Quality Improvement Impact Analysis

2019-2020

Denver Health Medicaid Choice and Child Health Plans
SFY Contract July 1, 2019 – June 30, 2020

DENVER HEALTH MEDICAID CHOICE

DENVER HEALTH MEDICAL PLAN INC.

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I. Executive Summary

Introduction

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated healthcare system that serves as the primary "safety net" system for the City and County of Denver. Denver Health Medical Plan, Inc. (DHMP) was originally incorporated on January 1st, 1997. DHMP is licensed by the State of Colorado Division of Insurance as a Health Maintenance Organization (HMO). On July 1st, 2003, DHHA entered into a contract with the Colorado Department of Health Care Policy and Financing (HCPF) in order to provide comprehensive health care services to Child Health Plan Plus (CHP+) eligible enrolled into DHMP. On May 1st, 2004, DHHA entered into a contract with HCPF to provide comprehensive health care services to Medicaid eligible Members enrolled into Denver Health Medicaid Choice (DHMC) health plan. In September, 2018, the contract with HCPF was transitioned from DHHA to Denver Health Medical Plan (DHMP). DHMP offers a full continuum of healthcare services for Members through DHHA's integrated care delivery system.

DHMP's Quality Improvement (QI) Program Description outlines DHMP's plan to improve quality of care, create and sustain a culture of service and ensure Member safety for its Members. The QI team systemically monitors and evaluates the delivery of health care services, with focus on improving Member outcomes. Utilizing QI interventions based on a continuous improvement cycle of PDSA – plan, do, study, act and incorporating LEAN methodology, QI interventions are planned, implemented and assessed with targets of improving functional outcomes for Members, delivering culturally competent care and service; and increasing Member satisfaction with services. The QI Program extends to all departments within DHMP, in recognition that teamwork and collaboration are essential for quality improvement. QI actively collaborates with other DHMP departments to develop, implement and evaluate quality improvement initiatives. Activities are coordinated with case management, member services, provider network, pharmacy, health management, marketing, utilization/care management and product line managers for DHMP. Our activities, with accompanying data, are analyzed, summarized and presented to the Quality Management Committee (QMC) of DHMP for feedback, guidance and oversight.

Our Provider network for the Medicaid and CHP+ Members is Ambulatory Care Services (ACS)/Community Health Services (CHS) of Denver Health. With a network of nine primary care clinics and eighteen school based health centers, ACS provides patient-centered medical home (PCMH) focused care for children, adults and geriatrics across the life continuum. Our PCMH is a model of primary care that is patient-centered, comprehensive, team-based, coordinated and accessible and focused on quality and safety in all we do. Our Providers and care teams strive to meet Members in their care where they are, working to assure care is received in the right place, at the right time, with the right Provider, in a way that best suits a Member's and their family's needs. A PCMH is responsible for care coordination and provides health maintenance preventive care, anticipatory guidance and health education, acute and chronic illness care, and coordination of medications, specialists and therapies. Members are provided with the education and support they need to make decisions and participate in their own care. In addition to the robust resources available within Denver Health, DHMP has partnered with the STRIDE Community Health Center network to provide primary care services for the Medicaid and CHP+ membership. This partnership adds sixteen additional facilities where members can receive primary care services. Another resource that DHMP has recently invested in is a contract with Dispatch Health, which will allow members to access and receive primary care and urgent care services within their own home.

In our work with ACS, we pursue joint QI initiatives through Ambulatory QI Committee (AQIC), disease and prevention specific work groups and incorporate patient experience into those work groups. In these

committees and groups, DHMP joins resources with ACS and actively work together to increase the health and well-being of our Members. The QI team also leads targeted interventions in clinic sites through partnership and collaboration with defined clinic leadership.

The QI program incorporates QI initiatives and implements activities based on Medicaid Choice and CHP+ contract requirements with HCPF. Core QI activities include production and oversight of the Health Effectiveness and Data Information Set (HEDIS) data analytics and the Consumer Assessment of Health Plan and Systems (CAHPS) surveys annually each spring. These reports provide data used to identify opportunities for improvement and to develop, implement and evaluate the effectiveness of interventions. DHMP works collaboratively with ACS to improve identified HEDIS and CAHPS measures, increase quality and access to care, and improve Member satisfaction.

ACS is endorsed as a PCMH to the Medicaid and CHP+ Members. ACS currently holds National Committee on Quality Assurance (NCQA) accreditation for their PCMH care services at Level II, initially receiving accreditation in 2011 and renewing in 2020. CAHPS Clinician and Group Surveys (CG-CAHPS) are utilized in the clinics to evaluate services received by Medicaid and CHP+ Members. This effort began in July 2013 at the ACS clinics to measure Members' satisfaction of their recent experience with Providers and clinical staff. CG-CAHPS metrics are reviewed with ACS workgroups to identify and work on specific service interventions to improve the clinic experience for Members and their families. DHMP QI Members participate in the patient experience efforts and work collaboratively on improving Member care and experience. Over the past year, ACS, along with DHMP and other leaders across Denver Health, participated in and lead a three year patient and Member experience initiative with a national consulting firm, Studer Group, to improve the experience of Members when they receive clinic services. The effort focuses on improvement of all CAHPS scores across the enterprise.

II. Quality Improvement Program Evaluation and Summary

Overview

The QI Program initially grew out of three quality initiatives at Denver Health: the DHMP Program, the ACS QI Program, and the DHMC Clinical Performance and Safety Improvement Program. The DHMP QI Program and the ACS QI Program function separately from each other as different departments under the umbrella of Denver Health, but continually seek opportunities for collaboration on quality improvement initiatives to effectively utilize resources in delivering quality care to benefit all Members. The DHMC Clinical Performance and Safety Improvement Committee plans, implements and coordinates system-wide regulatory efforts to maintain compliance with Colorado State Rules (healthcare CSR), Centers for Medicaid and Medicare (CMS) Conditions of Participation and Joint Commission Standards (JCAHO). The focus is on promoting Member/patient safety and quality of care at Denver Health.

QI Program Description and Work Plan

The QI Program is evaluated annually to assess overall effectiveness, track progress in completion of program objectives and monitor successes/challenges to inform opportunities. This process informs the development of the next year's QI Work Plan and Program Description. The QI Program Description and Work Plan provide guidance to the program structure and activities for a period of one fiscal year, July 1st to June 30th, following the state fiscal year calendar for Colorado. The Program Description describes DHMP's structure and range of activities in quality improvement, which is reported to and reviewed by the QMC. The QMC reviews all activities of DHMP giving guidance and oversight to all functions of DHMP, including utilization/care management, Member services, Provider relations, pharmacy and health management activities.

The QI Work Plan is prepared annually for the upcoming state fiscal year for submission to the QMC and the

DHMP Board of Directors for approval. The work plan includes the following elements:

- Written, measurable objectives for the year
- Quality of care and safety of clinical, preventive and services initiatives
- Overall scope of the QI program including clinical, safety and service indicators, review of initiatives, responsible parties and timeframe
- Schedule of reports and planned activities
- Timeframe for evaluation of the effectiveness of the QI program
- Input from DHMP medical management leadership, DHMP operations management, other departmental staff, ACS Provider network, data sources, Member satisfaction indicators and contractual requirements.

Quality Improvement Objectives for 2019-2020

- Continuously measured, analyzed, evaluated and improved the clinical care and administrative services of the plan and health care services delivered by contracted practitioners/Providers, using HEDIS measures and CAHPS Member survey data
- Evaluated care and service delivery to our Members and Providers and supported any targeted interventions to improve Member experience, utilizing Studer work with the Denver Health integrated care system
- Partnered effectively with our Provider/practitioner network in efficient use of resources and delivery of high quality care to our Members through workgroup collaboration and LEAN events
- Evaluated access to and availability of primary, specialty and behavioral health care, utilizing Open Shopper survey methodology and ongoing access reports to monitor availability for Members
- Integrated ACS clinical data with DHMP data to improve Member outcomes, utilizing the ACS quality improvement bundle, HEDIS metrics, scorecard methodology, etc.
- Identified opportunities for improvement and worked collaboratively with ACS Providers to further develop clinical and preventive guidelines, quality initiatives and care/disease management programs
- Adopted NCQA Quality Compass Medicaid & CHP+ benchmarks to evaluate current performance, evaluating for prioritized opportunities for improvement
- Empowered Members to lead a healthy lifestyle through health promotion activities, care support outreach and coordination with community resources
- Encouraged safe and effective clinical practice through established care standards and application of appropriate practice guidelines
- Measured and evaluated interventions to address continuity and coordination of care
- Developed efforts to improve reporting race/ethnicity/language data for every Member
- Began collaboration with the DHHA ACS QI department on ways to measurably improve the quality of health care services related to cultural and linguistic needs of the Member
- Supported staff and Provider training on working with various cultural, ethnic and medically underserved populations
- Reviewed language utilization and Provider language reports to evaluate network responsiveness to provide culturally appropriate care
- Monitored and evaluated high volume and/or high risk services, quality indicators for Special Health Care Needs (SHCN) populations, and over/under utilization reporting to identify opportunities for improvement
- Improved transitions of care across health care settings and practitioners
- Assured that culturally appropriate, health literate communication, education and health care services are provided to Members in all areas
- Improved data collection for quality management metrics to evaluate and improve HEDIS scores, including improvement of coding and documentation for clinical care services
- Improved data extraction for quality management metrics to improve the accuracy and completeness of

HEDIS scores.

- Monitored network adequacy performance
- Developed policies and procedures and documented processes to standardize quality improvement work
- Assured compliance with Medicaid Choice and CHP+ contractual requirements and all federal and state statutes

Impact and Effectiveness of the Quality Improvement Program

In the past year, the QI program team members have been instrumental in the planning, assessment, implementation and review of various QI activities, throughout the organization, accomplishing the following:

- Maintained and expanded active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits. Workgroups are established in the following areas: pediatric care, diabetes, obesity, asthma, cancer screening, perinatal/postpartum, integrated behavioral health, transitions of care, immunizations, and ambulatory care Quality Improvement Committee (QIC)
- Partnered in collaborative work process with QI Director of ACS and ACS QI staff to build joint quality improvement interventions, including shared data analytics
- Improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores
- Continued to identify and develop education and training to facilitate appropriate Provider coding and documentation in support of improving HEDIS scores
- Continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS scores
- Increased Member outreach through ACS care support outreach initiatives to follow up on gaps in care, preventive health screenings
- Implemented focused Member outreach to facilitate care transitions when acuity of need was identified
- Collaborated with ACS care coordination to increase assessment of Members for gaps in care and problem solving to achieve a more comprehensive Member approach to care and services
- Continued to evaluate and refine data to better evaluate desired outcome of increased adolescent well visit utilization, including interventions specific to this population through the Performance Improvement Project (PIP)
- Continued pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization
- Developed and implemented enhanced patient education materials specific to chronic disease states
- Conducted and reviewed Provider satisfaction survey. Incorporated data from ACS electronic medical records into supplemental files used for HEDIS reporting
- Maintained reporting of quality of care concerns (QOCC), and facilitated process improvements as identified during the QOCC review process
- Developed clinical practice guidelines to cover the lifespan from infancy to geriatric
- Streamlined clinical and preventive guidelines review and updating process
- Increased physician involvement in the development of clinical guidelines
- Increased compliance with EPSDT related standards, with additional Provider and Member communication on services, Provider communication about EPSDT requirements, and edits to related policy and procedures. Ongoing efforts continue for wrap around services outside of the health plan, and for tracking of referrals for services outside the Plan, by network Providers. Improved the number of EPSDT services tracked at CHS, available by clinic and Provider.

- Continued development, review and revision of policies and procedures annually through electronic tracking through the organization's transition to an updated system, PolicyStat.
- Maintained physician involvement within the Quality Management Committee (QMC) structure

The overall effectiveness of the QI program continues to be evaluated critically. The accreditation process for other lines of business within DHMP has provided an enhanced focus on opportunities for improvement. Meeting NCQA standards will align the quality improvement department of DHMP with improvement in HEDIS and CAHPS metrics more fully. 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 will help maximize our limited resource availability. LEAN fundamentals, visual management boards, and the improved use of the data analytics will help define priorities for the QI team and provide structure for improvement of daily activities.

We continue to evaluate our need for more resources, especially in HEDIS data collection and data and business analysis functions, along with access to and accuracy of data. We currently have two excellent Intervention Program Management staff, a QI Project Manager, and an experienced HEDIS program manager. Updating and evolving the administrative data extracting programming code had been challenging in terms of IS and QI resources needed for HEDIS and CAHPS. Sources of challenges include data accuracy and completeness, data configuration, and extraction, as claims and other supplemental data sources are a primary data source for HEDIS. This challenge and the effort to use administrative-only data are increasingly important, as a result of the changes to reporting requirements. Progress in resolving these challenges has provided for data credibility, validity and data reliability, essential to quality improvement methods, process and effectiveness. Beginning in 2017-18, we also used the DHMP internal Data Warehouse as the access point for the HEDIS data. We do believe that this approach will best serve DHMP through future ease of getting data accurately and with increased frequency. Best practice for increasing our HEDIS performance requires more than a once a year look at the data results to be effective and to give more real time feedback to our Providers on performance and to support iterative improvement process for quality improvement initiatives. Beginning in 2019, this effort resulted in monthly production of HEDIS data, and we have used that data to create SharePoint-based dashboards to track a variety of key performance indicators for DHMP Medicaid Membership.

Our committee structure continued to be evaluated over 2019-20. The QMC evolved during the past year, with increased regular attendance of physicians and practitioners. The Director of QI for ACS is a regular attendee, along with ACS clinic Providers and specialty care Providers. The structure change has proven to be significantly better. 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. There were also changes in several QMC reporting committees. With changes in some of the Medical Management departments occurring, Utilization Management and Care Management have updated the Medical Management Committee structure and their reporting up through the QMC in 2019-20. The Network Management Committee also had expanded scope and renewed commitment for meeting frequency. Continuous evaluation of the QMC process will continue throughout the next year, with a focus on increasing communication and collaboration of QI efforts organization-wide.

Practitioner participation continues to be strong in 2019-2020, maintaining one of our key elements for program success. We have increased our practitioner involvement with QMC, which allows practitioner input into all aspects of health plan operations and services. Increased involvement of QI team Members in ambulatory quality improvement work groups; clinical design work groups and disease and prevention work groups within DHHA's CHS will need to continue as a targeted focus.

A more defined focus for the QMC has given DHMP a valuable sounding board and feedback mechanism for all departments that present up through the committee. The involvement of the director of QI for ACS, a behavioral health physician, several ACS, practitioners and pharmacists, along with inviting extended network Cofinity Providers, as Members of the QMC committee, has provided a rich mix of differing insight and feedback to departments and the QI team in assisting in evaluating reports and interventions. The Director of QI is involved on several quality committees and workgroups within ACS, including the Ambulatory Quality Improvement Committee (QIC), which combines the previously separate ambulatory quality improvement and the clinical design work group committees and have integrated Member experience performance information into those workgroups. Members of the QI team staff attend and interact in a variety of ways with chronic disease and prevention work groups, led by senior medical leadership of ACS.

Opportunities for Improvement

- Continue to address improvement opportunities for HEDIS administrative data capture and extraction, and automation of provider assignments for HEDIS measures, while continuing to increase supplemental sources of data information for HEDIS measures, especially in anticipation of the evolution of HEDIS to include more electronic clinical data sets (ECDS).
- Develop more supplemental data resources to be used for HEDIS reporting. Continue to work on data issues to increase number and accuracy of administrative hits in HEDIS production run.
- Increase engagement and training of Providers in HEDIS metrics and provide meaningful, Provider-centric education and training to increase HEDIS scores through appropriate medical record documentation and coding.
- Utilize implementation of EPIC electronic medical record (EMR), and its ongoing optimization, to improve HEDIS scores and reduce gaps in care.
- Optimize the new, monthly HEDIS runs and corresponding 'gaps in care' lists, throughout the enterprise, through the development of Tableau based analytic tools.
- Integrate the gaps in care (GIC) lists into the Care Management Platform (Altruista), for use by case managers, in planned interactions with members
- Develop a plan with ACS QI leadership to address gaps in care with year-round interventions and activities.
- Align and partner quality improvement initiatives and interventions with ACS leadership and Provider networks to avoid duplication of effort and to utilize resources more effectively.
- Develop a new PIP, based on HCPF direction and test a series of interventions for PIP designed to inform and improve the performance of the HCPF designated care services, using the recently identified rapid-cycle model
- Continue to develop the use of LEAN framework within quality initiatives to develop A3 problem solving aligned with our PDSA (plan, do, study, and act) methodology. Utilize LEAN framework to develop and evolve standard work for QI team.
- EPSDT became a free-standing Medicaid standard last year, and is the topic of increased focus. In addition to overall compliance with the EPSDT standards, continuing to address an expanded set of EPSDT measures (previously a smaller set was captured as HEDIS 'study items') for improvement, are ongoing opportunities. Resolving the tracking of wrap around benefits referred by network providers, for services not managed by DHMP, is an ongoing opportunity.
- Increase use of school based health services to expand access and availability for adolescent Members. Educate parents of adolescent Medicaid & CHP+ Members that well child visits can be done during school day with written parental permission. Provide data to school based clinics to reach out to Members needing preventive health care.
- Work with ACS leadership to strategically communicate HEDIS and CAHPS information to Providers to

increase engagement and collaboration with the Medical Plan.

- Continue to create and enhance a culture of collaboration and conversation about improving health for all of our Members together. Incorporate cultural competency and health literacy strategies into our Member engagement strategies. Continue to evolve the leadership potential and role for the QMC by providing education and increasing opportunities for feedback, oversight and partnerships.
- Align and partner our quality improvement initiatives and interventions with ACS to avoid duplication of effort, increasing effective utilization of resources, and the integration of payer and care delivery systems.
- Transition from ACS to DHMP-based care coordination activities for Medicaid and CHP+ Members.
- Creation and ongoing evolution of a DHMP-based population health management strategy and its operation.
- Collaborate for a more comprehensive intervention strategy, utilizing patient navigators, and care support activities, transitions of care and EPIC-based tools and data in a more unified approach.

Moving Forward

While SFY 2019-20 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 DHMP, 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.

III. Quality of Clinical Care Activities

2019-2020 QI Activities/Interventions

The following 2020 HEDIS Indicators will be reported for the FY 2019-2020 in accordance with our contract requirements: Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status – Combos 2-10, Immunizations for Adolescents, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women, Follow-up Care for Children Prescribed ADHD Medication, Anti-depressant Medication Management , Effective Acute Phase Treatment, Effective Continuation Phase Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics, Appropriate Testing for Pharyngitis, Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation, Medication Management for People with Asthma, Asthma Medication Ratio, Persistence of Beta-Blocker Treatment After Heart Attack, Statin Therapy for Patients with Cardiovascular Conditions, Comprehensive Diabetes Care, Statin Therapy for Patients with Diabetes, Adults' Access to Preventive/Ambulatory Health Services, Children and Adolescents' Access to Primary Care Practitioners, Prenatal and Postpartum Care, Non-Recommended Cervical Cancer Screening in Adolescent Females, Appropriate Treatment for Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Imaging Studies for Low Back Pain, Use of Opioids at High Dosage, Use of Opioids from Multiple Providers, Pharmacotherapy for Opioid Use Disorder, Risk of Continued Opioid Use, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care, Frequency of Selected Procedures, # of specified procedures per 1000-member months, Inpatient Utilization – General Hospital/Acute Care, Antibiotic Utilization and Plan All-Cause Readmissions. All other measures listed are for other QI initiatives as designated by the Denver Health Managed Care Medical Management Committee and the Operations Management team.

Comprehensive Diabetes Care (CDC)

There are several measures that make up the overall comprehensive diabetes care (CDC) HEDIS measure. The

CDC measures include the percent of Members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

Measure/Data Element	HEDIS 2018 Rates (Medicaid Only)	HEDIS 2019 Rates (Medicaid Only)	HEDIS 2020 Rates (Medicaid Only)	HEDIS 2019 HMO Percentile* (Medicaid Only)	HEDIS 2019-2020Change
Eye Exam (Retinal) Performed	46.59%	45.83%	45.70%	10th	-0.13%
Medical Attention for Nephropathy	82.47%	81.51%	83.75%	<10th	2.24%
HbA1c Poor Control (>9.0%) ***lower score indicates better performance***	42.92%	40.38%	33.58%	25th	-6.80%
Blood Pressure Control (<140/90 mm Hg)	64.01%	61.67%	63.49%	50th	1.82%
Hemoglobin A1c (HbA1c) Testing	82.16%	82.06	84.43%	<10th	-2.37%
HbA1c Control (<8.0%)	45.45%	47.88%	55.47%	25th	7.59%

**HEDIS 2019 national percentiles are listed above. 2020 percentiles to be released in late 2020*

Analysis

Overall, our HEDIS 2020 results showed an increase in our Comprehensive Diabetes Care rates over HEDIS 2019 results. Improvement was noted in Medical Attention for Nephropathy, HbA1c Poor Control (>9.0%), Blood Pressure Control, HbA1c Testing and HbA1c Control (<8.0%), which showed the biggest improvement at 7.59%. Rates for the Eye Exam (Retinal) performed remained relatively stable from HY2019 to HY2020, showing a very slight decrease of 0.13%. All CDC measures are currently performing at or below the 50th percentile nationally. The QI team continues to work on increasing these rates through our collaboration with Denver Health Ambulatory Care Services (ACS).

Diabetes Collaborative Quality Improvement (QI) Workgroup

DHMP QI staff members as well as representatives from Denver Health's Ambulatory Care Services (ACS) participated in a monthly Diabetes Collaborative QI Workgroup. Participants provided regular updates, engaged in discussions related to diabetes metrics, and incorporated changes to ongoing diabetes interventions. Additionally, QI team members have become integral members of the newly formed Diabetes Collaborative subgroups, Diabetes Metrics and Diabetes Interventions, to help drive improvements in diabetes outcomes and measures. The collaborative tracked patient outcomes for diabetes control as well as blood pressure, nephropathy, and diabetic eye exams performed.

Medicaid: Diabetic Eye Exams

An intervention to increase the percentage of Members with diabetes receiving diabetic retinal exams has been in place for several years. The DHMP QI Department tracks the number of Members due for their diabetic eye exam in addition to those Members who received an exam each month. This dashboard also tracks the number of calls Eye Clinic Care Navigators complete on a monthly basis and is then shared with the Eye Clinic staff. The creation of a new SharePoint site in 2019 has improved our ability to target Members for outreach and track success rates of our efforts. During FY19/20, care navigators completed (defined as call where navigator is able to schedule Member for a DRE) 280 outreach calls to the eligible Medicaid population. In HEDIS 2020, there was a 0.13% decrease in Eye Exam (Retinal) Performed while we remained in the 10th percentile nationally. This remains an area of opportunity for FY20/21 and a priority collaboration between DHMP and ACS.

Action Plan

The DHMP QI team will continue to participate in both the Diabetes Collaborative and aforementioned Diabetes Collaborative Subgroups and explore additional ways to improve diabetes care for our Members, including controlling blood sugar, kidney disease monitoring, and performing eye exams. Increasing the completion rate of Diabetic Retinal Exams (DREs) will continue to be a priority as we remain in the 10th percentile nationally. To this end, Denver Health has purchased ten new retinal cameras for all primary care sites. Rollout of these cameras and associated trainings has begun with one DHHA clinic up and running and two additional clinics to be on boarded in the next month. Retinal cameras in all primary care sites will improve access for DHMP Members and contribute to an overall improvement in exam rates.

In FY20/21, DHMP will also develop and implement an integrated Population Health Management program for our Medicaid population with a focus area on diabetes management for our high risk patient population.

Performance Improvement Project (PIP)

The purpose of health care quality Performance Improvement Projects (PIPs) is to assess and improve processes and outcomes of care. States are required to conduct PIPs with Managed Care Organizations (MCOs). PIPs are designed to address deficits in health care delivery systems and are generally conceptualized by the state and implemented – through QI interventions – by health plans.

The most recent PIP cycle, a Rapid-Cycle PIP, began in September 2018, with a total timeframe of 18 months, and was scheduled to conclude on June 30, 2020. However, due to the impacts of the COVID-19 pandemic, the PIP was prematurely terminated in April 2020. HSAG chose a global PIP topic pertaining to Access to Care, with a focus on preventive and well care measures using HEDIS metrics. They further refined the population to be studied to adolescent Members due for an Adolescent Well-Care (AWC) check with DHMP choosing to further focus on Members age 15-18. DHMP's 2018 HEDIS rate for Adolescent Well Care (AWC), which measures annual well care attendance rates, was 36.33% for the MCD population and 37.64% in the CHP+ population, placing us in the 5th percentile and 10th percentile, respectively, for all health plans nationwide and highlighting the opportunity to improve completion of AWC visits across the organization. Additionally, this focus aligned with the State's Quality Strategy, which focuses on EPSDT-eligible children with emphasis on well care, depression screenings and individuals with special health care needs.

For this PIP, DHMP worked with the DHHA Webb Pediatric Clinic. The Webb Pediatric clinic historically has been an active partner in DHMP QI-based interventions and is the 2nd largest medical home by Member volume for pediatric Medicaid Choice and CHP+ Members. The specific goal for this PIP was, by June 30th, 2020, increase the percentage of DHMP Medicaid Choice and DHMP CHP+ Members aged 15-18 assigned to the Webb Pediatrics PCMH who attend at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner per year from 51.06% to 56.93% for the MCD population and from 54.36% to 66.44% for the CHP+ population. In order to achieve this goal, the QI team tested a series of interventions using PDSA cycles beginning in September 2019. These interventions included utilizing Healthy Communities to call the parent/guardian of members who had a birthday in that calendar month and were due for an AWC and scheduling an appointment for them and working with DHHA's 17 school-based health centers to have consented members receive an AWC at their assigned clinic. We had also hoped to test an intervention utilizing automated text messages sent to the parent/guardian of all MCD/CHP+ members who were overdue for an AWC but this was put on hold due to the suspension of AWC visits during the COVID-19 pandemic.

Our intervention testing began in September 2019 and concluded in March 2020. At that time our AWC

completion rate for MCD was 53.51%, below the MCD goal of 56.93% but a 3.42% improvement over our base line of 51.06% and for CHP+ was 62.50%, also below the CHP+ goal of 66.44% but an 8.14% improvement over our base line of 54.36%. Our key findings were that calls by Healthy Communities navigators resulted in a very modest increase in visits but that outreaching to members who were consented to be seen at one of our 17 school-based health clinics was a key driver in improving our completion rates (CHP+ rates improved from 59.73% to 63.54% in just one month). School-based health center outreach and scheduling began in February and was halted in March due to the COVID-19 pandemic but our early results suggested continued success in this intervention. We had also estimated that our text message intervention would also lead to another modest increase in AWC appointments completed. The QI team anticipates continuing our promising partnership with School-based Health Centers to complete Well-Child Exams when schools and their health centers are able to reopen as well as working with our ACS partners to reboot our text messaging intervention.

Asthma Measures

Denver Health Medicaid Choice Medication Management for People with Asthma (MMA)					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO Percentile ***	**HEDIS 2019-2020 Change**
5-11 Years - Medication Compliance 75%	21.62%	27.21%	28.57%	10th	1.36%
12-18 Years - Medication Compliance 75%	20.54%	19.42%	29.91%	10th	9.69%
19-50 Years - Medication Compliance 75%	33.11%	43.45%	38.10%	10th	-5.35%
51-64 Years - Medication Compliance 75%	47.83%	47.92%	61.90%	10th	13.98%
Total - Medication Compliance 75%	27.75%	33.10%	36.05%	10th	2.95%
5-11 Years - Medication Compliance 50%	41.22%	50.74%	63.39%	N/A**	12.65%
12-18 Years - Medication Compliance 50%	49.11%	42.72%	53.16%	N/A**	10.44%
19-50 Years - Medication Compliance 50%	64.19%	73.10%	61.90%	N/A**	-11.20%
51-64 Years - Medication Compliance 50%	76.09%	72.92%	73.81%	N/A**	0.89%
Total - Medication Compliance 50%	54.19%	58.80%	61.84%	N/A**	3.04%
Asthma Medication Ratio (AMR)					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO Percentile***	**HEDIS 2019-2020 Change**
5-11 Years - Asthma Medication Ratio	78.26%	58.87%	60.68%	50th	1.81%
12-18 Years - Asthma	64.80%	42.86%	48.94%	50th	6.08%

Medication Ratio					
19-50 Years Asthma Medication Ratio	55.79%	42.86%	38.95%	50th	-3.91%
51-64 Years - Asthma Medication Ratio	49.23%	39.19%	40.58%	10th	1.39%
Total - Asthma Medication Ratio	63.77%	46.60%	46.60%	50th	0.00%

** HEDIS 2019 national percentiles are listed above. 2020 percentiles to be released in late 2020.*

*** Percentiles for 50% Compliance not reported*

Denver Health CHP+ Medication Management for People with Asthma (MMA)					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO Percentile***	**HEDIS 2019-2020 Change**
5-11 Years - Medication Compliance 75%	N/A **	N/A **	N/A **	N/A **	N/A **
12-18 Years - Medication Compliance 75%	N/A **	N/A **	N/A **	N/A **	N/A **
Total - Medication Compliance 75%	N/A **	N/A **	N/A **	N/A **	N/A **
5-11 Years - Medication Compliance 50%	N/A **	N/A **	N/A **	N/A **	N/A **
12-18 Years - Medication Compliance 50%	N/A **	N/A **	N/A **	N/A **	N/A **
Total - Medication Compliance 50%	N/A **	N/A **	N/A **	N/A **	N/A **

**HEDIS 2019 national percentiles are listed above. 2020 percentiles to be released in late 2020*

***No rates were calculated due to an insufficient sample size*

****No percentiles are calculated for CHP+*

Analysis

Overall, our MCD Medication Management for People with Asthma rates have increased for both adherence at 50% and adherence at 75%. Despite this progress, DHMP fell from the 25th percentile overall to the 10th percentile due to adherence rates increasing nationally. DHMP's total Medication Compliance 75% measure

saw an almost 3% increase over the previous year. Similarly, the MCD Asthma Medication Ratio showed modest increases across most age bands and remained at a steady 46.60% overall. DHMP has not had an eligible CHP+ population for HEDIS since 2013. HEDIS asthma measure review continues to inform several opportunities for improvement. Collaboration between DHMP, DHHA's ACS Providers and the Asthma work group (AWG) resulted in several asthma interventions this past year:

Interventions

- The AWG and RN line utilizes a DHHA asthma-only telephonic line for Members needing assistance with asthma medication refills and triage. Members are also informed about the need to make an asthma assessment appointment with their PCP if they've refilled their rescue medication without refilling the appropriate number of controller medications
- ACS continues to utilize DHHA PNs to conduct a follow-up phone call within 48 hours of discharge from the ED or IP for pediatric Members with an asthma-related concern. PNs are tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a TOC flowsheet.
- Prior pharmacy refill and HEDIS data demonstrated that many asthmatics fill rescue asthma medications without filling the appropriate number of controller medications. The DHMP pharmacy team has directed more focus on the need to refill asthma controller medications on a consistent basis and will begin utilizing a pharmacy vendor tracking system in FY2020/2021 to streamline this process.

Action Plan

The DHMP QI team will continue to collaborate with the ACS QI asthma workgroup and DHMP Pharmacy team to analyze these metrics and develop interventions to address medication adherence. Priorities will include collaborating with DHMP Pharmacy and ACS on a process to obtain more complete pharmacy fill data for the Asthma Medication Ratio Metric, identifying members who have been filling rescue medications but not their prescribed controller medications. Beginning in FY2020/2021, the DHMP Pharmacy team will begin an intervention aimed at identifying members who have filled asthma rescue medications without filling the appropriate amount of controller medications and informing their care team that outreach is needed.

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)**	HEDIS 2018 Results (Medicaid Only)	HEDIS 2019 Results (Medicaid Only)	HEDIS 2020 Results (Medicaid Only)	HEDIS 2019 HMO Percentile (Medicaid Only)*	HEDIS 2019-2020 Change
Prenatal Care in 1st Trimester	64.59%	71.90%	91.73%	90th	19.83%
Postpartum Care (21-56 days)	49.06%	56.69%	Timeframe Change	***	***
Postpartum Care 7-84 Days after delivery* **	Timeframe New H2020	Timeframe New H2020	77.62%	90th	20.93%

**HEDIS 2019 national percentiles are listed in the following charts. 2020 percentiles to be released in late 2020.*
*** Prenatal and Postpartum Care (PPC) was submitted as a hybrid measure for H2020*
**** Prenatal and Postpartum Care (PPC) had a large change in the timeframe allowed for visits for H2020*

Analysis

HEDIS 2020 rates show a 19.83% increase in Prenatal Care in the 1st Trimester, and a 20.93% increase in Postpartum Care from HEDIS 2019. Prenatal and Postpartum Care (PPC) was submitted as a hybrid measure for H2020 which may have resulted in higher rates this year. There were also numerous changes to the PPC measure which may have impacted the rates. For Postpartum Care, the timeframe for a visit creating a numerator positive result changed from 21-56 days to 7-84 days. The Timeliness of Prenatal Care measure was also changed to allow for visits that occurred before the enrollment start date to be counted. Additional factors that may have contributed to the improvement in Prenatal Care rates are currently under evaluation by the Denver Health Perinatal Committee. These factors may include changes to provider templates to improve access to OB Intake visits. The continued improvement in Postpartum Care may also have been impacted by Denver Health's process of scheduling the postpartum visit for patients who deliver at Denver Health before they leave the hospital following delivery.

Action Plan for FY20/21

The DHMP QI team is collaborating with the DHHA Perinatal Committee on an ongoing basis to identify opportunities and best practice interventions to improve prenatal and postpartum rates. Ongoing efforts, through the Perinatal Quality Improvement workgroup are focused on improving the amount of OB intake visits that lead to improved engagement in ongoing prenatal care. Ongoing monitoring of process and impact are being performed.

Breast Cancer Screening

Denver Health Medicaid Choice Breast Cancer Screening Rates				
HEDIS 2018 Results (Medicaid Only)	**HEDIS 2019 Results (Medicaid Only)**	**HEDIS 2020 Results (Medicaid Only)**	**HEDIS 2019 HMO Percentile***	**HEDIS 2019-2020 Change**
50.65%	46.48%	46.01%	<10th	-0.47%

**HEDIS 2019 national percentiles are listed in the following charts. 2020 percentiles to be released in late 2020.*

Analysis

The 2020 HEDIS rate for Breast Cancer Screening (BCS) decreased by 0.47% from HEDIS 2019 and decreased below the 10th percentile (based on HEDIS 2019 percentiles).

To improve the rate of BCS, monthly mammogram mailers are sent to Members due for mammography. The mailer includes information on scheduling an appointment as well as a calendar for the women's mobile clinic. DHMP sent mammogram reminder mailers to 8,328 female Medicaid Members between July 1, 2019 and June 30, 2020. Of the patients who received mailers between July 2019 and May 2020, 672 Medicaid Members completed a mammogram during this time frame.

Through the Denver Health Cancer Screening Committee, DHMP QI team Members collaborated with the Women's Health team to develop more effective outreach strategies to engage Members in mammography screening. In recent months the mammogram mailer sent to Medicaid Choice Members was edited to include a Women's Health Care Navigator's name and phone number. In addition, the edited mailer now includes information on how Medicaid Choice Members can request transportation assistance.

Action Plan for FY2020-2021

Starting in March of 2020, the mailer intervention was adjusted in response to the COVID-19 pandemic. During

the initial part of the pandemic, the mammogram mailer intervention was put on hold due to required limitations for non-urgent radiologic services. Following the reopening of clinics for elective procedures, DHMP resumed sending mailers to all Medicaid Members who were due for a mammogram. Moving forward, lists of Members due for mammography will be generated on a monthly basis using claims and enrollment data. The Member population will be comprised of women 50 to 74 years old, as per HEDIS BCS specifications. Mailers will be sent to all members who are overdue for a Mammogram, and will be re-sent in 6 months if the Member has still not completed a mammogram at that time.

Due to changes to mammography services during the COVID-19 pandemic, the Women's Mobile Clinic discontinued direct outreach to Members who are due for mammograms in March of 2020. However, outreach will resume once the COVID-19 situation permits. Denver Health was planning to receive a new Women's Mobile Clinic in Q1 of 2020. However, the delivery of the Mobile Clinic was delayed and the delivery is anticipated for Q3 of 2020. Once the new Mobile Clinic is available, ACS is anticipating the implementation of a variety of technology interventions to improve BCS rates (e.g. patient self-scheduling in MyChart and automated text message reminders).

Cervical Cancer Screening

Denver Health Medicaid Choice Cervical Cancer Screening Rates				
2018 HEDIS Results (Medicaid Only)	**2019 HEDIS Results (Medicaid Only)**	**2020 HEDIS Results (Medicaid Only)**	**2019 HMO Percentile***	**HEDIS 2019-2020 Change**
43.03%	43.07%	45.58%	<10th	2.51%

**HEDIS 2019 national percentiles are listed in the following charts. 2020 percentiles to be released in late 2020.*

Analysis

The rates for Cervical Cancer Screening (CCS) increased by 2.51% in HEDIS 2020. In 2014, there were changes made to the CCS HEDIS specification which has resulted in lower CCS rates over the past several years. Efforts have been made to collaborate with Denver Health Ambulatory Care Services to align cervical screening guidelines at Denver Health with HEDIS specifications. Information regarding cervical cancer screening guidelines was added to the monthly mammogram mailer so that women scheduling a mammogram would also be reminded to schedule their cervical cancer screening. However, work is underway to move this information will be moved to a separate mailer in the latter part of 2020.

Action Plan for FY2019-20

QI plans to work with the Denver Health Cancer Screening Workgroup to develop and implement ongoing interventions aimed at increasing cervical cancer screening. QI is discussing opportunities to capitalize on other interventions that target Medicaid population and maximize outreach efforts.

Due to changes to mammography services during the COVID-19 pandemic, the Women's Mobile Clinic discontinued direct outreach to Members who are due for mammograms and other women's health screenings in March of 2020. However, outreach will resume once the COVID-19 situation permits. Denver Health was planning to receive a new Women's Mobile Clinic in Q1 of 2020. However, the delivery of the Mobile Clinic was delayed and the delivery is anticipated for Q3 of 2020. Once the new Mobile Clinic is available, ACS is anticipating the implementation of a variety of technology interventions to improve Women's health screening rates including cervical cancer screening rates (e.g. patient self-scheduling in MyChart and automated text

message reminders.)

Early Periodic Screening Diagnostic Testing (EPSDT)

DHMC established an EPSDT Program to address EPSDT contract requirements. DHMP has dedicated staff members who track and monitor EPSDT and plan interventions. DHMP uses the EPSDT and HEDIS results to identify and prioritize interventions.

As of January 2013, the EPSDT committee was rolled into the Ambulatory Care Quality Improvement Pediatric Preventive Work Group. This committee includes physician leadership from Denver Health and meets on a monthly basis to provide ongoing support and feedback on existing interventions.

CMS 416-EPSDT

Denver Health Medicaid Choice has well-child guidelines that are reviewed annually to be in compliance with contract requirements. Denver Health Medicaid Choice reports EPSDT screening ratios according to the CMS 416 form specifications and reports annually to the Colorado Department of Healthcare Policy and Financing (HCPF). EPSDT Screening Ratios are the percentage of Members who had expected number of initial and periodic screenings per age group; adjusted by the proportion of the year for which they are Medicaid eligible for DHMC.

CMS 416 Report Screening Ratios			
Age-Groups Screening Ratio	**EPSDT 10/1/16 - 9/30/17**	**EPSDT 10/1/17 -9/30/18**	**EPSDT 10/1/18 -9/30/19**
< 1 year	0.89	1.00	1.00
1-2 years	0.95	1.00	1.00
3-5 years	0.70	0.52	0.51
6-9 years	0.50	0.39	0.36
10-14 years	0.51	0.40	0.38
15-18 years	0.39	0.32	0.31
19-20 years	0.11	0.07	0.07
TOTAL	**0.60**	**0.58**	**0.58**

Analysis

The overall percentage of EPSDT participant remained the same from the 2017/2018 to the 2018/2019 reporting period. Although the screening ratio decreased for some age groups, the overall screening ratio remained the same.

Lower screening ratios are typically associated with older ages. This is evidenced by the low percentage of screening ratios continually seen in the 15-20 year old age groups. As a result of these lower screening ratios, Denver Health Medical Plan continues to collaborate with ACS to drive Adolescent Well-Care (AWC) rates. Additionally, AWC exams for patients' ages 15-18 years old was selected as the topic for our current Performance Improvement Plan (PIP). For this PIP, DHMP is working with the DHHA Webb Pediatric Clinic to test a series of interventions aimed at improving AWC rates for the MCD and CHP+ populations in the hopes that this work will lead to improvements and best practices that can be implemented enterprise wide.

Bright Futures Periodicity Schedule

Due to a need for improved granularity of results for EPSDT monitoring and opportunity identification, an ACS Bright Futures dashboard was created in 2019 to help monitor and improve these metrics. This system-wide

pediatric view includes: Pediatric Vaccinations- Combo 10. Pediatric Vaccinations – Combo 7, Adolescent Vaccinations, Dental Visit or Fluoride application once by 18 months, Persistent Asthma on Controller medication 2-18 years, Developmental Screening 12-36 months, MCHAT screening, Six Well-Child visits before 15 months, Well-Child visit rate – 3-6 years of age, Well-Child visit rate – 3-9 years of age, Well-Child visit rate 10-18 years of age, Primary Care 30-day Utilization – Pediatrics, Measles Vaccination Rate at 2-years old, Depression Screening/Monitoring at Visit – Adolescents, Hearing Screening – pediatrics, Vision Screening-Pediatrics, Chlamydia Screening – Adolescents, HIV Screening – Adolescents, Lead Screening – Pediatrics, Cholesterol Screening-Pediatrics, Anemia Screening – Pediatrics, and Chlamydia Screening at Visit. The dashboard provides a comprehensive view of these metrics for all clinics including Provider-level performance on each metric. The DHMP QI team will continue to monitor performance on these metrics and evaluate the data for opportunities for improvement.

Interventions FY2019/2020

All QI interventions that address well-child visits also include Medicaid Choice Members. Activities to increase well-child visits outlined and evaluated under the HEDIS related measures are dual efforts to improve EPSDT scores. Emphasis will continue to be placed on Members completing recommended visits and screenings through our SBHC intervention as well as collaboration with Healthy Communities to drive well-child visit rates. DHMP QI will also continue to present data findings and intervention progress to the Denver Health Ambulatory Care Services Pediatric QI Workgroup. Furthermore, we aim to ensure that data collection accurately reflects the number of completed EPSDT screenings. We will use encounter data, 416 CMS report data, and other data sources to identify gaps in care and ultimately address areas of need by developing or improving current interventions.

EPSDT Staff/Member Education

Members were notified about EPSDT benefits in several ways. Member Handbooks and Member Newsletters were sent to new Members. EPSDT informational brochures are available in both English and Spanish. The QI department regularly communicated the availability of the EPSDT benefits to Medicaid Choice Members through mailings and Member newsletters. Staff was educated about the EPSDT program on an as needed basis if there are changes or amendments to the existing benefit. DHMP also created an EPSDT page on the Denver Health Medicaid Choice website providing information to Members on EPSDT services, and how to obtain additional information if needed.

EPSDT Provider Education

Providers were informed about EPSDT through an annual training from the State of Colorado through the DHHA cornerstone training portal. In compliance with a HSAG recommended action, EPSDT training will be made available to Providers twice a year

EPSDT Reimbursement

EPSDT reimbursement was capitated when provided within Denver Health system and was based upon the Medicaid fee schedule when services are provided outside of the Denver Health system.

Barriers to Care

DHMP strived to identify barriers that impede Members from accessing appropriate services. Members may have other barriers that Denver Health is not aware of, so all Member mailings included the Member Services phone number detailing how this department could provide assistance with transportation, making an appointment or answering questions.

Action Plan for FY 20-21

DHMP is continuing collaboration with ACS via the Pediatric Quality Improvement Workgroup in order to address issues in accessing well-care services. Well-care is a focus of the QI department and will be an area of further development and evaluation. DHMP QI will continue working with SBHC to provide targeted well-child lists in order to identify those children in need of well care. Furthermore, DHMP partners with Healthy Communities by providing monthly lists of children who need to be scheduled for a well-care visit. Upon receiving the monthly list, Healthy Communities conducts outreach to Members and then returns the list to DHMP with outreach outcome information. Finally, DHMP will continue to monitor Provider activities and have discussions with ACS management to optimize the process for operationalizing wrap-around benefit and care coordination tracking processes at the clinic level.

Guidelines

Periodic screening is a method used to determine a child's mental and physical growth progress and to identify a disease or abnormality. Screening identifies additional diagnosis and treatments of physical and emotional problems. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Denver Health periodicity schedule. The periodicity schedules describes the intervals at which preventive physical, sensory, developmental and behavioral screening, including vision; hearing and dental services shall be performed for enrolled children and youth age 20 and under. The periodicity schedule also includes the recommended frequency of follow-up examinations.

Denver Health Medicaid Choice implements a periodicity schedule for screening services based on the American Academy of Pediatrics (AAP) Bright Futures Guidelines for Members from birth up through age 18 in the pediatric clinics. For Members ages 19 to 20, Denver Health Medicaid Choice follows the adult preventive care guidelines provided by the U.S. Preventive Service Task Force (USPSTF) and the National Institutes of Health (NIH). Denver Health Medicaid Choice follows the recommended immunization schedule provided by the Centers for Disease Control and Prevention (CDC) guidelines.

Childhood Preventive Measures

Denver Health Medicaid Choice Childhood Immunization Status (CIS)**					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
DTaP	75.43%	69.47%	70.80%	10th	1.33%
MMR	78.62%	79.93%	82.97%	10th	3.04%
OPV/IPV	84.68%	79.93%	82.00%	10th	2.07%
H Influenza type B (HiB)	84.72%	80.53%	82.00%	10th	1.47%
Hepatitis B	80.72%	82.53%	84.91%	10th	2.38%
Chicken Pox – VZV	83.67%	80.05%	82.97%	10th	2.92%
Pneumococcal Conjugate	74.03%	67.97%	70.32%	10th	2.35%
Hepatitis A	81.10%	79.39%	82.00%	25th	2.61%
Rotavirus	67.65%	62.56%	63.99%	10th	1.43%
Influenza	50.31%	51.50%	54.50%	50th	3.00%
Combo 2	68.27%	67.97%	70.56%	25th	2.59%

Combo 3	65.94%	64.72%	67.15%	25th	2.43%
Immunization for Adolescents (IMA)					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
Meningococcal	77.37%	79.43%	80.93%	25th	1.50%
Tdap/TD	81.92%	78.92%	80.65%	10th	1.73%
HPV	50.39%	50.98%	52.40%	90th	1.42%
Combo 1	75.69%	76.89%	78.06%	25th	1.17%
Combo 2	47.30%	49.46%	50.47%	90th	1.01%
Well-Child Visits (W15, W34, AWC)					
Measure / Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 change**
0-15 Months (6+ visits)	4.39%	52.28%	55.57%	<10th	3.29%
3-6 y/o (annual visit)	60.91%	63.59%	64.53%	<10th	0.94%
12-21 y/o (annual visit)	36.33%	41.29%	40.10%	<10th	-1.19%

**HEDIS 2019 national percentiles are listed in the following charts. 2020 percentiles to be released in late 2020.*
***Immunization measures were submitted with hybrid data for H2020*

Denver Health CHP+ Childhood Immunization Status (CIS) **					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
DTaP	BR***	69.84%	82.26%	75th	12.42%
MMR	BR***	78.57%	93.55%	90th	14.98%
OPV/IPV	BR***	75.40%	96.77%	95th	21.37%
H Influenza type B (HiB)	BR***	74.60%	95.16%	95th	20.56%
Hepatitis B	BR***	73.81%	100%	95th	26.19%
Chicken Pox – VZV	BR***	78.57%	93.55%	90th	14.98%
Pneumococcal Conjugate	BR***	69.05%	85.48%	90th	16.43%
Hepatitis A	BR***	80.16%	93.55%	95th	13.39%
Rotavirus	BR***	66.67%	87.10%	95th	20.43%
Influenza	BR***	53.17%	64.52%	90th	11.35%
Combo 2	BR***	67.46%	82.26%	95th	14.80%
Combo 3	BR***	65.87%	82.26%	95th	16.39%
Immunization for Adolescents (IMA)					
Measure/Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**

Meningococcal	71.56%	84.21%	91.14%	90th	6.93%
Tdap/TD	85.32%	85.53%	87.97%	25th	2.44%
HPV	56.88%	57.24%	55.70%	90th	-1.54%
Combo 1	68.81%	82.24%	87.34%	75th	5.10%
Combo 2	49.54%	55.92%	53.80%	95th	-2.12%
Well-Child Visits (W15, W34, AWC)					
Measure / Data Element	**HEDIS 2018 Rates**	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
0-15 Months (6+ visits)	N/A	63.64%	66.67%	50th	3.03%
3-6 y/o (annual visit)	46.64%	64.74%	71.33%	25th	6.59%
12-21 y/o (annual visit)	37.64%	45.30%	52.41%	25th	7.11%

**HEDIS 2019 national percentiles are listed in the following charts. 2020 percentiles to be released in late 2020.*
***Immunization measures were submitted with hybrid data for H2020*
****BR: "Biased Rate" – unreportable rate due to bias.*
***** N/A – small population size. No rate computed.*

Immunizations

Overall the childhood immunization rates for Medicaid members increased slightly from HEDIS 2019. Rate increases ranged from 1.33% for the DTaP series to 3.00% for the Influenza vaccine. Adolescent immunization (IMA) rates for Medicaid members also increased slightly with increases ranging from 1.01% for IMA Combo 2 to 1.50% for the Meningococcal vaccine.

The childhood immunization rates for CHP members showed much greater increases ranging from 11.35% for the Influenza vaccine to 20.43% for the Rotavirus vaccine. Outcomes for adolescent immunization (IMA) rates for CHP+ members were more mixed with changes ranging from a decrease of 2.12% for IMA Combo 2 to an increase of 6.93% for the Meningococcal vaccine.

It should be noted that for H2020, CIS rates are hybrid rates for both Medicaid and CHP+. Historically, several sources have been identified as potential operations and data issues. These pertain to coding, file formatting and immunization schedule differences between DHMP and ACS:

- DHMP receives a yearly file from a CDPHE database listing the applicable Members and their immunization history. This file is used in conjunction with claims and Epic data to compute HEDIS immunization measures. Historically, the influenza vaccine rate dropped 8.21% from 2017-2018. This was thought partially due to a vaccine name change in DHHA's Epic system, resulting in coding discrepancies in DHMP claims data. This name change has also been addressed and rectified for HEDIS 2019 submissions. In advance of H2020 submissions, the DHMP HEDIS team completed additional coding mapping for immunizations which may have resulted in improved data capture.
- Immunizations may also be administered in clinics without an applicable claim sent to DHMP resulting in incomplete capture of immunizations in administrative data-based measures. In advance of H2020 submissions, the DHMP HEDIS team completed additional off season review which may have improved rates for H2020.
- Overall drops in immunization scores have been observed since HEDIS 2017 (CY 2016). This has been concurrent with the implementation of Epic system and a change to an 'administrative data only' reporting specification. However, a decreasing trend in ACS vaccination rates has also been noted. The DHMP QI team participated in targeted meetings and Lean events in July of 2019 to evaluate the

decrease in Combo 7 rates. Intervention planning for improving the timing and frequency of visits to increase the rate of Combo 7 is ongoing.

- HEDIS 2017 (CY 2016 data) marked the first year of administrative-only data for Medicaid. Immunizations provided that did not produce claims to DHMP would not be recognized. Hybrid review rates for MCD / CHP+ were made available, but only administrative data was published.
- ACS Providers are required to follow the UDS immunization timeframe requirement for all immunizations to be received in the first three years of life. HEDIS requires immunizations occur in the first two years of life. This creates a schedule discrepancy with some vaccines falling outside HEDIS measure timeframes.

As a system, immunization data is improving. Denver Health has historically and consistently performed well in immunization scores. ACS Providers and staff are diligent in reviewing immunization records with Members and educating them on the benefits of prevention. Data collection issues between State databases, Epic and claims data have been readily acknowledged and collaborative solutions between multiple DHHA departments have been initiated. Additionally, the greater system experience by DHHA Providers in Epic will continue to improve documentation and coding for HEDIS. The DHMP QI department attends the ACS Medical Immunization Workgroup and has brought to light these data challenges and vaccine schedule variability.

Following the Lean events regarding immunizations in July of 2019, ACS implemented a variety of interventions aimed at improving immunization rates. These interventions included reminder calls and letters to members coming due or overdue for childhood vaccinations. These interventions may be partially responsible for the increases in immunization rates for HEDIS 2020.

Well Child Visits

Rates for Medicaid well child visits for members in the 0-15 months and 3-6 years age range showed modest increases from HY2019-2020 while adolescent well care visits (ages 12-21) showed a slight decrease. All three of these measures are currently below the 10th percentile nationally, highlighting the need for more robust improvement activities. Rates for CHP+ Well Child Visits continue to outperform MCD and increased year over year for all three age groups (0-15 months, 3-6 years and 12-21 years). Nationally, the rates for well visits for the 0-15 month measure increased to the 50th percentile and rates for both the 3-6 year old and 12-21 year old measures increased to the 25th percentile.

Healthy Hero Birthday Cards

In an effort to reach Members ages 19 and under, DHMP QI and Marketing sends annual birthday cards monthly to children ages 2 through 19 that provide a checklist with information on healthy eating, development, vaccines and physical activity. The birthday cards are intended to provide visit reminders as well as prepare and educate children and parents on what will happen at upcoming well child visits. The card for Medicaid Choice Members also included the contact information for Healthy Communities and how to schedule an appointment through Healthy Communities. For FY2019-2020, the DHMP mailed an average of 2,663 birthday cards a month to Medicaid Choice Members and an average of 387 birthday cards a month to CHP+ Members. As a result of the COVID-19 pandemic, Healthy Heroes reminder cards were not sent for April and May as most DHHA clinics were not scheduling non-essential visits.

Healthy Communities Outreach:

To address the historically low rates of well-child and well-care visits Healthy Communities navigators conducted outreach calls to schedule Members for well-child and adolescent well-care visits. In FY2019-2020, navigators made 870 outreach calls to MCD and CHP+ members. Due to state budget cuts, Healthy Communities will not

operate during FY20/21 and DHMP will explore other opportunities to outreach to members to encourage scheduling well child visits.

Action Plan for FY 2019-2020

QI will continue to focus on improving rate of completion for annual well child visits. The QI Department participates in the Pediatric Quality Improvement Workgroup, and will continue to bring issues to the group to improve well-child and well-care rates. Furthermore, in FY20/21, DHMP will also develop and implement an integrated Population Health Management program for our MCD population with a focus area on promoting wellness and improving the percent of children and adolescents (ages 0-21 years) who receive an annual well-child visit. DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit.

School Based Health Centers

Denver Health Medicaid Choice and CHP+ Members have access to 18 SBHCs within Denver Public elementary, middle, and high schools. SBHCs provide a variety of services such as well child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral health care services. DHHA and DHMP continue to encourage eligible Members to access care through our network of SBHCs. This information is sent directly to Member households in newsletters and is also available on the DHMP Member website. In addition, the DHHA appointment center utilizes a process that alerts schedulers of a SBHC enrolled student which will prompt them to schedule the child at a SBHC for their clinic needs.

DHMP also worked closely with the Director of School-based Health during our Performance Improvement Project (PIP) (described in detail above) to refine a process to identify members who are consented to receive their care at SBHC and are due for their annual wellness exam. Lists of these members are sent to the SBHC Program Manager for distribution to the respective school clinics. Members can then be directly scheduled for an annual exam by clinic staff. As a result of the COVID-19 pandemic, this pilot was only in operation for a little over a month but we were able to see rates in our pilot CHP+ population improve from 59.73% to 63.54% suggesting that continuing this partnership would have been successful. To that end, DHMP hopes to continue piloting and potentially expanding this intervention when DPS schools open for in person learning and SBHC are able to reopen safely.

Action Plan FY20/21

DHMP QI staff will continue to collaborate with the Pediatric Quality Improvement Workgroup and SBHC team to develop interventions to improve health care outcomes for pediatric Members. In FY20/21, 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. When DPS schools open for in person learning and SBHC's are able to reopen safely, DHMP hopes to continue our growing partnership with the SBHC program to identify members who are consented to be seen at a SBHC and facilitate ensuring that they are scheduled to receive their annual wellness exam at the appropriate clinic.

Weight Management Measures

Denver Health Medicaid Choice Adult BMI Assessment (ABA)				
HEDIS 2018 Rates	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
83.25%	81.44%	92.46%	25th	11.02%

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS 2018 Rates	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
BMI Percentile Documentation				
16.75%	21.89%	25.11%	<10th	3.22%
Counseling for Nutrition				
5.97%	7.45%	9.16%	<10th	1.71%
Counseling for Physical Activity				
1.36%	5.90%	8.08%	<10th	2.18%

Denver Health CHP+ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS 2018 Rates	**HEDIS 2019 Rates**	**HEDIS 2020 Rates**	**HEDIS 2019 HMO %tile***	**HEDIS 2019-2020 Change**
BMI Percentile Documentation				
17.71%	21.80%	23.81%	<10th	2.01%
Counseling for Nutrition				
6.41%	7.93%	8.31%	<10th	0.38%
Counseling for Physical Activity				
1.40%	6.65%	7.41%	<10th	0.76%

**2019 percentiles listed. 2020 percentiles to be released in late 2020*

The administrative-only reporting for HEDIS 2018 also resulted in decreased measures for the Weight Assessment and counseling for Nutrition and Physical Activity (WCC) HEDIS measure. This measure records the frequency at which BMI percentile and nutrition / physical activity anticipatory guidance is documented during a well-child visit. Previously, this measure was a hybrid review and the DHMP HEDIS team conducted medical record review, eliminating the need to analyze the medical coding behind the encounter data. DHMP anticipated the drop in the WCC measure for HEDIS 2018, given the historical lack of encounter coding for these data elements.

The DHMP QI Team maintained an active presence at all of the ACS Workgroups and pertinent HEDIS data is presented on a consistent basis. The DHMP QI Team also attended the Weight Management Workgroup until meetings for this workgroup were put on hold by ACS in early 2020. ACS has not yet set a date to resume these meetings. We look forward to developing new interventions to target and evaluate current progress towards reducing pediatric and adult obesity rates.

Active interventions addressing obesity rates include:

- A Healthy Heroes birthday card is sent every month to eligible pediatric MCD / CHP+ Members to encourage follow-up well-visits with the Member's PCP.
- The DHMP Marketing Department publishes articles regarding healthy eating, encourage exercise and encourage maintaining a healthy lifestyle.
- Working with ambulatory epic analysts to customize automated coding and billing options for anticipatory guidance and BMI documentation.

- Data interventions focusing on the improvement of HEDIS data capture in DHMP claims and coding in DHHA's Epic system. Changes to EPIC to help improve data capture for the above pediatric measures were implemented Q4 2019. We anticipate improvements to the rates for these measures in MY 2020 due to the improved data capture.

Clinical and Preventive Health Care Guidelines

The DHMPQMC reviews and approves preventive care guidelines annually, per contract. The purpose of preventive health guidelines is to help with the prevention or early detection of illness and disease and to promote wellness and appropriate self-care for Members. DHMP has preventive guidelines for all ages of life. These are based on a variety of scientific evidence and established through the knowledge of practitioners involved in the care of a given condition. Denver Health Medicaid Choice and CHP+ will provide all Members including Members with disabilities with the same preventive health services.

Denver Health Medicaid Choice Preventive Care Guidelines

- Perinatal Care
- Pediatric and Adult Immunization
- Well Child Visit Guidelines
- Adolescent Health Guidelines
- Clinical Preventive Health Recommendations for Adults
- Fall Prevention Guideline for 65+

DHMP CHP+ Preventive Care Guidelines

- Well Newborn Care
- Pediatric and Adult Immunization
- Well Child Visit Guidelines
- Adolescent Health Guidelines

The DHMP QMC annually reviews and approves clinical practice guidelines. The purpose of clinical practice guidelines is to provide recommendations for practitioners to guide them through essential components of disease management. These guidelines standardize routine care of patients to reduce the progression of illness and complications. These guidelines are not intended to set legal standards of care.

Denver Health Medicaid Choice Clinical Guidelines

- Diabetes Management
- Management of Asthma in Adults and Children
- ADHD in Pediatrics
- Treatment of Depression in Adults

DHMP CHP+ Clinical Guidelines

- Management of Asthma in Adults and Children
- ADHD in Pediatrics

Activities planned for 2020/2021

- Review guidelines according to schedule and revise as appropriate.
- Guidelines are reviewed annually and updated as required, per contract by the DHMP QMC and consistent with other DHHA clinical guideline initiatives and health plan benefits.

Care Coordination

Care Coordination uses the process of identifying, screening and assessing members' needs, identification of and referral to appropriate services, and coordinating and monitoring an individualized treatment plan. This treatment plan shall also include a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

Care Coordination manages and identifies persons with special health care needs, specifically as persons having ongoing health conditions that:

- Have a biologic, psychologic or cognitive basis
- Significant limitation in areas of physical, cognitive or emotional function
- Dependency on medical or assistive devices to minimize limitation of function or activities
- For children:
    - Significant limitation in social growth or developmental function
    - Need for psychologic, educational, medical or related services over and above the usual for the child's age
    - Special ongoing treatments such as medication, special diets, interventions or accommodations at home or at school.

Care Coordination also assists members requiring health care services from multiple providers, facilities and agencies, to obtain those services and to coordinate with behavioral health organizations, specialty services, and social services provided through community agencies and organizations. Community referrals are created and tracked in the medical management software system. Referrals are also used to promote continuity of care and cost-effectiveness of care.

2019-2020 Care Coordination Transition

DHMP completed all CC activity and oversight in-house for the year ending 2018. In the beginning of January 2019, DHMP did outsource the Care Coordination departments, which included, Complex Case Management, Medicare Advantage D-SNP Choice HMO, Transitions of Care, Care Coordination, and Population Health (Disease Management). The full outsourcing of activities was to be completed by June 2019. The vendor unexpectedly withdrew from the established contract and scope of work in April and the contract with HI/EXL was terminated on December 31st 2019**.** DHMP leadership decided to retain CC services and develop the CCM and TOC Programs in-house after the contracts termination. As of August 2019 the CC Programs were back under the management of DHMP.

Complex Case Management (CCM)

This care coordination program was developed in August 2019. The DHMP CCM Program is available to members enrolled in any of the DHMP plans. The Program addresses the complex medical, behavioral and/or psychosocial needs of members by providing personalized case management services and goal-setting. DHMP's CCM Program is intended to empower members who have complex medical needs and require a wide variety of resources to manage their health, improve their quality of life and take control of their health care needs. DHMP does so by coordinating quality health care services and optimizing benefits through a case management plan. CCM Care Managers collaborate with members to set Specific, Measurable, Attainable, Relevant and Timely (SMART) goals. These Care Managers are Licensed Clinical Social Workers (LCSWs), LPNs and Registered Nurses (RNs); LCSWs and LPNs work under the supervision of an RN.

CCM Metrics – DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Complex Case Management Metrics	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun
CCM Referrals	8	19	6	6	10	8
CCM Actively Managed	23	30	26	33	28	27
CCM Graduated	3	5	0	0	1	0
CCM Member Calls	158	135	550	118	129	146
CCM Member Assessments	10	51	6	7	14	15
CCM Care Coordination Tasks	26	32	33	29	3	290

Transitions of Care (TOC)

This care coordination program was developed in August 2019. The DHMP TOC Program is a keystone program to ensure that members transitioning out of an in-patient setting are appropriately connected to resources, information, and support. The TOC team contacts all members that have been discharged from an in-patient setting within 48 hours to offer support. The program is an opt-in care coordination program that lasts for 30 days. Outreach is done at a minimum of once a week (dependent on member need) and assessments are completed to determine readmission risk and to develop an individuated care plan with the member. At the completion of the 30 days, the TOC nurse will either graduate the member or refer the member on to our care coordination team or the complex care management team for more follow up and support. Care coordination activities provided by the TOC include but are not limited to:

- In-network PCP coordination if not already established
- Appointment reminders – PCP and specialty visits
- DME
- Home Health
- Prescriptions/pharmacy
- Disease Management
- Education
- Transportation

TOC Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Transitions of Care Metrics	20-Jan	20-Feb	20-Mar	20-Apr	20-May	20-Jun
TOC Member Outreach	626	893	687	1117	1175	1245
TOC Care Coordination Activities	311	240	332	298	352	541
Hospital Readmissions W/I 30 days	3	5	12	4	2	7
TOC Referrals	160	161	134	129	133	184
TOC Members Graduated	11	38	26	27	21	33

TOC Members Lost to Follow	4	14	17	20	19	16
TOC Opt-Out	7	8	7	5	8	17
TOC Did not meet/Disenrolled	5	18	13	8	5	4
TOC UTR (Unable to Reach)	129	75	63	66	71	77

Medicaid Care Coordination Program

This Care Coordination program was developed in February 2020. This program is intended to manage high risk Medicaid members with multiple risk factors including chronic diseases, behavioral health conditions and over and under-utilization patterns that increase risk of poor outcomes. Member are referred to this program through multiple methods, including provider and internal referrals, member responses to Health Needs Survey, but the majority are identified using a risk stratification tool created with data from physical and behavioral health claims to identify a list of known risks factors. The program creates individualized care plans but will also target specific gaps such as frequent ED utilization or no PCP visit in the last 12 months, with targeted population campaigns.

Care coordination activities provided by the Medicaid Care Coordination Program include but are not limited to:

- Community Resources Assistance
- Condition/Disease Management
- Education
- Health Acuity/Needs
- Medication Management
- Health Care Provider Coordination
- Transportation
- Appointment Reminders
- Meal Coordination
- Applications/Membership Assistance

Care Coordination Program Metrics - Program Effective 2/20/2020	February-20	March-20	April-20	May-20	June-20
CC Member Education	2	6	-	1	-
CC Member Community Resources	3	9	18	28	14
CC Member Provider Support	-	1	30	54	9

CC Member Disease Management/Health Acuity	10	33	23	35	24
CC Applications/Membership Assistance	-	-	1	7	-
CC Medication Management	-	-	1	5	-
CC COVID-19 Outreach	-	-	498	639	112
CC Member Outreach (Started 8/24/20)	-	-	-	-	-
CC Member Outreach - Calls	15	49	571	769	159

Medicaid CC Program Metrics:

COVID-19 Member Outreach Program

COVID-19 emergency planning and program implementation was initiated across the state of Colorado. The onset of COVID-19 necessitated Denver Health Medical Plan to pivot and respond to the pandemic, which impacted programming and services across the company. Meetings, interactions, and services with community partners were also impacted. DHMC made accommodations going forward to address care coordination and interacting with members and community partners to keep everyone safe while still ensuring quality care. Planned work in several areas was put on hold to allow for more staff capacity to implement COVID-related programming such as pharmacy programs, direct mailings, and care coordination outreach. The restrictions placed on in-person interactions significantly reduced direct interactions with DHMP members; however, the advent of telehealth services has been a success in maintaining member interactions with providers. Care Coordination started the outreach program in April 2020.

COVID-19 Metrics

COVID-19 Metrics - Program Effective 4/1/20	20-Apr	20-May	20-Jun	20-Jul
DSNP COVID-19	44	75	26	14
DSNP TOC COVID-19	14	9	3	2
CC COVID-19	498	639	112	-
CCM COVID-19	-	2	-	-
DOC COVID-19	12	3	4	9
TOC COVID-19	104	133	55	8
TOTAL COVID-19 Member Outreach - Calls	**672**	**861**	**200**	**33**

ACS Quality Improvement and Ongoing Monitoring

DHHA has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services to promote cost effective quality health care services for all patients, regardless of payer. DHHA tracks a number of quality indicators including patient experience data to monitor ongoing clinic performance. Areas of focus include, but are not limited to preventive health care, chronic disease management, access and availability of health services, patient satisfaction, and the promotion of excellence in staff performance. The selection and prioritization of these quality measurements is developed with partnership with the Ambulatory Quality Improvement Committee (QIC) and the Ambulatory Care Service (ACS) Central Management Team (CMT). AQIDC oversees 15 condition-focused QI workgroups (e.g. CVD, diabetes, perinatal care, immunization, etc.) who are responsible for identifying priorities for their specialty, developing and monitoring QI indicators, and proposing interventions to improve care in their area of expertise. Through QIC, the QI/PI Program assesses performance for indicators on a monthly basis.

DHHA utilizes an ambulatory score card to measure all areas within the outpatient setting. Organizational targets are based off industry standards and previous year's performance. The outcomes presented reflect the percentage of patients that meet the standard. The whole number located in the bottom right of each cell represents the dominator of that metric (i.e., the number of patients within the clinic that meet the measurement parameters). The score cards are reviewed on an ongoing basis with clinic and executive leadership in the form of regular Gemba walks. The Gemba walks are used to explain the individual measures and discuss ongoing efforts surrounding performance improvement plans. A monthly update is also publish to update the Denver Health leadership and providers of the progress of Strategic Metrics.

DHHA QI is also monitored by payer/line of business. For the purposes of this analysis, the DHMP Medicaid Choice and CHP+ populations are measured against DHHA's all patients and internal organizational wide targets. Below, DHHA strategic measures are included as well as pediatric measures for CHP+.

DHHA all patients:

Ambulatory Quality Scorecard Summary

Strategic Metrics | June 2020

			Diabetes A1c <=9	Diabetic Medical Attention for Nephropathy	Hypertension BP Controlled	Breast Cancer Screening	Cervical Cancer Screening	Colorectal Cancer Screening	Persistent Asthma on Controller Meds 5-64 yrs	Peds Vaccinations Combo 7	First Trimester Entry into Prenatal Care**	Depression Screen and Follow-up Plan if Positive	Chlamydia Screening at Visit 14-24 yrs	Ambulatory Quality Strategic Index
			77%	91%	68%	68%	77%	66%	75%	73%	73%	70%	67%	12 pts
CHS	Overall	Total	68.76%	86.9%	64.05%	55.47%	67.17%	54.76%	75.82%	71.68%	68.13%	61.07%	77.91%	7 pts
			9,944	9,944	24,286	14,984	46,299	27,543	4,525	3,118	2,203	84,750	2,856	

Medicaid – Strategic Metrics:

			Diabetes A1c <=9	Diabetic Medical Attention for Nephropathy	Hypertension BP Controlled	Breast Cancer Screening	Cervical Cancer Screening	Colorectal Cancer Screening	Persistent Asthma on Controller Meds 5-64 yrs	Peds Vaccinations Combo 7	First Trimester Entry into Prenatal Care**	Depression Screen and Follow-up Plan if Positive	Chlamydia Screening at Visit 14-24 yrs	Ambulatory Quality Strategic Index
			77%	91%	68%	68%	77%	66%	75%	73%	73%	70%	67%	12 pts
CHS	Overall	Total	64.44%	85.34%	63.46%	51.4%	64.53%	50.22%	75.85%	70.97%	64.33%	61.96%	79.37%	7 pts
			1,842	1,842	4,962	2,938	12,311	5,585	1,818	1,674	771	21,786	1,197	

CHP+ Strategic Metrics:

			Diabetes A1c <=9	Diabetic Medical Attention for Nephropathy	Hypertension BP Controlled	Persistent Asthma on Controller Meds 5-64 yrs	Peds Vaccinations Combo 7	First Trimester Entry into Prenatal Care**	Depression Screen and Follow-up Plan if Positive	Chlamydia Screening at Visit 14-24 yrs	Ambulatory Quality Strategic Index
			77%	91%	68%	75%	73%	73%	70%	67%	12 pts
CHS	Overall	Total	0.0%	0.0%	75.0%	74.67%	82.86%	42.86%	67.57%	71.23%	7 pts
			2	2	4	75	105	7	808	73	

CHP+ Non-Strategic Metrics:

Ambulatory Quality Scorecard Summary

Peds Metrics | June 2020

		Chlamydia Screening at Visit 14-24 yrs	Peds Vaccinations Combo 10	Peds Vaccinations Combo 7	Adolescent Vaccinations	Dental Visit or Fluoride Application, 1x by 18 mos	Persistent Asthma on Controller Meds 2-18 yrs	Developmental Screening, 12-36 mos	MCHAT Screening	Six Well Child Visits Before 15 Months	Well Child Check Rate 3-6 year olds	Well Child Check Rate 3-9 year olds	Well Child Check Rate 10-18 year olds	Depression Screen and Follow-up Plan if Positive - Adolescents	Measles 2 yr olds
		67%	60%	73%	80%	75%	75%	85%	90%	79%	78%	76%		70%	
Overall	Total	71.23%	61.9%	82.86%	91.2%	96.3%	76.83%	93.06%	89.52%	55.93%	71.98%	67.7%	61.5%	68.55%	100.0%
		73	105	105	875	27	82	144	105	118	678	1,133	1,543	760	105

	Measles 4-6 yr olds	Depression Screening/Monitoring at Visit - Adolescents	Hearing Screening - Peds	Vision Screening - Peds	Chlamydia Screening - Adolescents	HIV Screening - Adolescents	Lead Screening - Peds	Cholesterol Screening - Peds	Anemia Screening - Peds
Overall	86.84%	57.84%	76.03%	77.69%	19.66%	21.98%	55.08%	38.46%	61.02%
Total	342	102	121	121	1,109	91	118	91	118

The AQIC workgroups condition-focused QI workgroups have focused on a variety of interventions to improve care in their area of expertise. Some interventions are visit-based such as standardized medical assistant rooming activities to determine gaps in care and converting sick visits into well child visits. Other interventions can include patient outreach for returning colorectal cancer screening and fecal immunochemical tests, as well as annual reminders to schedule well child checks, mammography's or receive the flu vaccine.

As an example of an intervention evaluation, an analysis of the well child check outreach intervention is included. This intervention entails a monthly text message sent to the parents of DHHA patient's ages 1 to 9 years who are due or due soon for a well child check. The messages are sent in English and Spanish (based on patient language) reminding parents that regular check-ups keep children up to date on vaccines and in good health. The message also provides the centralized appointment number. A total of 3,203 reminders have been sent to 1,148 CHP+ Members and 29,408 reminders to 8,989 Medicaid Members. An evaluation was also completed to determine if Members received a well child check within three months of receiving the text message. The number of Members who received the well child check was 638 for CHP+ and 5,172 for Medicaid.

Patient experience is one of Denver Health's top priorities. It is at the center of everything we do. Patient experience data is collected by Press Ganey using the Ambulatory Care Patient Experience Survey. Results are reviewed and summarized for each PCMH and distributed to the clinics through the use of Visual Management Boards. Denver Health utilizes this survey because it is an industry standard, allowing us to compare the results to other nationally recognized organizations. CMT and the Board of Directors set annual performance targets that are monitored and contribute towards the organizations strategic initiatives. Additionally, Denver Health contracts with the Studer Group to implement evidence based practices aimed at continual improvement in our patient experience scores.

Data are provided below for all DHHA PCMHs (CHS Overall) as well as all Medicaid Choice patients surveyed across the clinics. Medicaid Choice patients responded similarly to all patients.

Medicaid Choice

Rating of Provider	Number of Respondents	Percentage
0	3	0.35%
1	1	0.12%
2	3	0.35%
3	1	0.12%
4	6	0.69%
5	17	1.96%
6	12	1.38%
7	35	4.03%

8	108	12.43%
9-10	683	78.60%
Grand Total	869	

CHS Overall

Rating of Provider	Number of Respondents	Percentage
0	15	0.48%
1	3	0.10%
2	9	0.29%
3	11	0.35%
4	22	0.71%
5	63	2.02%
6	60	1.92%
7	128	4.10%
8	414	13.27%
9-10	2394	76.76%
Grand Total	3119	

IV. Safety and Quality of Clinical Care

Quality of Service

Annual CAHPS Surveys

DHMP conducted Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys in 2019 using SPH Analytics (formerly Morpace) an NCQA-certified vendor. SPH Analytics follows NCQA protocols and uses statistically appropriate methodologies to determine Member satisfaction scores. Surveys were conducted on both the adult and child Medicaid populations. The Colorado Department of Health Care Policy and Financing (HCPF) contracts with Health Services Advisory Group (HSAG) to conduct the CAHPS survey for the CHP+ population. CHP+ Results for 2020 are due to the Plan by the end of September 2020. Reports will be updated once results data has been received and the analysis has been completed.

The following tables show the survey results from 2017 through 2019 CAHPS surveys for Adult and Child Medicaid. The table still reflects 2018 CHP+ as the team awaits 2019 results from the State. The Overall Ratings report the percentage of Members who rated the measure as an 8, 9, 10 on a ten-point scale, with 0 being the worst possible experience and 10 being the best possible experience. The Composite Ratings report the percentage of Members who responded with Usually or Always, on a scale of None of the Time, Some of the Time, Most of the Time, or Usually/Always. For the Medicaid populations, annual CAHPS results are compared to health plans nationally using the following percentile rankings: $\leq 5^{th}$, 10^{th}, 25^{th}, 50^{th}, 75^{th}, 90^{th}, or $\geq 95^{th}$. CHP+ scores are similarly compared to national benchmarks using these percentile rankings: $<25^{th}$, 25^{th}, 50^{th}, 75^{th}, $\geq 95^{th}$.

	Adult Medicaid CAHPS Results 2019			
Overall Member Satisfaction Ratings (% 8, 9, 10)	**2017**	**2018**	**2019**	**2019 Quality Compass Percentile**
Health Care	74%	77%	70.6%	10^{th}

Personal Doctor (PCP)	86%	86%	82.0%	75th
Specialist	86%	84%	85.0%	81st
Health Plan	76%	74%	71.6%	10th
	Composite Satisfaction Ratings (%Always/Usually)			
Getting Care Quickly	76%	78%	73.5%	<5th
Getting Needed Care	76%	76%	71.8%	5th
How Well Doctors Communicate	93%	93%	92%	88th
Health Plan Customer Service	87%	86%	90%	51st

	Child Medicaid CAHPS Results 2019			
Overall Ratings (% 8, 9, 10)	**2017**	**2018**	**2019**	**2019 Quality Compass Percentile**
Health Care	88%	91%	92.4%	<5th
Personal Doctor (PCP)	92%	96%	96.2%	32nd
Specialist	90%	94%	83.8%	41st
Health Plan	86%	88%	89.8%	7th
	Composite Ratings (%Always/Usually)			
Getting Care Quickly	84%	86%	87.2%	<5th
Getting Needed Care	80%	85%	78.2%	<5th
How Well Doctors Communicate	94%	95%	95.5%	62nd
Health Plan Customer Service	85%	92%	86.1%	56th

CHP+

Overall Ratings (% 8, 9, 10)	**2016**	**2017**	**2018**	**2018 Quality Compass Percentile**
Health Care	61.7%	67.8%	70.2%	N/A
Personal Doctor (PCP)	75.6%	80.3%	84.6%	N/A
Specialist	58.3%	77.4%	84.1%	N/A
Health Plan	62.4%	67.4%	65.3%	N/A
Getting Care Quickly	76.4%	80.5%	88.4%	N/A
Getting Needed Care	65.8%	75.8%	83.5%	N/A
How Well Doctors Communicate	93.5%	96.5%	95.6%	N/A
Health Plan Customer Service	82.2%	81.4%	84.4%	N/A

Analysis

CAHPS ratings increased from 2018 to 2019 for many Child Medicaid measures including Health Care, Personal Doctor, Getting Care Quickly and How Well Doctors Communicate. Notable increases did occur in the Child Medicaid measures Specialist and Customer Service. CAHPS ratings decreased in many areas for Adult Medicaid from 2018 to 2019. Notable decreases occurred in Getting Needed Care and Getting Care Quickly.

CHP data from 2019 will be updated once received from the State around the end of September 2020. CHP+'s overall ratings for 2018 had several measures which were at or above the 90th percentile for NCQA. This included the rating of overall Health Care, rating of Personal Doctor (PCP), Specialist seen most often and How well doctors communicate.

Since 2016, there has been a notable decrease in the number of survey respondents for CHP+. 412 surveys were completed in 2018, compared with 516 in 2016 and 497 in 2017.

Response rates continue to be a challenge. The 2018 CAHPS response rate for DHMP Medicaid Choice were at 14% with 2019 final response rates at 10%. HCPF, who administers the CAHPS surveys for CHP+ Members, has begun identifying Best Practices amongst health plans in an effort to improve the delivery of and response rate to the annual surveys. This topic is frequently discussed at regional state Quality Improvement Meetings, where Plans have the ability to explain interventions designed to improve response rates of their populations. As stated above, the Plan expects current 2019 CHP+ data form the State by the end of September 2020.

SPH Analytics, who administers the CAHPS surveys for DHMP's Adult and Child Medicaid populations, identifies Key Drivers with each year's survey administration. These Key Drivers are used by the Plan to identify areas of opportunity to improve delivery of service.

Key Drivers which identify Areas of Opportunity:

High Correlation with Rating of Health Plan and Lower 2019 Percentile	High Correlation with Rating of Health Care and Lower 2019 Percentile
• Spend Enough Time with You	• Care Coordination • Spend Enough Time with You

Key Drivers which demonstrate Areas of Success

High Correlation with Rating of Health Plan and Higher 2019 Percentile	High Correlation with Rating of Health Care and Higher 2019 Percentile
• Show Respect for What You Had to Say • Got Information or Help Needed	• None

Improvements in overall scores can indicate that initiatives to improve CAHPS scores are working; however, many measures CAHPS scores decreased and overall rankings nationally remain low. Substantial efforts are needed to ensure continuous improvement. Annual DHMC CAHPS scores are reviewed with DHHA ACS for oversight and feedback. CAHPS interventions are a regular topic of discussion at the State's Quality Improvement meeting, where best practices from plans are discussed and presented. Looking forward into 2020, the DHMP and SPH team will collaboratively host a results session for leadership to review results and develop action strategies in August 2020. Further improvement efforts are needed to ensure steady improvement over time. Main areas of opportunity include improving Getting Needed Care, Getting Care Quickly, and Health Plan Customer Service.

<u>Getting Needed Care and Getting Care Quickly</u>

The DHHA system is working to provide greater appointment availability by expanding capacity, hours of operation, and specialty services. In the past year, DHHA expanded access to care across numerous clinics. Furthermore, established patients are able to message their PCP and care team and schedule primary care visits through Epic MyChart. There are a number of efforts taking place to drive MyChart utilization. In addition, the

DHHA appointment center has started triaging calls to escalate care when medically necessary. There is a 24-hour Nurse Line that is available for Members when the Appointment Center is closed and when Members describe experiencing specific symptoms. Organizationally, there is an increased focus on improving Empanelment for the DHMP Medicaid Choice population. Consistent access to a care delivery network results in increased satisfactory with the health care system and better health outcomes for the population.

Health Plan Customer Service

Efforts are currently in place to improve Health Plan Customer Service. The HPS Team provides real time training for staff regarding member service call quality improvement. The HPS Team Lead reviews every call from every staff member and performs on the spot evaluation and training. The Team Lead performs sample audits of calls for each call representative on a regular basis. All HPS phone audit report results are presented and discussed bi-monthly at the DHMP Quality Management Committee (QMC.)

DHMP has worked with the Member Services department to develop a work plan that outlines the processes to effectively track Member satisfaction. Each one of our telephonic contacts with a Member Services representative concludes with the question 'Have I provided the help or information you needed today?' This is recorded in DHMP's care management software. Monitoring is conducted to ensure that Member Service representatives are asking the question. When Members answer "no" to the above question, Member Service representatives are tracking the reasons the Member cites for not getting the help or information they needed. Tracking these reasons will assist in identifying process improvement and staff training opportunities.

DHMP is also working collaboratively with ACS clinics, Providers and Committees to improve the referral process. In an effort to enhance the referral process for members being referred to an outside specialty, DHMP will work with the Provider Relations Team to clearly communicate the different requirements for referral timeliness within the Provider Network. DHMP will also perform a quality review of the cases on a regular basis to determine if there are any quality of care concerns related to potential delays in care. DHMP will also participate in collaborative meetings with DHHA such as the Medical Neighborhood Committee and Care Coordination Collaborative to facilitate, collaborate and problem solve referral issues.

Pharmacy Review to Prevent Fraud Waste and Abuse

Background

On a quarterly basis, the Pharmacy Department monitored for fraud waste and abuse by reviewing a report that identified members who were:

- Taking 4 or more controlled substance medications
- Written by 4 or more prescribers
- Filling these medications at 4 or more pharmacies

The Primary Care Provider for each member was identified (if applicable) and a letter was sent providing information on their patient's medication fills and urged the provider to review the Colorado Prescription Drug Monitoring Program (PDMP) prior to prescribing additional controlled substance medications.

Table 1. 4x4x4 Identified Members Resulting in Provider Outreach by Quarter

Report Quarter	Number of Members Identified	Number of Provider Letters Sent
3Q2019	13	6
4Q2019	7	0
1Q2020	NA	NA
2Q2020	NA	NA

Analysis

In reviewing the last 2 quarters of 2019 data, the number of members that met the 4x4x4 criteria and that resulted in a letter getting sent to their provider, continued to decrease. This is most likely due to the implementation of several point-of sale (POS) edits that have been in place for approximately 30 months. Since the implementation of these edits, the number of members receiving opioid prescriptions from multiple providers has dropped significantly. Therefore, the plan decided to retire the 4x4x4 summary report, as the resources to continue to run and review the report, were not justified in the number of members that actually had a letter sent to their provider. It appears that the POS edits have been successful in reducing opioid related fraud, waste and abuse in this population.

Opioid Cumulative Dosing Impacted Claims Activity (Morphine Equivalent Dosing Limit)

In December of 2017, the plan implemented a limit on morphine equivalent dose (MED) for Medicaid members. This limits the amount of opioid medication a member can get to 250 MED per day. Every opioid prescription is converted to this MED factor to quantify the daily dose. In January of 2019, after one year of having this edit in place, the plan reduced the limit to 200 MED per day. This was done as a measure to reduce opioid overutilization and hopefully reduce the risk of opioid overdose. State Medicaid implemented this lower limit prior to DHMP. DHMP monitors what the state is doing and works to maintain some consistency between the two Medicaid plans so that members do not try and switch to the plan that has more lenient restrictions in place. The following are quarterly reviews of the claims impacted by this edit in the past calendar year.

Opioid Cumulative Dosing Program (OCDP) Results

3rd Quarter 2019		
Total Claims Approved:	**49**	**29.2%**
Total Claims Denied:	**119**	**70.8%**
Total Soft Denials (OCDP)	**0**	
Total Hard Denials (OCDP)	**119**	
Total Member Count:	**21**	
Total Prescriber Count:	**32**	
Total Pharmacy Count:	**22**	
Total Denied Claim Count Subsequent Fill:	**92**	
Total Denied Claim Count No Subsequent Fill:	**27**	
Total First Denied Claims:**	**28**	
Total First Approved Claims:**	**23**	
Total Ingredient Cost Denied Claims:**	**$5,200.68**	
Total Ingredient Cost Approved Claims:**	**$766.19**	
Average Ingredient Cost/Denied Claim:**	**$185.74**	
Average Ingredient Cost/Approved Claim:**	**$33.31**	

***First denied claim or first approved claim for same Brand Name Strength contributes to the Total Ingredient Cost.*

4th Quarter 2019		
Total Claims Approved:	**64**	**33.9%**
Total Claims Denied:	**125**	**66.1%**
Total Soft Edit Denials (OCDP only):	**0**	
Total Hard Edit Denials (OCDP only):	**125**	
Total Member Count:	**20**	
Total Prescriber Count:	**30**	
Total Pharmacy Count:	**26**	
Total Denied Claim Count Subsequent Fill:	**100**	
Total Denied Claim Count No Subsequent Fill:	**25**	
Total First Denied Claims**	**30**	
Total First Approved Claims**	**25**	
Total Ingredient Cost Denied Claims**	**$5,180.28**	
Total Ingredient Cost Approved Claims**	**$817.43**	
Average Ingredient Cost/Denied Claim**	**$172.68**	
Average Ingredient Cost/Approved Claim**	**$32.70**	

*** First denied claim or first approved claim for same Brand Name Strength contributes to the Total Ingredient Cost.*

1st Quarter 2020		
Total Claims Approved:	**43**	**38.1%**
Total Claims Denied:	**70**	**61.9%**
Total Soft Denials (OCDP)	**0**	
Total Hard Denials (OCDP)	**70**	
Total Member Count:	**16**	
Total Prescriber Count:	**14**	
Total Pharmacy Count:	**18**	
Total Denied Claim Count Subsequent Fill:	**52**	
Total Denied Claim Count No Subsequent Fill:	**18**	
Total First Denied Claims**	**19**	
Total First Approved Claims**	**17**	
Total Ingredient Cost Denied Claims**	**$1,718.90**	
Total Ingredient Cost Approved Claims**	**$448.28**	
Average Ingredient Cost/Denied	**$90.47**	

Claim:		
Average Ingredient Cost/Approved Claim:	**$26.37**	

First denied claim or first approved claim for same Brand Name Strength contributes to the Total Ingredient Cost.

2nd Quarter 2020		
Total Claims Approved:	**36**	**29.3%**
Total Claims Denied:	**87**	**70.7%**
Total Soft Denials (OCDP)	**0**	
Total Hard Denials (OCDP)	**87**	
Total Member Count:	**19**	
Total Prescriber Count:	**20**	
Total Pharmacy Count:	**19**	
Total Denied Claim Count Subsequent Fill:	**66**	
Total Denied Claim Count No Subsequent Fill:	**21**	
Total First Denied Claims:	**23**	
Total First Approved Claims:	**18**	
Total Ingredient Cost Denied Claims:	**$4,756.75**	
Total Ingredient Cost Approved Claims:	**$548.43**	
Average Ingredient Cost/Denied Claim:	**$206.82**	
Average Ingredient Cost/Approved Claim:	**$30.47**	

First denied claim or first approved claim for same Brand Name Strength contributes to the Total Ingredient Cost.

Analysis

The numbers have stabilized this past year, and on average around 20 members are above the limit at a given time. The lowering of the limit occurred in 1st quarter 2019 and since that time, it has remained unchanged. The plan accepts and reviews prior authorizations for members with cancer pain, sickle cell disease, in hospice, in palliative care, or to allow time to taper the dose down to the appropriate limit.

3Q2019	# of PAs	6
4Q2019	# of PAs	11
1Q2020	# of PAs	5
2Q2020	# of PAs	5

There have not been very many members affected by this edit, which reflects positively on the Denver Health Medicaid Provider's prescribing habits. There have not been very many PAs received in this past year, which is also a positive indicator of the success of these edits. Most of the rejected claims that are identified by this edit are due to overlapping day supply (if the prescription is being submitted too early) which falsely inflates the MED. The pharmacy generally will end up filling the prescription in subsequent days, which results in a lower

morphine equivalent daily dose and therefore an approved claim.

There are a few members that have been taking relatively high doses of opioid medications for many years, and it is very difficult to taper them down after gaining such a tolerance. The plan monitors these members via the prior authorization process to make sure the prescriber has attempted to taper the dose. However, it is understood that it may not always be possible to comply with the limit. Having this limit in place moving forward is helpful in preventing new members starting on opioids getting titrated up to unsafe dosages.

Pharmacy Review and Notification of Drug Recalls

Background
The Pharmacy Department evaluates drug recalls and voluntary market withdrawals that have occurred and tracks this information in the Drug Recall and Voluntary Withdrawal Tracking Log. This log was reviewed to assess that notification was provided in a timely and appropriate manner. The plan is notified of drug recalls via the pharmacy benefit manager, and then the plan notifies providers and members as appropriate.

Table 1. Drug Recalls by Quarter

Report Quarter	Members Affected	Notification Timely
3Q2019	3	Y
4Q2019	98	Y
1Q2020	0	NA
2Q2020	1024	Y

Analysis
On September 24, 2019 the plan was notified that the FDA is advising consumers not to use Sandoz Pharmaceuticals Ranitidine Hydrochloride due to a confirmed contamination with N-nitrosodimethylamine (NDMA) above levels established by the FDA. This recall was expanded to additional manufacturers on 10/29/2019. This recall was further expanded to additional manufacturers and syrup on 10/31/2019. The plan identified 101 members affected by the recalled lots and timely notifications were sent to the member and prescriber.

On January 8, 2020 the plan was notified that Appco Pharmaceuticals announced the voluntary recall of all quantities and lots, within expiry, of Ranitidine tablets both 150mg and 300 mg to the consumer. The lots of Ranitidine are being recalled because of the presence or potential presence of N-nitrosodimethylamine (NDMA) levels above the accepted daily intake levels established by the FDA, based on FDA-validated tests.

On April 2, 2020 the plan was notified that the agency has determined that the impurity in some Ranitidine products increases over time and when stored at higher than room temperatures and may result in consumer exposure to unacceptable levels of this impurity. As a result of this immediate market withdrawal request, Ranitidine products will not be available for new or existing prescriptions or over-the-counter (OTC) use in the U.S. The plan identified 718 members affected by the recalled lots and timely notifications were sent to the members and prescribers.

On June 4, 2020 the plan was informed that Amneal Pharmaceuticals was notified by the FDA that the agency's testing of seven lots of Metformin Hydrochloride Extended Release tablets, USP, 500 mg and 750 mg, showed N-nitrosodimethylamine (NDMA) amounts above acceptable FDA levels. The plan identified 306 members affected by the recalled lots and timely notifications were sent to the members.

The PBM's policy and procedure titled "Drug Manufacturer Recall and Withdrawal" was reviewed. Timely and appropriate action was taken by the PBM for all recalls and withdrawals in accordance with this policy. This data is reported out to the Medical Management Committee once a year.

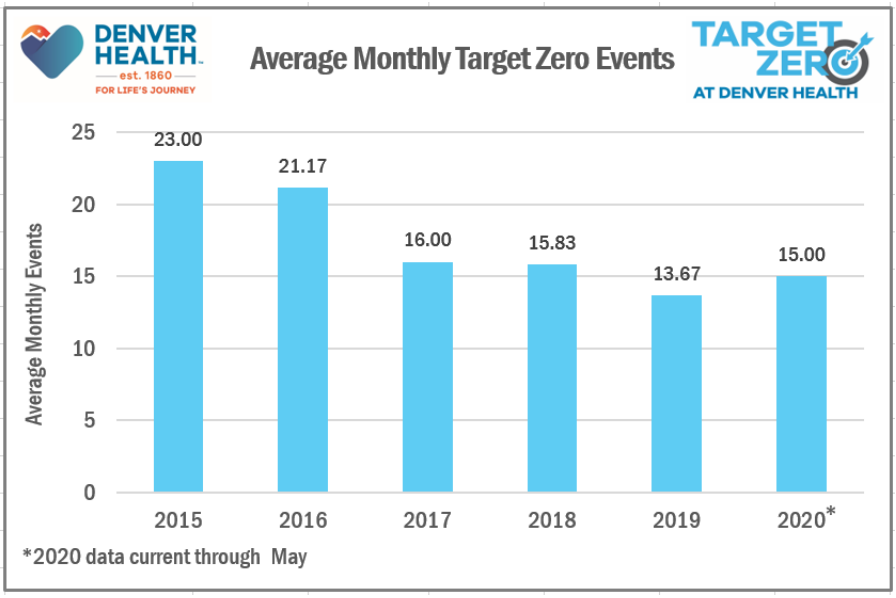
Quality of Care

Patient Safety

In 2019-20, DHMP was able to actively address the following patient safety objectives:

- Trended adverse events reporting in safety practices (e.g. medication errors)
- Focused existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety
- Reviewed and investigated serious outcomes where a patient injury has occurred or patient safety has been impaired in collaboration with risk management
- Collected and analyzed data, evaluated care processes for opportunities to reduce risk and initiate actions
- Incorporated patient safety education into job competencies.
- Encouraged organizational learning about medical and health care errors.

In 2020-2021, DHMP will continue to address patient safety objectives to improve the quality of care delivered to our Members, and with the participation of the DHMP Medical Director's participation on the DHHA Patient Safety Committee as they pursue a culture of safety and specific "Target Zero" initiatives on behalf of our patients. Target Zero initiatives aim to reduce surgical site infections, hospital acquired VTE's, medication safety events and falls with injuries. Since 2017, there has been a 3% reduction overall for all categories combined. In addition to Target Zero, Denver Health is focusing efforts on reducing chronic opioid use and post-operative complications, increasing hand washing awareness, and fall risk monitoring. As a result, falls with injuries have had a 40% decrease since 2017 at Denver Health. Overall, across all initiatives, the rate of average monthly events has fallen over the last 5 years.



Grievance Reporting and Trending

Medicaid and CHP+ SFY 2019-2020

Category	1Q	2Q	2019 TOTAL	3Q	4Q	2020 TOTAL	GRAND TOTAL
Access	1	4	5	0	0	0	5
Quality of Service /Customer Service	2	3	5	0	3	3	8
Eligibility	0	1	1	0	0	0	1
Enrollment/ Disenrollment	2	0	2	0	0	0	2
Billing/Financial	4	9	13	14	0	14	27
Benefit Package	1	1	2	1	3	4	6
HIPAA	0	1	1	0	0	0	1
Organization Determination and Reconsideration Process	0	1	1	0	0	0	1
Clinical Care	0	1	1	1	1	2	3
Transportation	2	2	4	0	0	0	4
GRAND TOTAL OF COMPLAINTS DURING REPORT PERIOD							58

DHMP gathered informative feedback from Members by tracking grievances filed by Members and their authorized representatives. The Grievance and Appeals department monitored the following aspects of each grievance received and prepared reports tracking this data: the timeliness of the problem resolution process, whether regulatory requirements were met, whether Member notification of a resolution was provided in an easy to understand and culturally competent manner, and whether the root cause of the grievance was discovered and addressed. The department also worked to identify patterns in grievances which may indicate the need for further investigation or performance improvement opportunities by DHMP and its affiliate entities and Providers.

The data for SFY 2019-2020 indicated that the primary area of concern for DHMP is Billing/Financial issues. Further analysis indicated that the many of the grievances in this category stem from denials due to lack of authorization and grievances from members being balance billed by providers for Medicaid covered services. To address these issues, Grievance and Appeals reached out to providers who were balance billing the member to notify them that HCPF prohibits members from being billed more than the member's normal cost share for Medicaid covered services. Grievances and Appeals also provided education to the members in the grievance

resolution letter about when an authorization must be obtained prior to receiving services.

All complaint data was presented, reviewed, and discussed at the QMC on a routine basis. During these committee meetings, monthly grievance data is reviewed and analyzed for trends, anomalies, etc. Committee Members had the opportunity to provide input regarding the data and findings.

Quality of Care Concerns (QOCC's) are tracked, trended, and reported quarterly to the Quality Management Committee (QMC).

Denver Health Medicaid Choice

***QOCC Review Outcomes**	**First Quarter** July – Sept 2019	**Second Quarter** Oct-Dec 2019	**Third Quarter** Jan – Mar 2020	**Fourth Quarter** Apr –June 2020	**Total for SFY 2020**
Unsubstantiated	0	0	2	1	0
Borderline	0	0	0	0	0
Substantiated	0	0	0	0	0
Total	0	0	2	1	3

There have been a total of 3 QOCC cases for Medicaid Choice plan members for the timeframe designated in the grid.

Unsubstantiated Case #1: The Members care was given at two facilities, and it was all within national standards for multiple diagnoses. There was no action taken.

Unsubstantiated Case #2: The Members care was given during IP stay and was deemed appropriate upon chart review. The complaints against RN and CNA were not substantiated upon review. There was no action taken.

Unsubstantiated Case #3: There was no clinical information available for review of this complaint. The facility changed ownership and the records were lost. There was no action taken. DHMP did not provide authorization for this stay.

QOCC Review Outcomes Defined*:*

- Unsubstantiated - No Quality of Care identified; meets medical community standard of care
- Inconclusive - Questionable, but not injurious to member
- Substantiated - Quality of Care identified; below medical community standard of care

*The above grid includes only QOCCs for Denver Health CHP+ members.

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

DHMP Medicaid Language Data*

Language	Measure	FY2019/2020
English	**Count**	52,331
	Rate	48.0%
Spanish	**Count**	21,474
	Rate	19.7%
Vietnamese	**Count**	457
	Rate	0.4%
Chinese	**Count**	207
	Rate	0.2%
Amharic	**Count**	313
	Rate	0.3%
Arabic	**Count**	419
	Rate	0.4%
Russian	**Count**	120
	Rate	0.1%
Burmese	**Count**	122
	Rate	0.1%
Nepali	**Count**	110
	Rate	0.1%
French	**Count**	143
	Rate	0.1%
Somali	**Count**	148
	Rate	0.1%
Persian	**Count**	119
	Rate	0.1%
Unknown/No Language Selected	**Count**	32,491
	Rate	29.8%
Grand Total	**Count**	108,974

**Numbers reflect enrollment 7/1/2019-6/30/2020*

DHMP Medicaid Member Language Summary

As of June 2020, there were 48 distinct languages identified that were spoken by our DHMP Medicaid members. However, only 12 languages were spoken by our members at 0.1% or greater, or 500 persons or more, (English, Spanish, Vietnamese, Chinese, Amharic, Arabic, Russian, Burmese, Nepali, French, Somali and Persian) for the Medicaid product line in FY2019/2020. It is also important to note that preferred language data is unknown for approximately 30% of DHMP Medicaid members which highlights a strategic enterprise need to more effectively collect and track REL data.

DHMP Medicaid Plans Race/Ethnicity Data*

Race/Ethnicity	FY2019/2020	
	Count	Rate
Unknown/Not Reported	51,846	47.6%
Hispanic or Latino	21,930	20.1%
White	19,828	18.2%
Black/African American	12,103	11.1%
Asian	2,136	2.0%
Alaskan/American Indian	827	0.8%
Hawaiian	310	0.3%
Grand Total	108,974	

**Numbers reflect enrollment 7/1/2019-6/30/2020*

DHMP Medicaid Member Race/Ethnicity Summary

Medicaid member race/ethnicity and language data from the July 2019-June 2020 eligibility files were examined. Based on our analysis for our Medicaid line of business in FY2019/2020, Hispanic or Latino was the predominant race/ethnic of our member population at 20.1% followed by White at 18.2% and Black/African American at 11.1%. 47.6% of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

DHMP CHP+ Language Data*

Language	Measure	FY2019/2020
English	Count	2,325
	Rate	32.0%
Spanish	Count	3,010
	Rate	41.3%
Vietnamese	Count	46
	Rate	0.6%
Amharic	Count	47
	Rate	0.6%
Arabic	Count	22
	Rate	0.3%
Russian	Count	15
	Rate	0.2%
Burmese	Count	22
	Rate	0.3%
Nepali	Count	35
	Rate	0.5%
French	Count	18
	Rate	0.2%
Unknown/No Language Selected	Count	2,032

	Rate	**28.0%**
Grand Total	**Count**	**7285**

**Numbers reflect enrollment 7/1/2019-6/30/2020*

DHMP CHP+ Member Language Summary

As of June 2020, there were 26 distinct languages identified that were spoken by our DHMP CHP+ members. However, only 9 languages were spoken by our members at 0.1% or greater, or 500 persons or more, (English, Spanish, Vietnamese, Amharic, Arabic, Russian, Burmese, Nepali and French) for the CHP+ product line in FY2019/2020. It is also important to note that preferred language data is unknown for approximately 28% of DHMP CHP+ members which highlights a strategic enterprise need to more effectively collect and track REL data.

DHMP CHP+ Race/Ethnicity Data*

Race/Ethnicity	**FY2019/2020**	
	Count	**Rate**
No Ethnicity/Unknown/Not Reported	**3,561**	**48.9%**
Hispanic or Latino	**2,483**	**34.1%**
White	**735**	**10.1%**
Black/African American	**540**	**7.4%**
Asian	**240**	**3.3%**
Alaskan/American Indian	**33**	**0.5%**
Hawaiian	**31**	**0.5%**
Grand Total	**7,285**	

**Numbers reflect enrollment 7/1/2019-6/30/2020*

DHMP CHP+ Member Race/Ethnicity Summary

CHP+ member race/ethnicity and language data from the July 2019-June 2020 eligibility files were examined. Based on our analysis for our CHP+ line of business in FY2019/2020, Hispanic or Latino was the predominant race/ethnic of our member population at34.1% followed by White at 10.1% and Black/African American at 7.4%. 48.9% of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

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 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 and will continue this partnership 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 insurance[5]
- Hispanic populations…tend to respect and consult older family members when it comes to health decisions[4]
- 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, DHHA has integrated cultural competency into its annual training. In 2019, 5,888 DHHA 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-DHHA 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 FY2020/2021:

- 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 FY2019/2020, reducing disparities in health related to race, ethnicity and language was identified as an enterprise opportunity, increasingly so as the COVID-19 pandemic has emphasized the continuing disparities in health outcomes related to race and ethnicity. In FY20/21, in addition to ongoing system wide work to improve COVID-19 outcomes across racial/ethnic groups, DHMP will develop and implement an integrated Population Health Management program for our MCD population with a focus on identifying and eliminating racial and ethnic health disparities. The program will include concerted focus on metrics traditionally associated with high levels of disparities such as, children's wellness exams and immunizations, prenatal care and members with multiple chronic conditions. Additionally, 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 FY2019/2020, 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.

Access Measures

Access Measures	Denver Health Medicaid Choice				
	HEDIS 2018 Results: MCD	HEDIS 2019 Results: MCD	HEDIS 2020 Results: MCD	2019 HEDIS MCD Percentile	HEDIS 2019-2020 Change
Children and Adolescents' Access to PCP (CAP)					
12-24 Months	86.84%	88.52%	89.11%	<10th	0.59%
25 Months-6 Years	72.12%	75.09%	74.46%	<10th	-0.63%
7-11 Years	75.53%	80.08%	80.05%	<10th	-0.03%
12-19 Years	75.43%	80.30%	79.19%	<10th	-1.11%
Adults' Access to PCP (AAP)					
Ages 20-44	49.43%	48.84%	49.81%	<10th	0.97%
Ages 45-64	64.43%	62.17%	63.53%	<10th	1.36%
Ages 65+	75.20%	68.56%	71.75%	<10th	3.19%
Total	55.19%	53.89%	55.30%	<10th	1.41%

Access Measures	Denver Health CHP+				
	HEDIS 2018 Results: CHP	HEDIS 2019 Results: CHP	HEDIS 2020 Results: CHP	2019 HEDIS MCD Percentile	HEDIS 2019-2020 Change
Children and Adolescents' Access to PCP (CAP)					
12-24 Months	69.03%	90.36%	90.00%	<10th	-0.36%
25 Months-6 Years	57.24%	73.58%	81.24%	10th	7.66%
7-11 Years	81.33%	86.93%	84.85%	10th	-2.08%
12-19 Years	78.05%	82.04%	82.08%	<10th	0.04%
Adults' Access to PCP (AAP)					
Ages 20-44	NA	NA	NA	NA	NA
Ages 45-64	NA	NA	NA	NA	NA
Ages 65+	NA	NA	NA	NA	NA
Total	NA	NA	NA	NA	NA

Analysis

Medicaid Choice

Children and Adolescents' Access to PCP (CAP)

HEDIS rates for children remained relatively stable from 2019 – 2020, with changes ranging from a decrease of 1.11% for the 12-19 Years age group to an increase of 0.59% for the 12– 24 Months age group. When compared to the 2019 national percentiles for the CAP measure, DHMP MCD Choice Members fall below the 10th percentile for access to PCP. An important note regarding the national percentile distribution of this measure is that there is only an average of 17% difference between the 5th and 90th percentile for this measure. Plans' abilities to improve their national percentile rankings can be more difficult, as the bar for improvement is set within a high numerical band.

Adults' Access to PCP (AAP)

All Adults' Access to PCP measures increased slightly for HEDIS 2020 when compared to HEDIS 2019. Access and empanelment of adult DHMP Medicaid Members continues to be an ongoing area of opportunity within Denver Health and for Denver Health Medial Plan. Interventions involving a robust Member outreach are an ongoing source of discussion within Denver Health's Ambulatory Care Services with the goal of increasing the overall numbers of PCP empanelment and connection to care.

CHP+

Children and Adolescents' Access to PCP (CAP)

HEDIS rates for children varied by age group from 2019 – 2020, with changes ranging from a decrease of 2.08% for the 7-11 Years age group to an increase of 7.66% for the 25 Months- 6 Years age group. When compared to the 2019 national percentiles for Medicaid HMO for the CAP measure, DHMP CHP+ Members fall at or below the 10th percentile for access to PCP. An important note regarding the national percentile distribution of this measure is that there is only an average of 17% difference between the 5th and 90th percentile for this measure. Plans' abilities to improve their national percentile rankings can be more difficult, as the bar for improvement is set within a high numerical band.

Action Plan for FY2019/20

- Continue to facilitate transportation for Members in need of assistance.
- Share HEDIS access results with DHMP, ACS and DHHA leadership
- Plan to continue to drill down on the data for identification of barriers for children, adolescents, and adults.
- Continue to provide Members information about how to access care and services
- Ongoing discussion and identification of areas of opportunity to increase empanelment, connect Members to care via care / case management and patient navigation services

Analysis and Plan

DHHA has focused on expansion of primary care capacity over the past year. CAHPS scores are reviewed with ACS in the Ambulatory Quality Improvement Committee workgroup for oversight and development of quality improvement initiatives.

To address access issues in Primary and Specialty Care, DHHA ACS has improved access in the last year in the following ways:

- ACS continued to partner with the DHHA NurseLine to address patient needs that may not require an appointment. Members now have access to EPIC My Chart which allows them to message their PCP and care team, schedule primary care visits, review lab results and request refills. Denver Health also continued to operate 17 School Based Health Centers (SBHCs) that provide health care in an easy and convenient setting to all Plan Members who attend Denver Public Schools.
- Several strategies were developed to reduce the wait list, including an improved new patient workflow for the Appointment Center, the hiring and placement of Providers in key locations, collaboration between the Appointment Center and clinics to fill open appointment slots, and adjusted Provider panel sizes. Saturday morning hours for primary care at 3 locations have continued at the Montbello Health Center, Denver Health main campus and at the Westside Family Health Center on Federal Boulevard.
- As mentioned previously, the DHMP QI team maintained a close collaboration with Ambulatory Care Management workgroups, including conversations and intervention proposals with the Transition of Care Ambulatory Care Workgroup. The topic of increasing empanelment of MCD / CHP+ Members is a frequent topic of discussion, involving clarification of data points and DHHA clinic operations to improve

Member outreach. The DHHA Ophthalmology Clinic continued to offer priority scheduling for DHMP/DHHA

- Members for diabetic eye screenings which resulted in an overall increase in appropriate screenings for this population. In addition, 10 diabetic retinal cameras have been placed at several Primary Care centers around the DHHA campus to screen for potential eye health complications, such as diabetic retinopathy or macular degeneration. Having screening cameras in Primary Care clinics will boost the number of overall screenings; as well as decrease the amount of patients who miss appointments in the eye clinic itself.
- In June of 2018, construction began on the new DHHA Outpatient Medical Center (OMC). The anticipated completion date is in August 2020. The OMC will be a 293,000 square-foot, state of the art facility located just across from the main hospital that will consolidate 20 specialty clinics, procedural areas, day surgery, and ancillary services into one convenient location, providing increased space and access in specialty care areas such as cardiology, orthopedics, outpatient behavioral health, and dental services. Once the OMC is complete, it will also free space on the main campus to continue growth in pediatric services and allow us to increase the number of inpatient psychiatric beds. The modern facilities and state-of-the-art technology will increase capacity and allow us to coordinate services more effectively; enabling Providers to deliver better care for Members at its opening date.
- The opioid epidemic requires DHHA to envision a different care practice, one that fundamentally, not incrementally, changes our traditional model of medicated assisted treatment delivery.
- The Center for Addictions Medicine continues to offer a full continuum of care that provides the Denver Health patient access to an array of substance treatment services. These services span a wide range of areas, including prevention and education, harm reduction, formal treatment and management of addiction disorders, along with post-treatment services, tools and resources that support ongoing recovery.

Additionally, DHHA renovated the Adult Behavioral Health facilities and increased the number of beds and living space for patients. Denver Health also doubled capacity in the ACUTE Center for Eating Disorders, allowing increased available treatment for these severely ill patients and has begun offering state of the art therapies and advanced treatments for people suffering from non-healing wounds at the Wound Care Center. Thus removing barriers to care for Members and offering more comprehensive care, including, medication management, surgical procedures, skin assessment and pain management. Patient flow improvement initiatives for inpatient services included:

- Increased the total number of beds available for observation care and reduced care team handoffs by working to keep patients on the same medical service when patients converted from observation to inpatient patient class
- Restructured interdisciplinary rounds on two medicine floors to focus on the patient's discharge plan. Also created a tool within Epic to give interdisciplinary visibility by pulling discharge planning documentation from the interdisciplinary team into one central location
- Created consistent guidelines to assess the risk of patients presenting the emergency department with chest pain to determine next steps for admission, tests, etc. to more appropriately admit patients.
- Conducted multiple communications with medicine Providers (and on daily safety call) about patients who no longer meet medical necessity. This increased awareness of the problem and created a new process for real-time escalation with physician advisors.

Denver Health Medicaid Choice and CHP+ provided Members with information on how to access the care they need through the Provider Directory, Member Handbook, and Member Newsletters. These materials provided

information on how to obtain primary care, specialty care, after-hours, emergency care, ancillary and hospital services. The Denver Health Member Handbook contains information on Member benefits and how to access care within the DHMP network.

New DHMP Members are sent a welcome packet including their ID card and Quick Reference Guide. DHMP also provides Orientation Videos in English and Spanish on the website for Members. These videos inform our Members about their benefits and provide information on how the plan works. DHMP staff strive for excellence in care and service for all our Members in accordance with contract requirements.

The scope of DHMP QI program includes topics pertaining to quality of care, and continuity of care. Denver Health Medicaid Choice and CHP+ maintained quality standards to identify, evaluate, and remedy problems relating to access of care. DHMP evaluated access standards primarily through the Grievance process and monitoring Member disenrollment. Denver Health Medicaid Choice and CHP+ shall promote accessibility and availability of covered services directly to ensure that appropriate services and accommodations are made available to Members with a disability or Members with special health care needs. Covered services for Members with disabilities or special health care needs are provided in such a manner that promotes independent living and Member participation in the community at large.

Denver Health Medicaid Choice and CHP+ respond within 24 hours, after written or oral notice by the Member, to the Member's parents, guardian, or designated client representative, to any diminishment of capacity of a Member with a disability to live independently. Denver Health Medicaid Choice and CHP+ will continue to provide expedited authorization to support the Member's ability to live independently (e.g., an appropriate wheelchair).

New enrollees with special needs may continue to see a non-plan Provider for 60 days from the date of enrollment in Denver Health Medicaid Choice and CHP+ if the enrollee is in an ongoing course of treatment with a previous Provider and only if the previous Provider agrees to terms as specified in Section 26-4 117, C.R.S. New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of post-partum care directly related to the delivery only if the practitioner agrees to terms as specified in Section 26-4 117, C.R.S. New enrollees with special needs may continue to see ancillary Providers at the level of care received prior to enrollment for a period of up to 75 days. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the Provider and enrollee agree to work in good faith with Denver Health Medicaid Choice and CHP+ toward a transition.

Denver Health Medical Plan's most recent Performance Improvement Project (PIP) revolved around Access to Care for pediatric MCD / CHP+ Members. For this PIP, the DHMP QI team collaborated with the Webb Pediatrics clinic – the 2nd largest DHHA PCMH by MCD Choice / CHP+ Member Volume, to design, implement and evaluate several interventions to improve Members' access to care. . These interventions included utilizing Healthy Communities to call the parent/guardian of members who had a birthday in that calendar month and were due for an AWC and scheduling an appointment for them and working with DHHA's 17 school-based health centers to have consented members receive their AWC at their assigned clinic. DHMP had also hoped to test an intervention utilizing automated text messages sent to the parent/guardian of all MCD/CHP+ members who were overdue for an AWC but this was put on hold due to the suspension of AWC visits during the COVID-19 pandemic. This remains a priority opportunity for DHMP to test for this population in FY2020/2021.

Finally, there are ongoing efforts to enhance contract-aligned availability standards reporting, for the purpose of increasing the accuracy of identifying opportunities for availability improvement. Additionally, we are doing

granular analysis for Out of Network (OON) data, to identify geographic and service type opportunities for improvement in access and availability.

Open Shopper Study

The Open Shopper Study will be completed annually to assess performance against National Committee for Quality Assurance (NCQA) and contractual standards and to evaluate Member experience as it relates to access to care. The results of the study will be used to guide process improvement efforts across the organization. The Open Shopper Study analysis and findings will be presented to the Quality Management Committee (QMC) for oversight and feedback. The report will be shared throughout primary, specialty and behavioral health care departments across Denver Health (DHHA).

The Open shopper analysis will be owned by the Medicaid Product Line Management team. With this change, there was an opportunity to reassess the study method, to ensure its relevancy and alignment with the MCD and CHP+ access standards. No Open Shopper study was performed in 2019.

In 2020, DHMP will utilize an open shopper process to monitor adherence of its provider network to the required access to care standards for primary care, specialty care and behavioral health care services. It is crucial to understand the current state of access in order to best support efforts that improve access to care. The results of the open shopper surveys will be provided to the Network Management Committee (NMC) to determine if the network is sufficient to provide services to members on a timely basis; identified provider non-compliance will be addressed through the corrective actions process. The overall goals of the open shopper process include:

1. Ensuring timely access to care and services for DHMP's Medicaid Choice and CHP+ members;
2. Monitoring DHMP's provider network for adherence to required access to care standards;
3. Taking appropriate corrective actions to address identified non-compliance.

The 2020 results will be compared against the access standards. As a result of assessment items changing beginning in 2020, trending will not be performed until 2021. However, analysis and trending of the member experience of access to care is also captured in the annual CAHPS survey.

Access-Related Consumer Assessment of Health Plan Providers and Systems (CAHPS) Scores

Denver Health Medical Plan, Inc. (DHMP) conducts the CAHPS Survey annually under contract with SPH Analytics, and NCQA-Certified vendor. SPH Analytics e follows NCQA protocols and statistically-appropriate methodologies to determine Member satisfaction scores.

The CAHPS overall Member satisfaction scores were compared for trends across adult Medicaid, child Medicaid and CHP+ plans. Three category scores (Getting Care Quickly, Getting Needed Care and Rating of Health Plan) provide a snapshot of the Member's overall satisfaction.

Getting Care Quickly improved for adult Medicaid, child Medicaid for 2019 and CHP+ in 2018 for the percentage of Members who rated their plan a 9 or above (on a 10-point scale):

- from 78% to 75% for adult Medicaid (2019 data)
- from 86% to 87%for child Medicaid (2019 data)
- from 76% to 81% for CHP+ (2018 data)

Getting Needed Care improved for adult Medicaid, child Medicaid for 2019 and CHP+ in 2018 for the percentage of Members who rated their plan a 9 or above (on a 10-point scale):

- from 78% to 72% for adult Medicaid(2019 data)
- from 85% to 78% for child Medicaid (2019 data)
- from 66% to 76% for CHP+ (2018 data)

The scores above are key drivers to the overall satisfaction with DHMP. In 2018 there was continued improvement with child Medicaid and CHP+, as determined by the percentage of Members rating the health plan an 8 or above on a 10-point scale.

- from 74% to 72% for adult Medicaid,(2019 data)
- from 88% to 90% for child Medicaid, (2019 data)
- from 62% to 67% for CHP+, (2018 data)

A key driver analysis was conducted to understand the impact that different aspects of service and Provider care have on Member's overall satisfaction with DHMP. In 2019, these measures included Spend Enough Time with You, Show Respect for What You had to Say and Got Information or Help Needed. These areas have been the focus of HPS team enhancements that are presented at the QMC. Some of the activities include increased staff training, all staff audits of call scripts and targeted monitoring of the use of the Closing Phrase: "Did you get the help you needed today?" The Plan elevates that measure as a key driver of the global rating measure of Overall Health Plan Rating. There was Committee feedback that the monitoring of this measure is a great best practice to improve this important measure.

Annual DHMP CAHPS scores are reviewed with Ambulatory Care Services (ACS) in the Ambulatory Quality Improvement Committee and the quarterly Patient Experience Advisory Committee, for oversight and feedback. The monthly Denver Health Patient Experience Workgroup focuses on the development of QI initiatives related to patient experience, along with the review of clinician and group scores (CG-CAHPS) from the clinic visits. The responses are reviewed to assess patients' perceptions of care, including getting appointments and health care when needed.

The QI Director for DHMP is an active and participating Member of the Ambulatory Quality Improvement Committee (AQIDC). Through this committee, clinical and Member satisfaction metrics, including any access-related issues, are reviewed. This includes monthly monitoring of QI interventions and indicators. A collaborative, partnership-based approach across DHMP and ACS is utilized to advance QI initiatives, with a goal of more effective use of limited resources and improved quality outcomes. DHMP Intervention and Healthcare Effectiveness Data and Information Set (HEDIS) Program Managers actively participate in disease-based and prevention workgroups, including perinatal, pediatric, asthma, preventive screening, diabetes and cardiovascular disease workgroups.

ACS is endorsed as a Patient Centered Medical Home (PCMH) to Medicaid and CHP+ Members. ACS currently holds NCQA Accreditation for their PCMH care services at Level II, receiving accreditation in 2014. CG-CAHPS are utilized in the clinics to evaluate services received by Medicaid and CHP+ Members. This effort began in July 2013 at the ACS clinics to measure Members' satisfaction of their recent experience with Providers and clinical staff. CG-CAHPS metrics are reviewed monthly in the Patient Experience Workgroup to identify and work on specific service interventions to improve the clinic experience for the Member and their families. Company QI Members participate in the Patient Experience Workgroup and the DH Diversity Steering Committee Workgroups and work collaboratively on improving Member care and experience.

Access-related CAHPS surveys are actively shared with medical management and operational leadership of ACS to facilitate joint planning of QI efforts and initiatives. Access-related Quality of Care Concerns (QOCCs) are also shared, if appropriate, to improve care and quality. Access-related CAHPS are brought annually and access-

related QOCCs are brought to the bi-monthly DHMP Network Management Committee (NMC).

Privacy and Confidentiality Monitoring

In the course of providing quality assurance and utilization management services, DHMP (the Company??) receives confidential information from Members and from Providers. DHMP will use and share such information in accordance with applicable state and federal laws. Policies are in place at DHMP to ensure the confidentiality of the information, including the following:

- At the time of initial hiring, all Company personnel shall be trained on the proper handling of confidential information and informed of the disciplinary action that will result from a breach of confidentiality
- All staff shall be trained annually on the proper handling of confidential information as part of their mandatory training curriculum.
- DHMP shall treat all information as confidential which specifically identifies or permits identification of a certain health plan Member and describes the physical, emotional, or mental conditions of such person.
- DHMP may retain and use such confidential information in performance of its obligations relating to costs, charges, procedures, or treatments employed by a Provider in treating any Member.

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 authorized to receive it. Any confidential information which DHMP finds it necessary to disclose in the performance of utilization management services shall not be disclosed to any unauthorized entity without prior consent of the Member or as required by law.

All confidential information, whether physical or digital, retained by DHMP shall be held in a secure manner. All confidential information will be retained in accordance with applicable state and federal laws.

In the course of performing its utilization management responsibility, it is the policy of DHMP 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 Company employees, any 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.

IV. Overall Structure of the QI Program

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

Medical Director responsibilities include, but are not limited to:

- Providing direction and support related to the development and evaluation of 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
- Delegating components of the QI Work Plan to other Members of the Operations Management Committee

- Serving on the QMC, AQIC, Pharmacy and Therapeutics Committee (P&T), Utilization Management Committee, Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee and Denver Health Physician Executive Committee
- Evaluating and managing DHMP's Quality of Care Concerns (QOCCs) and quality of care reportables related to physical health and behavioral health problems, working in conjunction with the clinical staff supporting the QI department.
- Serving as the chairperson of the Credentialing Committee

DHMP's Quality Improvement Department

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

- Developing, leading and monitoring the QI Program
- Reporting findings from clinical interventions and annual audits to appropriate groups, such as the QIC, QMC, and the DHMP Board of Directors
- Completing preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, QIC and DHMP Board of Directors
- Directly assuming authority and responsibility for the organization and administration of the QI Program, including annual submission of the QI Program Description, Impact Analysis and Work Plan
- Directing, providing subject matter expertise and participating in the execution of the QI Program through collaboration with other Company and Denver Health Departments as appropriate for regulatory compliance and quality improvement
- Reporting QOCCs to the DHHA Patient Safety and Quality department and external network Providers through the Medical Director, as appropriate.
- Serving as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
- Leading LEAN initiatives related to the QI Department, including standard work
- Providing oversight, supervision and direction to the QI team, including all regulatory submissions

HEDIS Program Manager responsibilities include, but are not limited to:

- Managing all aspects of HEDIS-related projects, including roadmap submission & annual audit
- Evaluating opportunities for supplemental data sources to improve HEDIS compliance
- Providing summation of findings from medical record review process to improve coding & documentation and to inform interventions in collaboration with other managers
- Evaluating and analyzing HEDIS results, recommending measures for targeted improvement
- Providing recommendations to QI Director for cost efficiency, process improvements and quality interventions
- Working collaboratively with Intervention Managers on interventions related to HEDIS
- Validating the accuracy and integrity of HEDIS data & all data related to submission

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

- Organizing all aspects of CAHPS-related projects
- Managing evaluation and interventions related to Medicare Stars
- Evaluating and analyzing CAHPS results
- Leading CAHPS improvement projects, working in collaboration with Intervention Managers, and operations leaders
- Provide project management leadership for a variety of QI department deliverables
- Organizing data from various sources to support QI program activities, serving as SME data advisor

- Providing recommendations to QI Director for cost efficiency, process improvements, and quality interventions
- Oversight of QI vendor contracts for CAHPS and HOS, along with delegated activities
- Managing activities of QI team, including SharePoint sites
- Leading QI project planning activities related to regulatory and accreditation requirements
- Lead EPSDT compliance activities and improvement efforts
- Leading weekly huddles for the QI team
- Coordinate QMC meetings, assuring reporting is meeting standards and deliverable timelines
- Functions as main administrative contact for QMC
- Works in collaboration with Intervention Managers to maintain timeline deliverables

Intervention Managers responsibilities include, but are not limited to:

- Developing, managing, and evaluating all quality interventions related to adults and pediatrics
- Analyzing data and opportunities to develop quality interventions
- Serving as lead contact and developing interventions with SBHCs
- Leading PIP process for Medicaid Choice contract
- Developing, managing and evaluating quality interventions related to adults
- Evaluating R/E/L data for integrity and CLAS purposes
- Analyzing data and opportunities to develop quality interventions
- Contributing to multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services use and monitoring

QI RN and RN staff resource responsibilities include, but are not limited to:

- Managing QOCCs and quality concerns process in a timely and effective matter
- Providing clinical consultation for the QI team
- Conducting practitioner chart review using HEDIS criteria
- Developing and updating all preventive and clinical guidelines
- Developing and updating all clinical policies and procedures related to the QI team

Quality Management Committee Structure (QMC)

The 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 Company Medical Management activities and processes, including but not limited to: Utilization Management, Case Management, Health Management, Pharmacy, Member Services and Provider Relations. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC reviews and patient safety initiatives. The QMC includes primary care Providers and specialty Providers from both DHHA and the extended practitioner network.

QI Activities Summary

DHMP continues to conduct an in-depth review of all its initiatives and intervention activities, using best practices, LEAN tools and cost/benefit analysis as guides. 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. Interventions that do not meet performance targets may be selected to undergo a root cause analysis and/or barrier analysis. DHMP seeks to improve Member education, health literacy and cultural competency in the services we provide.

Results from QI activities for 2018-20 have been outlined throughout this impact analysis and are also contained in the 2020-21 work plan and strategic access plan. QI will continue to work collaboratively with other departments and the ACS Provider network to improve HEDIS and CAHPS scores. We will strive to increase access to needed care and access to getting care quickly, while focusing on customer service, the Member experience and increasing Member engagement of our Members in the management of their health.