.

2017 Prevention and Screening Measures QI Activities/Interventions

Preventive Cancer Screening Workgroup

QI collaborates with the cancer screening work group that meets monthly to improve colorectal, breast and cervical cancer screenings. The workgroup consists of members representing Denver Health Ambulatory Care Services, Community Clinics, Women's Mobile Clinic, GI clinic, radiology, and Denver Health Medical Plan. The workgroup continued to work on:

- Standardized Health Care Partner (HCP) check-in process to include identifying patients lacking breast, cervical, or colorectal cancer screenings
- HCPs schedule member for an appointment if possible and alert the provider to the tests needed
- Patient education materials about each cancer and the importance of screenings
- Developed cancer metrics and implementation of registries to report screening rates on a quarterly basis to clinics
- Epic optimization and standardization for the identification of patients on DHHA cancer registries

- Coordinated Patient Navigator outreach for DHMP Medicare members who have outgoing FIT tests and no return

The QI department is currently collaborating with the QI department of Ambulatory Care Services for a targeted outreach program for Medicare members who have an outgoing FIT but have not yet returned them to the laboratory. Three Patient Navigators (PNs) centrally located in the ACS QI Department receive bi-weekly lists of DHMP Medicare members to contact with outstanding laboratory specimens. The PNs contact these members to remind them to bring back FITs or facilitate members receiving a new colorectal screening kit.

Navigators review the chart for any subsequent updates, including referrals to the GI lab or returned lab specimens and conduct outreach appropriately. This intervention was implemented in late September of 2017 and was tracked through the end of the year. Navigator outreach in other interventions has been shown to be an effective method in closing gaps in care for preventive screenings. Operational improvement and increasing outreach will ideally lead to this intervention being widened to a larger targeted population and result in more appropriate colorectal screenings completions.

# MCR members identified for outreach	# positive FITs returned subsequent to lists	FIT return success rate
84	20	24%

Action Plan for 2018
QI will continue to participate on the Preventive Cancer Screening Workgroup. Colorectal and Cervical Cancer Screening preventive screening guidelines will remain on the mammogram mailer. The Colorectal Cancer Screening intervention that was implemented in late September of 2017 will continue.

Osteoporosis Management for Women Who Had a Fracture (OMW)

The DHMP QI department partnered with the Ambulatory Central Clinical Support (CCS) team in 2017 to design and implement and intervention focusing on the OMW measure which targets Medicare women aged 67-85 who sustained a fracture in the last six months. The goal of the intervention is to identify these members and facilitate either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months following the fracture.

The CCS team expanded the outreach to include DHMP Medicare members aged 52-98, in alignment with the goals set by the ACS QI department. Each month, the DHMP QI team produces a list of eligible members for outreach from DHMP claims and sends this list to the CCS team for coordinated outreach. The CCS team is comprised of ambulatory pharmacists, pharmacy techs and RNs who do comprehensive medical record review and then facilitate communication to the PCP through Epic in order to arrange a BMD or Rx.

The QI team developed a SharePoint site as a tracking mechanism which allows for real-time tracking of metrics for this intervention without a data delay.

The 2017 Reported HEDIS rate for OMW was 18.18%, which was a 4.04% from drop from HEDIS 2016. This metric also is also a measured in Medicare Stars but DHMP has not reported on OMW as a Star measure because the small population size has been N/A.

HEDIS measure	DHMP Medicare Members			
	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS percentile	% from Moving up to Next Percentile
OMW	22.22%	18.18%	10th	6.82%

This intervention began in August 2017 and carried through to the end of the year. 38 women were identified for targeted outreach between August & December 2017. Once identified for outreach, there is a 6-month window in which a member can undergo a BMD or receive an Rx for osteoporosis in order to meet the measure. Because some women had fracture dates that have yet to reach the 6-month expiration dates and due to claims run-out, not all eligible members have a reported outcome.

Metrics displayed below*

OMW Screening Intervention			
# MCR Members identified for outreach	Members still eligible for screening	# members who did not meet measure	# Members who met measure
38	13	7	14

*#s are per activity on 2/13/2018, per CCS operations & DHMP Claims data

The DHMP QI Intervention Manager meets monthly with the CCS team to discuss project updates, clarify metrics and review workflow. Despite the small population size for Medicare Stars, the plan is to continue with this intervention through 2018, with the longer-term goals of ensuring that all eligible women receive the appropriate treatments and reaching a potential 4 Star rate on this measure.

Prenatal/ Postpartum Care

2017 HEDIS Prenatal/Postpartum Indicator Results

	DHMP Commercial			
	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS percentile	% from Moving up to Next Percentile
Prenatal Care in 1st Trimester	95.98%	96.28%	90th	0.98%
Postpartum care within 21-56 days after delivery	81.41%	80.17%	50th	4.01%

HEDIS 2017 Changes

- Deleted the use of infant claims to identify deliveries
- Clarified the tests that must be included to meet criteria for an obstetric panel in the hybrid selection

Summary of 2017 HEDIS Prenatal/Post-Partum Results

For HEDIS 2017, we saw a small increase in the rate of women who receive prenatal care in the first trimester, and small decrease in the rate of women who receive postpartum care within the 21-56 day timeframe. For the Timeliness of Prenatal Care measure, we are in the 90th percentile. For Postpartum Care, we are in the 50th percentile. There was a 0.3% increase in the Prenatal Care measure and a 1.24% decrease in the Postpartum Care measure. In 2017, the QI department continued its collaboration with the Denver Health clinics and DHMP marketing department for prenatal care incentives and programs; however, the incentive program did not yield a significant improvement in HEDIS rates.

Mom and Baby Program

In 2011, DHMP QI collaborated with the Denver Health Woman's Care Clinic to develop a program that offered additional benefits for mothers receiving prenatal care at Denver Health. The program, which started in January 2012, provided incentives to women who completed a series of prenatal visits during their pregnancy.

In 2013, Marketing at DHMP rolled out a program involving additional incentives for keeping well-child visits within the baby's first year at Denver Health.. Moms coming into clinics for their postpartum visits would be eligible for and receive incentives through the Mom/Baby program. To receive the incentives for these programs, members request a coupon book from the DHMP and then have the provider place an encounter sticker on the coupon for each visit listed in the flyer.

Since the start of the program, Quality Improvement and Marketing staff made concerted efforts to educate and inform clinics and new mothers and members about the available incentive programs through the Denver Health Medical Plan, Inc. These marketing and outreach efforts will no longer be a DHMP QI intervention in 2018, as it was not financially feasible and did not result in a significant improvement of HEDIS rates.

DHMP Commercial Prenatal Benefits								
Year	**1ST Visit: Coupon Book Requests**	**6-10 Week Visit: Spa Kits**	**20 Week Ultrasound Visit: Photo Frames**	**20-30 Week Visit: Onesies**	**Denver Health Tour: Umbrella Strollers**	**After Delivery: Car Seats**	**After Delivery: 2 Month Supply of Diapers**	**Postpartum Visit: 1 month Supply of Diapers**
2015	137	51	53	52	53	65	52	28
2016	148	63	50	63	63	62	63	41
2017	181	63	63	65	61	84	57	36

2018 Action Plan

QI has discontinued its Mom/Baby program and Baby's First Year program (see program description below), as the program financial costs did not results in significantly improved HEDIS rates. The program will be carried out through the summer of 2018 by the DHMP Commercial and Government departments as service and value-added programming. Both departments will determine whether they will continue the program. Other prenatal and postpartum QI interventions are currently under consideration, including collaboration with ongoing ACS workgroup initiatives.

Baby's First Year

In 2013, the "Baby's First Year" incentive program was started to educate mothers on the importance of

completing timely well-child visits and encourage mothers to participate. For each newborn visit completed in the first 12 months of life, members received various gifts. Marketing and QI will no longer continue to monitor and track participation in the program for 2018.

DHMP Commercial Baby's First Year						
Year	**2 Week Visit: Diaper Bag**	**2 Month Visit: Baby Monitor**	**4 Month Visit: Healthy Baby Kit**	**6 Month Visit: Activity**	**9 Month Visit: Booster Chair**	**1 Year Visit: 1 month Supply of Diapers**
2015	19	19	12	12	6	5
2016	20	29	22	17	12	6
2017	17	22	17	15	11	8

2018 Action Plan

In 2018, DHMP Commercial and Government products departments will administer the Baby's First Year incentive program and will no longer be under the purview of DHMP QI. Discussions are underway to identify a new intervention to address barriers to prenatal and postpartum care for DHMP members.

Childhood Preventive Health

2017 HEDIS Childhood Preventive Health Indicator Results

Childhood Preventive Measures	**Commercial**			
	2015 HEDIS Results	**2016 HEDIS Results**	**2017 HEDIS Results**	**2017 HEDIS Percentile**
	Childhood Immunization Status			
DTaP	91.60%	94.93%	92.06%	75th
MMR	94.66%	98.55%	96.83%	90th
OPV/IPV	93.13%	97.10%	93.65%	50th
H Influenza	95.42%	99.28	96.03%	75th
Hepatitis B	88.55%	92.75	92.06%	50th
Chicken Pox	93.13%	97.10%	96.03%	90th
Pneumococcal	91.60%	98.55%	93.65%	90th
Hepatitis A	90.84%	94.93%	94.44%	90th
Rotavirus	85.50%	86.96%	90.48%	95th
Influenza	77.10%	78.26%	84.92%	95th
Combo 2	82.44%	88.41%	89.68%	90th
Combo 3	81.68%	88.41%	89.68%	95th
	Immunizations for Adolescents			
Meningococcal	83.33%	78.21%	84.14%	50th
Tdap/Td	92.86%	91.67%	93.10%	75th
Combo 1	82.54%	78.21%	82.07%	50th

	Well Child Visits			
0-15 months (6+ visits)	78.15%	73.55%	81.15%	25th
3-6 y/o (annual)	77.37%	74.17%	77.99%	25th
12-21 y/o (annual)	44.69%	41.13%	43.21%	25th

HEDIS 2017 Changes

Childhood Immunization Status

- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology

Immunizations for Adolescents

- Added a two-dose HPV vaccination series
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology

Commercial Summary of 2017 HEDIS Child Immunization Results

Denver Health Medical Plan, Inc. continues to demonstrate strong immunization rates for the commercial pediatric members, though many of the 2017 immunization rates are lower than the 2016 rates. The three Immunization for Adolescents metrics increased from 2016 to 2017, but are not in the 90th percentile. For 2018, DHMP will continue to partner with the Denver Health Pediatric Quality Improvement Work Group, and School Based Health Centers (SBHC) to address any barriers to immunization adherence. Efforts to increase timely well-child visits should also have a positive impact on the vaccinations required to complete in the first 2 years of life. Efforts to capture changes to immunization naming and coding changes in EPIC and mapping to HEDIS data tables is also ongoing.

Commercial Summary of 2017 HEDIS Well-child Visits

Well Child Visits (W15, W34, AWC)

Between HEDIS 2016 and HEDIS 2017, the rates for Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34), and Adolescent Well-Care Visits improved; however, all well-child visit measures scored in the 25th percentile.

DHMP will continue to address well-child visit rates and analyze potential interventions to improve them. In collaboration and education with Ambulatory Care Services and School Based Health Centers, DHMP QI will address medical record documentation and coding issues and claims submission issues that have a significant impact HEDIS well-child visit rates. DHMP also plans to partner with the Denver Health pediatric clinics to improve processes around standardized documentation and coding in 2018.

2017 Preventive Health QI Activities

School Based Health Centers (SBHC) Collaboration

In the fall of 2014, an intervention was implemented to address and improve adolescent well-care visits. The intervention was part of a new initiative to encourage adolescents to complete their annual well-care visit at a Denver Health School-Based Health Center (SBHC). The 17 SBHCs are located in middle schools and high schools with another 20 satellite elementary schools that feed into the SBHCs.

Denver Health Medical Plan and the SBHC team leads developed an incentive which would provide a $10 gift card to members age 12-19 that completed their well-care visit at a school-based health center. This reduced potential barriers to receiving timely health care by allowing children to attend clinic visits during school hours without the potential loss of work time for parents and transportation concerns. After the child attended a visit the clinic would send their information to DHMP QI, who then verified their membership and mailed them a gift card.

In 2017, this intervention was discontinued due to growing concern from the SBHC providers that giving gift cards to DHMP members for visits unfairly excluded non-DHMP members. In 2018, DHMP QI proposes a change that will provide an incentive payment to the clinics if they are able to complete 50% to 75% of the eligible annual well-care visits throughout the school year.

Action items for 2018

DHMP will continue to partner with the SBHC team leads to identify potential barriers around adolescent well-care visits. DHMP QI has developed a new report which identifies members who are eligible for their AWC on a monthly basis. In addition, this report identifies the members who had a completed AWC in the previous months. These reports will be sent to SBHC team leads and patient navigators at the beginning of each month in order to track progress and conduct outreach to members who are due for their AWC.

Birthday Cards for DHMP Members

In an effort to reach members of all age groups who are eligible for a well-child or adolescent well-care visit we developed a birthday card that provides educational materials/health tips. In addition, the birthday cards remind children to come in for their annual well-visit. The cards are sent monthly to children ages 2 through 19. In 2017, the average monthly mailing was 70 postcards across the commercial line of business.

Year	Avg. DHMP Postcards Mailed/Month
2015	171
2016	76
2017	70

Commercial Adult Measures

Preventive Cancer Screenings

Cancer Screening Measures	Commercial				
	2014 HEDIS Results	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90th Percentile
Breast Cancer Screening	65.22%	67.76%	65.81%	69.91%	80.63%
Cervical (21-64y/o)	86.62%	78.83%	98.30%	77.37%	82.77%
Colorectal (50-80 y/o)	53.53%	53.53%	87.83%*	58.39%	74.09%

*Sudden jump in COL screening rates from 2015-2016 attributed to a sampling bias, elevating DHMP's HEDIS rates to the 95th percentile. A regression to the mean is expected for HEDIS 0217 results.

Commercial Summary of 2017 HEDIS Preventive Cancer Screening Results

The rates for the breast and colon cancer screenings overall increased from 2016 to 2017. The BCS

measure demonstrated an improvement of 4.1%. HEDIS 2018 rates for BCS are expected to rise, as the number of DHMP Commercial members undergoing a mammogram increased. The QI team continues to collaborate with the Denver Health Women's Mobile Clinic and maintains a presence at the ambulatory Cancer Screening Committee, where similar metrics are discussed. . Though there are no active interventions specifically targeting the CCS or COL rates, the DHMP marketing department, with input from QI, placed the recommended preventive screening guidelines, as per agreed upon by the Preventive Cancer Screening Group for both of these measures. Not counting the random sampling bias that led to the sudden increase in colorectal cancer screening rates from 2015-2016, the overall rate increased by 5.36% from 2015-2017. Cervical Cancer Screening rates also had a significant jump, as a result of the random sampling bias, from 78.83% in 2015 to 98.3% in 2016, with regression to 77.37% in 2017.

HEDIS 2017 Changes

There were various changes to HEDIS 2017:

- CCS: clarification that reflex testing does not meet the criteria for hybrid review
- COL: clarification for the instances in which pathology reports may be used for numerator compliance
- BCS: clarification that diagnostic mammograms are not included as part of the measure

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For HEDIS operations, challenges resulting from the 2017 transition of IS staff supporting HEDIS data extraction and submission were approached with internal QI and external IS consultants to produce a viable 2018 HEDIS (CY 2017) submission. This effort is ongoing and has resulted in identification of opportunities for improvement in rates through coding, configuration, and queries that are beyond patient interventions.

2017 Preventive Cancer QI Activities/Interventions

The Mammogram Outreach Reminder Mailing intervention which includes Commercial members, continued in 2017. Specifically, this intervention reminds members to schedule a mammogram exam appointment. The mailing card provides information on how to schedule an appointment for a mammogram through the Denver Health radiology clinic or Women's Health Mobile Van. A total of n=1044 commercial members were sent postcard reminders in 2017. Of those, n=673 members completed BCS screenings, which is an increase of an additional 137 from 2016. This is a general upward trend, with an increase of 150 additional screenings in the commercial population between 2015 & 2016. HEDIS results for this measure are expected to rise as a result of this increase for HEDIS production year 2018.

Preventive Cancer Screening Workgroup

QI collaborated with the cancer screening work group that meets monthly to improve colorectal, breast and cervical cancer screenings. We continued to work on:

- Standardized Health Care Partner (HCP) check-in process to include identification of patients lacking breast, cervical, or colorectal cancer screenings. HCPs schedule members for appointments if possible and alert the provider to the tests needed
- Patient Navigation regarding colorectal cancer screening options through Denver Health
- Patient education materials about each cancer and the importance of screenings
- Review and reporting of cancer screening quality measures through implementation of registries to report screening rates on a quarterly basis to clinics
- Epic optimization and standardization for the identification of patients on DHHA cancer registries

Action Plan for 2018

QI will continue to participate on the Preventive Cancer Screening Workgroup. COL and Cervical Cancer Screening recommended preventive screening guidelines, per DHHA Cancer Screening Workgroup specs, have been added to the monthly Mammogram mailer. It is a longer-term goal of the QI department to partner with the DH GI Lab to implement a cancer screening intervention in the DHMP commercial population. The QI department will continue to foster discussion regarding this possibility, with the goal of increasing the rate of appropriate colorectal screening for our populations.

Asthma

2017 HEDIS Asthma Indicator Results

Medication Management for People w/Asthma (MMA)	DHMP Commercial			
	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90th Percentile
Ages 5-11	*NA	*NA	25.00%	48.84%
Ages 12-18	*NA	*NA	18.18%	48.92%
Ages 19-50	42.50%	39.22%	40.98%	55.8%
Ages 51-64	*NA%	*NA	57.89%	65.75%
Total	41.10%	32.43%	39.62%	59.39%%

*NA = Sample size < 30

Asthma Medication Ratio (AMR)	DHMP Commercial			
	2015 HEDIS Results	2016 HEDIS Results	2017 HEDIS Results	2017 HEDIS 90th Percentile
Ages 5-11	*NA	*NA	*NA	48.84%
Ages 12-18	*NA	*NA	*NA	48.92%
Ages 19-50	65.12%	69.09%	73.13%	81.08%
Ages 51-64	*NA	*NA	*NA	88.64%
Total	63.75%	65.29%	69.89%	86.90%

HEDIS 2017 Changes

- There were no major changes to HEDIS 2017 for the MMA or AMR (Asthma Medication Ratio) measure

Summary of 2017 HEDIS Asthma Results

In both the MMA & AMR measures, the HEDIS rates are showing general trends of increasing year over year. The AMR Total ratio has increased 6 percentage points between 2015 & 2017 while the MMA ratio has only demonstrated a 1% increase from 2015 to 2017. While no specific interventions are aimed at the Commercial population for these two measures currently, the QI department maintains a focus on improving the overall management of asthma medications in all populations.

Action Plan for 2018

The DHMP QI department now participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. Meetings are monthly and discuss progress relating to updating ambulatory asthma registries, summaries of current asthma-related interventions and medication change updates. The QI department has been attending and will continue to solicit and contribute feedback about asthma initiatives taking place between ACS and DHMP. Additionally, the DHMP Pharmacy implemented a telephonic-based intervention designed to improve the AMR of DHMP Medicaid patients. The DHMP QI department will assess the possibilities of assisting with this intervention on an ongoing basis.

Health Management Programs

STRONG body STRONG mind Disease Management

Objective and Relevance

The DHMP **STRONG body STRONG mind** disease management program is designed to support the mission of DHMP by improving the quality of care and disease outcomes for the plan members. This is achieved through an assessment of member needs, provision of ongoing care monitoring, implementation of culturally appropriate and individually tailored interventions and provision of self-management support so that members are empowered to play an active role in their health care. DHMP, Inc. is targeting depression and diabetes as its two disease management programs.

The DHMP Commercial population totals 16,868 members of which approximately 12,609 or 75% are adults. Of this adult population, 268 (2.1%) of the members have been identified as having diabetes and 1,269 (10.1%) have been identified as having depression. The DHMP Medicare population totals 4,545 members of which all are adults. Of this adult population, 644 (14.2%) of the members have been identified as having diabetes and 674 (14.8%) have been identified as having depression.

Frequency of Reporting

Members eligible to participate in the **STRONG body STRONG mind** disease management programs will be identified monthly and reported on at least annually. These members will be stratified by risk level and the interventions provided based on assessment of disease severity will be reported at least annually. The eligible member active participation rate will be calculated and reported on at least annually. Member satisfaction with the disease management services as well as audited HEDIS results specific to depression and diabetes will be reviewed and analyzed at least annually.

Indicators/Metrics

- Number of members identified as eligible for the **STRONG body STRONG mind** disease management program(s)
- Number and type of interventions provided based on assessment of disease severity
- Number of eligible members who actively participated in the program(s)
- Member satisfaction with the disease management program(s) including:
    - Number of member complaints and inquiries related to the DM program
    - Rating of overall satisfaction with the DM program
    - Rating of DM program staff
    - Rating of usefulness of the information disseminated
    - Rating of member's ability to adhere to recommendations
- Audited HEDIS results relevant to Depression and Diabetes including:
    - Depression – Antidepressant Medication Management (AMM)
        - Effective Acute Phase Treatment
        - Effective Continuation Phase Treatment
    - Diabetes – Comprehensive Diabetes Care (CDC)
        - HbA1c% Poor control (>9.0%)
        - HbA1c% Good control (<8.0%)

Commercial Quantitative Analysis

In total, 1,269 commercial members were identified as eligible to participate in our **STRONG body STRONG mind** Depression disease management program and of those 335 (26.4%) were determined to be low risk, 684 (53.9%) were medium risk, and 250 (19.7%) were high/critical risk. Of the 268 members identified as eligible for the **STRONG body STRONG mind** Diabetes disease management program, 52 (19.4%) were determined to be low risk, 150 (56%) were medium risk, and 66 (24.6%) were high/critical risk.

Of the 1,269 members identified for **STRONG body STRONG mind** Depression program, 10 unique members (0.7%) actively participated. Of the 268 eligible members identified for the **STRONG body STRONG mind** Diabetes program, 11 unique members (0.8%) actively participated. Combined, a total of 21 members (1.7% of our eligible commercial membership) were active in our disease management program between January 1, 2017 through December 31, 2017 review period. During this review period, January 1, 2017 through December 31, 2017, there were zero member complaints for the commercial population.

Of the 4 members who completed the Satisfaction Survey, the about half of the members rated all items either a 4 or 5. However, there are a few areas for improvement based upon the results of the Disease Management Satisfaction Survey given that our goal is to have at least 90% of members rate the items either a 4 or 5. Those areas for improvement include, 'how satisfied are you with how the health coach helped you understand how you can improve your health,' 'how satisfied are you with the overall health coaching program,' how useful the information your health coach provided to you during your phone calls,' and how useful was the information your health coach mailed to you, emailed to you, or directed you to the internet.' Increasing sample size will also be a targeted area. Please reference the full SBSM Reporting Evaluation Document for specifics.

Our performance on the audited HEDIS results related to the Effective Acute Phase Treatment for depression is 76.44% for the Effective Continuation Phase Treatment DHMP's reported rate is 56.44%. For the Poor HbA1c Control (>9.0%), DHMP's reported rate is 34.98%. For the HbA1c Control (<8.0%), DHMP's reported rate is 50.77%. Please reference the full SBSM Reporting Evaluation Document for specifics.

Medicare Quantitative Analysis

In total, 674 Medicare members were identified as eligible to participate in our **STRONG body STRONG mind** Depression disease management program and of those 215 (31.9%) were determined to be low risk, 153 (22.7%) were medium risk, 306 (26.9%) were high/critical risk. Of the 644 members identified as eligible for the **STRONG body STRONG mind** Diabetes management program for diabetes, 201 (31.2%) were determined to be low risk, 142 (22.1%) were medium risk, 301 (46.7%) were high/critical risk. Please reference the full SBSM Reporting Evaluation Document for specifics.

Of the 674 members identified for the **STRONG body STRONG mind** Depression program, 43 unique members (6.4%) actively participated. Of the 644 eligible members identified for the **STRONG body STRONG mind** Diabetes program, 63 (9.8%) actively participated. Combined, a total of 109 unique members (8.3% of our eligible Medicare membership) were active in our disease management program between January 1, 2017 through December 31, 2017.

During this review period, January 1, 2017 through December 31, 2017, there were zero member complaints for the Medicare population.

Of the 7 who completed the Satisfaction Survey, the majority rated all items either a 4 or 5. However, there are areas for improvement based upon the results of the Disease Management Satisfaction Survey given that our goal is to have at least 90% of members rate the items either a 4 or 5. The question, 'how satisfied are you with how the health coach helped you understand how you can improve your health,' was rated a 71%. There were 4 other questions that were ranked with an overall score of 86%. These areas will be evaluated throughout 2018 and efforts to increase disease management satisfaction will be a priority. Increasing sample size will also be a targeted area. Please reference the full SBSM Reporting Evaluation Document for specifics.

Our performance on the audited HEDIS results related to the Effective Acute Phase Treatment for depression is 67.66% for the Effective Continuation Phase Treatment DHMP has a reported rate of 48.76%. For the Poor HbA1c Control (>9.0%), DHMP's reported rate is 26.03%. For the HbA1c Control (<8.0%), DHMP's reported rate is 58.88%. Please reference the full SBSM Reporting Evaluation Document for specifics.

Commercial Qualitative Analysis/Barriers/Opportunities for Improvement

Although we have identified a significant percentage of the adult commercial membership that is eligible to receive disease management services, a relatively low number of these individuals are identified through the UM/CM process, health coaching program or through direct provider and member/caregiver referrals. A recent version upgrade to the Guiding Care - Care Management Software platform and data platform should make the ease of referrals less cumbersome and more straightforward. In addition to the care management version upgrade, updated and new workflows have been completed so that staff members are trained on both the care management software and the overall processes.

Future efforts to engage members in the **STRONG body STRONG mind** disease management programs will focus on outreach calls to the high risk members as identified by the CDPS stratification guidelines. Disease management requires individuals to devote substantial amount of time and effort to improving their health. The Commercial population is often difficult to engage and keep engaged. Efforts to increase engagement will include continuing education for disease management for low patient compliance and the use of technology aides that commercial members may find more useful. Communicating the benefits of disease management to this population is vital and technology enhancements that may enhance the message commercial members receive and encourage them to enroll and remain compliant.

The Health Management Department went through a significant restructuring in 2017 where new staff was hired and current staff changed roles. In addition, the CMS – Model of Care for the D-SNP Medicare population came back to DHMP, mid-year, to the Health Management Team, from ACS, so the newly hired staff was completing the regulatory requirements while also completing disease management outreach and enrollment. To mitigate staff from working on multiple projects, at the same time, additional staff has been hired for 2018 so that employees can be dedicated to the appropriate disease management programs.

Medicare Qualitative Analysis/Barriers/Opportunities for Improvement

As with the Commercial population, we have identified a significant percentage of the Medicare membership that is eligible to receive disease management services, a relatively low number of these individuals are identified through the UM/CM process, health coaching program or through direct provider and member/caregiver referrals. A recent version upgrade to the Guiding Care - Care Management Software platform and data platform should make the ease of referrals less cumbersome and more straightforward. In addition to the care management version upgrade, updated and new workflows have been completed so that staff members are trained on both the care management software and the overall processes.

Future efforts to engage members in the **STRONG body STRONG mind** disease management programs will focus on outreach calls to the high risk groups. Disease management requires individuals to devote substantial amount of time and effort to improving their health. This may be difficult for the Medicare population due to other comorbidities and lack of resources. The Medicare populations often require a lot of knowledge about their disease states upon enrollment in the disease management programs. Stigma of having a disease also contributes to compliancy issues.

The Health Management Department went through a significant restructuring in 2017 where new staff was hired and current staff changed roles. In addition, the CMS – Model of Care for the D-SNP Medicare population came back to DHMP, mid-year, to the Health Management Team, from ACS, so the newly hired staff was completing the regulatory requirements while also completing disease management outreach and enrollment. To mitigate staff from working on multiple projects, at the same time, additional staff has been hired for 2018 so that employees can be dedicated to the appropriate disease management programs.

Commercial and Medicare: Proposed Actions to Address Identified Opportunities for Improvement

There is significant room for improvement in most of the HEDIS measures and this remains a high priority for the health plan as a whole. The **STRONG body STRONG mind** disease management program will continue to focus its efforts on the members at highest risk in an attempt to help improve these results and work with the quality improvement team to implement strategies within our department.

Based on our experience with other programs in the Health Management department, members who are directly referred tend to be the most engaged. Therefore, we plan to focus on increasing identification of members for the **STRONG body STRONG mind** disease management programs through direct referral. This may include increasing the number of emails sent to providers to solicit direct referrals as well as outreach to them through telephonic and/or other technology-based programming.
Future trainings will include follow-up questions at the end of the calls to determine need so that we can better direct our members to the services they need. The results of the Satisfaction Survey are shared with staff in order to highlight their strengths and also raise awareness of opportunities for improvement. Ongoing training and discussion will occur at team meetings and technology outreach efforts will be evaluated.

In addition to determining opportunities for improvement for disease management, the Health Management team is working to redesign their programs to accompany Commercial and Medicare needs. In doing this, the Health Management team is completing a thorough population analysis so that services can best be matched on member needs and diagnoses. While disease management will continue to be a focus, the Health Management team is reviewing current accreditation standards to serve the needs on a population health basis and focus on the entire membership.

Complex Case Management

The Health Management (HMD) Department administers the Complex Case Management (CCM) Program for Commercial Highpoint and Medicare members. This program has been created to target specific member populations and address a variety of our members' needs. The complex case management is considered to be an "opt- out" service available to all plan members.

The CCM Program was created to provide systematic coordination of care to all members enrolled. Members who are enrolled into CCM, have experienced a critical event or diagnoses that requires an extensive use of resources, need help navigating the system to facilitate the appropriate delivery of care, or both. The goal of the CCM program is to help members regain optimum health, improve their functional capabilities, educate members regarding their chronic conditions, and reinforce provider care plans. With these goals in mind, case managers (LCSW or RN) will complete a comprehensive initial assessment; identify available benefits and appropriate resources; and create a plan of care with prioritized patient-centered goals and a monitoring plan. For Medicare members, case managers will also consult with the interdisciplinary care team to provide further input on members' care coordination needs.

Evaluation of Complex Case Management

DHMP performs an evaluation of the CCM Program on an annual basis. Relevant measured processes or outcomes may include: satisfaction with CCM services and/or utilization and cost data through statistical process control. Please reference the full HMD- CCM Reporting Evaluation Document for specifics.

Performance Goal

100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied).

Eligible Population

All Commercial HighPoint and Medicare Advantage members are eligible to participate in the DHMP CCM Program. The CCM Program is defined as a program of coordinated care and services for DHMP members who have experienced a critical event or diagnosis that requires extensive use of resources.

Analysis

During the analysis period of 1/1/17-12/31/17, there were a total of 9 members with a closed CCM case. Of those, 3 members agreed to complete the CCM Satisfaction Survey. One member termed eligibility, five members were unable to reach for a survey, and three members completed the satisfaction survey. Members were asked to rate their case managers 'helpfulness' and 'satisfaction with the program' on a scale from 1-5 (1=not at all, 2=a little, 3=somewhat, 4=most of the time, 5=always/very).

2017 CCM Satisfaction Survey (n=3)					
	(1)	**(2)**	**(3)**	**(4)**	**(5)**
How satisfied are you with how the case manager helped you understand your treatment and care plan?	**0**	**0**	**0**	**0**	**3**
How satisfied are you with how the case manager helped you get the care you needed?	**0**	**0**	**0**	**0**	**3**
How satisfied are you with how the case manager paid attention to you and helped you with problems?	**0**	**0**	**0**	**0**	**3**
How satisfied are you with how the case manager treated you?	**0**	**0**	**0**	**0**	**3**
How helpful was your case manager when you had a question or concern?	**0**	**0**	**0**	**0**	**3**
How helpful was your case manager in communicating your available benefits and referring you to other community resources, if needed?	**0**	**0**	**0**	**0**	**3**
How well did your case manager share important information with you when it was needed?	**0**	**0**	**0**	**0**	**3**
How helpful was your case manager in helping you access services (doctors' appointments, specialty appointments, etc.)?	**0**	**0**	**0**	**0**	**3**
How satisfied are you with the timeliness of your complex case management services?	**0**	**0**	**0**	**0**	**3**
If you had any complaints, how satisfied are you with how your case manager addressed any complaints or concerns?	**0**	**0**	**0**	**0**	**3**
Overall, how satisfied are you with the complex case management program?	**0**	**0**	**0**	**0**	**3**

	(1)	(2)	(3)	(4)	(5)

Any additional member feedback from CCM satisfaction survey
"Member states that CM consistently kept in touch and checked in with member throughout period of marked medical difficulties; member states that CM was consistently receptive to concerns."
During the review period (01/01/2017 -- 12/30/2017), there were no documented member complaints regarding the CCM Program.

Please reference the full HMD- CCM Reporting Evaluation Document for specific analyses and 2018 eligibility criteria for inclusion to CCM.

Member Satisfaction with CCM performance goal: 100%

IV. Safety and Quality of Clinical Care

2017 Quality of Care Concern Cases (QOCC) - DHMP Commercial and Medicare

Plan	Total Cases 2017	Unsubstantiated	Substantiated	Inconclusive	Change from 2016
Commercial	2	1	1*	0	-1
Medicare	3	3	0	0	-1

Commercial Analysis
There were a total of two QOCC cases for 2017 which was one (1) fewer than in 2016. *The substantiated case had multiple issues: The access to care issues were found to be substantiated and the other issues over HIPAA and post-op infection were found to be unsubstantiated.

Medicare Analysis
There were a total of three QOCC cases for 2017 which was one (1) fewer than in 2016. One of the three cases was withdrawn by the member and is listed in the unsubstantiated category.

Cultural and Linguistically Appropriate Services Program (CLAS)

Denver Health Medical Plan (DHMP) provides health coverage to a culturally diverse population; therefore, it is important to educate staff about cultural differences that impact healthcare delivery. As of December 2017, there were 5 distinct languages identified that were spoken by our DHMP Medicare Advantage members and 7 distinct languages spoken by our DHMP Commercial population. However, only two languages were spoken by our members at 0.1% or greater (English and Spanish) for both product lines in 2017.

DHMP Medicare Advantage Plans Language Data*

Language	Measure	2015	2016	2017
English	Count	3,788	3,718	3,745
	Rate	86.9%	84.78%	82.4%
Spanish	Count	560	661	793

	Rate	12.9%	15.07%	17.4%
Vietnamese	Count	4	4	4
	Rate	0.1%	.09%	0.0%
Chinese	Count	2	2	1
	Rate	0.0%	0.0%	0.0%
Amharic	Count	1	0	1
	Rate	0.0%	0.0%	0.0%
Grand Total	Count	4,355	4,385	4,544

**Numbers reflect enrollment as of 12/31/2017.*

DHMP Medicare Advantage Plans Race/Ethnicity Data*

Race/Ethnicity	2015		2016		2017	
	Count	Rate	Count	Rate	Count	Rate
No Ethnicity	4,300	98.69%	6	0.17%	4	0.0%
Hispanic or Latino	26	0.60%	27	0.62%	24	.52%
Caucasian	12	0.28%	690	15.7%	1,096	24%
African American	8	0.18%	216	4.9%	300	6.6%
Unknown	9	0.21%	3,417	77.9%	3,064	67.4%
Not Hispanic or Latino	2	0.05%	1	0.02%	13	0.28%
Asian/Pacific	0	0.0%	12	0.045%	23	.50%
Alaskan/American Indian	Not reported	Not reported	12	0.045%	10	.20%
Other	Not reported	Not reported	5	0.11%	10	.20%
Grand Total	4,357		4,386		4,544	

**Numbers reflect enrollment as of 12/31/2017.*

DHMP Medicare Advantage REL Summary

Medicare member race/ethnicity and language data from the December 2015 to December 2017 eligibility files were examined. Based on our analysis for our Medicare line of business in 2017, English was the predominant language of our member population followed by Spanish. Analysis of the race/ethnicity data indicates that the most prevalent race in this population is White/Caucasian at 24%, followed by African American at 6.6%. 67.4% of members are listed as Unknown, which highlights a need to more effectively collect and track REL data.

DHMP Commercial Language Data

Language	Measure	2016	2017
English	Count	15,738	16,773
	Rate	99.6%	99.4%
Spanish	Count	57	82
	Rate	.36%	0.48%
Vietnamese	Count	n/a	2
	Rate	n/a	0.01%
Korean	Count	n/a	1
	Rate	n/a	0.0%
Hungarian	Count	2	2

	Rate	.01%	0.01%
German	Count	2	2
	Rate	.01%	0.1%
Nepali	Count	n/a	1
	Rate	n/a	0.0%
Grand Total	Count	15,799	16,863

DHMP Commercial Race/Ethnicity Data

Race/Ethnicity	2016		2017	
	Count	Rate	Count	Rate
No Ethnicity	6,535	41.3%	2,621	15.5%
Hispanic or Latino	364	2.3%	555	3.2%
Caucasian	4.931	31.2%	4,462	26.4%
African American	675	4.3%	611	3.6%
Unknown	2,307	14.6%	2,085	12.3%
Not Hispanic or Latino	n/a	n/a	1	0.0%
Asian/Pacific	166	1.05%	173	1.0%
Alaskan/American Indian	32	0.2%	34	0.0%
Other	764	4.8%	755	4.4%
Asian Indian	n/a	n/a	3	0.0%
Hawaiian	n/a	n/a	20	0.0%
?	n/a	n/a	5,543	32%
Grand Total	15,799		16,863	

DHMP Commercial REL Summary

Commercial member race/ethnicity data from the December 2017 eligibility files were examined. Based on our analysis for our Commercial line of business in 2017, English was the predominant language of our member population followed by Spanish. In comparison to 2016, there are several more languages spoken among the members, though the number of members speaking languages other than English and Spanish remain relatively low. Analysis of race/ethnicity data indicates that White/Caucasian members were the most prevalent known race among Commercial members at 26.2%, with no other reported REL rates reaching a 5% proportion . A majority of Commercial members identified their race and/or ethnicity as “Other” or did not report race or ethnicity. As such, 59% of Commercial members did not provide race or ethnicity data..

DHMP has remained committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible members in accordance with our contract with Centers for Medicaid and Medicare (CMS). Furthermore, DHMP Division has policies and procedures to provide cultural and linguistic appropriate services that meet the needs of its members. The Medicare Advantage policies are referred to as the MCR_QI05 v. 02 Cultural and Linguistic Appropriate Services (CLAS) Program Description for Denver Health (DH) Medicare Advantage Plans. Our CLAS program goals are reviewed and implemented annually.

Additionally, in recognition of our efforts to support culturally responsive healthcare delivery, in June 2012 DHMP received the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction for both our

Medicaid and Medicare product lines. This prestigious distinction recognized our efforts to improve culturally and linguistically appropriate services and reduce healthcare disparities for our Medicare and Medicaid memberships. In 2016, we were re-accredited for the NCQA Multicultural Distinction through July 1, 2018, with a score of 93%.

Due to the importance of CLAS, REL data and language services, these standards are now included in the NCQA standards and guidelines for the accreditation of health plans. DHMP will continue to support, offer and engage in CLAS resources for our members though the health plan standards, and will not renew MHC distinction going forward. As a result of the importance of this work, DHMP has collaborated with DHHA to address REL disparities in health. Formerly, this was accomplished through DHMP and DHHA's involvement with American Hospital Association's 123Pledge for Equity; however, DHHA will no longer be participating in the pledge. DHMP creating initiatives to improve the accuracy and capture of REL data, the assessment of REL related disparities, and the identification of opportunities for health disparities interventions in 2018.

2017 CLAS Activities

DHMP Quality Improvement Department annually reviews CLAS policies and procedures, work plan and annual evaluation against contract requirements for updates and quality/process improvements. In addition, program initiatives and interventions are presented to our Quality Management Committee for feedback and suggestions in making process improvements through the QI Workplan. In a system wide initiative, DHHA created and instituted a required annual training module for CLAS for all DHHA and DHMP staff.

Opportunities for CLAS at DHMP

As a result of the NCQA accreditation audit, opportunities to improve the collection of REL data for members and providers and the ongoing monitoring of language service utilization, including satisfaction of services, were identified.

REL data collection improvement efforts

In an effort to improve understanding of REL related need for members, REL data collection improvement has been identified as an opportunity. Member REL Data is being actively collected from various sources:

- The Denver Health Human Resources department supplies a monthly list of all new Denver Health employees who have chosen DHMP as their insurance carrier. Part of the application process to Denver Health includes the voluntary submission of the applicant' s self-identification of 'ethnicity' in *PeopleFluent*, the software application used for new applicants applying to work at Denver Health. The HR department compiles this voluntary field, removing individual employee/ member identifiers and providing a sum total of the responses.
- In May 2018, Epic data, including member race, ethnicity, and language, will be populated in the DHMP data warehouse. From there, reports can be run to identify REL and health disparities.
- Language and member race/ethnicity data are supplied by the state in monthly enrollment files.
- Voluntary language and race data supplied by members previously enrolled in DHMP's Complex Case Management and Health Coaching modules. Members enrolled in these two medical management programs all completed an Initial Comprehensive Assessment where voluntary race and language data was requested.
- Results from survey responses collected by DHMP's Member Services department during introductory new member calls.

These activities are designed to support more complete collection of REL data, across lines of business, to improve our ability to identify need and align services and initiatives to meet those needs.

Disparities in Health

In 2017, DHMP was involved with an intervention to improve the post-partum care visit return rates for African-American moms. The DHHA/DHMP analysis indicated a disparity of African American mom's returning at a rate of 46%, while the Hispanic and White mom's returning at rates of 59% and 57% respectively. DHHA did not renew the Pledge for Equity in 2018. As such, DHMP will identify and prioritize health disparities to be addressed in 2018. Improvements in the collection of REL data will aid in tailoring health disparities interventions. DHMP added supplemental questions to the Commercial and Medicare CAHPS surveys, inquiring about whether physicians and the health plan communicated in a way that is respectful to the member's cultural background. For Commercial members, 97% of Denver Health physicians and 95% of the inquiries to the health plan were handled in a way that was respectful to the member's cultural background. Similarly, for Medicare members, 95% of Denver Health physicians and 93% of the inquiries to the health plan were handled in a way that was respectful to the member's cultural background. Hispanics responded the same or better than non-Hispanics for most CAHPS measures for both lines of business. Similarly, there were no significant differences in the CAHPS responses between whites, African Americans, and members of other cultural heritages.

Health Literacy Project

Background

In addition to the need for improving the technical components of care, there is a constant need to support and improve the interpersonal aspects of healthcare. This includes strategies to support culturally sensitive interaction between patient, provider and the health plan. Therefore, fostering cultural communication can go a long way in increasing patients' engagement, involvement and adherence to care regimens which ultimately improve health outcomes and member's ratings of their overall health status.

In 2015, the Health Literacy Committee (HLC) was reestablished under a new charter. This Committee is currently comprised of employees from the DHMP Marketing and QI Department and is tasked with ensuring consistency in the establishment of activities and training pertaining to the promotion of appropriate Health Literacy levels within DHMP.

Health Literacy, as defined by the Department of Health and Humans Services *Healthy People 2010* is the degree to which individual have the capacity of obtain, process, and understand basic health information and services needed to make appropriate health decisions. This includes the ability to synthesize health-related information written and oral form. DHMP's member base includes a population with limited educational backgrounds, varying degrees of English proficiency, cognitive impairments and additional social and medical factors that restrict access to pertinent health information and contribute to low literacy levels. It is the HLC's commitment to DHMP to making appropriate efforts to make member-disseminated materials clear and concise in order to improve readability and comprehension, ultimately leading to a member base better equipped to make pertinent health decisions that affect their wellbeing.

The HLC works toward the goals of making all efforts to ensure that readability standards, per the requisites established per line of business, are met on all member-disseminated documents. The HLC conducts trainings on the use of Health Literacy *software (Health Literacy AdvisorTM)* installed on multiple computers at DHMP. Documents submitted through the software are reviewed and then awarded a reading Grade Level concurrent with the readability level. It is a regulation of Medicaid and CHP+ to have all member-disseminated materials at a Fry 6th Grade Level or lower. All other plans strive to meet 10th Grade Level or lower.

Action Plan for 2018

In 2018, at least one employee from each department at DHMP has the software installed on his or her computer and is that department's 'champion' for submitting all member materials through the software to ensure that the appropriate Grade Level is obtained. All documents submitted through the software are then recorded and logged on DHMP's server to create a historical record for future auditing purposes. The HLC conducts training on the appropriate and optimal usage of this software to ensure consistency in Grade Level dissemination and in order to meet contractual requirements per LOB.

The HLC has been discussing the implementation of departmental-wide trainings on Health Literacy with support from management at DHMP. Trainings were originally discussed during 2017 to coincide with the re-implementation of the New Employee Orientation, but staffing resources were limited and trainings did not occur. The HLC will be exploring new avenues of company participation in Health Literacy efforts through such potential examples as DHMP Town Halls, member/employee newsletters and at departmental meetings.

V. Quality of Service

2017 Member Satisfaction - Annual CAHPS Survey and Feedback

DHMP conducted the Adult Consumer Assessment of Health Plan Providers and Systems (CAHPS) survey in 2017 for the Commercial and Medicare plans. CAHPS surveys were conducted under contract with Morpace, an NCQA certified vendor. Morpace follows NCQA protocols and statistically appropriate methodologies to determine member satisfaction scores.

Background

The CAHPS survey assesses health plan member satisfaction with the experience of care. In October 1995, the Agency of Healthcare Research and Quality (AHRQ) began the CAHPS initiative with researchers from Harvard Medical School, RAND, and Research Triangle Institute, Inc. The first survey data from the CAHPS survey was reported to NCQA in 1998. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

A subset of members in the Commercial and Medicare plans were chosen to participate in the survey using a randomized selection method set forth by NCQA and CMS. Those randomly selected members were sent a questionnaire and cover letter through the mail, followed by a thank you/reminder postcard. Those members who did not respond to the first questionnaire were sent a second questionnaire/cover letter, followed by a reminder postcard. If a selected member still did not respond to the questionnaire, at least four telephone calls were made to complete the survey over the phone using trained telephone interviewers.

A total of 1,418 Commercial plan members and 861 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 301 Commercial plan members and 345 Medicare members who chose to complete the survey.

Results

Table 1: Denver Health Medical Plan score comparison to national ratings

		Denver Health Medical Plan, Inc.	2017 Non-PPO/EPO Quality Compass^							
	Adult Commercial Survey Questions	2017	Percentile	Mean	5th	10th	25th	50th	75th	90th	95th
	Getting Care Quickly *(% Always/Usually)*	**79.73**	15th	84.46	75.99	77.60	81.94	85.15	88.22	90.00	90.90
Q4	Getting care as soon as needed	83.45	14th	88.03	79.75	82.44	85.21	88.89	92.00	93.18	94.51
Q5	Getting appointment as soon as needed	76.02	14th	81.66	73.18	75.00	79.11	82.33	85.19	88.34	89.60
	Shared Decision Making *(% Yes)*	**87.74**	98th	81.77	76.38	78.10	79.58	81.84	83.82	85.62	86.57
Q10	Discussed reasons to take medicine	96.89	93rd	94.12	90.20	91.75	93.06	94.23	95.37	96.62	97.04
Q11	Discussed reasons not to take medicine	80.00	93rd	73.55	64.60	66.96	70.30	73.75	76.51	79.67	80.74
Q12	Asked preference for medicine	86.34	98th	77.71	69.18	72.38	74.58	77.56	80.88	84.43	85.44
	How Well Doctors Communicate *(% Always/Usually)*	**95.70**	56th	95.08	91.66	92.26	94.09	95.50	96.51	97.19	97.65
Q17	Explain things in a way you could understand	96.98	64th	96.06	92.16	93.13	95.19	96.53	97.64	98.35	98.70
Q18	Listen carefully to you	94.85	38th	95.03	90.91	92.58	93.93	95.28	96.55	97.31	97.54
Q19	Show respect for what you had to say	98.28	92nd	96.18	92.50	93.91	95.12	96.55	97.47	98.19	98.40
Q20	Spend enough time with you	92.70	40th	93.06	88.00	89.34	91.57	93.24	95.06	96.52	96.96
	Getting Needed Care *(% Always/Usually)*	**75.91**	3rd	86.33	77.54	80.12	84.75	87.37	89.41	91.53	92.09
Q14	Easy to get care believed necessary	79.85	5th	88.75	78.89	82.10	86.32	89.86	92.09	93.85	95.36
Q25	Easy to get appointment with specialist	71.97	2nd	84.16	74.36	76.80	81.87	85.06	87.61	89.93	91.10
	Customer Service *(% Always/Usually)*	**76.06**	2nd	88.25	77.94	80.37	86.02	88.90	90.79	94.16	95.53
Q35	Got information or help needed	67.02	2nd	82.21	68.63	72.43	78.86	83.46	86.32	90.00	93.63
Q36	Treated you with courtesy and respect	85.11	1st	94.35	87.05	88.54	93.24	95.05	96.53	98.16	98.38
	Plan **Information on Costs*** *(% Always/Usually)*	**62.16**	43rd	63.37	52.40	55.80	60.27	63.16	67.19	70.09	71.75
Q31	Obtained information on cost of service/equipment*	63.76	58th	62.95	51.49	56.30	59.15	62.65	66.74	71.29	73.33
Q33	Informed of cost for specific prescription medicines*	60.56	26th	63.63	51.82	55.33	59.86	63.36	67.83	70.79	72.52
	Claims Processing *(% Always/Usually)*	**69.78**	1st	88.15	78.32	82.50	85.42	88.22	91.29	93.93	95.76
Q40	Health plan handled claims quickly	67.03	1st	86.61	75.86	80.43	83.44	86.92	89.92	93.14	95.62
Q41	Health plan handled claims correctly	72.53	1st	89.67	80.58	83.74	86.86	90.38	92.95	95.52	96.52
Q13	Rating of Health Care *(%8, 9, 10)*	74.91	31st	77.23	65.68	69.70	74.13	77.31	81.28	84.67	86.22
Q23	Rating of Personal Doctor *(%8, 9, 10)*	88.37	84th	84.75	77.71	79.89	82.55	84.95	87.42	89.43	90.69
Q27	Rating of Specialist *(%8, 9, 10)*	74.15	1st	84.64	77.40	80.12	82.61	84.54	87.18	89.09	90.55
Q42	Rating of Health Plan *(%8, 9, 10)*	66.44	57th	63.38	43.87	48.09	55.41	63.45	72.35	77.82	84.91
Q8	Health Promotion and Education *(% Yes)*	71.91	19th	75.43	67.19	69.03	72.51	75.87	78.51	80.95	82.67
Q22	Care Coordination *(% Always/Usually)*	80.50	25th	83.18	75.65	76.92	80.50	83.76	86.13	88.12	89.95
HEDIS^ Measures											
Q45	Flu (Ages 18-64)	85.61	99th	48.13	32.17	36.41	41.52	48.35	54.37	60.07	62.60
Q47	Advising Smokers and Tobacco Users to Quit*	57.41	1st	75.08	66.67	67.31	70.13	74.51	81.18	84.46	84.92
Q48	Discussing Cessation Medications*	42.59	26th	48.07	33.33	38.21	41.94	45.29	53.39	63.00	66.44
Q49	Discussing Cessation Strategies*	37.04	33rd	42.94	30.08	31.68	35.25	40.00	47.52	60.48	63.76

Commercial

The results above detail the Commercial CAHPS survey as compared to health plans nationally. DHMP scored in the:

- 56th percentile for 'How Well Doctors Communicate'(Decreased from the 87th percentile in 2016),
- 84th percentile for 'Rating of Personal Doctor'(Improved from the 62nd percentile in 2016),
- 57th percentile for 'Rating of Health Plan'(Improved from the 38th percentile in 2016),
- 43rd percentile for 'Plan Information on Costs'(Improved from the 19th percentile in 2016),
- 15th percentile for 'Getting Care Quickly'(Improved from the 2nd percentile in 2016),
- 31st percentile for 'Rating of Health Care',(Improved from the 8th percentile in 2016),

- 5th percentile or below for, 'Getting Needed Care', 'Customer Service', 'Claims Processing', and 'Rating of Specialist'

Medicare

CAHPS results below are reported as part of the CMS Medicare 5-star rating. For the member experience measures, the percent column indicates the percentage of the best possible score the plan earned for the measure. For the screening measure, the percent column indicates the percentage of respondents who received the screening.

Denver Health Medicare members rated the plan at five out of five stars for:

- 'Annual Flu Vaccine', and 'Care Coordination'

The plan received:

- Four stars for 'Getting Needed Prescription Drugs'
- Three stars for 'Customer Service' and 'Rating of Drug Plan'
- Two stars for 'Getting Appointments and Care Quickly', 'Rating of Health Care Quality', and 'Rating of Health Plan'
- One star for 'Getting Needed Care'

Medicare CAHPS Results and 5-Star Ratings

Reporting Composite or Item		
Member Experience with Health Plan	**Percent**	**Star**
Getting Needed Care	76%	★
Getting Appointments and Care Quickly	70%	★
Overall Rating of Health Care Quality	83%	★★
Rating of Health Plan	83%	★★
Customer Service	85%	★★★
Care Coordination	85%	★★★★★
Member Experience with Drug Plan		
Getting Needed Prescription Drugs	89%	★★★★
Rating of Drug Plan	85%	★★★
Screening		
Annual Flu Vaccine	77%	★★★★★

Analysis

Commercial CAHPS results revealed an increase in eight of the key measures including 'Getting Care Quickly', 'Getting Needed Care', and 'Claims Processing". Medicare CAHPS improved in five out of nine categories. Efforts will continue to improve CAHPS scores across multiple categories for both the Commercial and Medicare plans. The QI team completed a comprehensive Open Shopper Study in 2017 to evaluate access to care and followed up on the recommendations. This Open Shopper Study evaluated access by provider type (i.e. primary care, specialty, behavioral health), and outlined findings and recommendations by type. See the Open Shopper Report for detailed findings and recommendations. We actively partner with Ambulatory Care Services (ACS) to facilitate expansion of clinic hours and evaluate ways to increase access to care and availability. A new clinic opened in Southwest Denver in April, 2016 with expanded hours and weekend access which has contributed to improved scores in many categories. Productivity is an ongoing focus for the clinics, with pilots looking at four-day work weeks to support expanded hours.

The Patient Experience Group combines collaboration goals and interventions to improve the consumer experience in the ACS clinics. The QI team participates in that group, working to improve customer service and enhance provider and clinic communication. An organization-wide Studer initiative for the past year across all areas of Denver Health involves a concerted effort to improve patient experience. Additionally, an assessment of health plan customer service is underway to identify areas for improvement and implement appropriate strategies.

Grievance Reporting and Trending

The complaint analysis report period covers the period of January 1, 2017 to December 31, 2017 and describes the number and types of member grievances and appeals received during the report period. In addition, a summary of activities is provided that demonstrates DHMP's commitment to quality improvement.

One of the ways DHMP gathers information from members is by tracking grievances filed by members and/or their authorized representatives. Efforts are spent on analyzing the timeliness of the problem resolution process, whether regulatory requirements are met and member notification of a resolution is provided in an easy to understand and culturally competent manner, but also on identifying patterns of grievances which may suggest the need for further investigation and/or performance improvement opportunities by DHMP and/or its affiliate entities and providers.

It is important to note that the DHMP Grievance and Appeal Department underwent changes in 2017. In September of 2017, the Grievance and Appeals Department began using the Guiding Care system for data entry and tracking of member grievances and appeals. In the fourth quarter of 2017, the Grievance and Appeal Department transitioned from reporting to the Call Center Operations Manager to the newly created position of Grievance and Appeals Manager. In addition, the provider appeals Grievance and Appeals Coordinator was moved from Provider Relations to the Grievance and Appeals Department and began training on member appeals in the fourth quarter of 2017. The Grievance and Appeals Coordinators already attached to the Grievance and Appeal Department also began cross training on provider appeals at that time. As of now, this report only pertains to member grievances and appeals.

COMMERCIAL GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	4	3	1	6	14	.86
Financial/ Billing	13	8	10	8	39	2.39
Quality of Service	1	3	1	1	6	.37

(Customer Service/Attitude)						
Quality of Clinical Care	1	1	0	0	2	.12
Legal Rights	0	0	0	0	0	0
Fraud, Waste, and Abuse	0	1	0	0	1	.06
HIPAA Privacy and Confidentiality	1	0	0	0	1	.06
Benefit Package	2	1	1	1	5	.31
Transportation	0	0	0	0	0	0
Provider Network	2	0	0	0	2	.12
Quality of Practitioner Office Site	0	0	0	0	0	0
Marketing	0	0	0	0	0	0
Eligibility	0	0	0	1	1	.06
Managed Care Department Specific Concerns	0	0	2	4	6	.37
GRAND TOTAL	24	17	15	21	77	4.71

ELEVATE (MARKETPLACE) GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	1	0	0	0	1	1.44
Financial/ Billing	2	4	0	0	6	8.62
Quality of Service (Customer Service/Attitude)	0	2	0	0	2	2.87
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Marketing	0	0	0	0	0	0
GRAND TOTAL	3	6	0	0	9	12.93

MEDICARE GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	1	0	2	2	5	.05
Financial/ Billing	7	3	2	5	17	.18

Quality of Service (Customer Service/Attitude)	**3**	**2**	**2**	**0**	**7**	**.07**
Quality of Clinical Care	**1**	**0**	**1**	**1**	**3**	**.03**
Legal Rights	**0**	**0**	**0**	**0**	**0**	**0**
Fraud, Waste, and Abuse	**0**	**0**	**0**	**1**	**1**	**.01**
HIPAA Privacy and Confidentiality	**0**	**0**	**0**	**0**	**0**	**0**
Benefit Package	**1**	**1**	**0**	**3**	**5**	**.05**
Transportation	**0**	**1**	**3**	**0**	**4**	**.04**
Provider Network	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Marketing	**1**	**0**	**0**	**0**	**1**	**.01**
Eligibility	**2**	**2**	**0**	**0**	**4**	**.04**
Managed Care Department Specific Concerns	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**16**	**9**	**10**	**12**	**47**	**.49**

COMMERCIAL APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	**0**	**0**	**0**	**0**	**0**	**0**
Financial/ Billing	**13**	**16**	**20**	**11**	**60**	**3.67**
Quality of Service (Customer Service/Attitude)	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Clinical Care	**0**	**0**	**0**	**0**	**0**	**0**
Legal Rights	**0**	**0**	**0**	**0**	**0**	**0**
Fraud, Waste, and Abuse	**0**	**1**	**0**	**0**	**1**	**.06**
HIPAA Privacy and Confidentiality	**0**	**0**	**0**	**0**	**0**	**0**
Benefit Package	**1**	**4**	**3**	**2**	**10**	**.61**
Transportation	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**1**	**3**	**1**	**0**	**5**	**.31**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**

Marketing	**1**	**0**	**0**	**0**	**1**	**.06**
Eligibility	**0**	**0**	**0**	**0**	**0**	**0**
Managed Care Department Specific Concerns	**2**	**1**	**0**	**0**	**3**	**.18**
GRAND TOTAL	**18**	**25**	**24**	**13**	**80**	**4.89**

ELEVATE (MARKETPLACE) APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	**0**	**0**	**0**	**0**	**0**	**0**
Financial/ Billing	**0**	**0**	**0**	**1**	**1**	**1.44**
Quality of Service (Customer Service/Attitude)	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Clinical Care	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**0**	**1**	**0**	**0**	**1**	**1.44**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Marketing	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**0**	**1**	**0**	**1**	**2**	**2.87**

MEDICARE APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	**0**	**0**	**0**	**0**	**0**	**0**
Financial/ Billing	**1**	**3**	**6**	**5**	**15**	**.16**
Quality of Service (Customer Service/Attitude)	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Clinical Care	**0**	**0**	**0**	**0**	**0**	**0**
Legal Rights	**0**	**0**	**0**	**0**	**0**	**0**
Fraud, Waste, and Abuse	**0**	**0**	**0**	**0**	**0**	**0**
HIPAA Privacy and Confidentiality	**0**	**0**	**0**	**0**	**0**	**0**
Benefit Package	**2**	**5**	**8**	**8**	**23**	**.24**
Transportation	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Practitioner	**0**	**0**	**0**	**0**	**0**	**0**

Office Site						
Marketing	**0**	**0**	**0**	**0**	**0**	**0**
Eligibility	**0**	**0**	**0**	**0**	**0**	**0**
Managed Care Department Specific Concerns	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**3**	**8**	**14**	**13**	**38**	**.40**

QUALITATIVE ANALYSIS—OVERALL HEALTHCARE

GRIEVANCE DATA

Access

The Access category has the second highest number of complaints for the report period. For the Commercial plan, 17% of the grievances were related to access (down from 27% in 2016). For Medicare, 11% of the grievances were related to access (down from 15% in 2016). Both Commercial and Medicare members experienced dissatisfaction with the Denver Health Medical Center appointment scheduling system, which uses the same processes for all patients/payer sources. Several members had issues with scheduling a specialty appointment in a timely manner. The number of grievances related to access was too small to make any broad determinations for improvement. Only one specialty and one clinic appeared in more than one Grievance. Three Commercial grievances and one Medicare grievance were related to eye care. There were two grievances in the Commercial line of business involving difficulty getting a timely appointment at the Lowry Clinic.

Quality of Service (Customer Service/Attitude)

The Quality of Service category has the third highest number of complaints for the report period. Within this category, the majority of concerns dealt with member experience of rudeness by a staff member in the hospital or physician clinic setting.

Financial/Billing

The highest category with complaints is Financial Billing. The majority of the complaints stemmed from concerns over having financial responsibility when the member believes they should not owe a copay/coinsurance/deductible. Many members received bills in the mail after accessing services and the bills were incorrect, indicating that the claims system processed the claim incorrectly. Other members are getting the correct billing information but were not aware what the member responsibility would be.

Benefit Package

Benefits accounted for the fourth highest reason for complaints from both Commercial and Medicare members.

Quality of Care

In 2017, the Medical Plan received five complaints regarding Quality of Care.

Provider Network

In 2017, the Medical Plan received two complaints regarding the Provider Network, both from the Commercial line of business.

Quality of Practitioner Office Site

During calendar year 2017, there were zero (0) complaints filed with DHMP related to quality of practitioner office site. Because of this no analysis is able to be offered.

In overall review, timeliness of care, especially for specialty services, is a perceived challenge from members. Specialty care appointments have a longer wait time for services than routine primary care, which members can experience difficulty in understanding and accepting. Correct claims processing and adjudication is also a pertinent challenge from members.

APPEAL DATA

Access

During calendar year 2017, there were no access-related appeals for the Commercial or Medicare plans.

Quality of Service (Customer Service/Attitude)

During calendar year 2017, there were zero (0) appeals filed with DHMP related to Quality of Service. As a result, no evaluation is provided.

Financial/Billing

During calendar year 2017, there were seventy-five (75) appeals filed with DHMP related to Financial/Billing. In most of these appeals, DHMP incorrectly processed the member claim and thus the member received a bill for the service(s). Some of the cases were related to not obtaining a referral or authorization in a timely manner which culminated in a claim denial and member financial responsibility.

Benefit Package

During the report period, there were thirty-three (33) appeal cases filed related to Benefit Package. While the cases that were filed each were unique and had different issues, many cases were regarding care that is outside the scope of coverage (e.g. additional physical therapy visits beyond benefit package of 20 visits) or for coverage for a medical treatment that was denied at the initial level.

Quality of Care

During calendar year 2017, there were zero (0) appeal filed with DHMP related to Quality of Care.

Provider Network

During calendar year 2017, there were six (6) appeals related to the Provider Network. Of these appeals, five (5) for the Commercial plans and one (1) for Elevate. There were none in this category for Medicare. Most were related to changes in networks at the beginning of the year.

Quality of Practitioner Office Site

During calendar year 2017, there were zero (0) appeals filed with DHMP related to quality of practitioner office site. As a result, no evaluation is provided.

COMMERCIAL OUT-OF-NETWORK DATA

	Previous Year Out-of-Network Request, Total
2017 Out -of-Network Requests	612

538 of the requests were for services not available at Denver Health, which included the following types of care:

- Allergy (78)

- Ancillary Services (1)
- Audiology (3)
- Burn Clinic (2)
- Cardiology (6)
- Child Development Center (7)
- Cleft Palate (1)
- Concussion Clinic (2)
- Dermatology (18)
- Developmental Peds (4)
- Diagnostic Procedures (19)
- Durable Equipment (7)
- Ear Nose and Throat (7)
- Endocrinology (10)
- Gastroenterology (13)
- General Surgery (30)
- Genetics (32)
- Gynecology (8)
- Hematology/Oncology (9)
- Home Visit – RN, LPN, HHA, MD (3)
- Laboratory (11)
- Medical (Inpatient, E.R, Obsv Stay Only) (6)
- Mental/Behavioral Health (INPT,E.R,OBSV) (1)
- Multidisciplinary Specialist (1)
- Nephrology (5)
- Neurology (8)
- Neurosurgery (2)
- Nutrition (5)
- OB Care Other (OFFICE,E.R.,INPT,OBSRV) (3)
- Occupational Therapy (5)
- Oncology (5)
- Ophthalmology (9)
- Ortho Joint (6)
- Ortho Knee/Hip/Leg (7)
- Orthopodiatry (4)
- Orthospine (2)
- Ortho sports (2)
- Orthopedic Congenital Disorder (11)
- Other (10)
- Other Speciality (47)
- Otolaryngology (1)
- Pain Clinic (13)
- Pediatrics (1)
- Physiatry/Physiatrist (1)
- Physical Therapy (13)
- Plastic Surgery (1)
- Podiatry (2)
- Psychiatry (Outpatient/Clinic) (3)
- Pulmonary Medicine/PFL (3)
- Radiation Therapy (12)

- Radiology (10)
- Rehab (Outpatient) (2)
- Rheumatology (4)
- Sleep Studies (37)
- Speech Therapy (2)
- Transplant, Outpatient (7)
- Urology (16)

74 requests were due to lack of timely access of services at Denver Health.

ELEVATE (MARKETPLACE) OUT-OF-NETWORK DATA

	Previous Year Out-of-Network Request, Total
2017 Out -of-Network Requests	24

22 of the requests were for services not available at Denver Health, which included the following types of care:

- Allergy (2)
- Dermatology (2)
- Diagnostic Procedures (3)
- Durable Equipment Supplies (1)
- Gastroenterology (1)
- General Surgery (1)
- Nephrology (1)
- Radiation Therapy (1)
- Radiology (1)
- Sleep Studies (2)
- Transplant (3)
- Urology (1)
- Other Specialty (4)

One request was due to lack of timely access of services at Denver Health. One request did not have additional information in the system and will require further investigation.

MEDICARE OUT-OF-NETWORK DATA

	Previous Year Out-of-Network Request, Total
2017 Out -of-Network Requests	312

262 of the requests were for services not available at Denver Health, which included the following types of care:

- Allergy (9)
- Audiology (1)

- Burn Clinic (2)
- Cardiology (16)
- Dermatology (8)
- Diagnostic Procedures (30)
- Durable Equipment/Supplies (11)
- Ear, Nose, Throat (5)
- Endocrinology (2)
- Gastroenterology (5)
- General Surgery (5)
- Genetics (3)
- Gynecology (1)
- Hematology Oncology (1)
- Laboratory (1)
- Medical Rehab (Inpatient) (2)
- MRI (2)
- Neurology (2)
- Neurosurgery (4)
- Oncology (3)
- Ophthalmology (8)
- Optometry (1)
- Ortho Joint (6)
- Ortho Knee/Hip/Leg (4)
- Orthopodiatry (2)
- Other (3)
- Other Specialty (8)
- Otolaryngology (1)
- Pain Clinic (3)
- Pharmacy (2)
- Physical Therapy (4)
- Podiatry (4)
- Psychiatry (Outpatient/Clinic) (1)
- Pulmonary Medicine/PFL (5)
- Radiation Therapy (23)
- Radiology (13)
- Rehab (Outpatient) (1)
- Repair (1)
- Sleep Studies (46)
- Speech Therapy (1)
- Transplant, Outpatient (7)
- Urology (4)

50 requests were due to lack of timely access of services at Denver Health.

EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT

Despite any health plan's best efforts, complaints will occur. How they are received will affect the success of their resolution. Seeing a member's complaint as an opportunity for improvement is the first step in developing an effective complaint process. DHMP seeks to uncover root causes of a complaint, identify trends in data, and develop effective solutions in which all parties are satisfied.

Please see Attachment C_CY 2017 Complaint Data Analysis for full report

Appeals and grievances data was compared to CAHPS results for both Commercial and Medicare product lines. Appeals and grievances data, in addition to requests for out-of-network services, were evaluated for the Elevate Marketplace plan. Additionally, cultural needs and preferences data was considered.

The 2017 Complex Case Management Population Assessment Report was evaluated for the Commercial line, and CAHPS data by race and ethnicity were evaluated for both Commercial and Medicare product lines. Supplemental questions were added to the Medicare and Commercial CAHPS surveys inquiring about whether physicians and the health plan communicated in a way that was respectful to the member's cultural background.

- For Commercial members, 97% of Denver Health physicians and 95% of the inquiries to the Health Plan were handled in a way that was respectful to the member's cultural background. Hispanics responded either the same or more favorably than whites for most CAHPS measures. Likewise, there were not statistically significant differences in CAHPS reporting between white members, African American members, and members of other racial heritage.
- For Medicare members, 95% of Denver Health physicians and 93% of the inquiries to the health plan were handled in a way that was respectful to the member's cultural background. Hispanics responded either the same or more favorably than whites for most CAHPS measures. Likewise, there were not statistically significant differences in CAHPS reporting between white members, African American members, and members of other racial heritage.

For commercial, Elevate (Marketplace), and Medicare product lines, financial/billing issues, customer service/attitude, and access to care were selected as opportunities for improvement based on appeals/grievances results and corresponding CAHPS results.

- With regard to financial/billing issues, DHMP recognized that there were errors in the claims processing system, and initiated efforts to resolve these systematic problems quickly. The systemic issues were corrected and claims reprocessed for payment. However, the root causes remained ongoing, and as such, DHMP elevated claims processing issues as a key strategic improvement opportunity for 2017. A number of LEAN meetings/problem solving activities were completed, involving key leaders across claims, finance, QI, provider relations, UM, and the Executive Team. An action plan for improvement was developed, and is in progress. Other times, even though the member felt that they did not have a financial responsibility, after review of their benefit package, exclusions, and limitations; it truly was their financial responsibility. The DHMP Grievance and Appeal Department will continue to monitor the data and make the appropriate interventions when necessary.
- Quality improvement efforts for access to care are outlined in the analysis section of Member Satisfaction. These efforts are pertinent to both Commercial and Medicare lines of business because access is the same at Denver Health regardless of payer source.
- With regard to customer service, the grievances dealt with rudeness in the hospital or clinic setting. DHMP works collaboratively with ACS to address these issues as they surface. However, 2017 CAHPS results also indicated that DHMP customer service could use improvement, receiving a ranking in the 30th percentile nationally. DHMP elevated health plan customer service as a strategic imperative for 2017. A workgroup was created to review and make recommendations to improve customer satisfaction. Efforts are underway to implement first call resolution for all incoming member services calls. This includes developing scripting, call monitoring, weekly training, and team coaching. Lastly, there are efforts to improve the level of courtesy and respect given to callers who phone the health plan with questions/needs. AIDET competency training is focal to this effort.

Please see Attachment C_CY 2017 Complaint Data Analysis for full report

QUANTITATIVE ANALYSIS-BEHAVIORAL HEALTHCARE

Commercial Grievance Data

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	1	0	0	1	.06
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	2	0	0	0	2	.12
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	2	1	0	0	3	.18

Medicare Grievance Data

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	1	0	0	1	.01
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	0	1	0	0	1	.01

Commercial Appeal Data

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	3	2	1	0	6	.37
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	1	0	1	0	2	.12
Quality of Practitioner Office Site	0	0	0	0	0	0

GRAND TOTAL	**4**	**2**	**2**	**0**	**8**	**.49**

Medicare Appeal Data

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	**0**	**0**	**0**	**0**	**0**	**0**
Financial/ Billing	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Service (Customer Service/Attitude)	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Clinical Care	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**0**	**0**	**0**	**0**	**0**	**0**

GRIEVANCE DATA—BEHAVIORAL HEALTHCARE

Access

Zero complaints were filed for 2017 for Medicare and Commercial product lines.

Financial/Billing

Zero complaints were filed for 2017.

Quality of Service (Customer Service/Attitude)

Two complaints were filed for 2017, one for commercial and one for Medicare. Both grievances involved incorrect information given to the member.

Evaluation and Opportunities for Improvement—Behavioral Healthcare

CAHPS data is not collected for behavioral healthcare independently. Alternatively, DHMP conducts an annual Open Shopper Study, which evaluates access to care for routine, urgent, and emergent behavioral healthcare services, while assessing the quality of the member experience for obtaining services. The Open Shopper results are used, in addition to the appeals and grievances data, to assess service by category and identify opportunities for improvement. Although collected in aggregate for healthcare overall, multicultural health data was also evaluated to identify priorities. DHMP added supplemental questions to the Commercial and Medicare CAHPS surveys, inquiring about whether physicians and the health plan communicated in a way that is respectful to the member's cultural background. For Commercial members, 97% of Denver Health physicians and 95% of the inquiries to the health plan were handled in a way that was respectful to the member's cultural background. Similarly, for Medicare members, 95% of Denver Health physicians and 93% of the inquiries to the health plan were handled in a way that was respectful to the member's cultural background. Hispanics responded the same or better than non-Hispanics for most CAHPS measures for both lines of business. Similarly, there were no significant differences in the CAHPS responses between whites, African Americans, and members of other cultural heritages.

Sources for service category evaluation are collected as follows:

- Quality of care (assessed through appeals and grievances)

- Access (assessed through the Open Shopper Study and appeals and grievances)
- Attitude and service (assessed through the Open Shopper Study and appeals and grievances)
- Billing and financial issues (assessed through appeals and grievances)
- Quality of practitioner office site (assessed through appeals and grievances)

The Open Shopper Study identified opportunities for improving access to care and customer service. This included access for routine behavioral healthcare at Outpatient Behavioral Services (OBHS) at Denver Health for both adults and children. The appointment scheduling experience improved significantly from 2016. However, additional opportunities were identified for ongoing improvements in both access and customer experience with appointment scheduling. Results were presented to the QMC for discussion and identification of opportunities. Results were shared with OBHS leaders, and there are ongoing activities to disseminate findings to key stakeholders to improve access and customer experience; these efforts will be re-evaluated in 2018 to assess intervention effectiveness. See full Open Shopper Report for complete findings.

Appeals and grievances data (previous section) found no issues for either Commercial or Medicare product lines.

Member Services

Monitoring Member Services' Telephonic Performance

Member Services has in place a departmental Performance Report that monitors four telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, and overall Call Volume. The Member Services Performance Report monitors these telephonic statistics by each individual Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) lines of business. Tracking, comparison, and evaluation occur on a monthly as well as annual basis. The Member Services Lead Customer Service Representative pulls all telephonic statistical data from the Cisco Telephony System reporting system Cisco Unified CXX Historical Reports and prepares the report for the Call Center Operations Manager. The Operations Manager reviews each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The Operations Manager presents the Performance Report as well as his or her Summary and Analysis at each bi-monthly QMC meeting.

Monitoring Member Services' Benefit Info for Quality and Accuracy

In order to satisfy regulatory standards and monitor the telephonic quality of DHMP Member Services, the Member Services Quality Assurance Program has instituted reporting occurring on a monthly basis. The MS QA Program allows the Member Services Leadership Team (MSLT) to determine any deficiencies in quality and service provided by the Member Services Representatives (MSRs) as well as work to correct any identified deficiencies. The QA Program serves as a valuable tool in staff development and satisfaction and is also incorporated into the annual MSR evaluation process to ensure that it is meaningful to the team and its individual members.

The QA program entails monitoring and reporting on two components, telephonic productivity and performance as well as quality and accuracy of benefit information provided. Productivity is evaluated on specific metrics from the Cisco Telephony System, specifically Inbound Call Volume, Average Talk Time, Not Ready Time, and Reserved Time. The quality component of the QA Program is evaluated by direct call monitoring and evaluation by the MS Supervisor. The MS Supervisor selects 10 random calls for each MSR that occurred in the specific month out of the Call Copy Call Recording Software. The MS Supervisor will evaluate the call for the quality and accuracy of the information provided based upon various criteria (member information confirmation, identifying issues, knowledge of benefits, documenting the call, tone of

voice, etc.) and scores the MSR on a sliding scale dependent upon the accuracy of the information given. The overall evaluation of MSR performance in both areas is compiled, reviewed, and provided to the MSRs on a monthly basis. One on one coaching will occur if deemed necessary. In addition, an overall departmental MS Monthly Call Quality Performance Report is compiled to track the progress of quality maintained by the MSRs from month to month on an individual as well as departmental basis. All MSRs and the department overall must maintain an accuracy rate of 85% or higher. If this is not maintained, corrective actions are taken.

VI. Safety of Clinical Care

Patient Safety

The DHMP Medical Director is a member of the DHHA Patient Safety and Quality Committee. In 2017, DHMP and DHHA were able to actively address the following patient safety objectives:

- Encourage organizational learning about medical and health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Incorporate patient safety education into job competencies
- Implement corrective, preventative, and general medical error reduction education programs to reduce the possibility of patient injury
- Involve patients in decisions about their health care to promote open communication about medical errors and consequences that result
- Collect and analyze data to evaluate care processes for opportunities to reduce risk and initiate actions.
- Review and investigate serious outcomes in collaboration with risk management where patient injury occurred or patient safety was impaired
- Review and evaluate actual and potential risk of patient safety in collaboration with risk management
- Report findings and actions internally with a focus on processes and systems to reduce risk
- Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety
- Focus existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety
- Trend adverse events reporting in safety practices (e.g. medication errors).
- Annually review and evaluate clinical practice guidelines to ensure safe practices

In 2018, DHMP will continue to address patient safety objectives in collaboration with the hospital and ACS to improve the continuity and coordination of care and quality of care delivered to our members.

Privacy and Confidentiality Monitoring

In the course of providing quality assurance and utilization management services, DHMP receives confidential information from members and from providers. In accordance with state and federal laws, DHMP will receive and retain such information subject to the following conditions:

- At the time of initial hiring, all DHMP personnel shall be informed of confidentiality and the disciplinary action that will result from breach of confidentiality

At the time of hire, all staff shall sign and acknowledge understanding of the Denver Health and Hospital Authority Confidentiality Agreement on an annual basis. DHMP shall treat all information as confidential to the extent that such information specifically identifies or permits identification of a certain health plan member and describes the physical, emotional, or mental conditions of such person, provided; however, that DHMP may retain and use for its purposes in performance of its obligations any information it obtains relating to costs, charges, procedures, used or treatments employed by a provider in treating any member, to the extent such information does not disclose the identity of the person. Confidential information obtained in the process of

performing utilization management services will be used solely for utilization and quality management and will be shared only with parties who are authorized to receive it. Any confidential information, which DHMP finds it necessary to disclose, in the performance of utilization management services, shall not be disclosed to any unauthorized entity without prior consent of the member or as required by the federal law.

All confidential information retained by DHMP shall be held in secured and locked files or rooms. DHMP is in accordance with applicable State of Colorado and federal laws shall remain confidential information. In the course of performing its utilization management responsibility, it is the policy of the DHMP's Medical Management Department not to record telephone conversations.

In the event of a Conflict of Interest: No person may participate in the review, evaluation, or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. All DHMP employees, members of committees not employed by the organization and the board of directors are required to review and sign the Conflict of Interest statement annually.

VII. Overall Structure of the QI Program

The following DHMP personnel are actively involved in implementing specific aspects of the QI Program and delegating daily operational activities as needed:

Medical Director responsibilities include, but are not limited to:

- Providing direction and support related to the development, implementation, and evaluation of all clinical activities of the QI department
- Working in collaboration with the QI Director and the QI Intervention Managers on development and assessment of clinical interventions
- Designing clinical activities in the QI Work Plan
- Serving on the QMC, AQIC, Pharmacy and Therapeutics Committee (P&T), Medical Management Committee, Credentialing Committee, Operations Management Committee, and Denver Health Physician Executive Committee, and the DHHA Patient Safety and Quality Committee (PSQC)
- Evaluating and managing DHMP's Quality of Care Concerns (QOCCs) related to physical health problems, working in conjunction with the QI RN, and reporting to the PSQC as indicated for the reporting of QOCC's to the appropriate Directors of Service at Denver Health Hospital and Authority (DHHA) and external network providers
- Overseeing DHMP's clinical and preventive health guidelines

DHMP's Quality Improvement Department

DHMP Director of Quality Improvement responsibilities include, but are not limited to:

- Development, management, and monitoring of the QI Program
- Acts as staff representative to the DHMP Board of Directors
- Directly assumes authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation, and Work Plan annually

- Coordinates, provides advice and participates in the execution of the QI Program through collaboration with other DHMP and Denver Health Departments as appropriate for regulatory compliance
- Serving as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
- Annually ensures all policies, procedures, and guidelines related to the QI Department are updated appropriately
- Oversight of QI vendor contracts and delegated activities
- Provides oversight and direction to the QI team, consisting of the following:

Healthcare Effectiveness Data and Information Set (HEDIS) Program Manager responsibilities include, but are not limited to:

- Manages all aspects of HEDIS production including oversight of related projects
- Performs, and is the lead for, Medical Record Review (MRR) and MRR validation
- Evaluates and analyzes HEDIS results
- Provides recommendations to QI Director for cost efficiency, process improvements and quality interventions
- Works collaboratively with Intervention Managers on process improvements and interventions related to HEDIS
- Validates the accuracy of HEDIS data and supporting documents

Clinical Project Manager responsibilities include, but are not limited to:

- Manages all aspects of Consumer Assessment of Health Providers & Systems (CAHPS) related projects
- Evaluates and analyzes CAHPS results
- Provides recommendations to QI Director for cost efficiency, process improvements, and quality interventions
- Works collaboratively with Intervention Managers on process improvements and interventions related to CAHPS and Medicare Stars
- Leading project planning activities related to regulatory and accreditation requirements
- Facilitates and evaluates open shopper studies related to member experience and access
- Assists Intervention Managers in data pulls for HEDIS interventions, as needed

QI Project Manager responsibilities include, but are not limited to:

- Analyzing the effectiveness of intervention activities
- Coordinates all efforts related to work plans, evaluations and program descriptions

- Project lead's activities related to regulatory and accreditation requirements
- Works in collaboration with Intervention Managers to maintain a timeline deliverables
- Co-directing and working with QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and obtaining bi-monthly reporting requirements. Functions as main administrative contact for QMC
- Oversees QI NCQA requirements and functions in conjunction with Director of Quality Improvement

Intervention Managers *(2x)* responsibilities include, but are not limited to:

- Develops, manages and evaluates all quality interventions
- Works collaboratively with the Medical Director, QI Director, AQIDC, ACS condition-specific work groups, external provider network HEDIS Program Manager, Clinical Project Manager. QI Project Administrator and Data Analyst on all quality interventions
- Lead healthcare initiatives related to health literacy and cultural disparities
- Overseeing multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services, and identification of any health disparities

RN Staffing support for QI Activities, include but are not limited to:

- Manages QOCCs and quality of service concerns process in a timely and effective matter
- Works in collaboration with HEDIS Program Manager to perform HEDIS chart review
- Develops training materials, facilitating training, testing for inter-rater reliability (IRR), retraining for staff
- Provides clinical consultation for the QI team
- Conducts practitioner chart review using HEDIS criteria
- Develops and updates all preventive and clinical guidelines

Committee Structure

The Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. The QMC is charged with responsibility for oversight of all quality-related DHMP Medical Management activities and processes, including but not limited to: Utilization Management, Case Management, Health Management, Pharmacy, Member Services, and Provider Relations. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, and patient safety initiatives. The QMC includes primary care providers and specialty providers from both Denver Health Hospital Authority and extended practitioner network.

VIII. QI Activities Summary

DHMP is going through an in-depth review of all its initiatives and intervention activities, using best practices as a guide. All approved activities will have performance measures attached with PDSA embedded into their

standard work cycles. Yearly work plans will have measurable goals and/or benchmarks. Identified interventions that do not meet performance targets will undergo a barrier analysis and/or root cause analysis. DHMP seeks to improve health care quality, member education, health literacy, and access to care and services.

VIII. Attachments:

Attachment A_QI Commercial and Medicare Work Plan 2018
Attachment B_Commercial_Monitoring MS Performance_2017 Final
Attachment C_CY 2017 Complaint Data Analysis - Commercial_Medicare

DENVER HEALTH MEDICAL PLAN, INC.
Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
QUALITY IMPROVEMENT PROGRAM STRUCTURE								
***2018 QI Program Description-Scope**	The QI Program Description will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC).	**Annually** **Program must include:** • Program Structure • How patient safety is addressed • How designated physician is involved • How BH practitioner is involved • Oversight of QI functions by QMC • Annual work plan • Objectives for serving a culturally and linguistically diverse membership • Objectives for serving members with complex health needs, including behavioral health	**Objective:** • All requirements must be met • Reviewed and updated annually • Submitted for review to the QMC and BOD	Annually	QI Director	1/2018	3/2018	QMC Board of Directors
***2018 Annual QI Work Plan**	The QI Work Plan schedule is developed after review of previous year's QI Work Plan and Evaluation. The revised Work Plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measureable and analyzed annually during the Program Evaluation.	**Work Plan must address:** • Quality of Clinical Care • Quality of Service • Safety of Clinical Care • Member's Experience • QI Program Scope • Yearly Objectives and planned activities • Time Frame in which each activity is to be achieved • The staff member responsible for each activity • Monitoring of previously identified	**Objective**: • All 9 requirements must be met • Yearly objectives must be measureable • Submitted to and reviewed by the QMC and BOD	Annually	QI Director	1/2018	3/2018	QMC Board of Directors

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		issuesEvaluation of the QI Program						
***2017 QI Program Evaluation Report** (includes all indicators for the present year.)	The Program Evaluation report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI Work Plan.	**Evaluation includes:** • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service • Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices	**For all goals not met:** • QI must conduct a root cause or barrier analysis to identify the underlying causes and recommend changes to improve. • Analysis must include organizational staff with direct experience of processes that have presented barriers to improvement. **Evaluation Summary must include and address:** • Analysis and overall effectiveness • Completed and ongoing activities • Trending of QI measures/results	Annually	QI Director	1/2018	3/2018	QMC Board of Directors
QI PROGRAM OPERATIONS								
Quality Management Committee	DHMP's Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members.	**Committee functions include:** • Analyzes and evaluates the results of QI activities • Ensures practitioner participation in the QI program through planning, design, implementation or review • Review and make recommendations on policy decisions • Identifies needed actions • Ensures follow-up, as needed	**Objective**: • Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes • Provides oversight to working subcommittees and determines final opportunities for selection for reporting requirements.	Bi-Monthly	QI Director QI Project Admin	Ongoing	Ongoing	QMC

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Medical Management Committee	DHMP's Medical Management Committee (MMC) acts as a working sub-committee to the QMC. The MMC assists the QMC in overseeing and ensuring quality of clinical care, patient safety, State/CMS/NCQA reporting requirements and program operations provided throughout the organization.	The MMC is responsible for assisting the organization in providing oversight, critical evaluation, and delegation of actions and selection of opportunities while maintaining a constructive relationship with medical staff and approving/overseeing policies and procedures.	**Goals:** • Providing strong support and oversight to an initiative to improve Continuity and Coordination of Care • Works in collaboration with the QMC • Works in collaboration with the Network Adequacy Committee • Ensure all regulatory and NCQA requirements are reported in a consistent, accurate and reliable manner	Bi-monthly	Medical Director Director Health Management	Ongoing	Ongoing	QMC
Network Adequacy Committee	The Network Management Committee (NAC) is tasked with establishing, maintaining and reviewing network standards and operational processes.	The scope of the NAC responsibility includes: (1) Network development and procurement; (2) Provider contract management, including oversight; and (3) Periodic assessment of network capacity.	**Goals:** • Develop standard work, policies and procedures for network management. • Review network capacity and develop plans to address opportunities for improvement. • Review provider interest in network participation and evaluate against DHMP network needs. • Review provider terminations and determine continuity of care concerns. • Review new regulatory legislation and contractual requirements and implement, as appropriate. • Review Quality of Service Concerns and develop plan to address, as necessary	Monthly	Director of Provider Relations	Ongoing	Ongoing	MMC

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Medicare Star Ratings Workgroup	Key plan and ACS representatives work together to identify opportunities and implement interventions to improve our Medicare Star ratings.	**Committee functions include:** • Evaluate & identify opportunities • Intervention approval and support • Resource allocation • Review results to evaluate effectiveness	**Objective:** Committee analyzes and targets specific Stars measures for improvement. Interventions are then reviewed with ACS provider network and/or DHMP departments for approval and support. Metrics are set up to evaluate effectiveness.	Quarterly	Clinical Project Manager QI Director	Monthly	Ongoing	QI Director
Collaborative QI Workgroups	QI health plan representatives sit on several collaborative workgroups led by ACS leadership.	**Workgroups QI participates in includes:** • Cancer screening • Pediatric Preventive Health • Diabetes • Perinatal Care • Asthma • Transition of CarePeds CMMI • Immunizations • Patient Experience Committee	**Objective:** Established active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits.	Monthly	QI Intervention Managers	Ongoing	Ongoing	QI Director
QUALITY OF CLINICAL CARE								
***2018 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis**	HEDIS is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of 94 measures across 7 domains of care which allow for comparison of quality performance nationally across health plans.	**Procedure**: • HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures. • Data validation prior to submission date • Meet submission deadline • ***Data from the HEDIS project is analyzed to determine areas of intervention and improvement.	**Objective**: Evidence of annual analysis includes: • Presentation to the QMC • Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes. • Increase medical record compliance by improving coding and documentation. • To measure effectiveness of intervention; analysis will be	Annually	QI HEDIS Project Manager QI Director	12/2017	6/2018	QMC

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			accomplished by comparing previous year results with current year results.					
***HEDIS Impact: Breast Cancer Screening**	Every month a list will be drawn from the data warehouse, and run against claims and the active member's list. All Commercial and Medicare women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment. ✓ Affects member experience	**DHMP's QI Department:** QI will coordinate and advertise employee days and locations of BCS screenings (mobile van) on the Pulse and Frontlines. • Conducts monthly data pull • Defines eligible participants • Distributes member list to PDI for mailing	**Commercial Current HEDIS 2017:** 71.25% (33.33th percentile) **Commercial HEDIS 2018 Goal:** 72.76% (50th percentile) **Medicare Current HEDIS 2017:** 71.25% (33.33th percentile) **Medicare Goal HEDIS 2018:** 72.22% (50th percentile)	Annually	QI Int. Managers	1/2018	12/2018	QMC HEDIS
QI LEAN Management	Use LEAN practices and tools to identify and research new quality improvement targets. Implement QI strategies (interventions or process improvements) based on findings.	Objectives including utilizing the use of: • A3 problem solving • PSDA cycle • Chart(s) • Visual Management Boards • Weekly QI team huddle	**Objective:** • Increase collaboration in LEAN efforts • Improve quality of data •	Ongoing	QI Team	01/2018	12/2018	QI Director
***Bone Density Screening (OMW)**	To improve HEDIS rates for the measure, Osteoporosis Management in Women who had a Fracture.	Create monthly list of women 67-85 years of age who had a fracture in the last 3 months and who have not had either a bone mineral density test or a prescription for a drug to treat for osteoporosis since the fracture. Provide to ACS for follow up, as appropriate.	**Current Medicare 2017 HEDIS Rate (2016 data):** 18.18% (10th percentile)**Goal Medicare 2018 HEDIS Rate :** 25% (25th percentile) Compliance in 22 of 43 women.	Monthly	Int. Manager	01/2018	12/2018	QMC

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***Improving Diabetic Retinal Exams (CDC)**	To improve HEDIS rates for the Diabetic Retinal Exam component of the HEDIS CDC measure. Quality will target members for outreach who meet the following criteria: (1) the member is 18-75 years of age, (2) the member has been diagnosed with diabetes (type 1 and type 2), (3) the member has not had a retinal exam performed is the last year.	Create monthly list of members 18-75 years of age that have not had a retinal exam in the last year. Provide to ACS Eye Clinic Navigators to outreach and schedule the exam.	**Current Medicare 2017 HEDIS Rate** (2016 data): 68% (3 stars) Needed 49 additional members to reach most recent 4 star cut point. **Goal Medicare 2019 HEDIS Rate** (2018 Data): >=96% (4 stars) Compliance in 1173 of 1222.	Annually	QI Intervention Manager	Monthly	Monthly	QMC
QUALITY OF CLINICAL CARE								
Improving Perinatal Health: HEDIS documentation and coding education	DHMP QI HEDIS Program Manager and QI Intervention Manager provide guidance and education on appropriate coding and documentation at the Denver Health Hospital and Ambulatory Care Clinics.	**Procedure:** • QI participates in the perinatal workgroup on a monthly basis. QI provides guidance and education on appropriate coding and documentation for PPC HEDIS compliance.	**Commercial Current Prenatal 2017 HEDIS Rate:** 96.28%(90th percentile) **Commercial Prenatal Goal 2018:** 97.26% (95th percentile) **Commercial Current Postpartum 2017 HEDIS Rate:** 80.17% (50th percentile) **Commercial Postpartum Goal 2018:** 82% (66.67th percentile)	Monthly	QI HEDIS Program Manager QI Int. Manager	1/2018	12/2018	QMC

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***Improving Well-Child Visits: HEDIS Rates**	To improve the Commercial HEDIS Rates for Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34), and Adolescent Well-Care Visits (AWC) ✓ Affects member experience	The following interventions will be ongoing in 2018: • Healthy Heroes Birthday Cards, with amendment • SBHC Targeted Lists • SBHC Enrollment Increase • Improving Medical Record Documentation for HEDIS specifications: Provider Education	**Commercial W15 (6+ visits)** **Current HEDIS 2017 Rate**: 81.15% (25th percentile) **Goal - HEDIS 2018**: 82.81% (50th percentile) **Commercial W34** **Current HEDIS 2017 Rate**: 77.99% (25th percentile) **Goal - HEDIS 2018:** 79.3% (50th percentile) **Commercial AWC** **Current HEDIS 2017 Rate**: 43.21% (25th percentile) **Goal – HEDIS 2018:** 45% (33.33th percentile)	Annually	QI Director, HEDIS Program Manager QI Int. Manager	1/2018	12/2018	QMC

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***Improving Well-Child Visits: Healthy Heroes Birthday Cards**	Commercial children 2-19 years of age who still require an annual well child visit for the year will receive a birthday card informing them to come for their annual visit. Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care. ✓ Affects member experience	Procedure: • QI pulls list from BI portal monthly • QI cleans data and separates per LOB • QI forwards list to the printer to send out reminder cards	**Goal:** Engage children who have not gone in for their annual well child visit through the healthy hero birthday cards **WCC Counseling for Physical Activity** **Current HEDIS 2017 Rate:** 63.50% (50th percentile) **Goal HEDIS 2018:** 67.38% (75th percentile) **WCC BMI** **Current HEDIS 2017 Rate:** 91.24% (95th percentile) **Goal HEDIS 2018**: 95% (95th percentile **WCC Counseling for Nutrition** **Current HEDIS 2017 Rate:** 80.05% (75th percentile) **Goal HEDIS 2018**: 89.95% (95th percentile)	Quarterly	QI Intervention Manager	1/2018	12/2018	QMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
QUALITY OF CLINICAL CARE								
***Improving Well-Child Visits: School-Based Health Centers Targeted Lists**	Twice a year, QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. **2nd Quarter Objective**: Increase the % of Commercial members with a well-child visit by providing targeted lists to SBHCs HCPs ✓ Affects member experience	**Procedure**: • SBHC sends enrollment lists to QI runs the list against active members to determine who is in need of well-child visit • Send list back to clinic so HCPs can complete well visit in SBHC. • Provide updated list on monthly basis back to clinic so they are not providing services to children who may have completed well visit elsewhere and as way to track who receives a visit and where.	**Goal:** Assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit. 50%+ completion of visits for total eligible population	Quarterly	QI Int. Manager School-Based Health Center Administrative Contacts	10/17	5/18	QMC
***School Based Health Clinics (SBHC) - Well Child Visit Incentive Program**	As part of the Denver Health Managed Care network, children who are members of Denver Health Medicaid Choice or any Denver Health Medical Plan, Inc. plan, have access to the Denver Health School-Based Health Centers (SBHC). These children can receive health care services at one of the many SBHCs with no cost sharing to the member. ✓ Affects member experience	**Procedure (Well Child Visits):** QI will reward clinics for every well-child visit completed between 50% and 75% completion of visits for the total eligible population.	**Well Child Visits:** **Goal for SBHC Clinics: 50-75% completion of visits for the total eligible population** **WCC Counseling for Physical Activity** **Current HEDIS 2017 Rate:** 63.50% (50th percentile) **Goal HEDIS 2018:** 67.38% (75th percentile)	Monthly	QI Int. Manager School Based Health Center Dr. Sonja O'Leary	9/2017	5/2018	QI Director QMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

			WCC BMI **Current HEDIS 2017 Rate:** 91.24% (95th percentile) **Goal HEDIS 2018**: 95% (95th percentile **Commercial AWC** **Current HEDIS 2017 Rate**: 43.21% (25th percentile) **Goal – HEDIS 2018:** 45% (33.33th percentile)					

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

D-Special Needs population Measurable Goals and Health Outcomes for the Model of Care	The SNP beneficiary specific performance measures are collaboratively developed in conjunction with DHMP and the DHHA Ambulatory Quality Committee (ACQIDC). This SNP-MOC specific set of goals reflect process, impact and outcome measures.	**Procedure:** • DHMP Health Management department produces an annual SNP MOC program evaluation responsible for the operations of the SNP MOC HRAT, ICP and ICT facilitation. • The results of the MOC annual program evaluation, updated program description, and work plan will be reviewed and approved annually by the QMC • Final approval is provided by the DHMP Board of Directors • SNP MOC evaluation content is then distributed to the Denver Health Ambulatory QI Committee (ACQIDC)	**Current 2017 # and % of member for who outreach attempts were completed for HRA completion, initial or annual:** 88% **2018 Goal:** 90% **Current 2017 # and % of members for whom an Individual Care Plan with identified goals was completed, initial or annual:** 38% **2018 Goal:** 44.2% **Current 2017 rate of emergency department encounters/1000 members:** ** **2018 Goal: **** **Current 2017 rate of inpatient admissions/1000 members: ** 2018 Goal: **** **Current 2017 average length of stay index for inpatient admissions: ** 2018 Goal: **** **Current 2017 rate of 30-day all cause readmissions:** 8.5% **2018 Goal:** 8.2% **Current 2017 % of patients with pharmacotherapy management of COPD Exacerbation- Systemic Corticosteroid:** 71.4% **2018 Goal:** 72.14%	Annually	Director of Health Management DHMP Medical Director QI Director	1/2018	5/2018	QMC DHMP Board of Directors

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			Current 2017 % of patients with pharmacotherapy management of COPD Exacerbation- Bronchodilator: 91.1% **2018 Goal:** 91.1% **Current 2017 % of patients with colorectal cancer screening up to date:** 57.9% **2018 Goal:** 60.25%					
Complex Case Management: Population Assessment	Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner.	**Assessment must consider and include the following:** • Relevant characteristics of specific populations • DHMP's total covered population, not just members identified for complex case management • Needs of individuals with disabilities and serious and persistent mental illnesses	**Goals:** • Assesses the characteristics and needs of its member population and subpopulations • Reviews and updates its complex case management processes to address member needs, if necessary • Reviews and updates its complex case management resources to address member needs, if necessary	Annually	Director of Health Management	11/2018	1/2019	MMC QMC

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QUALITY OF SERVICE								
Complex Case Management: Measuring Program Effectiveness	Complex Case Management annually measures the effectiveness of its complex case management program using three measures.	**For each measure, Complex Case Management:** • Identifies a relevant process or outcome • Uses valid methods that provide quantitative results • Sets a performance goal • Clearly identifies measure specifications • Collects data and analyzes results • Identifies opportunities for improvement, if applicable	**Goals:** **Member Satisfaction:** • 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied). **Develop a dashboard for tracking** • Analyze data for high cost and high utilizers along with utilization data.	Annually	Director of Health Management	11/2018	12/2018	MMC QMC
Population Health Management (PHM) Strategy: Monitoring Member Participation Rates	The Health Management Department has a population health strategy for meeting the care needs of its member population.	• The strategy describes goals and populations targeted for each of the four areas of focus, Keeping members healthy, Managing members with emerging risk, Patient safety or outcomes across settings, and Managing multiple chronic illnesses, the programs and services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about PHM programs.	**2018 PHM Participation Goal:** • Establish baseline data for the four avenues of the population health strategy ***Keeping members healthy*** **Goal:** Decrease A1c levels by 2% in members who have a pre-diabetes A1c reading between 5.7 – 6.4 **Target Population:** Members identified as pre-diabetes with an A1c reading between 5.7 – 6.4. ***Managing members with emerging risk*** **Goal:** Improve portion of days covered (PDC) rates by 2% from baseline in members who take	Annually	Director of Health Management	12/2018	1/2019	QMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

			antidepressant medications for depression. **Target Population:** – Members who are <80% PDC with medications for depression management. – Members who are prescribed antidepressant medications for depression. ***Patient safety or outcomes across settings*** **Goal:** Improve medication adherence and knowledge in members who have 8 or more prescriptions and <80% PDC rates for all medications. **Target Population:** Members with =/> 8 prescriptions and < 80% PDC rates ***Managing multiple chronic illnesses*** **Goal:** For members with diabetes and high BMI: lower A1c by 2% or to <9 or lower BMI by 5% or to <25 for members who exceed both measures. **Target Population:** – Members with controlled diabetes – Members who have a BMI >25					

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

***2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis**	Assess member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS member satisfaction survey. ✓ Affects member experience	**DHMP's QI Department:** • Sends CAHPS surveys out annually to members via random sample. • Validates data before submission • Meets CAHPS submission deadline • Analyzes survey results to determine areas of intervention and improvement	**Evidence of annual analysis includes:** • Presentation to the QMC • Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.	Annually	QI Clinical Project Manager QI Director	Ongoing	Ongoing	QMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

Cultural and Linguistic Appropriate Services (CLAS)	To deliver culturally and linguistically appropriate services to Denver Health membership. ✓ Affects member experience	**Objective:** • Ongoing to reduce REL related disparities in health based on available data. Ensure appropriate literacy levels in member materials Improvement of REL membership data	**Goal:** • Reduce health care disparities as it relates to REL • Improve collection of REL membership data	Annually	QI Int. Managers	1/2018	Ongoing	QMC Denver Health Diversity Committee
QUALITY OF SERVICE								
Monitoring Network Availability of Practitioners	DHMP conducts an annual assessment to ensure that it maintains an adequate network of primary care, behavioral health and specialty care practitioners. We monitor effectiveness of the network in meeting needs and preferences of our membership.	**Analysis includes:** • Collecting member complaint data related to cultural, racial, ethnic and linguistic preferences • Performance against the number and geographical distribution standards for primary care, behavioral healthcare and specialty care	**Goals**: Meet urban, suburban and rural provider availability standards set in the Access to Care and Services Policy	Annually	Director of Provider Relations	9/2018	10/2018	QMC
***Commercial Quality of Care Concerns (QOCC)**	DHMP Medical Director and QI RN appropriately investigate potential QOCC's.	**Timeframe requirements:** • Acknowledgment letter: 2 business days. • Expedited Response: 72 hrs. • Standard Response: 30 business days. • Extension letter: 15 business days.	**Goal**: • 100% Timeframe Compliance	Quarterly	QI Director RN Case Manager	Ongoing	Ongoing	QMC
***Medicare Quality of Care Concerns (QOCC)**	DHMP Medical Director and QI RN appropriately investigate potential QOCC's.	**Timeframe requirements:** • Acknowledgment letter: N/A • Expedited Response: 24 hrs. • Standard Response: 30 calendar days.	**Goal**: • 100% Timeframe Compliance	Quarterly	QI Director RN Case Manager	Ongoing	Ongoing	QMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

		• Extension letter: 14 calendar days.						
Monitoring Accessibility of Services	DHMP has established mechanisms to ensure access to primary and specialty care services, along with behavioral health services. DHHA Appointment Center services are responsible for meeting established standards.	**Assessment incorporates:** Self-reported access data from practitioners captured via Secret Shopper Studies, supplemented with an analysis of complaints related to access.	**Goals**: • Meet urban, suburban and rural standards set in the Access to Care and Services Policy	Annually	Director of Provider Relations	1/2018	2/2018	QMC
***Adoption and Distribution of Clinical Practice and Preventive Health Guidelines**	DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members and providers for the provision of non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties.	**CPG's must be updated annually or when the following circumstances exist:** • New scientific evidence or national standards are published prior to the annual review date • National guidelines change prior to the annual review date	**Objective:** **Adoption and dissemination by:** • Establishing the clinical/scientific basis for the guidelines • Review guidelines annually, with updates as needed • Distributing guidelines to appropriate practitioners	Annually	QI Director QI RN	Ongoing	Ongoing	QMC
***Evaluating Utilization Management Criteria**	Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate.	**DHMP's UM Department has:** • Written UM decision-making criteria that are objective and based on medical evidence • Written policies for applying the criteria based on individual needs • Written policies for applying the criteria based on an assessment of the local delivery system • Involvement of appropriate practitioners in developing,	**Objective**: Criteria must consider at least the following when applying criteria to a given individual: • Age • Comorbidities • Complications • Progress of Treatment • Psychosocial situation • Home environment, when applicable	Annually	Director of UM Medical Director	2/2018	3/2018	QMC MMC

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

		adopting and reviewing criteria						
***Monitoring Consistency of Applying UM Criteria**	Utilization Management monitors and reviews application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency, action is taken to improve the consistency of reviewer determinations.	**DHMP's Utilization Management Department annually:** • Evaluates consistency of health care professionals making UM decisions by applying criteria consistently and appropriately • Acts on opportunities to improve reliability of criteria application when identified	**Goal**: • 85% Accuracy Rate for Criteria Application	Annually	Director of UM Medical Director Pharmacy Director	11/2018	12/2018	MMC
***Monitoring of Formulary and Pharmaceutical Management Procedures**	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes.	**DHMP's Pharmacy Department annually:** • Review the procedures • Review list of pharmaceuticals • Updates the procedures and pharmaceuticals, as appropriate	**Goal**: • Must present and review all pharmaceutical management procedures annually to address areas for improvement	Annually	Pharmacy Director	10/2018	11/2018	P&T – approval QMC - review
QUALITY OF SERVICE								
Quality of Service Concerns (QSC)	The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns. ✓ Affects member experience	**Timeframe requirements:** • Acknowledgment letter: 5 business days. • Standard Response: 30 business days. • Extension letter: 15 business days. • Expedited: 72 hours	**Goal:** • 100% Timeframe compliance	Quarterly	Director of Member Services	Ongoing	Ongoing	QMC
Member Annual Communication Requirements	The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan	**Members receive:** • Information about the quality program goals and outcomes as related to member care and service	**Goals**: • Must provide evidence of annual communication to all members	Annually	Director of Marketing	1/2018	12/2018	Outreach Committee

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

	topics related to patient care and service.	• Pharmaceutical restriction and preference information, including formulary.						
Member Communication Requirements Upon Enrollment and Annually Thereafter	The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan design and benefits ✓ Affects member experience	**Members are provided the following information, including but not limited to:** • Member rights and responsibilities statement • Subscriber information • PHI use and disclosure information • The process for members to self-refer to case management • How to access staff • An affirmative statement about incentives	**Goals**: • Must provide evidence of communication to all commercial members upon enrollment and annually thereafter	Annually	Director of Marketing	1/2018	12/2018	Outreach Committee
Practitioner and Provider Communication Requirements	The Marketing Department provides timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.	**Practitioners and Providers are provided the following information, including but not limited to:** • Member rights and responsibilities statement • The process for the practitioner to refer members to case management • Disease Management Program information • Clinical practice and preventive health guidelines (to appropriate practitioners) • How to obtain UM criteria • How to access staff • An affirmative statement about incentives	**Goal**: • Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter • Must provide evidence of annual communication to all network practitioners and providers	Annually	Marketing Manager	1/2018	12/2018	Network Adequacy Committee

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		• Information about the quality program goals and process outcomes related to member care and service • Pharm restriction and preference information, including formulary.						
Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
QUALITY OF SERVICE								
Physician and Hospital Directory Usability Testing	The Marketing department evaluates DHMP's web-based physician and hospital directory for health literacy, ability for member understanding and usefulness of information to members and prospective members.	**Evaluation considers:** • Font size • Reading level • Intuitive content organization • Ease of navigation • Directories in additional languages, if applicable to membership	**Goals**: • There must be a documented process demonstrating how usability testing is performed and how testing frequency is determined. • Reports indicating initial usability testing was performed before and after any upgrades to functionality or design that directly affects how members use the site.	Annually	Marketing Manager	3/2018	4/2018	QMC
Accessing Member Understanding of DHMP Procedures	The Marketing department has a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures. ✓ Affects member experience	**Assessment includes:** • Monitoring new member understanding of DHMP procedures • Implementing procedures to maintain accuracy of marketing communication • Acting on opportunities for improvement	**Goals**: • There must be evidence of a systematic and ongoing process for assessing new-member understanding of DHMP operations and policies. • If DHMP finds that new members have enrolled without an accurate understanding of key DHMP policies and procedures, DHMP must initiate	Annually	Director of Marketing	Quarterly	Quarterly	QMC

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			a quality improvement process to correct the possibility of future misrepresentation.					
***Ongoing Monitoring of Network Practitioners and Providers Site Quality**	Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP's office-site standards. This is achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality.	**Provider Relations and Credentialing:** • Sets performance standards and thresholds for office site quality • Establishes a documented process for ongoing monitoring and investigation of member complaints related to practice sites	**Goals**: • Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met • Deliver corrective action plans within 30 calendar days of site visit • Repeat site visits are conducted 6 months after delivering corrective action plans to assure compliance	Quarterly	Director of Provider Relations	Ongoing	Ongoing	Cred. Cmte.
***Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues**	DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified. .	**Ongoing review and monitoring by:** • Collecting and reviewing Medicare and Medicaid sanctions • Collecting and reviewing sanctions or limitations on licensure • Collecting and reviewing complaints • Collecting and reviewing information from identified adverse events	**Goals**: • Review sanction information within 30 calendar days of its release • Implementing appropriate interventions when instances of poor quality are identified		Medical Director	Ongoing	Monthly	Cred. Cmte.
***Monitoring Member Services' Telephonic Performance**	The Member Services Department has a process for monitoring and evaluating telephonic metrics against established thresholds.	**Reporting categories:** • Service level • Average delay to answer • Abandonment rate • Call volume	**Goals**: • Service level: at or above 80% • Time to answer: 30 seconds or less. • Abandonment rate: 5% or less.	Monthly	Director of Member Services	Ongoing	Ongoing	QMC

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***Continuity and Coordination of Medical Care**	DHMP uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.	**Annual identification of opportunities to improve coordination of medical care by:** • Collecting data on member movement between practitioners and across settings • Conducting qualitative and causal analyses of data to identify improvement opportunities • Identifying and selecting at least opportunities for improvement • Acting on at least 3 opportunities for improvement and measuring effectiveness	**Goals**: • Identify and select at least 4 opportunities to improve the coordination of medical care • Measure the effectiveness of improvement actions taken for at least 3 opportunities	Annually	Director of UM	1/2018	12/2018	QMC MMC

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***Continuity and Coordination Between Medical Care and Behavioral Healthcare**	DHMP will conduct an assessment of continuity and coordination of care efforts between medical health care providers and behavioral health care providers (Denver Health and Cofinity providers).	**Annual identification of opportunities to improve coordination of medical and behavioral healthcare by:** • Collecting data on opportunities for collaboration between medical care and behavioral healthcare • Conducting qualitative and causal analyses of data to identify improvement opportunities • Identifying and selecting at least 2 opportunities for improvement • Measuring effectiveness on 2 opportunities implemented	**Goals**: • Identify and select at least 2 opportunities to improve collaboration between medical and behavioral healthcare • Measure the effectiveness of improvement actions taken for at least 2 opportunities	Annually	Director of UM Director of Health Management	1/2018	12/2018	QMC MMC

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***Monitoring Satisfaction with Complex Case Management**	Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction. ✓ Affects member experience	**Satisfaction data is collected through the following methods:** • Obtaining survey feedback from members • Analyzing member complaints for tracking/trending	**Goals**: **Members**: 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied).	Annually	Director of Health Management	11/2018	12/2018	QMC
***Open Shopper Study**	Denver Health Medical Plan, Inc. (DHMP) has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an "Open Shopper" study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is to determine what percent of clinics within the Denver Health system meet our access standards; what percent of high-volume providers within the expanded Cofinity Network meet our access standards; and what percent of behavioral health providers who serve our members meet our access standards ✓ Affects member experience	**Objectives**: • Semi-annually, call all DHMP HMO outpatient clinics (n=9) and a random sample of POS provider clinics (n=50) to assess compliance with DHMP Primary Care Access Standards for routine appointments, urgent after-hours care and acute care access. • Semi-annually, call all Behavioral Health providers who see 2 or more of our members to assess compliance with DHMP Behavioral Health Access Standards for routine appointments, urgent after-hours care and acute care access.	**Goals**: • Emergency Care: 24 hours a day, 7 days a week -Met 100% of the time • Emergency Care-Behavioral Health Non-life Threatening: Within 6 hours- Met 100% of the time • Urgent Care-Medical and Behavioral Health: Within 24 hours-Met 100% of the time • Primary Care-Routine Symptoms Non-urgent : Within 7 calendar days- Met ≥ 90% of the time • Primary Care-Access to Afterhours Care: Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician -Met ≥ 90% of the time • Specialty Care-Non-Urgent: Within 60 calendar days- Met ≥ 90% of the time	Semi-Annually	QI Director	1/2018	7/2018	QMC

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			• Routine Behavioral Health Care: Within 10 business days - Met ≥ 90% of the time • Preventive Visits/Well Visits: Within 30 calendar days- Met ≥ 90% of the time					
***Monitoring Member Satisfaction**	DHMP monitors member satisfaction with our services and identifies areas of potential improvement. To assess member satisfaction with our services, DHMP annually evaluates member complaint and appeal data to analyze tracking and trending. ✓ Affects member experience	**Aggregate member complaints and appeals by reason, showing rates related to:** • Quality of Care • Access • Attitude and Service • Billing and Financial Issues • Quality and Practitioner Office Site.	**Goals:** Evidence of monitoring includes: • Annual reporting to the QMC • Root-cause analysis provided to identify opportunities for improvement.	Annually	Director of Member Services	1/2018	3/2018	QMC
***Monitoring Satisfaction with the Utilization Management Process**	DHMP continually assesses member and practitioner satisfaction with our Utilization Management process to identify areas in need of improvement. ✓ Affects member experience	**Components of the process:** • Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities • Taking action designed to improve member and practitioner satisfaction based on assessment of the data	**Goals**: • **Members**: Of the surveyed members (CAHPS) who required an authorization for services, 90% or more reported being either "Somewhat or Very Satisfied" with the authorization process (question 31A). • **Practitioners**: 90% of the surveyed providers will indicate a high level of satisfaction with the UM program by answering each of the Provider UM Satisfaction questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied)."	Annually	Director of UM	12/2018	1/2019	QMC

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***Monitoring Satisfaction with Disease Management**	The Health Management Department annually evaluates satisfaction with its disease management services to identify opportunities to improve member satisfaction. ✓ Affects member experience	**Satisfaction data is collected through the following methods:** • Obtaining member survey feedback • Analyzing complaints and inquiries	**Goals**: • **Members**: 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied).	Annually	Director of Health Management	12/2018	1/2019	QMC
QUALITY OF SERVICE								
Monitoring Member Services' Benefit Information for Quality and Accuracy	The Member Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.	**Components of the process:** • Collecting data on quality and accuracy of information provided • Analyzing data against standards or goals • Determining the cause of deficiencies, as applicable • Acting to correct identified deficiencies	**Goals**: • Telephone: 85% accuracy • Online: 85% accuracy	Quarterly	Director of Member Services	Ongoing	Quarterly	QMC
Monitoring Pharmacy Benefit Information for Quality and Accuracy	The Pharmacy Department has a quality improvement process in place to assess the quality and accuracy of pharmacy benefit information provided to members telephonically and online.	**Components of the process:** • Collects data on quality of service and accuracy of pharmacy benefit information provided both telephonically and online • Analyzes data results • Acts to correct identified deficiencies. Results are presented to Compliance Committee and QMC for review and feedback.	**Goals**: • Telephone: 85% accuracy • Online: 85% accuracy	Semi-annually	Pharmacy Director	01/2018	12/2018	QMC Compliance Committee

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***2016 Utilization Management Program Evaluation**	The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the MMC & QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program.	**Evaluation includes:** • Completed and ongoing activities • Quantitative and Qualitative Analysis • Evaluation of effectiveness	**Presentation to QMC must include:** • Committee discussion and input on program summary • Actions, if applicable • Committee approval of 2018 UM Program	Annually	Medical Director	01/2018	02/2018	QMC MMC
SAFETY OF CLINICAL CARE								
Patient Safety Initiatives	The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Behavioral Health and Wellness Departments to provide clinical quality monitoring> Identification of performance improvement opportunities related to member safety are reviewed and implemented. ✓ Affects member experience	**Process:** The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches.	**Objectives:** • Encourage organizational learning about medical and health care errors • Incorporate patient safety education across organization • Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee. • Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result • Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions	Annually	Director of QI	Ongoing	Ongoing	QMC

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			• Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired under the quality of care concern process. • Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk • Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety • Focus existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety • Annually review and evaluate clinical practice guidelines against practice guidelines to ensure and improve safe practices					

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***Pharmaceutical Patient Safety Issues**	The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacists or practitioners. This represents an opportunity to provide patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons. ✓ Affects member experience	**Objectives:** • Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety. • An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall. • Results are presented to Compliance Committee annually and MMC for review and feedback semiannually.	**Goals:** **100% Compliance for:** • Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification. • Class II: Affected members and providers notified within thirty days of the FDA notification. • Class III: Affected members and provider notified within sixty days of FDA notification.	Annually & Semi-annually	Pharmacy Director	Ongoing	Ongoing	MMC - Semiannually Compliance Committee - Annually
SAFETY OF CLINICAL CARE								
***Monitoring Privacy and Confidentiality**	The Compliance Department has a process for identifying, reporting and taking action on impermissible uses or disclosure of sensitive information. ✓ Affects member experience	**The Compliance Department implements procedures for:** • Identifying impermissible uses or disclosure of sensitive information • Reporting impermissible uses or disclosures of sensitive information • Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information	**Goals**: • Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality. • If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections may include, but are not limited to: ▪ Education and training ▪ Process/procedural revisions ▪ Progressive discipline	Annually	Compliance Director	Ongoing	Ongoing	Compliance Committee Board of Directors

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

DENVER HEALTH MEDICAL PLAN INC.™

Monitoring Member Services' Telephonic Performance

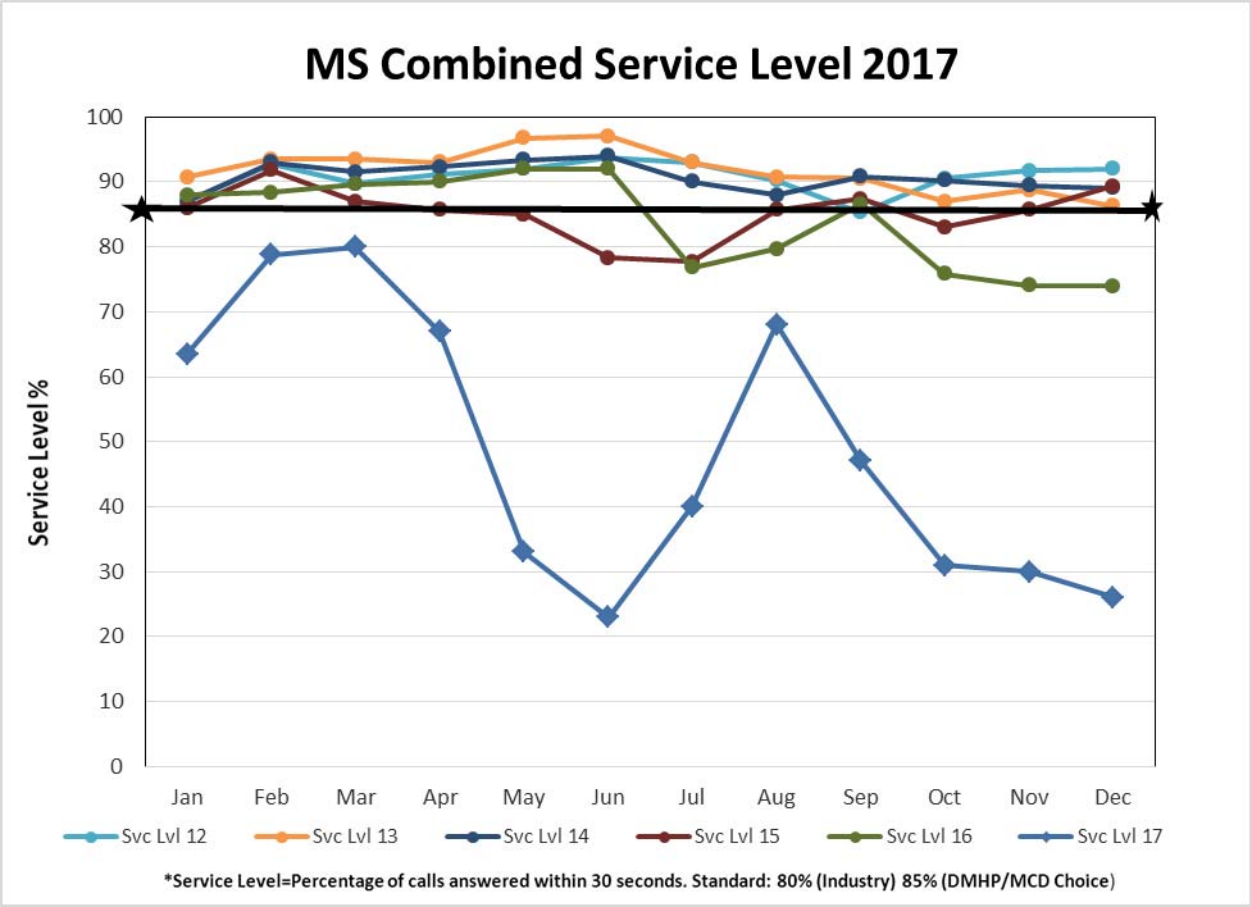
Commercial and Medicare

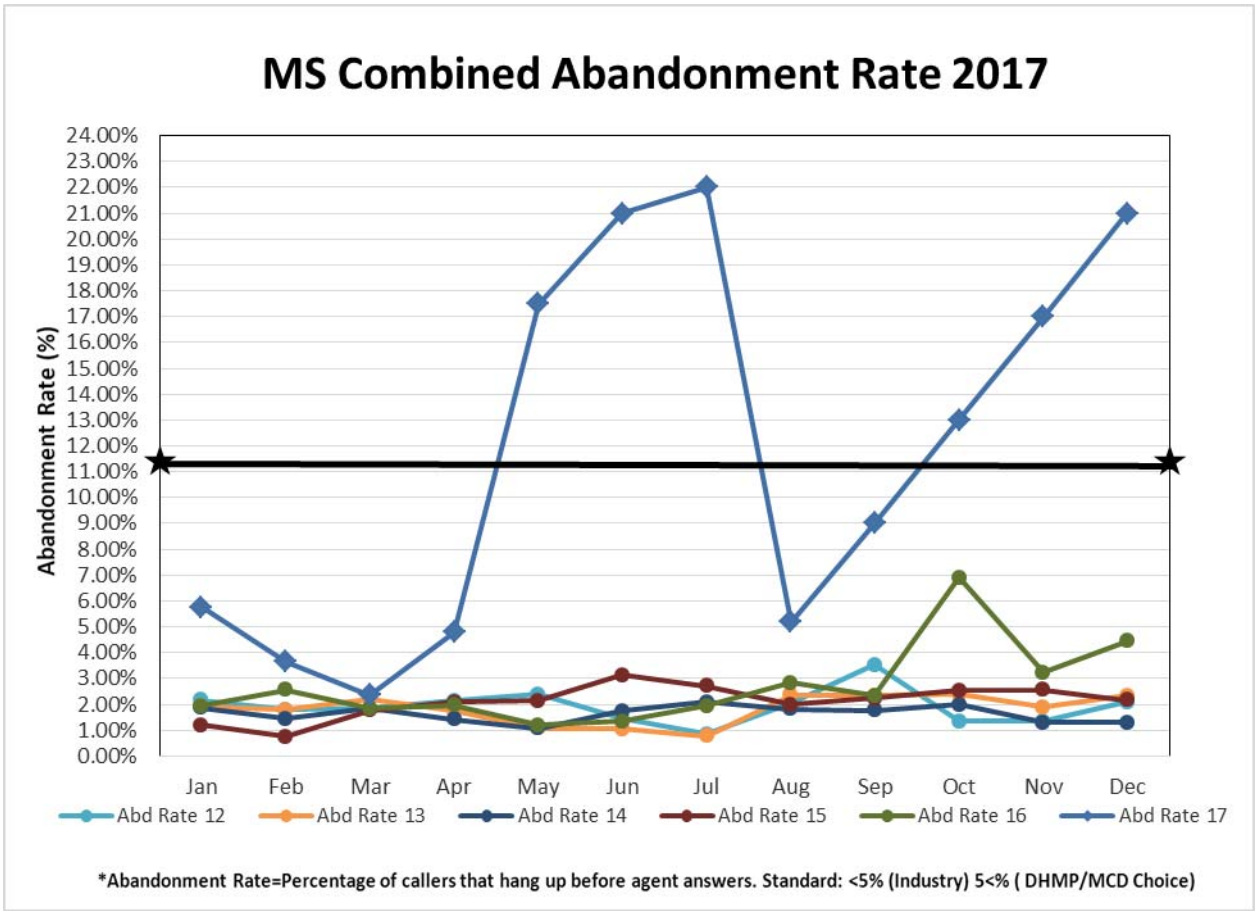
Report Period: January 1, 2017 to December 31, 2017
Submission Date: March 13, 2018

Prepared By:
Managed Care Member Services Department

Monitoring Member Services' Telephonic Performance

Member Services has in place a departmental Performance Report that monitors four telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, and overall Call Volume. The Member Services Performance Report monitors these telephonic statistics by each individual Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) line of business. Tracking, comparison, and evaluation occurs on a monthly as well as annual basis. The Member Services Lead Customer Service Representative pulls all telephonic statistical data from the Cisco Telephony System reporting system Cisco Unified CXX Historical Reports and prepares the report for the Call Center Operations Manager. The Operations Manager reviews each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The Operations Manager presents the Performance Report as well as his or her Summary and Analysis at each quarterly Quality Management Committee meeting.




MS Combined Abandonment Rate 2017
Abandonment Rate (%)
24.00%
23.00%
22.00%
21.00%
20.00%
19.00%
18.00%
17.00%
16.00%
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%
9.00%
8.00%
7.00%
6.00%
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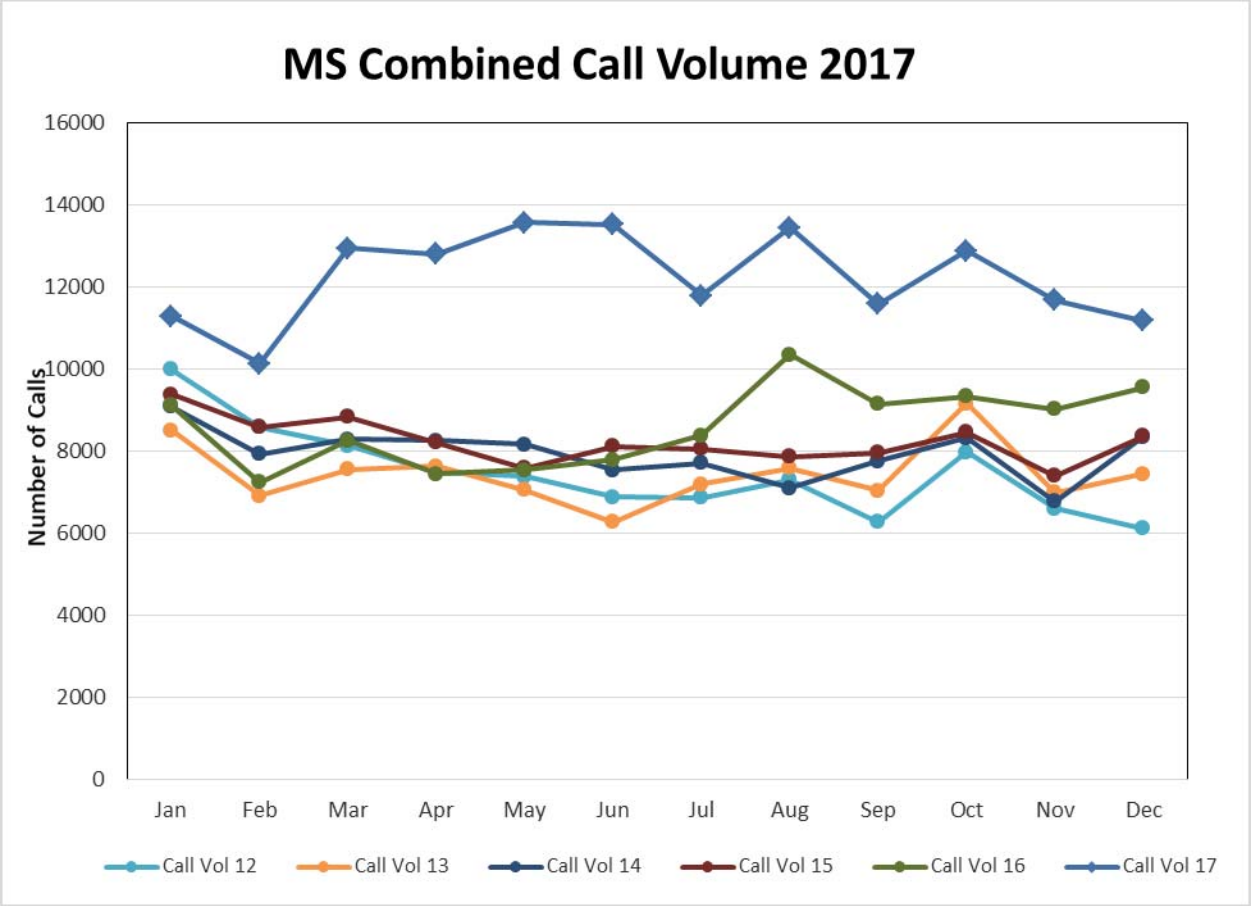
*Abandonment Rate=Percentage of callers that hang up before agent answers. Standard: <5% (Industry) 5<% (DHMP/MCD Choice)

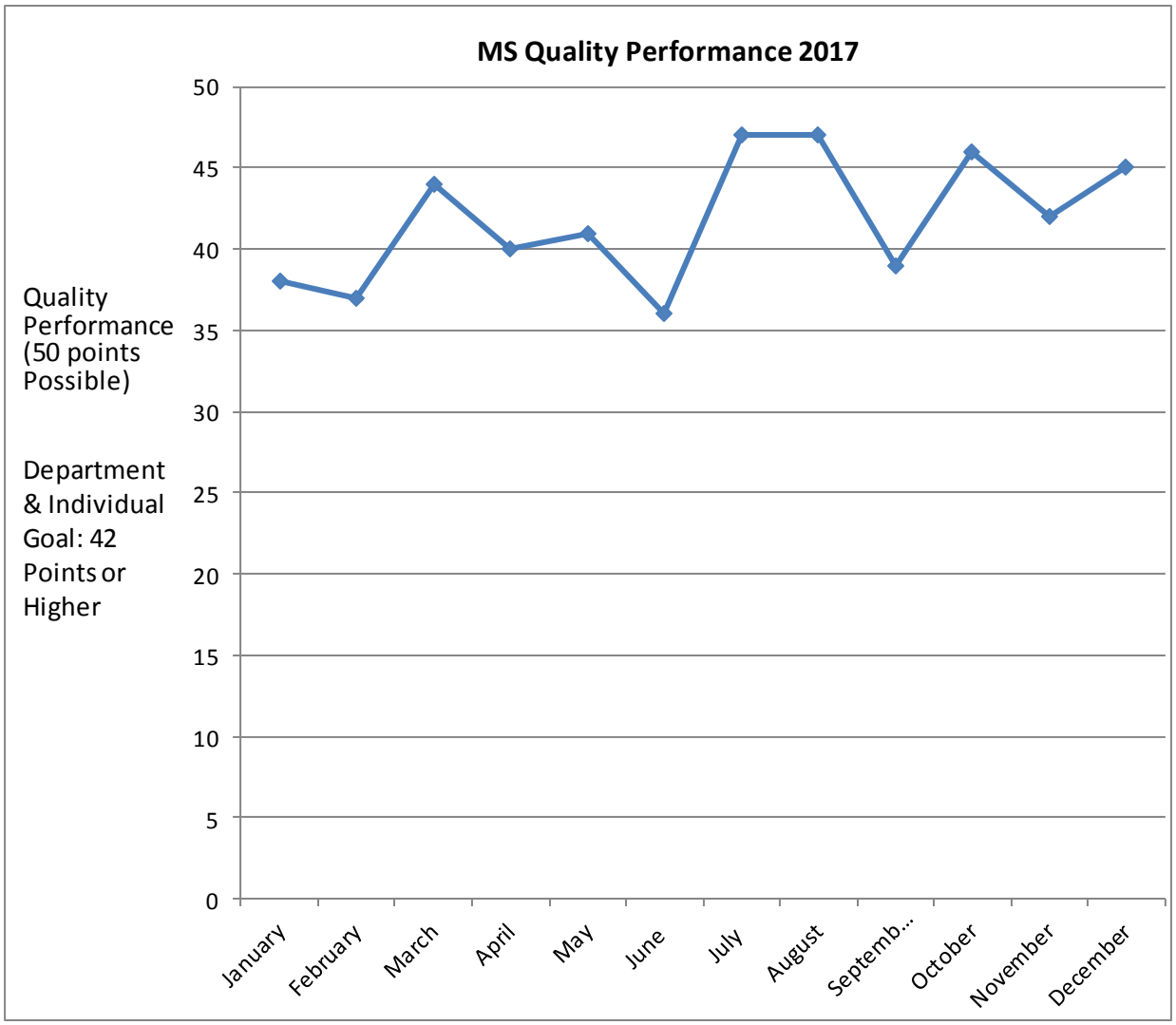


Monitoring Member Services' Benefit Info for Quality and Accuracy

In order to satisfy regulatory standards and monitor the telephonic quality of DHMP Member Services, the Member Services Quality Assurance Program has instituted reporting occurring on a monthly basis. The MS QA Program allows the Member Services Leadership Team (MSLT) to determine any deficiencies in quality and service provided by the Member Services Representatives (MSRs) as well as work to correct any identified deficiencies. The QA Program serves as a valuable tool in staff development and satisfaction and is also incorporated into the annual MSR evaluation process to ensure that it is meaningful to the team and its individual members.

The QA program entails monitoring and reporting on two components, telephonic productivity and performance as well as quality and accuracy of benefit information provided. Productivity is evaluated on specific metrics from the Cisco Telephony System, specifically Inbound Call Volume, Average Talk Time, Not Ready Time, and Reserved Time. The quality component of the QA Program is evaluated by direct call monitoring and evaluation by the MS

Supervisor. The MS Supervisor selects 10 random calls for each MSR that occurred in the specific month out of the Call Copy Call Recording Software. The MS Supervisor will evaluate the call for the quality and accuracy of the information provided based upon various criteria (member information confirmation, identifying issues, knowledge of benefits, documenting the call, tone of voice, etc.) and scores the MSR on a sliding scale dependent upon the accuracy of the information given. The overall evaluation of MSR performance in both areas is compiled, reviewed, and provided to the MSRs on a monthly basis. One on one coaching will occur if deemed necessary. In addition, an overall departmental MS Monthly Call Quality Performance Report is compiled to track the progress of quality maintained by the MSRs from month to month on an individual as well as departmental basis. All MSRs and the department overall must maintain an accuracy rate of 85% or higher. If this is not maintained, corrective actions are taken.



DENVER HEALTH MEDICAL PLAN INC.™

Complaint Analysis Report

Commercial and Medicare

Report Period: January 1, 2017 to December 31, 2017
Submission Date: March 13, 2018

Prepared By:
Managed Care Grievance and Appeal Department

I. PURPOSE

Denver Health Medical Plan, Inc. (DHMP) believes member satisfaction is one of the most important performance measures. DHMP has an established internal complaints management procedure which aims to ensure procedural fairness in the handling of complaints, standardize complaint investigation practices, and establish mechanisms to track the number and types of complaints received.

The purpose of this report is to provide an overview and analysis of the number of member complaints filed with DHMP under its Commercial and Medicare lines of business, which includes the following plans: Denver Medical Care HMO, Denver Medical Care Expanded HMO, Point of Service, Career Services Authority Medical Care HMO, Career Services Authority Medical Care DHMO, Denver Police Protective Association Medical Care HMO, Denver Police Protective Association Medical Care DHMO, DERP Non-Medicare Primary, DPS Highpoint CDHP, CHP+, Elevate, Medicare Select, and Medicare Choice. The complaint analysis report period covers the period of January 1, 2017 to December 31, 2017 and describes the number and types of member grievances and appeals received during the report period. In addition, a summary of activities is provided that demonstrates DHMP's commitment to quality improvement.

II. DATA COLLECTION

One of the ways DHMP gathers information from members is by tracking grievances filed by members and/or their authorized representatives. Efforts are spent on analyzing not only the timeliness of the problem resolution process, whether regulatory requirements are met, whether member notification of a resolution is provided in an easy to understand and culturally competent manner, but also on identifying patterns of grievances which may suggest the need for further investigation and/or performance improvement opportunities by DHMP and/or its affiliate entities and providers.

It is important to note that the DHMP Grievance and Appeal Department again underwent changes in 2017. In September of 2017, the Grievance and Appeals Department began using the Guiding Care system for data entry and tracking of member grievances and appeals. In the fourth quarter of 2017, the Grievance and Appeal Department transitioned from beneath the Call Center Operations Manager to the newly created position of Grievance and Appeals Manager. In addition, the provider appeals Grievance and Appeals Coordinator was moved from Provider Relations to the Grievance and Appeals Department and began training on member appeals in the fourth quarter of 2017. The Grievance and Appeals Coordinators already attached to the Grievance and Appeal Department also began cross training on provider appeals at that time. As of now, this report still only pertains to member grievances and appeals.

III. SAMPLING METHODOLOGY

DHMP did not take a sample of the universe of complaints. All appeals and grievances for the entire reporting period are included in the analysis.

IV. PROCESS

The definition of a complaint for the Commercial lines of business is defined as:

- *A written communication primarily expressing a grievance.*
- *A grievance is further defined as a circumstance regarded as a cause for protest, including the protest of an adverse determination.*

*(*Citation: Colorado Division of Insurance Regulation 4-2-17, "Prompt Investigation of Health Claims Involving Utilization Review and Denial of Benefits and Rules related to Internal Claims and Appeal Processes.)

The definition of a complaint for the Medicare Advantage lines of business is defined as:

- *Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement (QIO) by and enrollee made orally or in writing.*

(Citation: Medicare Managed Care Manual Chapter 13, "Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plan (HCPPs), (collectively referred to as Medicare Health Plans))

In addition to the regulatory definitions given above, DHMP has further interpreted and adopted the definition to mean *"an expression of dissatisfaction or concern regarding the provision of a service, a decision, or action made by DHMP.*

There are four phases involved in managing a complaint submitted to DHMP. They are:

1. Receiving a complaint
2. Actions taken to address a complaint
3. Outcome and system improvement
4. Monitoring effectiveness and reporting

V. RECEIVING A COMPLAINT/APPEAL

A. Method of Contact (Intake and Assessment)

Grievances may be received via any mode of communication in order to express dissatisfaction. DHMP requires members and/or their Designated Personal Representatives (DPRs) to submit their appeal in writing. Initial contact can be made:

- In person
- By telephone
- In writing
- By fax
- By email

B. Actions Taken to Address a Complaint

When a decision about a complaint is being undertaken, various steps need to occur during the investigation process. They include:

- A review of any relevant regulation or internal policies and procedures
- Gathering of necessary information, consultation with relevant persons and assurance of a thorough understanding of the issues
- Impartial consideration of all relevant information
- Establishment of facts, including analysis of any evidence for quality and corroboration or contradiction by independent sources
- Consideration of the application of relevant policies and procedures and assessment criteria
- Consideration as to whether the original decision (even though made in accordance with relevant policies and procedures) was fair and reasonable
- Consideration given to whether current practice and procedures are still in accordance with best practice
- Consideration of the merits of the original determination/s, if relevant

C. Outcome and Systems Improvement

Remedial action or system improvement recommendations that may be appropriate and reasonable in response to findings made, can include:

- An explanation and statement of apology
- A change of benefit coverage decision
- Correction of misleading or incorrect records
- Policy and procedure review or development
- Staff training and other professional developmental activity
- Dissemination of outcomes and opinions to any staff involved in the original complaint matter to facilitate practice improvements and learnings

DHMP gives consideration, to the extent the action will:

- Prevent the recurrence of similar complaint issue/s; and
- Promote the continuous improvement of departmental services

In cases where remedial actions and/or systemic improvement recommendations appear likely to result, consultation with the affected business areas regarding any recommendations that are to be proposed are essential to ensure appropriate, implementable and sustainable outcomes.

D. Monitoring Effectiveness and Reporting

Recording of complaints information enables departmental reporting requirements to be met and will allow for identification of any trends or system issues that may suggest improvements to products and services delivered.

VI. QUANTITATIVE ANALYSIS

COMMERCIAL GRIEVANCE DATA

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	5	3	1	6	15	.88
Financial/ Billing	15	12	10	8	45	2.64
Quality of Service (Customer Service/Attitude)	1	5	1	1	8	.50
Quality of Clinical Care	1	1	0	0	2	.12
Legal Rights	0	0	0	0	0	0
Fraud, Waste, and Abuse	0	1	0	0	1	.06
HIPAA Privacy and Confidentiality	1	0	0	0	1	.06

Benefit Package	**2**	**1**	**1**	**1**	**5**	**.31**
Transportation	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**2**	**0**	**0**	**0**	**2**	**.12**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Marketing	**0**	**0**	**0**	**0**	**0**	**0**
Eligibility	**0**	**0**	**0**	**1**	**1**	**.06**
Managed Care Department Specific Concerns	**0**	**0**	**2**	**4**	**6**	**.37**
GRAND TOTAL	**27**	**23**	**15**	**21**	**86**	**4.71**

MEDICARE GRIEVANCE DATA

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	**1**	**0**	**2**	**2**	**5**	**.05**
Financial/ Billing	**7**	**3**	**2**	**5**	**17**	**.18**
Quality of Service (Customer Service/Attitude)	**3**	**2**	**2**	**0**	**7**	**.07**
Quality of Clinical Care	**1**	**0**	**1**	**1**	**3**	**.03**
Legal Rights	**0**	**0**	**0**	**0**	**0**	**0**
Fraud, Waste, and Abuse	**0**	**0**	**0**	**1**	**1**	**.01**
HIPAA Privacy and Confidentiality	**0**	**0**	**0**	**0**	**0**	**0**
Benefit Package	**1**	**1**	**0**	**3**	**5**	**.05**
Transportation	**0**	**1**	**3**	**0**	**4**	**.04**
Provider Network	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Marketing	**1**	**0**	**0**	**0**	**1**	**.01**
Eligibility	**2**	**2**	**0**	**0**	**4**	**.04**
Managed Care Department Specific Concerns	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**16**	**9**	**10**	**12**	**47**	**.49**

COMMERCIAL APPEAL DATA

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	13	16	20	12	61	3.58
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Legal Rights	0	0	0	0	0	0
Fraud, Waste, and Abuse	0	1	0	0	1	.06
HIPAA Privacy and Confidentiality	0	0	0	0	0	0
Benefit Package	1	4	3	2	10	.61
Transportation	0	0	0	0	0	0
Provider Network	1	4	1	0	6	.35
Quality of Practitioner Office Site	0	0	0	0	0	0
Marketing	1	0	0	0	1	.06
Eligibility	0	0	0	0	0	0
Managed Care Department Specific Concerns	2	1	0	0	3	.18
GRAND TOTAL	18	26	24	14	82	4.81

MEDICARE APPEAL DATA

Categories	1Q2017	2Q2017	3Q2017	4Q2017	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	1	3	6	5	15	.16
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0

Legal Rights	**0**	**0**	**0**	**0**	**0**	**0**
Fraud, Waste, and Abuse	**0**	**0**	**0**	**0**	**0**	**0**
HIPAA Privacy and Confidentiality	**0**	**0**	**0**	**0**	**0**	**0**
Benefit Package	**2**	**5**	**8**	**8**	**23**	**.24**
Transportation	**0**	**0**	**0**	**0**	**0**	**0**
Provider Network	**0**	**0**	**0**	**0**	**0**	**0**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Marketing	**0**	**0**	**0**	**0**	**0**	**0**
Eligibility	**0**	**0**	**0**	**0**	**0**	**0**
Managed Care Department Specific Concerns	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**3**	**8**	**14**	**13**	**38**	**.40**

VII. QUALITATIVE ANALYSIS

GRIEVANCE DATA

A. Access

The Access Category has the second highest number of complaints for the report period. For the commercial plan, 17% of the grievances were related to access (down from 27% in 2016). For Medicare, 11% of the grievances were related to access (down from 15% in 2016). Both commercial and Medicare members experienced dissatisfaction with the Denver Health Medical Center Appointment Scheduling System, which uses the same processes for all patients/payer sources. Several members had issues with scheduling a specialty appointment in a timely manner. The number of grievances related to Access was too small to make any broad determinations for improvement. Only one specialty and one clinic appeared in more than one Grievance. Three Commercial Grievances and one Medicare Grievance were related to eye care. There were two Grievances in the Commercial Line of Business involving difficulty getting a timely appointment at Lowry Clinic.

B. Quality of Service (Customer Service/Attitude)

The Quality of Service Category has the third highest number of complaints for the report period. Within this category, the majority of concerns dealt with member experience of rudeness by a staff member in the hospital or physician clinic setting.

C. Financial/Billing

The highest category with complaints is Financial Billing. The majority of the complaints stemmed from concerns over having financial responsibility when the member believes they should not owe a copay/coinsurance/deductible. Many members received bills in the mail after accessing services and the bills

were incorrect, indicating that the claims system processed the claim incorrectly. Other members are getting the correct billing information but were not aware what the member responsibility would be.

D. Benefit Package
Benefits accounted for the fourth highest reason for complaints from both Commercial and Medicare members.

E. Quality of Care
In 2017, Managed Care received zero complaints regarding Quality of Care.

F. Quality of Practitioner Office Site
During calendar year 2017, there were zero (0) complaints filed with DHMP related to quality of practitioner office site. Because of this no analysis is able to be offered.

In overall review, timeliness of care, especially for specialty services, is a perceived challenge from members. Specialty care appointments have a longer wait time for services than routine primary care, which members can experience difficulty in understanding and accepting. Correct claims processing and adjudication is also a pertinent challenge from members.

APPEAL DATA

A. Access
During calendar year 2017, there were no access-related appeals for the Commercial or Medicare plans.

B. Quality of Service (Customer Service/Attitude)
During calendar year 2017, there were zero (0) appeals filed with DHMP related to Quality of Service. As a result, no evaluation is provided.

C. Financial/Billing
During calendar year 2017, there were seventy-five (75) appeals filed with DHMP related to Financial/Billing. In most of these appeals, DHMP incorrectly processed the member claim and thus the member received a bill for the services. In some of the cases were related to not obtaining a referral or authorization in a timely manner which culminated in a claim denial and member financial responsibility.

D. Benefit Package
During the report period, there were thirty-three (33) appeal cases filed related to Benefit Package. While the cases that were filed each were unique and had different issues, many cases were regarding care that is outside the scope of coverage (e.g. additional physical therapy visits beyond benefit package of 20 visits) or for coverage for a medical treatment that was denied at the initial level.

E. Quality of Care
During calendar year 2017, there were zero (0) appeal filed with DHMP related to Quality of Care.

F. Quality of Practitioner Office Site
During calendar year 2017, there were zero (0) appeals filed with DHMP related to quality of practitioner office site. As a result, no evaluation is provided.

VIII. EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT

Despite any health plan's best efforts, complaints will occur. How they are received will affect the success of their resolution. Seeing a member's complaint as an opportunity for improvement is the first step in developing an effective complaint process. DHMP seeks to uncover root causes of a complaint, identify trends in data, and develop effective solutions in which all parties are satisfied.

It is noted that the biggest category of dissatisfaction is in the Financial Billing category. Some of these issues arose due to system related matters. While these issues were corrected and claims reprocessed for payment, the root causes remained ongoing. Other times, even though the member felt that they did not have a financial responsibility, after review of their benefit package, exclusions, and limitations; it truly was their financial responsibility. The DHMP Grievance and Appeals Department will continue to monitor the data and make the appropriate interventions when necessary.