2019 QUALITY IMPROVEMENT PROGRAM EVALUATION

Commercial, Medicare and Exchange Products

DENVER HEALTH MEDICAL PLAN, INC.

DENVER HEALTH MEDICAL PLAN INC.™

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EXECUTIVE SUMMARY

Denver Health Medical Plan, Inc. (DHMP, the Plan) is a licensed Health Maintenance Organization (HMO), effective 01/01/1997, with a 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)
- Commercial Exchange:
  - Elevate Health Plans
- Medicare Advantage:
  - 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 Plan (SNP).

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 DHMP Commercial, Exchange and Medicare members. The QI 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, including complete analysis of results and evaluation of the overall value of the Program. From this evaluation process, recommendations are developed for the upcoming year, which are incorporated into the QI Program Description and Work Plan. DHMP is able to assess the strengths of the Program and identify opportunities for improvement, incorporating learning from the ongoing activities.

In this report, DHMP 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 recommendation to the Quality Management Committee (QMC). The QI Department actively collaborates with other DHMP Departments, as well as network providers, to develop, implement and evaluate QI initiatives. QI activities are coordinated and implemented with Case Management, Population Health Management, Pharmacy, Health Plan Services, Provider/Network Relations, Compliance, Health Plan Medical Management, Appeals and Grievances, Marketing and Product Line Managers for Commercial, Exchange and Medicare.

Our provider network includes the Ambulatory Care Services (ACS) of Denver Health (DH), also known as Community Health Services (CHS) for our HMO membership. For the Point of Service (POS) members, we offer the Cofinity Network, including University of Colorado (UCHealth) and Children's Hospital, under more expansive health plan offerings of expanded and POS benefits. We collaborate with CHS on QI initiatives through the Ambulatory Quality Improvement Committee (QIC), and ACS disease- and prevention-specific quality improvement work groups. 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 Advantage members affiliated with ACS/CHS, DH is promoted as their medical home. A Patient Centered Medical Home (PCMH) is responsible for care coordination and provides health maintenance, preventive care, anticipatory guidance and health education, acute and chronic illness care and includes 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 initially pursued National Committee for Quality Assurance (NCQA) accreditation for their PCMH care services in calendar year 2014, and maintains a Level II PCMH Accreditation.

Randomized provider and clinician Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are done at CHS clinics to measure patient satisfaction with their provider and their care. The information is provided through DHMP QMC, to leadership and ACS leadership for analysis and action planning targeting identification of best practices within the care delivery system.

The Cofinity provider network is expanded and is an essential part of our ongoing Commercial benefit structure. Providers comprising this network serve POS member for our Commercial plan. Our QI initiatives include members within the network, focused on improvement in quality and patient experience. Together, DHMP and ACS focus on raising the overall quality of services to achieve measurable outcomes and to more productively use resources.

QUALITY IMPROVEMENT PROGRAM EVALUATION AND WORK PLAN

OVERVIEW

The QI Program Description and QI Work Plan provide guidance to the QI Program structure and activities for a period of one calendar year. Input is obtained from a variety of sources, including the DHMP Operations Team, Health Plan Medical Management Department staff, QI Department staff, data sources, Healthcare Effectiveness Data and Information Set (HEDIS) reporting and CAHPS surveys. The Centers for Medicare and Medicaid Services (CMS) and contractual requirements for our Medicare Advantage, Commercial and Exchange lines of business are reviewed annually, with inclusion in our development and evaluation of QI Program indicators.

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

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

QUALITY IMPROVEMENT OBJECTIVES FOR 2019

- 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 HEDIS measures, QI projects and activities and CAHPS member surveys
- Implement internal QI activities, as necessary
- Adopt national, regional and/or local public health goals and industry performance benchmarks, evaluating available resources for QI to make sustainable decisions
- Promote medical and preventive care delivered by practitioners/providers that meet or exceed 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 application of 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
- Collaborate with ACS on the development of initiatives for special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate
- Maintain the health information system to comply to professional standards of health information management, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security laws and state privacy standards
- Acquire collaborative feedback from members of the QMC on quality initiatives

QUALITY IMPROVEMENT 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 (DME)
- Physical therapy (PT)
- 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 Department is responsible for 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 the member population
- Work collaboratively with ACS, Denver Public Health and other Plan partners to address health care quality initiatives
- Utilize national goals as well as NCQA, HEDIS and regional benchmarks to establish goals for the Plan
- Include and distribute the analysis of access and availability of providers and pharmacies for the membership
    - Annually, an Access Plan is created, which includes geo-access results for member access, panel sizes, telephone responsiveness, referral turnaround timeframes, monitoring of appointment standards and languages competencies of providers, at a minimum

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 and 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
- Re-evaluate for further 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, preventive health screenings and other quality of care indicators for children and adults. For quality of service, multiple sets of data are reviewed, including CAHPS member satisfaction survey data, HEDIS use of services and access and availability measures, grievance and appeal data and Quality of Care Concerns (QOCCs) and service complaints.

QUALITY IMPROVEMENT PROGRAM ACCOMPLISHMENTS AND STRENGTHS

In the past year, QI Department staff 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
- Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase the number of adolescent well-child visits and immunizations within Denver Public Schools
- Continued refinement of member outreach efforts, utilizing EPIC (electronic medical record) implementation for ACS and QNXT (claims processing system) BI reports for DHMP
- Collaborated with Health Management to build a comprehensive Population Health Program to help members improve knowledge and management of health
- Developed and implemented enhanced patient education materials; focused on health literacy and cultural competency
- Conducted an annual Provider Satisfaction Survey to evaluate satisfaction with DHMP departments and services, including knowledge of DHMP offerings to support patient care
- Conducted an annual Open Shopper Study to evaluate access and availability in both the ACS and Cofinity provider networks, including behavioral health care providers, and for the first time, addiction services, by the Product Line teams, to ensure relevance to each line of business
- Participated as a member of the Ambulatory Care Quality Improvement workgroup for cardiovascular disease to begin to address health literacy/cultural competency and reduce health disparities through services in DH
- Supported ongoing inclusion of Culturally and Linguistically Appropriate Services (CLAS) training in required annual training for DH providers and staff to support the delivery of culturally-sensitive care and engage fully in participation of a diverse workforce
- Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting

- Maintained oversight and follow up of delegated and facility credentialing relationships
- Increased outreach to DHMP members through ACS clinic staff and targeted member outreach in collaboration with the DH Appointment Center
- 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 the ACS network
- Initiated VBC for Exchange plans, as part of a Quality Improvement Strategy (QIC) for Elevate, Commercial and for Medicare plans
- Performed ongoing QI efforts for the Medicare Chronic Care Improvement Project (CCIP), focused on depression and anxiety screening
- Produced monthly HEDIS runs, and corresponding gaps in care lists for use in quality improvement initiatives
- Improved the timeliness and accuracy of the annual HEDIS production run

CHALLENGES AND OPPORTUNITIES

The adequacy of resources for the QI Program continued to be an opportunity, needing consistent refinement throughout 2019.2019 saw the transition of QI team data analyst resources to the IS team, and the plan for transition of NCQA project management from QI, to the newly formed Monitoring, Auditing and Training department for 2020. Significant progress and engagement with ACS partners for QI was also recognized in 2019. We continued to evaluate our need for more resources, especially in HEDIS data collection and analysis, along with access to and accuracy of data. Increasing our HEDIS scores required looking at the data results more than once per year to be effective and give timely feedback to providers on performance. In addition, ongoing analysis for key drivers of rate improvement included coding, documentation and claims system configuration for key data elements associated with HEDIS rate production. The creation of a DHMP data warehouse for medical and pharmacy claims data in 2018, along with emerging efforts to add EPIC-based encounter data in 2019, will enhance the foundation of improved data quality, completeness and timeliness to support QI intervention efforts moving forward.

DHMP 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, as well as with networks associated with the plan expansion into additional counties, will help maximize our limited resource availability. In addition, we continue to elicit the support of leadership to help align metrics, converge goals and move QI activities forward.

Our committee structure continued to be evaluated throughout 2019. The QMC evolved with regular attendance of physicians and practitioners. The director of QI for ACS was a regular attendee, along with ACS clinic and specialty providers, at the Committee. There is an opportunity to improve engagement from extended network providers as QMC members. The QMC has evolved to be a body reflecting on reach and effectiveness of our studies and interventions, serving as an “advisory board” to DHMP through the QMC process. Health Plan Medical Management Department changes within Case/Utilization and Care Management and Health Management drove the restructuring of the former Utilization Management Committee to the new Medical Management Committee (MMC). Many key Health Plan Medical Management operations, medical management standard performance activities, reporting and initiatives will be reviewed and developed as a result of changes to the plan of outsourcing the Medical Management services to a vendor solution provider, and a return of these functions to the Health Plan, including staffing, systems and performance reporting. The MMC reports through the QMC and began doing so in 2018. Continuous evaluation of the QMC process will continue throughout 2020, with a focus on increasing communication and collaboration of QI efforts organization wide.

Practitioner participation improved during 2019, allowing us to achieve one of our key metrics for evaluation. We have increased our medical and behavioral health practitioner involvement with QMC, which allows practitioner input into all aspects of Plan operations and services. Our Provider Satisfaction Survey was expanded to include other specialties to increase valuable information about improving continuity and coordination of care. Increased involvement of QI Department staff in ACS work groups, clinical design work groups and disease and prevention work groups within CHS will need to continue with targeted focus in 2020.

Leadership involvement, defined as the Operations Team from DHMP, and the Management and Operations Teams from CHS, continued to increase over the past year. The defined focus and contribution of the QMC gave DHMP a valuable sounding board and feedback mechanism for all departments presenting up through the committee. The involvement of the Director of QI for ACS, several ACS providers and practitioners, provided a rich mix of differing insight and feedback to committee and the QI Department to assist with improved evaluation of reports and interventions. The Director of QI is involved on multiple quality committees and work groups within ACS, including the ACS QIC. Members of the QI Department attend and interact in a variety of ways with Chronic Disease and Prevention work groups led by senior medical leadership of ACS which has historically included the Patient Experience Work Group, designed to focus on increasing metrics of patient experience, including CAHPS and customer service. There is an opportunity to reinvigorate the Patient Experience committee to ensure a voice of health plan members for patient experience.

FUTURE OPPORTUNITIES FOR IMPROVEMENT

- Develop a more rigorous data validation plan for HEDIS measures, confirming that data and counts and sample sizes are accurate, while continuing to increase supplemental sources of data for HEDIS measures
- Continue efforts to improve the capture and accuracy of provider data for HEDIS, including practice type, specialist coding and provider locations
- Evolve the real-time quality data availability and usability through the 2016 launch of the DHMP data warehouse and the 201 effort to integrate EPIC-based encounter data, and HEDIS data through the 2019 launch of Tableau reporting software
- Increase engagement and training of providers in HEDIS metrics and provide meaningful, provider-centric education and training to increase HEDIS scores and risk adjustment scores through appropriate medical record documentation and coding.
- Work with ACS and DH leadership in patient experience initiatives throughout DH, 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-round 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 QI initiatives and interventions with ACS leadership and provider networks to avoid duplication of efforts and to utilize resources more effectively
- Continue to develop the use of the LEAN framework within quality initiatives to develop A3 problem-solving aligned with the Plan-Do-Study-Act (PDSA) format
- Utilize the LEAN framework to develop and evolve standard work for the QI Department
- Integrate with Denver Health ACS disparities in health efforts, focused on hypertension for African-Americans, through the cardiovascular QI workgroup
- Continue monthly review of HEDIS to ensure more timely measures and interventions
- Expand and support QI team opportunities for growth and enhancement of skills
- Address known opportunities for NCQA accreditation improvement and an organizational plan for NCQA compliance and accreditation renewal
- Continue to evolve value based contracting for enhanced quality improvement outcomes

- Promote further alignment of DHMP and ACS strategic QI metrics and goals
- Continue progress in the evolution of the programs, platforms and staffing of UM, CCM and PHM functions at DHMP, associated with transitions from the plan of outsourcing to a vendor solution to a return of these functions to the health plan

Moving Forward:
While 2019 brought numerous opportunities and challenges for the QI Program, the mission to promote a culture of continuous quality improvement continues. Using NCQA standards, processes and deliverables as a road map to institutionalize and align efforts across the Denver Health system, the QI program strives to create a program with clearly defined goals and objectives, where the Company, Providers and Members may benefit. The ideal state is a comprehensive health plan and Provider network, driven by continuous quality improvement that treats and engages the whole person, respecting their culture and community, over their lifetime.

ANNUAL CLINICAL AND PREVENTIVE GUIDELINE REVIEW

Via QMC, a 2019 annual review of the following Guidelines for any nationally-recognized updates was completed. The following guidelines were reviewed and approved:

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

Both Clinical and Preventive Guidelines guide the QI Department 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 health care standards. Additionally, the QI Department partners with content experts (i.e., physicians) to review and modify the guidelines to meet member needs with the best practices.

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 health care and preventive health screening measures.
Audited review of these measures is conducted at least once per 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 2019, HEDIS rates for the Exchange LOB were reported separately from the overall Commercial rates as a result of reaching a threshold population size. 2019 HEDIS rates are based on Measurement Year 2018 data. For Medicare, Elevate and Commercial lines of business, improvement goals are a 3% increase year over year.

2019 QUALITY IMPROVEMENT ACTIVITIES/INTERVENTIONS

The following QI initiatives are focused on clinical indicators with the purpose of improving the quality of clinical care and health outcomes for our members:

DIABETES

2019 HEDIS Diabetes Results – Commercial Line of Business

Commercial					
Diabetes Indicators (CDC)	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 HEDIS Percentile	2018-2019 HEDIS Change
HbA1c Testing	89.16%	91.97%	91.97%	50th	0%
HbA1c Poor Control >9.0% (lower=better performance)*	34.98%	38.69%	44.95%	10th	+6.26%*
HbA1c Control <8.0%	50.77%	48.18%	43.43%	5th	-4.75%
Eye Exam	47.37%	48.66%	46.46%	25th	-2.20%
Medical Attention for Nephropathy	87.12%	82.48%	85.61%	5th	+3.13%
Blood Pressure Controlled <140/90	69.97%	73.24%	62.37%	25th	-10.87%

2019 HEDIS Diabetes Results – Medicare Line of Business

Medicare					
Comprehensive Diabetes Care (CDC)	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 HEDIS percentile	2018-2019 HEDIS Change
HbA1c Testing	90.02%	94.16%	94.16%	25th	0%
HbA1c Poor Control >9.0% (lower=better performance)*	26.03%	21.90%	23.36%	25th	+1.46%*
HbA1c Control <8.0%	58.88%	58.64%	62.29%	10th	+3.65%
Eye Exam	67.88%	76.89%	76.16%	25th	-0.73%
Medical Attention for	93.43%	93.43%	93.92%	10th	+0.49%

Nephropathy					
Blood Pressure Control <140/90	65.69%	65.69%	67.64%	25th	+1.95%

HEDIS 2019 CHANGES FOR DIABETES MEASURES

- Incorporated telehealth into the measure specifications.
- Added instructions to report the "Eye Exam (retinal) performed" indicator rate stratified by LIS/DE and Disability status for Medicare product line.
- Added exclusions for members with advanced illness and frailty.
- Added exclusions for the Medicare product line for members 65 years of age and older enrolled in an I-SNP or living long-term in institutional settings.
- Added methods to identify bilateral eye enucleation.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

DHMP DIABETES COLLABORATIVE QUALITY IMPROVEMENT WORKGROUP

DHMP QI Department staff, as well as representatives from DH and ACS, participate in the Denver Health Diabetes Collaborative QI work group. Participants provide regular updates on diabetes-related initiatives and engage in discussions related to diabetes quality measures. The DHMP QI Department staff provide regular updates on interventions to improve the rate of completed diabetic retinal exams (MCR, Commercial and Exchange) HbA1c poor control >9.0% and medical attention for nephropathy (both Medicare only). The collaborative regularly tracks patient outcomes for diabetes management and has promoted several EPIC/EMR system enhancements related to the management of diabetes.

SUMMARY OF HEDIS 2019 DIABETES RESULTS

COMMERCIAL

Comparison of 2019 HEDIS results against national benchmarks reveals that the 2019 Commercial HEDIS results are below the 90th percentile benchmark for all comprehensive diabetes care measures. Commercial rates improved for Medical Attention for Nephropathy, remained the same for HbA1c testing and decreased for HbA1c >9.0%, HbA1c Control <8.0%, Eye Exams and Blood Pressure Controlled <140/90.

MEDICARE

Medicare rates continue to be below the 90th percentile benchmark for all comprehensive diabetes care measures. In H2019, Medicare rates improved for HbA1c control <8.0% and Blood Pressure Control <140/90 and saw a slight improvement for Medical Attention for Nephropathy. HbA1c testing remained at 94.16% while HbA1c poor control >9.0% decreased and Eye Exams saw a slight decrease.

Due to a small population, Exchange rates for these measures were not reported in H2019.

2019 INTERVENTIONS

In 2019, QI continued the diabetic eye exam outreach project, originally started in 2015. This project is a collaboration between DHMP QI Department staff and Care Navigators from the DH Eye Clinic. The project involves Care Navigators conducting outreach calls to Medicare, Commercial and Exchange members 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 DH Eye Clinic. A "successful call" is defined as a call completed by a Care Navigator that resulted in a member being scheduled for an eye exam.

As a result of this intervention, the number of completed diabetic retinal exams in 2019 for Medicare members was 783 which was slightly below our goal of 806. The goal in 2019 for Commercial and Exchange members was 216; the final number of completed eye exams for Commercial and Exchange members was 187, falling short of that goal.

In addition, in 2019 the DHMP QI team began a collaboration with the DHHA Appointment Center to conduct outreach calls to Medicare members who had yet to receive HbA1c testing or medical attention for nephropathy for the year or who had a previous HbA1c of >9.0% during the year to schedule them for a visit with their PCP. These outreach calls were made to 230 unique diabetic members and were successful in scheduling an additional 9% of members.

2019 DM Eye Exam Outcomes		
LOB		**Total # of Completed Appointments**
Medicare		783
Commercial and Exchange		187
Total (Medicare, Commercial and Exchange)		**970**

ACTION PLAN FOR 2020

The QI team will continue to participate in the Diabetes work group and monitor the activities related to diabetic retinal exams. QI will continue to focus on increasing the Diabetic Eye Exams measure for 2020 for Medicare, Commercial and Exchange, which still sits well below the 90th percentile ranking, as well as medical attention for nephropathy and HbA1c poor control >9.0% for the Medicare population. In 2020, we will begin a collaboration with DH Ambulatory Care Services (ACS) to conduct outreach to those members who need medical attention for nephropathy, to complete an HbA1c test or who are in poor control (HbA1c >9.0%) and schedule them for PCP appointments at DH clinics through a combination of mailings, during and between visit activities, and select efforts with central Patient Navigators for telephonic outreach.

The ongoing collaborative intervention with the DHHA Eye Clinic has had strong performance for outreach with 38.5% of the outreached patients scheduled. Improvements in outreach tracking and Eye Clinic outreach staffing are intended to resolve the root cause of slower than expected DRE completion. These efforts, and an increased focus on Elevate and Medicare patients, by virtue of new value-based contracts with DREs as a key metric, will bring renewed focus and commitment to this intervention for next year. The DHMP QI team will continue our strong partnership with the DH Eye Clinic in 2020.

Additionally, DH will begin a pilot program which places eye cameras in the primary care clinics, eliminating the need for members to travel to the centrally located Eye Clinic for exams, improving appointment availability, and reducing wait times. Care Navigators located at the eye clinic will continue to address barriers around members getting to their appointment in an effort to address the issue of patient no-shows to the clinic.

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CARDIOVASCULAR SCREENING

2019 HEDIS Cardiovascular Conditions Measures Results

DHMP Commercial					
	2017 HEDIS Results	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS Percentile**	**2018-2019 HEDIS Change**
Controlling High Blood Pressure (CBP)	69.83%	58.88%	50.99%	10th	-7.89%
DHMP Exchange					
	2017 HEDIS Results	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS Percentile**	**2018-2019 HEDIS Change**
Controlling High Blood Pressure (CBP)	Not Reported	58.14%	73.08%	75th	+14.94%
DHMP Medicare					
	2017 HEDIS Results	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS Percentile**	**2018-2019 HEDIS Change**
Controlling High Blood Pressure (CBP)	74.94%	73.24%	69.34%	25th	-3.90%

HEDIS 2019 CHANGES

- Removed requirement to identify and use different thresholds for members 60-85 without a diagnosis of diabetes.
- Revised the definition of representative BP to indicate that the BP reading must occur on or after the second diagnosis of hypertension.
- Revised the event/diagnosis criteria to include members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
- Removed the diabetes flag identification from the event/diagnosis criteria.
- Incorporated telehealth into the measure specifications.
- Revised the age requirements for the Exclusions for Medicare members enrolled in an I-SNP or living long-term in an institution.
- Added exclusions for members with advanced illness and frailty.
- Added administrative method for reporting.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.
- Removed the requirement to confirm the hypertension diagnosis.

- Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

SUMMARY OF HEDIS 2019 CBP

The rate for Controlling High Blood Pressure (CBP) measure remains below the 90th percentile and there was a decrease in both the Commercial and the Medicare populations. The Commercial population recognized a decrease of 7.89%, while the Medicare population decreased 3.9%. The Exchange population, however, saw an increase in H2019 of 14.94% and is now in the 75th percentile nationally. DHMP Medicare is in the 25th percentile nationally, which is a decrease from the 33rd percentile achieved in H2018 while DHMP Commercial is in the 10th percentile as it was in H2018.

The DHMP QI team began participating in the DHHA ACS Cardiovascular Disease (CVD) Workgroup in 2019, recognizing the need to collaborate on data collection and interventions to improve HEDIS rates across populations and address disparities in blood pressure control outcomes. Although there are currently no active, ongoing interventions targeting this particular measure, the QI team and CVD workgroup will be collaborating in 2020 on an intervention to address health disparities in blood pressure control among racial/ethnic groups in our population.

ACTION PLAN FOR 2020

The QI team will continue to participate in the CVD workgroup and monitor activities and data collection related to Control of High Blood Pressure. Additionally, we will work closely with the CVD workgroup to implement an intervention to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. The blood pressure under control HEDIS measure monitors the percentage of Members 18–85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled. 2019 DH ACS data shows that Blacks have a lower rate of blood pressure control than their White or Hispanic counterparts system wide with adequate control for Blacks at 60.2% and Whites and Hispanics at 66.2% and 69.2%, respectively. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup will create an intervention to determine root causes of this disparity and create an intervention to address it.

PREVENTION AND SCREENING

2019 HEDIS Prevention and Screening Measures Results

	Commercial				
HEDIS Measure	**2017 HEDIS Results**	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS percentile**	**2018-2019 HEDIS Change**
Adult BMI Assessment (ABA)	92.21%	92.21%	81.16%	75th	-11.05%
Breast Cancer Screening (BCS)	69.91%	72.06%	73.13%	25th	+1.07%
Cervical (21-64y/o) (CCS)	77.37%	74.70%	75.04%	25th	+0.34%
Colorectal (50-80 y/o) (COL)	58.39%	61.07%	58.45%	25th	-2.62%

	Medicare				
HEDIS Measure	**2017 HEDIS Results**	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS percentile**	**2018-2019 HEDIS Change**
Adult BMI Assessment (ABA)	98.05%	98.30%	98.78%	50th	+0.48%

Breast Cancer Screening (BCS)	71.25%	71.80%	71.49%	5th	-0.31%
Colorectal Cancer Screening(COL)	60.58%	62.77%	62.29%	5th	-0.48%

	Exchange				
HEDIS Measure	**2017 HEDIS Results**	**2018 HEDIS Results**	**2019 HEDIS Results**	**2019 HEDIS percentile**	**2018-2019 HEDIS Change**
Adult BMI Assessment (ABA)	Not reported for H2017	98.65%	95.93%	95th	-2.72%
Breast Cancer Screening (BCS)	Not reported for H2017	NA	NA	NA	NA
Colorectal Cancer Screening(COL)	Not reported for H2017	50.00%	63.41%	25th (33rd)	+13.41%
Cervical Cancer Screening(CCS)	Not reported for H2017	49.23%	61.50%	<5th	+12.27%

HEDIS 2018 - 2020 CHANGES

For HEDIS operations, challenges resulting from the 2018 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. These changes will continue to apply for HEDIS 2020. There were no significant metric changes for Breast Cancer and Colorectal screenings for HEDIS 2020.

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
    - Healthcare Partners (HCPs) schedule members for appointments, if possible, and alert the provider to the tests needed
- Patient Navigation regarding colorectal cancer screening options through DH
- 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
- Coordinated Patient Navigator (PN) outreach for DHMP Medicare members who have outgoing FIT tests and no return
- Developed cancer metrics and implementation of registries to report screening rates on a quarterly basis to clinics

SUMMARY COMMERCIAL

Summary of HEDIS 2019 Results

The BCS measure demonstrated an improvement of 1.07% from H2018 to H2019. As outreach and the number of DHMP Commercial members receiving a mammogram increase, HEDIS rates for BCS are expected to incrementally improve. The overall rate of colorectal screenings decreased by 2.62% for H2019 compared to H2018. Cervical Cancer Screening rates saw a slight increase of 0.34% for H2019.

Interventions 2019

The QI team continues to collaborate with the DH Women's Mobile Clinic and maintains a presence at the Ambulatory Cancer Screening Committee, where similar metrics are discussed. There were no active interventions specifically targeting the Preventive Cancer Screening CCS rates. However, the DHMP QI team collaborated with the DHMP marketing department to include the recommended preventive screening guidelines (agreed upon by the Preventive Cancer Screening Group) in the DHMP mammogram mailer. The DH Women's Mobile Clinic will also continue to offer Pap testing for members. In addition, the QI team has participated in a Denver Public Health initiative to improve immunization rates in children for HPV, a precursor to cervical cancer. DHMP utilized various communication channels to share with members the importance of having their children vaccinated against HPV and also provided data to support the work.

In 2018, in order to address an identified key barrier of the patient self-scheduling mammograms, new clinic-based standard work was created for Medical Assistants to schedule patients during their physician visit. Implementation of this standard work was in-process during 2019 and will be assessed for barriers and sustainability in 2020.

SUMMARY MEDICARE

Summary of HEDIS 2019 Results

For the Medicare population, there has been an increase in the ABA rate, and slight decreases for BCS and COL rates. ABA rates increased by 0.48%, BCS rates decreased by 0.31% and COL screening rates decreased by 0.48% in HEDIS 2019. All Medicare measures continue to rank below the 90th percentile. Of these three measures only ABA reached the Medicare Stars 4-Star cut point, based on 2018 data.

Interventions 2019 – 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 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. In 2018, in order to address an identified key barrier of the patient self-scheduling mammograms, new clinic-based standard work was created for Medical Assistants to schedule patients during their physician visit.

To improve BCS rates, the DHMP QI team implemented an intervention in collaboration with Appointment Center in September of 2019 to call patients overdue for a mammogram to schedule them for an appointment. While we recognized some improvement in 2019, we will track the impact on the population rate following the completion of HEDIS medical record review in Spring, 2020.

Interventions 2019 – COL

From late September through February of 2018 the QI department collaborated with ACS QI department for a targeted outreach program for Medicare members who had an outgoing fecal immunochemical test (FIT) sent home

following a clinic visit, and had not yet returned the kit to the laboratory. Three Patient Navigators (PN) located in the ACS QI department received bi-weekly lists of DHMP Medicare members and contacted those with outstanding FIT kits. This initiative has been restructured to be part of a larger PN intervention of in clinic and outreach gaps in care effort in October 2018. In summer of 2019, DHMP contracted with an external vendor (BioIQ) to mail fecal immunochemical test (FIT) kits, test the samples, and mail result letters to patients and providers. Results from this intervention are still being collected. Additionally, ACS implemented a pilot project in Q4 2019 to send follow-up letters to members who had received a FIT kit at a clinic visit but who had not yet returned the kit. This intervention, and the assessment of its performance, are ongoing.

SUMMARY EXCHANGE

Summary of HEDIS 2019 Results

This is the second year of reporting for Exchange members since reaching the reporting threshold. The Adult BMI Assessment measure decreased 2.72%. The Breast Cancer Screening measure was not reportable for H2018 due to a small sample size.

However, both Colorectal and Cervical Cancer Screening increased notably. The Colorectal Cancer Screening increased by 13.41% and Cervical Cancer Screening by 12.27%. DHMP will continue to track and trend Exchange outcomes for H2020 to determine if any interventions are warranted.

PREVENTION AND SCREENING ACTION PLAN FOR 2020

BREAST CANCER SCREENING ACTION PLAN

All Medicare, Exchange 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 in 2020.

Starting in 2020, ACS will also begin mailing Patient Health Report Cards to members with gaps in care (including breast cancer screening gaps) and calling members who scheduled a mammogram appointment and then no-showed or canceled the appointment and did not reschedule. The DHMP QI team will monitor the effects of this intervention on HEDIS rates and assess additional opportunities to conduct telephonic outreach for those members overdue for mammograms.

COLORECTAL CANCER SCREENING

PREVENTIVE CANCER SCREENING ACTION PLAN

QI will continue to participate on the Preventive Cancer Screening Workgroup. Colorectal 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. This initiative has been restructured to be part of a larger Patient Navigator intervention of in-clinic and outreach gaps in care effort in October 2018 and is ongoing for 2020. Starting in 2020 ACS will also begin mailing Patient Health Report Cards to members with gaps in care (including Colorectal and Cervical Cancer Screening). The DHMP QI team will monitor the effects of this intervention on HEDIS rates and assess additional opportunities to improve these metrics.

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. In 2018 and 2019, the intervention continued with the DHMP QI team producing a monthly list from DHMP claims of eligible members for outreach and sending the 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 claims data delay.

The H2019 rate for OMW was 30%, which was a 5% decrease from H2019. This metric also is also a measure in Medicare Stars but DHMP has not reported on OMW as a Star measure due to the small population size.

HEDIS Measure	DHMP Medicare Members				
	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS	2019 Percentile	2018-2019 HEDIS Change
OMW	18.18%	35.00%	30.00%	10th	-5.00%

In 2019, 57 women were identified for targeted outreach. 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.

OMW Screening Intervention			
# MCR Members identified for outreach	Members still eligible for screening	# members who did not meet measure	# Members who met measure
64	11	24	28

OMW ACTION PLAN FOR 2020

The DHMP QI Intervention Manager meets quarterly with the CCS team to discuss project updates, clarify metrics and review workflow, discuss barriers and their root causes, and opportunities for improvement. Despite the small population size for Medicare Stars, the plan is to continue with this intervention through 2020, with the longer-term goals of ensuring that all eligible women receive the appropriate treatments and reaching a 4 Star rating on this measure. In 2020, the QI Team and the Ambulatory Central Clinical Support (CCS) team will also partner with the ACS Geriatric Workgroup to improve performance on this measure.

PRENATAL/POSTPARTUM CARE

HEDIS 2019 Prenatal/Postpartum Indicator Results

DHMP Commercial					
	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 Percentile	2018-2019 HEDIS Change
Prenatal Care in 1st Trimester	96.28%	96.22%	88.05%	50th	-8.17%
Postpartum care within 21-56 days after delivery	80.17%	88.13%	80.89%	50th	-7.24%

DHMP Exchange					
	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 Percentile	2018-2019 HEDIS Change
Prenatal Care in 1st Trimester	Not reported for H2017	N/A	N/A	N/A	NA
Postpartum care within 21-56 days after delivery	Not reported for H2017	N/A	N/A	N/A	NA

HEDIS 2019 Changes

- Updated the administrative numerator specification to indicate when codes must be on the same claim and when codes can occur on different dates of service

SUMMARY OF COMMERCIAL H2019 PRENATAL/POSTPARTUM RESULTS

For Commercial HEDIS 2019, we saw a decrease of 8.17% in the rate of women who receive prenatal care in the first trimester, and a 7.24% decrease in the rate of women who receive postpartum care within the 21-56 day timeframe. For both the Commercial Timeliness of Prenatal Care and Postpartum Care measures, we are in the 50th percentile.

Interventions 2019

In 2019, 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.

The DHMP QI team continued to participate in the ACS Perinatal Workgroup. In 2019, the ACS Perinatal Workgroup completed a key driver analysis of the Timeliness of Prenatal Care metric and determined that a lack of access to appointments was not a key driver of DH performance on this metric. Additionally, Denver Health clinics are in the process of implementing changes in workflow and documentation to improve performance on these metrics.

PRENATAL/ POSTPARTUM CARE ACTION PLAN FOR 2020

The DHMP QI team will continue to participate in the ACS Perinatal Workgroup in 2020. Key driver analyses and clinical quality improvement efforts to improve these metrics are ongoing. One of the key barriers for post-partum care was that the standard appointment cycle of 2 weeks and 2 month follow up visits, fell outside the 21-56 day timeframe for 2019 HEDIS. With the change to the HEDIS 2020 metric specification to 7-84 days we will track the measures performance for expected improvement for 2020.

CHILDHOOD PREVENTIVE HEALTH

2019 HEDIS Childhood Preventive Health Indicator Results

Childhood Preventive Measures	Commercial				
	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 HEDIS percentiles	2018-2019 HEDIS Change
Childhood Immunization Status					
DTaP	92.06%	94.19%	94.73%	95th	+0.54%
MMR	96.83%	95.93%	95.57%	75th	0.36%
OPV/IPV	93.65%	95.35%	88.18%	10th	-7.17%
HiB	96.03%	96.51%	88.67%	10th	-7.84%
Hepatitis B	92.06%	95.35%	81.77%	95th	-13.58%
Varicella (VZV)	96.03%	95.98%	95.07%	75th	-0.91%
Pneumococcal	93.65%	93.60%	84.24%	90th	-9.36%
Hepatitis A	94.44%	94.19%	96.06%	95th	+1.87%
Rotavirus	90.48%	89.53%	81.28%	90th	-8.25%
Influenza	84.92%	83.14%	80.30%	95th	-2.84%
Combo 2	89.68%	91.86%	77.34%	95th	-14.52%
Combo 3	89.68%	91.28%	76.85%	95th	-14.43%
Combo 7	85.71%	84.88%	74.38%	50th	-10.50%
Immunizations for Adolescents					
Meningococcal	84.14%	87.85%	86.70%	50th	-1.15%
Tdap/Td	93.10%	93.37%	90.96%	75th	-2.41%
Combo 1	82.07%	86.74%	84.04%	75th	-2.70%
Well-Child Visits					
0-15 mo (6+ visits) w15	81.15%	BR*	88.34%	50th	NA
3-6 y/o (annual) w34	77.99%	83.54%	85.86%	50th	+2.32%
12-21 y/o (annual) AWC	43.21%	48.60%	44.49%	25th	-4.11%

Childhood Preventive Measures	Exchange				
	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 Percentile	2018-2019 HEDIS Change
Childhood Immunization Status					
DTaP	Not reported	N/A	N/A	N/A	N/A
MMR	Not reported	N/A	N/A	N/A	N/A
IPV	Not reported	N/A	N/A	N/A	N/A

HiB	Not reported	N/A	N/A	N/A	N/A
Hepatitis B	Not reported	N/A	N/A	N/A	N/A
VZV	Not reported	N/A	N/A	N/A	N/A
Pneumococcal	Not reported	N/A	N/A	N/A	N/A
Combo 3	Not reported	N/A	N/A	N/A	N/A
Immunizations for Adolescents					
Meningococcal	Not reported	N/A	N/A	N/A	N/A
Tdap/Td	Not reported	N/A	N/A	N/A	N/A
HPV	Not reported	N/A	N/A	N/A	N/A
Combo 3	Not reported	N/A	N/A	N/A	N/A
Well-Child Visits					
0-15 months (6+ visits) w15	Not reported	N/A	N/A	N/A	N/A
3-6 y/o (annual) w34	Not reported	N/A	N/A	N/A	N/A

2019 HEDIS Changes

- None

COMMERCIAL SUMMARY OF H2019 CHILD IMMUNIZATION RESULTS

Commercial

Denver Health Medical Plan continues to demonstrate strong immunization rates for Commercial pediatric members.

Exchange

This is the second year reporting CIS and IMA for Exchange members. Because of small populations, CIS and IMA were reported N/A for H2019.

Interventions 2019

In 2019, the DHMP QI team participated in the Denver Health Pediatric Quality Improvement Work Group and collaborated in a Lean event in July 2019 to create an action plan to improve performance on this metric. The DHMP QI team also conducted a key driver analysis into Combo 7 outcomes and diseminated these findings during the Lean event. Based on the outcomes from this event, ACS began telephone outreach to patients who are 21 months old and have not yet completed their Combo 7 vaccines in Q4 2019. Additional planning for interventions to improve these metrics is ongoing.

ACTION PLAN FOR 2020

For 2020, DHMP QI team 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 (particularly IPV and Combo 7 rates). ACS will continue telephone outreach to patients who are 21 months old and have not yet completed their Combo 7 vaccines and will begin outreach to members who are overdue to begin their Rotavirus vaccine series. Efforts to capture changes to immunization naming and coding changes in EPIC and mapping to HEDIS data tables are also ongoing.

In addition, the QI team has participated in a Denver Public Health initiative to improve immunization rates in children for HPV, a precursor to cervical cancer. DHMP utilized various communication channels to share with members the importance of having their children vaccinated against HPV and also provided data to support the work.

COMMERCIAL SUMMARY OF H2019 WELL-CHILD VISITS (W15, W34, AWC)

Commercial

The HEDIS 2019 Well Child Visits 0-15 months rate was 88.34%, increasing 8.19% from the prior measurable year (HEDIS 2018 Well Child Visits 0-15 months was unreportable due to rate bias). Well Child Visits for 3-6 year olds saw a 5.55% increase placing DHMP in the 50th percentile. Adolescent Well Child increased as well by 5.39%, however, DHMP is still in the 25th percentile for this measure.

DHMP will continue to address well-child visit rates and analyze potential interventions to improve them. In collaboration and education with ACS and SBHCs, DHMP QI will address medical record documentation and coding issues, claims submission and provider practice type data issues that may 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 2019.

Exchange

This is the first year reporting W15 and W34 for Exchange members. Because of small populations, both were reported N/A for H2019.

2019 PREVENTATIVE HEALTH QUALITY IMPROVEMENT ACTIVITIES

SCHOOL BASED HEALTH CENTERS (SBHC) COLLABORATION

DHMP and DHHA continue to encourage eligible members particularly adolescents to complete their annual well-care visit at a Denver Health SBHC. There are 18 SBHCs located in middle schools and high schools with another 20 satellite elementary schools that feed into the SBHCs. SBHCs provide a variety of services such as well child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral health care services. DHMP sends information about SHBCs directly to Member households in newsletters and posts information on the DHMP Member website. In addition, the DHHA appointment center informs members who call to schedule appointments of their ability to be seen at a SBHC.

ACTION PLAN FOR 2020

QI staff will continue to collaborate with the DHHA ACS Pediatric Quality Improvement Workgroup and SBHC team to develop interventions to improve health care outcomes for pediatric Members. In early 2020, the QI team will begin a collaboration with the SBHC program where DHMP provides a list of SBHC-eligible members who are due for a well-child check each month for the SBHC program team to reach out to and schedule the member at their designated clinic.

Additionally, we hope to streamline the process of acquiring parental consent for children to be seen at SBHCs by providing consent forms online via various communication channels at DHMP and ACS. DHHA opened an additional

SBHC at Denver East High School for the 2019/2020 school year, improving access to care for DHMP members attending East High School. In addition, the DHMP QI team continues to have discussion with the ACS SBHC teams around developing incentive programs program to drive adolescent well-care rates for DHMP members who attend a Denver Public School.

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, DHMP sends Commercial and Exchange members a birthday card that provides educational information regarding the need for wellness visits and what services to expect their child to receive. In addition, the birthday cards remind parents that it is time to bring their children in for their annual well-visit. The cards are sent monthly to parents of children ages 2 through 19. In 2019, the average monthly mailing was 110 postcards across the Commercial and Exchange lines of business.

Year	Avg. Commercial/Exchange Postcards Mailed/Month
2017	70
2018	70
2019	110

ASTHMA

2019 HEDIS Asthma Indicator Results

	DHMP Commercial				
Medication Management for People w/Asthma (75% compliance MMA)	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 HEDIS Percentile	2018-2019 HEDIS Change
Ages 5-11	25.00%	*N/A	*N/A	N/A	N/A
Ages 12-18	18.18%	*N/A	*N/A	N/A	N/A
Ages 19-50	40.98%	50.00%	55.51%	50th	+5.51%
Ages 51-64	57.89%	*N/A	*N/A	N/A	N/A
Total	39.62%	46.67%	48.46%	25th	+1.79%

*NA=Sample size <30

	DHMP Exchange				
Medication Management for People w/Asthma (75%	2017 HEDIS	2018 HEDIS	2019 HEDIS	2019 HEDIS Percentile	2018-2019 HEDIS Change

compliance MMA)	Results	Results	Results		
Ages 5-11	Not reported	Not reported	*N/A	*N/A	N/A
Ages 12-18	Not reported	Not reported	*N/A	*N/A	N/A
Ages 19-50	Not reported	Not reported	*N/A	*N/A	N/A
Ages 51-64	Not reported	Not reported	*N/A	*N/A	N/A
Total	Not reported	Not reported	*N/A	*N/A	N/A

	DHMP Commercial				
Asthma Medication Ratio (AMR)	2017 HEDIS Results	2018 HEDIS Results	2019 HEDIS Results	2019 HEDIS Percentile	2018-2019 HEDIS Change
Ages 5-11	*NA	*NA	*NA	*NA	*NA
Ages 12-18	*NA	*NA	*NA	*NA	*NA
Ages 19-50	73.13%	75.71%	67.95%	10th	-7.76%
Ages 51-64	*NA	*NA	*NA	*NA	*NA
Total	69.83%	81.30%	74.63%	10th	-6.67%

*NA=Sample size <30

	DHMP Exchange			
Asthma Medication Ratio (AMR)	2016 HEDIS Results	2017 HEDIS Results	2018 HEDIS Results	2018-2019 HEDIS Change
Ages 5-11	Not reported	Not reported	*N/A	N/A
Ages 12-18	Not reported	Not reported	*N/A	N/A
Ages 19-50	Not reported	Not reported	*N/A	N/A
Ages 51-64	Not reported	Not reported	*N/A	N/A
Total	Not reported	Not reported	*N/A	N/A

HEDIS 2019 Changes

MMA:

- Removed “Mast cell stabilizers” from the Asthma Controller Medications List.
- Revised step 4 of the numerator calculation to indicate that the ratio should be rounded to the nearest whole number using the .5 rule.

AMR:

- Removed “Mast cell stabilizers” from the Asthma Controller Medications List.
- Revised step 4 of the numerator calculation to indicate that the ratio should be rounded to the nearest whole number using the .5 rule.

SUMMARY OF 2019 HEDIS ASTHMA RESULTS

In both the Commercial MMA & AMR measures, the HEDIS rates are showing general trends of increasing year over year. However, the AMR total ratio registered a decrease of 6.67% for H2019 while the MMA ratio increased only slightly by 1.79%. As in H2018, the Exchange MMA measure was reported as N/A due to a small sample size. In 2019, the DHHA ACS Asthma QI workgroup completed the planning process for a central pharmacy intervention which will more closely monitor member refills of rescue asthma medications.

ACTION PLAN FOR 2020

The DHMP QI department participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. In 2020, the workgroup will focus on a central pharmacy intervention which monitors member refills of asthma rescue medications in relation to their refills of asthma control medications in an effort to ensure that members with persistent asthma are prescribed and are regularly using an asthma control medication. In addition, the Asthma QI workgroup will continue to work on collecting the necessary non-DHHA pharmacy prescription fill data so that we can more accurately track asthma medication ratio rates across the Plan and prompt member outreach to those not filling appropriate asthma medications throughout the year.

SAFETY AND QUALITY OF CLINICAL CARE

QUALITY OF CARE CONCERNS

2019 Quality of Care Concern Cases (QOCC) – DHMP Commercial, Exchange and Medicare

Plan	Total Cases 2019	Unsubstantiated	Substantiated	Inconclusive
Commercial (Includes Exchange)	6	3	3	0
Medicare	4	3	0	1

ANALYSIS

Commercial and Exchange

There were a total of six QOCC cases for 2019 which was an increase of 4 cases from 2018. There were 3 substantiated cases within the 1st quarter that were turned over to DH Patient Advocate for resolution. No trends were identified.

Medicare

There were a total of four QOCC cases for 2019 which was the same number of 2018 cases. No trend was identified.

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 2019, 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, or 500 persons or more, (English and Spanish) for both product lines in 2019.

DHMP Medicare Advantage Plans Language Data*

Language	Measure	2017	2018	2019
English	Count	3,745	3,700	3,543
	Rate	82.4%	80.24%	75.75%
Spanish	Count	793	906	1,012
	Rate	17.4%	19.65%	21.64%
Vietnamese	Count	4		4
	Rate	.0%		.09%
Chinese	Count	1	1	4
	Rate	0.0%		.09%
Amharic	Count	0	0	0
	Rate	0.0%		0%
Samoan	Count			1
	Rate			0%
Grand Total	Count	4,544	4,611	4,676

**Numbers reflect enrollment as of 12/31/2019.*

DHMP Medicare Advantage Plans Race/Ethnicity Data*

Race/Ethnicity	2017		2018		2019	
	Count	Rate	Count	Rate	Count	Rate
No Ethnicity	4	0.00%	3	0.0%	2	0.0%
Hispanic or Latino	24	0.52%	10	.22%	5	0.11%
White	1,096	24.00%	1,519	32.94%	1864	39.87%
African American	300	6.6%	347	7.5%	400	8.55%
Unknown	3,064	67.4%	2,683	58.19%	2,351	50.28%
Not Hispanic or Latino	13	0.28%	6	.13%	3	0.0%
Asian/Pacific	23	0.505%	22	.48%	26	0.56%
Alaskan/American Indian	10	0.20%	12	.20%	14	0.30%
Other	10	0.20%%	9	.20%	11	0.24%
Grand Total	4,544		4,611		4,676	

**Numbers reflect enrollment as of 12/31/2019.*

DHMP Medicare Advantage REL Summary

Medicare member race/ethnicity and language data from the December 2018 to December 2019 eligibility files were examined. Based on our analysis for our Medicare line of business in 2019, 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 at 39.87%%, followed by African American at 8.55%. 50.28% of members are listed as Unknown, which highlights a need to more effectively collect and track REL data.

DHMP Commercial Language Data

Language	Measure	2018	2019
English	Count	14,148	14,208
	Rate	98.47%	97.93%
Spanish	Count	204	284
	Rate	1.42%	1.96%
Vietnamese	Count	1	1
	Rate	0.00%	0.00%
Korean	Count	1	1
	Rate	0.0%	0.0%
Hungarian	Count	2	2
	Rate	0.01%	0.01%
German	Count	2	2
	Rate	0.01%	0.01%
Nepali	Count	1	1
	Rate	0.0%	0.0%
Egyptian	Count		1
	Rate		0.00%
Russian	Count		2
	Rate		0.01%
French	Count		2
	Rate		0.01%
Amharic	Count		2
	Rate		0.01%
Arabic	Count		4
	Rate		0.02%
Grand Total	Count	14,366	14,508

DHMP Commercial Race/Ethnicity Data

Race/Ethnicity	2018		2019	
	Count	Rate	Count	Rate
No Ethnicity	2,164	15.10%	1761	12.14%
Hispanic or Latino	689	4.80%	584	4.03%
White	4,158	28.94%	3,768	25.97%
Black/African American	566	3.9%	509	3.51%
Unknown	5,888	40.99%	6,973	48.06%
Not Hispanic or Latino	1	0.0%	2	0.01%

Asian/Pacific	**161**	**1.12%**	**150**	**1.03%**
Alaskan/American Indian	**24**	**0.17%**	**43**	**0.30%**
Other	**692**	**4.82%**	**698**	**4.81%**
Asian Indian	**5**	**0.0%**	**7**	**0.05%**
Hawaiian	**18**	**0.13%**	**20**	**0.14%**
Grand Total	**14,366**		**14,508**	

DHMP Commercial REL Summary

Commercial member race/ethnicity data from the December 2019 eligibility files were examined. Based on our analysis for our Commercial line of business in 2019, English was the predominant language of our member population followed by Spanish. In comparison to 2018, 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 members were the most prevalent known race among Commercial members at 25.97%, with no other reported REL rates reaching a 5% proportion or 500 person threshold. A majority of Commercial members identified their race and/or ethnicity as "Other, No Ethnicity" or did not report race or ethnicity "Unknown". As such, DHMP does not have accurate race or ethnicity data for 65% of Commercial members.

DHMP Provider REL data

For providers, the top five (5) ethnicities reported were 'Blank' (83.18%), 'Caucasian' (13.27%), 'Hispanic' (1.11%), 'Asian' (0.71%) or 'Other' (0.64%). Note that 83.82% of providers chose not to self-report their ethnicity by selecting 'Other' or by leaving their response 'Blank' ([3,543/4,227]*100).

In comparing the self-reported ethnicity needs of members against the self-reported ethnicity offerings of providers, ethnicity needs are met; however, because 83.18% of providers selected 'Blank', it is hard to be sure.

For providers, the top three (3) languages reported in CY18 were 'English' (63.13%), 'Spanish' (18.23%), 'Blank' (10.94%). Note that 16.78% of members chose not to self-report their language by selecting 'No Language', 'Other', or 'Unknown', or by leaving their response 'Blank' [(24,638/146,862)*100]. For providers, the top three (3) languages reported were 'Blank' (i.e., 'English') (97.46%), 'Spanish' (1.87%) and 'French' (0.22%).

In comparing the self-reported language needs of members against the self-reported language offerings of providers, language needs are met, and no opportunities are identified..

DHMP has remained committed to delivering 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 (MHC) 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 will participate with ACS to address identified REL related disparities in health in 2020.

Analysis

Studies show that a member's culture can profoundly impact their health care. As such, it is important to understand the culture of members at DHMP, to ensure the care they receive and the experience they have are positive. "Being culturally sensitive is not limited to providing an interpreter for patients who require one. Many aspects of communication are non-verbal, and culture plays a huge role in medical interactions. Everything from eye contact to whom to address in the exam room can be affected by patients' cultural backgrounds."[4]

In 2017, Colorado was identified as one of the top ten states with the largest Hispanic or Latino population. This is evidenced at DHMP as 19.31% of members reported their ethnicity as Hispanic or Latino. The following has been noted:

- Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance5
- Hispanic populations…tend to respect and consult older family members when it comes to health decisions4
- Hispanics have the highest uninsured rates of any racial or ethnic group within the United States5
- 72.00% of Hispanics speak a language other than English at home[5]

To ensure providers and staff are aware of and considering culture when providing care, DH has integrated cultural competency into its annual training. In 2019, 5,888 DH staff passed the module, called the 'Denver Health Experience.'

Barriers

The following barriers to assessing the culture, race, ethnicity and language of DHMP members, providers and practitioners were identified:

- No race data available for members
- No race data available for providers and practitioners
- No culture, race, ethnicity or language data available for non-DH providers and practitioners
- The majority of members and providers failed to self-report ethnicity
- Members failed to self-report language

Opportunities for Improvement

Based on the aforementioned barriers, the following opportunities for improvement have been identified:

- Utilize internal resources (e.g., Epic, MyChart) to obtain data elements
- Utilize the Council for Affordable Quality Healthcare, Inc. (CAQH) Application to obtain provider data elements for those providers who self-report
- Collaborate with the Employee Engagement Committee to offer additional cultural competency training to DHMP staff
- Collaborate with Marketing to offer education in Member and Provider Newsletters regarding the importance of self-reporting culture, race, ethnicity and language data
- Collaborate with Product Line Managers to ensure culture, race, ethnicity and language questions are included in annual Member Experience Surveys

Interventions

Based on the aforementioned opportunities for improvement, the following interventions have been identified as priorities for 2020:

- Update the DHMP Roster Management Template to include additional languages (i.e., beyond English) spoken by the provider
- Update the Provider Directory to list the primary language as 'English' if self-reported as 'Blank'
- Update the Provider Directory to display additional languages spoken
- Collaborate with Product Line Managers to ensure culture, race, ethnicity and language questions are included in annual Member Experience Surveys, and leverage any data captured in the regulatory annual CAHPS survey.

Regulatory References/Citations

- 2019 National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans, NET1 Element A, Availability of Practitioners – Cultural Needs and Preferences
- 2019 NCQA Standards and Guidelines for the Accreditation of Health Plans, RR3 Element B, Subscriber Information – Interpreter Services

Disparities in Health

In 2019, reducing disparities in health related to race, ethnicity and language was an identified enterprise opportunity. In 2020, DHMP will continue to participate in ongoing planning, identification and any initiatives in collaboration with DHHA's Ambulatory Care Services (ACS), ACS quality improvement workgroups, as well as Plan product line management, marketing and health plan services.

The QI team will collaborate with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. The blood pressure under control HEDIS measure monitors the percentage of Members 18–85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled. 2019 data shows that Blacks have a lower rate of blood pressure control than their White or Hispanic counterparts system wide with adequate control for Blacks at 60.2% and Whites and Hispanics at 66.2% and 69.2%, respectively. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup will create an intervention to determine root causes of this disparity and create an intervention to address it. Additional efforts are being made to improve data collection around Member race, ethnicity, and language (see above).

Health Literacy

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. 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.

Health literacy, as defined by the Department of Health and Humans Services *Healthy People 2020* is the degree to which individuals 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 in 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 DHMP's commitment 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. In 2019, DHMP revived a previous Member Outreach Committee which reviews and coordinates member communications and will include the formation of a Member Materials Review Committee which will meet quarterly and review DHMP created member materials for understanding, cultural appropriateness and ease of use. The QI team is an integral part of this committee.

In addition, DHMP works toward the goal of ensuring that readability standards, per the requisites established per line of business, are met on all member-disseminated documents. The Marketing Department provides support on the use of health literacy *software (Health Literacy Advisor™)* 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 2020

In 2019, at least one employee from each department at DHMP had the software installed on his or her computer and was 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 Marketing Department provides support 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 newly revised Member Outreach Committee which reviews and coordinates Member communications will continue to review DHMP created Member materials for understanding, cultural appropriateness and ease of use.

QUALITY OF SERVICE

MEMBER SATISFACTION

2019 MEMBER SATISFACTION – ANNUAL CAHPS SURVEY AND FEEDBACK

DHMP conducted the Adult Consumer Assessment of Health Plan Providers and Systems (CAHPS) survey in 2019 for the Commercial, Exchange and Medicare plans. CAHPS surveys were conducted under contract with SPH Analytics, an NCQA certified vendor. SPH Analytics 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, Exchange 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 1,595 Commercial plan members, 465 Exchange members, and 880 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 288 Commercial plan members, 76 Exchange members and 307 Medicare members who chose to complete the survey.

RESULTS

Commercial

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

- 75th percentile for 'How Well Doctors Communicate'(Increased from the 45th percentile in 2018),

- 84th percentile for 'Rating of Personal Doctor'(This percentile stayed the same from 2018 to 2019),
- 58th percentile for 'Rating of Health Plan'(Increased from the 40th percentile in 2018),
- 4th percentile for 'Plan Information on Costs'(Decreased from the 19rd percentile in 2018),
- 10th percentile for 'Getting Care Quickly'(Increased slightly from the 5th percentile in 2018),
- 81st percentile for 'Rating of Health Care' (Increased from the 13th percentile in 2018),
- 5th percentile or below for, 'Customer Service', 'Plan Information on Costs' and 'Claims Processing.'

The table below details the historical trend for the last 3 years:

Table 1: 2019 Adult Commercial CAHPS Historical Trending

Exchange

In 2019, the Elevate by Denver Health sample size was 465 with 76 total completed surveys for a 21% response rate.

	2018	2019
QRS Measures	**Summary Rate Scores**	**Summary Rate Scores**
Access to Care	NR	NR
Cultural Competence	NR	NR
Care Coordination	NR	NR
Access to Information	NR	NR
Plan Administration	NR	NR
Overall Rating Measures		
Health Plan	43%	28%
Health Care	59%	46%
Personal Doctor	81%	74%
Specialist	NR	57%
HEDIS® Measures		
Flu Vaccinations for Adults Ages 18-64	72%	51% ↓
Advising Smokers and Tobacco Users to Quit*	NR	NR
Discussing Cessation Medications*	NR	54%
Discussing Cessation Strategies*	NR	58%
Sample Size	*(328)*	*(465)*
# of Completes	*51*	*76*
Response Rate	*19%*	*21%*

↑/↓Statistically higher/lower compared to prior year results.
NR = Non-reportable data due to small sample sizes (n <11) is not displayed.
NA = Data not available due to changes in composite.
*Measure is reported using a Rolling Average Methodology. The score shown is the reportable score for the corresponding year.

SPH Analytics

2019 QHP Enrollee Experience Survey
Elevate by Denver Health Medical Plan
M190002 July 2019 7

The Exchange CAHPS results above reflect a low denominator for many of the measures, indicated by the NR measurement indicator. However, the following Overall Rating Measures indicate an Index score of 64% (compared to 76% the previous year) for the Health Plan, an 76% rating (compared to 83% in 2018) for Health Care, an 88% rating for Personal Doctor (compared to 91%) and 79% for Specialist (vs 87% in the previous year.).

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 four out of five stars for:

- 'Care Coordination ,' 'Getting Needed Prescription Drugs,' 'Rating of Drug Plan,' and Annual Flu Vaccine'

The plan received:

- Three stars for 'Overall Rating of Health Care Quality' and 'Customer Service'
- Two stars for 'Rating of Health Plan'
- Two stars for 'Getting Needed Care' and 'Getting Appointments and Care Quickly'

Medicare CAHPS Results

Measure	Mean Score	Base Group	Statistical Significance	Reliability	Number of Stars	Star Rating
Getting Needed Care	79	1	Below Average	Low	2	★★
Getting Appointments and Care Quickly	75	2	No Difference	Good	2	★★
Customer Service	88	2	No Difference	Good	2	★★
Getting Needed Prescription Drugs	90	4	No Difference	Good	4	★★★★
Care Coordination	87	4	No Difference	Good	4	★★★★
Rating of Health Care Quality	86	3	No Difference	Good	3	★★★
Rating of Health Plan	85	3	Below Average	Good	2	★★
Rating of Drug Plan	83	2	Below Average	Good	2	★★
Annual Flu Vaccine	74	3	No Difference	Good	3	★★★

ANALYSIS

Commercial CAHPS results revealed an increase in Getting Needed Care and Getting Appointments and Care Quickly. The following measures maintained the same starts rating from 2018 to 2019 - Customer Service, Getting Needed Prescription Drugs, Care Coordination, Rating of Health Care Quality, Rating of Health Plan, Rating of Drug Plan, and Annual Flu Vaccine. Efforts will continue to improve CAHPS scores across multiple categories for the Commercial, Exchange and Medicare plans.

There were a number of additional initiatives performed by the Medicare product line team in 2019. Health Plan Services partnered with the Medicare product line team to do outreach calls to members in 2019. Health Plan Services Call center staff helped perform welcome and disenrollment surveys to provide clear, consistent information as well as answer any questions. The Medicare team also performed an off-cycle CAHPS survey at the end of 2019. DHMP worked with an external vendor (SPH) to send a non-official CAHPS survey to a sample of the population to get feedback to help positively impact the 2020 stars rating. The surveys were sent out on 10/15 and data was received by our vendor and sent to DHMP by 12/20. Currently, Gorman Health Care is compiling the information to provide detailed interventions and analysis. We will continue planning on additional interventions to help increase member satisfaction for 2021 star ratings.

DHMP also plans to expand the service area and move to an external sales team/broker (To Insure Me). They will perform calls to all of our members to invite them to an annual notice of change (ANOC) town hall for all members to provide feedback. This external broker will continue to perform additional outreach calls to all of our members in 2020.

Finally, the MCR team also partnered with the population health program to address gaps in care through in home visits. Approximately 1000 members with gaps in a number of areas such as diabetic measures, BMI, Fit Kit, and Bone Density will be outreached for further follow-up. The Population Health team is configuring their system and purchasing the necessary equipment to absorb the process changes necessary for success. In addition, the Medicare team also utilized an external partner, BioIQ (vendor) for Fit Kit mailings (colorectal screening tests) in an effort to tackle that particular gap in care.

Grievance Reporting and Trending:
The complaint analysis report period covers the period of January 1, 2019 to December 31, 2019 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 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.

Changes made in processes, in 2018 led to improved outcomes in timeliness and a broader base of knowledge among the Grievance and Appeals Specialists in 2019. In 2019 additional actions were taken to improve outcomes related to grievances and appeals, including have the Grievance and Appeals Manager attend a Health Plan Services Staff meeting on a quarterly basis to review identifications of grievances and appeals and address any issues the Health Plan Services Team may be having. In addition, training on identification of grievances and appeals has been incorporated into the new hire training for DHMP. This was tested in 2019 and is anticipated to be finalized in Q1 of 2020. Trends noted in the Grievance and Appeals data is now shared weekly with the recently created Problem Solvers Group, which is new as of 2019.

COMMERCIAL GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	3	2	5	1	11	.807
Financial/ Billing	14	25	27	21	87	6.39
Quality of Service (Customer Service/Attitude)	3	1	1	1	6	.44
Quality of Clinical Care	1	1	0	0	2	.15
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	3	6	2	4	15	1.10
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	1	0	0	1	.07

Managed Care Department Specific Concerns	2	0	4	2	8	.89
GRAND TOTAL	26	36	39	29	130	9.54

ELEVATE (MARKETPLACE) GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	0	1	0	0	1	1.21
Financial/ Billing	2	3	5	2	12	14.55
Quality of Service (Customer Service/Attitude)	2	0	0	1	3	3.64
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	1	0	1	1.21
GRAND TOTAL	4	4	6	3	17	20.61

MEDICARE GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	2	1	2	2	7	1.50
Financial/ Billing	5	10	8	7	30	6.41
Quality of Service (Customer Service/Attitude)	9	10	4	12	35	7.48
Quality of Clinical Care	1	1	0	1	3	.64
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	4	1	7	3	15	3.21
Transportation	1	3	5	7	16	3.42
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Marketing	0	0	1	0	1	.21
Eligibility	1	0	0	1	2	.43
Managed Care Department Specific Concerns	0	0	1	0	1	.21
GRAND TOTAL	23	26	28	33	103	23.52

COMMERCIAL APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	5	0	0	0	5	.37
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	0	2	12	7	21	1.54
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	5	2	12	7	26	1.91

ELEVATE (MARKETPLACE) APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	1	0	0	0	1	1.21
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
Marketing	0	0	0	0	0	0
GRAND TOTAL	1	0	0	0	1	1.21

MEDICARE APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	5	5	11	14	35	7.48
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	1	6	10	6	23	4.92
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	4	2	6	1.28
GRAND TOTAL	6	11	25	22	64	13.68

QUALITATIVE ANALYSIS—OVERALL HEALTHCARE GRIEVANCE DATA

Access

The Access category has had a drop in the number of grievances received in CY 2019 compared to CY 2018. This is due to initiatives put in place to increase DHMP's collaboration with the Denver Health and Hospital Authority's appointment center to ease getting appointments for members and working with Select Physical Therapy to increase availability of Physical Therapy appointments.

Quality of Service (Customer Service/Attitude)

The Quality of Service category has the highest number of complaints for Medicare and the fifth highest for the Commercial lines of business. This category was fourth for both lines of business in 2018. Within this category, the majority of concerns dealt with member experience of rudeness by a staff member in the hospital or physician clinic setting. Grievance identification training across DHMP teams, has helped DHMP to better identify grievances wherever they may come in.

Financial/Billing

The highest category with complaints is Financial/Billing, with the number of complaints in this category almost doubling for the Commercial line of business. This is not due to an increase in complaints but due to corrections in how DHMP classifies grievances vs appeals according to state regulatory definitions. Now many cases that would be treated as appeals for the Commercial and Exchange plans are being correctly classified as grievances. This is seen in the corresponding drop of Commercial appeals. Most of these complaints involve services that were received without prior authorization.

Benefit Package

Benefits accounted for the second highest reason for complaints from Commercial members and the fourth highest from Medicare members. This is due to more substantive changes made regarding Commercial benefits, leading to member confusion and dissatisfaction as a small percentage of members were affected negatively.

Quality of Care

In 2019, the Medical Plan received five complaints regarding Quality of Care. This is unchanged from 2018.

Provider Network

In 2019, the Medical Plan received no complaints regarding the Provider Network.

Quality of Practitioner Office Site

During calendar year 2019, there were zero complaints filed with DHMP related to quality of practitioner office site. Because of this no analysis is able to be offered.

In overall review, confusion about which providers are in network and which services require authorization seem to generate the most complaints from members. Initiatives were put into place in 2019 to improve the usefulness of the Provider Directory and there are initiatives to simplify the requirements for authorizations in the beginning of 2020.

APPEAL DATA

Access

During calendar year 2019, there were no access-related appeals for the Commercial or Medicare plans.

Quality of Service (Customer Service/Attitude)

During calendar year 2019, there were zero appeals filed with DHMP related to Quality of Service. As a result, no evaluation is provided.

Financial/Billing

During calendar year 2019, Financial/Billing issues were the largest reason for appeals. In most of these appeals, 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. In some of the cases, DHMP incorrectly processed the member claim and thus the member received a bill for the service(s).

Benefit Package

During the report period, Benefit Package appeals were the second highest categories. While each of the cases filed 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 2019, there were zero appeals filed with DHMP related to Quality of Care.

Provider Network

During calendar year 2019, there were zero appeals related to the Provider Network.

Quality of Practitioner Office Site

During calendar year 2019, there were zero appeals filed with DHMP related to quality of practitioner office site. As a result, no evaluation is provided.

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.

As discussed above, changes and initiatives in 2018 had a significant impact on 2019 figures. With increased attention to issues found in Grievances and Appeals in the Problem Solvers Group, there were also swift fixes to issues in the 2019 year. With the addition of a Monitoring, Auditing and Training Team to DHMP, there is the expectation of further opportunity to identify issues promptly and make further improvements.

Please see Attachment C_CY 2019 Complaint Data Analysis for full report.

QUANTITATIVE ANALYSIS – BEHAVIORAL HEALTHCARE

Commercial Grievance Data

Categories	1Q2019	2Q2019	3Q2019	4Q2019	TOTAL	Per 1000 Members
Access	0	1	1	0	2	.15
Financial/ Billing	0	3	0	0	3	.22
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	4	1	0	5	.37

Medicare Grievance Data

Categories	1Q2019	2Q2019	3Q2019	4Q2019	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

Commercial Appeal Data

Categories	1Q2019	2Q2019	3Q2019	4Q2019	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

Medicare Appeal Data

Categories	1Q2019	2Q2019	3Q2019	4Q2019	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

Two complaints were filed for 2019 for the Commercial product line. None were filed for Medicare.

Financial/Billing

Three complaints were filed for 2019 for the Commercial product line. None were filed for Medicare.

Quality of Service (Customer Service/Attitude)

No complaints were filed for 2019.

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.

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. In addition, 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 will be 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 2019 to assess intervention effectiveness. See full Open Shopper Report for complete findings.

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

COMMERCIAL OUT-OF-NETWORK DATA

The total number for Out-of-Network (OON) service requests for services not available at DH, across all lines of business, has increased by 244 requests. See table below. This table represents the largest 20 types of out-of-network services. Both the Medicare Advantage and Elevate lines of business show more referrals for out-of-network services while the Large Group line of business shows a decrease of 51 service requests. The other category shows the largest out-of-network referrals; it represents miscellaneous services that overall are too small to categorize individually. Allergies represent the largest number of referrals, 128, followed by radiology services at 116.

MMC meets bi-monthly to review and discuss trends identified. OON data is used to guide decision-making and direct actions to impact services. MMC reports OON utilization to QMC and brings a review of data and analysis, identified opportunities and recommended improvement initiatives as necessary.

2018 Summary: Out-of-Network Requests for Services Not Available at DH

	ELEVATE	LARGE GROUP	MEDICARE ADVANTAGE	Grand Total
Allergy	14	100	14	128
Other	26	95	48	169
Radiology	15	35	66	116
Genetics	7	65	5	77
Sleep Study	2	31	41	74
Radiation Therapy	6	15	45	66
Dermatology	3	43	34	80
Transplant	33	7	30	70
Cardiology	5	7	33	45
Gastroenterology	3	15	26	44
Therapies OT/PT/ST		31	26	57
Durable Medical Equipment	1	9	41	51
Orthopedics	2	18	10	30
Laboratory		32		32
General Surgery		19	8	27
Ophthalmology		4	32	36
Hematology Oncology	2	11	13	26
Pulmonary	1	5	19	25
Endocrinology	3	8	5	16
Neurology	3	11	9	23
2018 Totals	**126**	**561**	**505**	**1192**
2017 Totals	24	612	312	948

Outside referrals due to services not being available in a timely manner have decreased slightly, by 7 referrals, when compared to the 2017 data. See table below. Services not being available in a timely manner for the Medicare Advantage and the Large Groups line of business exceeded 50 referrals each in 2019.

2018 Summary: Outside Referrals Due to Services not Available in a Timely Manner

	ELEVATE	LARGE GROUP	MEDICARE ADVANTAGE	Grand Total
Therapies OT/PT/ST	1	35	7	43
Orthopedics		3	5	8
Neurology	2	3	3	8
Other	2	1	2	5
General Surgery	1		1	2
Ophthalmology	3	4	4	11
Podiatry		5	1	6
Transplant			10	10
Cardiology	1		2	3
Dermatology				0
Urology			1	1
Gastroenterology			3	3
Sleep Study		1	2	3
Radiology		3	2	5
Nephrology	1	1	2	4
Home Health				0
Mental Health			3	3
Ear Nose Throat			1	1
Gynecology				0
Dialysis			2	2
Grand Total	**11**	**56**	**51**	118
2017 Totals	1	74	50	125

HEALTH PLAN SERVICES

MONITORING HEALTH PLAN SERVICES' TELEPHONIC PERFORMANCE

Health Plan Services (HPS) has in place departmental Performance Report that monitors six telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 80%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, overall Call Volume, Reasons for calls, and Quality/Accuracy of calls. The Health Plan Services Performance Report monitors these telephonic statistics by Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) lines of businesses. Tracking, comparison, and evaluation occur on a daily, monthly as well as annual basis. Lead/Management pulls statistical data from the Cisco Unified Intelligence Center Historical Reports and prepares it for the Call Center Operations Manager/Health Plan Services Director and executive team. The Operations Manager/Lead 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 Summary and Analysis at each bi-monthly QMC meeting.

COMMERCIAL:

Average Delay (seconds)	**2017**	**2018**	**2019**
Annual Totals	103	194	161
Abandonment Rate (%)	**2017**	**2018**	**2019**
Annual Totals	8.5%	18.3%	13.3%
Call Volume (# of calls)	**2017**	**2018**	**2019**
Annual Totals	84529	72079	68807

MEDICARE:

Average Delay (seconds)	**2017**	**2018**	**2019**
Annual Totals	11	53	43
Abandonment Rate (%)	**2017**	**2018**	**2019**
Annual Totals	16.7%	9.6%	3.9%
Call Volume (# of calls)	**2017**	**2018**	**2019**
Annual Totals	7565	13938	12914

ELEVATE:

Average Delay (seconds)	**2017**	**2018**	**2019**
Annual Totals	16	318	236
Abandonment Rate (%)	**2017**	**2018**	**2019**
Annual Totals	2.8%	21.3%	15.4%
Call Volume (# of calls)	**2017**	**2018**	**2019**
Annual Totals	4523	7189	3970

Analysis:

For all product lines, the HPS team has made improvements in 'average delay' and 'abandonment rates' from 2018 to 2019 with overall 'call volume' trending downward. Fluctuations in staffing levels continue to cause challenges within the HPS team, but improvements in staff onboarding, training and retention are under development.

MONITORING HEALTH PLAN SERVICES' BENEFIT INFORMATION FOR QUALITY AND ACCURACY

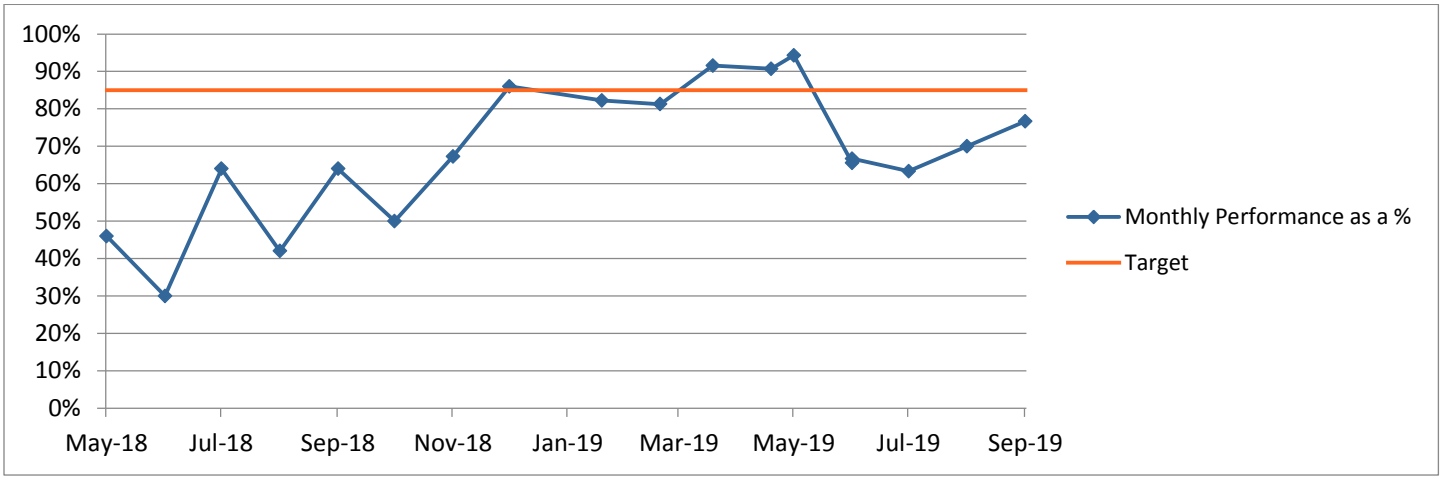
In order to satisfy regulatory and departmental standards and monitor the telephonic quality of DHMP Health Plan Services, the Health Plan Services Quality Assurance Program (HPS QA) has instituted reporting occurring on a daily/monthly basis. The HPS QA Program allows the Health Plan Services Leadership Team (HPSLT) to determine any deficiencies in quality and service provided by Health Plan Representatives (HPR) and works to correct any identified deficiencies. This serves as a valuable tool in staff development and satisfaction and is also incorporated into the annual HPR evaluation process to ensure that it is meaningful to the team and its individual members.

The QA program entails monitoring and reporting on multiple components, such as Call Details, Greeting, Caller Identification (HIPAA/PHI), Professionalism & Courtesy, Quality, Accuracy and Call Closing. Productivity is evaluated on specific metrics, such as 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 HPS Lead. The HPS Lead selects up to 10 random calls and/or targeted random calls for each HPR that occurred in the specific month out of the Nice Uptivity Call Recording Software. The HPS Lead 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 HPR. The overall evaluation of HPR performance in both areas is compiled, reviewed, and provided to the HPRs. One on one coaching will occur if deemed necessary. In addition, overall departmental HPS Monthly Call Quality Performance Reports are compiled to track the progress of quality maintained by the HPRs from month to month on an individual as well as departmental basis. All HPRs and the department overall have a goal to maintain an accuracy rate of 90% or higher. If this is not maintained, additional training/education, coaching or corrective actions may be taken.

CUSTOMER SERVICE PERFORMANCE

Additionally, the Health Plan Services Quality Assurance Program (HPS QA) has instituted standard work that has each HPS representative end every call with the question "Have I provided the help and information you needed today?" The target has been set at 85% of all calls be required to end with this question. HPS leads randomly audit between 50-140 calls monthly and collect data to increase member satisfaction and level of customer service.

Data:



By September 2019, the HPS team ended at 83% compliance (with an overall goal of 85%) for the 'closing phrase used'. Since January 2019, the closing phrase has been a part of the HPS representative's monthly QA standard work.

INTERVENTIONS

In an effort to continue process improvements to serve the DHMP members to the best of our ability, the HPS team has taken on a number of new initiatives to increase customer service satisfaction levels. The HPS team is proactively working to enhance onboarding, data sharing and internal collaboration for new and existing staff. A new Manager of Administration and Training (MAT) position was created to work in a number of areas, including the enhanced new hired training for all HPS employees. The MAT works with each individual for up to 3 weeks to onboard new staff and be available to address real time questions and concerns. Secondly, HPS managers continue to post all staff performance statistics around call volume, time and performance to allow transparency in identification of strength and challenges. New hires also are on boarded by intentional scheduled meetings with key Department staff such as the Product Line Mangers, the Manager of Appeals and Grievances and the Director of Finance. These efforts are ongoing and remain a priority.

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 and on an annual basis, all staff shall sign and acknowledge understanding of the Denver Health and Hospital Authority Confidentiality Agreement. 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 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.

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 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
- Act as QI staff representative to the DHMP Board of Directors
- Directly assume authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation, and Work Plan annually
- Coordinate, provide advice and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health Departments, as appropriate, for regulatory compliance
- Report QOCCs to the appropriate Directors of Service at DHHA and external network providers, as directed

- Serve as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
- Annually ensure all policies, procedures, and guidelines related to the QI Department are updated appropriately
- Oversight of QI vendor contracts and delegated activities
- Provide oversight and direction to the QI team, consisting of the following members:

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

- Manage all aspects of HEDIS production, including oversight of related projects
- Evaluate and analyze HEDIS results
- Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
- Work collaboratively with Intervention Manager(s) on process improvements and quality interventions related to HEDIS
- Validate the accuracy of HEDIS data and supporting documents

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

- Manage all aspects of CAHPS-related projects
- Analyze the effectiveness of intervention activities
- Coordinate all efforts related to Work Plans, Evaluations and Program Descriptions
- Lead activities related to regulatory and accreditation requirements
- Work in collaboration with Intervention Manager(s) to maintain a timeline for deliverables
- Co-direct and work with the QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and bi-monthly reporting requirements
- Function as main administrative contact for the QMC
- Oversee QI National Committee for Quality Assurance (NCQA) requirements and functions in conjunction with QI Director

Intervention Manager responsibilities include, but are not limited to:

- Evaluate, analyze and report CAHPS results, as well as facilitate improvement efforts
- Develop, manage and evaluate all quality interventions
- Work collaboratively with the Medical Director, QI Director, AQIDC, Ambulatory Care Services, 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 health care initiatives related to health literacy and racial/ethnic health disparities
- Oversee 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:

- Manage QOCCs and quality of service concerns processes in a timely and effective matter
- Work in collaboration with HEDIS Program Manager to perform HEDIS chart reviews
- Develop training materials, facilitate training, test for inter-rater reliability (IRR) and retrain staff
- Provide clinical consultation for the QI Department
- Conduct practitioner chart review using HEDIS criteria
- Develop and update 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, Population Health Management, Pharmacy, Member Services, Appeals and Grievances, Provider Relations, Marketing, Compliance, and Product Line Managers. 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 invited primary care providers, specialty and behavioral health providers from both Denver Health Hospital Authority and extended practitioner network.

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.