Quality Improvement Impact Analysis

2022-2023

Denver Health Medicaid Choice and Child Health Plans
SFY Contract July 1, 2022 – June 30, 2023

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I. Executive Summary

Introduction

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated healthcare system that serves as the primary "safety net" system for the City and County of Denver.

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

DHMP established and maintains a comprehensive Quality Improvement (QI) Program to systemically define, evaluate, monitor and provide continuous quality improvement. The QI Program aims to ensure high-quality, cost-effective care and services are provided to DHMP Medicaid and CHIP members.

Quality Improvement Program

The QI Program incorporates evaluation of key indicators of care and safety 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.

DHMP's Quality Improvement (QI) Program Description outlines DHMP's plan to improve quality of care, create and sustain a culture of service and ensure Member safety. The QI team systemically monitors and evaluates the delivery of health care services, with a focus on improving Member outcomes. Utilizing QI interventions based on a continuous improvement cycle of PDSA – plan, do, study, act and incorporating LEAN methodology, QI interventions are planned, implemented, and assessed with targets of improving functional outcomes for Members, delivering culturally competent care and service; and increasing Member satisfaction with services.

The QI Program extends to all departments within DHMP, in recognition that teamwork and collaboration are essential for quality improvement. DHMP's QI Team actively collaborates within all areas of DHMP's organization to develop, implement and evaluate quality improvement initiatives. Activities are coordinated with case management, member services, provider network, pharmacy, health management, marketing, utilization/care management and product line managers for DHMP. Our activities, with accompanying data, are analyzed, summarized, and presented to the Quality Management Committee (QMC) of DHMP for feedback, guidance and oversight.

Annually, DHMP's QI Department's Teams reviews ongoing and completed QI activities. This evaluation includes a complete analysis of performance improvement metric result, effectiveness of QI Projects and evaluation of the overall value of the QI Program.

Out of this evaluation process, recommendations for quality improvements are developed and planning begins for the upcoming year. Additionally, DHMP is able to assess the strengths of the QI Program and identify opportunities for improvement, incorporating learning from the ongoing activities.

Annually, the QI Evaluation, QI Program Update and QI Work Plan are crafted, and presented to the DHMP's Quality Improvement Committee (QIC) and DHMP's Governing Board of Directors for approval.

Provider Network

Our Provider network for the Medicaid and CHP+ Members is Ambulatory Care Services (ACS)/Community Health Services (CHS) of Denver Health. With a network of nine primary care clinics and eighteen school based health centers, ACS provides patient-centered medical home (PCMH) focused care for children, adults and geriatrics across the life continuum.

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

In our work with ACS, we pursue joint QI initiatives through Ambulatory QI Committee (AQIC), disease and prevention specific work groups and incorporate patient experience into those work groups. In these committees and groups, DHMP joins resources with ACS and actively works together to increase the health and well-being of our members. The QI team also leads targeted interventions in clinic sites through partnership and collaboration with defined clinic leadership.

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

CAHPS measures, increase quality and access to care, and improve Member satisfaction.

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

II. Quality Improvement Program Evaluation and Summary

Overview

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

QI Program Description and Work Plan

The QI Program 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) and CMS Core Measure 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 2022-2023

- Maintain 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
- Adopt NCQA Quality Compass Medicaid & CHP+ benchmarks to evaluate current performance, evaluating for prioritized opportunities for improvement
- Empower Members to lead a healthy lifestyle through health promotion activities, care support outreach and coordination with community resources
- Encourage safe and effective clinical practice through established care standards and application of appropriate practice guidelines
- 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
- Measure and evaluate interventions to address continuity and coordination of care
- Developed efforts to improve reporting race/ethnicity/language data for every Member
- Continue collaboration with the DHHA ACS QI department on ways to measurably improve the quality of health care services related to cultural and linguistic needs of the Member
- Support staff and Provider training on working with various cultural, ethnic and medically underserved populations
- Review language utilization and Provider language reports to evaluate network responsiveness to provide culturally appropriate care
- Monitor and evaluated high volume and/or high-risk services, quality indicators for Special Health Care Needs (SHCN) populations, and over/under utilization reporting to identify opportunities for improvement
- Improv transitions of care across health care settings and practitioners
- 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

- Assure that culturally appropriate, health literate communication, education and health care services are provided to Members in all areas
- Improve data collection for quality management metrics to evaluate and improve HEDIS and Core Measure scores, including improvement of coding and documentation for clinical care services
- Improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS and Core Measure scores.
- Monitor network adequacy performance
- Collaborate with internal DHMP departments to improve quality of care and services to our members
- Develop policies and procedures and documented processes to standardize quality improvement work
- Assure compliance with Medicaid Choice and CHP+ contractual requirements and all federal and state statutes

Accomplishments

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

- NCQA Designation for ECDS, DHMP is the only plan in Denver to hold this designation
- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention.
- Partnered in collaborative work process with QI Director of ACS and ACS QI staff to build joint quality improvement interventions, including shared data analytics
- 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
- Improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores
- 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
- Developed and implemented enhanced patient education materials; focused on health literacy and cultural competency
- Continued to identify and develop education and training to facilitate appropriate provider coding and documentation in support of improving HEDIS and Core Measure scores
- Continued to improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS and Core Measure scores
- Increased Member outreach through ACS care support outreach initiatives to follow up on gaps in care, preventive health screenings
- Implemented focused Member outreach to facilitate care transitions when acuity of need was identified
- Collaborated with ACS care coordination to increase assessment of Members for gaps in care and problem solving to achieve a more comprehensive Member approach to care and services

- Continued to evaluate and refine data to better evaluate desired outcome of increased follow up after a positive depression screening in adolescents
- Continued pharmacy initiative to increase mental health center prescriber knowledge of formulary utilization
- Developed and implemented enhanced patient education materials specific to chronic disease states
- Conducted and reviewed Provider satisfaction survey. Incorporated data from ACS electronic medical records into supplemental files used for HEDIS and Core Measure reporting
- Maintained process to capture, investigate and report on quality-of-care grievances (QOC-G), and Serious Reportable Adverse Events (SRAE).
- Developed clinical practice guidelines to cover the lifespan from infancy to geriatric
- Streamlined clinical and preventive guidelines review and updating process
- Increased physician involvement in the development of clinical guidelines
- Increased compliance with EPSDT related standards, with additional Provider and Member communication on services, Provider communication about EPSDT requirements, and edits to related policy and procedures. Ongoing efforts continue for wrap around services outside of the health plan, and for tracking of referrals for services outside the Plan, by network Providers. Improved the number of EPSDT services tracked at CHS, available by clinic and Provider.
- Continued development, review and revision of policies and procedures annually through electronic tracking through the organization's transition to an updated system, PolicyStat.
- Maintained physician involvement within the Quality Management Committee (QMC) structure
- Updated Member and Provider facing Population Health and Quality Improvement Websites

Challenges/Barriers

In 2022, a rebound effect of patients accessing healthcare created an access to care issue with DHMP's medical providers. Another challenge that was noted in 2022 was related to staffing. Staffing shortage and turnover was noted throughout DHMP as well as in the Quality Management department.

The Quality Management department experienced staff turnover that encompassed the following leadership roles, QI Director/QI Manager and Project Managers (2 positions). The QI Director responsibilities are being fulfilled by the Senior Director of Health Outcomes and Pharmacy (HOP). The QI Manager role is actively being recruited for. Two project management roles have been fulfilled. The two (2) project management roles support the following functions (1) Population Health and (1) Quality Improvement.

DHMP's Population Health management program continued to show growth during 2022 which resulted in the 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 Senior 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 QI department. In 2022 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.

The Quality Management Committee (QMC) structure continued to be evaluated during 2022. 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 the 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 2022 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 the 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 Sr. Director of HOP 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.
Finally, this year has had an 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; resulting in barriers to routine and preventive care services, and member hesitancy in care seeking.

Opportunities for Improvement

- Develop a more rigorous data validation plan for HEDIS and Core measures, confirming that data and counts and sample sizes are accurate, while continuing to increase supplemental sources of data for HEDIS measures and Core Measures
- Continue efforts to improve the capture and accuracy of provider data for HEDIS and Core Measures, including practice type, specialist coding and provider locations.
- Evolve the real-time quality data availability and usability through ongoing IS collaboration.
- Increase engagement and training of providers in HEDIS and Core metrics and provide meaningful, provider- centric education and training to increase HEDIS scores and risk adjustment scores through appropriate medical record documentation and coding.
- Develop a process to align with HCPF's announced changes to QOC-G's.
- Continue developing strategies with ACS QI leadership to address gaps in care with year-round interventions and activities.
- Utilize EPIC electronic medical record (EMR), and its ongoing optimization, to improve HEDIS and Core Measure scores and reduce gaps in care.
- Optimize monthly HEDIS runs and corresponding 'gaps in care' lists, throughout the

enterprise, through the development of Tableau based analytic tools.

- Develop a plan with ACS QI leadership to address gaps in care with year-round interventions and activities.
- Align and partner quality improvement initiatives and interventions with ACS leadership and Provider networks to avoid duplication of effort and to utilize resources more effectively.
- Begin baseline data collection and define intervention plan for new PIP projects to include: Well Child Visits ages 3-21 and SDOH Screening.
- Continue to develop the use of LEAN framework within quality initiatives to develop A3 problem solving aligned with our PDSA (plan, do, study, and act) methodology. Utilize LEAN framework to develop and evolve standard work for QI team.
- Continue to develop DHMP Health Equity plan and work to integrate with Denver Health ACS health equity efforts
- EPSDT is a free-standing Medicaid standard and is the topic of increased focus. In addition to overall compliance with the EPSDT standards, continuing to address an expanded set of EPSDT measures for improvement, are ongoing opportunities. Resolving the tracking of wrap around benefits referred by network providers, for services not managed by DHMP.
- Increase use of school-based health services to expand access and availability for adolescent Members. Educate parents of adolescent Medicaid & CHP+ Members that well child visits can be done during school day with written parental permission. Provide data to school-based clinics to reach out to Members needing preventive health care.
- Work with ACS leadership to strategically communicate HEDIS, Core Measure and CAHPS information to Providers to increase engagement and collaboration with the Medical Plan.
- Continue to create and enhance a culture of collaboration and conversation about improving health for all of our members together. Incorporate cultural competency and health literacy strategies into our member engagement strategies. Continue to evolve the leadership potential and role for the QMC by providing education and increasing opportunities for feedback, oversight and partnerships.
- Align and partner our quality improvement initiatives and interventions with ACS to avoid duplication of effort, increasing effective utilization of resources, and the integration of payer and care delivery systems.
- Ongoing evolution of our DHMP-based population health management strategy and its operation.
- Collaborate for a more comprehensive intervention strategy, utilizing patient navigators, and care support activities, transitions of care and EPIC-based tools and data in a more unified approach.

Moving Forward

While SFY 2022-23 brought numerus opportunities and challenges for the QI Program, the mission to promote a culture of continuous quality improvement continues. Using the Medicare and commercial products' NCQA standards, processes and deliverables as a road map to institutionalize and align efforts across the Denver Health system, the QI program strives to create a program with clearly defined goals and objectives, where DHMP, Providers and Members may benefit. The ideal state is a comprehensive health plan and Provider network, driven by continuous quality improvement that treats and engages the whole person, respecting their culture and community, over their lifetime.

III. Quality of Clinical Care Activities

2022 - 2023 QI Activities/Interventions

The following HEDIS Measurement Year 2022 Indicators will be reported for the FY 2022-2023 in accordance with our contract requirements: Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Childhood Immunization Status – Combos 2-10, Immunizations for Adolescents, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women, Follow-up Care for Children Prescribed ADHD Medication, Anti-depressant Medication Management , Effective Acute Phase Treatment, Effective Continuation Phase Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics, Pharmacotherapy for Opioid Use Disorder, Appropriate Testing for Pharyngitis, Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation, Medication Management for People with Asthma, Asthma Medication Ratio, Persistence of Beta-Blocker Treatment After Heart Attack, Statin Therapy for Patients with Cardiovascular Conditions, Comprehensive Diabetes Care, Statin Therapy for Patients with Diabetes, Adults' Access to Preventive/Ambulatory Health Services, Children and Adolescents' Access to Primary Care Practitioners, Prenatal and Postpartum Care, Non-Recommended Cervical Cancer Screening in Adolescent Females, Appropriate Treatment for Upper Respiratory Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Imaging Studies for Low Back Pain, Use of Opioids at High Dosage, Use of Opioids from Multiple Providers, Risk of Continued Opioid Use, Well Child Visits in the First 30 Months of Life, Well Child Visits,, Frequency of Selected Procedures, # of specified procedures per 1000-member months, Inpatient Utilization – General Hospital/Acute Care, Ambulatory Care – Outpatient and/or ED, Antibiotic Utilization and Plan All-Cause Readmissions.

The following Measurement Year 2022 CMS Adult and Child Core Measures will be reported: Cervical Cancer Screening (CCS-AD), Chlamydia Screening in Women Ages 21 to 24 (CHL-AD), Colorectal Cancer Screening (COL-AD), Flu Vaccinations for Adults Ages 18 to 64, Breast Cancer Screening (BCS-AD), Childhood Immunization Status (CIS-CH), Well-Child Visits in the First 30 Months of Life (W30-CH), Immunizations for Adolescents (IMA-CH), Developmental Screening in the First Three Years of Life (DEV-CH) Child and Adolescent Well-Care Visits (WCV-CH), Lead Screening in Children (LSC-CH), Live Births Weighing Less Than 2,500 Grams (LBW-CH), Prenatal and Postpartum Care (PPC-AD), Contraceptive Care – Postpartum Women Ages 21 to 44, Contraceptive Care – All Women Ages 21 to 44 (CCW-AD), Low-Risk Cesarean Delivery (LRCD-CH), Controlling High Blood Pressure (CBP-AD) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD), Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)**, Hemoglobin A1c Control for Patients With Diabetes (HBD-AD)** ,Diabetes Short-Term Complications Admission Rate (PQI01-AD), Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD), Heart Failure Admission Rate (PQI08-AD), Asthma in Younger Adults Admission Rate (PQI15-AD), Plan All-Cause Readmissions (PCR-AD), Ambulatory Care: Emergency Department (ED) Visits (AMB-CH), Asthma Medication Ratio: Ages 19 to 64 (AMR-AD), HIV Viral Load Suppression (HVL-AD), Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD), Concurrent Use of Opioids and Benzodiazepines (COB-AD), Initiation and Engagement of Substance Use Disorder Treatment (IET-AD), Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD), Antidepressant Medication Management (AMM-AD), Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD), Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD), Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD), Use of Pharmacotherapy for Opioid Use Disorder (OUD-

AD), Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD), Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD), Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD), Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH), Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH), Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH), Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH), Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH), Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH), Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD).

All other measures listed are for other QI initiatives as designated by the Denver Health Managed Care Medical Management Committee and the Operations Management team.

Comprehensive Diabetes Care (CDC)

There are several measures that make up the overall comprehensive diabetes care (CDC) HEDIS measure. The CDC measures include the percent of Members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

Measure/Data Element	HEDIS MY2020 Rates (Medicaid Only)	HEDIS MY2021 Rates (Medicaid Only)	HEDIS MY2022 Rates (Medicaid Only)	HEDIS MY2021 HMO Percentile* (Medicaid Only)	HEDIS MY2021-MY2022 Change
Eye Exam (Retinal) Performed ^	36.25%	41.55%	51.58%	N/A	+10.03%
HbA1c Poor Control (>9.0%) *lower score indicates better performance* ^	52.46%	46.15%	36.98%	N/A	-9.17%
Blood Pressure Control (<140/90 mm Hg) ^	50.23%	54.39%	63.50%	N/A	+9.11%
HbA1c Control (<8.0%) ^	38.41%	43.88%	53.28%	N/A	+9.40%
Kidney Health Evaluation for Patients with Diabetes	31.64%	48.13%	51.40%	90th	+3.27%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.
^Measure changed in MY2022, so no percentiles will be available until MY2024

Analysis

Overall, our HEDIS MY2022 results showed improvement in each of the Comprehensive Diabetes Care rates measures compared with MY2021. Of the measures, Eye Exam for Patients with Diabetes showed the most improvement, at 10.03%. Percentiles for diabetes measures are not available, with the exception of Kidney Health Evaluation for Patients with Diabetes (90th percentile), due to a reworking of the former CDC measure into separately tracked HEDIS measures in MY2022; however, when compared to MY2021, all diabetes measures are performing better. 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, kidney health evaluations, and diabetic eye exams performed.

Medicaid: Diabetic Eye Exams
A collaboration between DHMP QI Department staff and Care Navigators from the DH Eye Clinic began in 2015 to increase the percentage of members with diabetes receiving diabetic retinal exams. The project involves Care Navigators conducting outreach calls to Medicaid 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 2022, 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.

<u>Action Plan for FY2023-2024</u>
The DHMP QI team will continue to participate in both the Diabetes Collaborative and explore additional ways to improve diabetes care for our members, including controlling blood sugar, kidney disease monitoring, and performing eye exams.

In FY21/22, DHMP implemented 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 identify high risk, poorly controlled and/or 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 access to physical and mental health care across our spectrum of diabetic members.

Performance Improvement Projects (PIPs)

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

The most recent PIP cycle begins in SFY23-24, with a baseline measurement period of July 1, 2022-June 30, 2023. DHMP will be completing a clinical and a non-clinical PIP for both the Medicaid and CHP+ populations, totaling four PIPs. The clinical PIPs will focus on improving well-child visit rates for members aged 3-21, and the non-clinical PIPs will aim to improve social determinants of health screening rates. DHMP is currently collecting and validating baseline data to submit to HCPF in late

October 2023.

Asthma Measures

Asthma Medication Ratio (AMR)					
Measure/Data Element	HEDIS MY2020 Rates (Medicaid Only)	HEDIS MY2021 Rates (Medicaid Only)	HEDIS MY2022 Rates (Medicaid Only)	HEDIS MY2020 HMO Percentile* (Medicaid Only)	HEDIS MY2021-MY2022 Change
5-11 Years - Asthma Medication Ratio	63.04%	64.38%	62.50%	5th	-1.88%
12-18 Years - Asthma Medication Ratio	54.26%	56.73%	53.49%	5th	-3.24%
19-50 Years Asthma Medication Ratio	48.91%	47.01%	51.71%	5th	+4.70%
51-64 Years - Asthma Medication Ratio	41.98%	48.57%	52.50%	10th	+3.93%
Total - Asthma Medication Ratio	51.41%	50.97%	53.57%	<5th	+2.60%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Asthma Medication Ratio (AMR)					
Measure/Data Element	HEDIS MY2020 Rates (CHP+ Only)	HEDIS MY2021 Rates (CHP+ Only)	HEDIS MY2022 Rates (CHP+ Only)	HEDIS MY2021 HMO Percentile * (CHP+ Only)	HEDIS MY2021-MY2022 Change
5-11 Years - Asthma Medication Ratio	N/A	N/A	N/A	N/A	N/A
12-18 Years - Asthma	N/A	N/A	N/A	N/A	N/A

Medication Ratio					
19-50 Years Asthma Medication Ratio	N/A	N/A	N/A	N/A	N/A
51-64 Years - Asthma Medication Ratio	N/A	N/A	N/A	N/A	N/A
Total - Asthma Medication Ratio	N/A	N/A	N/A	N/A	N/A

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Analysis

Medication Management for People with Asthma was retired by NCQA in 2020, leaving the Asthma Medication Ratio as the only asthma metric for the MCD and CHP+ populations. Due to a small sample size, AMR is not reported for CHP. In the MCD population, the AMR rate saw modest increases in MY2022 overall and across adult age groups, while pediatric age groups saw a slight decline. Overall, the MCD AMR increased slightly from 50.97% to 53.57%; however, DHMP remains in the 5th percentile or lower nationally for all age groups except 51-64 years, which improved to the 10th percentile, indicating a need to focus on improvement interventions for this measure. HEDIS asthma measure review continues to inform several opportunities for improvement. Collaboration between DHMP, DHHA's ACS Providers, and the Asthma work group (AWG) resulted in several asthma interventions this past year:

Interventions

- The AWG and RN line utilizes a DHHA asthma-only telephonic line for members needing assistance with asthma medication refills and triage. Members are also informed about the need to make an asthma assessment appointment with their PCP if they've refilled their rescue medication without refilling the appropriate number of controller medications.
- ACS continues to utilize DHHA PNs to conduct a follow-up phone call within 48 hours of discharge from the ED or IP for pediatric members with asthma-related concerns. PNs are tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a TOC flowsheet.
- Prior pharmacy refill and HEDIS data demonstrated that many asthmatics fill rescue asthma medications without filling the appropriate number of controller medications. The DHMP pharmacy team has directed more focus on the need to refill asthma controller medications on a consistent basis and began utilizing a pharmacy vendor tracking system in FY2020/2021 to streamline this process. In Q4 of FY20/21, the DHMP pharmacy team began working with DHHA ACS to provide lists of non-compliant members to their respective PCPS for outreach and

intervention. This effort continues into FY23/24.

Action Plan for FY2023-2024

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 2023 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 MCD population. The collaboration with the DHMP Pharmacy team to analyze these metrics and develop interventions to address medication adherence will continue in 2023. Priorities will include collaborating with DHMP Pharmacy and ACS on a process to obtain more complete pharmacy fill data for the Asthma Medication Ratio Metric, proactively identifying members who have been filling rescue medications but not their prescribed controller medications.

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)	HEDIS MY2021 Rates (Medicaid Only)	HEDIS MY2021 Rates (Medicaid Only)	HEDIS MY2022 Rates (Medicaid Only)	HEDIS MY2021 HMO Percentile* (Medicaid Only)	HEDIS MY2021-MY2022 Change
Prenatal Care in 1st Trimester	88.56%	88.56%	80.78%	50th	-7.78%
Postpartum Care 7-84 Days after delivery	77.86%	77.86%	76.64%	50th	-1.22%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Analysis

HEDIS MY2022 rates show a 7.78% decrease in Prenatal Care in the 1st Trimester and a 1.22% decrease in Postpartum Care from HEDIS MY2021, though the percentile for Postpartum Care increased from 10th to 50th.

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.

DHMP rolled out a Maternal care management program for its MCD and CHP+ members in 2021. This program is intended to improve early prenatal care and identification of high-risk pregnancies. DHMP coordinates with DH to ensure high risk assessments are utilized in identification. DHMP is collaborating

with DH on peer and support groups and access to community programs. DH provides screening and access to Behavioral health within the Women's High-Risk clinic. DHMP will provide additional education and support to increase engagement with the healthcare system, identify changeable SDOH and decrease inequities in care across our spectrum of pregnant members.

Action Plan for FY2023-2024

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 is being performed. The DHMP CM team will continue to outreach to at risk MCD and CHP+ members to enroll them in the Maternal Care management program described above as well assist in the scheduling and completing of prenatal and postpartum visits.

Breast Cancer Screening

Denver Health Medicaid Choice Breast Cancer Screening Rates				
HEDIS MY2020 Rates (Medicaid Only)	HEDIS MY2021 Rates** (Medicaid Only)	HEDIS MY2022 Rates** (Medicaid Only)	HEDIS MY2021 HMO Percentile* (Medicaid Only)	HEDIS MY2021-MY2022 Change
42.60%	39.05%	44.40%	5th	+5.35%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Analysis

The MY2022 HEDIS rate for Breast Cancer Screening (BCS) increased by 5.35% from HEDIS MY2021 and remained in the 5th percentile (based on HEDIS MY2021 percentiles).

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 to 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. In FY2022-23, the QI team sent 9412 mailers to Medicaid members. Through the Denver Health Cancer Screening Committee, DHMP QI team members collaborated with the Women's Health team to develop more effective outreach strategies to engage members in mammography screening. As a result, the mammogram mailer sent to Medicaid Choice members was edited to include a Women's Health Care Navigator's name and phone number and information on how Medicaid Choice members can request transportation assistance.

Action Plan for FY2023-2024

As in previous years, mammogram reminder mailers will be sent to all members who are overdue for a

mammogram and will be re-sent in six months if the member has still not completed a mammogram at that time. DHMP QI will also continue to collaborate with the Cancer Screening workgroup to plan and implement breast cancer screening interventions. ACS has completed the implementation of a variety of technology interventions to improve BCS rates (e.g., patient self-scheduling in MyChart and automated text message reminders to members due for a mammogram).

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 as most DHMP members prefer to receive their mammogram when the mobile van visits their medical home. In addition, the Women's Imaging staff at DHHA continue to seek ways to improve timely access to mammograms across the DHHA system.

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 with overdue mammograms.

Cervical Cancer Screening

Denver Health Medicaid Choice Cervical Cancer Screening Rates				
HEDIS MY2020 Rates (Medicaid Only)	HEDIS MY2021 Rates (Medicaid Only)	HEDIS MY2022 Rates (Medicaid Only)	HEDIS MY2021 HMO Percentile* (Medicaid Only)	HEDIS MY2021-MY2022 Change
41.11%	39.36%	39.42%	5th	+0.06%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Analysis
The rates for Cervical Cancer Screening (CCS) increased by 0.06% in HEDIS MY2022.

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. In addition, ACS is anticipating the implementation of a variety of technology interventions to improve Women's health screening rates including cervical cancer screening rates (e.g., patient self-scheduling in MyChart and automated text message reminders.)

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.

Action Plan for FY2023-24
QI will continue to work with the Denver Health Cancer Screening Workgroup to develop and implement

ongoing interventions aimed at increasing cervical cancer screening. QI is discussing opportunities to capitalize on other interventions that target Medicaid population and maximize outreach efforts.

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 as most DHMP members prefer to receive their mammogram and other women's health screenings when the mobile van visits their medical home.

Early Periodic Screening Diagnostic Testing (EPSDT)

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

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

CMS 416-EPSDT

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

CMS 416 Report Screening Ratios

Age-Groups Screening Ratio	EPSDT 10/1/18 -9/30/19	EPSDT 10/1/19 -9/30/20	EPSDT 10/1/20 – 9/30/21
< 1 year	1.00	1.00	1.00
1-2 years	1.00	1.00	0.82
3-5 years	0.51	0.47	0.64
6-9 years	0.36	0.29	0.46
10-14 years	0.38	0.32	0.45
15-18 years	0.31	0.29	0.39
19-20 years	0.07	0.07	0.12
TOTAL	0.58	0.46	0.53

Analysis

The overall percentage of EPSDT participants remained relatively stable from the 2019/2020 to the 2020/2021 reporting period. The screening ratios increased for all age groups except 1-2 years; where it decreased slightly.

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

Bright Futures Periodicity Schedule

Due to a need for improved granularity of results for EPSDT monitoring and opportunity identification, an ACS Bright Futures dashboard was created in 2019 to help monitor and improve these metrics. This system-wide pediatric view includes Pediatric Vaccinations- Combo 10. Pediatric Vaccinations – Combo 7, Adolescent Vaccinations, Dental Visit or Fluoride application once by 18 months, Persistent Asthma on Controller medication 2-18 years, Developmental Screening 12-36 months, MCHAT screening, Six Well-Child visits before 15 months, Well-Child visit rate – 3-6 years of age, Well-Child visit rate – 3-9 years of age, Well-Child visit rate 10-18 years of age, Primary Care 30-day Utilization – Pediatrics, Measles Vaccination Rate at 2-years old, Depression Screening/Monitoring at Visit – Adolescents, Hearing Screening – pediatrics, Vision Screening- Pediatrics, Chlamydia Screening – Adolescents, HIV Screening – Adolescents, Lead Screening – Pediatrics, Cholesterol Screening-Pediatrics, Anemia Screening – Pediatrics, and Chlamydia Screening at Visit. The dashboard provides a comprehensive view of these metrics for all clinics including Provider-level performance on each metric. The DHMP QI team will continue to monitor performance on these metrics and evaluate the data for opportunities for improvement.

Interventions FY2022/2023

All QI interventions that address well-child visits also include Medicaid Choice members. Activities to increase well-child visits outlined and evaluated under the HEDIS related measures are dual efforts to improve EPSDT scores. Emphasis will continue to be placed on members completing recommended visits and screenings. Our SBHC interventions related to well-child visits became more challenging due to the COVID-19 pandemic and there was less emphasis on this intervention due to remote learning.

However, DHMP is resuming this intervention as it was originally designed. Additionally, due to the termination of the Healthy Communities program, a collaboration with DHMP's Care Management team to provide EPSDT services, care coordination, and resolution of barriers to drive well-child visit rates through outreach has replaced the function of Healthy Communities. DHMP QI will also continue to present data findings and intervention progress to the Denver Health Ambulatory Care Services Pediatric QI Workgroup. Furthermore, we aim to ensure that data collection accurately reflects the number of completed EPSDT screenings. We will use encounter data, 416 CMS report data, and other data sources to identify gaps in care and ultimately address areas of need by developing or improving current interventions.

EPSDT Staff/Member Education

Members were notified about EPSDT benefits in several ways. Member Handbooks and Member Newsletters were sent to new Members. EPSDT informational brochures are available in both English and Spanish. The QI department regularly communicated the availability of the EPSDT benefits to Medicaid Choice Members through mailings and Member newsletters. Staff were educated about the EPSDT program on an as needed basis if there are changes or amendments to the existing benefit. DHMP also created an EPSDT page on the Denver Health Medicaid Choice website providing information to Members on EPSDT services, and how to obtain additional information if needed. DHMP's Care Management Team employed various methods to inform eligible members about EPSDT services and assist members with accessing services, including an informational flyer on EPSDT services and through completion of a health needs assessment for new members.

EPSDT Provider Education

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

EPSDT Reimbursement

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

Barriers to Care

The DHMP Care Management team uses a variety of tools to identify and overcome barriers to care. When a new Medicaid member joins the plan, they are sent a Health Needs Assessment (HNA) through a third-party vendor, along with an informational flyer regarding EPSDT services. This vendor conducts outreach calls in addition to the mailing to encourage members to complete the HNA. The results of the HNA are reviewed by DHMP's Care Management team for EPSDT needs and barriers to care. Members in need are outreached by the Care Management team for engagement in Care Management services and programs. Barriers may also be identified through internal assessments used for specific care management programs. The Care Management team is able to support members in overcoming barriers to care by providing transportation and language assistance, coordinating appointments and providing reminders, and supporting members with meeting other SDOH related needs which may impact their ability to participate in care. Members may have other barriers that Denver Health is not aware of, so all Member mailings included the Member Services phone number detailing how this

department assists with transportation, making an appointment or answering questions.

Action Plan for FY23-24

DHMP is continuing collaboration with ACS via the Pediatric Quality Improvement Workgroup to address issues in accessing well-care services. QI will continue to focus on improving the rate of completion for annual well child visits. The QI Department participates in the Pediatric Quality Improvement Workgroup and will continue to bring issues to the group to improve well-child and well-care rates. The MCD Population Health Management Program will also continue to prioritize increasing the percentage of children and adolescents (ages 0-21 years) who receive an annual well child visit through our outreach efforts and Care Management programming. DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit. Additionally, DHMP is restarting 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.

DHMP's Care Management Team will continue to identify members in need of EPSDT services through use of the HNA and other internal assessments. Care Management continues to provide support to members by addressing barriers in care and coordinating care between DHMP and network providers. Information regarding these services will continue to be provided to all Medicaid members. DHMP's Care Management team also conducts outreach for services based on provider, UM, or patient self-referrals. Finally, DHMP will continue to monitor Provider activities and have discussions with ACS management to optimize the process for operationalizing wrap-around benefit and care coordination tracking processes at the clinic level.

Guidelines

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

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

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

schedule provided by the Centers for Disease Control and Prevention (CDC) guidelines.

Childhood Preventive Measures

Denver Health Medicaid Choice Childhood Immunization Status (CIS)**					
Measure/Data Element	HEDIS MY2020 Rates	HEDIS MY2021 Rates	HEDIS MY2022 Rates	HEDIS MY2021 HMO %tile*	HEDIS MY2021-MY2022 Change
DTaP	69.47%	65.93%	75.15%	25th	+9.22%
MMR	84.04%	76.87%	85.73%	5th	+8.86%
OPV/IPV	82.19%	75.71%	85.53%	5th	+9.82%
H Influenza type B (HiB)	81.93%	77.20%	84.63%	10th	+7.43%
Hepatitis B	85.09%	74.40%	88.72%	5th	+14.32%
Chicken Pox – VZV	83.68%	76.92%	85.43%	10th	+8.51%
Pneumococcal Conjugate	74.21%	68.13%	76.95%	25th	+8.82%
Hepatitis A	82.54%	77.25%	85.23%	25th	+7.98%
Rotavirus	63.77%	60.22%	64.67%	10th	+4.45%
Influenza	50.26%	52.09%	53.79%	50th	+1.70%
Combo 2	68.51%	Retired	Retired	N/A	N/A
Combo 3	67.98%	61.92%	72.46%	25th	+10.54%
Immunization for Adolescents (IMA)					
Measure/Data Element	HEDIS MY2020 Rates	HEDIS MY2021 Rates	HEDIS MY2022 Rates	HEDIS MY2021 HMO %tile*	HEDIS MY2021-MY2022 Change
Meningococcal	78.25%	66.58%	72.26%	5th	+5.68%
Tdap/TD	77.64%	66.73%	74.56%	5th	+7.83%
HPV	49.79%	37.04%	37.21%	50th	+0.17%
Combo 1	75.70%	64.92%	71.81%	10th	+6.89

					%
Combo 2	45.11%	35.93%	36.86%	50th	+0.93 %
Well-Child Visits (W15, W34, AWC)					
Measure / Data Element	HEDIS MY2020 Rates	HEDIS MY2021 Rates	HEDIS MY2022 Rates	HEDIS MY2021 HMO %tile*	HEDIS MY2021-MY2022 Change
Well-Child Visits in the First 30 Months of Life (First 15 Months)	54.69%	54.34%	58.28%	25th	+3.94 %
Well-Child Visits in the First 30 Months of Life	57.13%	54.42%	59.29%	5th	+3.87 %
(15 Months-30 Months)					
Child and Adolescent Well-Care Visits (Total)	39.31%	41.93%	42.90%	10th	+0.97 %

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

Immunizations
Overall, the childhood immunization MY2022 rates for Medicaid members increased from HEDIS MY2021. Rate increases ranged from 1.70% for the Influenza vaccine to 14.32% for the Hepatitis B vaccine, largely making up for MY2021 decreases. Adolescent immunization (IMA) rates for Medicaid members also increased, with increases ranging from 0.17% for HPV to 7.83% for Tdap/TD.

The childhood immunization rates for CHP members showed more notable fluctuations ranging from -67.79% for the varicella vaccine to +22.41% for the DTaP vaccine, though generally rates increased. Outcomes for adolescent immunization (IMA) rates for CHP+ members increased with minor changes ranging from 3.26% for the HPV vaccine to an increase of 17.76% for Combo 1.

ACS Providers are required to follow the UDS immunization timeframe requirement for all immunizations to be received in the first three years of life. HEDIS requires immunizations to occur in the first two years of life. This creates a schedule discrepancy with some vaccines falling outside HEDIS measure timeframes.

In 2022 and 2023, the DHMP QI team participated in the Denver Health Pediatric Quality Improvement Work Group. Many of the interventions in 2022/23 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 transitioned 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 2022, 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 throughout 2022. Additional planning for interventions to improve these metrics is ongoing.

Well Child Visits

In FY22/23, DHMP continued to implement and integrated Population Health Management program for our MCD population with a focus area on promoting wellness and improving the percent of children and adolescents (ages 0-21 years) who receive an annual well-child visit. This effort includes mailing campaigns (Healthy Heroes cards) to remind families of the need to schedule a well-child visit and of the importance of these visits, EPSDT outreach conducted by the DHMP Care Management team, Health Needs Assessments for members who are newly enrolled in DHMP Medicaid, outreach to families of members who are signed up to participate in the DHHA MyChart system, and the collaboration with DH School Based Health in utilizing school based health centers to provide well-child exams to those members who attend a DPS school and who are consented to receive school-based services.

Healthy Hero Birthday Cards

In an effort to reach members ages 19 and under, DHMP QI and Marketing sends annual birthday cards monthly to children ages 2 through 19 that provide a checklist with information on healthy eating, development, vaccines, and physical activity. The birthday cards are intended to provide visit reminders as well as prepare and educate children and parents on what will happen at upcoming well child Visits. They also include information on how to schedule an appointment for a well child's visit. For FY2022-2023, DHMP mailed an average of 1670 birthday cards a month to Medicaid Choice members and an average of 122 birthday cards a month to CHP+ members.

EPSDT Outreach

With the termination of the Healthy Communities program, EPSDT outreach conducted by DHMP Population Health Medicaid efforts conducted by the Plan will continue throughout SFY23/24 and remain a powerful way to identify members in need of screenings and services.

Action Plan for FY 2023-2024

QI will continue to focus on improving the rate of completion for annual well child visits. The QI Department participates in the Pediatric Quality Improvement Workgroup and will continue to bring issues to the group to improve well-child and well-care rates. The MCD Population Health Management Program will also continue to prioritize increasing the percentage of children and adolescents (ages 0-21 years) who receive an annual well child visit through our outreach efforts and Care Management programming.

DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit.

School Based Health Centers
Denver Health Medicaid Choice and CHP+ Members have access to 18 SBHCs within Denver Public elementary, middle, and high schools. SBHCs provide a variety of services such as child visits, sport physicals, immunizations, chronic disease management, primary care, and behavioral health care services. DHHA and DHMP continue to encourage eligible Members to access care through our network of SBHCs. This information is sent directly to Member households in newsletters and is also available on the DHMP Member website. In addition, the DHHA appointment center utilizes a process that alerts schedulers of a SBHC enrolled student which will prompt them to schedule the child at a SBHC for their clinic needs. For our adolescent population, collaboration with the DPS School Based Health Centers to identify and see members for Well Child visits during school hours has been highly successful in the past and will continue in SFY23/24.

Action Plan FY23/24
DHMP QI staff will continue to collaborate with the Pediatric Quality Improvement Workgroup and SBHC team to develop interventions to improve health care outcomes for pediatric Members. DHMP hopes to continue our growing partnership with the SBHC program to identify members who are consented to be seen at a SBHC and facilitate ensuring that they are scheduled to receive their annual wellness exam at the appropriate clinic. The QI team is currently working on reporting that will help the SBHC teams to identify and prioritize DHMP members.

Weight Management Measures

Denver Health Medicaid Choice				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS MY2020 Rates	HEDIS MY2021 Rates	HEDIS MY2022 Rates	HEDIS MY2021 HMO %tile*	HEDIS MY2021-MY2022 Change
BMI Percentile Documentation				
65.36%	70.33%	91.24%	10th	+20.91%
Counseling for Nutrition				
69.85%	74.36%	83.21%	50th	+8.85%
Counseling for Physical Activity				
69.19%	73.75%	81.27%	50th	+7.52%

Denver Health CHP+ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
HEDIS MY2020 Rates	HEDIS MY2021 Rates	HEDIS MY2022 Rates	HEDIS MY2021 HMO %tile*	HEDIS MY2021-MY2022 Change
BMI Percentile Documentation				

63.96%	72.47%	92.94%	10th	+20.47%
Counseling for Nutrition				
70.36%	77.72%	84.18%	50th	+6.46%
Counseling for Physical Activity				
69.92%	77.33%	83.21%	50th	+5.88%

*HEDIS MY2021 national percentiles are listed in the following charts. MY2022 percentiles to be released in late 2023.

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

Active interventions addressing obesity rates include:

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

COVID-19 Vaccination Outreach

The DHMP QI team has been working closely with the DHMP MCD team, HCPF and our partners at DHHA ACS to increase outreach and access to MCD members who are currently eligible to receive a COVID-19 vaccine and/or booster. In FY2022/23, DHMP performed targeted COVID vaccination outreach campaigns to identified members of color focused on leveraging established partnerships within the community, conducting a phone campaign to members that have not yet received the vaccine and a direct mailer that includes information regarding vaccine events in the community and provides contact information for care management resources. Care managers determined if a member had received their vaccine using CIIS data and member outreach lists. If a member had not received their vaccine, the coordinator also screened for additional needs and services that the member may require such as transportation, housing, and other community-based services. They also supported the member in scheduling an appointment to receive their vaccine and/or setting up transportation for the appointment.

Action Plan for FY2023/2024

DHMP will work with our partners at DHHA ACS Pediatrics including School Based Health Centers to identify and outreach to MCD Choice members ages 0-18 who are now eligible to receive the COVID vaccine. DHHA SBHC and Pediatric clinics will offer vaccine distribution to all MCD members. For the adult MCD population, DHMP and DHHA will send reminders about the need for booster shots and/or initial shots to members as appropriate. Members can self-schedule for a COVID vaccine visit through

their MyChart account.

Clinical and Preventive Health Care Guidelines

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

Denver Health Medicaid Choice Preventive Care Guidelines

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

DHMP CHP+ Preventive Care Guidelines

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

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

Denver Health Medicaid Choice Clinical Guidelines

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

DHMP CHP+ Clinical Guidelines

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

Activities planned for 2022/2023

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

Care Coordination Annual Evaluation SFY 2022-2023

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.

Outcomes are evaluated using metrics around member engagement in Care Management, utilization patterns, specific outcomes for disease management, cost containment, and member satisfaction. At least annually, DHMP evaluates member experience with its Care Management and Care Coordination programs by obtaining feedback from members. Data collected and analyzed includes member feedback about:

- The overall program
- The care management staff
- Usefulness of the information disseminated
- Member's ability to adhere to recommendations
- Percentage of members indicating that the program/services helped them achieve health goals
- In addition, member complaints are analyzed to improve satisfaction with its care management programs/services

The Care Management team assists patients requiring health care services from multiple Providers, facilities, and agencies in obtaining those services. The team coordinates with behavioral health organizations, specialty services, and social services provided through community agencies and organizations. Community referrals are created and tracked in the medical management platform system. Referrals are used to promote continuity of care and cost-effectiveness of care.

DHMP continues to collaborate with ACS in the provision of care coordination and quality improvement services and programs for patients and Members. In 2022-2023, DHMP successfully implemented quality improvement initiatives for Care Coordination activities, including:

- Development and implementation of the Foster Care Program
- Expansion of the Controlling Blood Pressure Program to all lines of business
- Changes to the adult complex care population definition which allowed the CM team to better target members with poor utilization patterns and multiple chronic conditions.
    - Adults with 3 or more "winnable" conditions and >$25,000 in care costs
- Development of a Complex Care dashboard to track metrics for Complex Care population.
- Updates to the risk stratification tool to identify members with special health care needs.
- Updates to the risk stratification tool to include an indicator for members with at least 1 inpatient admission in the past year.
- Development of a Maternal Care Dashboard to help identify members with high-risk pregnancies and track Care Management outreach and engagement.
- Development of a member centric dashboard to easily identify gaps in care, last and next appointments, and ED/inpatient utilization.
- Development of an MLR dashboard to track MLR metrics for the Medicaid population.

- Enhanced member support during the PHE unwinds, including assisting members with enrollment challenges as well as challenges related to rising SDOH needs

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.

SFY 22-23 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 Activity Metrics:

Activity Name	Number of Activites Performed
CCM Applications/Membership Assistance	4
CCM Assessment	12
CCM Benefit Resource Coordination	44
CCM Condition Management	6
CCM Engagement / Enrollment	328
CCM Health Care Provider Coordination	4
CCM Housing Resource Coordination	5
CCM Language Services	10
CCM LTSS Coordination	6
CCM Member Follow-up	4845
CCM Other Community Resource Coordination	29
CCM Other Follow-up	127
CCM Pharmacy Review	25
CCM Program	308
CCM Program Update	38
CCM Provider Follow-up	5
CCM Referral	6
CCM Tobacco Cessation Coordination	2
CCM Transportation Coordination	16
Grand Total	**5820**

Figure 1 - CCM Activities SFY 2022-2023

Assessment Name	Distinct Member Count
FSA (NCQA Edition)	19
HRA (NCQA Edition)	18
SDOH (NCQA Edition)	18
Grand Total	**19**

Figure 2 - CCM Assessments SFY 2022-2023

CCM Program Metrics:

CCM Referrals 2022-2023	
Program Status	**Members**
Changed Programs	3
Completed Program	2
Deceased	1
Declined- Opt Out	3
Declined Program	3
Did Not Meet Criteria	2
Eligibility Termed	1
LTC/SNF Placement	1
Member Enrolled in Program	17
Member Readmitted IP	1
Opted Out	5
Unable To Reach	14
UTR No Valid Contact Information	2
Total Referrals (SFY 2022-2023)	**55**

Figure 3 - CCM Completed Referrals SFY 2022-2023

Members Engaged in CCM Program SFY 2022-2023	
Status Description	**Number of Members**
Changed Programs	1
Completed Program	2
Deceased	1
Eligibility Termed	1
LTC/SNF Placement	1
Member Enrolled in Program	30
Total Members Engaged	**36**

Figure 4 - CCM Program Outcomes - Engaged Members SFY 2022-2023

CCM Outcome Metrics:

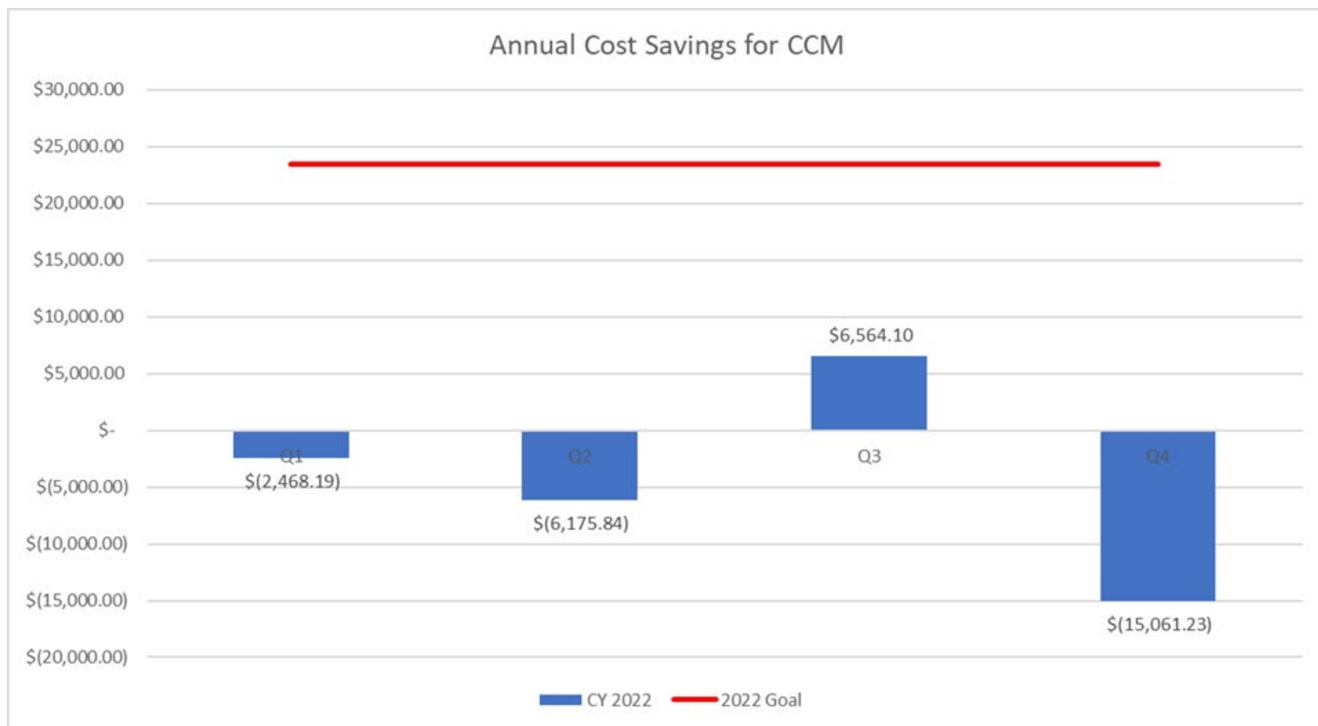

Figure 5 - CCM Cost Savings CY 2022

CCM Cost Savings			
Quarter (CY 2022)	Average Annual Per Member Cost (2022)	Average Annual Per Member Cost (2021)	Cost difference
Q1	$ 40,124.69	$ 37,656.50	$ (2,468.19)
Q2	$ 42,965.93	$ 36,790.09	$ (6,175.84)
Q3	$ 53,635.69	$ 60,199.79	$ 6,564.10
Q4	$ 50,500.71	$ 35,439.48	$ (15,061.23)

Figure 6 - CCM Cost Savings Breakdown CY 2022

Results/Analysis:

- 5820 activities were completed in SFY 2022- 2023
- A total of 53 distinct members were referred to CCM in SFY 2022-2023 across 55 total referrals.
  - 19 members (35.84%) were enrolled in the program during SFY 2022-2023, with 2 of those members completing the program and 17 members still being enrolled as of 6/30/2023.
- 36 members were actively managed under the program in SFY 2022-2023
  - 30 members were actively enrolled as of 6/30/2023
  - 2 members completed the program
  - 1 member changed programs
  - 1 member had their eligibility term
  - 1 member was placed in SNF/LTC
  - 1 member passed away
- As of the end of CY 2022, the average per member cost for members enrolled in CCM was $15,061.23 higher than in 2021
  - This data is based on members who were in the program for at least 60 days.
- When evaluating cost data on members who had been enrolled in the CCM program for at least 1 year, costs were reduced by $10,707.60 per member between 2021 and 2022.
  - This indicates that new members may be skewing cost data as many members are referred to CCM because they are high cost / high risk members.

Barriers/Lessons Learned:

- It is difficult to measure cost related outcomes due to turnover of membership and challenges associated with members being in a high-cost bucket within their first 60 days in the program.
  - Outreach lists to build the CCM caseload comes from our top 10 high utilizer report, which are our most expensive members.
  - Caseload is small due to the regulatory requirements of this program, so one member can skew cost data significantly.
  - Utilization patterns may have been different in 2022 vs. 2021 due to the impact of the COVID-19 pandemic being greater in 2021.
  - In CY 2023, DHMP temporarily suspended cost savings as an indicator for this program and will be working with external vendors to capture member outcome data on a programmatic level.

Complex Care Medicaid Program

DHMP's Complex Care Program addresses the complex medical, behavioral and/or psychosocial needs of members by providing personalized care management services and goal setting. The program is designed to help members with complex conditions and social situations to obtain access to necessary care and services in a coordinated and cost-effective manner. The 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. The care managers collaborate with members and providers to set SMART goals and address barriers. This program also assists members with transitions of care across different levels of care. Managing member transitions between care settings is essential for member safety, quality of care, and cost-effective outcomes.

Members are identified for outreach using the clinical risk stratification dashboard. Outreach lists are generated routinely for the MCD team. The risk stratification tool was successfully updated in January 2022 to support identification of Complex Care Members. The criteria for pediatric Complex Care for July 2022 – June 2023 are members ages 0-20 with care costs exceeding $25,000. From July 2022 - November 2023, the Complex Care criteria for adult members are members ages 21+ with 4 or more "winnable" conditions. In 2022, DHMP partnered with HCPF to review a change in the definition of Complex Care for adult members. The new definition started in November 2022. The new complex definition includes adult Medicaid and Dual Special Needs Population (DSNP) members with 3 or more conditions and care costs exceeding $25,000. While cost or number of conditions alone do not necessarily indicate complex needs, the combination of high care costs combined with number of conditions may be an indicator that the member has at least one condition that is not well controlled and may also indicate over or under utilization of key services. Data pulled to evaluate the risks of this group demonstrated high ED utilization, readmission rates, and no follow up to a PCP within 30 days of hospital discharge. This group also demonstrated high rates of poly-rx and pain medication usage, as well as high rates of mental health diagnoses.

SFY 22-23 Complex Care Medicaid 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.

[Complex Care Population Overview:]

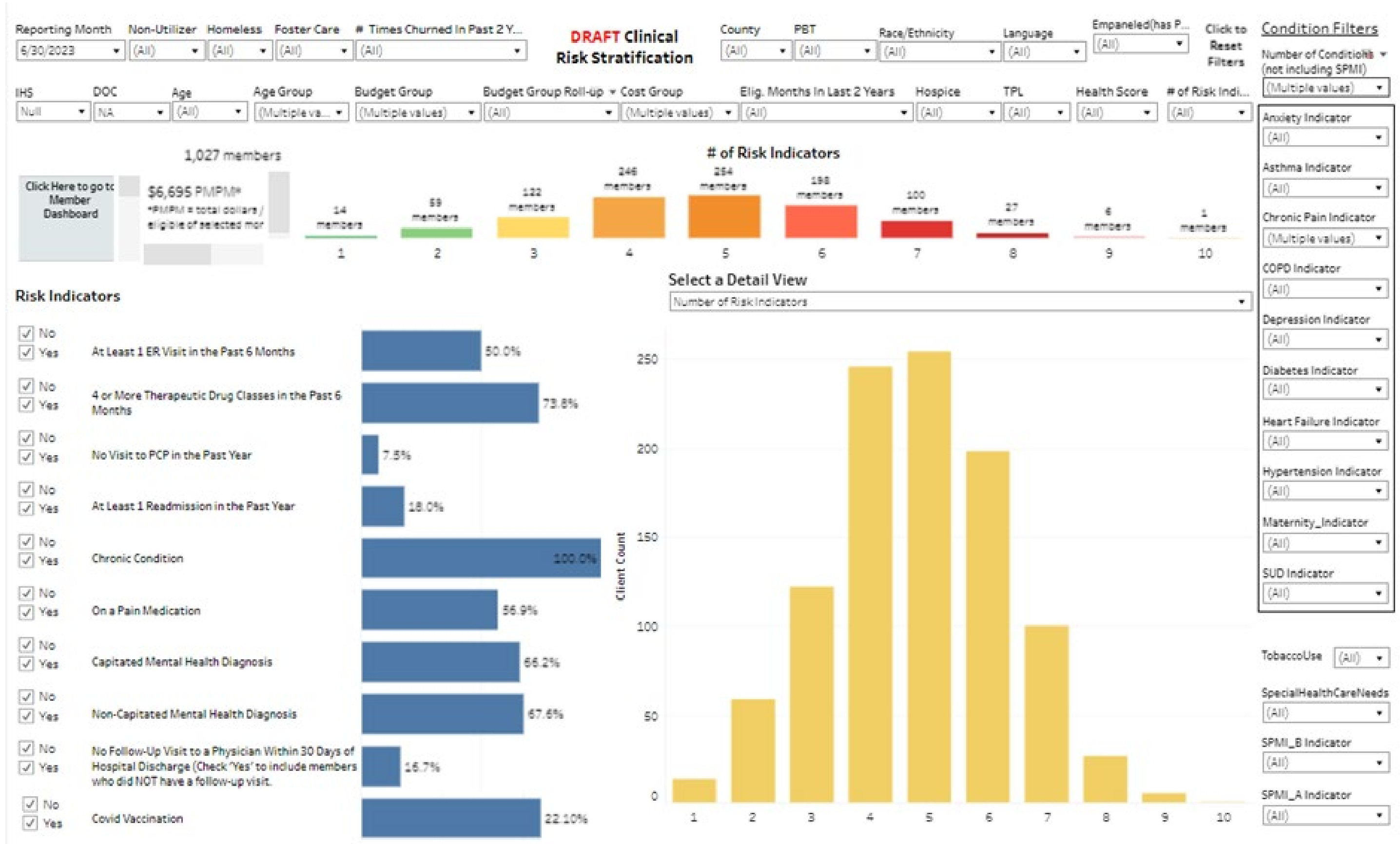

Figure 7 - Adult Members with Complex Care Needs - June 2023

Figure 8 - Pediatric Members with Complex Care Needs - June 2023

Complex Care Medicaid Program Metrics:

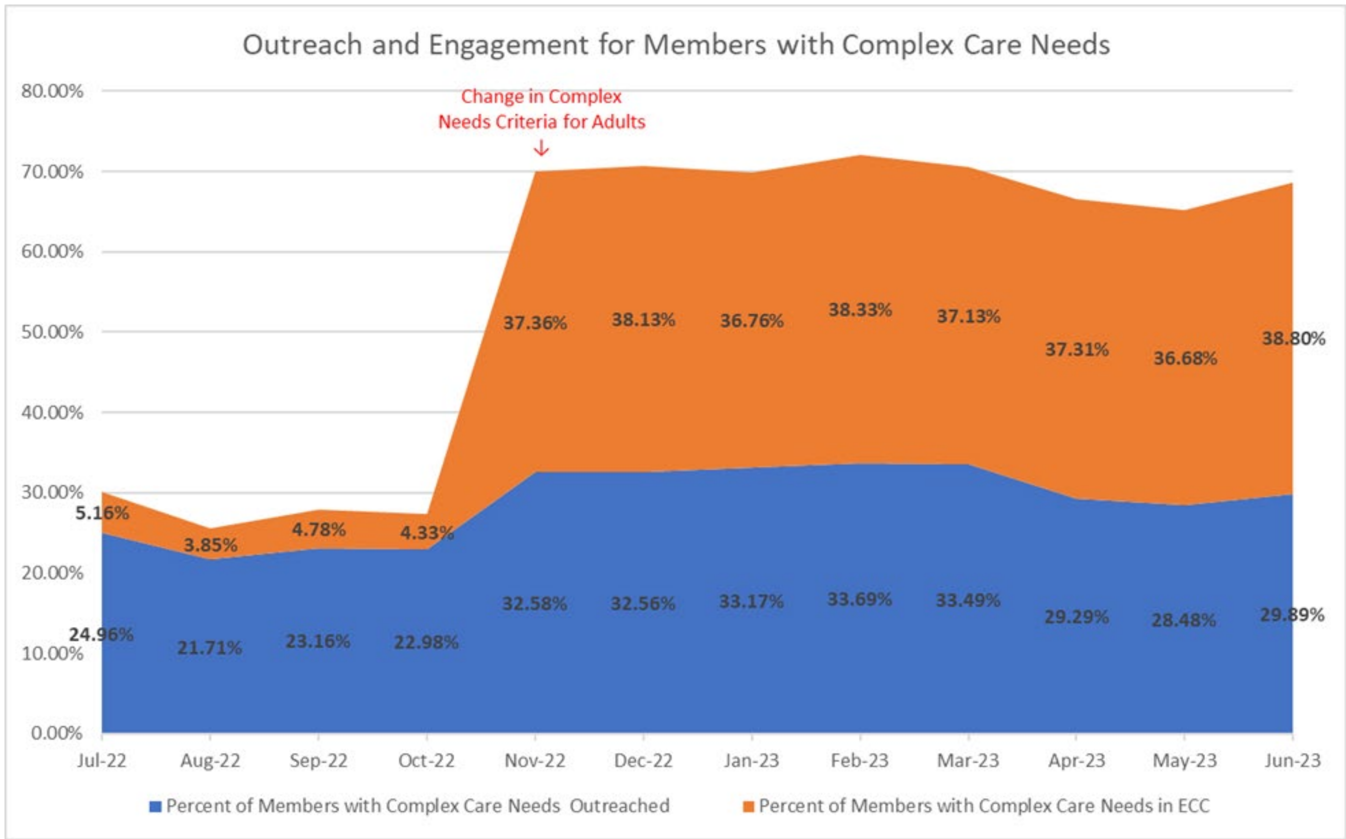

Figure 9 - Outreach and Engagement in Extended Care Coordination - Complex Care - SFY 2022-2023

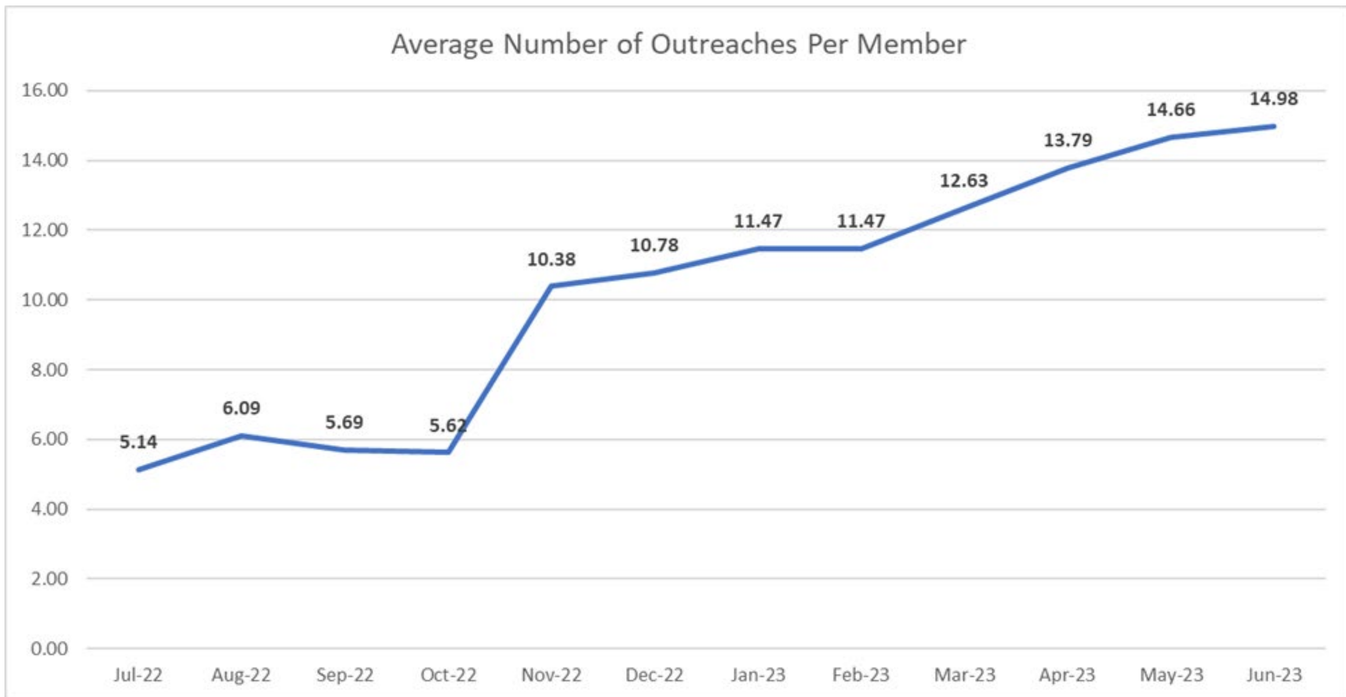

Figure 10 - Complex Care Average Number of Outreaches Per Member - SFY 2022-2023

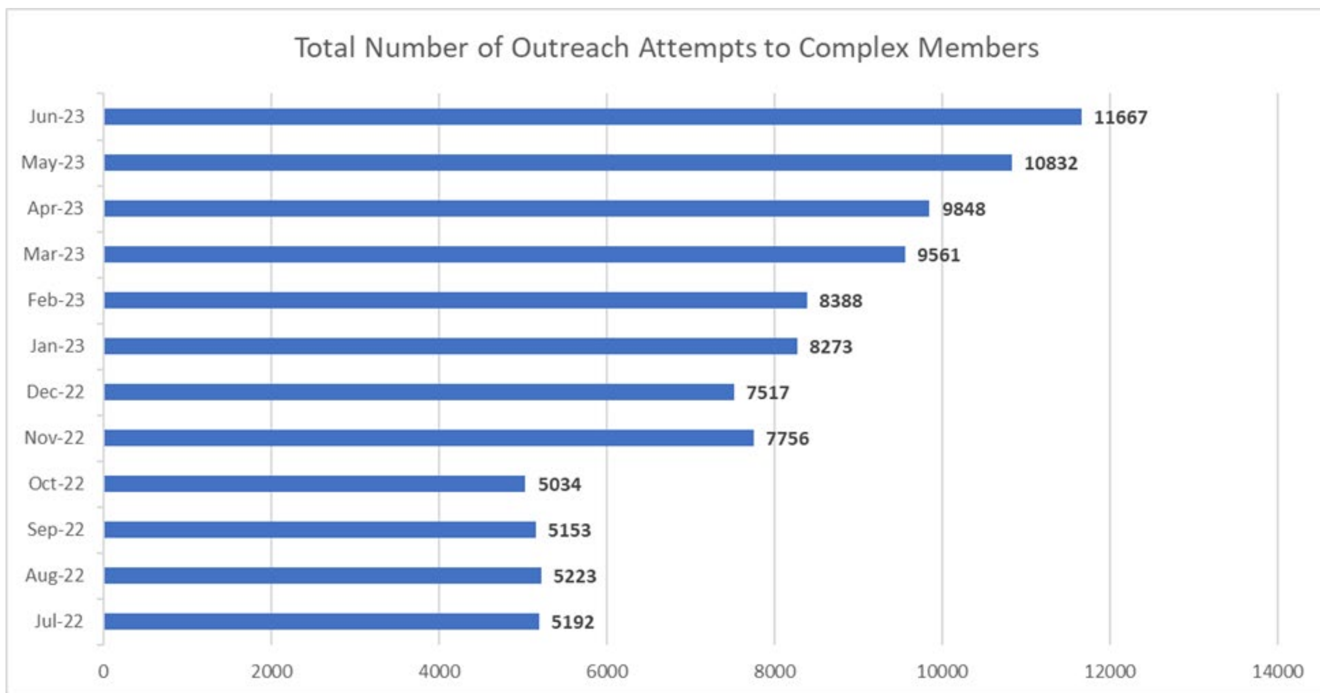

Figure 11 - Total Number of Outreach Attempts - Complex Care - SFY 2022-2023

Results/Analysis:

- In November 2022, DHMP partnered with HCPF to review a change in the definition of Complex Care for Adult members
  - One of the challenges faced by the organization was the increase in adult members meeting Complex Care criteria after HCPF changed the definition from adult members with care costs exceeding $25,000 to adult members with 4 or more chronic conditions.
  - The change in this definition increased the number of complex members four-fold, making it difficult for the Care Management team to make a meaningful impact on this population.
  - Additionally, the new definition did not parse out members with well-controlled conditions from those whose conditions were uncontrolled.
- The new complex definition includes adult Medicaid and Dual Special Needs Population (DSNP) members with 3 or more conditions and care costs exceeding $25,000.
  - While cost or number of conditions alone do not necessarily indicate complex needs, the combination of high care costs combined with number of conditions may be an indicator that the member has at least one condition that is not well controlled and may also indicate over or under utilization of key services.
  - As of June 2023, 1,027 adult members met criteria for complex needs under the new definition.
    - Members in this group demonstrate a high level of emergency department (ED) utilization (50.0%) and high readmission rates (18.0%), with a large portion of these members not following up with their primary care provider (PCP) within 30 days of hospital discharge (16.7%), indicating that these members may have utilization patterns that CM can help intervene with
    - 7.5% of members in this group had no PCP visit within the past year.
    - 73.8% of members in this group have four (4) or more therapeutic drug classes and 56.9% of members are on a pain medication, indicating a potential need for medication reconciliation,

        - medication safety review, and member education
        - This group demonstrates a high level of both capitated and non-capitated mental health diagnoses (66.2% and 67.6%)
        - 22.10% of members in this group had not received a vaccination for COVID-19
- The definition for complex needs for pediatric members did not change during the evaluation period; however, this is in process
- Member engagement in Extended Care Coordination (ECC) has increased over the past year; with an average of 31.34% of members engaged in ECC in Q3Q4 SFY 2022-2023, compared to 26.33% of members engaged in ECC in Q1Q2 SFY 2022-2023
- Member outreach for members who are not engaged in ECC has also increased – from an average of 15.70% in Q1Q2, to an average of 37.50% of members outreached in Q3Q4 SFY 2022-2023
- Many of these increases were seen after the change in the adult definition of complex needs – this allowed CMs to better target outreach to members and capture our highest risk members - members with multiple chronic conditions with care costs that indicate that those conditions are not being effectively managed
- Allowing the CM team to focus on a more targeted population has also increased the number of overall outreaches being conducted as well as the outreaches per member
    - June 2023 saw 11,667 total outreaches to members with an average of 14.98 outreaches per member, compared to 5192 outreaches completed with an average of 5.14 outreaches per member in July 2022
    - The increase in outreaches per member indicate that the members are engaging more and obtaining more services from the Care Management team

Barriers/Lessons Learned**:**

- Outreach and ECC engagement for members with complex care needs declined slightly towards the end of the assessment period
    - It is not clear why ECC engagement has decreased since July 2022, but the change may be related to some members no longer meeting complex care criteria (if a member does not have care costs exceeding $25,000 in care costs for previous 12 months, they will no longer meet complex criteria), while new members hit the cost threshold of $25,000 annually
    - This highlights a major challenge of identifying risk based on cost alone – a single event could drive a member into complex needs but may not actually indicate a member with complex needs.
- While ECC rates increased under the new adult complex care definition, member engagement in ECC continues to be challenging
    - Complex care members are vulnerable, and many members demonstrate low engagement and even distrust in the medical community
    - The DHMP Care Management team works with members to build rapport and trust, which means that several outreaches over multiple months may occur before a member agrees to participate in a CM program
    - Some members do not wish to engage in a CM program but will agree to receive support on an as-needed basis from the CM team
    - The DHMP CM team meets members where they are and provides a level of service that the members feel is right for them.
- DHMP continues to explore options for changing the definition of complex care for pediatric members
    - Areas of interest for DHMP include rising risk members, members in foster care, and members with special health care needs
    - These populations are noted to experience exceptional challenges in care coordination and would benefit from CM services

- DHMP is partnering with Square ML to conduct assessment of rising risk populations within DHMP, but Square ML is still in the process of ingesting and testing data
- While they have preliminarily identified rising risk adult populations (currently in data validation/testing), they have not yet identified a pediatric rising risk population
- The goal is to have a new pediatric complex care definition by the end of SFY 2023

Dual Special Needs Program (DSNP)

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 for every member. The ICP is completed upon enrollment, updated at least annually and is an on-going plan of care with members. 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.

SFY 22-23 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 Activity Metrics:

DSNP Metrics	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Member Calls (Outreach)	2,864	2,707	3,131	2,922	2,718	2,395	2,459	2,304	2,732	2,545	2,755	2,674	32,206
Member Letters (Mailed Outreach)	696	664	814	771	629	571	449	479	441	503	639	738	7,394
Care Coordination Activities	2,735	2,972	3,939	4,261	3,099	2,854	2,618	3,343	2,620	3,197	3,732	3,863	39,233
Total Health Risk Assessments Completed	260	230	350	193	157	145	152	135	145	219	202	233	2,195
HRA Completed by Member	184	142	236	119	104	101	105	101	108	161	133	146	1,548
Initial HRA Completed by Member	39	18	63	41	22	32	37	29	39	41	38	26	422
Annual HRA Completed by Member	145	124	173	78	82	69	68	72	69	120	95	120	1,126
Initial HRA General - Unable to Reach	14	13	28	14	14	11	17	8	15	15	20	12	174
Initial HRA General - Member Refused	3	2	1	1	0	1	5	1	3	1	2	3	23
Annual HRA General - Unable to Reach	54	66	76	52	34	27	23	22	17	40	44	62	402
Annual HRA General - Member Refused	5	7	9	7	5	5	3	3	2	2	3	10	48
HRA Untimely Completion	0.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%
DSNP HRA Assessment Rate	70.77%	61.74%	67.43%	61.66%	66.24%	69.66%	69.08%	74.81%	74.48%	73.52%	65.84%	62.66%	70.52%
Care Plan Meetings (ICT)	224	240	269	363	203	178	159	187	144	200	214	235	2,616
DSNP Care Plan Compliance (ICP)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Food Security	8	15	13	8	23	21	31	37	38	19	22	29	264
Transportation Coordination	28	28	18	18	17	44	30	21	44	36	47	43	374
DSNP Enrollment - Medicare Choice DSNP HMO	1,850	1,862	1,848	1,833	1,848	1,865	1,893	1,910	1,921	1,944	1,977	1,995	2,414
DSNP Actively Managed Members	1,815	1,834	1,829	1,832	1,830	1,839	1,873	1,884	1,897	1,923	1,976	1,930	2,414

Figure 12 - DSNP Activities CY 2022

DSNP Metrics	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	YTD
Total Health Risk Assessments Completed	399	309	659	325	282	250							2,224
HRA Completed by Member	335	243	413	210	190	171							1,562
Initial HRA Completed by Member	191	106	286	98	89	81							851
Annual HRA Completed by Member	144	137	127	112	101	90							711
Initial HRA General - Unable to Reach	10	4	129	40	41	32							256
Initial HRA General - Member Refused	2	5	33	13	3	6							62
Annual HRA General - Unable to Reach	47	53	79	53	44	37							313
Annual HRA General - Member Refused	5	4	5	9	4	4							31
HRA Untimely Completion	0.00%	0.00%	0.05%	0.00%	0.00%	0.00%							0.01%
DSNP HRA Completion Rate	83.96%	78.64%	62.67%	64.62%	67.38%	68.40%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	70.23%
Care Plan Meetings (ICT)	266	393	483	522	380	350							2,394
DSNP Enrollment - Medicare Choice DSNP HMO	2,530	2,636	2,687	2,743	2,750	2,777							3,295
DSNP # Unique Members Actively Managed	1,284	1,365	1,646	1,632	1,555	1,366							1,941

Figure 13 - DSNP Activities January - June 2023

DSNP Outcome Metrics:

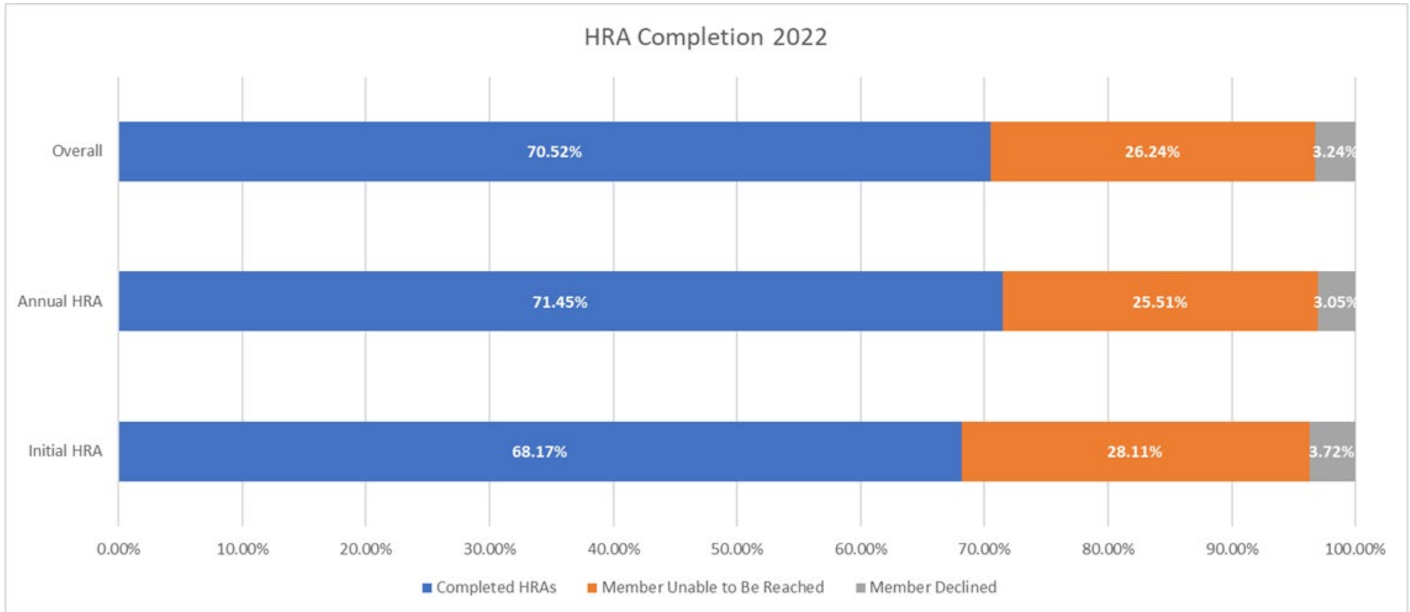

Figure 14 - HRA Completion Rates CY 2022

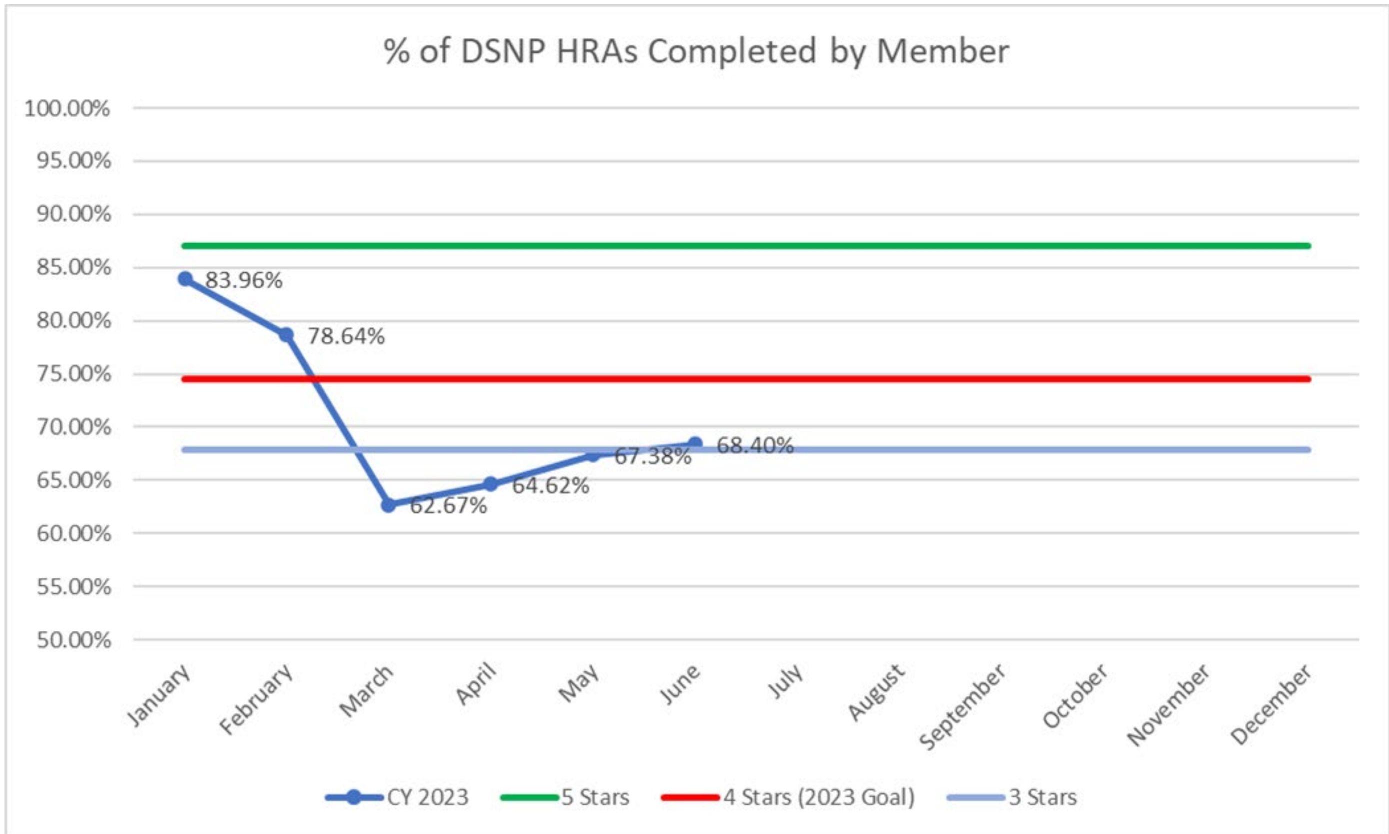

Figure 15 - HRA Completion Rates January - June 2023

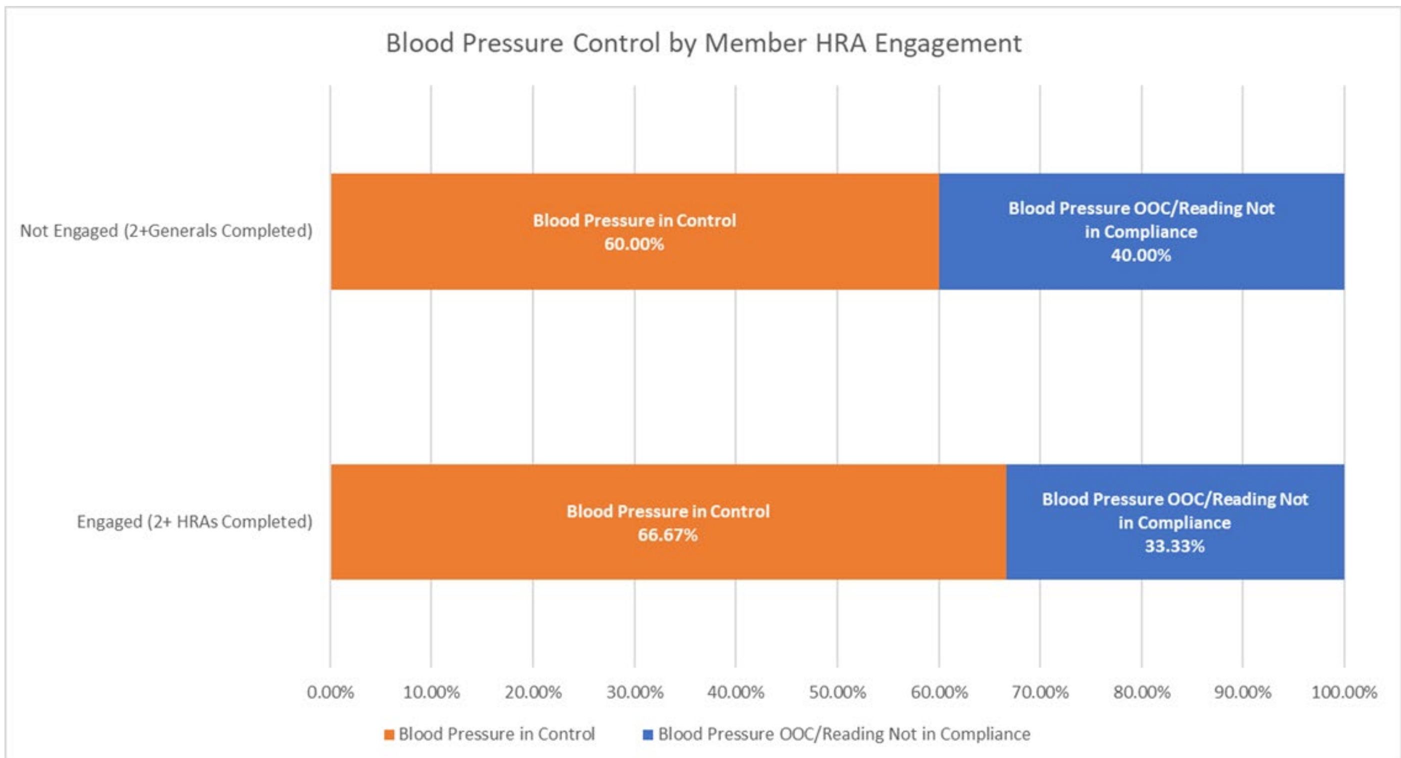

Figure 16 - Blood Pressure Control for DSNP Members by HRA Engagement - CY 2022

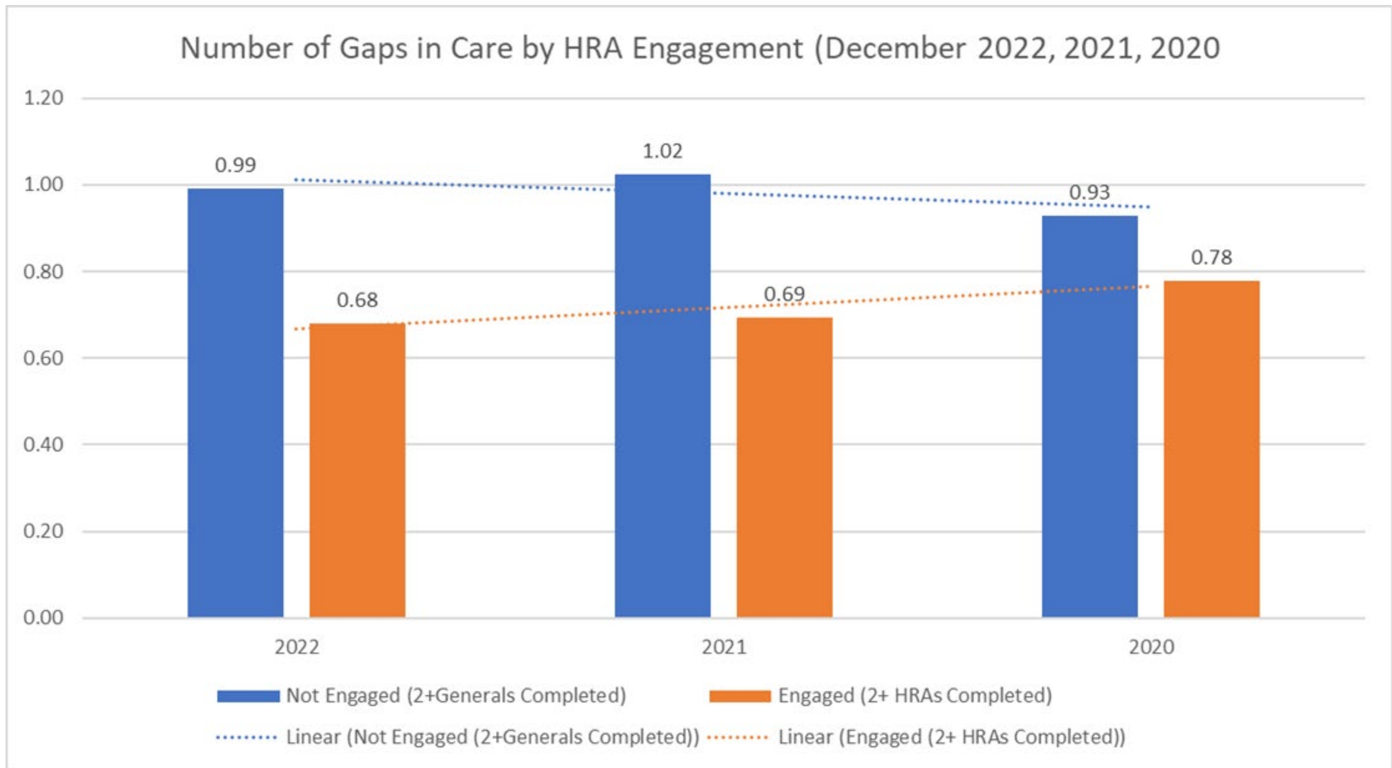

Figure 17 - Number of Gaps in Care for DSNP Members by HRA Engagement – YOY Comparison 2020-2022

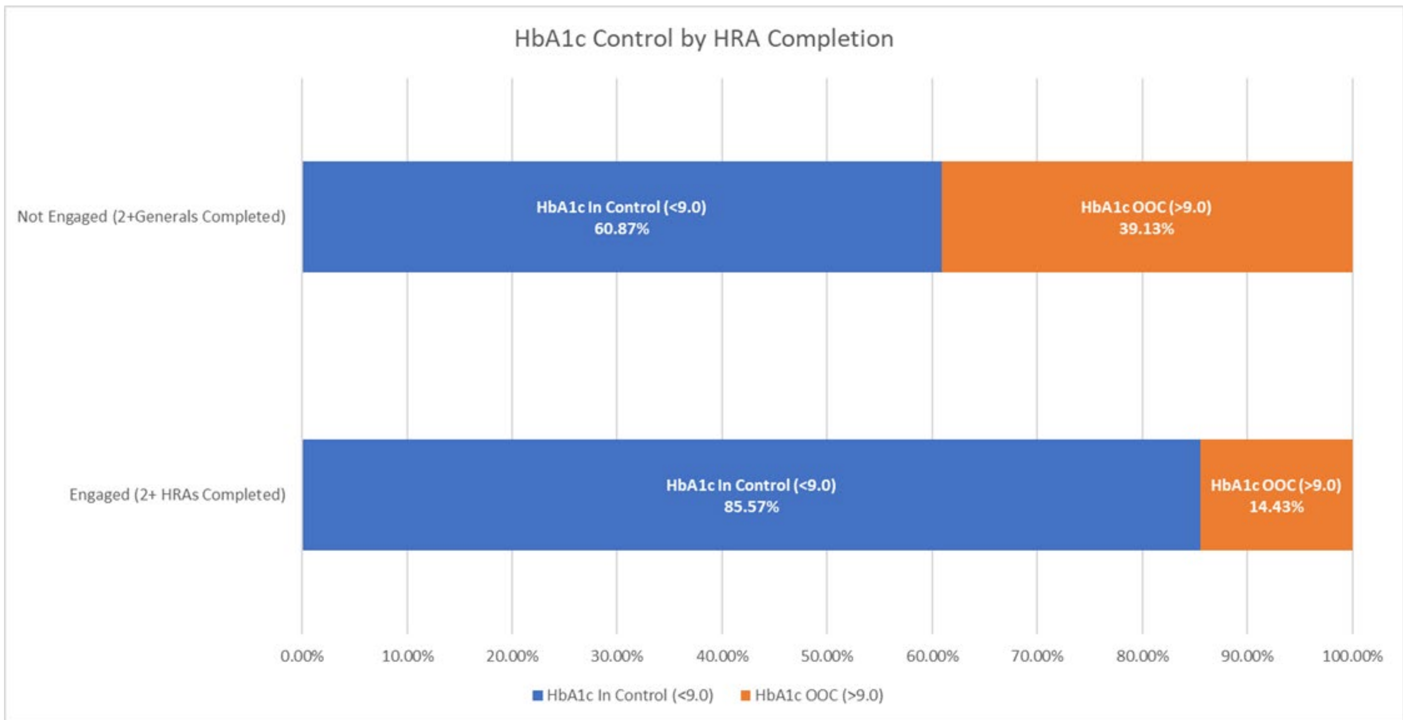

Figure 18 - HbA1c Control for DSNP Members by HRA Engagement - CY 2022

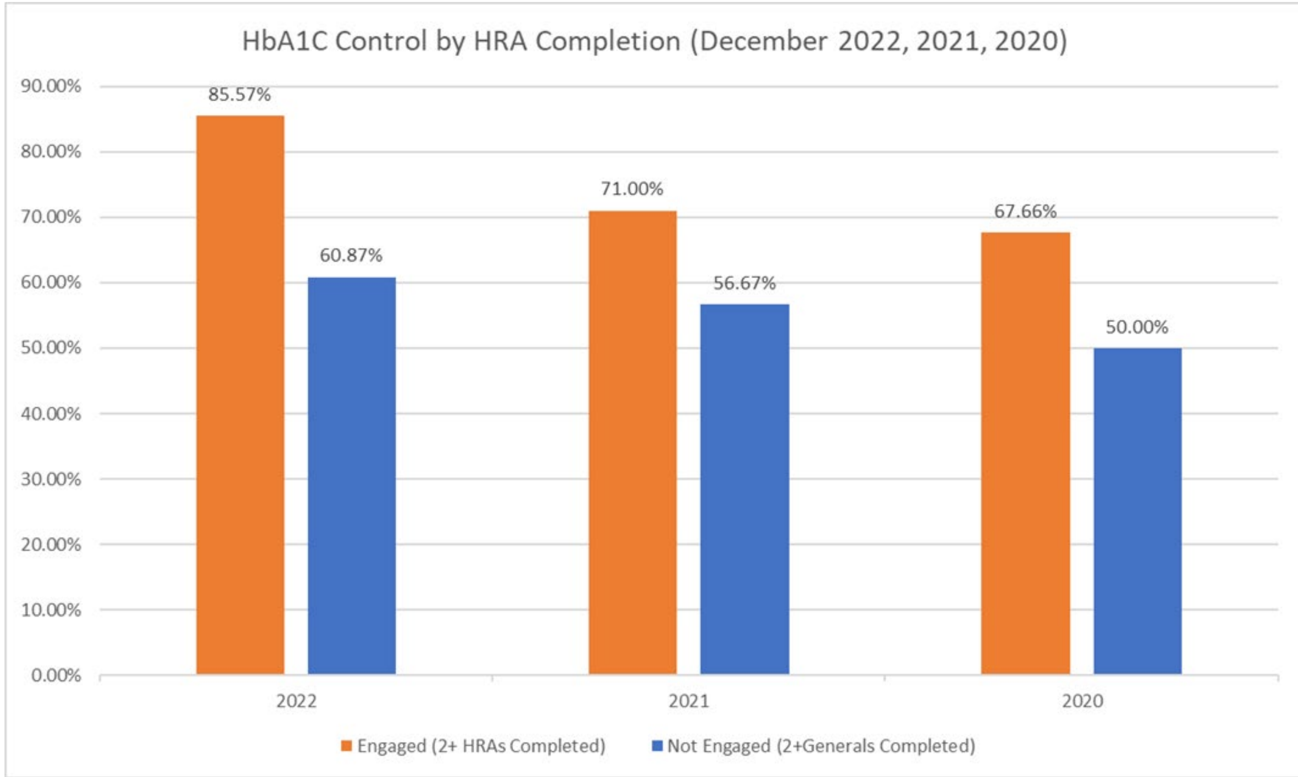

Figure 19 - HbA1c Control for DSNP Members by HRA Completion - YOY Comparison 2020-2022

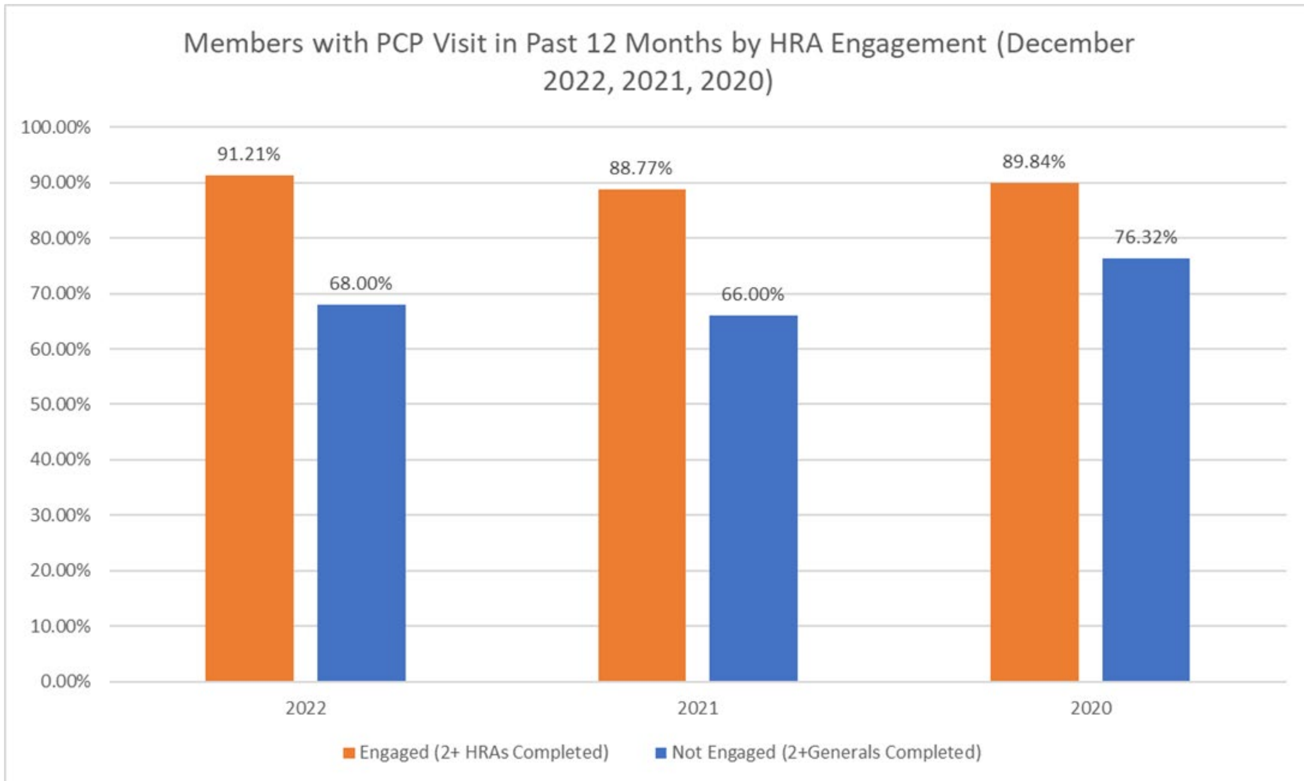

Figure 20 - PCP Engagement for DSNP Members by HRA Completion - YOY Comparison 2020-2022

Results/Analysis:

- From January to June 2023, a total of 3,295 distinct members were actively enrolled in the DSNP CM Program, with 2,777 members enrolled as of June 2023.
    - A total of 2,2241 HRAs were completed with 1,562 HRAs (70.23%) completed by the member
        - 569 members (25.58%) outreached for an initial or annual HRA were unable to be reached
        - 93 members (4.18%) outreached for an initial or annual HRA declined
- In 2022, a total of 2,414 DSNP members were actively engaged in the DSNP CM Program
    - 1548 Total Health Risk Assessments were completed in 2022
    - The DSNP program had 100% care plan compliance in 2022
    - The HRA completion rate for 2022 was 70.52%, a decrease from 2021
        - 26.24% of members outreached for an initial or annual HRA were unable to be reached
        - 3.24% of members outreached for an initial or annual HRA declined
- In CY 2022, members who were engaged in the HRA process (have participated in 2 or more HRAs) had fewer gaps in care than members who were not engaged in the HRA process (member has 2 or more general HRAs)
    - In 2022, members engaged in the HRA process and fell into the gaps in care denominator had an average of 0.68 gaps in care versus 0.99 gaps in care for non-engaged members
        - Gaps in care have decreased year over year for members engaged in the HRA process
    - Members engaged in the HRA process were more likely to have a blood pressure reading in control (66.67%) than those who were not engaged in the HRA process (60.00%)
    - Diabetic members engaged in the HRA process were more likely to have an HbA1c reading that is in control (<9.0, 85.57%) than members who were not engaged in the HRA process (60.87%)
- In CY 2022, members engaged in the HRA process were more likely to have at least one PCP visit within the past 12 months (91.21%) than members not engaged in the HRA process (68.00%)

Barriers/Lessons Learned:

- Engagement via telephonic outreach failed to reach 25.58% of members from January – June 2023, which is a slight reduction from 2022 rates (engagement via telephonic outreach failed to reach 26.24% of our members in 2022)
    - 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, which would increase opportunities to support members with accessing specialty care
- In 2023, DHMP implemented a HRA incentive to improve member engagement in CM services as well as the introduction of HRA reminder post cards that include:
    - Information on and importance of completing the initial HRA
    - A 90-day reminder that a member's annual HRA is due
    - All postcards will promote the new HRA incentive

Special Health Care Needs Care Management Program

This program aims to meet the complex needs of members with special health care needs. Services provided for members

with special health care needs were previously provided under the Complex Care Medicaid Program. The program is designed to ensure members that have Special Health Care Needs have access to care, including PCP, specialty, and community resources. The Centers for Medicare and Medicaid (CMS) define SHCN as having a biological, physiologic, or cognitive basis, significant limitation in areas of physical, cognitive, or emotional function, dependency on medical or assistive devices to minimize limitation of function or activities. In addition, for children, significant limitation in social growth or developmental function, need for psychological, educational, medical, or related services over and above the usual for the child's age, or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school. The program includes assessments, the development of individual treatment plan, follow-up, accommodate specific cultural and linguistic needs, and input from the member/family and from the member's multidisciplinary team in the development of the treatment plan.

Services are focused on meeting the complex needs of members with SHCN, including benefit coordination and access to services to include child checks, LTSS, and PDN services. Members are identified for outreach through a variety of sources, including MCD reporting, state reporting, provider referrals, and UM referrals.

SFY 22-23 Special Health Care Needs 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. Note that this program is new in 2022 and outcome data is not readily available.

Special Health Care Needs Population Overview:

Figure 21 - Population Overview - Members with Special Health Care Needs - June 2023

Special Health Care Needs Care Management Activity Metrics:

Activity Name	Number of Activites Performed
SHCN Applications/Membership Assistance	40
SHCN Assessment	38
SHCN Benefit Resource Coordination	819
SHCN Care Plan Update	409
SHCN Condition Management	124
SHCN Dental Care Coordination	16
SHCN Education Provided	524
SHCN Engagement / Enrollment	167
SHCN EPSDT Provider Coordination	5
SHCN Food Security Coordination	38
SHCN Health Acuity / Needs Assessed	18
SHCN Health Care Provider Coordination	438
SHCN Housing Resource Coordination	56
SHCN Immunization Coordination	3
SHCN Language Services	493
SHCN LTSS Coordination	28
SHCN Medication Management	66
SHCN Member Outreach	1521
SHCN Nutritional Support	2
SHCN Other Community Resource Coordination	694
SHCN Other Follow-up	124
SHCN Peer Support/Groups	2
SHCN Provider Follow-up	548
SHCN Referral	104
SHCN SNAP Coordination	79
SHCN Transportation Coordination	117
SHCN Utilities Coordination	8
SHCN Well Child Coordination	9
Grand Total	**6490**

Figure 22 - Special Health Care Needs Activities Performed SFY 2022-2023

Special Health Care Needs Care Management Program Metrics:

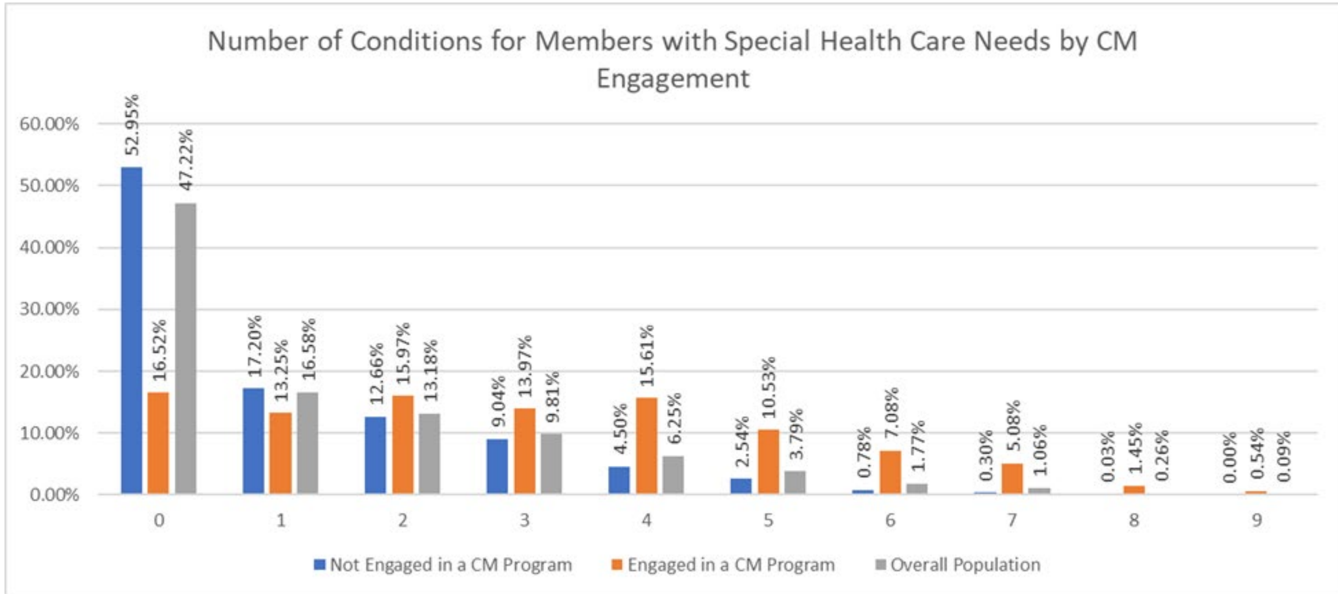

Figure 23 - Number of Conditions for Members with SHCN by CM Engagement - June 2023

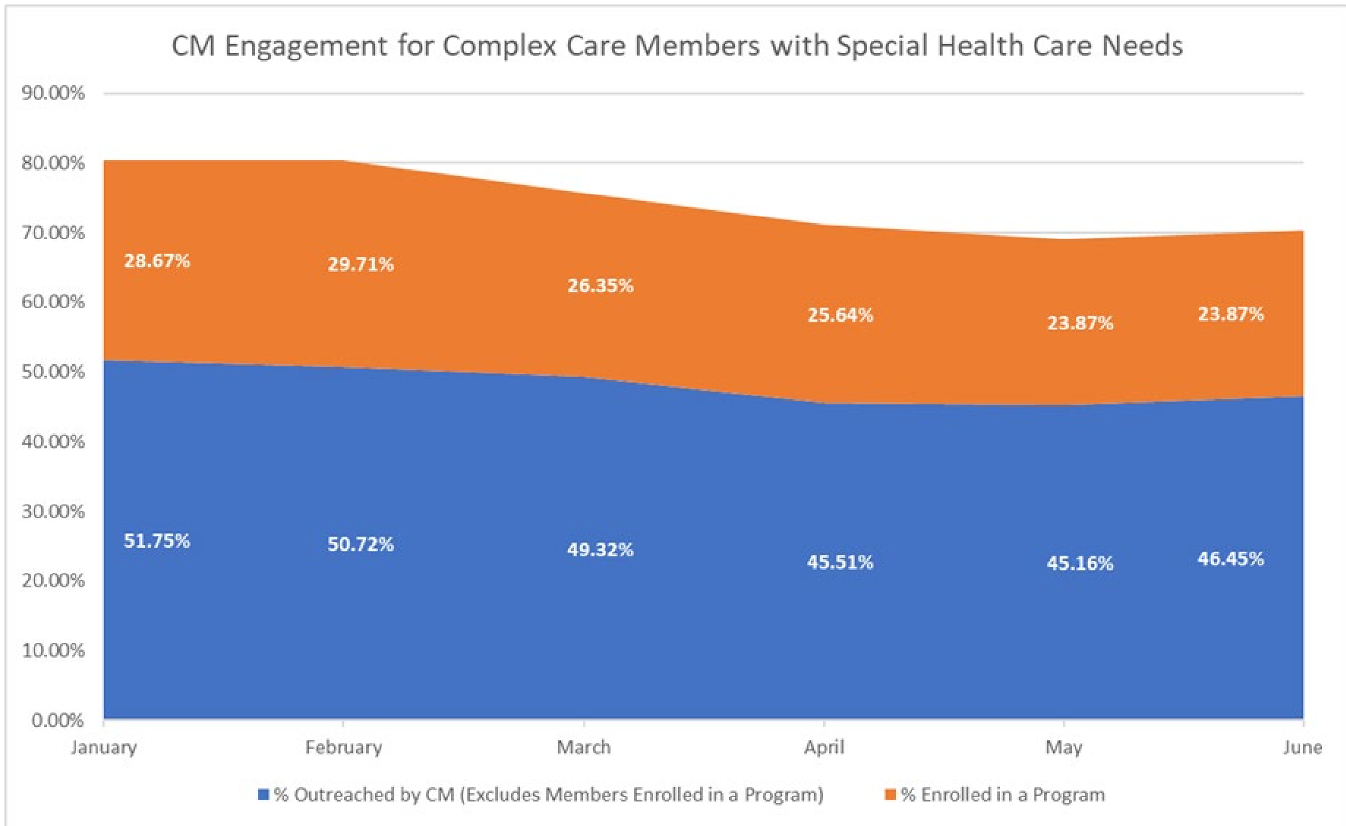

Figure 24 - Outreach and Engagement in Extended Care Coordination for Members with SHCN and Complex Care Needs January - June 2023

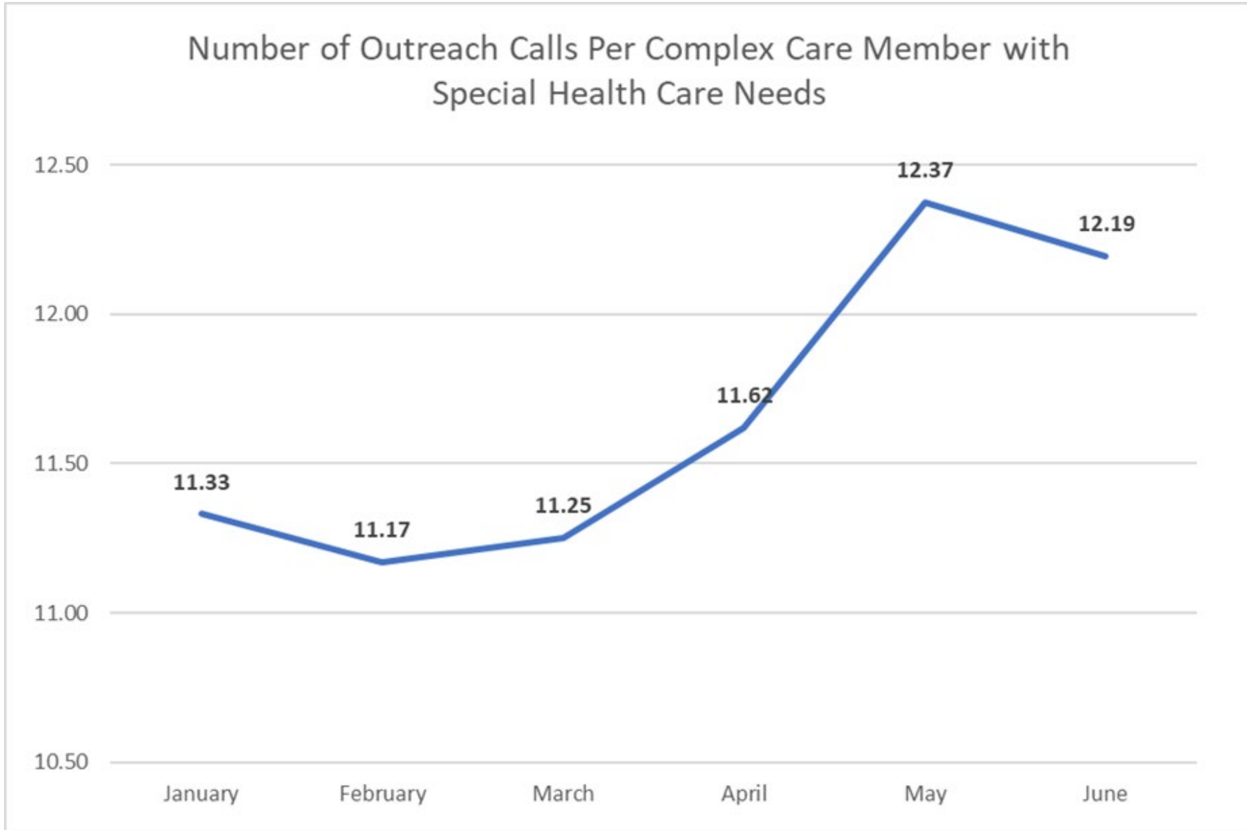

Figure 25 - Number of Outreach Calls Per Member - Members with SHCN and Complex Care Needs January - June 2023

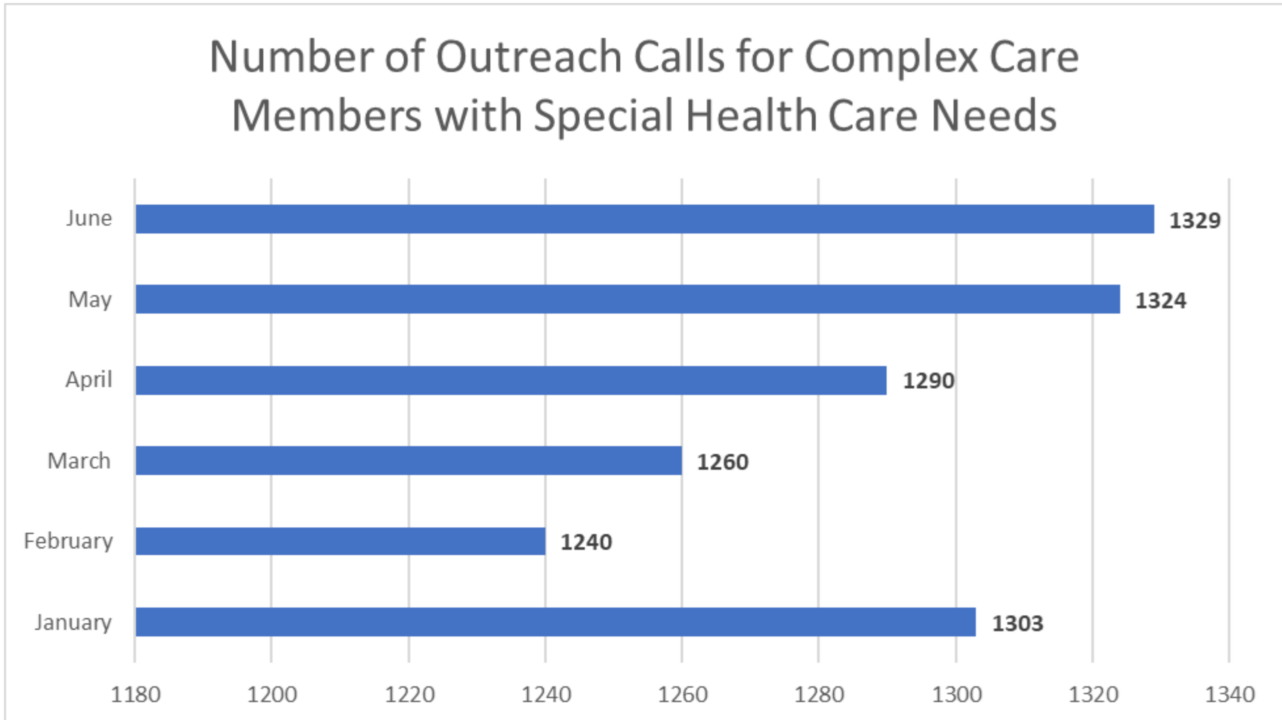

Figure 26 - Total Number of Outreaches for Members with SHCN and Complex Care Needs - January - June 2023

Special Health Care Needs Care Management Outcome Metrics:

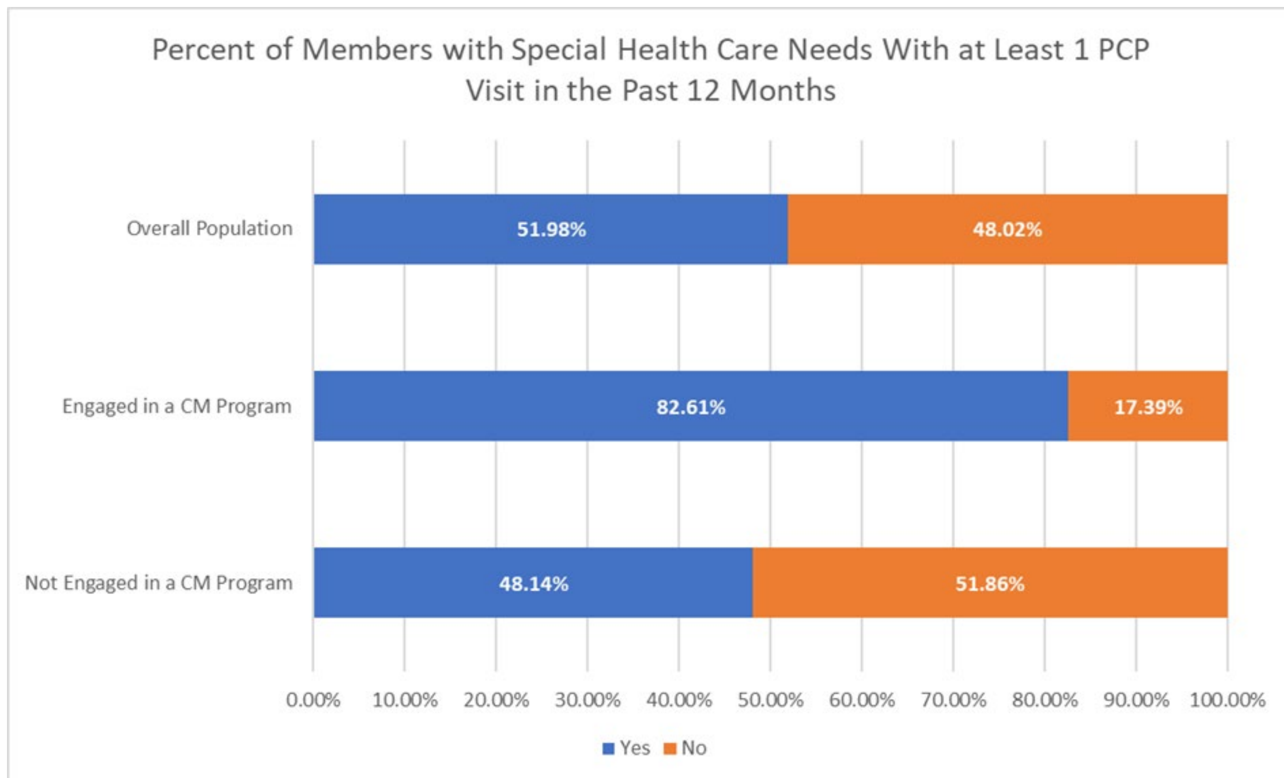

Figure 27 - Percent of Members with Special Health Care Needs with at Least 1 PCP Visit in the Past 12 Months - June 2023

Results/Analysis:

- Of the 3505 members identified with Special Health Care Needs as of June 2023, 350 distinct members (9.99%) have engaged in Care Management services within the past year and 551 distinct members (15.72%) have been outreached by Care Management in the past 12 months
  - 131 distinct members were served under the Special Health Care Needs Program, with 6,490 activities performed across those members
  - 65 distinct members enrolled in the Special Health Care Needs Program in SFY 2022-2023
- CM outreach is focused on our highest needs members; as such, most of the SHCN members engaged in our services have multiple conditions that need to be managed
  - Members with SHCN who are engaged in a CM program have an average of 3.28 conditions, whereas members with SHCN who are not engaged in a program have an average of 1.05 conditions
- Engagement with a PCP is higher for members with SHCN who are engaged in CM services than those members who are not engaged in CM services
  - 82.61% of members with SHCN who were engaged in a CM program had at least 1 PCP visit within the past 12 months, compared to 48.14% of members who are not engaged in Care Management
- An average of 74.51% of members with SHCN who also Complex Care needs have been either engaged in a program or have been outreached by CM from January-June 2023
  - An average 48.15% of members who are not engaged in a program were outreached by CM in the past 6

months
        - An average 26.35% of members with SHCN and Complex Care Needs were engaged in a program in the past 6 months
- The number of outreaches per member is increasing since February, with 12.19 average outreach attempts per member enrolled or outreached by
    - 11.66 outreaches per member average January – June 2023

Barriers/Lessons Learned:
- Outcome data for major programmatic goals such as linking members to testing services is not readily available
    - The CM team is requesting updates to the condition management dashboard which would allow the team to look at engagement with Care Management and Primary care for this population
    - There is a potential opportunity to develop a SHCN dashboard in the future to capture claims data related to testing services and other outcomes
    - There is an opportunity for the DHMP Care Management team to partner with Square ML to better identify the needs, opportunities, and outcomes for this population

Medicaid/CHP+ Care Management Program

This program is intended to manage Medicaid and CHP+ members with multiple risk factors including chronic diseases, behavioral health conditions and over and under-utilization patterns that increase risk of poor outcomes. Members are referred to this program through multiple methods, including provider referrals, internal referrals, and through identification of high-risk members using the risk stratification tool. The program will create individualized care plans but will also target specific gaps such as frequent ED utilization or no PCP visit in the last 12 months, with targeted population campaigns.

SPH Analytics is a third-party vendor that initiates the HNA outreach for all Medicaid and CHP+ new enrollments. All completed HNAs are reviewed by care coordinators for analysis and stratification of health care needs and outreach.

This program aims to improve member health and reducing health care costs by improving member adherence to treatment recommendations, improving communication and coordination among health care providers, and increasing access to support services and addressing social determinants of health (SDOH).

In 2022, DHMP developed a KPI of tracking the percentage of MCD/CHP+ members who are engaged in CC services who have had at least 1 PCP visit in the past year as an outcome measure for the program with a goal of 97.54% of members who are engaged in CC services in the current month having at least 1 PCP visit in the past 12 months. Additionally, DHMP began tracking the percentage of MCD/CHP+ Members engaged in CC services in the last 12 months with a goal of 2.50% of total membership.

SFY 22-23 Medicaid/CHP+ 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.

MCD/CHP+ Care Management Activity Metrics:

Activity Name	Number of Activities Completed	Distinct Members Served
CC Applications/Membership Assistance	9	5
CC Benefit Resource Coordination	141	36
CC Care Plan Update	18	6
CC Condition Management	92	24
CC Dental Care Coordination	14	4
CC Education Provided	202	68
CC Engagement / Enrollment	93	24
CC EPSDT Member Coordination	25	20
CC EPSDT Provider Coordination	3	2
CC Food Security Coordination	104	65
CC Health Acuity / Needs Assessed	1808	1287
CC Health Care Provider Coordination	1495	366
CC Housing Resource Coordination	170	109
CC Internal Activity	919	395
CC Language Services	309	68
CC LTSS Coordination	97	12
CC Medication Management	583	60
CC Member Outreach	5562	1350
CC Nutrition Support	13	5
CC Other Community Resource Coordination	217	78
CC Other Follow-up	112	44
CC Provider Follow-up	339	56
CC Referral	275	77
CC Safety_DV Coordination	2	1
CC SNAP Coordination	81	51
CC Tobacco Cessation Coordination	10	5
CC Transportation Coordination	303	89
CC Utilities Coordination	9	4
CC WIC Coordination	10	6
Grand Total	**13015**	**2284**

Figure 28 - Care Coordination Activities SFY 2022-2023

MCD/CHP+ Care Management Program Metrics:

Health Needs Survey Completion Rate	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Total
SPH Medicaid Choice Health Needs Survey	250	90	142	62	147	148	49	91	68	56	53	77	1,233
Medicaid State Survey	28	61	50	35	28	46	29	48	52	89	79	80	625
MCD HNA Outreach (Performed by SPH) Mailings	1,675	994	1,505	507	1,390	1,281	888	1,301	970	718	972	1,318	13,519
MCD HNA Outreach (Performed by SPH) Calls	1,674	934	1,420	380	1,281	1,206	807	1,206	869	645	870	1,242	12,534
Total Completed Surveys	290	155	198	109	176	207	83	150	126	155	132	157	1,938

Figure 29 - MCD/CHP+ Health Needs Survey Data CY 2022

Health Needs Survey Completion Rate	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
SPH Medicaid Choice Health Needs Survey	56	42	50	45	48	183	87						511
SPH CHP+ Health Needs Survey	12	5	5	11	8	16	16						73
Medicaid State Survey	99	93	92	83	102	108	79						656
MCD HNA Outreach (Performed by SPH) Mailings	624	666	896	938	880	3,351	1,669						9,024
MCD HNA Outreach (Performed by SPH) Calls	578	635	816	863	714	3,177	1,546						8,329
MCD Roster to SPH Missing Phone Numbers	39	26	69	74	162	123	103						596
CHP HNA Outreach (Performed by SPH) Mailings	109	93	177	153	103	223	315						1,173
CHP HNA Outreach (Performed by SPH) Calls	96	78	142	109	67	204	294						990
CHP Roster to SPH Missing Phone Numbers	6	14	34	43	35	14	14						160
Total Completed Surveys	167	140	147	139	158	307	182	0	0	0	0	0	1,240

Figure 30 - MCD/CHP+ Health Needs Survey Data - July 2023

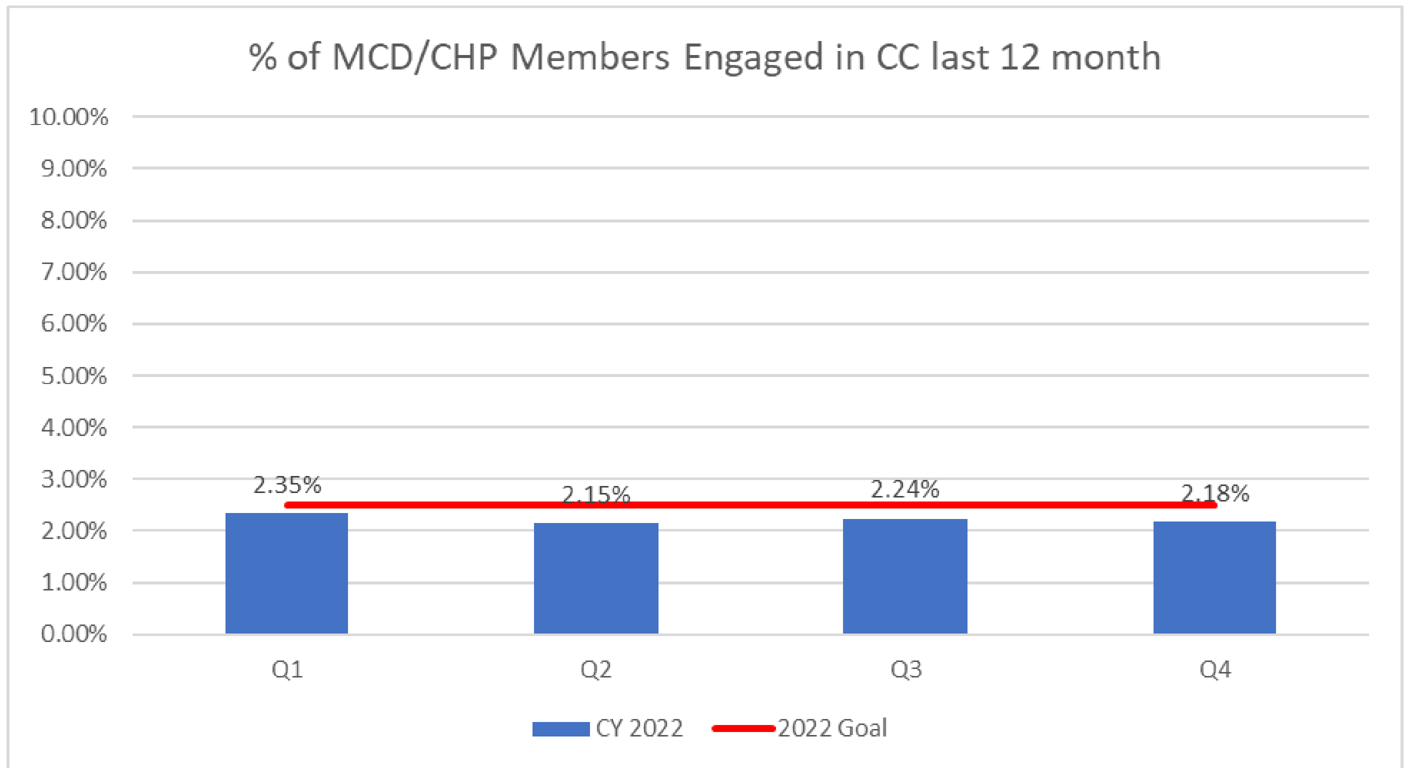

Figure 31 - Percent of All MCD/CHP+ Members Engaged in Care Coordination Services (CY 2022)

MCD/CHP+ Care Management Outcome Metrics:

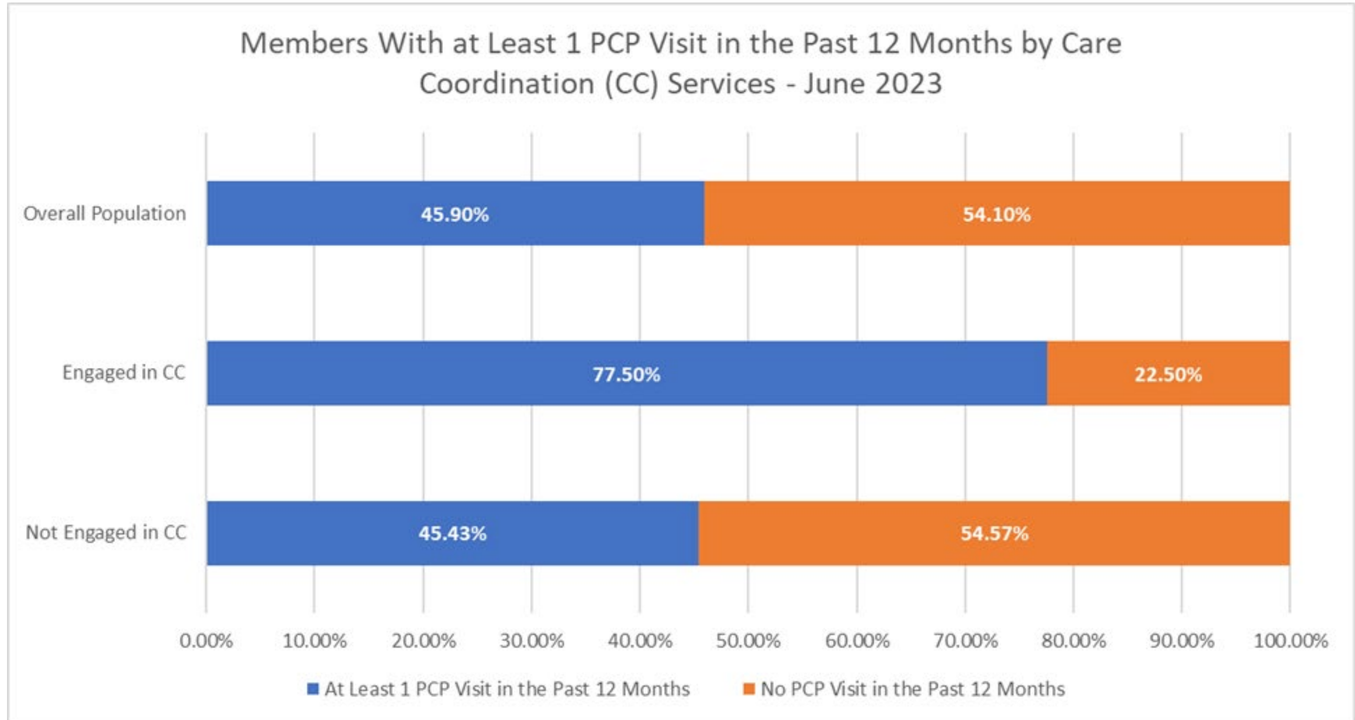

Figure 32 - Members With at Least 1 PCP Visit in the Past 12 Months by Engagement in Care Coordination Services - June 2023

Results/Analysis:

- As of June 2023, 2.17% of MCD and CHP+ member had received Care Coordination services in the past 12 months; however, 6.47% of all MCD and CHP+ members were outreached across all Care Management services in SFY 2022-2023
  - At the end of CY 2022, 2.18% of the total MCD/CHP+ population were engaged in Care Coordination Services
- Of those members engaged in Care Coordination Services, 77.50% had at least 1 PCP appointment in the past 12 months; while 78.42% of MCD/CHP+ members engaged in any Care Management service had at least 1 PCP visit in the past 12 months
  - Comparatively, only 45.43% of members not engaged in care coordination services had a visit to the PCP in the past 12 months
  - This is still a decrease from SFY 2021-2022, when 96.6% of members had at least 1 PCP visit in the past 12 months
    - It is not clear why PCP engagement rates decreased from SFY 2021-2022; however, the Care Coordination team conducted outreach to members who have been non-engaged in care, difficult to contact, and/or incarcerated, which may have influenced this metric
- A total of 1851 Health Needs Assessments (HNA) were completed in SFY 2022-2023
  - 1938 HNAs were completed in CY 2022, including 803 HNAs completed from July 2022-December 2022
  - 1058 surveys were completed from January-June 2023

Barriers/Lessons Learned:

- Member engagement in primary care continues to be a focus of this program, and there is an opportunity to

continue turning around the trend of decreasing PCP visits

- DHMP continues to focus on supporting members with PCP engagement and access to care
- There is an ongoing focus on the availability, safety, and importance of timely screening and use of telemedicine and home screening methods when appropriate

Transitions of Care

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.

Typically, transitions of care fall into two broad categories (planned and unplanned) and may occur between different care sites (hospital, home, skilled-nursing facilities, non-DH Providers). DHMP has a Transitions of Care (TOC) program that is focused on 30-day readmission avoidance. DHMP uses the LACE assessment tool to identify Members at risk for readmission or death within thirty days of discharge. 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

DHMP TOC staff identifies and coordinates transitions of care for patients to reduce readmissions, improve quality of care and improve patient and family satisfaction.

The Transitions of Care team has 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 among internal and external stakeholders to promote safe and effective discharge planning for complex needs members.

Members are tracked from inpatient notification through the referral process. Once a member is discharged to a home setting, members are referred to a Care Manager for outreach. The current process tracks members through to the conclusion of the referral, indicating whether the member met program criteria or opted to enroll in the program. In CY 2023, DHMP started the process of evaluating CORHIO data for development of an ADT live data feed.

SFY 2022-2023 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:

DENVER HEALTH MEDICAL PLAN INC. — 2022 TOC Dashboard

TOC	Jan-22	Feb-22	Mar-22	CY22 Q1	Apr-22	May-22	Jun-22	CY22 Q2	Jul-22	Aug-22	Sep-22	CY22 Q3	Oct-22	Nov-22	Dec-22	CY22 Q4	2022 Total/Avg	2022 GOAL	STRETCH GOAL
% of TOC Referred Members Enrolled in the Program	37.55%	57.14%	32.26%	39.54%	23.99%	29.95%	31.22%	27.78%	27.31%	31.33%	35.67%	31.10%	20.12%	27.60%	23.04%	22.88%	29.28%	25%	35%
% of Members enrolled who have MCD	78.65%	82.35%	78.00%	79.47%	80.28%	76.92%	74.58%	77.43%	86.44%	86.54%	81.97%	84.98%	85.51%	86.79%	90.57%	87.62%	81.99%	N/A	N/A
% of TOC Enrolled Members with Completed Outcome (Quarterly Measure)	N/A	N/A	N/A	76.44%	N/A	N/A	N/A	83.08%	N/A	N/A	N/A	72.67%	N/A	N/A	N/A			60%	70%
% of TOC Referrals with UTR Program Outcome (Reverse Measure)	58.23%	41.76%	43.23%	50.30%	46.28%	40.09%	53.97%	46.43%	47.69%	43.98%	54.39%	48.69%	69.10%	50.00%	60.43%	59.84%	52.34%	45%	35%
% of TOC Referred Members Readmitted (Reverse Measure)	0.72%	2.20%	0.65%	0.96%	0.34%	1.84%	1.65%	1.15%	1.85%	3.01%	1.17%	2.01%	4.66%	2.08%	0.87%	2.54%	1.74%	2%	1%
% of TOC Members Who Received Appointment Assistance at least once	9.45%	6.90%	7.77%	8.28%	4.06%	7.01%	6.45%	5.72%	4.81%	11.26%	16.93%	11.00%	16.07%	11.56%	12.06%	13.23%	9.64%	8%	10%
% of TOC Members who Received wrap around services	9.83%	9.20%	8.41%	9.25%	4.06%	13.48%	15.48%	10.45%	16.15%	18.09%	20.13%	18.12%	16.49%	14.97%	14.75%	15.40%	13.11%	10%	15%
% QI3 Members Enrolled	33.33%	66.67%	50.00%	50.00%	0.00%	50.00%	50.00%	44.44%	33.33%	100.00%	0.00%	66.67%	N/A	N/A	N/A	N/A	45.37%	30%	40%
% QI4 Members Enrolled	N/A	100.00%	100.00%	100.00%	N/A	N/A	50.00%	50.00%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80.00%	30%	40%
# of TOC Referrals	237	91	155	483	296	217	189	702	216	166	171	553	343	192	230	765	2503	N/A	N/A
# of Unique Members Engaged	487	348	309	1144	419	371	310	1100	291	293	313	897	473	294	372	1139	4280	N/A	N/A
# of Members Enrolled	89	51	50	190	71	65	59	195	59	52	61	172	69	53	53	175	733	N/A	N/A

Figure 33 - Transitions of Care Dashboard CY 2022

DENVER HEALTH MEDICAL PLAN INC. — 2023 TOC Dashboard

TOC - ALL LOB	Jan-23	Feb-23	Mar-23	CY22 Q1	Apr-23	May-23	Jun-23	CY22 Q2	Jul-23	Aug-23	Sep-23	CY22 Q3	Oct-23	Nov-23	Dec-23	CY22 Q4	2023 GOAL	STRETCH GOAL
% Of TOC Referred Members Enrolled in the Program	36.45%	36.19%	34.60%	35.75%	39.71%	42.94%	38.30%	40.32%									30%	35%
% of Members enrolled who have MCD	96.33%	86.36%	96.70%	93.13%	95.37%	95.00%	99.21%	96.53%									N/A	N/A
% of TOC Enrolled Members with a Completed Outcome (Quarterly)	N/A	N/A	N/A	74.06%	N/A	N/A	N/A	75%	N/A	N/A	N/A		N/A	N/A	N/A		70%	80%
% of TOC Members Who Received Appointment Assistance at least once	19.61%	15.47%	18.51%	17.86%	11.62%	15.27%	20.64%	15.84%									10%	15%
% of TOC Members who Received Wrap Around Services	13.92%	21.47%	13.52%	16.30%	15.13%	14.45%	17.07%	15.55%									15%	20%
# of Unique TOC Member Referrals	299	257	263	819	272	326	329	927									N/A	N/A
# of Unique Members Engaged	510	517	562	1589	542	609	533	1684									N/A	N/A
# of Unique Members Enrolled	105	87	91	283	108	140	126	374									N/A	N/A

Figure 34 - Transitions of Care Dashboard January - June 2023

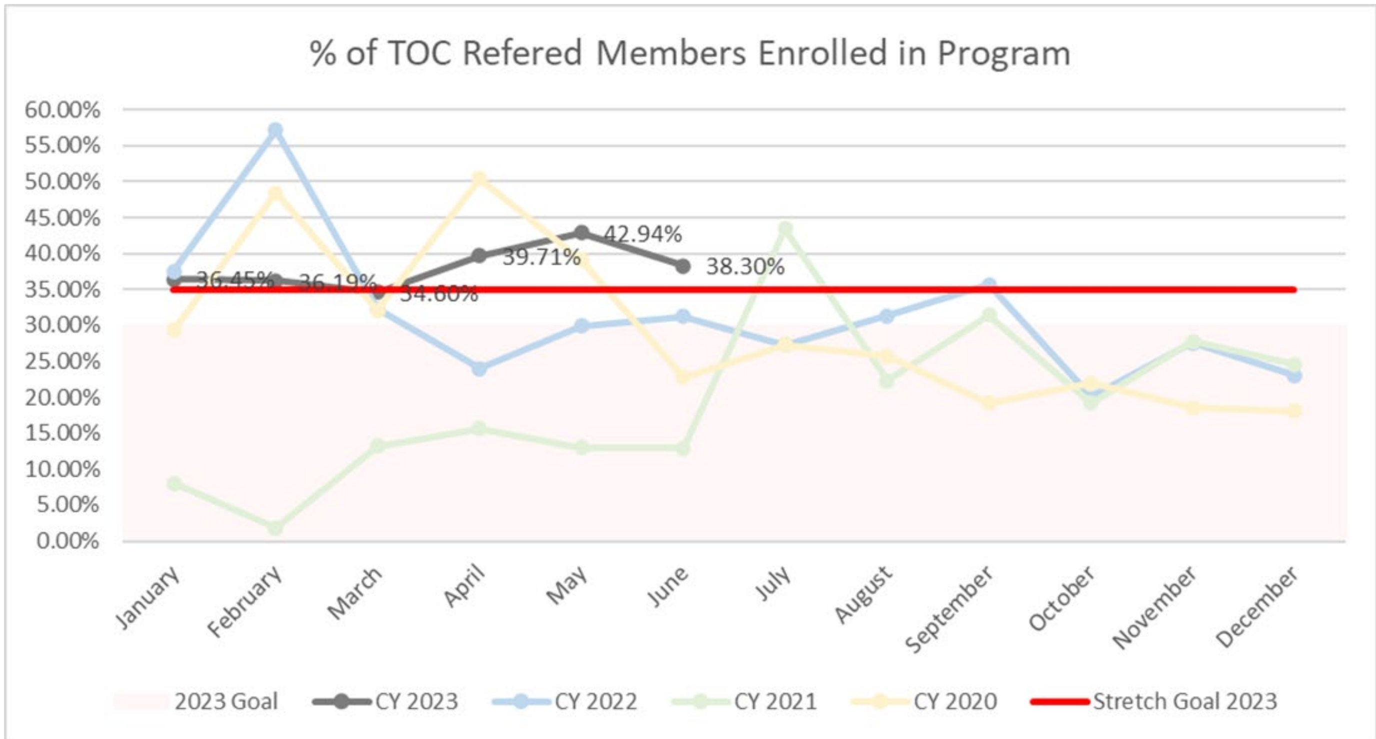

Figure 35 - Percent of Members Enrolled in Transitions of Care Following a Program Referral Q1 2020 – Q2 2023

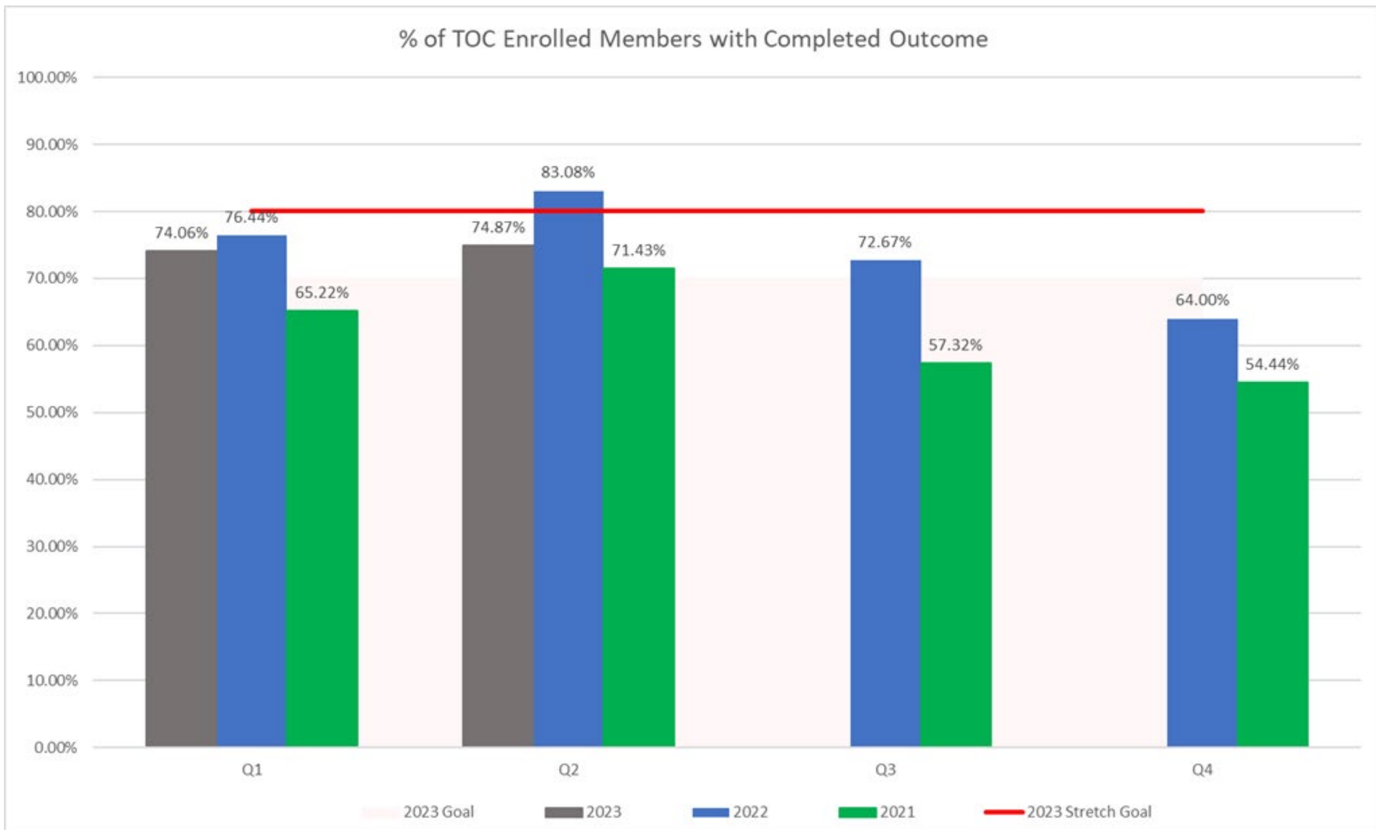

Figure 36 - Percent of Members who Successfully Completed the Transitions of Care Program Q1 2021 - Q2 2023

Results/Analysis:

- In SFY 2022-2023, the Transitions team received 3064 for on-going care transitions management, an increase over 2022 referral rates (2541 distinct member referrals)
  - Of the 3064 referrals, 1014 718 members (33.09%) enrolled in the TOC program, which is an improvement over 2022 (718 members, 28.26%)
    - As of Q4 SFY 22-23, 734 members had successfully completed the program, a total of 72.39% of enrolled members
      - This is an improvement over SFY 2022-2023 (63.48% of enrolled members completed program)
  - The most common reason for not enrolling was an inability for the TOC team to reach the member telephonically
- 5309 distinct members were outreached and/or engaged in SFY 2022-2023, an increase over the previous assessment period (SFY 2021-2022, 4573 distinct members outreached/engaged)

Barriers/Lessons Learned:

- Calculation of readmission rates for the program is currently not possible; the CM team is working with the DHMP IS team to adjust the DHMP Over/Under Utilization report which will allow the CM team to evaluate readmission rates for members enrolled in the program and to assess program efficacy
- While changes to the inpatient tracking process have led to earlier outreach and higher engagement rates, there are still some challenges with timely identification of members while IP
  - DHMP is working with CORHIO and outside vendors to develop an ADT feed based on CORHIO data
  - Timely notification is essential for program efficacy
- Engagement via telephonic outreach continues to be a large barrier for the team
  - 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 DHMP CM team is currently reviewing options for upgrades to the Guiding Care platform which would allow CMs to engage with members via text message, email, and/or through an app
- 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

Controlling Blood Pressure Program

The controlling blood pressure program is offered to DHMP 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 Dual Eligible Special Needs 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.

SFY 2022-2023 Controlling Blood Pressure 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.

Population Overview:

Figure 37 - Members with Hypertension Indicator - June 2023

Controlling Blood Pressure Activity Data:

Activity Name	**Number of Activites Performed**
Authorized BP Cuff	774
CBP Applications/Membership Assistance	6
CBP Benefit Resource Coordination	180
CBP Care Plan Update	31
CBP Condition Management	1720
CBP Education Provided	142
CBP Engagement / Enrollment	1143
CBP Food Security Coordination	8
CBP Health Acuity / Needs Assessed	2673
CBP Health Care Provider Coordination	190
CBP Housing Resource Coordination	12
CBP Language Services	187
CBP Medication Management	44
CBP Member Outreach	1732
CBP Other Community Resource Coordination	12
CBP Provider Follow-up	32
CBP Tobacco Cessation Coordination	6
CBP Transportation Coordination	19
Does not meet criteria for BP Cuff	53
Member has their own BP Monitor	208
Grand Total	**9172**

Figure 38 - Controlling Blood Pressure Program Activities SFY 2022-2023

Controlling Blood Pressure Program Outcome Data:

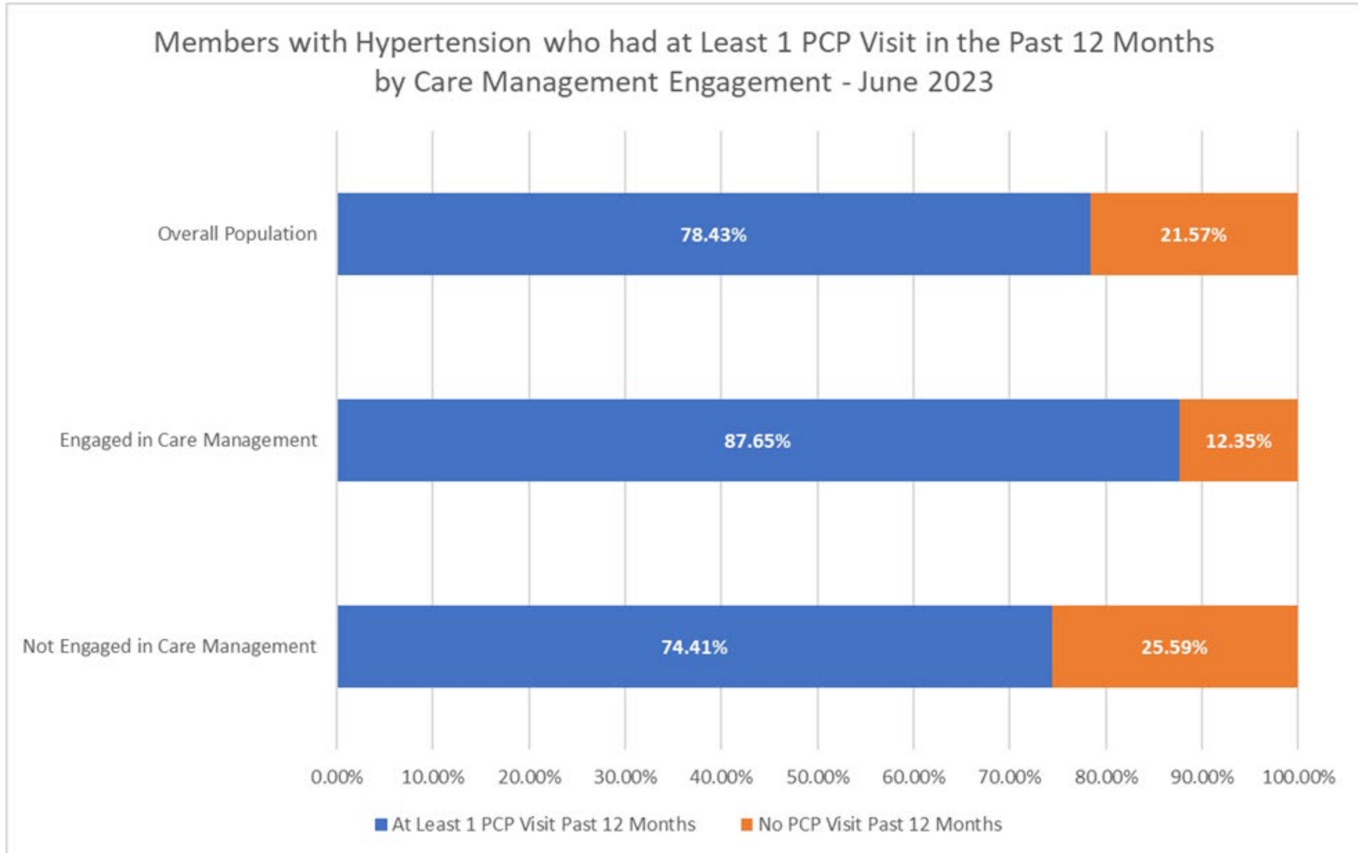

Figure 39 - Members with Hypertension who had at Least 1 PCP Visit in the Past 12 Months by CM Engagement - June 2023

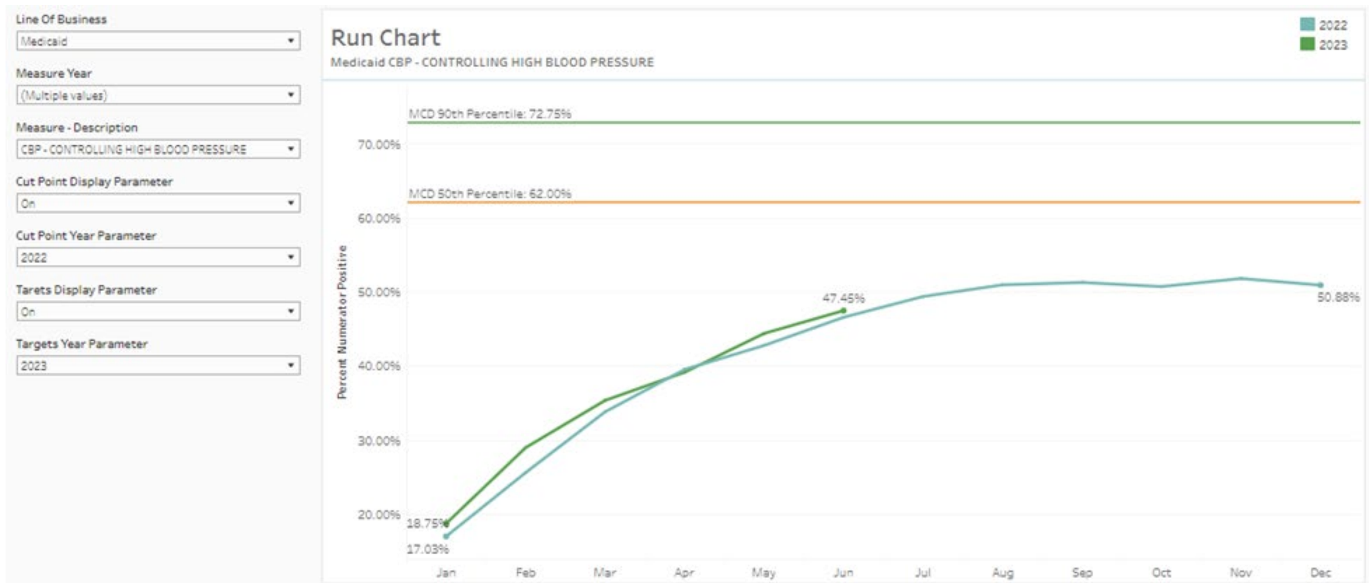

Figure 40 – Blood Pressure Control for Medicaid Members with Hypertension January 2022 – June 2023

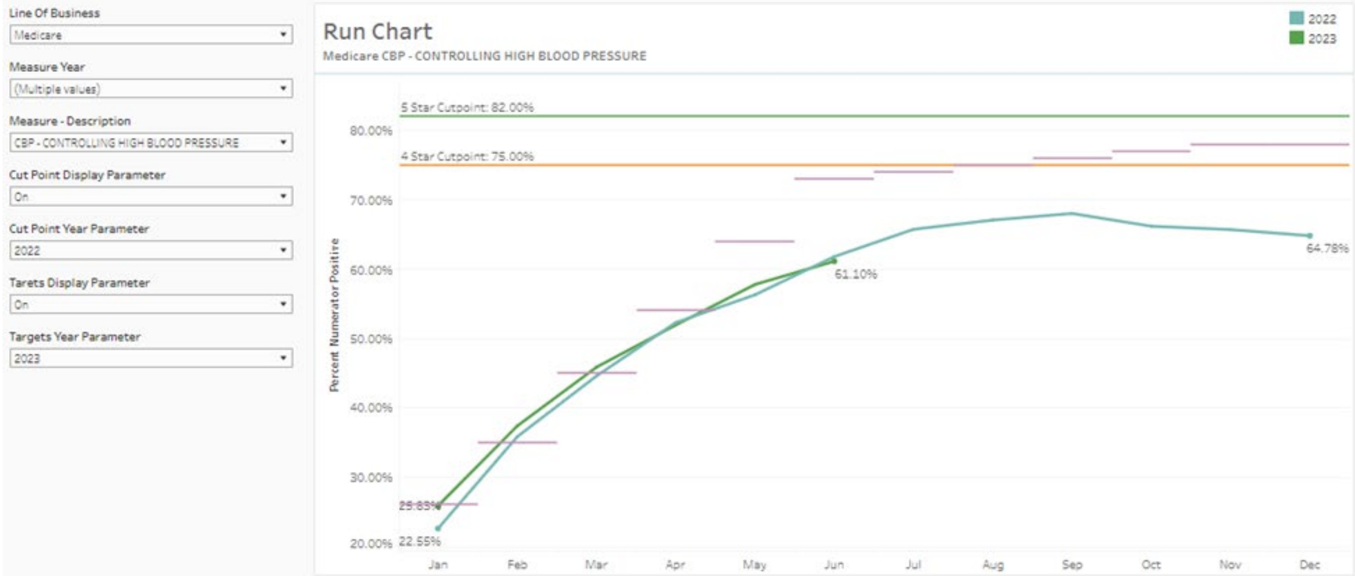

Figure 41 - Blood Pressure Control for Medicare Members with Hypertension January 2022 – June 2023 (Includes DSNP Members)

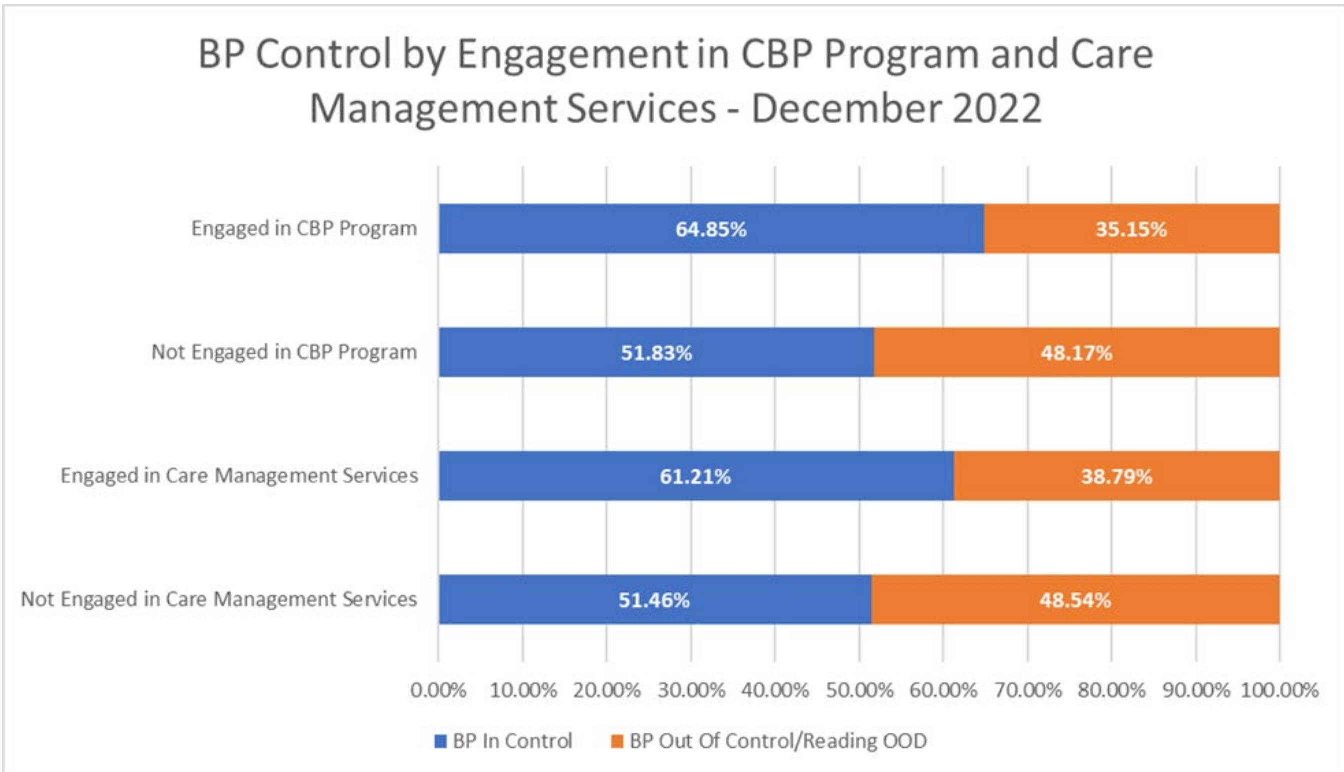

Figure 42 - Blood Pressure Control for Medicaid Members by CBP Program and CM Engagement - December 2022

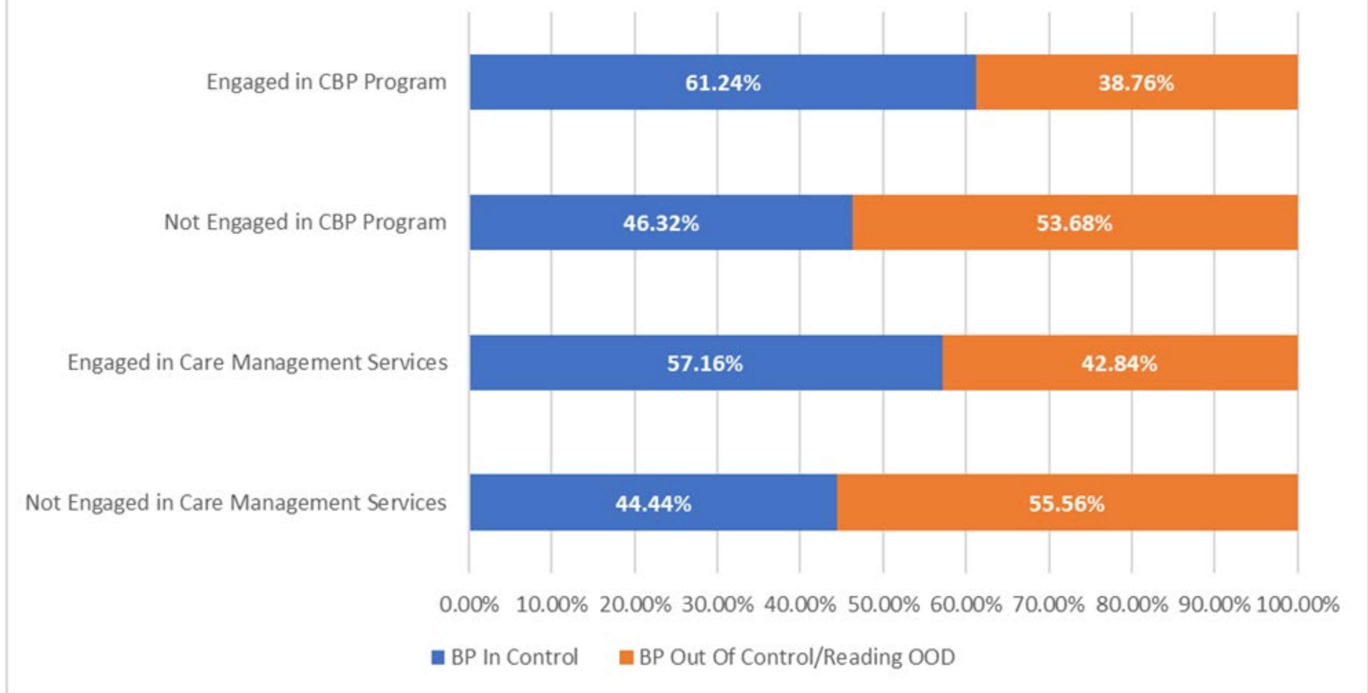

Figure 43 - Blood Pressure Control for Medicaid Members by CBP Program and CM Engagement - June 2023

Results/Analysis**:**

- A total of 2129 members were enrolled in the CBP program in SFY 2022-2023
  - 9172 distinct activities were completed in SFY 2022-2023
  - 165 distinct members were authorized for a blood pressure cuff in SFY 2022-2023
    - 40 members had their own monitor at home
    - 12 members did not meet criteria for the BP cuff
- As of June 2023, 3,335 distinct Medicaid, CHP+, and DSNP members with the hypertension indicator were outreached by Care Management (30.39%)
- 87.65% of members with hypertension who engaged in CM services in the past 12 months had at least 1 PCP visit in the past year, compared to 74.41% of members with hypertension who were not engaged in services
- As of December 2022, 64.85% of all members engaged in the CBP program and 61.21% of all members who were engaged in Care Management services had a blood pressure reading that was in control
  - Comparatively, 51.83% of members who were not engaged in the CBP program had a blood pressure reading in control, and 51.46% of members not engaged in CM services had a blood pressure reading in control
- As of June 2023, 64.85% of all members engaged in the CBP program and 61.21% of all members who were engaged in Care Management services had a blood pressure reading that was in control
- A total of 30.05% of all Medicaid Choice and Medicare Choice HMO SNP members who were in the denominator for the controlling blood pressure measure as of December 2022 were outreached by the Care

Management team (992 distinct members), with 919 distinct members engaged in the CBP program (20.00%)
  - As of June 2023, 1207, distinct Medicaid Choice and DSNP members who were in the denominator for the controlling blood pressure measure were outreached by the Care Management team (29.23%)

Barriers/Lessons Learned:

- Compliance with this measure often "dips" towards the end of the year, which is influenced by multiple factors including seasonal illnesses, visits to urgent care, holiday stress, and poor compliance with diet during the holidays.
  - The DHMP Care Management team will provide ongoing efforts to provide ongoing support and services to members with high blood pressure, including monthly chart reviews, supporting eligible members with obtaining a blood pressure cuff for home monitoring, and supporting members with follow up readings and visits after an out-of-control reading.
- There is room to improve engagement of members in the CBP denominator.
  - In SFY 2023-2024, the CM team will generate outreach lists which focus on numerator negative members in this measure

Diabetes Care Management Program

The Diabetes Care Management 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.

SFY 2022-2023 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.

Population Overview:

Figure 44 - Members with Diabetes Indicator - June 2023

Diabetes Management Activity Data:

Activity Name	Number of Activities Performed
DM Applications / Membership	54
DM Assessment	273
DM Benefit Resource Coordination	573
DM Care Plan Update	1173
DM Condition Management	998
DM Dental Care Coordination	28
DM Education Provided	928
DM Engagement / Enrollment	805
DM Food Security Coordination	79
DM Health Care Provider Coordination	2016
DM Housing Resource Coordination	286
DM ICT Meeting	41
DM Language Services	1001
DM LTSS Coordination	190
DM Medication Management	442
DM Member Outreach	7605
DM Nutritional Support	89
DM Other Community Resource Coordination	574
DM Other Follow-up	104
DM Peer Support / Groups	9
DM Provider Follow-up	1176
DM Referral	145
DM SNAP Coordination	67
DM Transportation Coordination	509
DM Utilities Coordination	19
Grand Total	**19184**

Figure 45 - Diabetes Management Program Activities SFY 2022-2023

Diabetes Management Outcome Data:

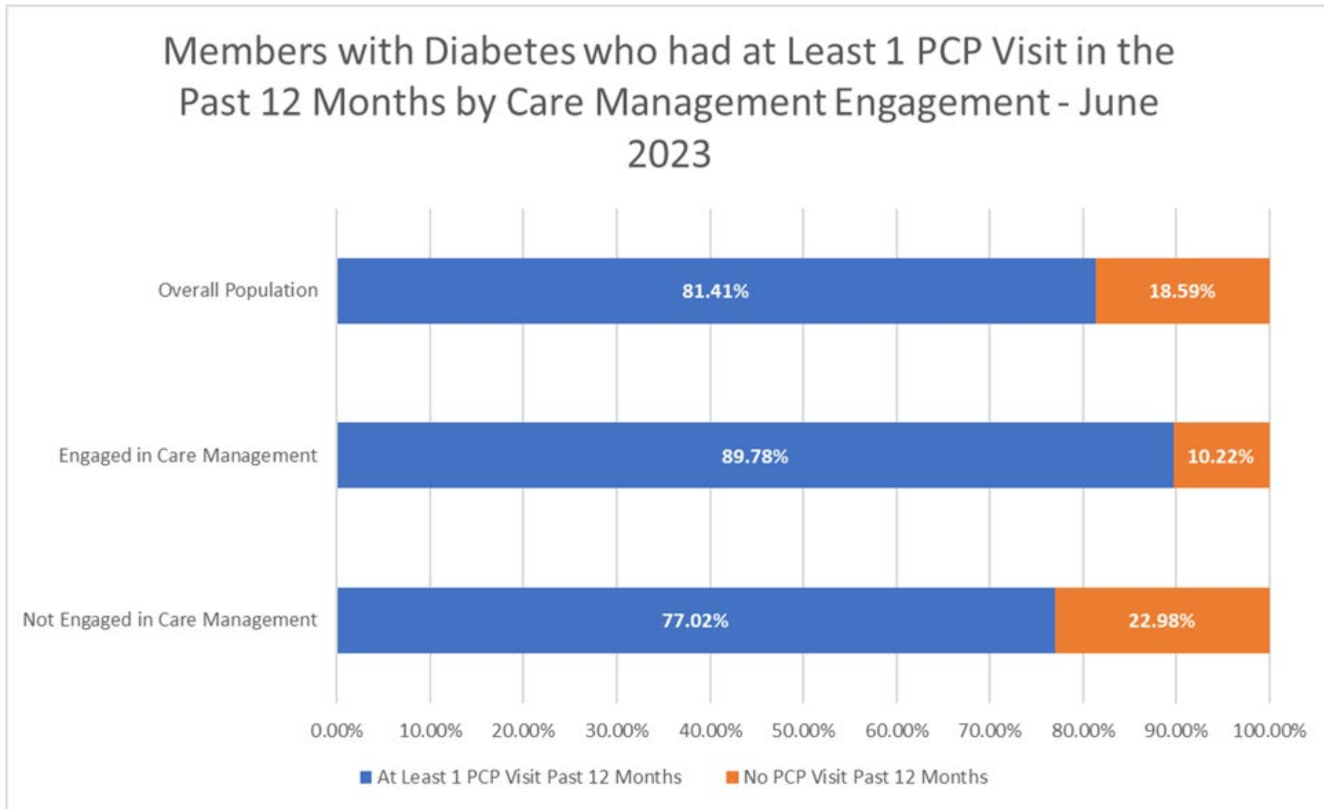

Figure 46 - PCP Engagement for Members with Diabetes by Care Management Engagement - June 2023

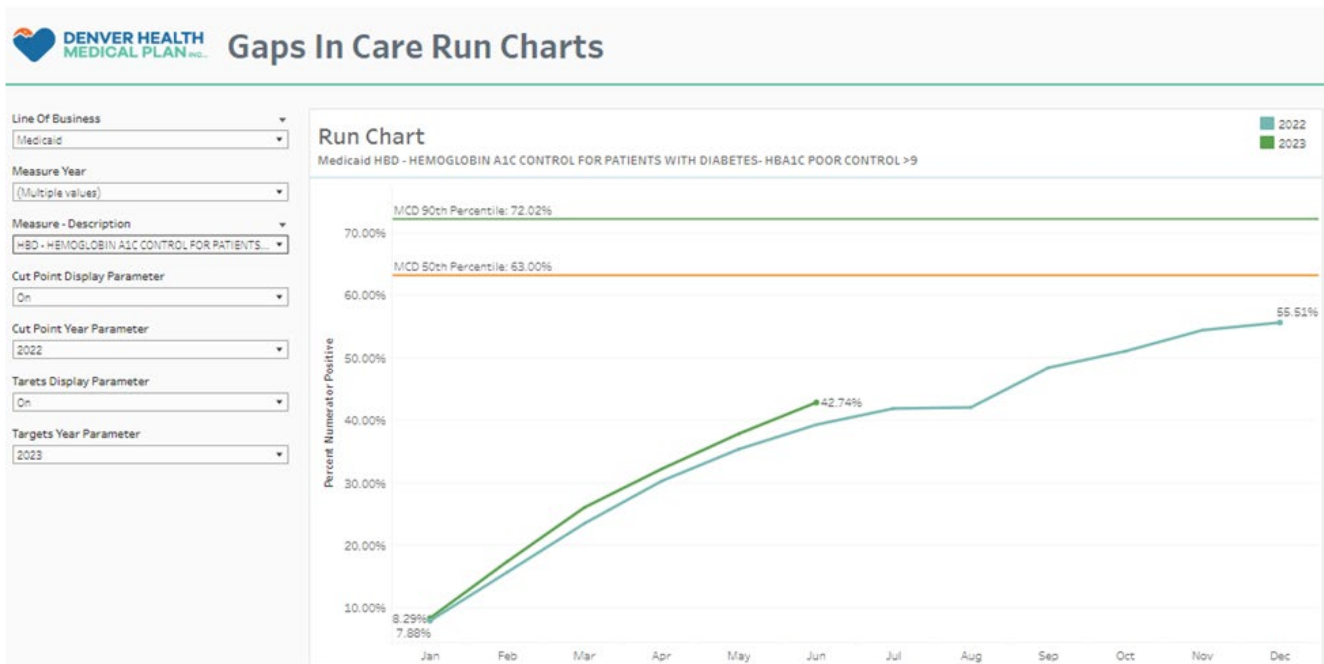

Figure 47 - A1C Control for Medicaid Members January 2022 - June 2023

DENVER HEALTH MEDICAL PLAN INC.

Gaps In Care Run Charts

Line Of Business: Medicare

Measure Year: (Multiple values)

Measure - Description: HBD - HEMOGLOBIN A1C CONTROL FOR PATIENTS...

Cut Point Display Parameter: On

Cut Point Year Parameter: 2022

Tarets Display Parameter: On

Targets Year Parameter: 2023

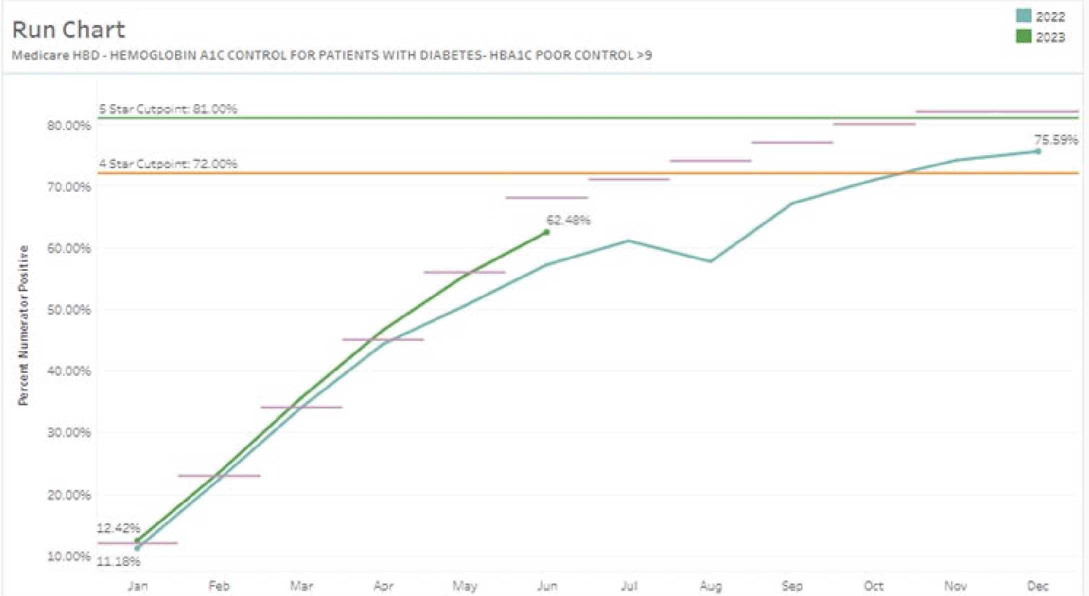

Figure 48 - A1C Control for Medicare Members January 2022 - June 2023 (Includes DSNP Members)

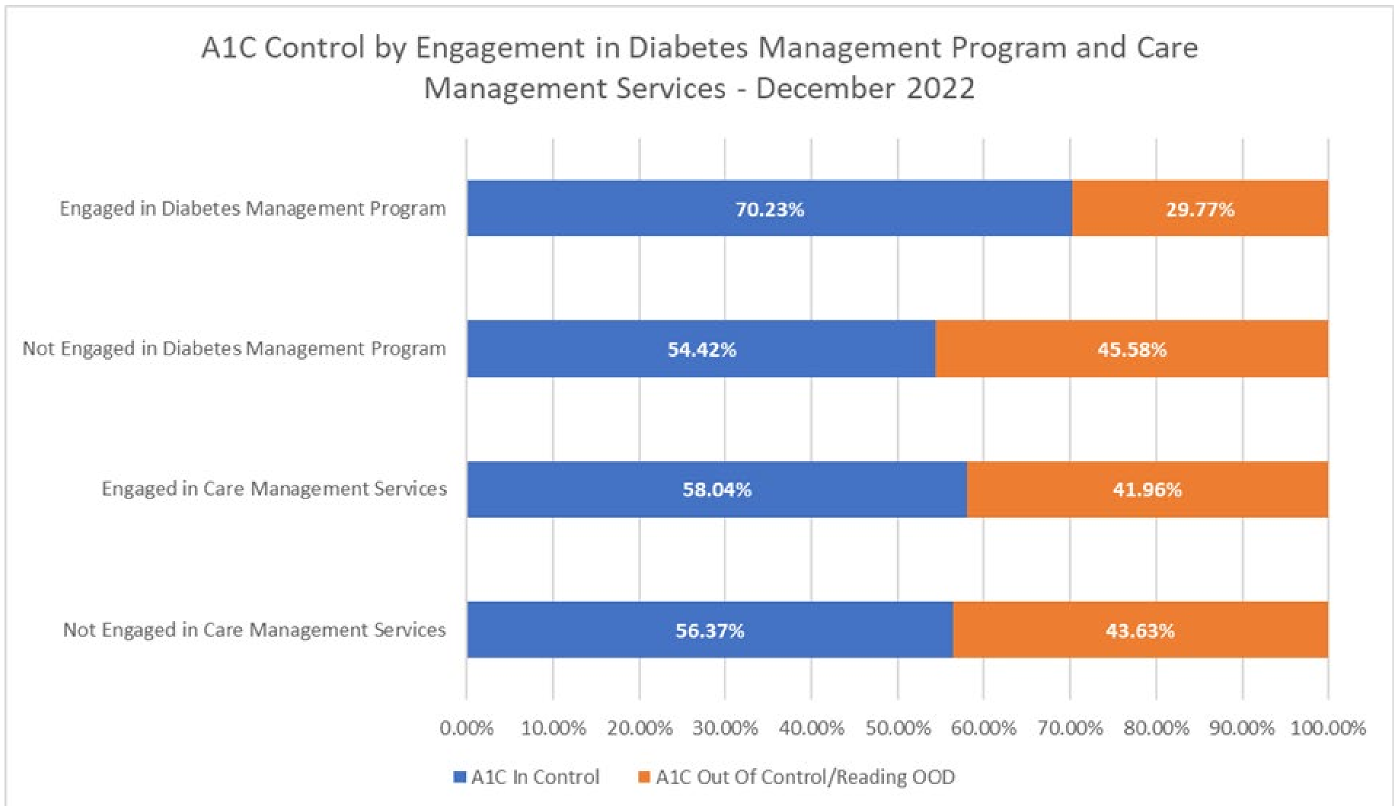

Figure 49 - A1C Control by Diabetes Management Program and Care Management Engagement - December 2022

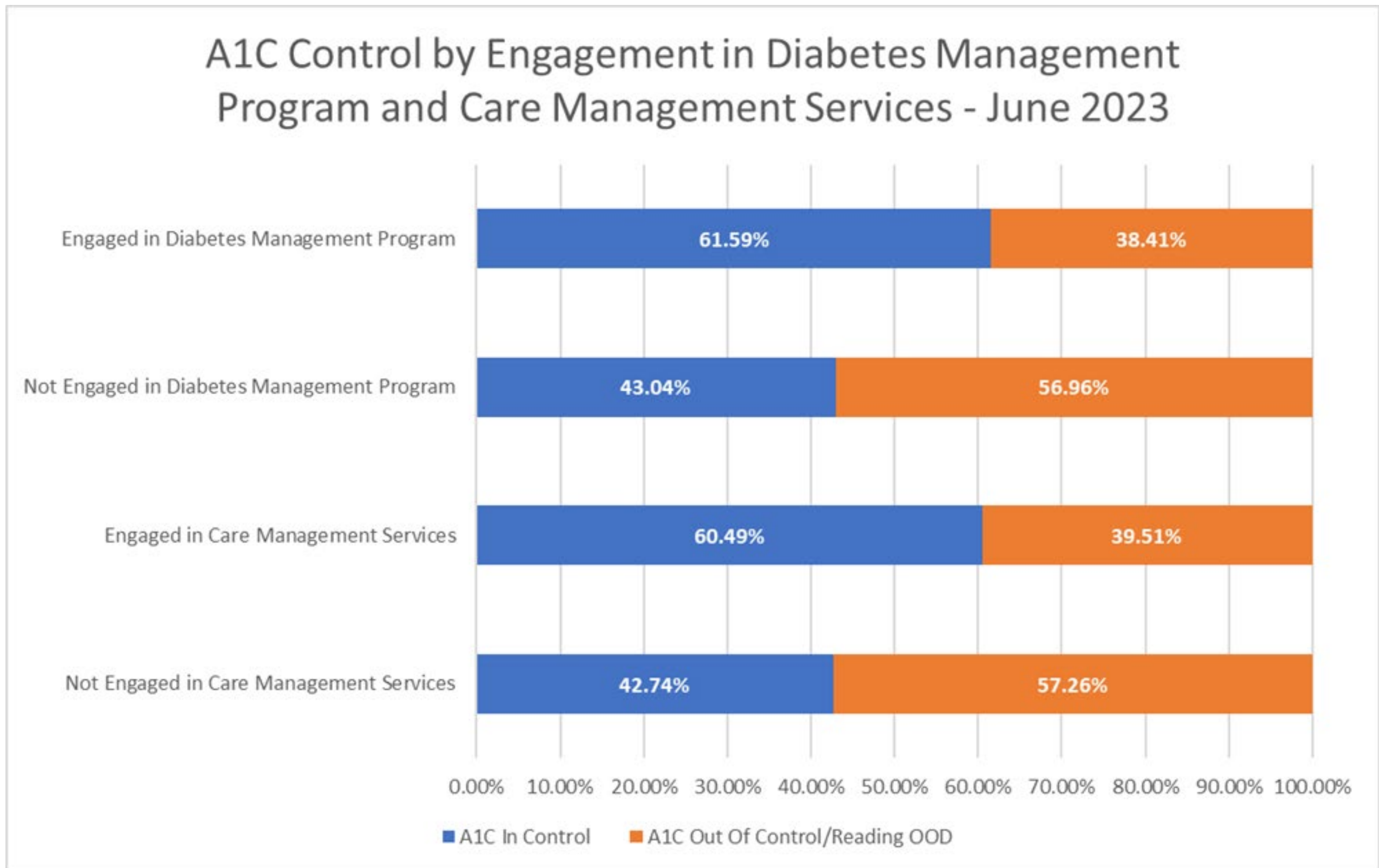

Figure 50 - A1C Control by Diabetes Management Program and Care Management Engagement - June 2023

Results/Analysis:

- A total of 1337 members were enrolled in the DM program in SFY 2022-2023
  - 19184 distinct activities were completed in SFY 2022-2023
- As of June 2023, 1956, distinct Medicaid, CHP+, and DSNP members with the diabetes indicator were outreached by Care Management (34.38%)
- As of June 2023, 610 distinct Medicaid Choice and DSNP members who were in the denominator for the HBD measure were outreached by the Care Management team (16.65%)
- 89.78% of members with diabetes who engaged in CM services in the past 12 months had at least 1 PCP visit in the past year, compared to 77.02% of members with diabetes who were not engaged in services
- As of December 2022, 56.37% of all members engaged in the Diabetes Management program and 58.04% of all members who were engaged in Care Management services had an A1C reading that was in control
  - Comparatively, 54.42% of members who were not engaged in the Diabetes Management program had an A1C reading in control, and 56.37% of members not engaged in CM services had an A1C reading in control
- As of June 2023, 61.59% of all members engaged in the Diabetes Management program and 60.49% of all members who were engaged in Care Management services had an A1C reading that was in control

Barriers/Lessons Learned:

- There is room to improve engagement rates for members who are in the denominator for the HBD (A1C Control) measure
  - In SFY 2023-2024, the CM team will generate outreach lists for all numerator negative members from the HBD list for engagement in the Diabetes Management Program

Maternal Care Management Program

The DHMP Maternal Care Management Program provides care management services by social workers, registered nurses, and a registered dietitian for high-risk women during pregnancy and for up to a year after delivery. The goal of this program is to ensure healthy pregnancies and healthy babies. The CM staff provide moms and kiddos help in managing access to care, coordination of care, developing individualized plans of care, assist with medication management, help arrange transportation to medical appointments, referrals to other programs like childbirth and breastfeeding education classes, family planning and to the WIC program. The care managers work closely with the members and their providers to meet their needs during their pregnancy. DHMP works in partnership with the providers and services offered at Denver Health including educational classes, virtual and on-site tours of the mom/Baby unit, coordination of care, and assisting in establishing care with DH providers. DH offers several types of prenatal care providers including physicians, midwives, and nurse practitioners.

DHMP has developed a Medical Loss Ratio (MLR) Dashboard which includes the metric of the percent of members who received a prenatal visit during pregnancy. This has helped the CM team identify members for outreach, even though some of these members may not meet criteria for the MC program. In SFY 2022-2023, the Care Management team worked with the Population Health Team to develop a Maternal Care dashboard. This dashboard will help identify members with high-risk pregnancies and allow for evaluation of Care Management engagement.

SFY 2022-2023 Maternal Care 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.

Maternal Care Management Activity Metrics:

Maternal Care Program Activities SFY 2022-2023	
Activity Name	Number of Activities Performed
MC Applications / Membership Assistance	47
MC Assessment	124
MC Benefit Resource Coordination	85
MC Care Plan Update	381
MC Condition Management	84
MC Disenrollment Summary	5
MC Education Provided	219
MC Engagement / Enrollment	48
MC Food Security Coordination	14
MC Health Acuity / Needs Assessed	21
MC Health Care Provider Coordination	563
MC Housing Resource Coordination	82
MC Immunization Coordination	1
MC Language Services	359
MC LTSS Coordination	6
MC Medication Management	26
MC Member Outreach	3260
MC Nutritional Support	5
MC Other Community Resource Coordination	159
MC Other Follow-up	26
MC Peer Support / Groups	2
MC Provider Follow-up	98
MC Referral	36
MC SNAP Coordination	50
MC Transportation Coordination	50
MC Well Child Coordination	65
MC WIC Coordination	65
Grand Total	**5881**

Figure 51 - Maternal Care Management Program Activities SFY 2022-2023

Maternal Care Program Metrics:

Members Enrolled in Maternal Care Program SFY 22-23	
Program Status	**Number of Members**
Changed Programs	3
Completed Program	140
Eligibility Termed	8
Lost to Follow	2
Member Enrolled in Program	79
Opted Out	1
Total Members Enrolled	**233**

Figure 52 - Maternal Care Program Status SFY 2022-2023

Maternal Care Management Program Outcomes:

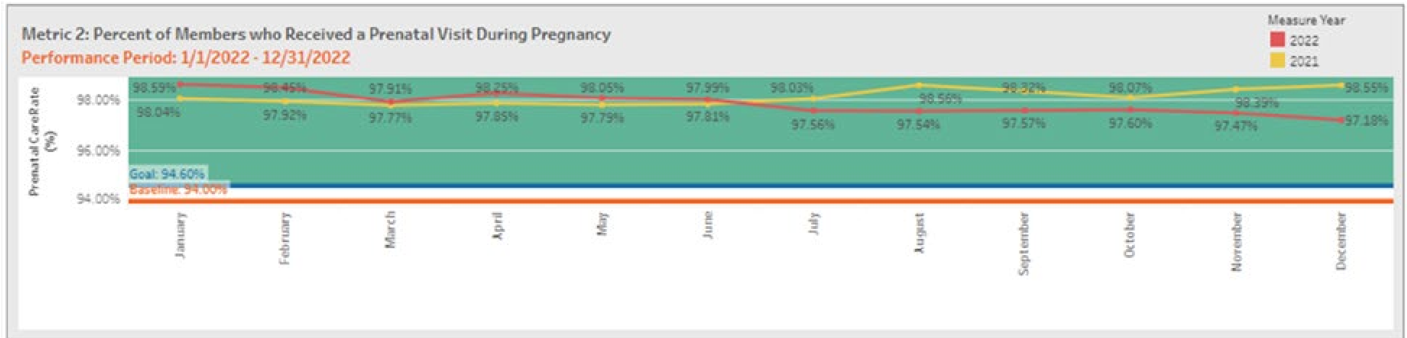

Figure 53 - Prenatal MLR Outcomes CY 2022

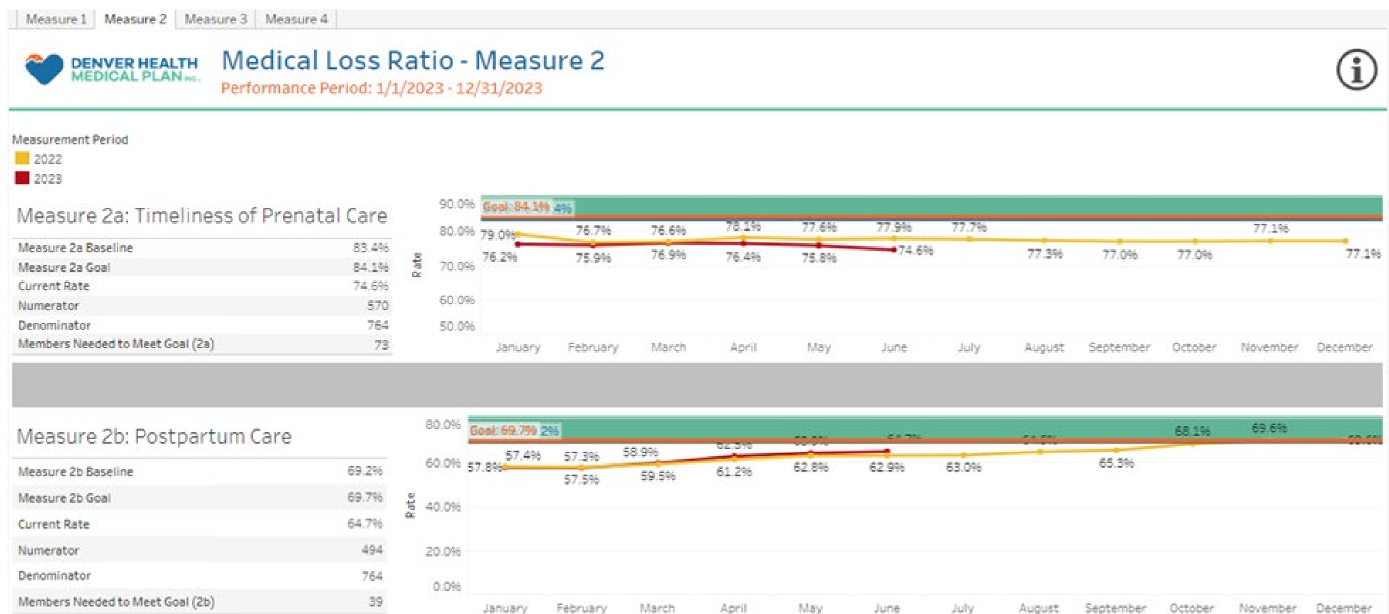

Figure 54 - Prenatal and Postpartum MLR Outcomes January - June 2023

Results/Analysis:

- The Maternal Care program was introduced in 2021 and has steadily grown, with 233 distinct members enrolled during SFY 2022-2023
  - 140 distinct members successfully completed the program in SFY 2022-2023 (60.09%)
  - 79 members were actively enrolled as of 6/30/2023
- 5881 distinct activities were conducted in the Maternal Care Program in SFY 2022-2023
- As of June 2023, 13.34% of members with the maternity indicator had been outreached by the CM team
- The DHMP team exceeded the 2022 MLR goal of 94.60% of pregnant members having at least one prenatal visit, with 97.10% of pregnant members having at least one prenatal visit

- As of June 2023, 74.6% of pregnant members had at least 1 prenatal visit, which Is below DHMP's goal of 84.1% set for calendar year 2023
- As of June 2023, 62.9% of members who had given birth had at least 1 postpartum visit, which is below the goal of 69.7% set for calendar year 2023

Barriers/Lessons Learned:

- Identification of pregnant members has inherent challenges, and this remained a challenge in SFY 2022-2023
  - Members will not be identified as pregnant unless the appropriate diagnosis code is indicated in their chart
  - Many members, especially those who have had more than one pregnancy, may not access prenatal care and may not have a diagnosis code on their chart or within claims data
  - DHMP is continuing to identify ways to identify members earlier in their pregnancy
- The Maternal Care dashboard was completed in SFY 2022-2023, and is going through updates to improve data capture, but there are inherent challenges
  - Delivery dates are often estimated to help the team plan for scheduling postpartum visits; however, incorporating the actual delivery date continues to be a challenge
  - Some members have experienced losses that have not been documented within the EMR, making it difficult for the CM team to prepare for the appropriate type of outreach call

High Utilizer Medication Management Program

The DHMP pharmacy team monitors members pharmacy utilization and will identify member that are on high-cost drugs and will refer them to the care coordination team for review and evaluation for case management services. The care coordination team will outreach to the members to discuss their specific condition and associated pharmacy needs. The care coordinator will attempt to get the member connected to a primary care provider if the member does not already have one.

DHMP participates in the 340b pharmacy program which results in a lower drug cost for the plan. However, DHMP does not restrict its membership to DHMP pharmacies which stresses the importance of ensuring the member is appropriately connected to the resources available to them within the DH network. The pharmacy does have options to receive medications via mail which allows the member to not have to visit the physical pharmacy locations.

SFY 2022-2023 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 SFY 2022-2023	
Program Status	**Distinct Members**
Completed Program	19
Deceased	1
Declined- Opt Out	1
Eligibility Termed	2
Member Enrolled in Program	12
Opted Out	1
Unable To Reach	7
Distinct Members Referred	**43**

Figure 55 - Referral Data - High Utilizer Medication Management Program SFY 2022-2023

High Utilizer Medication Management Cost Savings Data:

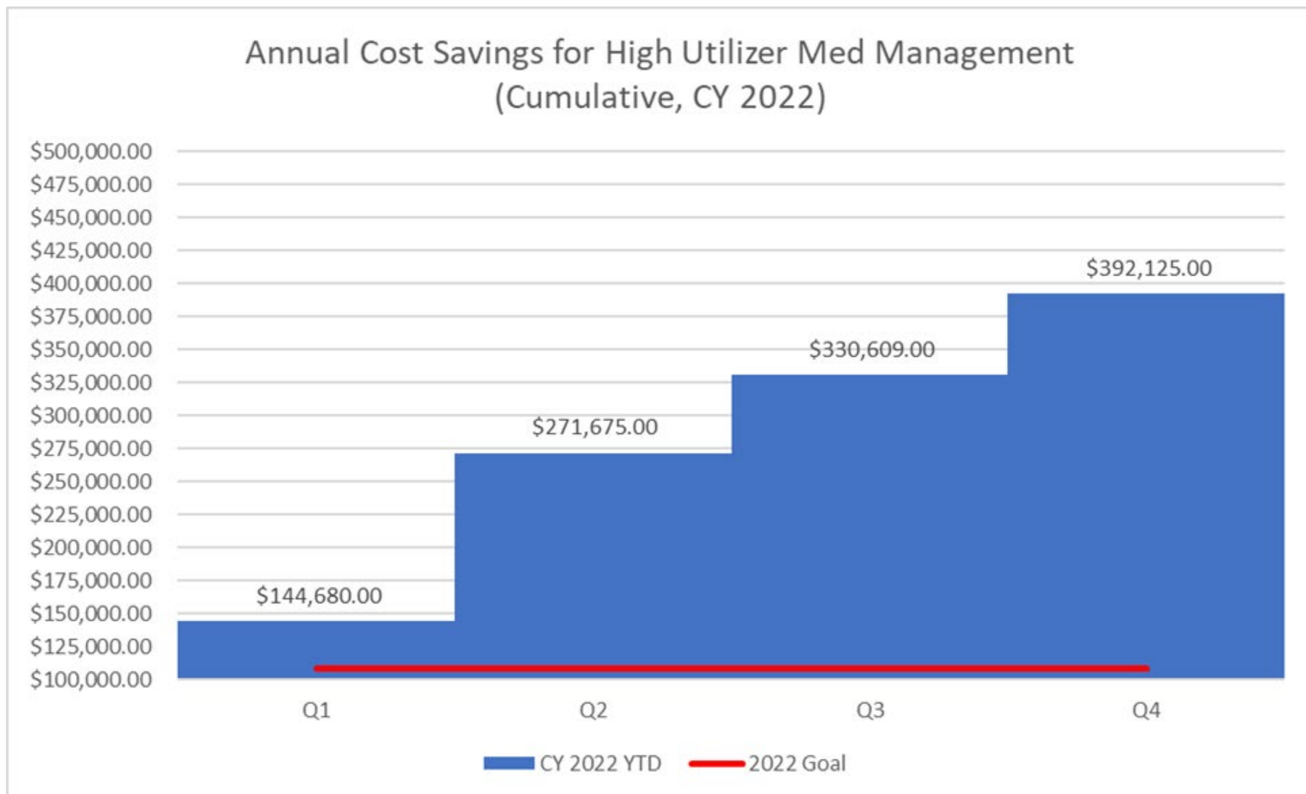

Figure 56 - Cost Savings for Option Care Program CY 2022

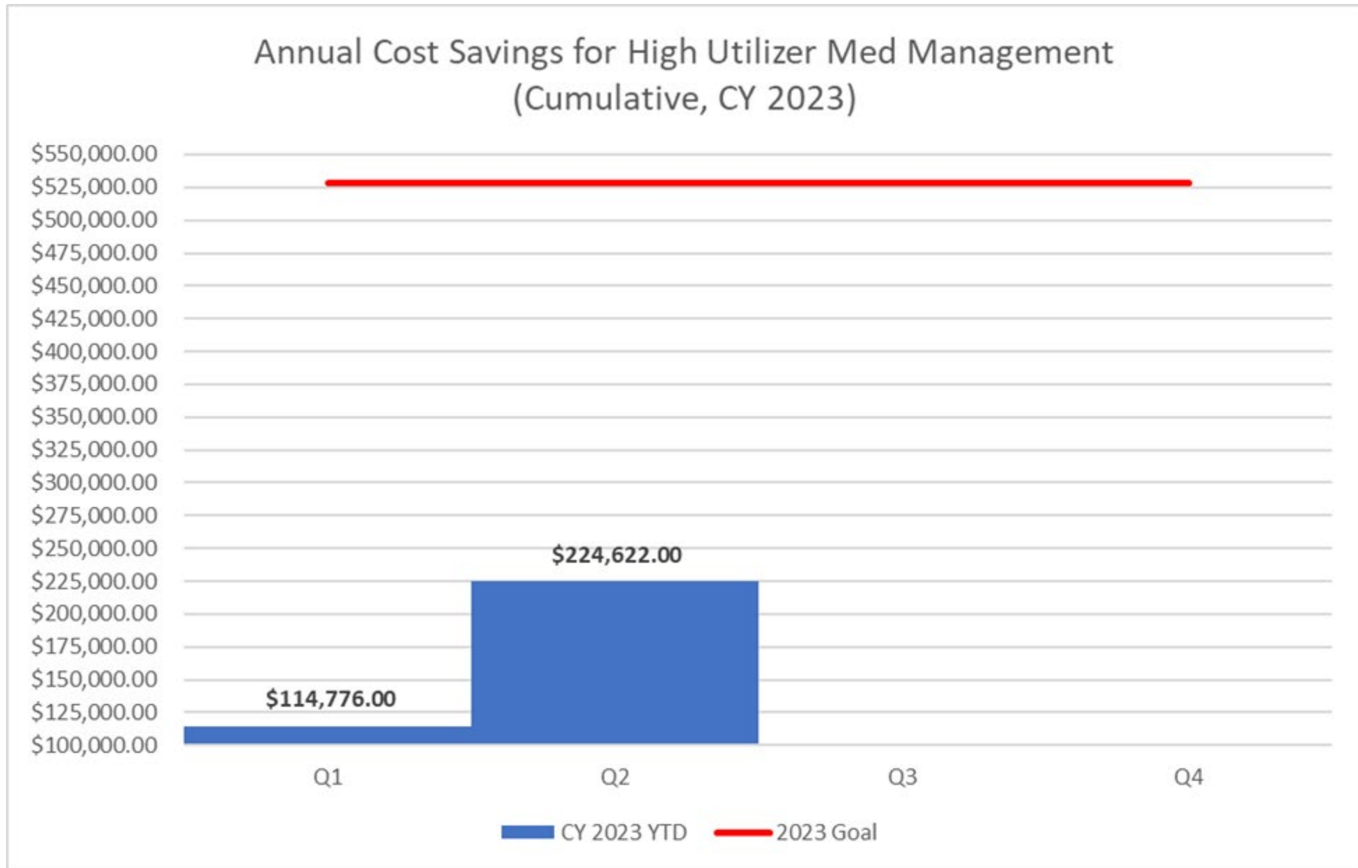

Figure 57 - Cost Savings for Option Care Program Q1 Q2 CY 2023

Results/Analysis**:**

- A total of 43 distinct members were referred to the program in SFY 2022-2023
  - 34 distinct members were engaged in the program in SFY 2022-2023 (79.07%)
    - 12 members were still enrolled in the program as of June 30, 2023
    - 19 members completed the program in SFY 2022-2023
    - 2 members engaged in the program but had their eligibility termed in SFY 2022-2023 and 1 member passed away
  - 7 members (16.28%) were unable to be reached, and 2 members (4.65%) opted out of the program in SFY 2022-2023
- During SFY 2022-2023, the Option Care Program resulted in $345,072.00 of cost savings for members in the high utilizer medication management program
  - In CY 2022, program cost savings totaled $392,125.00, exceeding the annual goal of $108,912.00
  - In Q1 Q2 CY 2023, program cost savings totaled $224,622.00, which is below CM's Q2 cost savings goal of $224,622.50

Barriers/Lessons Learned**:**

- Engagement via telephonic outreach failed to reach 16.28% 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

Continuity of Care Program

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.

SFY 2022-2023 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 Management Activity Metrics:

Activity Name	Number of Activities Performed (SFY 2022-2023)	Distinct Members Served (SFY 2022-2023)
Continuity of Care Language Services	19	4
Continuity of Care Member Coordination	157	65
Continuity of Care Provider Coordination	6	2
Grand Total	**182**	**69**

Figure 58 - Continuity of Care Activities SFY 2022-2023

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 182 activities were performed across 69 distinct members in SFY 2022-2023
- 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 ongoing 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-19 Member Outreach/COVID-19 Vaccination Care Coordination

COVID-19 emergency planning and program implementation was initiated across the state of Colorado in 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, shifting the focus to booster shots in 2022. In 2023 and moving forward, the Care Management Department will support DHHA and the state with the "normalization" of COVID-19 boosters as part of a routine vaccination series. These conversations will be a routine part of CM discussions with members in terms of primary/preventive care and will no longer be tracked as a metric by the department.

Department of Corrections Care Coordination

During a routine touch base meeting in October 2021, it was identified that Colorado Access (COA) had their own process to identify current and new members who are within the Department of Corrections (DOC). Colorado Access was conducting their own outreach for these members as well as providing services. In order to de-duplicate efforts, the DOC program no longer resides with DHMP, but rather, is managed by Colorado Access (COA). DHMP continues to provide support to members and to COA staff for the DOC program. DHMP and COA care management teams have an established referral and communication process to ensure the sharing and flow of member needs and information. The process is bi-directional, so DHMP can refer to COA for behavioral health related topics and needs, and COA can refer to DHMP any physical health or social determinant of health (SDOH) topics and needs.

Denver Health Care Managers assist with Medicaid resources and any additional needed care coordination for these individuals who have transitioned into the community. Resources and support include but are not limited to access to services such as primary care and social determinants of health (SDOH). COA Provides Behavioral Health services and services for substance use disorders for these members.

Substance Use Disorder (SUD) Care Management Program

The Substance Use Disorder (SUD) Program is available to all DHMP Members, and DHMP works closely with Colorado Access (COA) to meet the needs of DHMP Medicaid Members who need SUD services. 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 assist 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.

SFY 2022-2023 SUD 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.

Population Overview:

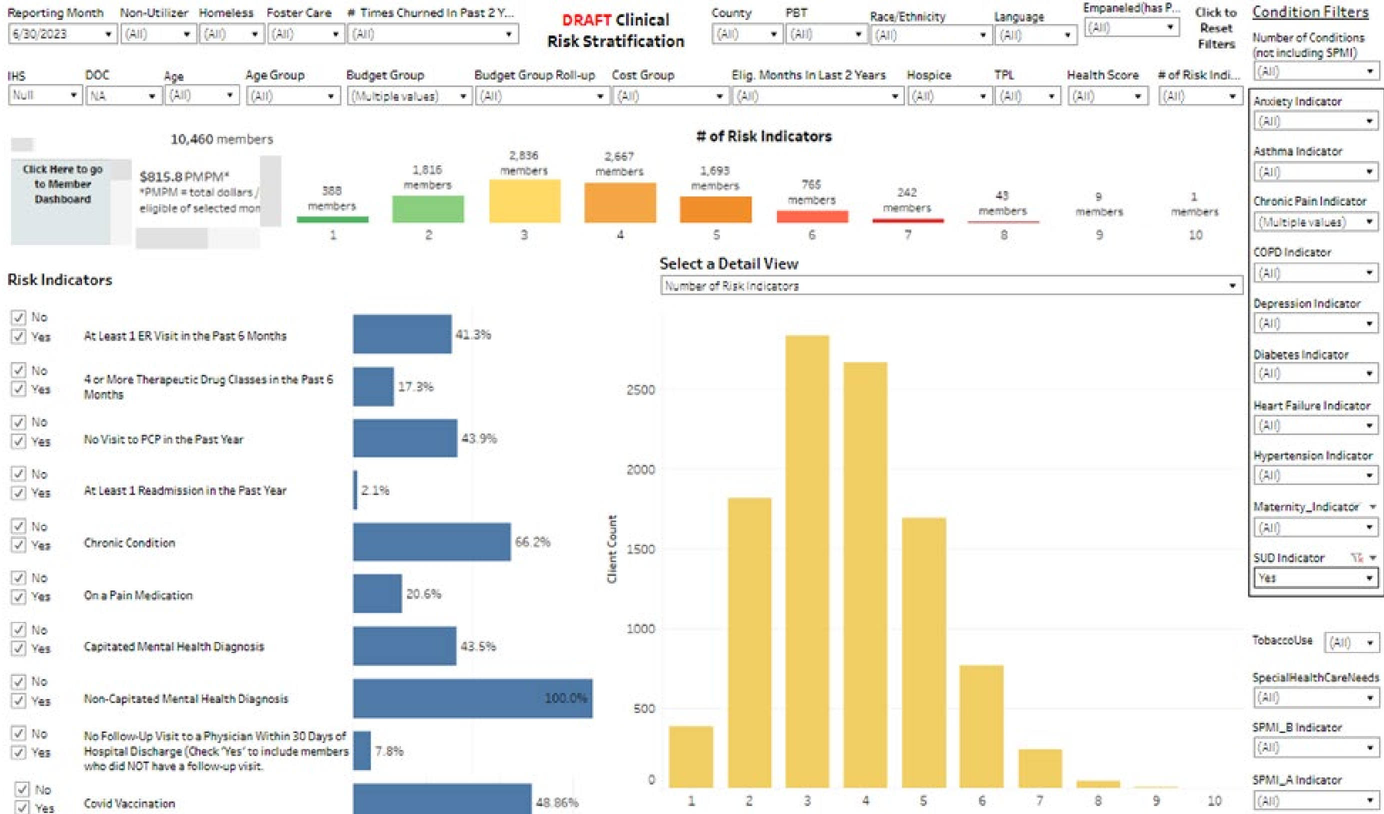

Figure 59 - Population Overview - Members with Substance Use Disorder - June 2023

SUD Activity Data:

Activity Name	Number of Activities Performed (SFY 2022-2023)	Distinct Members Served (SFY 2022-2023)
SUD Benefit Resource Coordination	2	1
SUD Health Care Provider Coordination	2	1
SUD Incoming Referral	2	1
SUD Language Services	3	1
SUD Member Outreach	3	1
SUD Other Community Resource Coordination	3	1
SUD Transportation Coordination	4	2
Grand Total	**19**	**8**

Figure 60 - Substance Use Disorder Program Activities SFY 2022-2023

SUD Program Outcome Data:

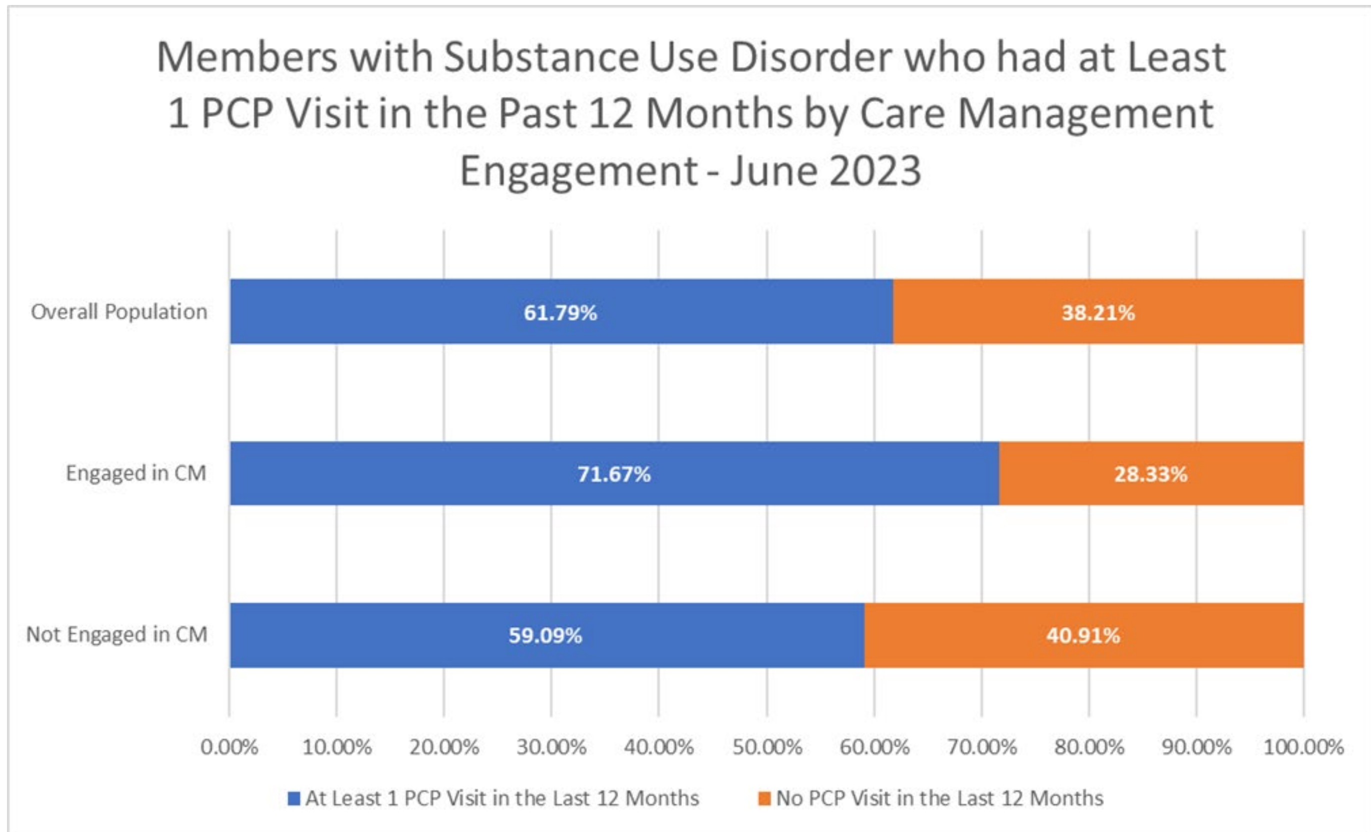

Figure 61 - Engagement in Primary Care for Members with Substance Use Disorder - June 2023

Results/Analysis:

- While only 8 Distinct members were engaged in the SUD program in SFY 2022-2023, 21.48% of all Medicaid, CHP+, and DSNP members with substance use disorder were engaged in Care Management Services in SFY 2022-2023
  - Services received by members include Care Coordination
- 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 specifically engaged in SUD services represents a small percentage of members with SUD who are otherwise engaged in Care Management Services
  - 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 additional SUD services.

Behavioral Health Care Coordination Program

The Behavioral Health Care Coordination Program is available to all DHMP members and promotes wellness by helping members access appropriate treatment and community resources. DHMP works closely with Colorado Access to support members in accessing their behavioral health benefits and connecting members to needed care. 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.

2022-2023 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 Member Outreach Activity Data:

Behavioral Health Care Coordination Activities		
Activity Name	**Number of Activities Performed**	**Distinct Members Served**
BH Care Coordination	599	277
COA Behavioral Health Referral	167	59
Internal Behavioral Health Referral	83	19
Grand Total	**849**	**351**

Figure 62 - Behavioral Health Program Activities SFY 2022-2023

Results/Analysis:

- 351 distinct members were engaged in the Behavioral Health Coordination Program
  - 59 members (16.81%) received a behavioral health referral for Colorado Access (COA), and 19 members (5.41%) received an internal behavioral health referral to Denver Health
- A total of 849 outreach calls were made in SFY 2022-2023, and of those, 599 (75.55%) were for BH Care Coordination

Barriers/Lessons Learned:

- 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 SFY 202-2023

Member Experience Survey

A total of 208 members completed the Care Management Member Experience Survey in 2022. Members are contacted by phone following completion of a program, or at year end for those who are continuously enrolled in a program. In 2022, member surveys were mailed out to members in the Medicare, Commercial, and Exchange Lines of Business; overall, 2367 surveys were mailed out, providing members with an alternative method for completing surveys. Health Plan Care Coordinators conducted calls for members who did not complete surveys mailed to them.

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.

2022 Care Management Member Experience Survey Results

Member Experience Survey Program Data		
Member Program	**# of Members**	**% Member Response**
Complex Case Management	3	1.44%
Controlling Blood Pressure	7	3.37%
Medicare Choice SNP HMO	189	90.87%
Transitions of Care	9	4.33%
Total	**208**	**100.00%**

Figure 63 - Member Experience Survey Responses by Program CY 2022

Member Experience Survey Outreach Data		
Survey Completion	**# of Members**	**% Members**
Completed Survey	208	8.79%
Did Not Complete Survey	2159	91.21%
Total Members Outreached	**2367**	**100.00%**

Figure 64 - Member Experience Survey Outreach Data CY 2022

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?	4	7	8	59	122		200	8	**9.55%**	**90.45%**
How satisfied are you with how the care manager helped you get the care you needed?	3	6	14	52	126		201	7	**11.50%**	**88.50%**
How satisfied are you with how the care manager paid attention to you and helped you with problems?	4	6	10	54	125		199	9	**10.10%**	**89.90%**
How satisfied are you with how the care manager treated you?	4	4	5	51	137		201	7	**6.50%**	**93.50%**
How helpful was your care manager when you had a question or concern?	4	7	8	51	130		200	8	**9.55%**	**90.45%**
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	5	5	13	52	118		193	15	**11.98%**	**88.02%**
How well did your care manager share important information with you when it was needed?	5	7	13	51	120		196	12	**12.82%**	**87.18%**
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	7	3	11	53	116		190	18	**11.11%**	**88.89%**
How satisfied are you with the timeliness of your care management services?	4	8	12	50	119		193	15	**12.50%**	**87.50%**
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	9	6	10	46	110	11	192	16	**13.09%**	**86.91%**
Overall, how satisfied are you with the care management program?	6	7	10	44	135		202	6	**11.50%**	**88.50%**

Figure 65 – Member Experience Survey Results CY 2022, N = 208

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 Complaints/ 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	2	5		8	1	**12.50%**	**87.50%**
How satisfied are you with how the care manager helped you get the care you needed?	0	0	1	1	5		7	2	**14.29%**	**85.71%**
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	1	0	2	4		7	2	**14.29%**	**85.71%**
How satisfied are you with how the care manager treated you?	1	0	0	0	6		7	2	**14.29%**	**85.71%**
How helpful was your care manager when you had a question or concern?	1	0	0	0	6		7	2	**14.29%**	**85.71%**
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	1	0	0	0	7		8	1	**12.50%**	**87.50%**
How well did your care manager share important information with you when it was needed?	1	0	0	1	7		9	0	**11.11%**	**88.89%**
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	1	1	7		9	0	**11.11%**	**88.89%**
How satisfied are you with the timeliness of your care management services?	1	0	0	1	7		9	0	**11.11%**	**88.89%**
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	1	0	0	0	5	2	8	1	**12.50%**	**87.50%**
Overall, how satisfied are you with the care management program?	1	0	0	0	8		9	0	**11.11%**	**88.89%**

Figure 66 - Member Experience Survey - Transitions of Care Program Results (CY 2022); N = 9

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 Complaints/ 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?	3	7	8	53	113		184	5	9.78%	90.22%
How satisfied are you with how the care manager helped you get the care you needed?	3	6	13	48	116		186	3	11.83%	88.17%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	4	5	10	49	116		184	5	10.33%	89.67%
How satisfied are you with how the care manager treated you?	3	4	5	48	126		186	3	6.45%	93.55%
How helpful was your care manager when you had a question or concern?	3	7	7	49	119		185	4	9.19%	90.81%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	4	5	11	49	106		175	14	11.43%	88.57%
How well did your care manager share important information with you when it was needed?	4	7	13	45	108		177	12	13.56%	86.44%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	7	3	8	50	103		171	18	10.53%	89.47%
How satisfied are you with the timeliness of your care management services?	3	8	10	46	107		174	15	12.07%	87.93%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	8	6	8	46	101	7	176	13	12.50%	87.50%
Overall, how satisfied are you with the care management program?	5	7	10	43	118		183	6	12.02%	87.98%

Figure 67 - Member Experience Survey - Medicare Choice SNP HMO Program Results (CY2022); N = 189

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 Complaints/ 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	1	0		1	2	0.00%	100.00%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	0	1	0		1	2	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	1	0		1	2	0.00%	100.00%
How satisfied are you with how the care manager treated you?	0	0	0	1	0		1	2	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	0	1	0		1	2	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	1	1	1		3	0	33.33%	66.67%
How well did your care manager share important information with you when it was needed?	0	0	0	2	1		3	0	0.00%	100.00%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	1	0	2		3	0	33.33%	66.67%
How satisfied are you with the timeliness of your care management services?	0	0	1	1	1		3	0	33.33%	66.67%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	1	0	1	0	2	1	50.00%	50.00%
Overall, how satisfied are you with the care management program?	0	0	0	0	2		2	1	0.00%	100.00%

Figure 68 - Member Experience Survey - Complex Case Management Program Results (CY 2022); N = 3

Member Experience Survey Results - Controlling Blood Pressure										
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 Complaints/ 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	3	4		7	0	0.00%	100.00%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	0	2	5		7	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	2	5		7	0	0.00%	100.00%
How satisfied are you with how the care manager treated you?	0	0	0	2	5		7	0	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	1	1	5		7	0	14.29%	85.71%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	1	2	4		7	0	14.29%	85.71%
How well did your care manager share important information with you when it was needed?	0	0	0	3	4		7	0	0.00%	100.00%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	1	2	4		7	0	14.29%	85.71%
How satisfied are you with the timeliness of your care management services?	0	0	1	2	4		7	0	14.29%	85.71%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	1	0	3	2	6	1	16.67%	83.33%
Overall, how satisfied are you with the care management program?	0	0	0	0	5		5	2	6.52%	100.00%

Figure 69 Member Experience Survey - Controlling Blood Pressure Program Results (CY 2022); N = 7

Member Satisfaction Survey Results - Behavior Modification						
Survey Question/Responses	No	Yes	Total	No Response	% 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.)	82	92	174	34	47.13%	52.87%

Figure 70 - Member Experience Survey Behavior Modification Results (CY 2022)

Behavior Changes Self-Reported by Members	
Reported Behavior Change	# Responses
Smoking Cessation	3
Quit Drinking	1
Medication Adherence	20
Engaged in Treatment	4
Utilized resources	4
Lifestyle Modification - Diet	30
Lifestyle Modification - Exercise	30
Lifestyle Modification - Other	23

Figure 71 - Member Experience Survey Behavior Modification Results (CY 2022)

Results/Analysis:

- The overall response rate to the 2022 Care Management Member Experience Survey was higher than 2021, with 8.79% of the 2367 outreached members completing the survey (208 members total)
  - In 2021, only 80 members responded to the survey
  - While overall survey response was higher than in previous years, the Transitions of Care and Complex Case Management Programs saw a decrease in response rates from 2021
    - 9 members completed the Transitions of Care survey compared to 38 members in 2021
    - 3 members completed the Complex Case Management survey compared to 6 members in 2022
- Of the 208 members who responded to the survey, 4.33% (9 members) had participated in the Transitions of Care Program, 90.87% (189 members) were participants in the Medicare Choice SNP HMO Program, 3.37% (7 members) had participated in the Controlling Blood Pressure Program, and 1.44% (3 members) had participated in the Complex Case Management Program
  - Overall satisfaction rates were highest for the Complex Case Management and Controlling Blood Pressure Programs, with 100% overall satisfaction rates
    - Question: “Overall, how satisfied are you with your care management program?”
  - The Transitions of Care program had the third highest overall satisfaction scores, with a 97.37% satisfaction rate
    - Question: “Overall, how satisfied are you with your care management program?”
    - This is a decrease from 2021, where 97.37% of members reported overall satisfaction with the program
    - Changes in rates from year to year may be a result of a reduced denominator from 38 respondents in 2021 to 9 respondents in 2022

            - The Medicare Choice HMO SNP had the lowest overall satisfaction rate of the four programs, with 87.98% of members reporting being satisfied with the program overall.
                - This is a decrease from the previous year's results with 93.33% members reporting overall satisfaction with the program.
                - Question: "Overall, how satisfied are you with your care management program?"
    - Results of the survey were favorable, with an 88.50% overall satisfaction rate, with an average score of 4.4 across all questions asked; however, this is a decrease from previous years.
        - This is below the performance goal of 4.8/5.0
        - This is below 2021 results, where 94.74% of members reported being satisfied overall with their Care Management program.
    - Satisfaction rates were highest for the following questions:
        - How satisfied are you with how the Care Manager treated you? (93.50% satisfied)
        - How satisfied are you with how the care manager helped you understand your treatment plan? (90.45% satisfied)
        - How satisfied are you with how the care manager helped you understand your treatment and care plan? (90.45% satisfied)
    - Satisfaction rates were lowest for the following areas:
        - If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns? (86.91% Satisfied)
        - How well did your care management share important information when it was needed? (87.18% satisfied)
        - How satisfied are you with the timeliness of your Care Management services (87.50% Satisfied)
    - Of the 174 respondents to the behavior modification question, 52.87% of members reported making a change in their behavior because of participating in a care management program.
        - This is an increase from 2021, where 34.92% (22 members) reported making a change in their behavior because of participating in a Care Management program.
        - Members were encouraged to provide more information about the lifestyle changes they have made:
            - 3 Members reported engaging in smoking cessation
            - 1 Member reported that they quit drinking
            - 20 Members reported greater medication adherence
            - 4 Members reported engaging in medical care or therapy related to their health condition
            - 4 members reported utilizing resources provided by the care manager
            - 30 members reported making changes to their diet
            - 30 members reported increasing physical activity
            - 23 members reported other lifestyle changes

Barriers/Lessons Learned:

- While outreach numbers and response rates to the Member Experience Survey improved in 2022, 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 to members who participated in that program each month.
        - This may increase the number of programs that DH is able to receive feedback on
        - This may increase response rates for individual programs.
    - Improved response rates may allow for more robust program-level analysis, which may lead to additional identified opportunities for improvement.

- Satisfaction rates were lower in 2022 than in 2021
  - Changes in member satisfaction scores may be related to the methodology that data was collected; members may be more comfortable providing feedback about negative experiences on a mail-in survey than they would on the phone with a member of the team.
  - Many negative comments from members included items that are outside of the scope of DHMP or DHMP Care Management
    - Many members confuse Denver Health Medical Plan with Denver Health Hospital Authority when they see materials from Denver Health
    - Many members rated the CM team based on their experiences with the hospital, clinics, PCP office, and specialty care providers.
- The current survey does not require members to report why they are satisfied or dissatisfied with services.
  - While some members provided feedback in the comments section, very few members explained their rating to the team, making it difficult to understand the specific issues they were experiencing.

ACS Quality Improvement and Ongoing Monitoring

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

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

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

DHHA all patients:

Strategic Metrics

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

Strategic Metrics

	Breast Cancer Screening 72%	Cervical Cancer Screening 73%	Colorectal Cancer Screening 56%	Diabetes A1c<=9 67%	Diabetes Kidney Health Evaluation 66%	Hypertension BP Controlled 66%	First Trimester Entry into Prenatal Care 81%	Depression Screen and Follow-up Plan if Positive 74%	Asthma Medication Ratio, 5-18 years 82%	HPV Completion 64%	Peds Immunization 1 year 82%
CHS Overall	72.2%	71.4%	54.9%	65.7%	58.5%	64.7%	78.9%	73.2%	74.6%	64.6%	76.6%

Medicaid – Strategic Metrics:

Strategic Metrics

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

Strategic Metrics

	Breast Cancer Screening 72%	Cervical Cancer Screening 73%	Colorectal Cancer Screening 56%	Diabetes A1c<=9 67%	Diabetes Kidney Health Evaluation 66%	Hypertension BP Controlled 66%	First Trimester Entry into Prenatal Care 81%	Depression Screen and Follow-up Plan if Positive 74%	Asthma Medication Ratio, 5-18 years 82%	HPV Completion 64%	Peds Immunization 1 year 82%
CHS Overall	73.5%	74.6%	52.1%	64.3%	62.3%	62.1%	81.9%	74.1%	73.5%	66.9%	76.4%

CHP+ Strategic Metrics:

Strategic Metrics

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

Strategic Metrics

	Cervical Cancer Screening	Diabetes A1c<=9	Diabetes Kidney Health Evaluation	Hypertension BP Controlled	First Trimester Entry into Prenatal Care	Depression Screen and Follow-up Plan if Positive	Asthma Medication Ratio, 5-18 years	HPV Completion	Peds Immunization 1 year
	73%	67%	66%	66%	81%	74%	82%	64%	82%
CHS Overall	53.7%	66.7%	33.3%	46.2%	77.8%	81.2%	93.3%	68.3%	75.6%

CHP+ Non-Strategic Metrics:

Peds Metrics

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

Peds Metrics

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

Peds Metrics

	Adolescent Vaccinations 80%	Anemia Screening - Peds	ASQ Positive Suicide Screening,	ASQ Suicide Screening	Asthma Medication Ratio, 12-18 years 82%	Asthma Medication Ratio, 5-11 years 82%	Asthma Medication Ratio, 5-18 years 82%	Chlamydia Screening - Adolescents	Chlamydia Screening at Visit 14-24 yrs 67%	Cholesterol Screening - Peds	Dental Visit or Fluoride Application, 1x by.. 75%	Depression Screen and Follow-up Plan if Positive 74%
CHS Overall	90.9%	32.6%	4.7%	62.7%	100.0%	90.0%	93.3%	40.3%	74.1%	44.4%	83.3%	81.2%

Peds Metrics

	Developmental Screening, 12-36 mos 85%	Hearing Screening - Peds	HIV Screening - Adolescents	HPV Completion 64%	HRSN Screen at WCCs 40%	Lead Screening - Peds	MCHAT Screening 90%	Measles 2 yr olds	Measles 4-6 yr olds	Peds Immunization 1 year 82%	Peds Vaccinations Combo 10 60%	Peds Vaccinations Combo 7 77%
CHS Overall	83.8%	75.5%	41.7%	68.3%	71.1%	34.9%	90.9%	96.4%	89.2%	75.6%	57.1%	78.6%

Peds Metrics

	Adolescents	HPV Completion 64%	HRSN Screen at WCCs 40%	Lead Screening - Peds	Peds Vaccinations Combo 10 60%	Six Well Child Visits Before 15 Months 79%	Vision Screening - Peds	Weight Assessment and Counseling - Peds 72%	Well Child Check Rate 10-18 year olds	Well Child Check Rate 3-18 year olds	Well Child Check Rate 3-6 year olds 78%	Well Child Check Rate 3-9 year olds 76%
CHS Overall	7%	68.3%	71.1%	34.9%	57.1%	46.9%	28.3%	80.7%	71.7%	74.3%	82.0%	78.6%

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

IV. Safety and Quality of Clinical Care

Quality of Service

Annual CAHPS Surveys
DHMP conducted Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys in 2023 using Press Ganey, an NCQA-certified vendor. Press Ganey follows NCQA protocols and uses statistically appropriate methodologies to determine Member satisfaction scores. Surveys were conducted on both the adult and child Medicaid populations. The Colorado Department of Health Care Policy and Financing (HCPF) contracts with Health Services Advisory Group (HSAG) to conduct the CAHPS survey for the CHP+ population

The following tables show the survey results from Reporting Year (RY) 2021 through 2023 CAHPS surveys for Adult Medicaid, Child Medicaid and CHP+. The Overall Ratings report the percentage of Members who rated the measure as an 8, 9, 10 on a ten-point scale, with 0 being the worst possible experience and 10 being the best possible experience. The Composite Ratings report the percentage of Members who responded with Usually or Always, on a scale of None of the Time, Some of the Time, Most of the Time, or Usually/Always. For the Medicaid populations, annual CAHPS results are compared to health plans nationally using the following percentile rankings: < 5th, 10th, 25th, 50th, 75th, 90th, or > 95th. CHP+ scores are similarly compared to national benchmarks using these percentile rankings: <25th, 25th, 50th, 75th,>95th.

	Adult Medicaid CAHPS Results Reporting Year (RY) 2021 - 2023			
Overall Ratings (% 8, 9, 10)	RY 2021	RY 2022	RY 2023	RY 2023 Percentile Rank
Health Care	75.8%	74.1%	73.0%	26th
Personal Doctor (PCP)	86.2%	80.8%	77.6%	10th
Specialist	84.0%	80.7%	74.0%	<5th
Health Plan	72.4%	72.0%	75.0%	24th
	Composite Satisfaction Ratings (%Always/Usually)			
Getting Care Quickly	79.9%	71.3%	71.3%	12th
Getting Needed Care	84.1%	71.7%	72.0%	5th
How Well Doctors Communicate	94.2%	92.1%	91.7%	31st
Health Plan Customer	91.5%	87.9%	88.9%	40th

Service				

	Child Medicaid CAHPS Results Reporting Year (RY) 2021 - 2023			
Overall Ratings (% 8, 9, 10)	RY 2021	RY 2022	RY 2023	RY 2023 Percentile Rank
Health Care	92.9%	87.0%	90.8%	86th
Personal Doctor (PCP)	95.5%	94.4%	91.1%	61st
Specialist	96.2%	100%	85.0%	34th
Health Plan	86.5%	89.7%	90.3%	83rd
	Composite Satisfaction Ratings (%Always/Usually)			
Getting Care Quickly	89.0%	82.1%	78.1%	<5th
Getting Needed Care	84.8%	80.2%	71.4%	<5th
How Well Doctors Communicate	96.3%	93.7%	94.0%	42nd
Health Plan Customer Service	91.3%	89.6%	88.9%	60th

Medicaid Analysis

CAHPS ratings have fluctuated but mostly trended downward from RY 2021 to RY 2023 for many Adult Medicaid CAHPS measures including Overall Rating of Health Care, Personal Doctor, Getting Needed Care, Getting Care Quickly and Health Plan Customer Service. The Adult Medicaid CAHPS rating score for Overall Health Plan rating has increased year-over-year. There were decreases year-over-year in How Well Doctors Communication, Personal Doctor, Specialist, Getting Care Quickly, Getting Needed Care, and Health Plan Customer Service for Child Medicaid CAHPS ratings. The Medicaid Child CAHPS score for Overall Rating of Health plan has seen a steady increase from RY 2021 to RY 2023.

The RY 2023 Adult Medicaid response rates were 6.9% compared to 9.5% in RY 2022. Child Medicaid response rates for RY 2023 were 8.7% compared to 9.2% in RY2.

CHP+ - Reporting Year (RY) 2021 - 2023			
Overall Ratings (% 9, 10)	RY 2021	RY 2022	RY 2023
Health Care	76.5%	65.1%	67.6%
Personal Doctor (PCP)	82.8%	78.4%	76.9%
Specialist	71.2%	66.7%	75.0%
Health Plan	70.9%	65.8%	61.6%
Composite Ratings (% Always/Usually)			
Getting Care Quickly	86.2%	77.2%	79.3%
Getting Needed Care	83.4%	68.2%	80.1%
How Well Doctors Communicate	94.9%	93.8%	94.8%
Health Plan Customer Service	87.0%	82.4%	82.5%

<u>CHP Analysis</u>

CHP+'s ratings for reporting year 2023 had one measure which was above the 90th percentile for the measure of How Well Doctor's Communicate. Overall, from RY 2022 to RY 2023, CHP+ CAHPS scores improved for five of the eight measures. Reliability is low for these survey scores due to low sample sizes related to low response rates, an ongoing challenge for this population.

HCPF, who administers the CAHPS surveys for CHP+ Members, has begun identifying Best Practices amongst health plans in an effort to improve the delivery of and response rate to the annual surveys. This topic is frequently discussed at regional state Quality Improvement Meetings, where Plans have the ability to discuss interventions designed to improve response rates of their populations.

Improvements in overall scores can indicate that initiatives to improve CAHPS scores are working; however, DHMP CAHPS scores for 2022 and 2023 remained relatively flat (no statistically significant changes overall) and overall national rankings remain low. Substantial efforts are needed to ensure continuous improvement. Annual DHMC CAHPS scores are reviewed with DHHA ACS for oversight and feedback.

CAHPS interventions are a regular topic of discussion at the State's Quality Improvement meeting, where best practices from plans are discussed and presented. Additionally, The DHMP and SPH team will collaboratively host a results session for leadership to review current results for all lines of business and develop action strategies in September 2023. The QI team also provides full results to all product line managers and a comprehensive summary of results to the DHMP executive team. Further improvement efforts are needed to ensure steady improvement over time.

General efforts to improve CAHPS scores have included:

- Improved communication with clinics about health plan quality improvement initiatives, including education about health plan CAHPS scores.

- Increased Member outreach through ACS care support outreach initiatives to follow up on gaps in care and preventive health screenings.
- Implemented focused Member outreach and Care Management to facilitate care transitions when acuity of need was identified.
- Continue to develop communications to members about enhanced provider network and provider resources, and how to access care, to address opportunities of getting needed care, and getting care quickly.

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

- **Getting Needed Care and Getting Care Quickly**
    - The DHHA system is working to provide greater appointment availability by expanding capacity, hours of operation, and specialty services. DHHA is working to expand access to care across numerous clinics and specialties including telemedicine. To improve communication options, established patients are able to message their PCP and care team and schedule primary care and certain specialty visits through EPIC MyChart. The DHHA appointment center triages call to escalate care when medically necessary. There is a 24-hour Nurse Line that is available for Members when the Appointment Center is closed and when Members describe experiencing specific symptoms. Organizationally, there is an increased focus on improving consistent access to care through a delivery network that builds relationships that results in increased satisfaction with the health care system and better health outcomes for the population.
    - To have increased insight into member's access to care, DHMP implemented a provider open shopper process. DHMP utilizes an external vendor to contact providers to request appointment availability for different types of services. This process allows DHMP to monitor the networks' ability to have timely access to services.
- **Health Plan Customer Service**
    - Efforts continue to improve the Health Plan Services department and customer service. The Health Plan Services (HPS) leadership team provides real-time training for staff regarding HPS call quality improvement. The HPS Team member designated by HPS Leadership, reviews calls, from every staff member and performs on the spot evaluation and training. The Team designee performs sample audits of calls for each call representative on a regular basis. All HPS phone audit report results are presented and discussed bi-monthly at the DHMP Quality Management Committee (QMC.)
    - DHMP has worked with the Health Plan Services department to develop a work plan that outlines the processes to effectively track Member satisfaction. Each one of our telephonic contacts with a Health Plan Services (HPS) representative concludes with the question 'Have I provided the help or information you needed today?'

Monitoring is conducted to ensure that HPS representatives are asking the question. When Members answer “no” to the above question, Member Service representatives track the reasons the Member cites for not getting the help or information they needed. Tracking these factors will assist in identifying process improvement and staff training opportunities.

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

- **Health Needs Assessment**
  - A key component of supporting an individual’s health needs is to understand both the member’s health and social needs. In order to understand the full spectrum of our members' needs DHMP has been performing a health needs assessment (HNA) of all new Medicaid and CHP+ members. DHMP engaged a vendor to outreach to members to perform an initial health needs assessment. The HNA engages the member with a series of health (physical and behavioral) and social determinants of health questions to identify the members concerns and needs. The results of the HNA are communicated to the care coordination team, who follows up with the member. Based on the individual's needs the care coordinator provides general information and resources (including community-based organizations), referrals, connection to a medical home, and general support. The HNA is mailed to all members and then is followed up with direct phone calls to the members.

- **Population Stratification**
  - Modeling HCPF’s risk stratification dashboard, DHMP continues to utilize a risk stratification tool that allows DHMP to monitor and analyze the membership’s health and needs. The tool allows DHMP to target specific conditions or issues (e.g., high number of emergency department visits) to outreach directly to members to provide education and resources.

Pharmacy Review to Prevent Fraud Waste and Abuse

Background

In reviewing the last 2 quarters of 2019 data, the number of members that met the 4x4x4 criteria

(Taking 4 or more controlled substance medications, written by 4 or more prescribers, and filling these medications at 4 or more pharmacies) and that resulted in a letter getting sent to their provider, continued to decrease. This is most likely due to the implementation of several point-of sale (POS) edits that have been in place for approximately 30 months.

Since the implementation of these edits, the number of members receiving opioid prescriptions from multiple providers has dropped significantly. Therefore, the plan decided to retire the 4x4x4 summary report, as the resources to continue to run and review the report, were not justified in the number of members that actually had a letter sent to their provider. It appears that the POS edits have been successful in reducing opioid related fraud, waste and abuse in this population, and this tracking and monitoring is ongoing.

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

In December of 2017, the plan implemented a limit on morphine equivalent dose (MED) for Medicaid members. This limits the amount of opioid medication a member can get to 250 MED per day. Every opioid prescription is converted to this MED factor to quantify the daily dose. In January of 2019, after one year of having this edit in place, the plan reduced the limit to 200 MED per day. This was done as a measure to reduce opioid overutilization and hopefully reduce the risk of opioid overdose.

DHMP monitors what Colorado State Medicaid is doing and works to maintain some consistency between the two Medicaid plans so that members do not try and switch to the plan that has more lenient opioid restrictions in place. The following are quarterly reviews of the claims impacted by this edit in the past calendar year.

Opioid Cumulative Dosing Program (OCDP) Results

3rd Quarter 2021		
Total Claims Approved:	32	27.6%
Total Claims Denied:	84	72.4%
Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	84	
Total Member Count:	11	
Total Prescriber Count:	18	
Total Pharmacy Count:	15	
Total Denied Claim Count Subsequent Fill:	71	
Total Denied Claim Count No Subsequent Fill:	13	
Total First Denied Claims**:	18	
Total First Approved Claims**:	14	
Total Ingredient Cost Denied Claims**:	$703.64	
Total Ingredient Cost Approved Claims**:	$239.90	

Average Ingredient Cost/Denied Claim**:	$39.09	
Average Ingredient Cost/Approved Claim**:	$17.14	

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

4th Quarter 2021		
Total Claims Approved:	40	29.9%
Total Claims Denied:	94	70.1%
Total Soft Edit Denials (OCDP only):	0	
Total Hard Edit Denials (OCDP only):	94	
Total Member Count:	15	
Total Prescriber Count:	16	
Total Pharmacy Count:	16	
Total Denied Claim Count Subsequent Fill:	78	
Total Denied Claim Count No Subsequent Fill:	16	
Total First Denied Claims**:	18	
Total First Approved Claims**:	18	
Total Ingredient Cost Denied Claims**:	$383.30	
Total Ingredient Cost Approved Claims**:	$396.53	
Average Ingredient Cost/Denied Claim**:	$21.29	
Average Ingredient Cost/Approved Claim**:	$22.03	

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

1st Quarter 2022		
Total Claims Approved:	29	31.5%
Total Claims Denied:	63	68.5%
Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	63	
Total Member Count:	14	
Total Prescriber Count:	20	
Total Pharmacy Count:	15	
Total Denied Claim Count Subsequent Fill:	48	

Total Denied Claim Count No Subsequent Fill:	15	
Total First Denied Claims**:	15	
Total First Approved Claims**:	11	
Total Ingredient Cost Denied Claims**:	$801.81	
Total Ingredient Cost Approved Claims**:	$289.88	
Average Ingredient Cost/Denied Claim**:	$53.45	
Average Ingredient Cost/Approved Claim**:	$24.16	

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

2nd Quarter 2022		
Total Claims Approved:	37	29.1%
Total Claims Denied:	90	70.9%
Total Soft Denials (OCDP)	0	
Total Hard Denials (OCDP)	90	
Total Member Count:	11	
Total Prescriber Count:	13	
Total Pharmacy Count:	10	
Total Denied Claim Count Subsequent Fill:	75	
Total Denied Claim Count No Subsequent Fill:	15	
Total First Denied Claims**:	17	
Total First Approved Claims**:	16	
Total Ingredient Cost Denied Claims**:	$382.19	
Total Ingredient Cost Approved Claims**:	$367.96	
Average Ingredient Cost/Denied Claim**:	$22.48	
Average Ingredient Cost/Approved Claim**:	$23.00	

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

Analysis
The number of members affected has maintained over the past year. On average, around 12 members are above the limit at a given time. This number was around 20 members per quarter two years ago and

has since stabilized. The lowering of the limit occurred in the 1st quarter of 2019 and since that time, it has remained unchanged. The plan accepts and reviews prior authorizations (PAs) for members with cancer pain, sickle cell disease, in hospice and in palliative care, as these diagnoses are excluded from these restrictions. The plan will also accept and review PAs to allow time to taper the dose down to the appropriate limit.

3Q2021	# of PAs	6
4Q2021	# of PAs	7
1Q2022	# of PAs	4
2Q2022	# of PAs	13

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

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

Summary of Opioid Controls

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

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

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

Pharmacy Review and Notification of Drug Recalls

Background

The Pharmacy Department evaluates drug recalls and voluntary market withdrawals that have occurred and tracks this information in the Drug Recall and Voluntary Withdraw Tracking Log.

This log was reviewed to assess that notification was provided in a timely and appropriate manner. The plan is notified of drug recalls via the pharmacy benefit manager, and then the plan notifies providers and members as appropriate.

Table 1: Drug Recalls by Quarter

Report Quarter	Members Affected	Notification Timely
3Q2021	157	Yes
4Q2021	23	Yes
1Q2022	0	N/A
2Q2022	0	N/A

On September 17, 2021, the plan was notified that all lots of Pfizer Chantix Tablets were recalled due to the presence of nitrosamine, N-nitroso-varenicline, at or above the FDA interim acceptable intake limit. It was determined long-term ingestion of N-nitroso-varenicline may be associated with a theoretical potential increased cancer risk in humans, but there is no immediate risk to patients taking this medication. The health benefits of stopping smoking outweigh the potential cancer risk from nitrosamine impurity in varenicline.

On October 14, 2021, the plan was notified Irbesartan 75 mg, 150 mg, 300 mg tablets or Irbesartan/hydrochlorothiazide (HCTZ) 150 mg/12.5 mg or 300 mg/12.5 mg tablets "Lupin" was recalled due to the analysis of certain tested batches (but not finished product batches) revealing the presence of a nitrosamine, N-nitroso-irbesartan, above the specification limit. Although Lupin has not received reports of illness assessed to be related to this issue, the company, out of an abundance of caution, is recalling all batches.

Quality of Care - Grievances-

Quality grievances which are harmful or potentially harmful to the member's life or safety are directed for additional review. Under the direction of the DHMP Medical Director, the RN investigates any potentially serious quality grievances from members or providers. A full summary of all findings during the investigation is presented to the Medical Director for review. Serious quality concerns are sent to the appropriate providers and/or facility for feedback. Appropriate reporting to any regulatory agency is performed when appropriate after investigation.

All quality grievances are tracked, trended and reported to the Product Line Mangers and the DHMP Quality Management Committee. Trending year over year for patterns is also performed. The QMC makes recommendations to help improve performance as needed. The QMC makes recommendations to help improve performance as needed.

A Statewide Quality-of-Care Audit was performed in 2022. Low numbers of reported cases were a noted finding for DHMP for both Medicaid and CHP+ populations. Due to the small enrollment population for CHP+, zero quality related grievances were reported for 2022. Medicaid also saw very low numbers with only 2 cases going for QOC review for calendar year 2022. Other payers within the State who manage CHP+ members also saw very limited numbers of quality grievances submitted.

The State of Colorado announced a new process which will be implemented in 2023 for quality grievances concerns. Any concerns other than an appeal (denial of an organization determination or a claims appeal) is now considered a quality-of-care grievance. Items previously identified as quality of service will be regrouped into quality grievances. This new process will impact both Medicaid (estimated September 2023) and CHP+ (estimated December 2023). The final process is still pending.

2022 Quality Grievances – Medicaid and CHP+

Plan	Total Cases 2022	Unsubstantiated	Substantiated	Inconclusive
Medicaid	2	2	0	0
CHP+	0	0	0	0

QOCC Review Outcomes Defined:

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

TRENDS ANALYSIS

Medicaid

When compared to 2021 statistics, the quality grievances for calendar year 2022 dropped to a new low. 2021 had 6 total cases. 2022 had a total of 2 unsubstantiated cases. This is a reduction of 66%. Quality of care and quality of service complaints are all to be classified as quality-of-care grievances. This new process is estimated to go into effect September 2023. This presents new opportunities for improvement in order to fully align with the State reporting requirements with the reporting template.

The actionable items for 2023 include:

- DHMP will continue to monitor this line of business for reported grievances and await finalization of the new QOC-G process.
- Perform staff training and creation of new desktop operating procedures.

There are no opportunities for improvement regarding turnaround times. DHMP has been 100% compliant with that requirement for 2022.

CHP+

Due to low membership, the year-over-year trend has been zero total cases for the last 7 years. With the pending change announced by the State, it is forecasted to rise next year. The actionable items for 2023 include:

- DHMP will continue to monitor this line of business for reported grievances and await finalization of the new QOC-G process.

- Perform staff training and creation of new desktop operating procedures.

Serious Reportable Events, Never Events and Hospital Acquired Conditions

All SRE/NE/HAC events are discovered by a report which is pulled from claims. Each event is investigated, summarized and presented to the Medical Director for review. A root cause analysis is performed on each event along with claims payment verification.

Event summaries and root cause analyses are then classified by the Medical Director as either:
- Not Actionable
- Track and Trend
- Referral for Peer Committee review.

This process is performed separately for both the Medicaid and CHP+ lines of business.

For Medicaid fiscal year 2022 to 2023, a total of 8 events were found. This is a decrease from the previous year of 11 events.

Type of Event by Category		
	Stage III and IV Pressure Ulcers	2 Events
	Catheter Associated Urinary Tract Infection (UTI)	4 Events
	Vascular Catheter - Associated Infection	2 Events
Grand Total	**8 Events**	

Events by Facility Name - Total Number

Facility	Total Number
St Joseph Hospital	3 Events
Denver Health Hospital Authority	4 Events
Presbyterian St Luke	1 Event

All information was presented to the Medical Management Committee for further review and discussion. After reviewing all discovered events, only 4 of the 8 events were found to be actionable. All 4 cases were placed on the Credentialling Team's Track and Trending Report.

There was noted improvement at Denver Health Hospital Authority from the previous year for Catheter Associated Urinary Tract Infections and Pressure Ulcer wounds.

For the CHP+ fiscal year 2022 to 2023, there were no events found via claims reporting for any serious reportable, hospital acquired or never events. There were no reported events communicated by outside facilities or provider to DHMP for these categories as well.

No actionable items, no opportunities for improvement were found for the CHP+ line of business.

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

Grievance Reporting and Trending

Medicaid and CHP+ SFY 2021-2022

Category	1Q	2Q	2021 TOTAL	3Q	4Q	2022 TOTAL	GRAND TOTAL
Access and Availability	4	3	7	0	4	4	11
Benefit Package	1	2	3	0	1	1	4
Clinical Care	3	0	3	1	1	2	5
Customer Service	1	2	3	0	0	0	3
Financial and Billing	3	5	8	3	1	4	12
Rights and Legal	2	1	3	0	1	1	4
GRAND TOTAL OF COMPLAINTS DURING REPORT PERIOD							39

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

The data for SFY 2021-2022 indicated that the primary area of concern for DHMP is Billing/Financial issues. Further analysis indicated that many of the grievances in this category stem from denials due to

lack of authorization and grievances from members being balance billed by providers for Medicaid covered services. To address these issues, Grievance and Appeals reached out to providers who were balance billing the member to notify them that HCPF prohibits members from being billed more than the member's normal cost share for Medicaid covered services. Grievances and appeals also provided education to the members in the grievance resolution letter about when an authorization must be obtained prior to receiving services.

Also observed in the SFY 2021-2022 data were zero (0) member grievances with the CHP+ line of business.

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

QOCC Review Outcomes					
Unsubstantiated					
Substantiated					
Inconclusive					
Total					

Cultural and Linguistically Appropriate Services Program (CLAS)

Denver Health Medical Plan (DHMP) provides health coverage to a culturally diverse population; therefore, it is important to educate staff about cultural differences that impact healthcare delivery

DHMP Medicaid Language Data*

Medicaid Language Data FY22/23

Language	Measure	FY22/23
ENGLISH	Count	83, 721
	Rate	77.40%
SPANISH	Count	21606
	Rate	19.97%
VIETNAMESE	Count	459
	Rate	0.42%
ARABIC	Count	382
	Rate	0.35%
AMHARIC	Count	381

	Rate	0.35%
OTHER	Count	263
	Rate	0.24%
PERSIAN	Count	167
	Rate	0.15%
FRENCH	Count	163
	Rate	0.15%
CHINESE	Count	128
	Rate	0.12%
SOMALI	Count	127
	Rate	0.12%
RUSSIAN	Count	114
	Rate	0.11%
NEPALI	Count	100
	Rate	0.09%
BURMESE	Count	94
	Rate	0.09%
DANISH	Count	77
	Rate	0.07%
UNKNOWN	Count	57
	Rate	0.05%
ARMENIAN	Count	36
	Rate	0.03%
KOREAN	Count	32
	Rate	0.03%
SAMOAN	Count	26
	Rate	0.02%
HAITIAN	Count	25
	Rate	0.02%
KAREN LANGUAGES	Count	21
	Rate	0.02%
MANDARIN CHINESE	Count	20
	Rate	0.02%
THAI	Count	18
	Rate	0.02%
SWAHILI	Count	17
	Rate	0.02%
Cemuhî	Count	15
	Rate	0.01%

ROMANIAN	Count	15
	Rate	0.01%
ENGLISH LRG PRT	Count	14
	Rate	0.01%
YUE CHINESE	Count	13
	Rate	0.01%
AMERICAN SIGN LANGUAGE	Count	13
	Rate	0.01%
HINDI	Count	11
	Rate	0.01%
PORTUGUESE	Count	11
	Rate	0.01%
ITALIAN	Count	10
	Rate	0.01%
TURKISH	Count	8
	Rate	0.01%
SWEDISH	Count	8
	Rate	0.01%
INDONESIAN	Count	7
	Rate	0.01%
TAGALOG	Count	7
	Rate	0.01%
Grand Total	**Count**	**108166**
	Rate	**100%**

*Numbers reflect enrollment 7/1/2022-6/30/2023

DHMP Medicaid Member Language Summary
As of June 2023, there were 48 distinct languages identified that were spoken by our DHMP Medicaid members. However, only 12 languages were spoken by our members at 0.1% or greater, or 500 persons or more, ((English, Spanish, Vietnamese, Arabic, Amharic, Persian, French, Chinese, Somali, Russian, Nepali and Burmese) for the Medicaid product line in FY2022/2023.

DHMP Medicaid Plans Race/Ethnicity Data*

Race/Ethnicity	FY2022-2023	
	Count	Rate
Unknown	14,231	13.38%
Hispanic or Latino	43,561	40.95%
White	26,172	24.60%
Black	18,023	16.94%
Asian	3,050	2.87%
Hawaiian	248	0.23%
Other Pacific Islander	334	0.31%
American/Alaskan Native	755	0.71%
Grand Total	106,374	

*Numbers reflect enrollment 7/1/2022-6/30/2023

DHMP Medicaid Member Race/Ethnicity Summary

Medicaid member race/ethnicity and language data from the July 2022-June 2023 eligibility files were examined. Based on our analysis for our Medicaid line of business in FY2021/2022, Hispanic or Latino was the predominant race/ethnicity of our member population, at 40.95%, followed by White at 24.6% and Black/African American at 16.94%. Aproximately 13.5 percent of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

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

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

DHMP will utilize this data for MCD and CHP+ members seen at DHHA clinics to improve our CLAS efforts starting in FY23/24.

DHMP CHP+ Language Data*

CHP+ Language Data FY22/23

Language	Measure	FY22.23
ENGLISH	Count	2011
	Rate	67.57%
SPANISH	Count	877
	Rate	29.47%
VIETNAMESE	Count	12
	Rate	0.40%
NEPALI	Count	11
	Rate	0.37%
ARABIC	Count	10
	Rate	0.34%
FRENCH	Count	9
	Rate	0.30%
AMHARIC	Count	9
	Rate	0.30%
BURMESE	Count	7
	Rate	0.24%
OTHER	Count	6
	Rate	0.20%
RUSSIAN	Count	4
	Rate	0.13%
TAGALOG	Count	4
	Rate	0.13%
PERSIAN	Count	4
	Rate	0.13%
CHINESE	Count	3
	Rate	0.10%
ARMENIAN	Count	2
	Rate	0.07%
UNKNOWN	Count	2
	Rate	0.07%
DANISH	Count	1
	Rate	0.03%
HINDI	Count	1
	Rate	0.03%
KOREAN	Count	1
	Rate	0.03%
SAMOAN	Count	1
	Rate	0.03%

KAREN LANGUAGES	Count	1
	Rate	0.03%
Grand Total	**Count**	**2976**
	Rate	**100%**

*Numbers reflect enrollment 7/1/2022-6/30/2023

DHMP CHP+ Member Language Summary

As of June 2023, there were 18 distinct languages identified that were spoken by our DHMP CHP+ members. However, only nine languages were spoken by our members at 0.1% or greater, or 500 persons or more, (English, Spanish, Vietnamese, Amharic, Arabic, Russian, Burmese, Nepali, and French) for the CHP+ product line in FY2022/2023.

DHMP CHP+ Race/Ethnicity Data*

Race/Ethnicity	FY2022/2023	
	Count	Rate
No Ethnicity/Unknown/Not Reported	717	24.33%
Hispanic or Latino	1,265	42.93%
White	503	17.07%
Black/African American	262	8.89%
Asian	171	5.80%
Alaskan/American Indian	12	0.41%
Hawaiian	12	0.41%
Other Pacific Islander	5	0.17%
Grand Total	2947	

*Numbers reflect enrollment 7/1/2022-6/30/2023

DHMP CHP+ Member Race/Ethnicity Summary

CHP+ member race/ethnicity and language data from the July 2022-June 2023 eligibility files were examined. Based on our analysis for our CHP+ line of business in FY2022/2023 Hispanic or Latino was the predominant race/ethnic of our member population, at 42.93%, followed by White at 17.07% and Black/African American at 8.89%. Over twenty four percent of members are listed as Unknown or Not Reported, which highlights a strategic enterprise need to more effectively collect and track REL data.

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

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

DHMP will utilize this data for MCD and CHP+ members seen at DHHA clinics to improve our CLAS efforts starting in FY23/24

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 2023.

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. DHMP reflects this as 38.2% of DHMP 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 2023, 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

Disparities in Health

In SFY2020/21, reducing disparities in health related to race, ethnicity and language was identified as an enterprise opportunity, increasingly so as the COVID-19 pandemic and vaccination effort have emphasized the continuing disparities in health outcomes related to race and ethnicity. In SFY2022/23, DHMP, with support from HCPF and FEMA, began conducting targeted outreach to DHMP MCD members of color and members who may be housebound to ensure that they have equal access to the COVID-19 vaccines with the goal of eliminating any disparity between the rate of white members being vaccinated and the rate of members of color being vaccinated.

In addition to this ongoing system wide work to improve COVID-19 outcomes and vaccination rates across racial/ethnic groups, DHMP continues to grow and define its integrated Population Health Management programming for our MCD and CHP+ populations with a focus on identifying and eliminating racial and ethnic health disparities. The program includes a concerted focus on metrics traditionally associated with high levels of disparities such as children's wellness exams and immunizations, prenatal care, members with multiple chronic conditions and members with mental health conditions.

Additionally, DHMP will continue to participate in ongoing planning, identification, and any initiatives in collaboration with DHHA's Ambulatory Care Services (ACS), ACS quality improvement workgroups, and the newly established Office for Health Equity as well as Plan product line management, marketing and health plan services. Potential initiatives in development with ACS partners include maternal complications 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. In addition, the QI and MCD teams will meet with the Office of Health Equity quarterly in order to ensure close collaboration on health equity interventions for this population.

In SFY23/24, the QI team will partner with the MCD and CHP+ teams in order to develop Health Equity Plans for our MCD and CHP+ members as required by HCPF. DHMP will collect and analyze data around four priority areas: COVID-19 vaccination, behavioral health access, preventive care services, and prenatal and postpartum care during this year and plan to implement a series of interventions aimed at reducing the disparity in outcomes between populations in SFY24/25 and beyond. The QI and MCD teams are also members of the State's Health Equity Taskforce.

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 patients, providers 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. 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 FY2022/2023
In FY2022/2023 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 onto DHMP's server to create a historical record for future auditing purposes. The Marketing Department provides support on the appropriate and optimal usage of this software to ensure consistency in Grade Level dissemination and in order to meet contractual requirements per LOB. The Member Outreach Committee which reviews and coordinates Member communications will continue to review DHMP created Member materials for understanding, cultural appropriateness and ease of use.

Access to Care and Services

Access Measures

Access Measures	Denver Health Medicaid Choice				
	HEDIS MY2020 Results	HEDIS MY2021 Results	HEDIS Measurement Year MY2022 Results	MY2021 HEDIS MCD Percentile	HEDIS MY2021-MY2022 Change
Adults' Access to PCP (AAP)					
Ages 20-44	47.79%	47.01%	44.52%	<5th	- 2.49%
Ages 45-64	58.29%	57.16%	55.62%	<5th	- 1.54%
Ages 65+	59.42%	65.85%	67.75%	<5th	1.9%
Total	47.79%	50.89%	48.95%	<5th	-1.94%

Access Measures	Denver Health CHP+				
	HEDIS 2020 Results	HEDIS MY2020 Results	HEDIS Measurement Year MY2021 Results	MY2020 HEDIS MCD Percentile	HEDIS MY2020-MY2021 Change
Adults' Access to PCP (AAP)					
Ages 20-44	N/A	N/A	N/A	N/A	N/A
Ages 45-64	N/A	N/A	N/A	N/A	N/A
Ages 65+	N/A	N/A	N/A	N/A	N/A
Total	N/A	N/A	N/A	N/A	N/A

Analysis

Medicaid Choice

Children and Adolescents' Access to PCP (CAP)

This measure was retired in measurement year 2020 and will no longer be reported out in this evaluation.

Adults' Access to PCP (AAP)
Three out of four Adults' Access to PCP measures decreased for HEDIS measurement year 2022 when compared to MY2020. For members ages 65+, access increased by 1.94% but remains in the >5th percentile national, as do all other age groups. Access measures may have been impacted by the large numbers of members seeking care postponed during the pandemic and the ongoing Public Health Emergency (PHE). Access and empanelment of adult DHMP Medicaid Members continues to be an ongoing area of opportunity within Denver Health and for Denver Health Medical Plan. Interventions involving a robust Member outreach are an ongoing source of discussion within Denver Health's Ambulatory Care Services with the goal of increasing the overall numbers of PCP empanelment and connection to care.

CHP+
Children and Adolescents' Access to PCP (CAP)
This measure was retired in measurement year 2020
and will no longer be reported out in this evaluation

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

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

- Denver Health continues to operate 18 School Based Health Centers (SBHCs) that provide health care in an easy and convenient setting to all Plan Members who attend Denver Public Schools.
- Several strategies were developed to reduce the wait list, including an improved new patient workflow for the Appointment Center, the hiring and placement of Providers in key locations, collaboration between the Appointment Center and clinics to fill open appointment slots, and adjusted Provider panel sizes. Saturday morning hours for primary care at 3 locations have continued at the Montbello Health Center, Denver Health main campus and at the Westside Family Health Center on Federal Boulevard.
- Denver Health Medicaid Choice and CHP+ provided Members with information on how to access the care they need through the Provider Directory, Member Handbook, and Member Newsletters. These materials provided information on how to obtain primary care, specialty care, after-hours, emergency care, ancillary and hospital services. The Denver Health Member Handbook contains information on Member benefits and how to access care within the DHMP network.
- New DHMP Members are sent a welcome packet including their ID card and Quick Reference Guide. DHMP also provides Orientation Videos in English and Spanish on the website for Members. These videos inform our members about their benefits and provide information on how the plan works.
- DHMP maintains a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine is capable of discussing the member's symptoms and concerns assisting the member in understanding the urgency of their need and can assist with deciding the best course of action based on the urgency to see their primary care provider or going to the urgent care or emergency department. Additionally, the NurseLine nurses can write prescriptions for some

illnesses and can also schedule a Dispatch Health visit.

- DHMP continues to contract with Dispatch Health to support the membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. DHMP has expanded the use of Dispatch Health to include SNF at home, Hospital at home and Bridging services to assist in early discharges.
- MyChart is a user-friendly application/website with multiple capabilities available to members to enhance and support their experience. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, review lab results, communicate directly with providers, and a centralized location for tracking their health outcomes and programs. It was used to send mass messages about the availability of Covid and flu vaccines. as requirements changed rapidly.
- DHHA has recently begun utilizing an e-consult process that allows for providers to refer members for an e-consult with a specialist who can review the case and provide recommendations for care without, in many cases, having to see the member for a visit. E-consults are generally acted on within 3 business days. This results in less wait times for specialty access. In the event that a follow up visit is needed the specialty provider can order a visit.
- Telehealth visits continue to offer expanded access for Members. Members can schedule telehealth visits including urgent care via MyChart.

DHMP continues to contract with STRIDE Community Health Center. The partnership adds 15 additional clinic locations (three of which have pharmacies onsite) and options for both DHMP Medicaid and CHP+ members.

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

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

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

New enrollees with special needs may continue to see a non-plan Provider for 60 days from the date of enrollment in Denver Health Medicaid Choice and CHP+ if the enrollee is in an ongoing course of treatment with a previous Provider and only if the previous Provider agrees to terms as specified in

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

Finally, there are ongoing efforts to enhance contract-aligned availability standards reporting, for the purpose of increasing the accuracy of identifying opportunities for availability improvement. Additionally, we are doing granular analysis for Out of Network (OON) data, to identify geographic and service type opportunities for improvement in access and availability.

Open Shopper Study

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

The Open shopper analysis is managed by the Director of Insurance Products.

It is crucial to understand the current state of access in order to best support efforts that improve access to care. The results of the open shopper surveys will be provided to the Network Management Committee (NMC) to determine if the network is sufficient to provide services to members on a timely basis; identified provider non-compliance will be addressed through the corrective actions process. The overall goals of the open shopper process include:

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

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

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

Annual DHMP CAHPS scores are reviewed with Ambulatory Care Services (ACS) in the Ambulatory

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

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

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

Access-related CAHPS surveys are actively shared with medical management and operational leadership of ACS to facilitate joint planning of QI efforts and initiatives.

Privacy and Confidentiality Monitoring

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

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

Member.

Confidential information obtained in the process of performing utilization management services will be used solely for utilization and quality management and will be shared only with parties authorized to receive it. Any confidential information which DHMP finds it necessary to disclose in the performance of utilization management services shall not be disclosed to any unauthorized entity without prior consent of the Member or as required by law.
All confidential information, whether physical or digital, retained by DHMP shall be held in a secure manner. All confidential information will be retained in accordance with applicable state and federal laws.
In the course of performing its utilization management responsibility, it is the policy of DHMP Medical Management Department not to record telephone conversations.
In the event of a Conflict of Interest, no person may participate in the review, evaluation, or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. All Company employees, any members of committees not employed by the organization, and the board of directors are required to review and sign the Conflict-of-Interest statement annually.

IV. Overall Structure of the QI Program

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

Medical Director responsibilities include, but are not limited to:

- Providing direction and support related to the development, 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
- Delegating components of the QI Work Plan to other Members of the Operations Management Committee
- Serving on the QMC, AQIC, Pharmacy and Therapeutics Committee (P&T), Medical Management Committee, Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee and Denver Health Physician Executive Committee
- Evaluating and managing DHMP's Quality of Care Grievances (QOC-Gs working in conjunction with the QOC RN, and reporting to the PSQC as indicated for

the reporting of QOC-Gs to the appropriate regulatory entities as appropriate. Overseeing DHMP's clinical and preventative health guidelines

- Serving as the chairperson of the Credentialing Committee

DHMP's Quality Improvement Department

Quality Improvement Department functions as a division of the Health Outcomes and Pharmacy (HOP)

DHMP Director of Quality Management is held by the Senior Director of HOP
Provides oversight and direction to all QI members, QI department program work and direct supervision of QI department leaders.
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.
- Serve as facilitator for the QMC, including determining the composition of the QMC and coordination of meeting execution.
-

Vacant QI Manager of QI responsibilities include, but are not limited to:

- Development, management, and monitoring of the QI Program
- Supports the Director with QMC and MMC responsibilities
- Coordinate, provide advice and participate in the execution of the QI Program through collaboration with other DHMP ad Denver Health departments, as appropriate for regulatory compliance and performance improvement
- Annually ensure all policies, procedures and guidelines related to the QI Department are updated appropriately
- Oversee QI vendor contracts and delegate reporting and monitoring activities
- Provide management and direction to the QI Department

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

Quality Management Committee Structure (QMC)

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 process, including but not limited to: Utilization Management, Case Management, Health Management, Pharmacy, Population Health Management, 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, QOC-G's and SNP MOC annual program evaluation and goals The QMC includes primary care Providers and specialty Providers from both DHHA and the extended practitioner network and other staff.

The Denver Health Quality Management Committee:

- Meets Bi-Monthly
- Is comprised of the following Members:
  - DHMP Director/ Manager of Quality Improvement (Facilitator)
  - DHMP Medical Director (Chair)
  - DHMP Manager of Compliance
  - DHMP Director of Health Plan Services
  - DHMP Director of Claims, Managed Care
  - HMP Director of Monitoring, Auditing and Training
  - DHMP Director of Provider Relations
  - DHMP Director of Pharmacy
  - DHMP Director of Utilization Management
  - DHMP Director of Case Management
  - DHMP Director of Insurance Products, Managed Care
  - PCP(s) from DHHA and the External Provider Network
  - Specialty Care Provider(s) from DHHA and the External Provider Network
  - Behavioral Health Physician (M.D) Provider(s) from DHHA or the External Provider Network
  - QI Project Manager
  - Intervention Project Managers
  - NCQA Project Manager
  - ACS Care Coordination Manager
  - QOC-G Nurse
  - Pharmacy and Therapeutics Pharmacist
  - Manager of Grievance and Appeals (non-voting unless designated by director)
  - Manager of Member Services (Non-voting unless designated by director)
  - Medicare Products Manager (Non-voting unless designated by director)
  - Medicaid/CHP Product Manager (Non-voting unless designated by director)
  - Commercial Products Manager (Non-voting unless designated by director)
  - Marketing Manager (Non-voting unless designated by director)

Functions of Denver Health Quality Management Committee:

- Review of the performance of QI activities.

- Review summary reports for the QMC subcommittees, ad hoc committees and QA/QI process improvement activities providing feedback and /or recommendations for improvement.
- Identify and analyze trends and evaluate the implementation of appropriate focused interventions to improve performance.
- Review and Approve Quality Improvement Projects (QIP
- Review, evaluate, develop and implement Population Health based QA/QI activities and satisfaction survey intervention plans.
- Provide oversight of all clinical and administrative aspects of the QI Program.
- Review practitioner membership annually or as needed to assure broad representation of primary care practitioners and specialists.
- Oversee accurate and clear reporting of QMC minutes and follow up actions.
- Recommend clinical and safety initiatives relevant to policy decisions. Review and evaluate the results of quality improvement activities.
- Oversee needed actions for improvement upon performance goals.
- Supervise follow-up of issues and activities, including root cause analysis or barrier analysis when needed.
- Review, update and approve clinical and preventive practice guidelines annually.
- Review member satisfaction and quality of care results, such as CAHPS, HEDIS, STARS and findings of Open Shopper studies.
- Review and evaluate activities that improve member experience, such as access to care and quality of services and make recommendations about ways to improve these results.
- Review, monitor, track and trend, findings of Quality of Care, Quality of Service, and Serious Reportable Events and make recommendations for Corrective Action Plans (CAP). Monitoring of CAPS
- Review of Credentialing Committee (CC), Medical Management Committee (MMC) and Network Management Committee (NMC) minutes for program(s) performance for selection of opportunities
- Review and final resolution of practitioner request for reconsideration of credentialing and/or recredentialing determinations and/or issues, termination of practitioner and /or provider contracts for quality-of-care issues, competence, or professional conduct.
- Provide oversight and recommendations regarding utilization of new technologies and benefit design.
- Provide oversight of QI Program deliverables including, but not limited to:
- QI Program Description
    - QI Work Plan
    - QI Evaluation
- Provide oversight of the Population Health Program
    - Annual PH Program Evaluation
    - Annual PH Program Strategy
- Provide oversight of Utilization Management Program (UM) including:
    - Annual UM Evaluation
    - Annual UM Program Description
    - Work Plan update
- Provides ongoing reporting to the DHMP Board of Directors

Reporting Committees to the QMC include, but are not limited to:

- Ambulatory Care Services QI Committee (AQIC)
- Medical Management Committee (MMC)
- Network Adequacy Committee (NMC)
- Credentialing Committee

QI Activities Summary

DHMP continues to conduct an in-depth review of all its initiatives and intervention activities, using best practices, LEAN tools, and cost/benefit analysis as guides. All approved activities will have performance measures attached with PDSA embedded into their standard work cycles. Yearly work plans will have measurable goals and/or benchmarks. Interventions that do not meet performance targets may be selected to undergo a root cause analysis and/or barrier analysis. DHMP seeks to improve Member education, health literacy, and cultural competency in the services we provide.

Results from QI activities for 201923 have been outlined throughout this impact analysis and are also contained in the 2022-23 work plan and strategic access plan. QI will continue to work collaboratively with other departments and the ACS Provider network to improve HEDIS and MCAHPS scores. We will strive to increase access to needed care and access to getting care quickly, while focusing on customer service, the Member experience and increasing Member engagement of our members in the management of their health.