Quality Improvement Impact Analysis

2020-2021

Denver Health Medicaid Choice and Child Health Plans
SFY Contract July 1, 2020 – June 30, 2021

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 2020-2021

- 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, cardiovascular disease, 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 follow up after a positive depression screening in adolescents, 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), Serious Reportable Adverse Events (SRAE), and facilitated process improvements if 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. In 2021, we anticipate enhancing the capability by adding member level data for HEDIS effectiveness of care measure to the foundation data warehouse, which will increase the breadth and depth of available and actionable information.

Our committee structure continued to be evaluated over 2020-21. 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, and now also includes the overall DH system Chief Quality Officer. 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 2020-21. 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 2020-2021, 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, the DHHA Chief Quality Officer, 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.
- Expand the list of HEDIS measures to include the many effectiveness of care measures, monthly, through importing a 'standard HEDIS data extract' into the DHMP data warehouse
- 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.
- Continue to execute a new PIP for follow up on positive depression screening for adolescents, 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, and leveraging the outreach previously performed by Healthy Communities, 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.
- 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 2020-21 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.
Finally, this year has had the impact on the health care system resulting from Covid-19 virus pandemic. It would come as no surprise that this has affected every aspect of care, care delivery, and operations across the integrated payer-care delivery system. We have recognized impact from Covid-19, in observed lower rates of non-urgent outpatient care, including preventive services, for all lines of business; in operations affecting QI initiatives; and a significant community impact including 'stay at home' orders at the community and State levels resulting in barriers to routine and preventive care services, and member hesitancy in care seeking. These trends and changes are also being seen nationally and decreases in rates and percentiles are anticipated for MY2020. Additionally, the situation surrounding the COVID-19 pandemic is still evolving and will continue to affect care delivery in 2021 and with emerging variants, 2022. Thus, we expect that the impact of the COVID-19 pandemic will be reflected in our interventions and QI activities for 2021-2022.

III. Quality of Clinical Care Activities

2020 - 2021 QI Activities/Interventions

The following HEDIS Measurement Year 2020 Indicators will be reported for the FY 2020-2021 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, Pharmacotherapy for Opioid Use Disorder, 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, 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, Well-Child Visits in the First 30 Months of Life, Child and Adolescents Well-Care Visits, Frequency of Selected Procedures, # of specified procedures per 1000-member months, Inpatient Utilization – General Hospital/Acute Care, Ambulatory Care – Outpatient and/or ED, 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 2019 Rates (Medicaid Only)	HEDIS 2020 Rates (Medicaid Only)	HEDIS MY2020 Rates** (Medicaid Only)	HEDIS 2020 HMO Percentile* (Medicaid Only)	HEDIS 2020-MY2020 Change
Eye Exam (Retinal) Performed	45.83%	45.70%	36.25%	10th	-9.45%
Medical Attention for Nephropathy	81.51%	83.75%	Retired	NA	NA
HbA1c Poor Control (>9.0%) *lower score indicates better performance*	40.38%	33.58%	52.46	50th	-18.88%
Blood Pressure Control (<140/90 mm Hg)	61.67%	63.49%	50.23%	25th	-13.26%
Hemoglobin A1c (HbA1c) Testing	82.06	84.43%	73.18%	10th	-11.25%
HbA1c Control (<8.0%)	47.88%	55.47%	38.41%	50th	--17.06%
Kidney Health Evaluation for Patients With Diabetes^	NA	NA	31.64%	NA	NA

*HEDIS 2020 national percentiles are listed above. 2020 percentiles to be released in late 2021
**NCQA Measurement year name change. HEDIS calendar year 2020 results are now known as HEDIS MY2020.
^New measure for MY2020

Analysis

Overall, our HEDIS MY2020 results showed a decrease in each of the Comprehensive Diabetes Care rates measures compared with MY2019. Of the measures that decreased, HbA1c Poor Control (>9.0%) and HbA1c Control (<8.0%) showed the most significant reduction at 18.88% and 17.06%, respectively. All CDC measures are currently performing at or below the 50th percentile nationally. The QI team hypothesizes that these reductions were are least partly caused by the significant drop in routine health screenings conducted during

the COVID-19 pandemic. Of note, the Medical Attention for Nephropathy measure was retired in MY 2020 and replaced with a new measure, Kidney Health Evaluation for Patients with Diabetes (KED). This measure looks at diabetic members (18-85) who received a kidney health evaluation, defined as an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. Since this is the first year of reporting for this measure, there are no established national percentiles. The QI team continues to work with our partners at Denver Health Ambulatory Care Services (ACS) on ways to increase routine health screenings for diabetic members who may have avoided them during the pandemic.
increasing these rates through our collaboration with

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. The collaborative tracked patient outcomes for diabetes control as well as blood pressure, nephropathy, and diabetic eye exams performed. Additionally, with the lessening of COVID-19 restrictions the Diabetes Collaborative Workgroup is also working on ways to ensure diabetic members are receiving timely routine health screenings.

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. As a result of the COVID-19 pandemic and the DHHA Eye Clinic moving to a new location, outreach for Diabetic Eye Exams was suspended for most of FY20/2. Limited outreach for MCD members resumed in Spring of 2021 with plans to increase outreach as the year progresses. Given that DHMP Medicaid continues to be in the 10th percentile nationally, this metric remains an area of opportunity for FY21/22 and a priority collaboration between DHMP and ACS.

Action Plan
The DHMP QI team will continue to participate in both the Diabetes Collaborative 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 new retinal cameras for all primary care clinics. Rollout of these cameras and associated trainings is currently taking place. 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 developed and began to implement an integrated Population Health Management program for our Medicaid population with a focus area on diabetes management for our high-risk patient population. This program aims to improve quality care of diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. DHMP is collaborating with DHHA on peer and support groups and access to community programs. DHMP will provide additional education and support to increase engagement with the healthcare system, identify changeable social determinants of health and decrease inequities in care and access to mental health across our spectrum of diabetic members.

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 preceding PIP cycle 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.

The most recent PIP cycle, a Rapid-Cycle PIP, began in September 2020, with a total timeframe of 18 months, and is scheduled to conclude on June 30, 2022. The topic for this PIP is Depression Screening and Behavioral Health Follow-up within 30 days of a Positive Depression Screen for adolescents ages 12-21. Depression screening and follow-up after a positive screen are topics that are particularly important for adolescents in Colorado. An analysis of Colorado Medicaid data showed that 8.6% of Colorado teens aged 12–17 with Medicaid coverage are diagnosed with depression. This rate is slightly higher than the national rate of 8% for the same population. This issue is particularly salient in Denver County, where a 2018 assessment from Denver Public Health reported that 15% of Denver youth noted that mental health issues were the most important factor impacting their health. Nearly 3 in 10 middle and high school students in Denver responding to the same survey noted that they were so sad or hopeless during the most recent two week period that they stopped doing some of their usual activities. This focus also aligns 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 is working with the DHHA Westside Pediatric Clinic. The Westside Pediatric clinic historically has been an active partner in DHMP QI-based interventions and is the largest medical home by member volume for pediatric Medicaid Choice and CHP+ Members. There are two specific goals for this PIP. The first goal is by June 30th, 2022, use key driver diagram interventions to increase the percentage of members who received at least one depression screening annually among Denver Health Medicaid Choice and CHP+ members aged 12-21 assigned to the Westside Pediatrics PCMH, from 71.40% to 74.39% for the Medicaid Choice population and from 68.46% to 76.15% for the DHMP CHP+ population. The second goal is By June 30th, 2022, use key driver diagram interventions to increase the percentage of members who completed a behavioral health visit within 30 days of a positive depression screening OR who had documentation that they are already engaged in care with an outside behavioral health provider among Denver Health Medicaid Choice and CHP+ members aged 12-21 assigned to the Westside Pediatrics PCMH from 41.63% to 51.58% for the Medicaid Choice population and from 46.43% to 75.00% for the DHMP CHP+ population.
In order to achieve these goals, the QI team will test a series of interventions using PDSA cycles beginning in August 2021. These interventions include conducting universal depression screening for adolescents at acute care visits in addition to well-care visits and focusing on connecting adolescent members with a positive depression screen to same-day in-clinic behavioral health services.

Asthma Measures

Denver Health Medicaid Choice Medication Management for People with Asthma (MMA)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS MY2020 HMO Percentile *	HEDIS 20120-MY2020 Change
5-11 Years - Medication	27.21%	28.57%	Retired	NA	NA

Compliance 75%					
12-18 Years - Medication Compliance 75%	19.42%	29.91%	Retired	NA	NA
19-50 Years - Medication Compliance 75%	43.45%	38.10%	Retired	NA	NA
51-64 Years - Medication Compliance 75%	47.92%	61.90%	Retired	NA	NA
Total - Medication Compliance 75%	33.10%	36.05%	Retired	NA	NA
5-11 Years - Medication Compliance 50%	50.74%	63.39%	Retired	NA	NA
12-18 Years - Medication Compliance 50%	42.72%	53.16%	Retired	NA	NA
19-50 Years - Medication Compliance 50%	73.10%	61.90%	Retired	NA	NA
51-64 Years - Medication Compliance 50%	72.92%	73.81%	Retired	NA	NA
Total - Medication Compliance 50%	58.80%	61.84%	Retired	NA	NA
Asthma Medication Ratio (AMR)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020	HEDIS2020 HMO Percentile*	HEDIS 2020-MY2020 Change
5-11 Years - Asthma Medication Ratio	58.87%	60.68%	63.04%	5th	2.36%
12-18 Years - Asthma Medication Ratio	42.86%	48.94%	54.26%	<5th	5.32%
19-50 Years Asthma Medication Ratio	42.86%	38.95%	48.91%	<5th	9.96%
51-64 Years - Asthma Medication Ratio	39.19%	40.58%	41.98%	<5th	1.40%
Total - Asthma Medication Ratio	46.60%	46.60%	51.41%	<5th	4.81%

*HEDIS 2020 national percentiles are listed above. MY2020 percentiles to be released in late 2021
**NCQA Measurement year name change. HEDIS calendar year 2020 results are now known as HEDIS MY2020.

Denver Health CHP+ Medication Management for People with Asthma (MMA)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020	HEDIS 2020 HMO Percentile*	HEDIS 2020-MY2020 Change
5-11 Years - Medication Compliance 75%	N/A **	N/A **	Retired	NA	NA

12-18 Years - Medication Compliance 75%	N/A **	N/A **	Retired	NA	NA
Total - Medication Compliance 75%	N/A **	N/A **	Retired	NA	NA
5-11 Years - Medication Compliance 50%	N/A **	N/A **	Retired	NA	NA
12-18 Years - Medication Compliance 50%	N/A **	N/A **	Retired	NA	NA
Total - Medication Compliance 50%	N/A **	N/A **	Retired	NA	NA
Asthma Medication Ratio (AMR)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020	HEDIS 2020 HMO Percentile*	HEDIS 2020-MY2020 Change
5-11 Years - Asthma Medication Ratio	NA	NA	NA	NA	NA
12-18 Years - Asthma Medication Ratio	NA	NA	NA	NA	NA
19-50 Years Asthma Medication Ratio	NA	NA	NA	NA	NA
51-64 Years - Asthma Medication Ratio	NA	NA	NA	NA	NA
Total - Asthma Medication Ratio	NA	NA	NA	NA	NA

*HEDIS 2020 national percentiles are listed above. MY2020 percentiles to be released in late 2021

**NCQA Measurement year name change. HEDIS calendar year 2020 results are now known as HEDIS MY2020.

Analysis

Medication Management for People with Asthma was retired by NCQA in CY2020 leaving the Asthma Medication Ratio as the only Asthma metric for the MCD and CHP+ populations. Due to a small sample size, AMR is not reported for CHP. In the MCD population, the AMR rate saw modest increases in MY2020 across all age groups, with the most significant being in the 19–50-year-old age group (increase of 9.96%). Overall, the MCD AMR improved to 51.41% from 46.60%. However, DHMP remains in the 5th percentile or lower nationally for all age groups indicating a need to focus on improvement interventions for this measure. 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 began utilizing a pharmacy vendor tracking system in FY2020/2021 to streamline this process. In Q4 of FY20/21, the DHMP pharmacy team began working with DHHA ACS to provide lists of non-compliant members to their respective PCPS for outreach and intervention. This effort will continue into FY21/22.

Action Plan

The DHMP QI team will continue to highlight to the ACS QI team and the Asthma Work Group, specifically, the importance of focusing on the AMR for our MCD and CHP+ populations. The collaboration with DHMP Pharmacy team to analyze these metrics and develop interventions to address medication adherence will continue into FY21/22. 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, proactively identifying members who have been filling rescue medications but not their prescribed controller medications..

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)**	HEDIS 2019 Results (Medicaid Only)	HEDIS 2020 Results (Medicaid Only)	HEDIS MY2020 Results (Medicaid Only)	HEDIS 2020 HMO Percentile (Medicaid Only)*	HEDIS 2020-MY2020 Change
Prenatal Care in 1st Trimester	71.90%	91.73%	87.10%	50th	-4.63%
Postpartum Care (21-56 days)	56.69%	Timeframe Change	Timeframe Change	***	***
Postpartum Care 7-84 Days after delivery***	Timeframe New H2020	77.62%	74.21%	50th	-3.41%

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late

2021.
** 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 MY2020 rates show a 4.63% decrease in Prenatal Care in the 1st Trimester, and a 3.41% decrease in Postpartum Care from HEDIS 2020. HEDIS 2020 was the beginning of numerous changes to the PPC measure. 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. Prenatal and Postpartum Care (PPC) was submitted as a hybrid measure for H2020 which may have resulted in higher rates last year.

However, it is very likely that the COVID-19 pandemic was also associated with the reduction in rates for these metrics. Early in the pandemic, ACS developed a process to complete initial prenatal care visits over the phone to help minimize potential exposure to COVID-19. The patient would be assessed over the phone and then brought in for an in-person visit and exam as necessary. ACS also developed a process for follow-up phone visits at specified intervals as well as postpartum. Since the phone visits do not count for initiation of care, it is likely that these changes contributed to the small decreases in these metrics.
Additional factors that may have contributed to the changes in Prenatal Care rates are currently under evaluation by the Denver Health Perinatal Committee.

Action Plan for FY21/22
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 2019 Results (Medicaid Only)	HEDIS 2020 Results (Medicaid Only)	HEDIS MY2020 Results (Medicaid Only)	HEDIS 2020 HMO Percentile*	HEDIS 2020-MY2020 Change
46.48%	46.01%	42.60%	<10th	-3.41%

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late 2021.

Analysis
The MY2020 HEDIS rate for Breast Cancer Screening (BCS) decreased by -3.41%from HEDIS 2020 and remained below the 10th percentile (based on HEDIS 2020 percentiles).

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.
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. 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 due to challenges related to the COVID-19 pandemic and Mobile Clinic Services at the new clinic did not resume until Q4 2020.

DHMP sent mammogram reminder mailers to 7,138 female Medicaid Members between July 1, 2020 and June 30, 2021. Of the patients who received mailers between July 2020 and June 2021, 1234 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 FY2021-2022
As in previous years, Mammogram reminder 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. DHMP QI will also continue to collaborate with the Cancer Screening workgroup to plan and implement breast cancer screening interventions. For one of these interventions, 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				
2019 HEDIS Results (Medicaid Only)	2020 HEDIS Results (Medicaid Only)	MY2020 HEDIS Results (Medicaid Only)	2020 HMO Percentile*	HEDIS 2020-MY2020 Change
43.07%	45.58%	41.11%	10th	-4.47%

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late 2021.

Analysis
The rates for Cervical Cancer Screening (CCS) decreased by 4.47% in HEDIS MY2020. 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 reminders was added to the ACS preventive screening mailers that were sent out in 2020.

Due to changes to mammography services during the COVID-19 pandemic, the Women's Mobile Clinic discontinued direct outreach to members who were due for mammograms and other women's health screenings in March of 2020. 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 due to challenges related to the COVID-19 pandemic and Mobile Clinic Services at the new clinic did not resume until Q4 2020. Direct telephone outreach by Women's Mobile Clinic staff resumed in spring of 2021. In addition, 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.)

Action Plan for FY2021-22
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.

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 10/1/17 -9/30/18	EPSDT 10/1/18 -9/30/19	EPSDT 10/1/19 -9/30/20
< 1 year	1.00	1.00	1.00
1-2 years	1.00	1.00	1.00
3-5 years	0.52	0.51	0.47
6-9 years	0.39	0.36	0.29
10-14 years	0.40	0.38	0.32
15-18 years	0.32	0.31	0.29
19-20 years	0.07	0.07	0.07
TOTAL	0.58	0.58	0.46

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 FY2020/2021

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. Our SBHC interventions related to well-child visits became more challenging due to the COVID-19 pandemic and there was less emphasis on this intervention due to remote learning. However, DHMP's intention is to resume this intervention as it was originally designed as soon as the COVID-19 situation allows. Additionally, due to the termination of the Healthy Communities program, a collaboration with DHMP's Care Management team to provide EPSDT services, care coordination, and resolution of barriers to drive well-child visit rates through outreach will replace the function of Healthy Communities. 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. DHMP's Care Management Team employed various methods to

inform eligible members about EPSDT services and assist members with accessing services, including an informational flyer on EPSDT services and through completion of a health needs assessment for new members.

EPSDT Provider Education

Providers were informed about EPSDT through an annual training from the State of Colorado through the DHHA cornerstone training portal. This training is mandatory for new providers. In compliance with a HSAG recommended action, EPSDT training will be made available to Providers twice a year. Additionally, information about the EPSDT program and updates were included in provider newsletters, the provider manual, notification of changes in the provider manual, and network email.

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's Care Management team outreached to new members to complete a Health Needs Assessment, which helps to evaluate eligibility for EPSDT services as well as barriers to care. New members were provided with an informational flyer on EPSDT services with the mailing of the Health Needs Assessment which outlines information on EPSDT services and additional DHMP services which may address barriers to care. Additionally, 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 assists with transportation, making an appointment or answering questions.

Action Plan for FY 21-22

DHMP is continuing collaboration with ACS via the Pediatric Quality Improvement Workgroup to address issues in accessing well-care services. 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. The MCD Population Health Management Program will also continue to prioritize increasing the percentage of children and adolescents (ages 0-21 years) who receive an annual well child visit through our outreach efforts and Care Management programming. DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit. Additionally, as students return to in person learning in the 21/22 school year, DHMP will be looking to restart our collaboration with the School Based Health Center team leads to get members who are consented to be seen at an SBHC the care they need in a timely manner, including COVID-19 vaccinations.

Furthermore, DHMP's Care Management Team identifies members in need of EPSDT services through use of a Health Needs Assessment. Care Management continues to provide support to members by addressing barriers in care and coordinating care between DHMP and network providers. Information regarding these services will continue to be provided to all Medicaid members. DHMP's Care Management team also conducts outreach for services based on provider, UM, or patient self-referrals. 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 schedule 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 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
DTaP	69.47%	70.80%	69.47%	10th	-1.33%
MMR	79.93%	82.97%	84.04%	<10th	1.07%
OPV/IPV	79.93%	82.00%	82.19%	<10th	0.19%
H Influenza type B (HiB)	80.53%	82.00%	81.93%	10th	-0.07%
Hepatitis B	82.53%	84.91%	85.09%	10th	0.18%
Chicken Pox – VZV	80.05%	82.97%	83.68%	10th	0.71%
Pneumococcal Conjugate	67.97%	70.32%	74.21%	10th	3.89%
Hepatitis A	79.39%	82.00%	82.54%	10th	0.54%
Rotavirus	62.56%	63.99%	63.77%	10th	-0.22%
Influenza	51.50%	54.50%	50.26%	50th	-4.24%
Combo 2	67.97%	70.56%	68.51%	25th	-2.05%
Combo 3	64.72%	67.15%	67.98%	25th	0.83%
Immunization for Adolescents (IMA)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2019-2020 Change
Meningococcal	79.43%	80.93%	78.25%	25th	-2.68%
Tdap/TD	78.92%	80.65%	77.64%	10th	-3.01%
HPV	50.98%	52.40%	49.79%	75th	-5.61%
Combo 1	76.89%	78.06%	75.70%	25th	-2.36%

Combo 2	49.46%	50.47%	45.11%	75th	-5.36%
Well-Child Visits (W15, W34, AWC)					
Measure / Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2019 HMO %tile*	HEDIS 2019-2020 change
0-15 Months (6+ visits)	52.28%	55.57%	Retired	<10th	3.29%
3-6 y/o (annual visit)	63.59%	64.53%	Retired	<10th	0.94%
12-21 y/o (annual visit)	41.29%	40.10%	Retired	<10th	-1.19%
Well-Child Visits in the First 30 Months of Life (First 15 Months)	Measure did not Exist	Measure did not Exist	54.69%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	Measure did not Exist	Measure did not Exist	57.13%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure
Child and Adolescent Well-Care Visits (Total)	Measure did not Exist	Measure did not Exist	39.31%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late 2021.

**Immunization measures were submitted with hybrid data for H2020

Denver Health CHP+ Childhood Immunization Status (CIS) **					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
DTaP	69.84%	82.26%	81.94%	75th	-0.32%
MMR	78.57%	93.55%	86.11%	10th	-7.44%
OPV/IPV	75.40%	96.77%	88.89%	25th	-7.88%
H Influenza type B (HiB)	74.60%	95.16%	87.50%	25th	-7.66%
Hepatitis B	73.81%	100%	94.44%	90th	-5.56%
Chicken Pox – VZV	78.57%	93.55%	86.11%	10th	-7.44%
Pneumococcal Conjugate	69.05%	85.48%	83.33%	75th	-2.15%
Hepatitis A	80.16%	93.55%	84.72%	25th	-8.83%
Rotavirus	66.67%	87.10%	80.56%	90th	-6.54%

Influenza	53.17%	64.52%	66.67%	90th	2.15%
Combo 2	67.46%	82.26%	81.94%	75th	-0.32%
Combo 3	65.87%	82.26%	81.94%	90th	-0.32%
Immunization for Adolescents (IMA)					
Measure/Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
Meningococcal	84.21%	91.14%	91.33%	75th	0.19%
Tdap/TD	85.53%	87.97%	90.00%	50th	2.03%
HPV	57.24%	55.70%	55.33%	90th	-0.37%
Combo 1	82.24%	87.34%	88.00%	75th	0.66%
Combo 2	55.92%	53.80%	54.00%	90th	0.20%
Well-Child Visits (W15, W34, AWC)					
Measure / Data Element	HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2019-2020 Change
0-15 Months (6+ visits)	63.64%	66.67%	Retired	25th	3.03%
3-6 y/o (annual visit)	64.74%	71.33%	Retired	25th	6.59%
12-21 y/o (annual visit)	45.30%	52.41%	Retired	25th	7.11%
Well-Child Visits in the First 30 Months of Life (First 15 Months)	Measure did not Exist	Measure did not Exist	64.52%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	Measure did not Exist	Measure did not Exist	66.18%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure
Child and Adolescent Well-Care Visits (Total)	Measure did not Exist	Measure did not Exist	46.11%	New HEDIS Measure No Percentile Calc until HMY2021	New HEDIS Measure

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late 2021.
**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 2021 rates for Medicaid members stayed relatively consistent with HEDIS 2020. Rate increases ranged from 0.18% for the Hepatitis B series to 3.89% for the Pneumococcal vaccine. Rate decreases ranged from 0.07% for the Hib vaccine to 4.24% for the influenza vaccine. Adolescent immunization (IMA) rates for Medicaid members decreased overall with decreases ranging from 2.36% for IMA Combo 1 to 5.61% for the HPV vaccine.

The childhood immunization rates for CHP members showed more notable decreases ranging from 0.32% for

the DTap vaccine to 8.83% for the Hepatitis A vaccine. Outcomes for adolescent immunization (IMA) rates for CHP+ members were more stable with minor changes ranging from a decrease of 0.37% for the HPV vaccine to an increase of 2.03% for the Tdap vaccine.

It should be noted that for H2020, CIS rates were hybrid rates for both Medicaid and CHP+ but for MY2020 the rates were non-hybrid, administrative only. 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, to capture these chart events, and provide the results as a supplemental administrative data source for annual HEDIS submissions, 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. As part of the continued work on this subject, ACS has started the transition to a two dose Rotavirus series which began in January 2021. The goal of this change is to support patient completion of the Rotavirus series and improve Combo 7 rates.

During the COVID-19 pandemic, there was a great deal of effort to ensure that children and adolescents continued to receive vaccinations. DH staff worked to send reminder letters and make reminder calls to help ensure that members received important vaccinations. In spite of the many challenges created by the COVID-19 pandemic, this work and focus helped to prevent significant reductions in the immunization metrics.

Well Child Visits

The previous Well Child Visit measures, Well Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life W34) and Adolescent Well-Care Visits (AWC) were retired by NCQA in MY2020. These measures were replaced with Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV). MY2020 is the first year that rates have been reported for these two measures and their relevant sub measures. Therefore, the QI team is unable to provide year over year comparisons or to compare DHMP rates for MCD and CHP+ with national benchmarks. Comparisons and trends for these measures will resume in HEDIS MY2021. In FY20/21, DHMP developed and implemented 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. This effort includes mailing campaigns (Healthy Heroes cards) to remind families of the need to schedule a well-child visit and of the importance of these visits, EPSDT outreach conducted by the DHMP Care Management team, Health Needs Assessments for members who are newly enrolled in DHMP Medicaid, outreach to families of members who are signed up to participate in the DHHA MyChart system, and the collaboration with DH School Based Health in utilizing school based health centers to provide well-child exams to those members who attend a DPS school and who are consented to receive school-based services...

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. They also include information on how to schedule an appointment for a well child visit. For FY2019-2020, the DHMP mailed an average of 2,600 birthday cards a month to Medicaid Choice Members and an average of 250 birthday cards a month to CHP+ Members.

EPSDT Outreach:

With the termination of the Healthy Communities program, EPSDT outreach conducted by DHMP Population Health Medicaid efforts conducted by the Plan will continue throughout SFY21/22 and remain a powerful way to identify members in need of screenings and services.

Action Plan for FY 2021-2022

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. The MCD Population Health Management Program will also continue to prioritize increasing the percent of children and adolescents (ages 0-21 years) who receive an annual well child visit through our outreach efforts and Care Management programming. . 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. For our adolescent population, collaboration with the DPS School Based Health Centers to identify and see members for Well Child visits during school hours has been highly successful in the past. As students return to in person learning in the 21/22 school year, DHMP will be looking to restart our collaboration with the School Based Health Center team leads to get members who are consented to be seen at an SBHC the care they need in a timely manner, including COVID-19 vaccinations.

Action Plan FY21/22

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. With DPS schools open for in person learning, 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 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
81.44%	92.46%	Retired	25th	11.02%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
BMI Percentile Documentation				
21.89%	25.11%	65.36%	10th	40.25%
Counseling for Nutrition				
7.45%	9.16%	69.85%	25th	60.69%
Counseling for Physical Activity				
5.90%	8.08%	69.19%	50th	61.11%

Denver Health CHP+ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS 2019 Rates	HEDIS 2020 Rates	HEDIS MY2020 Rates	HEDIS 2020 HMO %tile*	HEDIS 2020-MY2020 Change
BMI Percentile Documentation				
21.80%	23.81%	63.96%	10th	40.15%

Counseling for Nutrition				
7.93%	8.31%	70.36%	25th	62.05%
Counseling for Physical Activity				
6.65%	7.41%	69.92%	50th	62.51%

*HEDIS 2020 national percentiles are listed in the following charts. MY2020 percentiles to be released in late 2021.

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.

Data interventions focusing on the improvement of HEDIS data capture in DHMP claims and coding in DHHA's Epic system for the above pediatric measures were implemented Q4 2019. The notable improvements in the rates for these measures in MY2020 are due largely to these interventions which resulted in improved data capture.

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.

COVID-19 Vaccination Outreach

The DHMP QI team has been working closely with the DHMP MCD team, HCPF and our partners at DHHA ACS to increase outreach and access to MCD members who are currently eligible to receive a COVID-19 vaccine. DHMP is focusing on two main priority subpopulations, members of color and members who are potentially homebound. In FY2020/21, DHMP performed targeted COVID vaccination outreach campaigns to identified members of color focused on leveraging established partnerships within the community, conducting a phone campaign to members that have not yet received the vaccine and a direct mailer that includes information regarding vaccine events in the community and provides contact information for care management resources. Care managers determined if a member had received their vaccine using CIIS data and member outreach lists. If a member had not received their vaccine, the coordinator also screened for additional needs and services that the member may require such as transportation, housing, and other community-based services. They also supported the member in scheduling an appointment to receive their vaccine and/or setting up transportation for the appointment as well as educating them when and where they might be able to receive the vaccine if the member is not currently eligible.

For potentially homebound members, DHMP via the Health Plan Services (HPS) team conducted outreach via telephone to those who were eligible to receive the COVID-19 vaccine and helped them to complete the Homebound Vaccination Registration Form so that CDPHE could arrange for transportation and vaccination. DHMP care coordinators also supported all members by inquiring and identifying any additional services or supports the member may need such as transportation, food assistance, and chronic disease management, while communicating with members during routine calls. Additionally, DHMP staff have access to the mobile vaccination clinic calendar and can inform members when the mobile clinic will be in an area close to them and provide them the necessary information and resources. DHMP also utilized a direct mailer sent to homebound members that have not yet received the vaccination or are not responding to the initial telephonic outreach. Members in this group will received information on COVID-19 vaccines as well as a contact number for HPS to be contacted to complete the Homebound Vaccination Registration Form.

Action Plan for FY2021/2022

Outreach for members of color will continue in FY2021/2022 and will expand to include members ages 12-18. DHMP will work with our partners at DHHA ACS Pediatrics including School Based Health Centers to identify and outreach to MCD Choice members ages 12-18. DHHA SBHC and Pediatric clinics will offer vaccine distribution to identified members and track both the outreach conducted (phone, in school, etc.) and the number of vaccinations given at each DHHA clinic location by race/ethnicity. DHMP will provide monthly member lists with vaccination status using updated CIIS data. These members will be vaccinated at time of appointments for other needs or during special COVID vaccination clinics.

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 2021/2022

- 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 Annual Evaluation 2020-2021

For Members identified as needing basic support, including referral coordination, disease management education and support or support with addressing social disparities, like transportation needs, care coordinators can provide the following:

- Referral coordination assists patients 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 platform system. Referrals are also used to promote continuity of care and cost-effectiveness of care.
- Disease management services include patient education and between-visit care to manage conditions such as asthma, hypertension, diabetes, and depression. DH's primary care staffing model includes an enhanced care team that consists of patient navigators, clinical pharmacists for adults, nurse care coordinators for pediatrics, as well as social workers and behavioral health consultants to optimize clinical visits and support referred patients between visits or after care transitions. DHMP care coordinators may also be involved in the provision of disease management and education services. Denver Health's Acute Hospital Care Management team may be involved in disease prevention education as part of an inpatient admission. Some of the disease management activities at DH include:

    - Integrated Behavioral Health
    - Tobacco Cessation Clinic
    - Diabetes Prevention Program
    - Substance Abuse Treatment, Education and Prevention (STEP) Program - The STEP Programs is located on the DH campus and in several Denver Public Schools (DPS), and is a 12-week outpatient treatment program for adolescents and young adults 11 to 24 years of age
    - Denver Comprehensive Addictions Rehabilitation and Evaluation Services (CARES) Program - DH Outpatient Behavioral Health Services (OBHS) offers the CARES Program for treatment of non-opiate drug and alcohol substance use disorders. Patients are required to complete a comprehensive substance abuse evaluation and may be referred for treatment through several avenues, including by health care Providers, DHMP Care Coordinators or by self-referral. Hepatology – Hep C Program
    - Pharmacotherapy Management

In 2020-2021, DHMP successfully implemented quality improvement initiatives for Care Coordination activities, including:

- Development and Implementation of Department of Corrections Care Management Program
- Development and refinement of an internal risk stratification tool
- Development of policies for Transitions of Care, Care Coordination, and Continuity of Care
- Establishment of an external vendor to conduct Health Needs Assessments
- Full implementation of the Altruista Guiding Care© Medical Management Platform, including implementation of Altruista Tableau which pulls data from Guiding Care©
- Full implementation of Care Management Programs for eligible Medicaid and CHP+ Members:
    - Diabetes High Risk Management Program
    - Maternal Care High Risk Management Program
    - Complex Care – Focus on members with claims >$25k

Complex Case Management (CCM)

Patients who are identified as high-risk/medically complex and needing comprehensive care management services have a multidisciplinary care team available for support in managing their health. DHMP has complex case managers and social workers who can identify Members with complex needs, reach out to identified Members, complete a comprehensive multi-domain assessment with the Member and create a Care Plan with the Member that accounts for opportunities, goals and interventions designed to support the Member in achieving their desired health outcomes. All DHMP-initiated CCM activities and communicated and coordinated with the Members Denver Health PCMH whenever possible.

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: 2020-2021

Complex Case Management Metrics	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
CCM Referrals	4	1	21	4	3	4	8	8	4	3	1	2
CCM Actively Managed	29	25	26	29	30	31	28	26	27	28	29	31
CCM Graduated	1	1	0	0	1	0	0	0	0	0	1	0
CCM Member Calls	100	237	191	301	141	223	183	166	180	188	88	130
CCM Member Assessments	13	3	17	6	4	6	3	0	3	3	0	0
CCM Care Coordination Tasks	36	7	32	29	32	34	35	20	20	53	21	32

Results/Analysis:

- We saw reduced spending and inpatient utilization with members enrolled in CCM. Several potential mechanisms could explain the observed decreases in utilization and spending. Improved management of medical, social, and behavioral risk factors may have prevented acute exacerbations of chronic disease. Member engagement may have led to improved self-management and adherence. Social and behavioral stabilizations may have facilitated safe discharge planning, reducing the need for, or duration of, inpatient admissions.
- This decrease in utilization can also be attributed to the COVID-19 pandemic. Members were hesitant to visit the ED except for the most life-threatening services for fear of contracting the virus, and/or emergency rooms better triaging non-emergent patients to lower levels of care (urgent care, PCP).

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: 2020-2021

Transitions of Care Metrics	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
TOC Member Outreach	955	932	604	604	1067	748	1113	722	1043	1,011	875	533
TOC Care Coordination Activities	844	1142	1129	1328	894	1434	1025	1199	1552	1,360	1,452	2023
Hospital Readmissions W/I 30 days	19	25	20	33	23	1	0	0	0	0	0	1
TOC Referrals	187	206	151	191	194	166	175	166	205	179	161	194
TOC Members Graduated	21	26	32	35	38	38	6	11	6	30	25	19
TOC Members Lost to Follow	12	10	7	2	1	0	0	0	1	1	0	0
TOC Opt-Out	26	18	23	10	16	27	32	18	81	32	33	21
TOC Did not meet/Termed Eligibility	7	7	5	20	9	20	13	5	20	5	6	4
TOC UTR (Unable to Reach)	82	109	79	80	101	123	96	83	156	110	100	111

Results/Analysis:

- The transition of care program is working, in that members are having shorter inpatient stays, and the readmission rate remained flat. Additionally, during a pandemic where a member's condition can deteriorate quickly; it would be expected that the readmission rate might climb. However, it did not, and perhaps the measures that are in place can continue to reduce the readmission rate when pandemic mitigation efforts are fully engaged.
- Engagement via telephonic outreach failed to reach 57% of our members. DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity. Strategies that incorporate other forms of outreach (e.g. in-person, text message, email) and partnerships with community organizations could improve engagement among DHMP Medicaid/CHP+ members.

Medicaid & CHP+ CC Program/Health Needs Assessments

This program is intended to manage Medicaid and CHP+ 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

Medicaid & CHP+ CC Program/Health Needs Assessments Metrics: 2020-2021

Care Coordination Program Metrics	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
CC Applications/Membership Assistance	2	7	16	18	9	12	6	3	2	7	3	10
CC Community Resource Assistance	12	37	100	135	66	82	89	96	89	72	85	139
CC Condition Management							19	53	39	17	23	36
CC COVID-19 Outreach	-	-	-	2	1	1	1	1	9	-	-	2
CC Education Provided	-	11	33	41	29	56	62	42	20	16	30	28
CC EPSDT Outreach (Activity Type Configured 10/28/20)				-	39	6	30	25	17	13	21	13
CC Health Acuity/Needs Assessed	21	232	610	641	327	313	376	256	278	220	448	336
CC Health Care Provider Coordination	1	24	67	92	44	89	98	98	95	79	120	136
CC Language Services							10	13	2	5	15	181
CC Medication Management Assistance	-	-	1	2	3	9	7	17	15	10	13	16
CC Member Outreach		186	552	511	241	290	381	297	270	228	437	344
CC SNAP Coordination				-	17	26	26	13	27	15	23	31
CC Vaccination Coordination			2	-	-	-	-	1	-	-	-	3
CC WIC Coordination				1	12	8	1	2	1	-	2	3
CC Member Outreach - Calls	22	453	1265	1290	713	798	1,106	917	864	682	1,220	1,278

Health Needs Survey Completion Rate	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
Medicaid Choice Health Needs Survey	500	246	300	268	225	432	152	303	343	391	287	399
CHP+ Health Needs Survey	84	14	29	5	6	17	8	3	1	13	5	11
Medicaid State Survey	29	22	41	45	40	49	52	44	37	49	35	34
MCD HNA Outreach (Performed by SPH) Mailings							2,941	2,911	2,781	2,592	2,037	2,378
MCD HNA Outreach (Performed by SPH) Calls							2,826	2,653	2,623	2,395	1,862	2,169
Total Completed Surveys	613	282	370	318	271	498	212	350	381	453	327	444

Results/Analysis:

- SPH Analytics is a third-party vendor that initiates the HNA outreach for all Medicaid and CHP+ new enrollments. All completed HNAs are reviewed by care coordinators for analysis and stratification of health care needs and outreach.
- The team identified areas of focus to improve member health and reducing health care costs by improving member adherence to treatment recommendations, improving communication and coordination among health care providers, and increasing access to support services and addressing social determinants of health (SDOH).

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: 2020-2021

COVID-19 Metrics	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun
TOTAL COVID-19 Member Outreach - Calls	33	16	17	18	54	56	245	386	128	125	131	1665

Results/Analysis:

- CM team focused on addressing food insecurity among members. They addressed social needs by linking our members to relevant resources, such as food banks, meal programs, referrals to WIC and SNAP, transportation and rideshare companies, and local food events happening in their communities.
- COVID-19 brought numerous mental health challenges due to elevated stress, financial insecurity, isolation and loneliness, and exposure to loss and traumatic events. CM addressed these needs by providing resources and education on behavioral health programs, emotional and well-being self-management programs that could be accessed on MyStrength. Resources for peer support groups, community-based programs, assistance scheduling appointments with Behavioral Counselors that were co-located at their medical homes, transportation, and medication management.

Full implementation of Care Management Programs for eligible Medicaid and CHP+ Members:

- Diabetes High Risk Management Program (MCD Only)
- Maternal Care High Risk Management Program (MCD and CHP+)
- Complex Care – Focus on members with claims >$25k (MCD Only)

These programs are new in 2021 and focus right now is building caseloads, finalizing policies and procedures, and tracking and trending metrics.

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). Ambulatory QIC oversees 1 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:

Strategic Metrics

	Breast Cancer Screening 62%	Cervical Cancer Screening 72%	Colorectal Cancer Screening 62%	Diabetes A1c<=9 (new denom) 65%	Diabetes Kidney Health Evaluation 40%	Hypertension BP Controlled 67%	First Trimester Entry into Prenatal Care 78%	Persistent Asthma on Controller Meds 5-64 yrs 77%	Depression Screen and Follow-up Plan if Positive 65%
CHS Overall	51.8%	59.3%	59.1%	66.8%	43.6%	64.7%	60.0%	76.0%	70.3%

Medicaid – Strategic Metrics:

Strategic Metrics

	Breast Cancer Screening 62%	Cervical Cancer Screening 72%	Colorectal Cancer Screening 62%	Diabetes A1c<=9 (new denom) 65%	Diabetes Kidney Health Evaluation 40%	Hypertension BP Controlled 67%	First Trimester Entry into Prenatal Care 78%	Persistent Asthma on Controller Meds 5-64 yrs 77%	Depression Screen and Follow-up Plan if Positive 65%	Peds Vaccinations Combo 7 75%
CHS Overall	50.7%	67.4%	51.9%	55.5%	40.5%	61.1%	79.5%	75.9%	69.0%	72.2%

CHP+ Strategic Metrics:

Strategic Metrics

	Cervical Cancer Screening 72%	Diabetes A1c<=9 (new denom) 65%	Diabetes Kidney Health Evaluation 40%	Hypertension BP Controlled 67%	First Trimester Entry into Prenatal Care 78%	Persistent Asthma on Controller Meds 5-64 yrs 77%	Depression Screen and Follow-up Plan if Positive 65%	Peds Vaccinations Combo 7 75%
CHS Overall	37.5%	50.0%	50.0%	50.0%	85.7%	78.8%	78.2%	85.1%

CHP+ Non-Strategic Metrics:

Peds Metrics

	Adolescent Vaccinations 80%	Anemia Screening - Peds	Chlamydia Screening - Adolescents	Chlamydia Screening at Visit 14-24 yrs 67%	Cholesterol Screening - Peds	Dental Visit or Fluoride Application, 1x by.. 75%	Depression Screen and Follow-up Plan if Positive 65%	Depression Screening/Monitor at Vis..	Developmental Screening, 12-36 mos 85%	Hearing Screening - Peds	HIV Screening - Adolescents	Lead Screening - Peds
CHS Overall	94.6%	56.1%	29.0%	67.9%	38.0%	100.0%	78.2%	80.0%	95.4%	73.1%	36.0%	56.1%

Peds Metrics

	MCHAT Screening 90%	Measles 2 yr olds	Measles 4-6 yr olds	Peds Vaccinations Combo 10 60%	Peds Vaccinations Combo 7 75%	Persistent Asthma on Controller Meds 2-18 yrs 75%	Six Well Child Visits Before 15 Months 79%	Vision Screening - Peds	Weight Assessment and Counseling - Peds 72%	Well Child Check Rate 10-18 year olds	Well Child Check Rate 3-6 year olds 78%	Well Child Check Rate 3-9 year olds 76%
CHS Overall	87.1%	98.9%	89.5%	66.7%	85.1%	83.3%	44.8%	74.2%	81.2%	71.7%	76.0%	75.9%

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 this past year is mailing Patient Health Summary Letters which show the patient's status on various indices of care (cancer screening, sugar control, blood pressure control, etc), these letters would then encourage patients to take action to address these gaps. Examples include self-schedule for a mammogram, set an appointment with their provider to address their diabetes or hypertension. We have been sending about 1,000 letter per month in the past few months. Analyses show that the letters made a difference in getting patients to clinic and improving a number of metrics 60 days after the letter was sent. This was compared to a population of patients who did not receive these letters during the same time period. The letters improved attending clinic appointments, getting a hemoglobin A1c test, cervical cancer screening, getting a mammogram, and returning the FIT kit (colon cancer screening). The next step is working with Epic to develop a more efficient (currently manual) process for sending out these letters.

Patient experience is at the center of everything we do and is, therefore, one of Denver Health's top priorities. Patient experience data is collected by Press Ganey in our Ambulatory Care settings using an e-survey that every patient receives following an encounter. Results are available to all clinic leaders through the Press-Ganey database, and they are reviewed, summarized, and distributed to each PCMH to be displayed on their 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 organization's strategic initiatives. Additionally, the Denver Health Patient Experience Team provides consult and coaching services to support the implementation of evidence-based practices aimed at continual improvement which enables us to deliver patient- and family-centric care.

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.

CHS Overall (Primary Care and Specialty Care Combined) (Service Date 7/1/2020 – 6/30/2021)

Care Provider Overall Rating		
Rating	**Number of Respondents**	**% of Total Responses**
Very Poor	1,640	1.80%
Poor	1,176	1.29%
Fair	3,303	3.62%
Good	15,017	16.48%
Very Good	70,001	76.81%
Total	91,137	

DHMP Medicaid Choice (Primary Care and Specialty Care Combined) (Service Date 7/1/2020 – 6/30/2021)

Care Provider Overall Rating		
Rating	**Number of Respondents**	**% of Total Responses**
Very Poor	298	1.65%
Poor	298	1.65%
Fair	758	4.20%
Good	3,208	17.77%
Very Good	13,494	74.73%
Total	18,056	

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 2020 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

The following tables show the survey results from 2018 through 2020 CAHPS surveys for Adult and Child Medicaid and CHP+. 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: < 5th, 10th, 25th, 50th, 75th, 90th, or > 95th. CHP+ scores are similarly compared to national benchmarks using these percentile rankings: <25th, 25th, 50th, 75th, >95th.

	Adult Medicaid CAHPS Results 2020			
Overall Member Satisfaction Ratings (% 8, 9, 10)	2018	2019	2020	2020 Quality Compass Percentile
Health Care	77%	70.6%	70.3%	10th
Personal Doctor (PCP)	86%	82.0%	88.3%	98th
Specialist	84%	85.0%	82.7%	50th
Health Plan	74%	71.6%	74.8%	26th
	Composite Satisfaction Ratings (%Always/Usually)			
Getting Care Quickly	78%	73.5%	73.5%	<5th
Getting Needed Care	76%	71.8%	74.5%	5th
How Well Doctors Communicate	93%	92%	94.2%	86th
Health Plan Customer Service	86%	90%	89.1%	51st

	Child Medicaid CAHPS Results 2020			
Overall Ratings (% 8, 9, 10)	2018	2019	2020	2020 Quality Compass Percentile
Health Care	91%	92.4%	79.4%	<5th
Personal Doctor (PCP)	96%	96.2%	89.4%	32nd
Specialist	94%	83.8%	87.0%	41st
Health Plan	88%	89.8%	80.7%	7th
	Composite Ratings (%Always/Usually)			
Getting Care Quickly	86%	87.2%	80.5%	<5th
Getting Needed Care	85%	78.2%	75.1%	<5th

	Child Medicaid CAHPS Results 2020			
Overall Ratings (% 8, 9, 10)	2018	2019	2020	2020 Quality Compass Percentile
How Well Doctors Communicate	95%	95.5%	94.9%	62nd
Health Plan Customer Service	92%	86.1%	89.0%	56th

CHP+				
Overall Ratings (% 8, 9, 10)	2018	2019	2020	2020 Quality Compass Percentile
Health Care	70.2%	69.2%	66.5%	N/A
Personal Doctor (PCP)	84.6%	75.7%	85.1%	N/A
Specialist	84.1%	85.3%	77.1%	N/A
Health Plan	65.3%	65.4%	65.0%	N/A
Composite Ratings (% Always/Usually)				
Getting Care Quickly	88.4%	85.0%	85.9%	N/A
Getting Needed Care	83.5%	79.7%	80.5%	N/A
How Well Doctors Communicate	95.6%	94.4%	96.9%	N/A
Health Plan Customer Service	84.4%	87.8%	86.1%	N/A

Analysis

CAHPS ratings decreased from 2019 to 2020 for many Child Medicaid measures including overall rating of Health Care, Personal Doctor, G Health Plan, Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate. Modest increases did occur in the Child Medicaid measures for overall rating of Specialist and Health Plan Customer Service. CAHPS ratings for the Adult Medicaid population largely increased or remained very similar in many areas from 2019 to 2020. Modest increases were seen in overall rating of Personal Doctor, Health Plan, Getting Needed Care and How Well Doctor's Communicate. Overall rating of Health Care, Getting Care Quickly and Health Plan Customer Service remained very similar year over year and Overall Rating of Specialist decreased from 85% to 82.7%, the largest decrease in this population.

CHP+'s overall ratings for 2020 had two measures which were at or above the 90th percentile for NCQA including Rating of Personal Doctor and How Well Doctor's Communicate. Overall, CHP+ CAHPS scores improved for two of the measures, decreased for two and remained relatively stable for four. Low response rates continue to be a challenge for this population. The 2019 CAHPS response rate for DHMP Medicaid Choice were at 10% with 2020 final response rates at 10.9%. 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. 2020 response rates for the CHP+ population were 18.74%.

Improvements in overall scores can indicate that initiatives to improve CAHPS scores are working; however, DHMP CAHPS scores for 2020 remained relatively stable (no statistically significant changes overall) 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. Additionally, The DHMP and SPH team will collaboratively host a results session for leadership to review current results for all lines of business and develop action strategies in September 2021. The QI team also provides full results to all product line managers and a comprehensive summary of results to the DHMP executive team. Further improvement efforts are needed to ensure steady improvement over time. Main areas of opportunity include improving Overall Rating of Health Care, Getting Needed Care and Getting Care Quickly,

General efforts to improve CAHPS scores have included:

- Improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores
- Increased Member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings
- Implemented focused Member outreach and Care Management to facilitate care transitions when acuity of need was identified
- Developed and implemented enhanced patient education materials specific to chronic disease states and Covid Vaccination
- Create member communication about enhanced provider network and provider resources, and how to access care, to address opportunities of getting needed care, and getting care quickly.

More precise efforts to improve scores on specific CAHPS measures include:

- Getting Needed Care and Getting Care Quickly

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 and opened the new Outpatient Medical Center (OMC) which is 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. The OMC frees space on the main campus to continue growth in pediatric services and allow us to increase the number of inpatient psychiatric beds . 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. Throughout the COVID-19 pandemic, DHMP members have been able to schedule Telehealth appointments with certain providers in order to receive ongoing and timely medical care without the health risks of being seen in person. Organizationally, there is an increased focus on improving Empanelment for the DHMP Medicaid Choice population. Outreach was conducted for high-risk Medicaid members who had not had a PCP visit to encourage them to schedule a primary care visit. The initial list included 614 members with 264 of them having completed a PCP visit by the end of the fiscal year. Consistent access to a care delivery network results in increased satisfaction with the health care system and better health outcomes for the population.

Health Plan Customer Service: Efforts continue to improve Health Plan Customer Service (HPS). 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 works directly 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 participates 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
In reviewing the last 2 quarters of 2019 data, the number of members that met the 4x4x4 criteria (Taking 4 or more controlled substance medications, written by 4 or more prescribers, and filling these medications at 4 or more pharmacies) 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, and this tracking and monitoring is ongoing.

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.

DHMP monitors what Colorado State Medicaid 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 opioid 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 2020		
Total Claims Approved:	37	33.3%
Total Claims Denied:	74	66.7%

Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	74	
Total Member Count:	13	
Total Prescriber Count:	19	
Total Pharmacy Count:	20	
Total Denied Claim Count Subsequent Fill:	53	
Total Denied Claim Count No Subsequent Fill:	21	
Total First Denied Claims**:	24	
Total First Approved Claims**:	16	
Total Ingredient Cost Denied Claims**:	$3,031.25	
Total Ingredient Cost Approved Claims**:	$1,162.84	
Average Ingredient Cost/Denied Claim**:	$126.30	
Average Ingredient Cost/Approved Claim**:	$72.68	

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

4th Quarter 2020		
Total Claims Approved:	14	24.1%
Total Claims Denied:	44	75.9%
Total Soft Edit Denials (OCDP only):	0	
Total Hard Edit Denials (OCDP only):	44	
Total Member Count:	12	
Total Prescriber Count:	16	
Total Pharmacy Count:	11	
Total Denied Claim Count Subsequent Fill:	29	
Total Denied Claim Count No Subsequent Fill:	15	
Total First Denied Claims**:	16	
Total First Approved Claims**:	7	
Total Ingredient Cost Denied Claims**:	$1,712.99	
Total Ingredient Cost Approved Claims**:	$1,208.31	
Average Ingredient Cost/Denied Claim**:	$107.06	
Average Ingredient Cost/Approved Claim**:	$172.62	

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

1st Quarter 2021		
Total Claims Approved:	30	33.3%
Total Claims Denied:	60	66.7%
Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	60	
Total Member Count:	10	
Total Prescriber Count:	18	
Total Pharmacy Count:	15	
Total Denied Claim Count Subsequent Fill:	47	
Total Denied Claim Count No Subsequent Fill:	13	
Total First Denied Claims**:	15	
Total First Approved Claims**:	12	
Total Ingredient Cost Denied Claims**:	$801.81	
Total Ingredient Cost Approved Claims**:	$289.88	
Average Ingredient Cost/Denied Claim**:	$53.45	
Average Ingredient Cost/Approved Claim**:	$24.16	

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

2nd Quarter 2021		
Total Claims Approved:	28	36.8%
Total Claims Denied:	48	63.2%
Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	48	
Total Member Count:	14	
Total Prescriber Count:	15	
Total Pharmacy Count:	12	
Total Denied Claim Count Subsequent Fill:	34	
Total Denied Claim Count No Subsequent Fill:	14	
Total First Denied Claims**:	14	
Total First Approved Claims**:	13	
Total Ingredient Cost Denied Claims**:	$707.40	
Total Ingredient Cost Approved Claims**:	$241.85	

Average Ingredient Cost/Denied Claim**:	$50.53	
Average Ingredient Cost/Approved Claim**:	$18.60	

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

Analysis

The number of members affected has decreased over the past year. On average, around 12 members are above the limit at a given time. This number was around 20 members per quarter the last year we reviewed. 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 (PAs) for members with cancer pain, sickle cell disease, in hospice and in palliative care, as these diagnoses are excluded from these restrictions. The plan will also accept and review PAs to allow time to taper the dose down to the appropriate limit.

3Q2020	# of PAs	7
4Q2020	# of PAs	7
1Q2021	# of PAs	7
2Q2021	# of PAs	8

There have not been many members affected by this edit, which reflects positively on the Denver Health Medicaid Provider's prescribing habits. There have also not been 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.

Summary of Opioid Controls

Since the previous analysis, there have been several other mechanisms put in place for controlling opioid utilization for our Medicaid members.

Specific Edit	Description
Days Supply for Opioid Naïve Members	The Opioid Naïve Days Supply Limitation edit limits the days supply of the first fill of opioids for opioid naïve members to a max of 7 days. Opioid naïve members are identified by a defined look back period into the member's claim history for any opioid prescriptions in the past 180 days. Effective 2019

Subsequent Fill Limits for Opioid Naïve Members	This restriction will limit the amount of opioid fills for members who have not recently filled an opioid prescription. Two claims within a 30-day period. *Most scenarios will not actually cause a denial. If a patient fills RX #1 on day 1 for 7-day supply, and then RX #2 on day 7 for a 30 -ay supply. They won't be subject to this edit upon the next refill. Effective March 2021
Duplicative Long-Acting Opioid Therapy	This program will identify and deny a long-acting opioid when it overlaps with another long-acting opioid of a different active ingredient. This will apply to prescriptions written by different prescribers. Effective March 2021
Opioid Cumulative Dosing	This program will deny an incoming opioid claim(s) that meets or exceeds a member's daily cumulative morphine milligram equivalent (MME) limit (200 mg per day). This has been in place since the end of 2017.
Opioid-Buprenorphine Concurrent Use	This restriction denies an incoming opioid claim when it overlaps with a claim for buprenorphine used for medication assisted treatment (MAT). These are suboxone type products containing buprenorphine. Effective March 2021
ProDUR Naloxone Pharmacy Alert	This alert sends an informational message to the pharmacy when a member has a drug combination indicating the member is at high risk for opioid overdose. "HIGH RISK POTENTIAL. CONSIDER DISPENSING OR PRESCRIBING NALOXONE." Effective March 2021

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 July 9, 2020 the plan was notified that Amneal Pharmaceuticals Metformin Hydrochloride Extended-Release tablets USP, 500mg and 1000mg were recalled as part of the ongoing assessment and continuation of dialog with the FDA. Additional analysis revealed that certain tested batches were above the acceptable daily intake limit for the impurity N-Nitrosodimethylamine (NDMA). Out of an abundance of caution, the company recalled all batches.

On August 6, 2020 the plan was notified that Ferring Pharmaceuticals US voluntarily recalled all lots of DDAVP® Nasal Spray 10 mcg/0.1mL, Desmopressin Acetate Nasal Spray 10 mcg/0.1mL, and STIMATE® Nasal Spray 1.5 mg/mL to the consumer level. These products were recalled due to superpotency or amounts of desmopressin that were higher than specified. The identification of these higher amounts were obtained during routine testing.

On September 10, 2020 the plan was notified that RLC Labs, Inc. was recalling all lots (total of 483) of Nature-Throid® and WP Thyroid® in all strengths and product sizes that were within current expiration dates to the consumer level. The products were recalled due to testing of samples from six lots by the U.S. Food and Drug Administration that found the samples to be sub-potent. The products may have had as low as 87% of the labeled amount of Liothyronine (T3) or Levothyroxine (T4) that it should have contained.

On December 30, 2020 the plan was informed that Sunstar Americas, Inc. (SAI) voluntarily recalled all lots of Paroex® Chlorhexidine Gluconate Oral Rinse USP, 0.12% products bearing an expiration date from 12/31/2020 – 9/30/2022 to the consumer level. The recall was due to a possible contamination with the bacteria Burkholderia lata. Twenty-nine adverse events had been reported to SAI related to this recall. Affected patients tested positive for Burkholderia lata infections, typically found in sputum cultures while under treatment for other serious medical conditions.

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

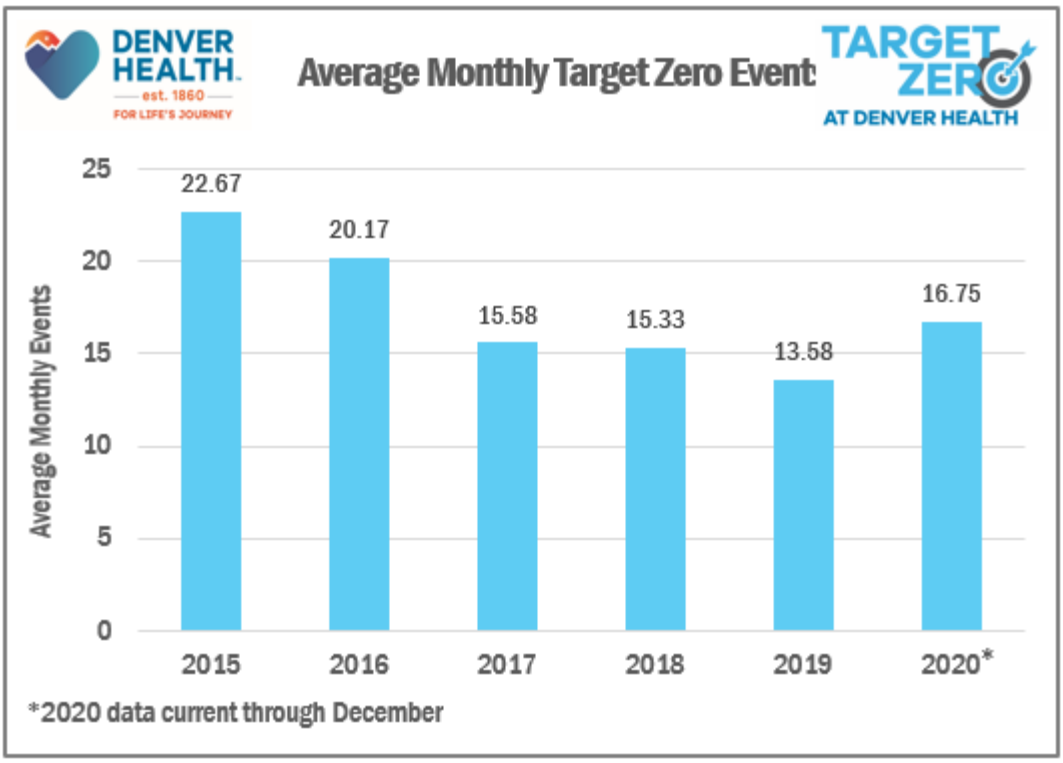
Patient Safety

In 2020-21, 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 2021-2022, 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 continues to pursue a culture of safety by supporting the aspirational goal of zero harm through "Target Zero" initiatives. Target Zero initiatives aim to eliminate preventable harm events

such as surgical site infections, hospital acquired VTE's, hospital acquired pressure injuries, hospital acquired c.difficile infections, central line infections, urinary tract infections associated with urinary catheters, and falls with injuries. Since 2015, there has been a 28% reduction overall for all categories combined. Greatest improvement has been the reduction in central line associated infections by 63% and 51% reduction in hospital associated c.difficile infections between 2015 and 2020.



In addition to Target Zero, Denver Health is focusing efforts on reducing chronic opioid use and post-operative complications, increasing hand washing awareness through electronic monitoring, measures to support clinical equality, improved virtual provider communication, and provider performance scorecards.

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.

Also reflected in the SFY 2020-2021 data were 3 member grievances with the CHP+ line of business. In analyzing these cases, the primary area of concern is Billing/Financial issues. These grievances stemmed from denials due to lack of authorization for out of network providers. All cases were resolved timely and with education to the members in the grievance resolution letters about when an authorization must be obtained. G&A continues to monitor these CHP+ cases for compliance of classification, timeliness and the regulatory requirements in the resolution process.

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)

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 2020	Second Quarter Oct-Dec 2020	Third Quarter Jan – Mar 2021	Fourth Quarter Apr –June 2021	Total for SFY 2021
Unsubstantiated	2	1	5	1	9
Substantiated	0	0	0	0	0
Inconclusive	0	0	0	0	0
Total	2	1	5	1	9

There has been a total of 9 cases which were submitted to the QOCC for review for the fiscal year. All were found to be unsubstantiated upon review of medical records. Member received appropriate care by providers.

Trends:

- 2 cases focused on prescriptions; one was for controlled substances. Both cases found to be ordered appropriately by MD. Second case was based on reactions and was discontinued appropriately. No actions needed.
- 2 cases for access or delay in care: first case delay due to COVID closures and member cancellations of appts; second case found active authorizations and appointments already scheduled. No actions needed.
- Remaining cases were incidental, and no trends or tracking required.

Denver Health CHP+

QOCC Review Outcomes	First Quarter July – Sept 2020	Second Quarter Oct-Dec 2020	Third Quarter Jan – Mar 2021	Fourth Quarter Apr –June 2021
Unsubstantiated	0	0	0	0
Inconclusive	0	0	0	0
Substantiated	0	0	0	0
Total	0	0	0	0

There have been no QOCCs from CHP+ plan members for the timeframe designated in the grid

QOCC Review Outcomes Defined:

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

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	FY2020/2021
English	Count	44,452
	Rate	41.5%

Spanish	Count	20,742
	Rate	19.3%
Vietnamese	Count	470
	Rate	0.4%
Chinese	Count	193
	Rate	0.2%
Amharic	Count	343
	Rate	0.3%
Arabic	Count	421
	Rate	0.4%
Russian	Count	96
	Rate	0.1%
Burmese	Count	109
	Rate	0.1%
Nepali	Count	137
	Rate	0.1%
French	Count	148
	Rate	0.1%
Somali	Count	151
	Rate	0.1%
Persian	Count	117
	Rate	0.1%
Unknown/No Language Selected	Count	39,113
	Rate	36.5%
Grand Total	Count	107,188

*Numbers reflect enrollment 7/1/2020-6/30/2021

DHMP Medicaid Member Language Summary

As of June 2021, there were 50 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 FY2020/2021. It is also important to note that preferred language data is unknown for approximately 36.5% 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	FY2020-2021	
	Count	Rate
Unknown/Not Reported	15,844	14.8%%
Hispanic or Latino	41,841	39.0%
White	27,431	25.6%
Black/African American	17,688	16.5%
Asian	3,155	2.9%
Alaskan/American Indian	773	0.7%
Hawaiian	177	0.2%

Grand Total	107,188

*Numbers reflect enrollment 7/1/2020-6/30/2021

DHMP Medicaid Member Race/Ethnicity Summary

Medicaid member race/ethnicity and language data from the July 2020-June 2021 eligibility files were examined. Based on our analysis for our Medicaid line of business in FY2020/2021, Hispanic or Latino was the predominant race/ethnic of our member population at 39.0%% followed by White at 25.6% and Black/African American at 16.5%. 14.8% of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

In late FY2020-2021, DHHA initiated a new process for collecting REL data, known as REAL (Race, Ethnicity and Language) Data collection. The REAL data collection process provides standardized tools for collecting more comprehensive and accurate REL data on the patients that DHHA serves. Updates include new data fields in the EMR called "Ethnic Background" with 300+ options for patients to choose as well as updated race and ethnicity drop-down options. Staff will ask all the following questions at least one time for all patients in the DHHA community including many DHMP members.

1. Ethnic background
2. Patient race
3. Hispanic/Latinx?
4. Birth country
5. Language
6. Need interpreter?

Data capture began in Spring of 2021 through our ACS partners. DHMP will utilize this data for MCD and CHP+ members seen at DHHA clinics to improve our CLAS efforts.

DHMP CHP+ Language Data*

Language	Measure	FY2020/2021
English	Count	927
	Rate	27.1%
Spanish	Count	1,322
	Rate	38.7%
Vietnamese	Count	19
	Rate	0.6%
Amharic	Count	15
	Rate	0.4%
Arabic	Count	12
	Rate	0.4%
Russian	Count	15
	Rate	0.4%
Burmese	Count	9
	Rate	0.3%
Nepali	Count	10
	Rate	0.3%
French	Count	11
	Rate	0.3%
Unknown/No	Count	1,039

Language Selected		
	Rate	30.4%
Grand Total	Count	3,417

*Numbers reflect enrollment 7/1/2020-6/30/2021

DHMP CHP+ Member Language Summary
As of June 2021, there were 22 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 FY2020/2021It is also important to note that preferred language data is unknown for approximately 30% 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	FY2020/2021	
	Count	Rate
No Ethnicity/Unknown/Not Reported	595	17.4%
Hispanic or Latino	1,784	52.2%
White	513	15.0%
Black/African American	322	9.4%
Asian	176	5.2%
Alaskan/American Indian	16	0.5%
Hawaiian	7	0.2%
Grand Total	3,417	

*Numbers reflect enrollment 7/1/2020-6/30/2021

DHMP CHP+ Member Race/Ethnicity Summary
CHP+ member race/ethnicity and language data from the July 2020June 2021 eligibility files were examined. Based on our analysis for our CHP+ line of business in FY2020/2021, Hispanic or Latino was the predominant race/ethnic of our member population at 52.2% followed by White at 15.0%% and Black/African American at 9.4%%. 17.4% of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

In late FY2020-2021, DHHA initiated a new process for collecting REL data, known as REAL (Race, Ethnicity and Language) Data collection. The REAL data collection process provides standardized tools for collecting more comprehensive and accurate REL data on the patients that DHHA serves. Updates include new data fields in the EMR called "Ethnic Background" with 300+ options for patients to choose as well as updated race and ethnicity drop-down options. Staff will ask all the following questions at least one time for all patients in the DHHA community including many DHMP members.
1. Ethnic background
2. Patient race
3. Hispanic/Latinx?
4. Birth country
5. Language
6. Need interpreter?

Data capture began in Spring of 2021 through our ACS partners. DHMP will utilize this data for MCD and CHP+

members seen at DHHA clinics to improve our CLAS efforts.

DHMP/DHHA Provider REL data
For DHHA providers, the top four ethnicities reported were 'Caucasian' (36.3%), 'Hispanic' (3.15%), 'Asian' (3.7%) or 'Black'' (0.6%). (Note that 52.9% of providers chose not to self-report their ethnicity by selecting 'Other' or by leaving their response 'Blank').

In comparing the self-reported ethnicity needs of members against the self-reported ethnicity offerings of providers, ethnicity needs are met; however, because 52.9%% of providers selected 'Blank', it is hard to be sure.

For providers, the top languages reported in CY2020 were 'English' (82.06%), 'Spanish' (15.00%), 'Note that members who chose not to self-report their language by selecting 'No Language', 'Other', or 'Unknown', or by leaving their response 'Blank' were included in the English-speaking group.

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

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

Additionally, in recognition of our efforts to support culturally responsive healthcare delivery, in June 2012 DHMP received the National Committee for Quality Assurance (NCQA) Multicultural Health Care (MHC) Distinction for both our Medicaid and Medicare product lines. This prestigious distinction recognized our efforts to improve culturally and linguistically appropriate services and reduce healthcare disparities for our Medicare and Medicaid memberships. In 2016, we were re-accredited for the NCQA Multicultural Distinction through July 1, 2018, with a score of 93%.

Due to the importance of CLAS, REL data and language services, these standards are now included in the NCQA standards and guidelines for the accreditation of health plans. DHMP will continue to support, offer and engage in CLAS resources for our members though the health plan standards, and will not renew MHC distinction going forward. As a result of the importance of this work, DHMP has collaborated with DHHA to address REL disparities in health. DHMP will continue to participate with ACS to address identified REL related disparities in health in FY2021/2022

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."

AS of 2021, Colorado is consistently identified as one of the top ten states with the largest Hispanic or Latino population. This is evidenced at DHMP as 38.2% 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
- Hispanic populations tend to respect and consult older family members when it comes to health decisions
- Hispanics have the highest uninsured rates of any racial or ethnic group within the United States
- 71% of Hispanics speak a language other than English at home

To ensure providers and staff are aware of and considering culture when providing care, DH has integrated cultural competency into its annual training. In 2021, 8,078 current and active DH staff passed the module, called the 'Denver Health Experience.'

Barriers

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

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

Opportunities for Improvement

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

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

Interventions

Based on the aforementioned opportunities for improvement, the following interventions have been identified as priorities for 2021

- Continue to update the DHMP Roster Management Template to include additional languages (i.e., beyond English) spoken by the provider
- Continue to 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.

Disparities in Health

In FY2020/21, reducing disparities in health related to race, ethnicity and language was identified as an enterprise opportunity, increasingly so as the COVID-19 pandemic and vaccination effort have emphasized the

continuing disparities in health outcomes related to race and ethnicity. In FY2021, DHNMP, with support from HCPF and FEMA, began conducting targeted outreach to DHMP MCD members of color and members who may be housebound to ensure that they have equal access to the COVID-19 vaccines with the goal of eliminating any disparity between the rate of white members being vaccinated and the rate of members of color being vaccinated.
In addition to this ongoing system wide work to improve COVID-19 outcomes and vaccination rates across racial/ethnic groups, DHMP continues to grow and define its integrated Population Health Management programming for our Medicare, Commercial and Exchange populations with a focus on identifying and eliminating racial and ethnic health disparities. The program includes a concerted focus on metrics traditionally associated with high levels of disparities such as, children's wellness exams and immunizations, prenatal care, members with multiple chronic conditions and members with mental health 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. Potential initiatives in development with ACS partners include low birth weight for Black women, HbA1c control in Latino members and hypertension control in Black members. More specifically, 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. 2020 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 58.9% and Whites and Hispanics at 61.1% and 64.6%, 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 FY2021/2022

In FY2020/2021, 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 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 to Care and Services

Access Measures

Access Measures	Denver Health Medicaid Choice				
	HEDIS 2019 Results: MCD	HEDIS 2020 Results: MCD	HEDIS Measurement Year 2020 Results: MCD	2020 HEDIS MCD Percentile	HEDIS 2019-2020 Change
Children and Adolescents' Access to PCP (CAP)					
12-24 Months	88.52%	89.11%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
25 Months-6 Years	75.09%	74.46%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
7-11 Years	80.08%	80.05%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
12-19 Years	80.30%	79.19%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
Adults' Access to PCP (AAP)					
Ages 20-44	48.84%	49.81%	47.79%	<5th	-2.02%
Ages 45-64	62.17%	63.53%	58.29%	<5th	-5.24%
Ages 65+	68.56%	71.75%	59.42%	<5th	-12.33%
Total	53.89%	55.30%	51.52%	<5th	-3.78%

Access Measures	Denver Health CHP+				
	HEDIS 2019	HEDIS 2020	HEDIS	2019	HEDIS 2019-2020

	Results: CHP	Results: CHP	Measurement Year 2020 Results: CHP	HEDIS MCD Percentile	Change
Children and Adolescents' Access to PCP (CAP)					
12-24 Months	90.36%	90.00%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
25 Months-6 Years	73.58%	81.24%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
7-11 Years	86.93%	84.85%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
12-19 Years	82.04%	82.08%	Retired HMY 2020	Retired HMY 2020	Retired HMY 2020
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)
This measure was retired in measurement year 2020.

Adults' Access to PCP (AAP)
All Adults' Access to PCP measures decreased for HEDIS measurement year 2020 when compared to HEDIS 2020 (measurement year 2019). Access measures may have been impacted in 2020 due to the COVID-19 pandemic, which required providers to implement telemedicine practices and reduce in-clinic patient volume. 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)
This measure was retired in measurement year 2020.
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:

- Denver Health continues 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 appointment 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.
- In Spring of 2021, the new DHHA Outpatient Medical Center (OMC) formally opened. The OMC is 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. The OMC frees 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. .
- 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 (CAM) 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.
- 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.
- DHMP maintains a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine is capable of discussing the member's symptoms and concerns assisting the member in understanding the urgency of their need and can assist with deciding the best course of action based on the urgency to see their primary care provider or going to the urgent care or emergency department. Additionally, the NurseLine nurses can write prescriptions for some illnesses and can also schedule a Dispatch Health visit.
- In early 2019 DHMP began contracting with Dispatch Health to support the membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. With the Covid 19 National Crisis impacting in hospital care, DHMP expanded the use of Dispatch Health to include SNF at home, Hospital at home and Bridging services to assist in early discharges.
- For Medicaid members identified as 'high risk' who had not had a PCP visit in last 12 months, Health Plan Services made outreach calls to help schedule appointments. Calls were made to

614 members and as of 6/30/2021 264 of those members had completed a PCP visit

- Throughout the Covid Public health emergency the ability to message their primary care provider (PCP) and care team and through MyChart has shown its value. MyChart is a user friendly application/website with multiple capabilities available to members to enhance and support their experience. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, review lab results, communicate directly with providers, and a centralized location for tracking their health outcomes and programs. It was used this year to send mass messages about the availability of Covid vaccines as requirements changed rapidly.
- DHMP expanded its primary care provider footprint by contracting with STRIDE Community Health Center. The partnership adds 15 additional clinic locations (three of which have pharmacies onsite) and options for both DHMP Medicaid and CHP+ members.
- In FY20/21 DHHA celebrated the opening of the Denver Health Sloan's Lake Primary Care Center, the 10th Community Health Center in the Denver Metro Area. Providing the same leading services offered at our other locations, the new center is easily accessible for patients in Denver's Sloan's Lake, West Colfax and Villa Park neighborhoods and operates in partnership with the Denver Housing Association which provides senior housing located above the clinic.

The Covid state of emergency has help launch a new way of providing care using telemedicine. All providers are working toward use of virtual technology, in particular a new telemedicine urgent care is now fully functional.

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.

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 quarterly to assess performance on 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 Network 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 process will be completed quarterly and 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, an 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 decreased for adult Medicaid and child Medicaid and increased slightly for CHP+ in 2020 for the percentage of Members who answered Always or Usually

- from 75% to 74% for adult Medicaid (2020 data)
- from 87% to 80% for child Medicaid (2020 data)
- from 85% to 86% for CHP+ (2020 data)

Getting Needed Care improved for adult Medicaid, and CHP+ for 2020 but decreased for child Medicaid for the percentage of Members who answered Always or Usually

- from 72% to 75% for adult Medicaid (2020data)
- from 78% to 75% for child Medicaid (2020 data)
- from 80% to 81% for CHP+ (2020 data)

The scores above are key drivers to the overall satisfaction with DHMP. In 2020, there was continued improvement with adult Medicaid with CHP+ remaining stable and child Medicaid decreasing as determined by the percentage of Members rating the health plan an 8 or above on a 10-point scale.

- from 72% to 75% for adult Medicaid, (2020 data)
- from 90% to 80% for child Medicaid, (2020 data)
- from 65% to 65% for CHP+, (2020 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/health plan rating with DHMP. In 2020, these measures included a customer service metrics for getting the information or help needed, when the member called.
This area has 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 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

Population Health and QI Intervention Project 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.