2022 QUALITY IMPROVEMENT PROGRAM EVALUATION

Commercial, Medicare and Exchange Products

DENVER HEALTH MEDICAL PLAN, INC.

DENVER HEALTH MEDICAL PLAN INC.™

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Denver Health Medical Plan, Inc. (DHMP, the Plan) is a licensed Health Maintenance Organization (HMO), effective 01/01/1997, with a responsibility for managing the following DHMP member groups and their health care:

- Commercial Large Group:
  - City and County of Denver (CSA)
  - Denver Health and Hospital Authority (DHHA)
  - Denver Employees' Retirement Program (DERP)
  - Denver Police Protective Association (DPPA)
- Commercial Exchange:
  - Elevate Health Plans
- Medicare Advantage:
  - Medicare Select HMO
  - Medicare Choice HMO SNP

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

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

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

In this report, DHMP QI Program activities are summarized and evaluated, including Program accomplishments and opportunities, with tracking and trending of results and data over time. Data is systematically collected prospectively, concurrently and/or retrospectively on clinical, safety, preventive and service performance. This data is analyzed, summarized and presented as information, with recommendation to the Quality Management Committee (QMC). The QI Department actively collaborates with other DHMP Departments, as well as network providers, to develop, implement and evaluate QI initiatives. QI activities are coordinated and implemented with Case Management, Population Health Management, Pharmacy, Health Plan Services, Provider/Network Relations, Compliance, Health Plan Medical Management, Appeals and Grievances, Marketing and Product Line Managers for Commercial, Exchange and Medicare.

Our provider network includes the Ambulatory Care Services (ACS) of Denver Health (DH), also known as Community Health Services (CHS) for our HMO membership. For the Point of Service (POS) members, we offer the Cofinity Network, including University of Colorado (UCHealth) and Children's Hospital, under more expansive health plan offerings of expanded and POS benefits. We collaborate with CHS on QI initiatives through the Ambulatory Quality Improvement Committee (QIC), and ACS disease and prevention-specific quality improvement work groups. In these committees and groups, we join quality resources and actively work together to increase the health and well-being of our members.

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

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

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

QUALITY IMPROVEMENT PROGRAM EVALUATION AND WORK PLAN

OVERVIEW

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

A QI Work Plan is prepared annually for the upcoming year for submission to the QMC and DHMP Governing Board of Directors for approval.

The Work Plan includes the following elements:

- Yearly written measurable objectives
- Quality clinical, preventive and service interventions and initiatives
- Overall scope of the QI Program including clinical, safety and service indicators, responsible parties, implementation, review and timeframe initiatives
- Schedule of reports and planned activities
- Evaluation of the effectiveness of the QI Program
- Evaluation of member experiences
- Evaluation of the effectiveness of the CM/UM Programs
- Evaluation and Strategy for the Population Health Programs

QUALITY IMPROVEMENT OBJECTIVES FOR 2022

- Maintains a Quality Improvement Program (QI) which continuously measures, analyzes, and evaluates the quality of care and services provided to our plan members
- Improve the overall health of our populations by supporting proven interventions to address behavioral, social and environmental determinants of health.
- Promote medical and preventive care delivered by practitioners/providers that meet or exceed the accepted standards/benchmarks of quality in the community
- Improve the health status of our members by providing high quality, cost-effective and affordable care

- Improve member satisfaction and Experience by focusing on improvements in the delivery clinical care and services
- Enhance the improvement of beneficiary health outcomes through nationally recognized evidence-based clinical practice guidelines that incorporate individual beneficiary health care needs and preferences, including cultural, ethnic, linguistic, and other social determinants of health
- Deliver high quality clinical care that meets community standards and offer customer-focused service to our members and practitioners/providers
- Improve the access to care for all our members by maintaining and increasing a robust provider network with highly qualified professionals
- Maintain a High level of Provider Satisfaction
- Evaluate and improve upon the beneficiary experience with care and services t
- Utilize a data-driven approach to improving care, safety, health outcomes and service of beneficiaries through the continuous monitoring and evaluation of industry recognized and internally developed key clinical care and service quality indicators
- Continuous evaluation of the QI program and implement interventions that improve the clinical care and administrative services of the Plan and health care services delivered by contracted practitioners/providers, using HEDIS measures, QI projects and activities and CAHPS member surveys
- Development of improvement actions based on results from the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the Health Outcomes Survey (HOS®), beneficiary inquiry, grievance, and appeal data
- Comply with the Centers for Medicare and Medicaid Services' (CMS) requirements regarding Quality Improvement Program activities
- Measure and report Quality Improvement and other program performance using standard measures and tools required by CMS
- Adopt national, regional and/or local public health goals and industry performance benchmarks, evaluating available resources for QI to make sustainable decisions
- Develop and implement pharmaceutical quality assurance measures and systems to identify and reduce medication errors, adverse drug interactions and improve medication use through retrospective and concurrent drug utilization review systems, as well as pharmaceutical policies and procedures
- Promote the effectiveness, efficiency, and compliance of all First Tier, Downstream and Related Entities (FDRs) with DHMP contractual and CMS requirements
- Coordinate delegated activities on behalf of contractual organizations

- Empower members to lead a healthy lifestyle through health promotion activities, Plan and community outreach efforts and coordination with public and private community resources
- Encourage safe, effective, and appropriate clinical practice through established care standards and application of appropriate practice guidelines
- Monitor and evaluate high-volume and/or high-risk services to identify opportunities for improvement
- Collaborate with ACS on the development of Population Health initiatives for special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate
- Collaborate with Network Providers to improve the access and delivery of care and services to our members
- Collaborate with internal DHMP departments to improve quality of care and services to our members
- Maintain the health information system to comply to professional standards of health information management, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security laws and state privacy standards
- Incorporate feedback from HealthPlan Members, ASC Work Groups, QMC and Subcommittees on QI Projects Interventions and Improvement activities

QUALITY IMPROVEMENT PROGRAM SCOPE

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

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

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

The QI Department is responsible for the following:

- Identify and prioritize quality activities based on NCQA and regulatory requirements
- Review data annually to determine QI activities that will have a significant impact on the member population
- Work collaboratively with ACS, Denver Public Health and other Plan partners to address health care quality initiatives
- Utilize national goals as well as NCQA, HEDIS and regional benchmarks to establish goals for the Plan
- Include and distribute the analysis of access and availability of providers and pharmacies for the membership
    - Annually, an Access Plan is created, which includes geo-access results for member access, panel sizes, telephone responsiveness, referral turnaround timeframes, monitoring of appointment standards and languages competencies of providers, at a minimum

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

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

The primary source of information for QI initiatives are from HEDIS, CAHPS and internal monitoring projects. HEDIS clinical outcomes measures data are reviewed for diabetes, cardiovascular conditions, musculoskeletal conditions, prenatal and postpartum care, respiratory conditions, medication management, behavioral health care, preventive health screenings and other quality of care indicators for children and adults. For quality of service, multiple sets of data are reviewed, including CAHPS member satisfaction survey data, HEDIS use of

services and access and availability measures, grievance and appeal data and Quality of Care Concerns (QOCCs) and service complaints.

QUALITY IMPROVEMENT PROGRAM ACCOMPLISHMENTS AND STRENGTHS

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

- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention
- Continued to identify and develop training to assist in appropriate provider documentation and coding to support improvement of HEDIS scores
- Increased member outreach to encourage preventive health screenings and to support members with chronic disease conditions, such as diabetic eye exams and mammograms
- Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase the number of adolescent well-child visits and immunizations within Denver Public Schools
- Increased member outreach in Covid-19 Vaccination Efforts
- Continued refinement of member outreach efforts, utilizing EPIC (electronic medical record) implementation for ACS and QNXT (claims processing system) BI and Tableau reports for DHMP
- Collaborated with Health Plan Medical Management to build a comprehensive Population Health Program to help members improve knowledge and management of health
- Developed and implemented enhanced patient education materials; focused on health literacy and cultural competency
- Conducted an annual Provider Satisfaction Survey to evaluate satisfaction with DHMP departments and services, including knowledge of DHMP offerings to support patient care
- Participated as a member of the Ambulatory Care Quality Improvement workgroup for cardiovascular disease to begin to address health literacy/cultural competency and reduce health disparities through services in DH
- Supported ongoing inclusion of Culturally and Linguistically Appropriate Services (CLAS) training in required annual training for DH providers and staff to support the delivery of culturally sensitive care and engage fully in participation of a diverse workforce
- Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting
- Maintained oversight and follow up of delegated and facility credentialing relationships
- Increased outreach to DHMP members through ACS clinic staff and targeted member outreach, as well as Vendor based screening initiatives
- Facilitated physician involvement in the development of clinical guidelines, including the streamlining process of guideline development
- Conducted development, review and revision of policies and procedures annually through electronic tracking process
- Maintained physician involvement within the QMC structure from the ACS network
- Maintained VBC for Exchange plans, as part of a Quality Improvement Strategy (QIS) for Elevate, as well as for Commercial and Medicare plans
- Continued the Medicare Chronic Care Improvement Project (CCIP), focused on controlling blood pressure
- Produced monthly HEDIS runs, and corresponding gaps in care lists for use in quality improvement initiatives
- Improved the timeliness and accuracy of the annual HEDIS production run

CHALLENGES AND OPPORTUNITIES

During the 2021 measurement year the QI program faced many challenges which in part were due to the continued National Health Pandemic, Covid -19. Member access to care was particularly affected by Corvid -19. It was identified that many members chose to forgo annual PCP visits, and testing during the 2020 Covid 19 Pandemic onset.

In 2021, a rebound effect of patients accessing healthcare created an access to care issue with DHMP's medical providers.

Another challenge that was noted in 2021 was related to staffing. Staffing shortage and turnover was noted throughout DHMP as well in the Quality Management department.
The Quality Management department experienced staff turnover that encompassed the following leadership roles, QI Director/QI Manager (vacant) and Project Managers (2 positions). The two project management roles have been back filled. The two (2) project management roles, support the following functions (1) Population Health and (1) Quality Improvement. Recruitment efforts for the Director of Quality are currently underway. During the absence of the QI Director the department is being led under the direct supervision of DHMP's Chief Medical Director.

DHMP's Population Health management program continued to show growth during 2021 which resulted in need to restructure QI Departmental resources. After careful evaluation it was determined that additional population health staff and management roles would be necessary to meet the increased demands of the growing program and support the ACS providers. To that end, a Population Health Manager role was created to provide additional leadership to the Population Health program. An additional Project Manager role has also been created to support the growth of the department.

In 2021 DHMP Population Health team worked collaboratively with ACS work group members, through combined population health and QI intervention projects. The focus of these collaborative workgroups was centered around the improvement in member health by leveraging outreach efforts to improve preventive health and chronic condition care, as well as applicable HEDIS metrics.

Outreach efforts consisted of mailing campaigns to remind members of annual checkups and preventive diagnostic testing such as mammograms and colonoscopy. Despite outreach efforts, as mentioned above Covid-19 posed a significant challenge to access to care. This is evidenced by the decrease in DHMP HEDIS metrics from prior year (see HEDIS rates pg. .

The NCQA accreditation project management remained in the Monitoring, Auditing and Training department during 2021. Leadership from both Quality Management department and the QMC had oversight of the project. The QMC monitors, reviews and gives input on the accreditation process

The QMC structure continued to be evaluated during 2021. In December the QMC charter was updated to provide for a broader organizational participation. Committee membership was expanded to include mid-level management and coordinators as non-voting but participating members. QMC leadership was also evaluated. In prior year the Director of QI chaired the QMC. After further evaluation it was determined that the committee would benefit under clinical leadership. The committee is now being chaired under the direction of DHMP's Chief Medical Director.

During 2021 the QMC continued to meet every other month. Operational leaders, ACS Members, and practitioners from DHMP network regularly attended. 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.

Leadership involvement, defined as the Operations Team from DHMP, and the Management and Operations Teams from CHS, continued to increase over the past year. The defined focus and contribution of the QMC gave DHMP a valuable sounding board and feedback mechanism for all departments presenting up through the committee. The involvement of the Director of QI for ACS, several ACS providers, and practitioners, provided a rich mix of differing insight and feedback to committee and the QI Department to assist with improved evaluation of reports and interventions. The

Director of QI is involved on multiple quality committees and work groups within ACS, including the ACS QIC. Members of the QI Department attend and interact in a variety of ways with Chronic Disease and 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 MY2021. Additionally, the situation surrounding the COVID-19 pandemic is still evolving and will continue to affect care delivery in 2022. Thus, the impact of the COVID-19 pandemic will be reflected in our interventions and QI activities for 2022.

Also noted in this year's evaluation a low number of QOCC 's identified in the Commercial and Medicare LOB's. When compared with like health plan's, with like membership sizes, DHMP' s QOCC cases are considerably lower, which makes DHMP an outlier.

For 2022 DHMP will put in processes to improve QOCC reporting from internal DHMP departments, UM, CM, and Member Services. Additionally, QOCC education will be administered to internal departments.

FUTURE OPPORTUNITIES FOR IMPROVEMENT

- Develop a more rigorous data validation plan for HEDIS measures, confirming that data and counts and sample sizes are accurate, while continuing to increase supplemental sources of data for HEDIS measures
- Continue efforts to improve the capture and accuracy of provider data for HEDIS, including practice type, specialist coding and provider locations
- Evolve the real-time quality data availability and usability (following the launch of the DHMP data warehouse, efforts to integrate EPIC-based encounter data, and launch of Tableau reporting software) through ongoing IS collaboration
- Increase engagement and training of providers in HEDIS metrics and provide meaningful, provider-centric education and training to increase HEDIS scores and risk adjustment scores through appropriate medical record documentation and coding.
- Work with ACS and DH leadership in patient experience initiatives throughout DH, focusing on customer service metrics and rounding of staff to improve CAHPS scores
- Continue developing strategies with ACS QI leadership to address gaps in care with year-round interventions and activities
- Conduct evaluation of member engagement strategy to increase member buy-in and involvement in self-management and preventive care goals
- Evaluate effective platforms for communication with members
- Align and partner QI initiatives and interventions with ACS leadership and provider networks to avoid duplication of efforts and to utilize resources more effectively
- Continue to develop the use of the LEAN framework within quality initiatives to develop A3 problem-solving aligned with the Plan-Do-Study-Act (PDSA) format
- Utilize the LEAN framework to develop and evolve standard work for the QI Department
- Integrate with Denver Health ACS health inequity efforts, focused on hypertension for African Americans, through the cardiovascular QI workgroup
- Continue monthly review of HEDIS data to ensure more timely measures and interventions
- Expand and support QI team opportunities for growth and enhancement of skills, and to automate tasks where possible to increase the functional capacity of the QI team
- Address known opportunities for NCQA accreditation improvement and an organizational plan for NCQA compliance and accreditation renewal
- Continue to evolve value-based contracting for enhanced quality improvement outcomes

- Promote further alignment of DHMP and ACS strategic QI metrics and goals
- Continue progress in the evolution of the programs, platforms and staffing of UM, CCM and PHM functions at DHMP.
- Develop internal QOCC education and processes
-

ANNUAL CLINICAL AND PREVENTIVE GUIDELINE REVIEW

Via QMC, a 2021 annual review of the following Guidelines for any nationally recognized updates was completed. The following guidelines were reviewed and approved:

- Clinical Guidelines
    - Diabetes Management Standards
    - Management of Asthma in Adults and Children
    - Treatment of Depression in Adults in Primary Care
    - Treatment of ADHD in Children and Adolescents
- Preventive Guidelines
    - Care of Well Newborn
    - Clinical Preventative Health Recommendations for Adults
    - Medicaid Behavioral Health Practice Guidelines
    - Pediatric, Adolescent and Adult Immunizations
    - Smoking Cessation
    - Well Child Adolescent Health
    - Perinatal Care
    - Fall Prevention Guideline for 65+ and Above
    - Routine Cervical Cancer Screening

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

QUALITY OF CLINICAL CARE ACTIVITIES

DHMP strive to continually evaluate, monitor and improve the quality of cared for our members.
Quality improvement activities during 2021 consisted of the following activities:

- Quality of Care Investigations
- Quality of Service Investigations
- HEDIS Outcome Metric
    - Diabetes Management Measures
    - Blood Pressure Monitoring Measures
    - Cardiovascular Medication Measures
    - Asthma Medication Management Measures
    - Pre- Natal and Post- Partum Care Measures
    - Behavioral Health Measures
    - Preventive Health Measures
- CAHPS Outcomes Metrics
- Quality Improvement Projects
- Inter- rater Reliability Audits

Quality of care and service audits and key performance metrics are tracked and trended. The results are regularly reported to the QMC and are trended to comparing year over year performance. The QMC makes recommendations to help improve performance as needed.

In 2021 Quality of Care and Services cases remained in line with prior year 2020, for the Commercial and Elevate lines of business. The Medicare service line did see increase in QOCC cases from zero in 2020 to five in 2021. As discussed above these numbers would be considered low when compared to like health plans. In 2022 DHMP will work to increase internal QOCC referrals.

HEDIS metrics are compared to prior year and trended over several years.
In 2019, HEDIS rates for the Exchange LOB were reported separately from the overall Commercial rates as a result of reaching a threshold population size. MY2020 HEDIS rates are based on calendar year 2020 data. For Medicare, Elevate and Commercial lines of business, improvement goals are a 3% increase year over year.

2021 QUALITY IMPROVEMENT ACTIVITIES/INTERVENTIONS

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

DIABETES CDC MEASURES

DHMP COMMERCIAL

Diabetes Indicators (CDC)	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
HbA1c Testing	90.40%	93.20%	85.05%	10th	-8.15%
HbA1c Poor Control >9.0% (lower=better performance) *	44.95%	27.96%	45.1%	10th	+17.14%*
HbA1c Control <8.0%	43.43%	59.95%	44.07%	10th	-15.88%
Eye Exam	46.46%	51.39%	37.89%	10th	-13.50%
Medical Attention for Nephropathy	85.61%	88.16%	Retired MY2020	Retired MY2020	N/A
Blood Pressure Controlled <140/90	62.37%	73.80%	55.67%	25th	-18.13%

DHMP MEDICARE

Comprehensive Diabetes Care (CDC)	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
HbA1c Testing	94.16%	95.38%	89.05%	50th	-6.33%
HbA1c Poor Control >9.0% (lower=better performance) *	23.36%%	18.49%	26.76%	50th	+8.27%*
HbA1c Control <8.0%	62.29%	66.67%	57.42%	25th	-9.25%
Eye Exam	76.16%	77.37%	63.02%	50th	-14.35%
Medical Attention for Nephropathy	93.92%	94.16%	99.31%	10th	+5.15%
Blood Pressure Control <140/90	67.64%	71.91%	60.81%	50th	-11.10%

DHMP EXCHANGE

Comprehensive Diabetes Care (CDC)	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile*	2020-MY2020 HEDIS Change
HbA1c Control <8.0%	N/A	51.43%	40.00%	10th	-11.43%
Eye Exam	N/A	62.86	31.11%	10th	-31.75%
Medical Attention for Nephropathy	N/A	85.71	91.11%	N/A	+5.37%

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^ 2019 rates were not reportable due to small sample size. Measure retired for MY2020 for commercial line of business, so no comparable percentile is available.

**HEDIS MY2020 Changes

Medical attention for Nephropathy was retired as a measure for the commercial line of business in MY2020.

SUMMARY OF HEDIS MY2020 DIABETES RESULTS

COMMERCIAL

Comparison of HEDIS MY2020 results against national benchmarks reveals that the HEDIS MY2020 Commercial results decreased for all Comprehensive Diabetes Care (CDC) measures. Further, Commercial rates decreased for each of the five components of the CDC metric. The measure with the largest change was Blood Pressure Control <140/90, which decreased from 73.80% in H2020 to 55.67% in HMY2020.

MEDICARE

Comparison of HEDIS MY2020 results against national benchmarks reveals that the HEDIS MY2020 Medicare results continue to be below the 90th percentile benchmark for five of the six CDC measures. Despite Medicare rates decreasing for five of the six components of the CDC metric, percentile rankings remained the same or improved in HMY2020. Medical Attention for Nephropathy was the only measure for which the rate improved, increasing by 5.15% over the H2020 rate to 99.31%, and ranking in the 90th percentile.

EXCHANGE

Comparison of HEDIS MY2020 results against national benchmarks reveals that the HEDIS MY2020 Exchange results decreased significantly for the Eye Exam measure, with rates falling from 62.86% in H2020 to 31.11% in HMY2020 and the percentile decreasing from 75th to 10th. The rate for HbA1c Control <8.0% also decreased in HMY2020, from 51.43% in H2020 to 40.00% in HMY2020. However, the Medical Attention for Nephropathy rate increased by 5.37%.

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.

Diabetic Eye Exams

This project is a collaboration between DHMP QI Department staff and Care Navigators from the DH Eye Clinic that began in 2015. The project involves Care Navigators conducting outreach calls to Medicare, Commercial and Exchange members who have been identified, through claims data, as needing either a dilated retinal exam or an eye camera screening. Once contacted, members are scheduled for an appointment at the DH Eye Clinic. A "successful call" is defined as a call completed by a Care Navigator that resulted in a member being scheduled for an eye exam.

In 2021, the QI team worked to reinstitute a limited outreach effort for diabetic eye exams (DRE) for a targeted group of Medicare members and supported the roll out of eye cameras across DHHA primary care clinics, an effort that was limited by the pandemic in 2020. The rollout of eye cameras in the primary care clinics was complicated by a need to upgrade the eye cameras in order for results to be read properly. This rollout continues into 2022. In April of 2021, the new Outpatient Medical Center opened, and the Eye Clinic moved into a larger space in that building in May. Through this transition proactive outreach to DHMP members was limited. More robust outreach resumed in late summer of 2021 and DHMP also utilized its contract with One Hour Optical for its Medicare Members to help manage access issues for Eye Exams at the DHHA Eye Clinic.

The DHHA ACS pharmacy team also implemented a medication therapy management program that included outreach to DHMP Medicare members to ensure that they were adherent to their diabetes medications during the COVID-19 pandemic, understood how to correctly take their medications and had an adequate supply of medications. Those members that needed additional follow up were advised to schedule an appointment with their PCP.

In 2021, the QI team worked with DH Ambulatory Care Services (ACS) to conduct outreach to those members who needed medical attention for nephropathy, to complete an HbA1c test or who were in poor control (HbA1c >9.0%) and schedule them for PCP appointments at DH clinics through a combination of routine patient health summary letter mailings and select efforts with central QI support staff for telephonic outreach. DHMP QI also sent direct mailings to our Medicare patients with a diabetes diagnosis to remind them of their annual care needs and encourage them to schedule an appointment with their PCP to ensure they were addressed timely.

ACTION PLAN FOR CDC IMPROVEMENT 2022

The DHMP QI team will continue to participate in both the Diabetes Collaborative and aforementioned Diabetes Collaborative Subgroups and explore additional ways to improve diabetes care for our members, including controlling blood sugar, kidney disease monitoring, and performing eye exams. QI will continue to focus on increasing the Diabetic Eye Exams measure for Medicare, Commercial and Exchange, which still sits well below the 90th percentile ranking, as well as medical attention for nephropathy and HbA1c poor control >9.0%. Significant changes to the kidney disease monitoring metric for 2021 (Commercial) 2022 (Medicare) will require additional collaboration between DHHA and DHMP QI to ensure that all members are receiving the most appropriate screenings to protect their kidney health.

Limited eye exam outreach for high priority, target populations will resume in 2021. Additionally, Denver Health has purchased ten new retinal cameras for all primary care sites, eliminating the need for members to travel to the centrally located Eye Clinic for exams, improving appointment availability, and reducing wait times. Rollout of these cameras and associated trainings was delayed by the arrival of COVID-19 in 2020 and continues into 2022. Retinal cameras in all primary care sites will improve access for DHMP Members, particularly as the central Eye Clinic struggles with capacity, and contribute to an overall improvement in exam rates. These efforts, and an increased focus on Exchange and Medicare patients, by virtue of continued value-based contracts with DREs as a key metric, will bring renewed focus and commitment to this intervention for next year.

In 2020, 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.

The DHHA central QI team will continue mailing patient health summary letters to the DHMP members who need to be seen for important diabetes screenings. Additionally, members who have MyChart accounts are also being sent the patient health summary letter electronically. DHMP QI will also continue to send direct mailings to our Medicare patients with a diabetes diagnosis to remind them of their annual care needs and encourage them to schedule an appointment with their PCP to ensure they are addressed timely.

CARDIOVASCULAR SCREENING MY^2020 HEDIS CARDIOVASCULAR RESULTS

DHMP COMMERCIAL, MEDICARE AND EXCHANGE CONTROLLING HIGH BLOOD PRESSURE

Commercial					
	2019 HEDIS Results	**2020 HEDIS Results**	**MY2020 HEDIS Results**	**MY2020 HEDIS Percentile**	**2020-MY2020 HEDIS Change**
Controlling High Blood Pressure (CBP)	50.99%	61.80%	55.72%	25th	-6.08%
	DHMP Medicare				
	2019HEDIS Results	**2020 HEDIS Results**	**MY2020 HEDIS Results**	**MY2020 HEDIS Percentile**	**2020-MY2020 HEDIS Change**
Controlling High Blood Pressure (CBP)	69.34%	68.13%	65.69%	25th	-2.44%
	DHMP Medicare				
	2019 HEDIS Results	**2020 HEDIS Results**	**2020 HEDIS Results**	**MY2020 HEDIS Percentile**	**2020-MY2020 HEDIS Change**
Controlling High Blood Pressure (CBP)	73.24%	69.34%	68.13%	25^{th}	-3.54%

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.

SUMMARY OF HEDIS MY2020 CONTROLLING BLOOD PRESSURE RESULTS

The rate for Controlling High Blood Pressure (CBP) measure remains below the 90th percentile across the Commercial, Medicare, and Exchange lines of business. The Commercial rate dipped from 61.80% in H2020 to 55.72% in HMY2020, and the Medicare rate decreased from 68.13% in H2020 to 65.69% in HMY2020. The Exchange rate also decreased from 65.08% in H2020 to 51.54% in HMY2020. Nationally, the Commercial line of business remained in the 25th percentile, while Medicare dropped from the 50th to the 25th percentile and the Exchange line of business, despite a small decrease in rate, increased from the 25th percentile to the 50th.

The DHMP QI team participates in the DHHA ACS Cardiovascular Disease (CVD) Workgroup recognizing the need to collaborate on data collection and interventions to improve HEDIS rates across populations and address disparities in blood pressure control outcomes. In 2020, reducing disparities in health related to race, ethnicity and language was identified as a DHHA enterprise opportunity, particularly as the COVID-19 pandemic has emphasized the continuing disparities in health outcomes related to race and ethnicity. The QI team continued to work collaboratively with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. Our most recent data (2021) 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 began an effort to determine root causes of this disparity and create a series of interventions to address it.

In 2021, DHMP continued our successful Controlling High Blood Pressure Care Management program for our Medicare members who have a current diagnosis of hypertension and whose last blood pressure reading was >140/90 mm Hg. Members identified are outreached to and encouraged to participate in the program. Those with a most recent blood pressure that is only moderately out of control (between 140-150/90-100 mm Hg) or whose blood pressure reading is out of date (no reading taken during the measurement year) will be offered the option of support seeing their physician and/or obtaining their medication or to participate in the full care management program. Those with a most recent blood pressure reading >150/100 mm Hg will be encouraged to participate in the full care management program. The DHMP QI team works closely with DHMP Care Management and DHHA Ambulatory Care Services to implement the program in order to provide members with poorly controlled blood pressure the support and care they need to more adequately manage their condition. As a result of this success, DHMP Population Health Management will look at the potential for expanding this intervention into other lines of business for 2022.

ACTION PLAN FOR CARDIOVASCULAR PERFORMANCE IMPROVEMENT 2022

The QI team will continue to participate in the CVD workgroup and monitor activities and data collection related to Control of High Blood Pressure. Additionally, we will work closely with the CVD workgroup to continue the implementation of an intervention to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise including working with community partners and conducting patient focus groups

The Controlling Blood Pressure Care Management program will continue into 2022 and focus on those Medicare members with a hypertension diagnoses whose blood pressure is not under control. Efforts to expand this program for members in the Exchange and Commercial Populations will continue to be a priority for the Population Health Management Team in 2022. In addition, the DHMP QI team will continue to utilize this intervention as our CMS mandated Chronic Condition Improvement Program for the Medicare Choice and Select lines of business.

PREVENTION AND SCREENING HEDIS MEASURE RESULTS

DHMP COMMERCIAL

Prevention and Screening	DHMP Commercial				
	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
Adult BMI Assessment (ABA)	81.16%	93.67%	Retired MY2020	Retired MY2020	N/A
Breast Cancer Screening (BCS)	73.13%	75.09%	72.01%	25th	-3.08%
Cervical (21-64y/o) (CCS)	75.04%	80.29%	79.08%	75th	-1.21%
Colorectal (50-80 y/o) (COL)	58.45%	63.99%	59.85%	25th	-4.14%

DHMP MEDICARE

Prevention and Screening	DHMP Medicare				
	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	2020 HEDIS Percentile	2020-MY2020 HEDIS Change
Adult BMI Assessment (ABA)	98.78%	99.03%	Retired MY2020	Retired MY2020	N/A
Breast Cancer Screening (BCS)	71.49%	75.47%	68.08%	50th	-7.42%
Colorectal Cancer Screening (COL)	62.99%	73.48%	76.16%	50th	+2.68%

DHMP EXCHANGE

Prevention and Screening	DHMP Exchange				
	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
Adult BMI Assessment (ABA)	95.93%	98.44%	Retired MY2020	Retired MY2020	N/A
Breast Cancer Screening (BCS)	N/A	N/A	55.56%	<5th	N/A
Colorectal Cancer Screening (COL)	63.41%	58.27%	53.26%	25th	-1.59%
Cervical Cancer Screening (CCS)	61.50%	67.92%	56.68%	<5th	-12.36%

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^2019 and 2020 rates were not reportable due to small sample size.

**HEDIS MY2020 CHANGES
Adult BMI Assessment (ABA) was retired in MY2020.

PREVENTIVE CANCER SCREENING WORKGROUP

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

- Standardized Health Care Partner (HCP) check-in process to include identification of patients lacking breast, cervical or colorectal cancer screenings
- Healthcare Partners (HCPs) schedule members for appointments, if possible, and alert the provider to the tests needed
- Patient Navigation regarding colorectal cancer screening options through DH
- Review and reporting of cancer screening quality measures through implementation of registries to report screening rates on a quarterly basis to clinics
- Coordinated outreach for DHMP Medicare members who have outgoing FIT tests and no return

Revised cancer metrics and implementation of registries to report screening rates on a quarterly basis to clinics.

COMMERCIAL LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2020 Results

The Breast Cancer Screening (BCS) measure rate decreased by 3.08% from H2020 to HMY2020. The overall rate of Colorectal Cancer Screenings (COL) decreased by 4.14% for HMY2020 compared to H2020. Further, Cervical Cancer Screening (CCS) rates decreased by 1.21% in HMY2020. Despite the slight decrease in rate, the percentile for CCS improved from the 50th in H2020 to 75th in HMY2020.

Interventions 2021

The QI team continues to collaborate with the DH Women's Mobile Clinic and maintains a presence at the Ambulatory Cancer Screening Committee, where similar metrics are discussed.

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 link for the women's mobile clinic. All women 50-74 years old, who are in need of a mammogram, are sent a mailer reminding them to schedule an appointment. As mentioned above, ACS also continued mailing Patient Health Summary letters in September 2020. This mailer included reminders for members who are overdue for a Breast Cancer Screening. In CY2021, the QI team sent 3397 mailers to Commercial and Exchange members in 2021. In 2021, the Women's Mobile Clinic was dealing with staffing issues as a result of the COVID-19 pandemic which limited efficacy of interventions as most DHMP members prefer to receive their mammogram when the mobile van visits their medical home and capacity was very limited.

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

MEDICARE LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2020 Results

For the Medicare population, percentile rankings remained steady in HMY2020. BCS rates decreased by 7.42% in HMY2020, while COL rates improved slightly, from 73.48% in H2020 to 76.16% in HMY2020.

Interventions 2021 – BCS

All women 50-74 years old, who are in need of a mammogram, are sent a mailer reminding them to schedule an appointment. The QI department uses HEDIS technical specifications and claims data to identify members due for a mammogram. Lists of eligible members are generated on a monthly basis. In CY2021, the QI team sent 4,677 mailers to Medicare members. Members have the option to either get their mammogram from the radiology clinic on the main Denver Health campus or utilize the Denver Health Women's Mobile Clinic. The Women's Mobile Clinic provides a private, comfortable and convenient setting to receive a mammogram. In 2021, the Women's Mobile Clinic was dealing with staffing issues as a result of the COVID-19 pandemic which limited efficacy of interventions as most DHMP members prefer to receive their mammogram when the mobile van visits their medical home and capacity was very limited.

ACS continued to work to improve implementation of Medical Assistant standard work to include scheduling patients due for a mammogram during their physician visit. In 2021, they continued to track this rate by clinic.

As mentioned above, ACS also continued mailing Patient Health Summary letters in 2021. This mailer included reminders for members who are overdue for a Breast Cancer Screening.

INTERVENTIONS 2020– COLORECTAL SCREENING

In 2021, DHMP continued their relationship with an external vendor (BioIQ) to mail fecal immunochemical test (FIT) kits, test the samples, and mail result letters to Medicare patients and providers. Based on the success of the BioIQ intervention, DHHA also began mailed FIT kits to patients who were due for a colorectal cancer screening and eligible for FIT screenings. Staff then followed up with members who needed to return the FIT kits with reminder letters and phone calls. Additionally, ACS began sending Colorectal Cancer screening reminders as part of the Patient Health Summary Letter intervention (see description above).

EXCHANGE LINE OF BUSINESS SUMMARY HEDIS MY 2020 SUMMARY

The BCS measure was not reportable in H2020 for the Exchange line of business due to a small sample size, but in HMY2020, performance on this measure was 55.56%, falling into the <5th percentile. Similarly, CCS rates for HMY2020 were 56.68%, falling from 67.92% in H2020 and remaining in the <5th percentile. COL rates fell slightly in HMY2020, by 1.59%; however, national performance comparison on this measure ranked in the 25th percentile, an increase from the 10th percentile in H2020.

PREVENTION AND SCREENING ACTION PLAN FOR 2022

BREAST CANCER SCREENING ACTION PLAN

All Medicare, Exchange and Commercial female members 50-74 years old, who are due for a mammogram, will continue to receive a mailer every 6 months reminding them to schedule an appointment. The QI Project Manager will continue to monitor the progress of this intervention. The DHMP QI department maintains a consistent presence at the Ambulatory Care Cancer Screening workgroup. This group provides an open forum for discussion surrounding collaboration with ambulatory care providers and the Women's Mobile Clinic. The QI department will continue this mailing intervention in 2022. ACS is anticipating the implementation of a variety of technology interventions to improve BCS rates. For example, patient self-scheduling in MyChart and automated text message and MyChart reminders. ACS will also continue their Patient Health Summary letter intervention in 2021, which contains BCS reminders.

The Women's Mobile Clinic was dealing with staffing issues throughout 2021 as a result of the COVID-19 pandemic. They have since hired new staff and are now operating at full capacity which should increase rates for 2022 as most DHMP members prefer to receive their mammogram when the mobile van visits their medical home.

The DHMP QI team will continue to monitor the effects of these interventions on HEDIS rates and assess additional opportunities to conduct telephonic outreach for those members overdue for mammograms.

COLORECTAL CANCER SCREENING

PREVENTIVE CANCER SCREENING ACTION PLAN

QI will continue to participate on the Cancer Screening Workgroup and explore innovative ways for DHMP Medicare members to receive and return FIT kits. In 2022, ACS will partner with a vendor (PolyMedCo) to send FIT kits to DHM Medicare members due for their screening and integrate the results into members EMR. This intervention involves reminder letters for unreturned FIT kits, with the potential to make outreach reminder calls as part of this intervention are being discussed. DHMP will also explore partnering with their 2021 vendor, BioIQ as needed to meet target goals.

Additionally, ACS will continue mailing Patient Health Summary letters to members with gaps in care (including Colorectal and Cervical Cancer Screening) and sending these letters to members via MyChart. The DHMP QI team will monitor the effects of these interventions on HEDIS rates and assess additional opportunities to improve these metrics.

OSTEOPOROSIS MANAGEMENT FOR WOMEN WHO HAD A FRACTURE (OMW)

The DHMP QI department partnered with the Ambulatory Central Clinical Support (CCS) team in 2017 to design and implement and intervention focusing on the OMW measure. The CCS team is comprised of ambulatory pharmacists, pharmacy techs and RNs who do comprehensive medical record review and then facilitate communication to the PCP through EPIC in order to arrange a BMD or Rx. The intervention targets Medicare women aged 67-85 who sustained a fracture in the last six months. The goal of the intervention is to identify these members and facilitate either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months following the fracture. The CCS team expanded the outreach to include DHMP Medicare members aged 52-98, in alignment with the goals set by the ACS QI department.

In 2020, DHMP QI was invited to collaborate with the Geriatrics Workgroup and attend the monthly workgroup meetings. As part of this collaboration, CCS began to connect members in the intervention with the ACS fracture liaison service. This collaboration continued through the Geriatric Workgroup in 2021.

The HMY2020 rate for OMW was 66.67%, which was a 25.00% increase from H2020. This metric is also a measure in Medicare Stars, but DHMP has not reported on OMW as a Star measure due to the small population size.

DHMP MEDICARE MEMBERS OMW RESULTS

	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
OMW	30.00%	41.67%	66.67%	90th	+25.00%

In 2021, 44 women were identified for targeted outreach. Once identified for outreach, there is a 6-month window in which a member can undergo a BMD or receive an Rx for osteoporosis in order to meet the measure. Because some women had fracture dates that have yet to reach the 6-month expiration dates and due to claims run-out, not all eligible members have a reported outcome. However, preliminary non-validated results from our monthly HEDIS runs indicate continued high performance reaching rates above the 4-Star level in 2021.

OMW ACTION PLAN FOR 2022

The DHMP QI Project Manager meets intermittently with the CCS team to discuss project updates, clarify metrics and review workflow, discuss barriers and their root causes, and opportunities for improvement. Despite the small population size for Medicare Stars, the plan is to continue with this intervention through 2022, with the longer-term goals of ensuring that all eligible women receive the appropriate treatments and reaching a 4-Star rating on this measure. In 2022, the QI Team and the Ambulatory Central Clinical Support (CCS) team will continue to partner with the ACS Geriatric Workgroup to improve performance on this measure. Over the next couple of years, anticipated spec changes to the OMW HEDIS measure may impact this intervention.

PRENATAL/POSTPARTUM CARE

DHMP COMMERCIAL

	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 Percentile	2020-MY2020 HEDIS Change
Prenatal Care in 1st Trimester	88.05%	98.16%	97.87%	95th	-0.29%
Postpartum care within 21-56 days after delivery	80.89%	Major Time Range Spec Change	Major Time Range Spec Change	Major Time Range Spec Change	N/A
Postpartum care within 7-84 days after delivery	N/A	95.85%	94.89%	95th	-0.96%

^2019 rates were unreportable due to small sample size.

DHMP EXCHANGE

	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 Percentile	2020-MY2020 HEDIS Change
Prenatal Care in 1st Trimester	N/A	N/A	N/A	N/A	N/A
Postpartum care within 21-56 days after delivery	N/A	Major Time Range Spec Change	Major Time Range Spec Change	Major Time Range Spec Change	N/A
Postpartum care within 7-84 days after delivery	N/A	N/A	N/A	N/A	NA

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^2019 and 2020 rates were not reportable due to small sample size.

SUMMARY OF COMMERCIAL HEDIS MY2020 PRENATAL/POSTPARTUM RESULTS

Numerous changes to the PPC measure in 2020 continue to impact our rates. For Postpartum Care, the timeframe for a visit creating a numerator positive result changed from 21-56 days to 7-84 days. The Timeliness of Prenatal Care measure was also changed to allow for visits that occurred before the enrollment start date to be counted. Additional factors that may have contributed to the improvement in Prenatal Care rates are currently under evaluation by the Denver Health Perinatal Committee. These factors may include changes to provider templates to improve access to OB Intake visits. The continued improvement in Postpartum Care may also have been impacted by Denver Health's process of scheduling the postpartum visit for patients who deliver at Denver Health before they leave the hospital following delivery. For Commercial HEDIS MY2020, the rate of women who received prenatal care in the first trimester decreased slightly, by 0.29%. The rate of postpartum care within 7-84 days after delivery also decreased slightly, by 0.96%. DHMP Commercial performance remains in the 95th percentile when compared to national performance.

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

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.

PRENATAL/ POSTPARTUM CARE ACTION PLAN FOR 2022

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.

CHILDHOOD PREVENTIVE HEALTH

DHMP COMMERCIAL CHILDHOOD HEDIS METRIC RESULTS MY 2020

Childhood Preventive Measures	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentiles	2020-MY2020 HEDIS Change
Childhood Immunization Status					
DTaP	84.73%	94.12%	94.71%	95th	+0.59%
MMR	95.57%	97.39%	98.24%	95th	+0.85%
OPV/IPV	88.18%	95.42%	97.06%	95th	+1.64%
HiB	88.67%	99.35%	97.65%	95th	-1.70%
Hepatitis B	81.77%	96.08%	97.65%	95th	+1.57%
Varicella (VZV)	95.07%	96.08%	97.65%	95th	+1.57%
Pneumococcal	84.24%	92.81%	95.29	95th	+2.48%
Hepatitis A	96.06%	95.42%	97.65%	95th	+2.23%
Rotavirus	81.28%	89.54%	94.12%	95th	+4.58%
Influenza	80.30%	86.93%	90.59%	95th	+3.66%
Combo 2	77.34%	91.50%	93.53%	95th	+2.03%
Combo 3	76.85%	89.54%	93.53%	95th	+3.99%
Combo 7	74.38%	83.66%	91.76%	95th	+8.10%
Immunizations for Adolescents					
Meningococcal	86.70%	92.11%	88.64%	50th	-3.47%
Tdap/Td	90.96%	96.71%	94.32%	75th	-2.39%
Combo 1	84.04%	91.45%	88.64%	50th	-2.81%
Well-Child Visits					

First 15 months	Measure did not Exist	Measure did not Exist	84.94%	50th	N/A
Ages 3-11	Measure did not Exist	Measure did not Exist	73.90%	50th	N/A
Ages 12-17	Measure did not Exist	Measure did not Exist	57.43%	25th	N/A

DHMP EXCHANGE CHILDHOOD HEDIS METRIS RESULTS MY 2020

Childhood Preventive Measures	DHMP Exchange 2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 Percentile	2020-MY2020 HEDIS Change
Childhood Immunization Status					
DTaP	N/A	N/A	N/A	N/A	N/A
MMR	N/A	N/A	N/A	N/A	N/A
IPV	N/A	N/A	N/A	N/A	N/A
HiB	N/A	N/A	N/A	N/A	N/A
Hepatitis B	N/A	N/A	N/A	N/A	N/A
VZV	N/A	N/A	N/A	N/A	N/A
Pneumococcal	N/A	N/A	N/A	N/A	N/A
Combo 3	N/A	N/A	N/A	N/A	N/A
Immunizations for Adolescents					
Meningococcal	N/A	N/A	N/A	N/A	N/A
Tdap/Td	N/A	N/A	N/A	N/A	N/A
HPV	N/A	N/A	N/A	N/A	N/A
Combo 3	N/A	N/A	N/A	N/A	N/A
Well-Child Visits					
First 15 months	Measure did not Exist	Measure did not Exist	N/A	N/A	N/A

Ages 3-11	Measure did not Exist	Measure did not Exist	N/A	N/A	N/A

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.

^2019, 2020, and MY2020 rates were not reportable due to small sample size.

**HEDIS MY2020 CHANGES

In HMY2020, well-child visit measures modified the age ranges for which results are reported. As such, results cannot be compared to prior year performance.

SUMMARY OF HEDIS MY2020 CHILD IMMUNIZATION RESULTS

COMMERCIAL

Immunization rates remain strong for the Commercial line of business, with all Child Immunization Status measures reported in HMY2020 in the 95th percentile, an improvement over H2020.

Immunizations for Adolescents measures experienced a slight decrease in HMY2020, with Meningococcal rates decreasing 3.47%, Tdap/Td rates decreasing 2.39%, and Combo 1 rates decreasing 2.81% from H2020. This led to a percentile decrease across each of the measures, with Meningococcal vaccination rates in the 50th percentile of national performance, Tdap/Td rates in the 75th percentile, and Combo 1 vaccination rates in the 50th percentile for HMY2020.

EXCHANGE

Due to small population numbers, child immunization rate results have not been reported for the Exchange line of business.

Interventions 2021

In 2021, the DHMP QI team participated in the Denver Health Pediatric Quality Improvement Work Group. Many of the interventions in 2021 were continuations of interventions that began in 2019 and 2020.

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 were initiated. The DHMP QI department attends the ACS Medical Immunization Workgroup and has brought to light these data challenges and vaccine schedule variability.

ACS has 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.

As the COVID-19 pandemic continued in 2021, 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. ACS also continued sending a Patient Health Summary letter to pediatric patients who are overdue on vaccines througout 2021. Additional planning for interventions to improve these metrics is ongoing.

ACTION PLAN FOR 2022

For 2022, the DHMP QI team will continue to partner with the Denver Health Pediatric Quality Improvement Work Group, and School Based Health Centers (SBHC) to address any barriers to immunization adherence. Efforts to increase timely well-child visits should also have a positive impact on the vaccinations required to complete in the first 2 years of life (particularly IPV and Combo 7 rates). ACS will continue sending letters to all patients who were non-compliant for Combo 7 at 15 months, followed by telephone outreach to patients who are 21 months old and have not yet completed their Combo 7 vaccines. ACS will also continue sending a Patient Health Summary letter to pediatric patients (other age groups) who are overdue on vaccines. Efforts to capture changes to immunization naming and coding changes in EPIC and mapping to HEDIS data tables are also ongoing.

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

COMMERCIAL SUMMARY OF HEDIS MY2020 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.

COMMERCIAL

HMY2020 well-child visit rates in the first 15 months of life fell into the 50th percentile for the Commercial line of business, at 84.94%. Well-child visit rates for ages 3-11 were 73.90%, and well-child visit rates for ages 12-17 were 57.43%, at the 50th and 25th percentiles in HMY2020, respectively.

EXCHANGE

Due to small population numbers, well-child visit rate results have not been reported for the Exchange line of business.

2021 PREVENTATIVE HEALTH QUALITY IMPROVEMENT ACTIVITIES

SCHOOL BASED HEALTH CENTERS (SBHC) COLLABORATION

DHMP and DHHA continue to encourage eligible members particularly adolescents to complete their annual well-care visit at a Denver Health SBHC. There are 18 SBHCs located in middle schools and high schools with another 20 satellite elementary schools that feed into the SBHCs. SBHCs provide a variety of services such as well child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral health care services. 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. DHHA also promotes receiving care through an SBHC and in 2020 added electronic parental consent forms to their website to facilitate the consent process. 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.

BIRTHDAY CARDS FOR DHMP MEMBERS

In an effort to reach members of all age groups who are eligible for a well-child or adolescent well-care visit, DHMP sends Commercial and Exchange members a birthday card that provides educational information regarding the need for wellness visits and what services to expect their child to receive. In addition, the birthday cards remind parents that it is time to bring their children in for their annual well-visit. The cards are sent monthly to parents of children ages 2 through 19. In 2021, the average monthly mailing was 120 postcards across the Commercial and Exchange lines of business.

Year	Avg. Commercial/Exchange Postcards Mailed/Month
2019	110
2020	307
2021	120

ACTION PLAN FOR 2022

QI staff will continue to collaborate with the DHHA ACS Pediatric Quality Improvement Workgroup and SBHC team to develop interventions to improve health care outcomes for pediatric members. DHMP hopes to continue piloting and potentially expanding the SBHC intervention described above in 2022. In addition, the DHMP QI team continues to have discussion with the ACS SBHC teams around developing incentive programs program to drive adolescent well-care rates for DHMP members who attend a Denver Public School. DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit.

In Q4 2020, ACS began sending Patient Health Summary letters to pediatric patients who are overdue for a Well Child Visit and/or immunizations. In December 2020, this initiative was expanded to send these alerts through MyChart for patients who have a MyChart account. Both of these initiatives will continue in 2022.

ASTHMA

DHMP COMMERCIAL MY2020 HEDIS ASTHMA INDICATOR RESULTS

Medication Management for People w/Asthma (75% compliance MMA)	2019 HEDIS Results	20 20HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-2021 HEDIS Change
Ages 5-11	*N/A	*N/A	Retired MY2020	N/A	N/A
Ages 12-18	*N/A	*N/A	Retired MY2020	Retired MY2020	N/A
Ages 19-50	55.51%	59.49%	Retired MY2020	Retired MY2020	N/A
Ages 51-64	*N/A	*N/A	Retired MY2020	Retired MY2020	N/A
Total	48.46%	52.76%	Retired MY2020	Retired MY2020	N/A

*N/A=Sample size <30

DHMP EXCHANGE MY 2020 ASTHMA INDICATOR RESULTS

Medication Management for People w/Asthma (75% compliance MMA)	2019HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-2020 HEDIS Change
Ages 5-11	N/A	N/A	Retired MY2020	Retired MY2020	N/A
Ages 12-18	N/A	N/A	Retired MY2020	Retired MY2020	N/A
Ages 19-50	N/A	N/A	Retired MY2020	Retired MY2020	N/A
Ages 51-64	N/A	N/A	Retired MY2020	Retired MY2020	N/A
Total	N/A	N/A	Retired MY2020	Retired MY2020	N/A

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^2019, 2020, and MY2020 rates were not reportable due to small sample size.

DHMP COMMERCIAL MY 2020 ASTHMA INDICATOR RESULTS

Asthma Medication Ratio (AMR)	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	MY2020 HEDIS Percentile	2020-MY2020 HEDIS Change
Ages 5-11	*N/A	*N/A	*N/A	*N/A	*N/A
Ages 12-18	*N/A	*N/A	*N/A	*N/A	*N/A
Ages 19-50	67.95%	63.95%	61.70%	<5th	-2.25%
Ages 51-64	*N/A	*N/A	*N/A	*N/A	*N/A
Total	74.63%	66.43%	67.86%	5th	+1.43%

*N/A=Sample size <30

DHMP EXCHANGE MY 2020 ASTHMA MEDICATION RATIO

Asthma Medication Ratio (AMR)	2019 HEDIS Results	2020 HEDIS Results	MY2020 HEDIS Results	2020-MY2020 HEDIS Change
Ages 5-11	Measure did not Exist	Measure did not Exist	N/A	N/A
Ages 12-18	Measure did not Exist	Measure did not Exist	N/A	N/A
Ages 19-50	Measure did not Exist	Measure did not Exist	N/A	N/A
Ages 51-64	Measure did not Exist	Measure did not Exist	N/A	N/A
Total	Measure did not Exist	Measure did not Exist	N/A	N/A

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^MY2020 rates were not reportable due to small sample size.

**HEDIS MY2020 CHANGES

Medication Management for People with Asthma – 75% compliance (MMA) was retired as a measure in HMY2020.

SUMMARY OF HEDIS MY2020 ASTHMA RESULTS

COMMERCIAL

For the Commercial line of business, HMY2020 results showed a slight increase in the Asthma Medication Ratio (AMR) measure. Overall AMR performance (all age groups included) increased by 1.43%, which puts DHMP at 5th percentile nationally. This is especially significant, as NCQA retired the MMA measure in HMY2020, placing increased importance on the AMR metric to assess how well health systems manage asthma moving forward.

EXCHANGE

Due to small population numbers, AMR measure results have not been reported for the Exchange line of business.

Interventions for 2021

- 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 2020 to streamline this process. In 2021, 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 2022.

ACTION PLAN FOR 2022

The DHMP QI department participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. Additionally, the Asthma Work Group will continue to focus on appropriately identifying and controlling adult asthma in 2022 after identifying a need in 2020 to more uniformly address the asthma needs of members in this age group.

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 MCR, COMM and EXCH populations. The collaboration with the DHMP Pharmacy team to analyze these metrics and develop interventions to address medication adherence will continue into 2022. 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.

COVID-19 VACCINATION OUTREACH 2021

The DHMP QI team has been working closely with the DHMP Care Management, IS and marketing teams and our partners at DHHA ACS to increase outreach and access to members who are currently eligible to receive a COVID-19 vaccine and/or booster. In 2021, DHMP performed targeted COVID vaccination outreach campaigns 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 or booster if the member (or their child) is not currently eligible. 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.

ACTION PLAN FOR 2022

Outreach for members who will continue in 2022 and will expand to include members who are overdue for a booster shot and families of eligible children who have not yet received the vaccine. DHMP will work with our partners at DHHA mobile vaccination clinic to identify zip codes where many members remain unvaccinated and schedule vaccination clinics in these areas. We will continue to highlight local pharmacies where members can also receive the vaccine. DHHA SBHCs will continue to offer vaccine distribution and events to student and family members. We will continue to look at our data by race/ethnicity in order to identify disparities in vaccine uptake.

SAFETY AND QUALITY OF CLINICAL CARE

QUALITY OF CARE CONCERNS

An RN Designee, with direction from the DHMP Medical Director, investigates any potential QOCCs from members or providers. All QOCCs are tracked, trended and reported to the Product Line Mangers and the DHMP QMC. Substantiated QOCC's regarding providers are sent to the Denver Health Patient Safety or Patient Experience Team, if necessary, for follow up. The DHMP Medical Director, along with the RN designee continuously monitor and trend all member QOCCs

2021 QUALITY OF CARE CONCERN CASES (QOCC) – DHMP COMMERCIAL, EXCHANGE AND MEDICARE

Plan	Total Cases 2021	Unsubstantiated	Substantiated	Inconclusive
Exchange	**2**	**1**	**1**	**0**
Medicare	**5**	**5**	**0**	**0**
Commercial	**0**	**0**	**0**	**0**

ANALYSIS

COMMERCIAL AND EXCHANGE

There was a total of two QOCC cases for 2021 which was consistent with the number submitted in 2020. Only one case in the 3rd Quarter was found to be substantiated and the case was submitted to the DH Patient Advocate for further investigation and resolution. No trends were identified. No improvement opportunities were identified.

Medicare

There was a total of five QOCC cases for 2021 which was higher than 2020 which had zero

Submissions. One case was in the 1st Quarter, three in the 3rd Quarter and one in the 4th Quarter. All were found to be unsubstantiated with randomly centered complaints. There were no trends identified. No improvement opportunities were identified.

CULTURAL AND LINGUISTICALLY APPROPRIATE SERVICES PROGRAM (CLAS)

Denver Health Medical Plan (DHMP) provides health coverage to a culturally diverse population; therefore, it is important to educate staff about cultural differences that impact healthcare delivery. As of December 2021, there were 6 distinct languages identified that were spoken by our DHMP Medicare Advantage members and 12 distinct languages spoken by our DHMP Commercial population. However, only two languages were spoken by our members at 0.1% or greater, or 500 persons or more, (English and Spanish) for both product lines in 2021.

DHMP MEDICARE ADVANTAGE PLANS LANGUAGE DATA*

Language	Measure	2019	2020	2021
English	**Count**	**3,543**	**3,791**	**3,617**
	Rate	**75.75%**	**78.23%**	**75.51%**
Spanish	**Count**	**1,012**	**1,051**	**1,113**
	Rate	**21.64%**	**21.69%**	**23.24%**
Vietnamese	**Count**	**4**	**2**	**2**
	Rate	**.09%**	**.04%**	**0.04%**
Chinese	**Count**	**4**	**1**	**1**
	Rate	**.09%**	**0.04%**	**0.02%**
Tigrigna	**Count**		**1**	**1**
	Rate		**0.04%**	**0.02%**
Arabic	**Count**	**0**		**1**
	Rate	**0%**		**0.02%**

Samoan	**Count**	**1**	**0**	**0**
	Rate			**0.0%**
Unknown	**Count**			**55**
	Rate	**0%**		**1.15%**
Grand Total	**Count**	**4,676**	**4,846**	**4,790**

**Numbers reflect enrollment as of 12/31/2021*

DHMP MEDICARE ADVANTAGE PLANS RACE/ETHNICITY DATA*

Race/Ethnicity	2019		2020		2021	
	Count	Rate	Count	Rate	Count	Rate
No Ethnicity	**2**	**0.0%**	**2**	**0.0%**	**0**	**0**
Hispanic or Latino	**5**	**0.11%**	**5**	**0.11%**	**2402**	**50.15%**
White	**1864**	**39.87%**	**1864**	**39.87%**	**1350**	**28.18%**
African American	**400**	**8.55%**	**400**	**8.55%**	**799**	**16.68%**
Unknown/Other	**2,351**	**50.28%**	**2,351**	**50.28%**	**141**	**2.94%**
Not Hispanic or Latino	**3**	**0.0%**	**3**	**0.0%**	**0**	**0**
Pacific Islander	**26**	**0.56%**	**26**	**0.56%**	**2**	**0.04$**
Alaskan/American Indian	**14**	**0.30%**	**14**	**0.30%**	**18**	**0.38%**
Asian					**77**	**1.61%**
Native Hawaiian					**1**	**0.02%**
Other	**11**	**0.24%**	**11**	**0.24%**	**0**	**0**
Grand Total	**4,676**		**4,846**		**4,790**	

**Numbers reflect enrollment as of 12/31/2021.*

DHMP MEDICARE ADVANTAGE REL SUMMARY

Medicare member race/ethnicity and language data from the December 2020 to December 2021 eligibility files were examined. Based on our analysis for our Medicare line of business in 2021, English was the predominant language of our member population followed by Spanish. Analysis of the race/ethnicity data indicates that the most prevalent race/ethnicity in this population is Hispanic at 50.15%, followed by White at 28.18% and African American at 16.68%. 2.94% of members are listed as Unknown, which highlights an improvement in the ability of DHMP to capture race/ethnicity data on our Medicare members.

In late 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 MCR, Commercial and Exchange members seen at DHHA clinics to improve our CLAS efforts.

DHMP COMMERCIAL/ EXCHANGE LANGUAGE DATA

Language	Measure	2020	2021
English	Count	14,910	2,974
	Rate	97.41%	19.64%
Spanish	Count	368	364
	Rate	2.40%	2.40%
Unknown	Count		11,780
	Rate		77.78%
Vietnamese	Count	1	2
	Rate	0.00%	0.01%
Korean	Count	1	1
	Rate	0.00%	0.00%
Hungarian	Count	2	2
	Rate	0.01%	0.01%
German	Count	2	2
	Rate	0.01%	0.01%
Egyptian	Count	1	1
	Rate	0.00%	0.00%
Russian	Count	3	4
	Rate	0.02%	0.02%
French	Count	1	4
	Rate	0.01%	0.02%
Amharic	Count	2	2
	Rate	0.01%	0.01%
Arabic	Count	5	4
	Rate	0.03%	0.02%
Ukrainian	Count	2	1
	Rate	0.01%	0.00%
Grand Total	Count	15,306	15,144

DHMP COMMERCIAL/EXCHANGE RACE/ETHNICITY DATA

Race/Ethnicity	2020		2021	
	Count	Rate	Count	Rate
No Ethnicity			NA	NA
Hispanic or Latino	1,549	10.12%	3,978	26.24%
White	606	3.96%	7,325	48.37%
Black/African American	3,552	23.21%	1,086	7.17%
Other/Unknown	482	3.15%	2,191	14.46%
Not Hispanic or Latino	2	0.01%	NA	NA
Asian	150	1.03%	499	3.30%

Alaskan/American Native	**43**	**0.30%**	**26**	**0.17%**
Other	**698**	**4.81%**	**NA**	**NA**
Pacific Islander			**30**	**0.19%**
Asian Indian	**7**	**0.05%**	**NA**	**NA**
Native Hawaiian	**20**	**0.14%**	**9**	**0.05%**
Grand Total	**14,508**		**15,144**	

DHMP COMMERCIAL/EXCHANGE REL SUMMARY

Efforts to improve and standardize REL data across lines of business at DHMP is ongoing and changes/progress was made during 2021 to correctly identify member's REL status. In previous years analysis if member language was missing for or listed as? the member's language was autonomically assigned as English, resulting in English being the listed language spoken by over 97% of the Commercial Population. In 2021, the QI team decided to remove that assignment and report blank/unknown or? in the language field as Unknown, accounting for the large percentage changes reported in the tables above.

Commercial member race/ethnicity data from the December 2021 eligibility files were examined. Based on our analysis for our Commercial line of business in 2021, English was the predominant language of our member population followed by Spanish, however, with a vast majority of members language listed as "Unknown". In comparison to 2020, a similar number of languages were spoken among DHMP members, though the number of members speaking languages other than English and Spanish remains relatively low. Analysis of race/ethnicity data indicates that White members were the most prevalent known race among Commercial members at 48.37%, with Hispanic or Latino members comprising 26.24% of the population and Blacks comprising 7.17% of the population. 14.46% of Commercial members identified their race and/or ethnicity as "Other, Unknown" which is an improvement from 2020 but still leaves room for improvement highlighting the continued need for more effective collection of accurate REL data at the plan level. Data capture began in Spring of 2021 through our ACS partners. DHMP will utilize this data for MCR, COMM and Exchange 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 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 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."

Colorado is 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
- 72% 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 DH staff passed the module, called the 'Denver Health Experience.'

BARRIERS

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

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

OPPORTUNITIES FOR IMPROVEMENT

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

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

INTERVENTIONS

Based on the aforementioned opportunities for improvement, the following interventions have been identified as priorities for 2022:

- 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 2020, reducing disparities in health related to race, ethnicity and language was identified as an enterprise opportunity, increasingly so as the COVID-19 pandemic has emphasized the continuing disparities in health outcomes related to race and ethnicity. In 2021, in addition to ongoing system wide work to improve COVID-19 outcomes across racial/ethnic groups, DHMP continued 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 will include 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 embers 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 2022

In 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.

QUALITY OF SERVICE

MEMBER SATISFACTION

2021 MEMBER SATISFACTION – ANNUAL CAHPS SURVEY AND FEEDBACK

DHMP conducted the Adult Consumer Assessment of Health Plan Providers and Systems (CAHPS) survey in 2021 for the Commercial, Exchange and Medicare plans. CAHPS surveys were conducted under contract with SPH Analytics, an NCQA certified vendor. SPH Analytics follows NCQA protocols and statistically appropriate methodologies to determine member satisfaction scores.

BACKGROUND

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

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

A total of 1,595 Commercial plan members, 715 Exchange members, and 1000 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 220 Commercial plan members, 131 Exchange members and 298 Medicare members who chose to complete the survey.

COMMERCIAL CAHPS RESULTS

In 2021, the commercial adult sample size was 1595 with 220 total completed surveys for a 14% response rate. Below is a table summarizing Commercial CAHPS results for the past two years

MEASURE	SUMMARY RATE		CHANGE	2021 PERCENTILE
	2020	2021		
How Well Doctors Communicate *(% Always or Usually)*	95.9%	96.7%	0.8%	71st
Rating of Personal Doctor *(% 8, 9 or 10)*	87.7%	83.7%	-4.0%	20th
Rating of Health Plan *(% 8, 9 or 10)*	66.4%	65.9%	-.5%	36th
Getting Care Quickly Getting Care Quickly *(% Always or usually)*	78.3%	80.0%	1.7%	17th
Rating of Health Care *(% 8, 9 or 10)*	82.4%	77.3%	-5.1%	28th
Customer Service and Claims Processing	**	**	**	**

Rating of Specialist *(% 8, 9 or 10)*	87.0%	82.8%	-4.2%	13th
Getting Needed Care *(% 8, 9 or 10)*	77.5%	74.6%	-2.9%	5th
Ease of Filling out Forms *(% Always or Usually)*	97.4%	98.6%	1.2%	81st

** **N/A as denoted by NCQA

Key Takeaways:

- Overall Rating of Health Plan (9-10) Summary Rate score is 39.7% and represents a change of -8.6% from 2020.

The table below details the historical trend for the last 2 years:

Table 1: 2021 Adult Commercial CAHPS Historical Trending

EXCHANGE CAHPS RESULTS

In 2021, the Elevate by Denver Health sample size was 715 with 131 total completed surveys for a 23.5% response rate.

Below is a table summarizing Exchange CAHPS results for the past two years

MEASURE	SCALED MEAN SCORE		CHANGE	2021 PERCENTILE
	2020	2021		
Rating of Health Plan	72.6	66.8	-5.8	23rd
Rating of Health Care	82.3	76.9	-5.4	12th
Rating of Personal Doctor	91.1	87.4	-3.7	33rd
Rating of Specialist	81.1	82.3	1.2	10th
Getting Care Quickly	75.6	72.7	-2.9	27th
Getting Needed Care	68.6	66.5	-2.1	9th
Access to Information	50.2	46.8	-3.4	23rd
Care Coordination	81.9	81.2	-0.7	30th
Plan Administration	71.4	66.2	-5.2	16th
Flu Vaccine for Adults 18-64	66.7%	54.1%	-12.6%	59th

Medical Assistance with Smoking Tobacco Use Cessation	69.6%	60.5%	-9.1%	73rd

Key Takeaways:

- Our overall Rating of Health Care Scaled Mean Score is 76.9 and represents a change of -5.4 from 2020.
- Your overall Rating of Health Plan Scaled Mean Score is 66.8 and represents a change of -5.8 from 2020.

Denver Health Medical Plan 2021 Received:

- Four stars for ''Care Coordination' and 'Getting Needed Prescription Drugs'
- Three stars Rating for 'Health Care Quality' and Annual Flu Vaccine
- Two stars Rating for 'Health Plan, Getting Needed Care, Customer Service and Rating of Drug Plan

MEDICARE CAHPS RESULTS

In 2021, the Medicare sample size was 1000 with 298 total completed surveys for a 29.9% response rate
Below is a table summarizing Medicare CAHPS results for the past two years

MEASURE	SCALED MEAN		CHANGE	CURRENT PERCENTILE	2021 STAR RATING
	2020	2021			
Getting Needed Care	77	76	-.06	8th	★★
Getting Appointments and Care Quickly	74	76	1.2	27th	★★
Customer Service	87	88	1.0	16th	★★
Getting Needed Prescription Drugs	87	87	0.6	9th	★★★★
Care Coordination	88	85	-2.3	43rd	★★★★
Rating of Health Care Quality	86	84	-2.2	19th	★★★
Rating of Health Plan	84	85	0.1	9th	★★
Rating of Drug Plan	88	88	-.1	59th	★★
Annual Flu Vaccine	80.5%	72.6%	-7.9%	44th	★★★

ANALYSIS

The pandemic caused significant disruption throughout most of 2020 and continuing into 2021. Therefore, it is best to interpret trend results with a degree of caution. Survey results from 2020 may have been impacted for some health plans because of the pandemic.

Most measures are relatively stable in 2021 after an increase in 2020. The largest increases from 2019 occurred on the ratings of Health Plan, Health Care Quality, and Drug Plan, as well as the Getting Appointments and Care

Quickly and Getting Needed Prescription Drugs composites. The Annual Flu Vaccine measure continues to trend upward from 2019.

GRIEVANCE REPORTING AND TRENDING:

The complaint analysis report period covers the period of January 1, 2021, to December 31, 2020, and describes the number and types of member grievances and appeals received during the report period. In addition, a summary of activities is provided that demonstrates DHMP's commitment to quality improvement.

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

Trends in member grievance and appeals are presented quarterly to the QMC and on an ad hoc basis through other informal mechanism as needed to resolve identified issues. As part of the ongoing NCQA monitoring efforts, all adverse appeal resolution letters are currently being monitored prior to mailing to ensure required elements are included in the letters. Quality review of cases is conducted monthly by the Grievance and Appeal manager on a sample of cases to confirm cases are being worked in accordance with internal policies and regulatory requirements.

COMMERCIAL GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	3	1	4	2	10	0.80
Financial/ Billing	44	40	27	41	152	12.29
Customer Service	1	3	0	2	6	0.48
Direct Member Reimbursement	0	0	0	0	0	0.0
Quality of Service	0	0	0	0	0	0.0
HIPAA Privacy and Confidentiality	0	1	1	0	2	0.16
Quality of Clinical Care	1	0	0	0	1	0.08
Benefit Package	0	0	2	1	3	0.24
Organization Determination and Reconsideration Process	0	0	1	0	1	0.08
Provider Network	0	0	0	0	0	0.0

Health Plan - Specific Department Concern	2	0	0	3	5	0.40
GRAND TOTAL	51	45	35	49	180	14.55

ELEVATE (MARKETPLACE) GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	3	0	1	0	4	2.50
Benefit Package	1	1	0	0	2	1.25
Customer Service	4	0	0	0	4	2.50
Financial/ Billing	3	6	7	8	24	15.0
Enrollment/Disenrollment	1	0	0	1	2	1.25
Health Plan-Specific Department Concern	0	0	0	1	1	0.62
Quality of Service	0	0	0	0	0	0.00
Quality of Clinical Care	0	0	1	0	1	0.62
GRAND TOTAL	12	7	9	10	38	23.76

MEDICARE GRIEVANCE DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	2	6	3	3	14	2.92
Customer Service	4	8	8	13	33	6.88
Direct Member Reimbursement	0	0	0	1	1	0.21
Enrollment/Disenrollment	3	1	0	2	6	1.25
Financial/ Billing	11	1	9	12	33	6.88
Health Plan - Specific Department Concern	0	0	1	0	1	0.21

Quality of Service	2	2	2	1	7	
HIPAA Privacy and Confidentiality	0	0	0	1	1	0.21
Benefit Package	9	3	3	5	20	
Transportation	8	14	13	15	50	
Eligibility	0	0	0	1	1	0.21
Grievance related to "CMS" issue	0	0	0	1	1	0.21
Quality of Clinical Care	1	1	0	0	2	0.42
GRAND TOTAL	40	36	39	55	170	35.46

COMMERCIAL APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	1	0	0	0	1	0.08
Financial/ Billing	0	4	5	4	13	1.05
Benefit Package	3	0	3	2	8	0.65
Health Plan - Specific Department Concern	3	4	2	3	12	0.97
GRAND TOTAL	7	8	10	9	34	2.75

ELEVATE (MARKETPLACE) APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Benefit Package	0	0	0	1	1	0.62
Health Plan - Specific Department Concern	0	0	0	1	1	0.62
GRAND TOTAL	0	1	0	2	2	1.25

MEDICARE APPEAL DATA—OVERALL HEALTHCARE

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Financial/ Billing	15	18	19	12	64	13.35
Benefit Package	6	9	7	6	28	5.84
Transportation	0	1	0	0	1	0.21
Organization Determination and Reconsideration Process	0	0	0	0	0	0.00
Health Plan - Specific Department Concern	1	1	3	3	8	1.67
GRAND TOTAL	22	29	29	21	101	21.06

QUALITATIVE ANALYSIS—OVERALL HEALTHCARE

GRIEVANCE DATA – REVIEW OF TOP GRIEVANCE CATEGORIES

Transportation

The transportation category has the highest number of complaints for Medicare. Complaints were received for a variety of issues including but not limited to delays or no-shows in pick-up of members for appointments, and complaints with member experience with various transportation vendors. The grievance and appeal team attempts to assist members where possible on a case-by-case basis to resolve complaints regarding transportation issues by working closely with our vendors and our Medicare PLM to ensure member satisfaction. Identified trends are escalated as needed to impacted stakeholders for resolution.

Financial/Billing

The highest volume of complaints for Commercial and Elevate members is within the financial/billing category and tied with Customer Service as the second highest in Medicare line of business. A trend identified in this category was Commercial members receiving bills from providers due to the late filing of claims by providers. This has led to some members being billed for the full cost of services when the claim is denied. The grievance and appeal team investigated each case to try and determine why the claim was submitted late by the provider. A few issues were identified: 1) Provider confusion: we found providers sometimes do not file the claim to the correct address for pricing. In this case, we try to educate to the provider about how to submit it correctly. 2) Complaints were received for claims that denied for no authorization or prior authorization denied. The grievance and appeal department provide member and provider education regarding prior authorization requirements on an ongoing basis for these complaints. They also are working closely with the Utilization Management team to prevent these types of claims from becoming appeals.

Benefit Package

Benefits accounted for the third highest reason for complaints for Medicare members and was among the top three reasons for complaints for Elevate members. Reasons for complaints included drugs not covered by health plan, dental and vision benefit coverage issues, and other non-covered benefits.

Access

Access to care was the second highest complaint with our Commercial and Elevate members and was in the top four highest complaints with our Medicare members. Trends identified in this category were unable to reach Denver Health Appointment Call Center line and appointment wait times for specialist. The Grievance and Appeals department worked these case-by-case in helping to obtain appointments within acceptable timeframes for our members. Some of the issues are staffing issues, therefore, the Grievance and Appeals department works to manage reasonable expectations for our member.

APPEAL DATA – REVIEW OF TOP APPEAL CATEGORIES

Financial/Billing

Financial/Billing issues had the highest volume of appeals for the Medicare and Commercial line of business. There were many appeals received for denied claims for the Medicare line of business. These claims often denied for lack of authorization. The grievance and appeal department provide member education regarding the reasons for these denials on an ongoing basis. In some of the cases, DHMP incorrectly processed the member claim and thus the member received a bill for the service(s). These errors were corrected through the appeal process.

Benefit Package

Benefit Package had the second highest volume of appeals for the Medicare line of business. Several appeals were for claim denials for no authorization. Additionally, there were several appeals for drug prior authorization requests for various reasons: member didn't meet the criteria for coverage; request was for an over-the-counter drug (not covered by Medicare); or request was for a drug that is not allowed to be covered by Medicare per Medicare rules. The grievance and appeal department provides member education regarding the reasons for these denials on an ongoing basis

Health Plan - Specific Department Concern

Appeals related to a specific department was the second highest reason for appeals for Commercial members. This category was also among the top three reasons for complaints for Medicare members. These majority of complaints were regarding decisions made in the Utilization Management department and denials for authorization requests. The grievance and appeal department provides member education regarding the reasons for these denials on an ongoing basis.

EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT

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

As mentioned in the analysis above. The grievance and appeal team attempt to assist members, if possible, on a case-by-case basis. The grievance and appeal department provide member and provider education when possible and as appropriate in our member grievance and appeal resolution letters. Identified trends are also escalated as needed to impacted stakeholders for resolution.

Regarding the high volume of financial billing complaints for commercial members, several corrective actions have been taken to address the high volume of complaints: 1) The grievance and appeal team provides education to providers who incorrectly submit claims. 2) There is currently a work group in place to address issues with claims coming into Cognizant/BMS. In the meantime, we are researching each grievance on a case-by-case basis to resolve but typically find that we need to waive timely filing so the claim can pay, and the member is not being held responsible for costs. Additionally, DHMP has worked on amending prior authorization requirements so that fewer procedures require prior authorization to reduce the number of denied claims.

QUANTITATIVE ANALYSIS – BEHAVIORAL HEALTHCARE

COMMERCIAL GRIEVANCE DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Quality of Service	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Benefit Package	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

ELEVATE GRIEVANCE DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Quality of Service	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Benefit Package	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

MEDICARE GRIEVANCE DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

COMMERCIAL APPEAL DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

ELEVATE APPEAL DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

MEDICARE APPEAL DATA

Categories	1Q2021	2Q2021	3Q2021	4Q2021	TOTAL	Per 1000 Members
Access	0	0	0	0	0	0
Financial/ Billing	0	0	0	0	0	0
Quality of Service (Customer Service/Attitude)	0	0	0	0	0	0
Quality of Clinical Care	0	0	0	0	0	0
Provider Network	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0

GRIEVANCE DATA—BEHAVIORAL HEALTHCARE - REVIEW OF TOP APPEAL CATEGORIES

NO BEHAVIORAL HEALTH GRIEVANCES WERE FILE FOR COMMERCIAL OR MEDICARE LINES OF BUSINESS.

APPEAL DATA – BEHAVIORAL HEALTHCARE - REVIEW OF TOP APPEAL CATEGORIES

NO BEHAVIORAL HEALTH APPEALS WERE FILED FOR COMMERCIAL OR MEDICARE LINES OF BUSINESS.

EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT—BEHAVIORAL HEALTHCARE

In the event members file a grievance or appeal regarding Behavioral Healthcare, the grievance and appeal team attempt to assist them, if possible, on a case-by-case basis to resolve their complaints and appeals. The grievance and appeal department provides member and provider education when possible and as appropriate in our member grievance and appeal resolution letters. Identified trends are also escalated as needed to impacted stakeholders for resolution.
Appeals and grievances data (previous section) found no issues for either Commercial, Elevate or Medicare product lines.

CARE COORDINATION AND CARE MANAGEMENT PROGRAM

The overall goal of Care Management and Care Coordination is to help members regain optimum health or improved functional capacity, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources and development and implementation of a care plan with performance goals, monitoring and follow up. Care management programs and activities are an opt-out program, and all eligible members have the right to participate or decline to participate.

DHMP uses various methods for risk stratification of members, dependent on the line of business (LOB) and associated regulatory/contractual requirements. Members may be stratified based on primary behavioral or physical health conditions, diagnosis information, over-or under-utilization of services, cost of care or other factors. DHMP compiles data from several sources, including self-reported data to identify members or populations with high-acuity concerns that can be addressed via care coordination, population health, or care

SUMMARY OF 2021 CARE COORDINATION ACTIVITES AND CARE MANAGEMENT PROGRAMS

COMPLEX CASE MANAGEMENT (CCM)

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

2021 CCM METRICS

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

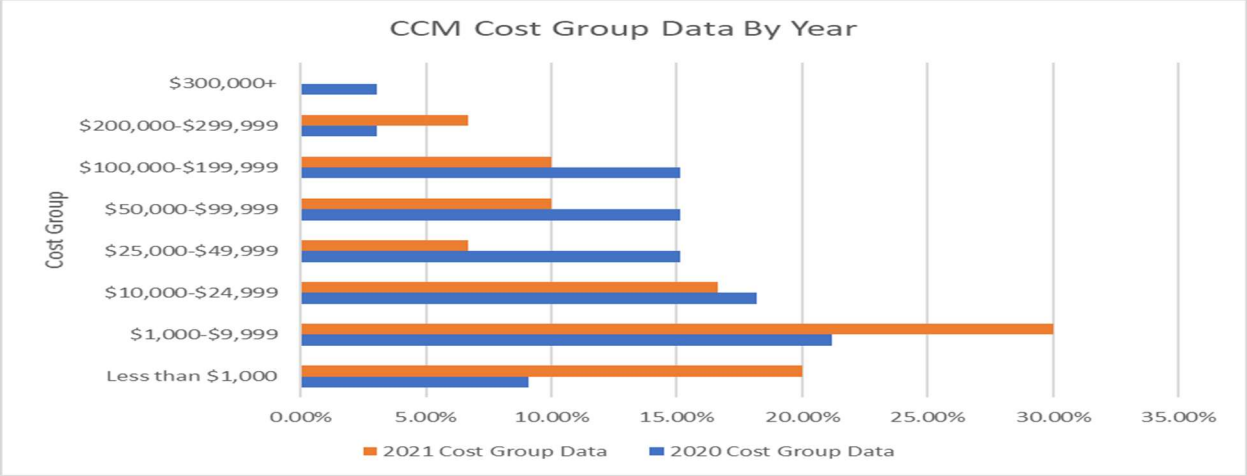
CCM PROGRAM METRICS

Complex Case Management Metrics	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
CCM Referrals	8	8	4	3	1	2	2	3	3	5	2	1	**42**
CCM Actively Managed	28	26	27	28	29	31	28	27	32	28	30	29	**36**
CCM Graduated	0	0	0	0	1	0	1	0	0	0	0	0	**2**
CCM Member Calls	183	166	180	188	88	130	147	100	69	94	86	73	**1504**
CCM Member Assessments	3	0	3	3	0	0	0	8	0	3	4	7	**31**
CCM Care Coordination Tasks	35	20	20	53	21	32	28	40	27	39	45	34	**394**

CCM ACTIVITY METRICS

Complex Case Management Activities	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
CCM Assessment		20											20
CCM Engagement / Enrollment		6	5	3	2	3	4	3	3	2	5	6	34
CCM Language Services						2							2
CCM Member Follow-up	32	35	32	32	32	30	30	26	26	31	30	28	69
CCM Other Follow-up	2	2	2	2		1	4	1		1		5	18
CCM Program	2		1	1			2	3	2	1	2	5	18
CCM Program Update			1	3				4	3	3	1		11
CCM Provider Follow-up		1			1			1			1		4
CCM Screening / Triage												2	2
CCM TOC Member Follow Up								2				1	3
CCM TOC Other Follow Up												2	2
CCM TOC Provider Follow Up												2	2
CCM Vaccination Coordination		3	1	1		1							6
Total CCM Activity Outreach	**33**	**60**	**35**	**34**	**33**	**35**	**34**	**32**	**27**	**33**	**33**	**34**	**112**

CCM OUTCOME METRICS



Cost Group Comparison		
Cost Groups	**2020**	**2021**
Less than $1,000	9.09%	20.00%
$1,000-$9,999	21.21%	30.00%
$10,000-$24,999	18.18%	16.67%
$25,000-$49,999	15.15%	6.67%
$50,000-$99,999	15.15%	10.00%
$100,000-$199,999	15.15%	10.00%
$200,000-$299,999	3.03%	6.67%
$300,000+	3.03%	0.00%
Average Per Member Annual Cost	**$ 65,998.08**	**$ 43,199.64**

RESULTS AND ANALYSIS

- A total of 42 new members met eligibility criteria
  - 59.52% of the new referrals (25 members) ultimately enrolled in the program
  - The most common reason for not enrolling was an inability for the CCM team to reach the member (15 of 42 members, 35.71%)
  - 4 of the 42 referred members (9.52%) declined/opted out of the CM program, but 2 of those who initially declined ultimately enrolled when referred to the program later in the year
- A total of 36 distinct clients participated in the CCM program in the past year
  - Of those, 2 members (5.55%) graduated from the program, 2 members (5.55%) were lost to follow, 1 member (2.78%) had their eligibility termed, and 2 members (5.55%) passed away
- We saw reduced spending and inpatient utilization with members enrolled in CCM in 2021.
  - The average annual cost per member decreased from $65,998.08 in 2020 to $43,199.64 in 2021, for an average per member annual decrease of $22,798.44
  - The proportion of members in cost groups exceeding $10,000 annually decreased between 2020 and 2021

- Half of the members in 2021 fell into cost groups that are under $9,999 annually, with 20.00% of members falling into the <$1,000 cost group.
- 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).

BARRIERS/LESSONS LEARNED

- Engagement via telephonic outreach failed to reach 35.71% 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 members.
- The COVID-19 pandemic has continued to have an impact on member utilization. While overall utilization of high-cost services appears to be down, so does utilization of preventative care services. Additionally, access to services has been impacted due to a backlog of demand and implementation of crisis standards of care in late 2021:
  - Many members in the CCM program were afraid to keep appointments due to the risk of contracting COVID-19 and required additional encouragement and support from their Care Manager to attend appointments
  - While telemedicine was a viable option for some members, some members did not like participating in telemedicine appointments
  - Some members experienced delays or holds on surgeries, which required additional care coordination with specialists and providers, as well as routine reviewing of surgical appointment availability and management of wait lists
  - Specialty care was often booked out due to high demand, requiring the Care Manager to contact clinics daily to look for openings due to cancellations so that CCM members could be seen sooner
  - Members expressed higher levels of anxiety living through the pandemic and sometimes had difficulty managing their conditions

TRANSITIONS OF CARE (TOC)

The DHMP TOC Program is an evidence-based program that focuses on helping reduce preventable readmissions by providing knowledge, confidence, and ability to self-manage health conditions. Transitions nurses support members and the inpatient care team during the inpatient stay and member discharge, and follow, educate, and support members for 30 days following their hospital discharge. Outreach is done at a minimum of once a week (based on member need) and assessments are completed to determine readmission risk and to develop an individualized 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.

In October 2021, the Transitions of Care team implemented a complex needs process which includes additional monitoring and discharge planning support for members who are inpatient for more than 14 days, are admitted

out of state, or whose medical needs meets complex needs criteria. These members are discussed weekly at a meeting involving UM and CM so that barriers to care and barriers to discharge can be resolved on the side of the hospital system, and repatriation to a Denver Health facility can be supported as appropriate.
Care coordination activities provided by the TOC include but are not limited to:

- In-network PCP coordination if not already established
- Appointment reminders- Ensuring timely physician follow-up care
- DME
- Home Health
- Reviewing mediation regimen
- Disease Management
- Education on health conditions and potential ''red flags'' for readmission
- Transportation
- Connecting members with helpful community resources

2021 TRANSITIONS OF CARE (TOC) METRICS

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

TOC PROGRAM METRICS:

Transitions of Care Metrics	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
TOC Member Outreach	1113	722	1043	1,011	875	533	1303	1,661	1156	1478	1926	1646	**14,467**
TOC Care Coordination Activities	1025	1199	1552	1,360	1,452	2023	1986	1,669	1188	1653	2011	1452	**18,570**
Hospital Readmissions W/I 30 days	0	0	0	0	0	1	6	6	5	6	3	7	**34**
TOC Referrals	175	166	205	179	161	194	131	264	210	234	301	239	**2,459**
TOC Members Graduated	7	15	8	36	31	22	31	34	37	29	27	57	**334**
TOC Members Lost to Follow	0	0	1	1	0	0	3	15	14	20	6	19	**79**
TOC Declined/Opt-Out Program	32	18	81	32	33	21	49	34	35	25	17	23	**400**
TOC Did not meet/Termed Eligibility	13	5	20	5	6	4	3	54	31	13	13	35	**202**
TOC UTR (Unable to Reach)	96	83	156	110	100	111	184	127	148	121	146	137	**1,519**
% Enrolled in TOC Program	**4%**	**9%**	**4%**	**20%**	**19%**	**11%**	**24%**	**13%**	**18%**	**12%**	**9%**	**24%**	**14%**

TOC ACTIVITY METRICS:

TOC Care Team - Care Activity Outreach	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
COVID-19 Outreach	20	11	4	4	13	10	14	3	4	7	4	3	**97**
Transitional Care Assessments	31	47	14	16	8	24	50	50	70	49	95	87	**541**
Appointment Reminders	5	5	0	1	0	0	1	1	6	10	3	0	**32**
Applications/Membership Assistance	5	2	3	1	1	2	1	5	8	10	30	19	**87**
Care Plan Update/Review	24	30	11	83	69	60	208	160	123	161	291	125	**1,345**
Community Resource Assistance	22	14	11	11	17	20	56	54	34	92	79	51	**461**
Education Provided	10	14	1	5	9	6	29	24	1	39	37	28	**203**
Food Security Coordination	0	2	0	0	0	0	1	0	0	0	0	0	**3**
Health Care Provider Coordination	7	8	11	2	23	28	50	71	12	41	29	35	**317**
Internal Admin Tasks	1,058	1,056	1,108	997	1,117	1,152	1,364	1,288	924	1,250	1,351	1,027	**13,692**
Language Services	7	6	7	8	13	11	37	33	1	21	30	31	**205**
Member Outreach	399	274	510	529	335	96	349	440	226	431	642	432	**4,663**
Pharmacy Referral	0	0	0	0	3	0	0	4	1	1	4	3	**16**
Program Engagement / Enrollment	191	163	477	365	383	270	743	844	734	666	757	701	**6,294**
Provider Follow-up	49	41	56	51	11	26	34	49	33	79	136	86	**651**
Referrals	190	180	231	296	313	390	330	278	160	274	425	249	**3,316**
Schedule Transportation	1	1	1	1	2	4	6	3	0	1	7	9	**36**
Schedule Appointments	3	1	1	1	8	2	13	21	7	8	17	13	**95**
Vaccination Coordination	4	5	2	0	2	14	3	2	0	1	0	1	**34**
Distinct TOC Members Outreached/Engaged	311	283	423	341	338	335	366	398	371	325	404	465	**4,360**
Total TOC Care Activity Outreach	**2,026**	**1,860**	**2,448**	**2,371**	**2,327**	**2,115**	**3,289**	**3,330**	**2,344**	**3,141**	**3,937**	**2,900**	**32,088**

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 the measures that are in place can continue to reduce the readmission rate when pandemic mitigation efforts are fully engaged.
- In 2021, the Transitions team received 2459 referrals for on-going care transitions management, a 10-fold increase from the previous year
- Of the 2459 referrals, 334 members (13.58%) enrolled into and successfully completed the TOC program
    - The most common reason for not enrolling was an inability for the TOC team to reach the member (1519 of 2459 members, 61.77%)
    - 400 of the 2459 (16.27%) new referrals declined and opted out of the program
        - Of these 400 members, 169 members (42.25%) declined the TOC program but agreed to receive other CM services to assist with their care
    - 34 members of the 2459 referred members (1.38%) were readmitted back to the hospital within 30 days of discharge
- 4360 distinct members were outreached and/or engaged in 2021

BARRIERS/LESSONS LEARNED

- Identifying and tracking members who are inpatient can be difficult due to lag times in the authorization process, and no authorizations being required for tier 1 hospitalizations. In November 2021, a comprehensive tracking and reporting system was implemented to improve the ability to capture inpatient hospitalizations and readmissions. This resulted in earlier referrals to the program and an increased volume of members outreached for and engaged in the program.
    - 129 total members were enrolled in the program in November and December 2021, which is twice the average number of enrollments in previous months
    - December 2021 had the highest number of members who completed the program (54 members), following the month with the highest number of enrollments (74 members enrolled in November 2021)
    - While it is too early to determine the full impact of this process, early results from enrollment and graduation data are promising
- Engagement via telephonic outreach failed to reach 61.77% 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 members.
    - As a part of ongoing quality improvement processes, DHMP is seeking opportunities to initiate TOC services while a member is still inpatient. This will allow for rapport building, introduction to the program, and the ability to capture up to date phone and other contact information.
    - In December 2021, letters and email were integrated into outreach efforts:
        - An introductory letter to the member upon notification of inpatient status
        - A follow up letter or email after two failed telephonic outreach attempts
        - The complex needs process allows for earlier connection between the DHMP
        - Care Management team and the member, and allows for enhanced discharge planning for high-risk members

    - It is too early to determine the impact of the addition of letters and emails to the success rate when outreaching members.
- Members declining the program has been an ongoing challenge; however, some members are willing to participate in Care Management services even though they do not wish to participate in a program. DHMP started tracking this as a separate outcome in Guiding Care in 2021.
- The COVID-19 pandemic has completely changed how members seek care. Lower ED visits are a double-edged sword, fewer members getting non-urgent care at the ED, versus members who need emergent care fearing going to the ED for treatment. The opportunity is to educate members about access to lower levels of care, (urgent care, PCP, telemedicine) while reinterring that the ED is a key venue for care when necessary. Education about safety protocols at the ED might help make members more comfortable about seeking care.
    - DHMP has learned that increased communication and beneficiary engagement are key strategies to engage members and ensure they receive the care necessary, despite the barriers to care that presented due to COVID.

TRANSITIONS OF CARE

This care management program was expanded in 2021 to include members on Medicare, commercial, and exchange plans. The DHMP pharmacy team monitors members pharmacy utilization and will identify members that are on high-cost drugs for care coordination review and evaluation for case management services. The care coordination team will outreach to the member to discuss their specific condition and associated pharmacy needs and connect members to a primary care provider if they are not already established with a provider.

2021 High Utilizer Medication Management Program Metrics

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

HIGH UTILIZER MEDICATION MANAGEMENT PROGRAM METRICS:

High Utilizer Medication Management Program Status	
Program Status	**Members**
Completed Program	1
Declined- Opt Out	1
Declined Program	1
Eligibility Termed	1
Member Engagement	2
Member Enrolled in Program	6
Unable To Reach	3
Grand Total	**15**

HIGH UTILIZER MEDICATION MANAGEMENT CARE ACTIVITY METRICS:

High Utilizer Medication Management Program													
Activity	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**YTD**
Appointment Reminder							2	2	2		2	7	15
BH Care Coordination												2	2
CC Condition Management Assistance										6	4	6	16
CC Health Acuity/Needs Assessed					2								2
CC Health Care Provider Coordination					3					2			5
CC Medication Management Assistance					4	2				8	4	2	20
CC Member Outreach		4			2					27			33
DHMP COMM Condition Management									1				1
EPIC Healthy Planet Link Look-up					3								3
Internal Admin Task										12	6	2	20
Member Call			1										1
Grand Total		**4**	**1**		**14**	**2**	**2**	**2**	**3**	**55**	**16**	**19**	**118**

OPTION CARE PILOT COST DATA:

Option Care Program				
Member	Facility Price	Option Care Price (excluding Administration Costs)	Number of Claims	Total Savings (after Administration Costs)
A	$ 25,054	$ 11,668	4	$ 46,672
B	$ 27,401	$ 3,645	2	$ 42,112
C	$ 16,539	$ 7,881	2	$ 16,956
Overall Savings				**$ 105,740**

RESULTS/ANALYSIS

A total of 15 distinct members were outreached for the program in 2021

- 9 members (60.00%) were engaged/enrolled in 2021, and 1 member (6.67%) completed the program
- 3 members (20.00%) were unable to be reached by a member of the care management staffing

October 2021, a pilot program was developed through a partnership with Option Care. This allowed for the highest utilizers of IV medications to do infusions at home, allowing for greater ease of access to medications while significantly reducing medication costs:

- 3 members were in the pilot Cost savings from 10/22/2021 to 12/31/2021 totaled $105,740 for members in the Option Care pilot
- Anticipated savings in 2022 if these members continue to be on the same plan with the same medication/dose is $553,424 for CY 2022

Medication Management Assistance, Condition Management Assistance, and Appointment Reminders were the most frequent services that members engaged in. These activities ensure that members understand and effectively manage their medical conditions and medications, and empower members to be active participants in their healthcare

BARRIERS/LESSONS LEARNED

Engagement via telephonic outreach failed to reach 20.00% 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 members.

The COVID-19 pandemic continues to impact the way that members access care, including medications. While this can be challenging in some cases, it has led to greater opportunity for some of our members to receive IV medications at home through programs such as option care.

CONTROLLING BLOOD PRESSURE (CBP)

The controlling blood pressure program is offered to DHMP Medicare Advantage members that are identified as out of control and/or non-adherent with controlling their blood pressure. This program is in collaboration with the DH Pharmacy team and QI/Population Health Team for interventions, including a CBP pilot program to send blood pressure cuffs to members to use in-home for telemedicine visits and personal monitoring. DHMP care managers focus on referring noncompliant members to their PCP/Clinician for management while supporting the member. The CM team will:

- Ensure that a plan of care is in place for members as well as identifying barriers including clinical, nonclinical, and social determinants of health
- Focus on organizing, supporting, and arranging resolutions to barriers
- Follow the member until the measure compliance is achieved Once achieved, less frequent outreach will be done to ensure member remains compliant
- Work closely with the member's PCP to offer support and assist in scheduling provider/clinician appointments
- Schedule appointments with clinic PharmD's using EpicCare Link
- Work with the member on medication management and arrange for medication synchronization, scheduled "blister packs" of medication, pillbox organizers and/or other tools if they could be helpful to resolve CBP Compliance barriers

2021 CBP METRICS

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

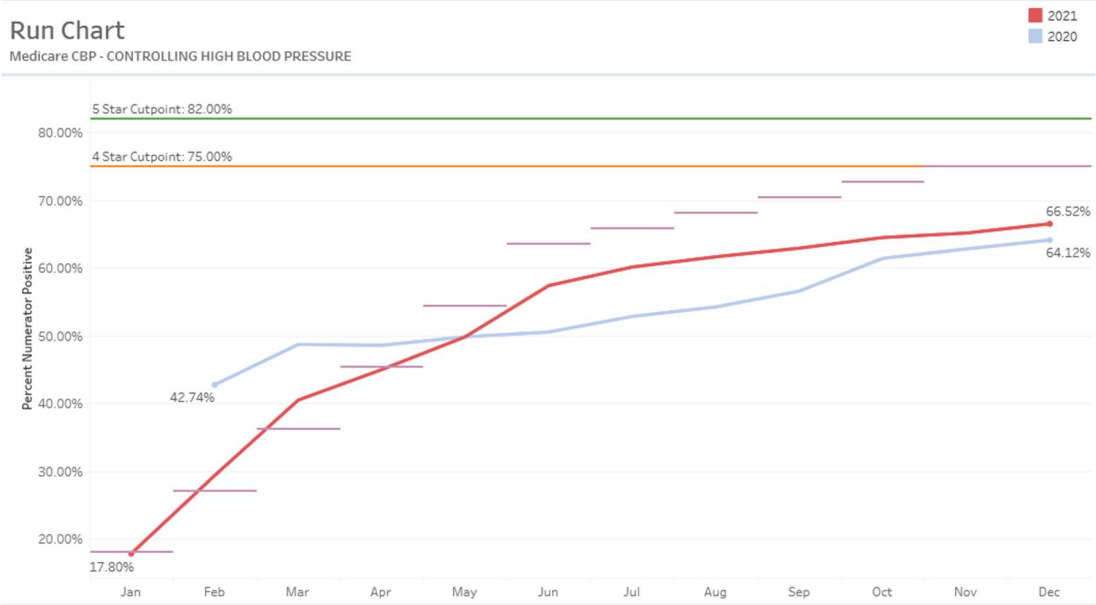
CBP PROGRAM METRICS

Controlling Blood Pressure	YTD 2021	Caseload December 2021	Caseload November 2021	Caseload October 2021	Caseload September 2021	Caseload August 2021	Caseload July 2021	Caseload June 2021	Caseload May 2021	Caseload April 2021	Caseload March 2021	Caseload February 2021	Caseload January 2021
CBP - Pending Member Engagement	-	-	-	-	-	-	-	-	-	-	-	-	-
CBP - Enrolled	1035	896	886	833	778	699	559	369	253	253	251	249	243
CBP - Unable to Reach (UTR)	9	-	-	-	1	7	1	-	-	-	-	-	-
CBP - Declined Program - Opt Out	14	-	-	-	-	10	4	-	-	-	-	-	-
CBP - Eligibility Termed / Deceased	98	48	2	3	8	16	9	-	3	2	5	2	-
CBP - Lost to Follow	-	-	-	-	-	-	-	-	-	-	-	-	-
CBP - Completed Program	-	-	-	-	-	-	-	-	-	-	-	-	-

CBP CARE ACTIVITIES METRICS

Controlling Blood Pressure	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
CBP - Community Resource Assistance	6	4	-	-	-	-	5	2	1	4	-	4	26
CBP - Condition Management	35	20	30	25	36	24	82	74	30	70	95	49	570
CBP - Education Provided	3	1	-	6	-	3	13	27	12	5	13	12	95
CBP - Engagement/Enrollment						1	31	130	46	74	38	24	344
CBP - Health Acuity / Needs Assessed	18	8	3	9	5	2	35	32	17	47	56	47	279
CBP - Healthcare Provider Coordination	12	4	4	7	2	5	19	10	3	16	11	4	97
CBP - Language Services	5	-	-	19	1	1	20	18	14	29	35	10	152
CBP - Medication Management	3	5	-	-	12	1	11	15	5	4	8	2	66
CBP - Member Outreach	53	35	45	151	40	25	120	142	97	155	178	93	1134
CBP - Pharmacy Referral	-	-	-	2	-	-	-	-	1	2	1	-	5
CBP - Provider Follow-up (Started tracking April 2021)				76	1	-	23	37	29	21	53	29	269
CBP - Vaccination Coordination	5	3	-	1	2	-	4	10	2	7	1	2	37
CBP Distinct Members Actively Engaged	74	20	30	60	28	15	133	220	110	214	230	166	899
TOTAL CBP Member Outreach	140	80	82	296	99	62	363	717	257	434	488	276	3074

CBP OUTCOME METRICS:



RESULTS/ANALYSIS:

- 1156 members were outreached for the CBP program in 2021
    - 1035 total members (89.53%) were enrolled in the CBP program in 2021
        - The most utilized services were condition management and provider follow up. The activity of provider follow up did not start tracking until April 2021.
    - Only 9 (0.78%) members had an outcome of "unable to reach," which is the lowest rate of unable to reach of any CM program
        - There may be opportunities to apply practices from this program to other programs to reduce overall rate of unable to reach outcomes across programs
    - 14 members (1.21%) declined the program
    - 98 members (8.477%) had an outcome of "eligibility termed" or "deceased"
- Rates of Medicare members whose blood pressure was in control were higher in 2021 than in 2020
    - As of December 2021, 66.52% of members had blood pressure readings that were in control, versus 64.12% of members in December 2020.
- The Care Management Team worked closely with other departments within DHMP to conduct outreach to members whose blood pressure reading was out of control or outdated
    - Outreach efforts allowed for opportunities to enroll eligible members into the CBP program
    - Outreach members allowed for opportunities to help get members back into clinical care who had not seen their PCP recently

BARRIERS/LESSONS LEARNED

Data capture for the CBP program demonstrates some challenges with Care Managers not utilizing the correct activity type; 1035 members were enrolled in the CBP program but only 899 members were captured for CBP activity outreach. Many members in the CBP program were also enrolled in another Care Management program and the selected activity type may have not accurately reflected the service for the appropriate program. Enhanced training on selecting the proper activity type for those enrolled in the CBP program will allow for more accurate data capture in the future.

It is likely that the ongoing COVID-19 pandemic discouraged members from obtaining preventative care. This is attributed to both a fear of seeking medical treatment, and de-prioritization or postponement of 'elective, non-urgent/emergent' services. In 2021, DHMP began a "Controlling Blood Pressure" pilot project that provided 60 members with a blood pressure cuff to allow for home monitoring and use at telemedicine visits. In October 2021, the Care Management Team obtained access to schedule appointments in epic with a Pharm-D at the member's Primary Care Medical Home. This allowed for members to receive updates to their prescription, counseling on how to use their medication, and additional oversight and monitoring of their blood pressure. In 2022, DHMP implemented a Special Supplemental Benefit for the Chronically Ill (SSBCI) for Medicare Choice HMO SNP and Medicare Select HMO members who require additional support to improve control of their blood pressure. The member must have an eligible ICD code in the last 12 months. Care Management will confirm eligibility and enroll the member in the CBP program as well as authorizing the blood pressure cuff to be sent out to the member Increased focus on communication and education to members, about the availability, safety, and importance not to continue to delay and necessary screening services. CM will work with members to continue to utilize home screening methods when appropriate.

DUAL SPECIAL NEEDS PROGRAM (DNAP)- AVAILABLE TO ALL DHMP MEDICARE CHOICE SNP MEMBERS

This is a Comprehensive Care Management program for our Dually Eligible Medicare and Medicaid members. All members in our Medicare Choice plan are enrolled in this program. Members can opt-out to participate in their own care but will still be outreached for Initial Health Risk Assessment (HRA), Transitions of Care (TOC), Change of Condition (COC), and Annual Health Risk Assessments (HRAs). HRA's are completed within 90 days of enrollment and annually thereafter. Individualized Care Plans (ICP) are completed on every member. The ICP is completed

upon enrollment, updated at least annually and is an on-going plan of care with member. ICT – Care Plan Meetings are completed on every member, and member involvement is encouraged. ICT Care Plan Meetings are completed upon enrollment, annually, and after a transition of care episode. Any time there is a change in condition with a member, the Individual Care Plan is updated and reviewed by the ICT committee.

2021 DSNP METRICS

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

DSNP Metrics	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Member Calls (Outreach)	2,340	3,296	3,399	3,638	2,852	2,123	2,610	2,479	2,284	2,488	2,511	3,044	**33,064**
Member Letters (Mailed Outreach)									400	465	567	642	**2,074**
Care Coordination Activities	3,175	3,736	4,178	3,748	3,233	3,695	3,248	2,809	2,142	2,002	2,717	2,640	**37,323**
Total Health Risk Assessments Completed	52	257	349	186	146	132	121	88	106	151	182	260	**2,117**
HRA Completed by Member	40	213	290	132	95	106	90	66	69	111	129	170	**1,589**
Initial HRA Completed by Member	18	63	63	37	36	45	40	20	24	28	38	17	**493**
Annual HRA Completed by Member	22	150	227	95	59	61	50	46	45	83	91	153	**1,096**
Initial HRA General - Unable to Reach	1.9%	3.5%	0.9%	3.2%	5.5%	4.5%	5.0%	5.7%	14.2%	6.6%	7.7%	3.9%	**18.3%**
Initial HRA General - Member Refused	0.0%	1.6%	1.7%	1.6%	4.1%	1.5%	5.8%	3.4%	3.8%	1.3%	1.6%	0.4%	**6.4%**
Annual HRA General - Unable to Reach	17.3%	9.3%	10.9%	19.9%	20.5%	9.8%	10.7%	11.4%	13.2%	16.6%	17.0%	26.5%	**19.8%**
Annual HRA General - Member Refused	3.8%	2.7%	3.4%	4.3%	4.8%	3.8%	4.1%	4.5%	3.8%	2.0%	2.7%	3.9%	**5.2%**
HRA Untimely Completion	**6.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.6%**
DSNP HRA Assessment Rate	**76.9%**	**82.9%**	**83.1%**	**71.1%**	**65.1%**	**80.3%**	**74.4%**	**75.0%**	**65.1%**	**73.5%**	**70.9%**	**65.4%**	**75.1%**
Care Plan Meetings (ICT)	180	275	263	309	195	177	166	134	134	140	148	205	**2,326**
DSNP Care Plan Compliance (ICP)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Food Security	-	5	9	14	22	25	6	11	11	13	14	16	**146**
Transportation Coordination	11	5	26	29	22	28	37	54	34	47	33	25	**351**
DSNP Enrollment - Medicare Choice DSNP HMO	1,732	1,743	1,752	1,748	1,763	1,792	1,812	1,823	1,832	1,848	1,865	1,888	**2,250**
DSNP Actively Managed Members	**1,569**	**1,732**	**1,727**	**1,733**	**1,731**	**1,749**	**1,780**	**1,799**	**1,802**	**1,834**	**1,849**	**1,854**	**2,250**

RESULTS/ANALYSIS

- In 2021, a total of 2,250 DSNP members were actively engaged in the DSNP CM Program
  - The HRA completion rate for 2021 was 75.1%, an increase over 2020
  - 2,117 Total Health Risk Assessments were completed in 2021
  - The DSNP program had 100% care plan compliance in 2021

BARRIERS/LESSONS LEARNED

Engagement via telephonic outreach failed to reach 20.00% 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 members.

MEDICARE SELECT CARE MANAGEMENT/HRA PROGRAM

The goal of this program is to complete Health Risk Assessments on all new Medicare Select enrollments and annually. Outreach calls are conducted on all Members that completed the HRA to develop an individualized plan of care. Members are identified as being appropriate for ongoing care management based upon physical health, behavioral health, and/or social determinants of health criteria. Members relate to resources for health and wellness, self-management programs, PCP coordination, behavioral health, disease management, medication management, and educational resources. Initial and annual HRA completion for the Medicare Select members is outsourced to the vendor SPH Analytics.

2021 MCR SELECT METRICS

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

Medicare Select Program Metrics	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Medicare Select Community Resource Assistance	1	4	7	10	7	2	2	1	1	2	2	3	**42**
Medicare Select Condition Management Assistance	2	1	2	2	2	-	2	-	-	1	1	-	**13**
Medicare Select Education Provided	1	5	5	-	2	-	2	-	-	1	1	-	**17**
Medicare Select Health Acuity / Needs Assessed	3	7	6	8	4	1	-	-	-	-	1	-	**30**
Medicare Select Health Care Provider Coordination	-	12	10	6	4	1	6	2	1	2	1	3	**48**
Medicare Select Applications/Membership Assistance	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Medicare Select Medication Management Assistance	1	-	1	-	-	1	-	-	-	-	-	-	**3**
Medicare Select COVID-19 Outreach	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Medicare Select Vaccination Coordination	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Medicare Select Language Services	1	2	2	-	3	-	1	-	-	-	-	-	**9**
Medicare Select Member Outreach	8	15	14	6	8	10	8	2	5	10	-	6	**92**
Medicare Select Initial HRA Completed (Performed by SPH)	82	13	5	4	7	8	9	2	3	6	2	2	**143**
Medicare Select Initial HRA Outreach (Performed by SPH)	360	66	138	70	46	75	58	58	44	38	12	14	**979**
Medicare Select Annual HRA Completed	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Medicare Select Outreach	**459**	**125**	**190**	**106**	**83**	**98**	**88**	**65**	**54**	**60**	**20**	**28**	**1376**

RESULTS/ANALYSIS

- SPH Analytics is a third-party vendor that initiates the HRA outreach for all New Medicare Select enrollments and annually based on date of enrollment. All completed HRAs are reviewed by Care Managers for analysis and stratification of health care needs
- 979 members were outreached for an initial HRA
    - Of those, 143 members (14.61%) completed the initial HRA
- 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.
- Health Care Provider Coordination and Community Resource Assistance are the two most frequently used services in the program. These services are crucial to ensure that members stay connected to care and have the resources that they need to manage their health and well-being.

BARRIERS/LESSONS LEARNED

- Response rate for HRAs remains a challenge (14.61% response rate in 2021). Multiple attempts are made telephonically and one mailing with the HRA is sent to new members by SPH. There may be an opportunity to explore other ways that members can complete the HRA.
- Annual HRAs are not being captured at this time. DHMP has been working to create and generate a roster of members that can be sent to the vendor for member outreach for annual HRA completion.
- The member experience survey did not have any respondents from this program, so it is difficult to assess member satisfaction with the program. Changes to how member satisfaction surveys are completed may improve the ability to collect member feedback from this program.
- Sicker members may be less likely than healthier ones to enroll and participate in programs and/or care coordination activities. Members voice they did not have the energy to deal with another health care provider despite the team's efforts to convince these members that care coordination could be most beneficial precisely during these times.

SUBSTANCE USE DISORDER (SUD) CARE MANAGEMENT

The Substance Use Disorder (SUD) Program is available to all DHMP Members. The goal of this program is to assist and equip members in navigating through the recovery process, community resources, education, and programs. This program empowers members to manage their diagnoses and make informed, healthy choices that support physical and emotional well-being, as well as encourage members to engage in creating a foundation of relationships and social networks to provide support. Care Managers provide assistance with housing, transportation, education, resources, and physical and emotional health. Care Managers works closely with Utilization Management to ensure that members can access approved treatments, support groups, and/or community programs under existing benefits.

2021 SUBSTANCE USE DISORDER PROGRAM METRICS

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

SUD Care Coordination	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
SUD Care Coordination	-	1	1	1	1	-	-	-	-	-	1	-	5
SUD Health Care Provider Coordination	-	1	-	1	1	-	-	-	-	-	-	-	3
SUD Member Education Assistance	-	-	-	-	-	-	-	-	-	-	-	-	0
SUD Community Resource Assistance	-	-	-	-	-	-	-	-	-	-	-	-	0
SUD Incoming Referral	1	1	-	-	1	-	-	-	-	-	-	-	3
SUD Member Outreach	1	1	-	-	-	-	-	-	-	-	-	-	2
DHMP COMM BH / SUD Referral	1	-	-	-	-	-	-	-	-	-	-	-	1
Distinct Members Engaged	**3**	**1**	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**10**
TOTAL Member Outreach - Calls	**3**	**4**	**1**	**2**	**3**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**14**

RESULTS/ANALYSIS:

- 10 Distinct members were engaged in the SUD program in 2021
    - Services received by members include Care Coordination (5 members, 50.00%) and Health Care Provider Coordination (3 members, 33.33%)
    - Member Education and Community Resource assistance was not provided to any members, indicating a potential missed opportunity
- Members are identified through SUD treatment denials for UM
    - Care Management attempts to engage with the member to provide wrap around services
    - Referrals dropped off significantly due to changes in SUD coverage which resulted in fewer UM denials
    - Most members with SUD treatment needs are managed by Colorado Access
- Despite being a small program, services are necessary
    - Members with active SUD treatment needs tend to be higher acuity, have higher ED utilization, and are less likely to engage in preventative and primary care services
    - Successful SUD treatment is often the first step in helping members to engage in preventative care services and reduce incidents and accents that result in ED utilization and hospitalization (i.e., overdoses, falls, other accidents).

BARRIERS/LESSONS LEARNED

- The program is small, and the number of members outreached represents a small percentage of members who would benefit from SUD service coordination

- DHMP is consistently working to improve its ability to identify members who may benefit from SUD services, which may result in an increase in referrals to this program
- Care Management will continue to work to identify members in existing programs and during outreach who may benefit from SUD services

DIABETES CARE MANAGEMENT

Implemented in July 2021, the Diabetes Care Management Program is available to Medicare Choice SNP Members, with services being expanded to include members covered under the Medicare Select HMO, Commercial, and Exchange Lines of Business. This program is designed 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 collaborates with Denver Health Hospital Authority on peer and support groups and access to community programs. Care Managers assist members with accessing screening and access to behavioral health through Denver Health. Care Managers provide additional education and support to increase engagement with the healthcare system, identify changeable SDOH and decrease inequities in care and access to mental health for diabetic members.

2021 DIABETES MANAGEMENT PROGRAM METRICS

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

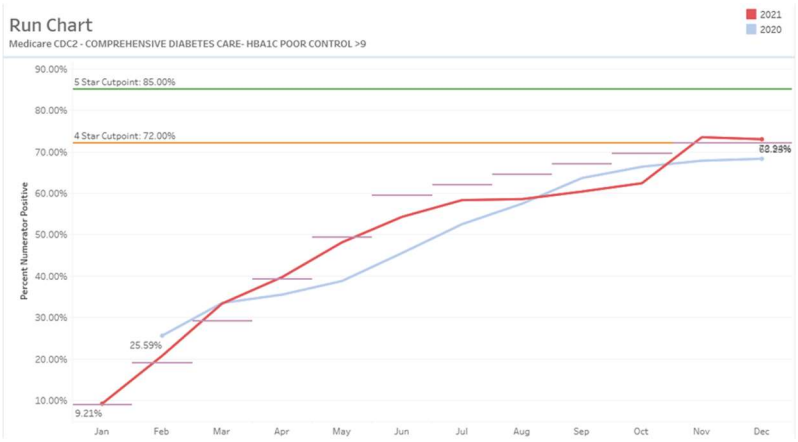
DIABETES MANAGEMENT PROGRAM DATA

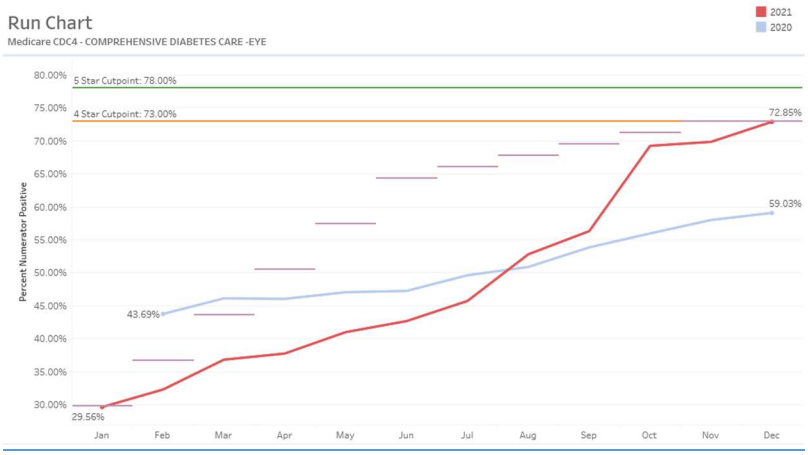
Diabetes Management Program Metrics	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
DM Enrolled	120	317	361	439	477	510	541
DM Pending Member Engagement	60	20	20	1	2	1	104
DM Declined Program	-	5	1	1	1	-	8
DM Did Not Meet Criteria	1	18	7	-	2	1	29
DM Unable to Reach	3	37	34	-	4		78
DM Termed Eligibility	3	8	3	4	-	21	39
DM Member Deceased	-	-	-	1	1	2	4
DM Observation Only	-	-	-	-	-	-	0
DM Planned/Scheduled Readmission	-	1	-	-	-	-	1
DM Lost to Follow	-	-	1	-	-	-	1
DM Changed Programs	1	-	-	-	2	-	3

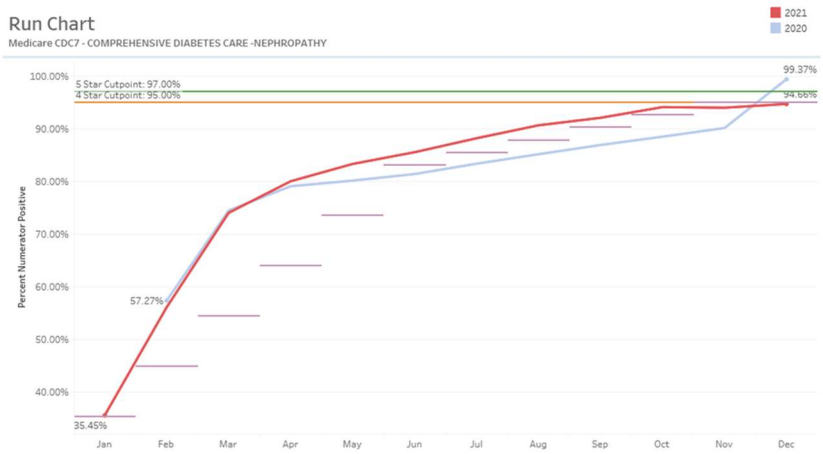
DIABETES MANAGEMENT ACTIVITY DATA

Diabetes Care Metrics -	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
DM Applications / Membership Assistance	-	11	2	5	2	2	22
DM Assessment	5	51	13	6	9	3	87
DM Care Plan Update	15	63	84	72	119	68	421
DM Community Resource Assistance	4	78	70	58	83	52	345
DM Condition Management	9	65	45	38	72	40	269
DM Education Provided	8	51	47	39	58	41	244
DM Engagement / Enrollment	15	278	96	56	37	14	496
DM Health Acuity/Needs Assessed	-	-	-	-	-	-	0
DM Health Care Provider Coordination	8	85	28	32	47	11	211
DM Internal Admin Task	112	515	247	224	287	109	1494
DM Language Services	9	21	31	29	44	22	156
DM Medication Management	6	40	33	28	34	24	165
DM Member Outreach	33	380	161	154	286	131	1145
DM Nutritional Support	4	12	5	7	6	6	40
DM Other Follow-up	1	20	67	35	49	27	199
DM Peer Support / Groups	1	3	-	1	2	1	8
DM Provider Follow-up	14	46	47	37	61	37	242
DM Referral	1	1	1	2	-	-	5
DM SNAP Coordination	-	10	1	2	6	8	27
Total Diabetes Care Outreach	245	1730	978	825	1202	596	5576
Diabetes Care Distinct Members	112	212	98	135	217	92	541

DIABETES MANAGEMENT OUTCOME DATA







RESULTS/ANALYSIS

- A total of 808 referrals were made to the Diabetes Management program in 2021
    - 541 members (66.96%) of members enrolled in the program in 2021
    - 104 members (12.87%) of members were outreached and engaged in 2021, but did not enroll in the program
    - 78 members (9.65%) were unable to be reached telephonically
    - Only 8 members (0.99%) declined to enroll in the program
- The program focuses on education and support for condition management, engagement in medical care, and access to behavioral health services, peer support services, and other community resources to help members manage their condition
    - Community resource assistance, condition management, and education were the most frequently utilized services in the program
    - Providers follow up and Health Care Provider Coordination accounted for 410 unique services provided
    - 40 members received nutritional support
    - 8 members received support with accessing peer support and/or peer support groups
- December 2021 Medicare rates for HBA1C Control and Diabetic Retinal Exams exceeded December 2020 rates; however, rates for Medical Attention for Nephropathy were higher in 2020 than in 2021:
- As of December 2021, 72.94% of qualifying members have an A1C that is in control, in contrast with 68.23% of members in December 2020
    - December 2021 data is above the 4-star cut point of 75.00%
- As of December 2021, 72.85% of qualifying members had received a diabetic retinal exam, compared to 59.03% in December 2020
    - December 2021 data is below the 4-star cut point of 73.00%, by 0.15%
- As of December 2021, Medical Attention for Neuropathy was at 94.66%, compared to 99.37% in November 2020
    - December 2021 data is below the 4-star cut point of 95.00%, by 0.34%

BARRIERS/LESSONS LEARNED

It is likely that the ongoing COVID-19 pandemic discouraged members from obtaining preventative care. This is attributed to both a fear of seeking medical treatment, and de-prioritization or postponement of 'elective, non-urgent/emergent' services. Increased focus on communication and education to members, about the availability, safety, and importance not to continue to delay and necessary screening services. CM will work with members to continue to utilize home screening methods when appropriate.

BEHAVIORAL HEALTH CARE COORDINATION

The Behavioral Health Care Coordination Program is available to all DHMP members and promotes wellness by helping members access appropriate treatment and community resources. Care managers assist members in developing goals focused on improving their health. Although behavioral health care managers do not provide counseling or mental health treatment services, they do work with the member to develop a self-management plan, coordinate care with the member's providers, prepare the member for interaction with providers to enhance treatment outcomes, facilitate communication between behavioral health providers and medical providers, identify and direct the member towards community resources, resolve barriers whenever possible, and manage treatment access and follow up with members with coexisting medical and behavioral disorders.

2021 BEHAVIORAL HEALTH CARE COORDINATION METRICS

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

Behavioral Health Coordination	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
Internal Behavioral Health Referral	4	4	2	1	3	3	6	1	3	3	2	1	**33**
COA Behavioral Health Referral	-	-	1	6	-	-	6	9	3	1	7	9	**42**
BH Care Coordination	3	4	1	125	34	50	58	53	57	45	47	58	**535**
DHMP COMM BH / SUD Referral	1	-	-	-	-	-	-	-	-	-	-	-	**1**
Distinct Members Engaged	**7**	**8**	**4**	**86**	**35**	**47**	**61**	**57**	**56**	**42**	**52**	**63**	**464**
TOTAL Member Outreach - Calls	**8**	**8**	**4**	**132**	**37**	**53**	**70**	**63**	**63**	**49**	**56**	**68**	**611**

RESULTS/ANALYSIS

- 464 distinct members were engaged in the Behavioral Health Coordination Program
    - 42 members (9.05%) received a behavioral health referral for Colorado Access (COA), and 33 members (7.11%) received an internal behavioral health referral to Denver Health
- A total of 611 outreach calls were made in 2021, and of those, 535 (87.56%) were for BH Care Coordination

BARRIERS/LESSONS LEARNED

The COVID-19 Pandemic has increased the need for Behavioral Health services but wait times can be long and services can be difficult to obtain. Additionally, many members seeking Behavioral Health services have expressed concern regarding in-person services due to the COVID-19 pandemic and have expressed interest in receiving telehealth behavioral health services.

In 2022, DHMP will implement telehealth behavioral health services in response to the rising demand for timely behavioral health services and members' requests to receive these services via telehealth.

There is an opportunity to collect enhanced data on services offered to members through this program. While many members receiving services through this program may be receiving other CM services, current reporting capabilities do not allow for tracking of more detailed data, such as:

- Pharmacy referrals
- Community Resource Assistance
- Development of Self-Management Plans
- Provider coordination

Updates to Altruista Tableau may allow for improved reporting in 2022. Additionally, planned integration of Altruista data into DHMP's Risk Stratification tool may allow for more defined member outcome data.

CONTINUITY OF CARE

The Continuity of Care Program started in April 2021 and is available to all DHMP Members and is designed to ensure members have access to out of network (OON) providers due to Transition of Care, Continuity of Care, Network Adequacy or due to a State of Emergency. Care Management and Utilization Management work collaboratively to ensure members have access to care for new members in active treatment with an OON provider at the time DHMP membership becomes effective; continued care is authorized for a defined transitional period as need to minimize disruption of care. Care Managers assist members in choosing an in-network provider. DHMP also provides coordination of care for members based on network adequacy issues for a defined period until a safe transfer of care can be arranged to an in-network provider. Ongoing services are reviewed, and efforts are made to redirect care when able.

2021 CONTINUITY OF CARE PROGRAM METRICS

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

Continuity of Care	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Continuity of Care Member Coordination (Started in April 2021)	-	1	40	14	18	48	38	18	30	**207**
Continuity of Care Provider Coordination (Started in April 2021)	1	4	22	18	7	37	25	8	16	**138**
Continuity of Care Total Services Provided	1	5	62	32	25	85	63	26	46	345
Continuity of Care Coordination Unique Members Engaged	*1*	*1*	*17*	*10*	*18*	*27*	*23*	*14*	*26*	***122***

RESULTS/ANALYSIS

- The Continuity of Care Program supports members with transitioning between in network and out of network providers to meet member needs
    - Members who are transitioning from an out of network provider can get assistance with transitioning to an in-network provider without gaps in service or care
    - Care Managers assist with establishing in network providers for members
    - Care Managers assist members to find services out of network when in-network services are inadequate to meet member needs
- A total of 122 distinct members were served under this program in 2021
- This program is necessary for ensuring that members do not experience gaps in care

BARRIERS/LESSONS LEARNED

The Grievance and Appeals department manage appeals requests pertaining to out of network services. There is an identified need to back up Care Management data to Appeals data to ensure that all members needing assistance with continuity of care are receiving appropriate services.

COVID MEMBER/OUTREACH COVID VACCINATION CARE COORDINATION

COVID-19 emergency planning and program implementation was initiated across the state of Colorado in 2020. 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. In 2021, there was a shift in the type of outreach conducted for our members as we encourage and educate our members on importance of the COVID vaccine. Ongoing efforts in 2022 will focus

on initial vaccinations for members who have not yet received them, as well as outreach efforts to encourage and educate members on the importance of booster shots for eligible member populations. The team will focus on barriers to receiving the vaccine and boosters while partnering with Denver Health, Denver Public Health, CDC, and other agencies to ensure we are meeting the needs of our members.

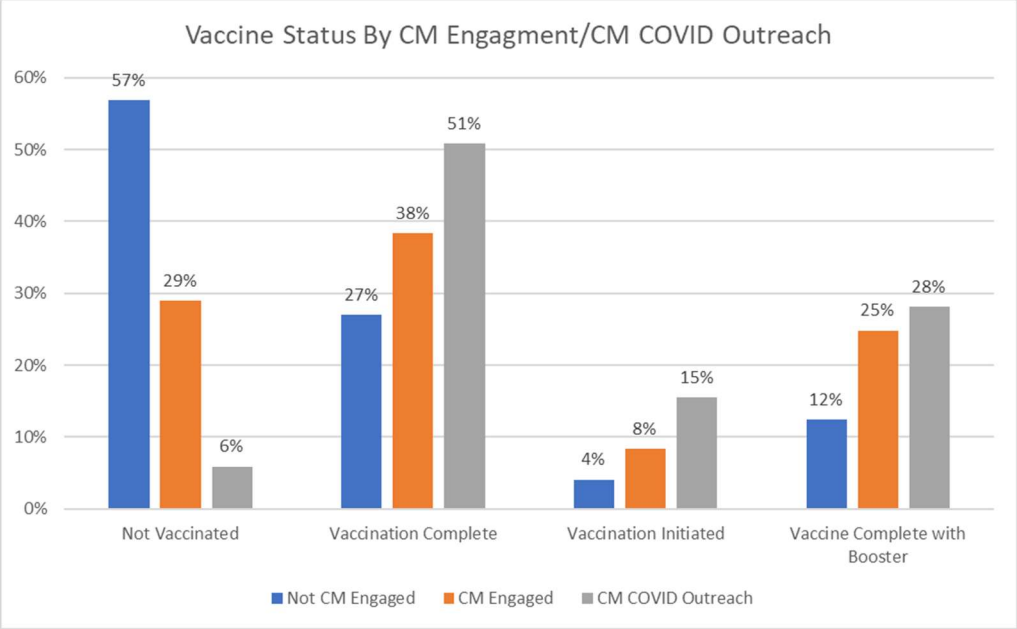
2021 COVID MEMBER OUTREACH METRICS

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

COVID MEMBER OUTREACH ACTIVITY DATA

COVID-19 Metrics	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
DSNP COVID-19	12	20	18	12	8	7	15	24	37	28	20	31	**232**
DSNP TOC COVID-19	13	8	10	11	1	3	-	-	-	-	-	-	**46**
CC COVID-19	1	1	9	-	-	5	-	-	-	3	1	3	**23**
CCM COVID-19	-	-	-	1	-	1	-	-	-	-	-	-	**2**
DOC COVID-19	-	-	-	1	-	-	-	-	-	-	-	-	**1**
TOC COVID-19	20	11	5	5	14	25	14	4	8	9	4	4	**123**
COVID Vaccine Coordination	199	346	86	95	108	1624	867	308	129	47	22	41	**3872**
TOTAL Member Outreach - Calls	**245**	**386**	**128**	**125**	**131**	**1665**	**896**	**336**	**174**	**87**	**47**	**79**	**4299**

COVID MEMBER OUTREACH OUTCOME DATA



RESULTS/ANALYSIS

- In 2021, as COVID-19 vaccines became available, the Care Management team was pivotal in conducting outreach to inform members about vaccine eligibility and assist with connecting members to a vaccine clinic or their primary care provider
- Outcome data demonstrates that members who were engaged in CM services demonstrate higher rates of COVID-19 vaccine initiation, completion, and completion with booster than those not engaged in CM services:
    - 28.93% of members engaged in CM services had not received any vaccination, compared to 56.87% of members who were not engaged in CM services
    - 8.37% of members engaged in CM services had initiated COVID-19 vaccination (completed one dose of a two-dose series), compared to 4.07% of members who were not engaged in CM services
    - A total of 63.19% of members engaged in CM services had completed the initial vaccination series; of those, 38.35% completed the initial vaccination series with no booster and 24.83% of members completed their vaccination series and received a booster. For members not engaged in CM, initial vaccination rates were 39.40% overall, with 27.00% of members receiving the initial vaccination series with no booster and 12.40% of members completing their initial vaccine series with a booster.
- Members targeted for COVID-19 outreach demonstrated the highest levels of vaccine initiation, completion, and completion with booster:
    - Only 5.89% of members who received CM COVID-19 outreach services did not get a vaccination in 2021
    - 15.47% of members who received CM COVID-19 outreach services had initiated their vaccination series
    - A total of 78.90% of members outreached for CM COVID-19 services in 2021 completed their initial vaccination. Of those members, 50.78% completed the vaccination series but did not receive a booster, and 28.11% completed both the vaccine series and received their booster shot.

BARRIERS/LESSONS LEARNED

- COVID-19 vaccination efforts are ongoing at the end of 2021, and there have been several barriers to getting members vaccinated:
    - Homebound members: the care management team has had to help in the identification of homebound members and assist them with accessing vaccines
        - Initial efforts to partner with Dispatch Health to administer vaccinations to homebound members was not successful
        - Care Managers were able to outreach to homebound members and connect them to the City and County of Denver to register them for homebound vaccines
        - Additional follow up for homebound members was conducted by Health Plan Services to offer the same support
    - Appointment availability for vaccinations is an ongoing challenge, especially towards the end of 2021 with the introduction of the omicron variant
        - DHMP has engaged in outreach campaigns to inform members about where they can access vaccinations outside of their doctors' offices, sometimes on a walk-in basis (i.e., local pharmacies, mobile clinics, etc.)
        - DHHA has conducted mobile vaccine clinics in the Denver Metro area, and DHMP CM has coordinated with the mobile clinic team to inform members of mobile clinic dates and times
    - Vaccine hesitancy around the COVID-19 vaccines is an ongoing challenge
        - When outreaching to unvaccinated members, some have cited concern about potential side effects and wanting to wait until there is more information about vaccines
        - The Care Management team has worked with members to discuss member concerns regarding the COVID-19 vaccines

The COVID-19 pandemic has completely changed how members seek care. Lower ED visits are a double-edged sword, fewer members getting non-urgent care at the ED, versus members who need emergent care fearing going to the ED for treatment. The opportunity is to educate members about access to lower levels of care, (Nurseline, Dispatch Health, Virtual Urgent Care, PCP, telemedicine) while reiterating that the ED is a key venue for care when necessary. Education about safety protocols at the ED might help make members more comfortable about seeking care. It is likely that the ongoing COVID-19 pandemic has discouraged members from obtaining preventative care. This is attributed to both a fear of seeking medical treatment, and de-prioritization or postponement of 'elective, non-urgent/emergent' services. DHMP has learned that increased communication and beneficiary engagement are key strategies to engage members and ensure they receive the care necessary, despite the barriers to care that presented due to COVID.

CARE COORDINATION ACTIVITIES

Many DHMP members benefit from Care Coordination services but may not want to opt-in to the programs offered in Care Management. Care Coordination Activities are available to all DHMP Members. Members are assisted with coordination of but not limited to:

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

2021 CARE COORDINATION METRICS

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

CARE COORDINATION ACTIVITY METRICS

Care Coordination Program Metrics	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep	21-Oct	21-Nov	21-Dec	YTD
CC COVID-19 Outreach	1	1	9	-	-	2	-	-	-	-	-	-	13
CC Applications/Membership Assistance	6	3	2	7	3	10	3	2	4	-	14	-	54
CC Community Resource Assistance	89	96	89	72	85	139	83	75	77	74	147	-	1,026
CC Condition Management	19	53	39	17	23	36	19	30	17	26	51	53	383
CC Education Provided	62	42	20	16	30	28	19	19	25	26	52	57	396
CC EPSDT Member Coordination (Started July 2021)							1	-	-	-	8	8	17
CC EPSDT Provider Coordination (Started July 2021)							1	1	-	-	-	-	2
CC EPSDT Outreach	30	25	17	13	21	13	20	17	12	1	1	-	170
CC Health Acuity/Needs Assessed	376	256	278	220	448	336	132	214	183	260	271	236	3,210
CC Health Care Provider Coordination	98	98	95	79	120	136	59	64	57	75	137	113	1,131
CC Language Services	10	13	2	5	15	181	35	8	17	18	26	24	354
CC Medication Management Assistance	7	17	15	10	13	16	7	8	9	8	26	19	155
CC Member Outreach	381	297	270	228	437	344	149	214	177	230	279	232	3,238
CC SNAP Coordination	26	13	27	15	23	31	21	18	9	7	10	12	212
CC Vaccination/Immunization Coordination	-	1	-	-	-	3	-	1	-	3	1	1	10
CC WIC Coordination	1	2	1	-	2	3	5	1	1	1	-	1	18
CC DHMP Member Outreach	1,106	917	864	682	1,220	1,278	554	672	588	729	1,023	756	10,389
CC DHMP Unique Members Engaged	388	263	290	252	481	504	173	237	227	301	298	288	3,388

CARE COORDINATION OUTCOME METRICS

Visit to PCP in Past Year by Care Coordination Engagement		
At Least 1 PCP Visit Last 12 Months	No CC Services	Engaged in CC Services
Yes	54.71%	96.29%
No	45.29%	3.71%

RESULTS/ANALYSIS

- A total of 3388 unique members were engages in Care Coordination services in 2021
  - The most frequently used services were Health Care Provider Coordination, Community Resource Assistance, and Education for members. These services help to ensure continuity of care, empower members to manage their health, and assist members with meeting basic needs so that they can focus on their healthcare
- 1256 wrap around services were provided to members to include community resource assistance, SNAP coordination, and WIC coordination
- Members who engaged in Care Coordination services had higher rates of attending at least 1 PCP visit in the past year compared to members who did not engage in Care Coordination services
  - 96.29% of members who engaged in CC services had at least 1 PCP visit in the past 12 months, compared to 54.71% of members who did not engage in these services
- These services help bridge the gap for members who only want or need a small number of services and who do not wish to participate fully in a CM program

BARRIERS/LESSONS LEARNED

The COVID-19 pandemic has completely changed how members seek care. Lower ED visits are a double-edged sword, fewer members getting non-urgent care at the ED, versus members who need emergent care fearing going to the ED for treatment. The opportunity is to educate members about access to lower levels of care, (Nurseline, Dispatch Health, Virtual Urgent Care, PCP, telemedicine) while reiterating that the ED is a key venue for care when necessary. Education about safety protocols at the ED might help make members more comfortable about seeking care. It is likely that the ongoing COVID-19 pandemic has discouraged members from obtaining preventative care. This is attributed to both a fear of seeking medical treatment, and de-prioritization or postponement of 'elective, non-urgent/emergent' services. Care Management works with members to overcome these barriers to ensure continuity of care.

DHMP has learned that increased communication and beneficiary engagement are key strategies to engage members and ensure they receive the care necessary, despite the barriers to care that presented due to COVID.

CARE MANAGEMENT MEMBER EXPERIENCE SURVEY

A total of 594 members were outreached to for the Care Management Member Experience Survey in 2021. Members are contacted by phone following completion of a program, or at year end for those who are continuously enrolled in a program. In 2021, a new question was added to the Member Experience Survey to assess whether members had changed their health behaviors because of their engagement in care management services. Members were encouraged to share information on the behavior changes they made because of participation in Care Management.

Member responses are scored based on the survey Likert scale of 1-5. Scores of a 1,2, or 3 are considered "not satisfied," while scores of 4 or 5 were considered "satisfied." Results are evaluated annually with a performance goal of 3.5 for the average rating. Members may skip survey questions if they wish. One question allowed for a response of "not applicable", and one question was a yes or no question to assess changes to member health behaviors as a result of their participation in the care management program.

This survey provides DHMP with important insight into the member's experience with case management services and provides information on how DHMP can improve the member's experience with the Care Manager and the overall program. In addition, the analysis of complaint data in conjunction with the survey results helps DHMP get a direct read on problems of which we might not be aware. The complaint data helps us pinpoint specific issues and process failures that might not have been isolated or identified in the care management survey.

Member Experience Survey Program Data		
Member Program	**# of Members**	**% Member Response**
Complex Case Management	8	1.35%
Controlling Blood Pressure	1	0.17%
Medicare Choice SNP HMO	538	90.57%
Transitions of Care	47	7.91%
Total	**594**	**100.00%**

Member Experience Survey Outreach Data		
Survey Completion	**# of Members**	**% Members**
Completed Survey	80	13.47%
Did Not Complete Survey	514	86.53%
Total Members Outreached	**594**	**100.00%**

Member Experience Survey Results										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have ccomplaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	1	0	1	10	58		70	10	2.86%	97.14%
How satisfied are you with how the care manager helped you get the care you needed?	1	1	1	10	58		71	9	4.23%	95.77%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	1	0	3	7	58		69	11	5.80%	94.20%
How satisfied are you with how the care manager treated you?	1	0	0	7	62		70	10	1.43%	98.57%
How helpful was your care manager when you had a question or concern?	2	0	3	11	53		69	11	7.25%	92.75%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	1	0	5	13	50		69	11	8.70%	91.30%
How well did your care manager share important information with you when it was needed?	1	1	1	10	54		67	13	4.48%	95.52%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	2	0	2	8	55		67	13	5.97%	94.03%
How satisfied are you with the timeliness of your care management services?	1	1	1	17	48		68	12	4.41%	95.59%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	1	1	2	9	31	25	69	11	5.80%	94.20%
Overall, how satisfied are you with the care management program?	1	1	2	7	65		76	4	5.26%	94.74%

Member Experience Survey Results - Transitions of Care										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have ccomplaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	1	5	26		32	6	3.13%	96.88%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	1	5	26		32	6	3.13%	96.88%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	1	6	24		31	7	3.23%	96.77%
How satisfied are you with how the care manager treated you?	0	0	0	6	26		32	6	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	1	0	1	8	21		31	7	6.45%	93.55%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	1	9	21		31	7	3.23%	96.77%
How well did your care manager share important information with you when it was needed?	0	1	0	6	22		29	9	3.45%	96.55%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	1	0	1	3	24		29	9	6.90%	93.10%
How satisfied are you with the timeliness of your care management services?	0	0	1	11	18		30	8	3.33%	96.67%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	1	0	6	13	11	31	7	3.23%	96.77%
Overall, how satisfied are you with the care management program?	0	1	0	7	30		38	0	2.63%	97.37%

Member Experience Survey Results - Medicare Choice SNP HMO										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have ccomplaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	1	0	0	4	26		31	5	3.23%	96.77%
How satisfied are you with how the care manager helped you get the care you needed?	1	1	0	4	26		32	4	6.25%	93.75%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	1	0	2	1	27		31	5	9.68%	90.32%
How satisfied are you with how the care manager treated you?	1	0	0	1	29		31	5	3.23%	96.77%
How helpful was your care manager when you had a question or concern?	1	0	2	1	27		31	5	9.68%	90.32%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	1	0	4	3	24		32	4	15.63%	84.38%
How well did your care manager share important information with you when it was needed?	1	0	1	4	25		31	5	6.45%	93.55%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	1	0	1	4	25		31	5	6.45%	93.55%
How satisfied are you with the timeliness of your care management services?	1	1	0	5	24		31	5	6.45%	93.55%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	1	0	1	3	18	8	31	5	6.45%	93.55%
Overall, how satisfied are you with the care management program?	1	0	1	0	28		30	6	6.67%	93.33%

Member Experience Survey Results - Complex Case Management										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have ccomplaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	0	0	6		6	0	0.00%	100.00%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	0	0	6		6	0	0.00%	100.00%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	0	0	6		6	0	0.00%	100.00%
How satisfied are you with how the care manager treated you?	0	0	0	0	6		6	0	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	0	0	6		6	0	0.00%	100.00%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	0	0	5		5	1	0.00%	100.00%
How well did your care manager share important information with you when it was needed?	0	0	0	0	6		6	0	0.00%	100.00%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	0	0	6		6	0	0.00%	100.00%
How satisfied are you with the timeliness of your care management services?	0	0	0	0	6		6	0	0.00%	100.00%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	0	0	1	5	6	0	0.00%	100.00%
Overall, how satisfied are you with the care management program?	0	0	0	0	5		5	0	0.00%	100.00%

Member Satisfaction Survey Results - Behavior Modification					
Survey Question/Responses	No	Yes	Total	% No	% Yes
Have you made any changes to your behavior as a result of participating in this program? (Behavior changes could include: taking your prescribed medication every day, starting a workout program, eating healthier etc.)	41	22	63	65.08%	34.92%

RESULTS/ANALYSIS

- In 2021, the Transitions of Care and Controlling Blood Pressure programs were added to the member experience survey. In 2020, only the Complex Case Management and Medicare Choice SNP HMO program were included.
- Of the members outreached, most members were in the Medicare Choice SNP HMO Program (90.57%, 538 members). Forty-seven members (7.91%) were in the Transitions of Care Program, 8 members (1.35%) were in the Complex Case Management program, and 1 member (0.17%) was in the Controlling Blood Pressure Program
- The overall response rate to the 2021 telephonic Care Management Member Experience Survey was higher than 2020, with 13.47% of the 594 outreached members completing the survey (80 members total). In 2020, only 13 members responded to the survey
- Of the 80 members who responded to the survey, 47.50% (38 members) had participated in the Transitions of Care Program, 45.00% (36 members) were participants in the Medicare Choice SNP HMO Program, and 7.50% (6 members) had participated in the Complex Case Management Program
    - Overall satisfaction rates were highest for the Complex Case Management program, with 100% satisfaction among the 6 members who completed the survey
    - The Transitions of Care program had the second highest overall satisfaction scores, with a 97.37% satisfaction rate
    - The Medicare Choice HMO SNP had the lowest overall satisfaction rate of 93.33%
- Results of the survey were favorable, with a 94.74% overall satisfaction rate, with an average score of 4.7 across all questions asked. This exceeds the performance goal of 3.5
- Satisfaction rates were highest for the following questions:
    - How satisfied are you with how the Care Manager treated you? (98.57% satisfied)
    - How satisfied are you with how the care manager helped you understand your treatment plan? (97.14% satisfied)
    - How satisfied are you with how the care manager helped you get the care you needed? (95.77% satisfied)
- Satisfaction rates were lowest for the following areas:

- How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed? (91.30% satisfied)
- How helpful was your care manager when you had a question or concern (92.75% satisfied)?
- How helpful was your care manager in helping you access services (doctor's appointments, specialty appointments, etc.)? (94.03% satisfied)

- Of the 66 respondents to the behavior modification question, 34.92% (22 members) reported making a change in their behavior as a result of participating in a Care Management program. Members were encouraged to provide more information about the lifestyle changes they have made. Of the 22 members who reported behavior changes, 17 members detailed the changes they had made with several members making multiple changes:
  - 2 Members reported engaging in smoking cessation
  - 5 Members reported greater medication adherence
  - 5 Members reported engaging in medical care or therapy related to their health condition
  - 2 members reported utilizing resources provided by the care manager
  - 8 members reported making changes to their diet
  - 5 members reported increasing physical activity
  - 1 member reported a lifestyle change of improving their sleep schedule

BARRIERS/LESSONS LEARNED

- While outreach numbers and response rates to the Member Experience Survey improved in 2021, there is room to improve outreach and response rates:
  - DHMP is considering having Health Plan Care Coordinators who work within specific programs to conduct outreach members who participated in that program each month
    - This may increase the number of programs that DH is able to receive feedback on
  - As previously mentioned, DHMP may consider mailing the surveys to members in the future, as requested by members, to improve overall response rates
  - Improved response rates may allow for more robust program-level analysis, which may lead to additional identified opportunities for improvement
- The current survey does not allow DHMP to understand why a member is satisfied or dissatisfied with services
  - DHMP is exploring opportunities to add comments to all the survey responses so that we can hear directly from members about why they are satisfied or dissatisfied with services
- While the performance goal was exceeded, there are areas that can be improved for next year:
  - Satisfaction rates were lowest for the question "How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?"
  - This score was lowest for the Medicare Choice SNP HMO Program, indicating an opportunity for improvement in helping those members access resources specific to their needs.
  - Comments from members on the specific question indicate that members are overwhelmed by the number of resources provided to them. There is an opportunity to improve this by tailoring resources to specific needs rather than mailing out blanket resource packets.

CARE MANAGEMENT AND CARE COORDINATION PLANS FOR 2022

- Collaboration with the DHHA Mobile Vaccination Clinic for enhanced COVID-19 Vaccination efforts
- Phase 2 – Guiding Care upgrade – CM Software Platform
- Upgrade to Altruista Tableau Reporting Software
- Final configuration and roll-out of the Medicare Select Health Risk Assessment (HRA) – working with Altruista and SPH Analytics to update current existing HRA. The new configuration will have a heavy focus on Medicare Stars, Gaps in Care, HOS, and Social Determinants of Health (SDOH)
- Implementation of a more defined Continuity of Care program that addresses members that are transitioning from another plan, out of network authorizations due to Network Adequacy and

timely appointments, one-time agreements, and a heightened focus on our Special Health Care Needs (SHCN) population

- Changes in TOC program to including monitoring managing, and outreaching to members in IP setting to improve discharge planning, member engagement/enrollment, and further reduce readmissions
- Continue expanding the Controlling Blood Pressure and Diabetes Management programs to other lines of business
- Explore and expand into health and wellness programs for Commercial and Exchange members
- Implementation of the new Population Health module in Guiding Care, this will allow the care management team to identify areas of opportunities and gaps in care during outreach and program management
- Explore setting up a Care Management dashboard that would reflect metrics, outcomes, and quality initiatives for the CM/CC Team using data from the Guiding Care platform and DHMP's Risk Stratification Tool
- Expand the Controlling Blood Pressure program pilot for Blood Pressure Cuffs mailed to members to ensure monitoring from home and promoting telemedicine appointments with their providers

QI ANNUAL EVALUATION OVERVIEW

CARE COORDINATION AND CARE MANAGEMENT PROGRAM STRUCTE

The overall goal of Care Management and Care Coordination is to help members regain optimum health or improved functional capacity, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources and development and implementation of a care plan with performance goals, monitoring and follow up. Care management programs and activities are an opt-out program, and all eligible members have the right to participate or decline to participate.

DHMP uses various methods for risk stratification of members, dependent on the line of business (LOB) and associated regulatory/contractual requirements. Members may be stratified based on primary behavioral or physical health conditions, diagnosis information, over-or under-utilization of services, cost of care or other factors. DHMP compiles data from several sources, including self-reported data to identify members or populations with high-acuity concerns that can be addressed via care coordination, population health, or care.

COMMERCIAL OUT-OF-NETWORK DATA

The total number of Out-Of-Network (OON) service requests for services not available at DH, across all lines of business, has increase compared to 2020 by 774 request. See Table Below. This is due to the impact of Covid with members deferring care in 2020 along with the State of Emergency in Colorado. The table represents all Treatment Types of OON services (we did not measure service that were untimely; >60 days for members to be seen).

2020 SUMMARY: OUT OF NETWORK REQUESTS FOR SERVICES NOT AVAILABLE AT DH

	Elevate	Large Group	Medicare Advantage	Grand Total
Allergy	20	150	1	171
Audiology	1	6	1	8
Behavioral Health	2	39	6	47
Burns		1		1
Medical Injectables	3	14	4	21
Medical	2	22	1	25

Infectious Disease	1	2		3
Sleep Medicine	1	17		18
Home Health Care		3	1	4
Heme/Oncology	3	10	1	14
ENT	1	9		10
Dialysis	2		2	4
Nutrition		15	1	16
OB/GYN		15		15
Genetics	6	76	2	84
Sleep Study	6	38	12	56
Radiation Therapy	3	16		19
Dermatology	3	24		27
Transplant	57	7	3	67
Cardiology	2	14	1	17
Hospice		1		1
Second Opinion	1	6		7
Gastroenterology	4	27		31
Therapies OT/PT/ST	3	28	4	35
Durable Medical Equipment	6	49	26	81
Orthopedics	3	52		55
Laboratory		3		3
Ophthalmology	2	15		17
Pulmonary	1	23	1	25
Endocrine	1	50		51
Neurosurgery		7		7
Radiology	8	31	3	42
Rheumatology	1	3	1	5
Surgical	4	10		14
Pain Clinic	1	29	4	34
Neurology	1	12	2	15
Nephrology	5	3		8
Urology	5	17	2	24
2021 Totals	158	844	79	1081
2020 Totals	29	235	43	307

HEALTH PLAN SERVICES

MONITORING HEALTH PLAN SERVICES' TELEPHONIC PERFORMANCE

Health Plan Services (HPS) has in place departmental Performance Report that monitors six telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 80%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, overall Call Volume, Reasons for calls, and Quality/Accuracy of calls. The Health Plan Services Performance Report monitors these telephonic statistics by

Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) lines of businesses. Tracking, comparison, and evaluation occur on a daily, monthly as well as annual basis. Leads/Manager pulls statistical data from the Cisco Unified Intelligence Center Historical Reports and prepares it for the Call Center Operations Manager/Health Plan Services Director and executive team. The Operations Manager/Leads reviews each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The Operations Manager presents the Performance Report as well as Summary and Analysis at each bi-monthly QMC meeting.

COMMERCIAL:

Average Delay (seconds)	**2019**	**2020**	**2021**
Annual Totals	159	173	338
Abandonment Rate (%)	**2019**	**2020**	**2021**
Annual Totals	13.3%	12.1%	16.9%
Call Volume (# of calls)	**2019**	**2020**	**2021**
Annual Totals	81548	73511	67987

MEDICARE:

Average Delay (seconds)	**2019**	**2020**	**2021**
Annual Totals	40	19	19
Abandonment Rate (%)	**2019**	**2020**	**2021**
Annual Totals	3.7%	3%	3%
Call Volume (# of calls)	**2019**	**2020**	**2021**
Annual Totals	15131	13019	13327

ELEVATE:

Average Delay (seconds)	**2019**	**2020**	**2022**
Annual Totals	232	250	341
Abandonment Rate (%)	**2019**	**2020**	**2021**
Annual Totals	15.3%	15%	20%

Call Volume (# of calls)	2019	2020	2021
Annual Totals	4965	8088	9601

ANALYSIS

For all product lines, in early 2020, the HPS team was sent home to work due to the pandemic and continue to work from home. Towards end of 2020, and continuing in 2021, except for Medicare, demonstrated increases with other product lines in Average Delay (seconds) and Abandonment Rates. Fluctuations in staffing levels, staff out FMLA/HWFA/COVID related, continue to cause challenges within the HPS team, though improvements in staff onboarding, training and retention have been implemented and additional staffing was justified & approved.

MONITORING HEALTH PLAN SERVICES' BENEFIT INFORMATION FOR QUALITY AND ACCURACY

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

The QA program entails monitoring and reporting on multiple components, such as Call Details, Greeting, Caller Identification (HIPAA/PHI), Professionalism & Courtesy, Quality, Accuracy and Call Closing. Productivity is evaluated on specific metrics, such as Inbound Call Volume, Average Talk Time, Not Ready Time, and Reserved Time. The quality component of the QA Program is evaluated by direct call monitoring and evaluation by the HPS Lead. The HPS Leads select up to 10 random calls and/or targeted random calls for each HPR that occurred in the specific month out of the Nice Uptivity Call Recording Software. The HPS Leads will evaluate the call for the quality and accuracy of the information provided based upon various criteria (member information confirmation, identifying issues, knowledge of benefits, documenting the call, tone of voice, etc.) and scores the HPR. The overall evaluation of HPR performance in both areas is compiled, reviewed, and provided to the HPRs. One on one coaching will occur if deemed necessary. In addition, overall departmental HPS Monthly Call Quality Performance Reports are compiled to track the progress of quality maintained by the HPRs from month to month on an individual as well as departmental basis. All HPRs and the department overall have a goal to maintain an accuracy rate of 90% or higher. If this is not maintained, additional training/education, coaching or corrective actions may be taken.

CUSTOMER SERVICE PERFORMANCE

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

DATA

2021, the HPS team ended at 81% compliance (with an overall goal of 85%, increased from 80% in 2019-2020) for the 'closing phrase used', down from 83% in 2020. Since January 2019, the closing phrase has been a part of the HPS representative's monthly QA standard work. Decrease in compliance was noted to be mostly with new hires throughout 2021.

INTERVENTIONS

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

WORKPLAN CONTENT:

***Monitoring Health Plan Services' Telephonic Performance**	The Health Plan Services Department has a process for monitoring and evaluating telephonic quality and metrics against established benchmarks and thresholds.	**Reporting categories:** • Calls per agent-per hour • Average talk time • Average delay to answer • Calls abandoned • Quality • Call volume	**Goals (monthly)**: • Service level: at or above 80% • Time to answer: 30 seconds or less • Abandonment rate: 5% or less	Manager Call Center Operations Health Plan Services Leads Director Health Plan Services

PRIVACY AND CONFIDENTIALITY MONITORING

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

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

At the time of hire and on an annual basis, all staff shall sign and acknowledge understanding of the Denver Health and Hospital Authority Confidentiality Agreement. DHMP shall treat all information as confidential to the extent that such information specifically identifies or permits identification of a certain health plan member and describes the physical, emotional, or mental conditions of such person,

provided; however, that DHMP may retain and use for its purposes in performance of its obligations any information it obtains relating to costs, charges, procedures, used or treatments employed by a provider in treating any member, to the extent such information does not disclose the identity of the person. Confidential information obtained in the process of performing utilization management services will be used solely for utilization and quality management and will be shared only with parties who are authorized to receive it. Any confidential information, which DHMP finds necessary to disclose, in the performance of utilization management services, shall not be disclosed to any unauthorized entity without prior consent of the member or as required by the federal law.

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

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

OVERALL STRUCTURE OF THE QI PROGRAM

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

Medical Director responsibilities include, but are not limited to:

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

DHMP'S QUALITY IMPROVEMENT DEPARTMENT

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

- Development, management, and monitoring of the QI Program
- Act as QI staff representative to the DHMP Board of Directors
- Reporting findings from clinical interventions and annual audits to appropriate groups, such as the QIC, QMC, and the DHMP Board of Directors
- Directly assume authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation, and Work Plan annually
- Completing preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, QIC and DHMP Board of Directors
- Coordinate, provide advice and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health Departments, as appropriate, for regulatory compliance
- Report QOCCs to the appropriate Directors of Service at DHHA and external network providers, as directed

- Serve as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
- Leading LEAN initiatives related to the QI Department, including standard work
- Annually ensure all policies, procedures, and guidelines related to the QI Department are updated appropriately.
- Provide oversight and direction to the QI team, consisting of the following members:

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

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

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

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

Population Health and QI Intervention Project Manager responsibilities include, but are not limited to:

- Evaluate, analyze and report CAHPS results, as well as facilitate improvement efforts
- Develop, manage and evaluate all quality interventions
- Work collaboratively with the Medical Director, QI Director, AQIC, Ambulatory Care Services, ACS condition-specific work groups, external provider network, HEDIS Program Manager, QI Project Manager and Data Analyst on all quality interventions
- Lead health care initiatives related to health literacy and racial/ethnic health disparities
- Oversee multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services and identification of any health disparities

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

- Manage QOCCs and quality of service concerns processes in a timely and effective matter
- Work in collaboration with HEDIS Program Manager to perform HEDIS chart reviews
- Develop training materials, facilitate training, test for inter-rater reliability (IRR) and retrain staff
- Provide clinical consultation for the QI Department
- Conduct practitioner chart review using HEDIS criteria
- Develop and update all preventive and clinical guidelines

COMMITTEE STRUCTURE

The Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. The QMC is charged with

responsibility for oversight of all quality related DHMP Medical Management activities and processes, including but not limited to: Utilization Management, Case Management, Health Management, Population Health Management, Pharmacy, Member Services, Appeals and Grievances, Provider Relations, Marketing, Compliance, and Product Line Managers. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, and patient safety initiatives. The QMC includes invited primary care providers, specialty and behavioral health providers from both Denver Health Hospital Authority and extended practitioner network.

QI ACTIVITIES SUMMARY

DHMP is going through an in-depth review of all its initiatives and intervention activities, using best practices as a guide. All approved activities will have performance measures attached with PDSA embedded into their standard work cycles. Yearly work plans will have measurable goals and/or benchmarks. Identified interventions that do not meet performance targets will undergo a barrier analysis and/or root cause analysis. DHMP seeks to improve health care quality, member education, health literacy, and access to care and services.

Approved By The DHMP Quality Management Committee on March 9th, 2022

_____

QMC Chair & Medical Director Dr. Christine Messersmith

Approved by The DHMP Board of Directors on April _____2022

_____

Board of Directors Representative