Denver Health Medical Plan, Inc.

Quality Improvement Program Evaluation

2016

Commercial & Medicare Products
I. Executive Summary

Denver Health Medical Plan, Inc. (DHMP) is a licensed Health Maintenance Organization (HMO), effective 1/1/97, with responsibility for managing the following DHMP member groups and their health care:

Commercial Large Group:
- City and County of Denver (CSA)
- Denver Health and Hospital Authority (DHHA)
- Denver Employees’ Retirement Program (DERP)
- Denver Police Protective Association (DPPA)
- Denver Public Schools

Commercial Exchange;
- Elevate Health Plans

The DHMP Medicare Advantage health plan includes:
- Medicare Select HMO
- Medicare Choice HMO SNP

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

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

Annually, we review ongoing and completed quality improvement activities, complete analysis of our results and evaluate the overall value of our program. From this evaluation process, we develop recommendations for the upcoming year, which are incorporated into the quality improvement program description and work plan. The Medical plan is able to assess the strengths of the program and identify opportunities for improvement, incorporating learning from the ongoing activities.

In this report, DMHP quality improvement program activities are summarized and evaluated, including program accomplishments and opportunities, with tracking and trending of results and data over time. Data is systematically collected prospectively, concurrently, and/or retrospectively on clinical, safety, preventive and service performance. This data is analyzed, summarized, and presented as information, with recommendations to Quality Management Committee (QMC). QI actively collaborates with other health plan departments, as well as our network providers to develop, implement and evaluates quality improvement initiatives. QI improvement activities are coordinated and implemented with case management, care management, pharmacy, member services, provider/network services, behavioral health & wellness services, marketing and product line managers for Commercial and Medicare.
Our provider network includes the Ambulatory Care Services of Denver Health, known as Community Health Services (CHS) for our health maintenance organization (HMO) membership. For the POS (point of service members), we offer the Cofinity Network, including University and Children’s Hospital, under more expansive health plan offerings of expanded and POS (point of service) benefits. We collaborate with Denver Health Community Health Services on QI initiatives through the Ambulatory Quality Improvement and Design Committee (ADQIC), disease and prevention specific work groups and the patient experience work group. In these committees and groups, we join quality resources and actively work together to increase the health and well-being of our members.

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

Randomized provider and clinician CAHPS surveys are done at CHS clinics to measure patient satisfaction with their provider and their care. The information is monitored monthly by the patient experience workgroup for analysis and action planning targeting identification of best practices within clinics.

The Cofinity provider network is an expanded and essential part of our ongoing Quality Management Committee (QMC) structure. Providers compromising this network serve our point of service (POS) members for our commercial plan. Our quality improvement initiatives support collaboration with these practices and facilities in working together to improve the quality and patient experience for our members. Together, the Medical Plan and ACS focus on raising the overall quality of services to achieve measurable outcomes and more productively use resources.

II. Quality Improvement Program Evaluation and Work Plan

Overview
The QI Program Description and QI Work Plan provide guidance to the program structure and activities for a period of one calendar year. Input is obtained from a variety of sources, including the DHMP operations management team, medical management department staff, QI staff, data sources, HEDIS reporting and CAHPS surveys. CMS and contractual requirements for our commercial groups are reviewed annually, with inclusion in our development and evaluation of quality program indicators.

A QI work plan is prepared annually for the upcoming year for submission to the Quality Management Committee (QMC) and the Medical Plan Board of Directors for approval. The work plan includes the following elements:

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

Quality Improvement Objectives for 2016
• Deliver quality care that meets community standards and offer customer focused service to our members and practitioners/providers.
• Continuously measure, analyze, evaluate and improve the clinical care and administrative services of the plan and health care services delivered by contracted practitioners/providers, using Healthcare Effectiveness Data and Information Set (HEDIS) measures, QI projects and activities, and CAHPS member surveys.
• Implement internal quality improvement activities as necessary.
• Adopt national, regional and/or local public health goals as benchmarks, evaluating available resources for QI to make sustainable decisions.
• Promote medical and preventive care delivered by practitioners/providers that meets or exceeds the accepted standards/benchmarks of quality in the community.
• Empower members to lead a healthy lifestyle through health promotion activities, community outreach efforts and coordination with public and private community resources.
• Encourage safe and effective clinical practice through established care standards and applying appropriate practice guidelines.
• Monitor and evaluate high volume and/or high risk services to identify opportunities for improvement.
• Coordinate delegated activities on behalf of contractual organizations.
• Address special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate.
• Maintain the health information system to comply professional standards of health information management, including HIPAA privacy and security laws and state privacy standards.
• Acquire collaborative feedback from members of the QMC on quality initiatives

QI Program Scope
The QI program includes all administrative departments and services rendered to members by participating providers and practitioners, including:
✓ Inpatient and outpatient care
✓ Durable medical equipment
✓ Physical therapy
✓ Imaging
✓ Laboratory pharmacy services
✓ Behavioral health services
✓ Ancillary services
✓ Skilled nursing care
✓ Home health
✓ Infusion therapy
✓ Hospice

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

The QI team is responsible to implement the following:

- Identify and prioritize quality activities based on NCQA and regulatory requirements
- Review data annually to determine QI activities that will have a significant impact on our population
- Work collaboratively with ACS, Denver Public Health and other health plan partners to address healthcare quality initiatives
- Utilize national goals as well as NCQA, HEDIS, and regional benchmarks to establish goals for the Plan
- Employ the use of geo-access software to analyze access and availability of providers and pharmacies for the membership. Annually, an access report is finalized with geo-access results for member access, panel sizes, telephone responsiveness, referral turnaround timeframes, and monitoring of appointment standards. Language competencies of providers are also evaluated.

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

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

The primary source of information for quality improvement initiatives are from HEDIS (Health Effectiveness and Data Information Set) and CAHPS (Consumer Assessment of Health Providers & System). HEDIS clinical outcomes measures data are reviewed for diabetes, cardiovascular conditions, musculoskeletal conditions, prenatal and postpartum care, respiratory conditions, medication management, behavioral health care and preventive health screenings for children and adults. For quality of service, multiple sets of data are reviewed: (i) CAHPS member satisfaction survey data (ii) HEDIS use of services and access and availability measures (iii) grievance and appeal data and (iv) quality of care concerns and service complaints.

**Quality Improvement Program Accomplishments and Strengths**

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

- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention
- Continued to identify and develop training to assist in appropriate provider documentation and coding to support improvement of HEDIS scores
- Increased member outreach to encourage preventive health screenings and to support members with chronic disease conditions, such as diabetic eye exams and mammograms
- Developed, implemented and evaluated incentives for members to engage in evidence based prenatal and postpartum care
• Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase number of well-child visits and immunizations within Denver Public Schools, including development of an incentive program to increase well child visits to those ages 12 and above
• Continued analysis of member outreach with focus on developing member communication platform in 2015/16, utilizing EPIC implementation for ACS and QNXT member portal for DHMP
• Collaborated with behavioral health and wellness to increase comprehensive contact with members, increase scope in health coaching disease management and evaluate reach and effectiveness of services.
• Developed and implemented enhanced patient education materials, focused on health literacy and cultural competency
• Conducted an annual provider satisfaction survey to evaluate satisfaction DHMP departments and services, including knowledge of DHMP offerings to support patient care
• Conducted an annual medical interpretation survey to evaluate scope and responsiveness of services
• Conducted an annual open shopper survey to evaluate access and availability in both the ACS and Cofinity provider networks, including behavioral healthcare providers
• Collaborated with patient experience workgroup on increasing provider participation with patients in shared decision making and understanding treatment options more fully
• Participated as a member of the Denver Health diversity steering committee to increase health literacy/cultural competency through services in Denver Health
• Facilitated culturally linguistic appropriate services (CLAS) workgroup to identify opportunities to work with other community partner agencies to address health disparities
• Led culturally linguistic appropriate services (CLAS) training series for Denver Health providers and staff to support the delivery of culturally sensitive care and engage fully in participation of a diverse workforce
• Achieved a renewal of the NCQA accreditation for Multicultural Healthcare distinction
• Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting
• Maintained over sight and follow-up of delegated and facility credentialing relationships
• Increased outreach to DHMP members through ACS clinic staff and targeted member outreach at high volume point of service offices
• Facilitated physician involvement in the development of clinical guidelines, including the streamlining process of guideline development
• Conducted development, review and revision of policies and procedures annually through electronic tracking process
• Increased physician involvement within the Quality Management Committee (QMC) structure from both ACS and Cofinity networks

The overall effectiveness of the QI program continues to be evaluated critically. Success in achieving NCQA accreditation for Medicare, as an ‘add-on’ to the commercial/exchange line of business accreditation over the past year has provided a dedicated focus on opportunities for improvement. Meeting NCQA standards will align the quality improvement department of DHMP with improvement in HEDIS and CAHPS metrics more fully, as improvement in scores will be required for commercial re-accreditation in 2017.

Challenges and Opportunities
The adequacy of resources for the QI program continues to be challenging, needing consistent refinement throughout 2016. The Quality Improvement team was fully staffed for a four month period over the past year, as positions continue to be vacated and filled. There have been challenges with communication and collaboration across departments of DHMP and Denver Health overall, combined with opportunities in the competitive job
market for staff that provide better compensation. We continue to evaluate our need for more resources, especially in HEDIS data collection and analysis, along with access to and accuracy of data. The IS (information systems) conversion from our Dell claims platform to a Trizetto QNXT product has continued to be challenging in terms of IS resources needed for HEDIS and CAHPS. In addition, the DHHA migration to EPIC has posed challenges for data completeness, accuracy and extraction. Increasing our HEDIS scores requires more than once a year looking at the data results to be effective and to give timely feedback to our providers on performance. The creation of a DHMP data warehouse for medical and pharmacy claims data in 2016, along with emerging efforts at adding EPIC based encounter data in 2017 will provide the foundation of improved data quality, completeness and timeliness to support QI intervention efforts.

DMHP will need to strategize and continuously evaluate how to best use QI resources. Alignment and collaboration with other QI initiatives being done by ACS and providers in the Cofinity network will help maximize our limited resource availability. In addition, we continue to elicit the support of leadership to help move QI activities forward.

Our committee structure continued to be evaluated over 2016. The QMC evolved throughout 2015, with regular attendance of physicians and practitioners. The director of quality improvement for ACS was a regular attendee, along with Cofinity providers, ACS clinic providers, UPI providers and specialty care providers. The structure change, done in late 2013, has proven to be significantly better. The QMC has evolved to be a body reflecting on reach and effectiveness of our studies and interventions, servicing as an “advisory board” to DHMP through the QMC process. With changes in some of the medical management departments occurring, case/utilization and care management will be working on the former utilization management committee structure, and it’s restructure as the Medical Management Committee and their reporting up through the QMC in 2017. Continuous evaluation of the QMC process will continue throughout 2017, with a focus on increasing communication and collaboration of quality improvement efforts organization wide.

Practitioner participation improved over 2016, achieving one of our key metrics for evaluation. We have increased our practitioner involvement with QMC, which allows practitioner input into all aspects of health plan operations and services. Our provider survey was expanded to include other specialties to increase valuable information about improving continuity and coordination of care. Increased involvement of QI team members in ambulatory quality improvement work groups; clinical design work groups and disease and prevention work groups within CHS will need to continue with targeted focus in 2017.

Leadership involvement, defined as the operations teams from DHMP, the management and operations teams from CHS and provider involvement from our Cofinity network, has continued to increase over the past year. A defined focus and contribution of the QMC has given DHMP a valuable sounding board and feedback mechanism for all departments that present up through the committee. The involvement of the director of QI for ACS, several ACS and school based health center (SBHC) providers and practitioners, along with Cofinity network and UPI providers has provided a rich mix of differing insight and feedback to departments and the QI team in assisting in evaluating reports and interventions. The director of QI is involved on several quality committees and workgroups within ACS, including the ambulatory quality improvement and design committee (AQIDC), which combines the previously separate ambulatory quality improvement and the clinical design work group committees, along with the patient experience workgroup (designed to focus on increasing metrics of patient experience, including CAHPS and customer service). Members of the QI team staff attend and interact in a variety of ways with chronic disease and prevention work groups, led by senior medical leadership of ACS.
Future Opportunities for Improvement

- Develop a data validation plan for HEDIS measures, confirming that data and counts are accurate, while continuing to increase alternative sources of data information for HEDIS measures.
- Evolve the real-time quality data availability and usability through the 2016 launch of the DHMP data warehouse and the 2017 effort to integrate EPIC based encounter data.
- Increase engagement and training of providers in HEDIS metrics and provide meaningful, provider-centric education and training to increase HEDIS scores through appropriate medical record documentation and coding.
- Work with ACS and DH leadership in the Studer patient experience initiatives throughout Denver Health, focusing on customer service metrics and rounding of staff to improve CAHPS scores.
- Develop a plan with ACS QI leadership to address gaps in care with year around interventions and activities.
- Conduct evaluation of member engagement strategy to increase member buy-in and involvement in self-management goals. Evaluate effective platforms for communication with members.
- Align and partner quality improvement initiatives and interventions with ACS leadership and provider networks to avoid duplication of effort and to utilize resources more effectively.
- Increase leadership support with the medical plan to a more collaborative movement.
- 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) format. Utilize LEAN framework to develop and evolve standard work for QI team.
- Align cultural educational initiatives with the DH diversity workgroup to improve use of resources.
- Develop and implement quarterly review of HEDIS to ensure more timely measures and interventions.
- Expand and support QI opportunities for growth and enhancement of skills.
- Obtain NCQA Accreditation status for the Medicare lines of business.

Clinical Guidelines
Anually reviewed the following Clinical Care Guidelines in 2016 for any nationally recognized updates:

- Diabetes Management Standards
- Management of Asthma in Adults and Children
- Treatment of Depression in Adults in Primary Care
- Treatment of ADHD in Children and Adolescents

Preventive Guidelines
Anually reviewed the following Preventive Care Guidelines in 2016 for any nationally recognized updates:

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

Both Clinical and Preventive Guidelines guide the QI team in their clinical care quality activities and interventions with providers and members. Each guideline is developed to reflect nationally recognized sources, as well as community healthcare standards. Additionally, QI partners with content experts (Physicians) to review and modify the guidelines to meet member needs with the best practices.
III. Quality of Clinical Care Activities

Indicators for clinical care are based on HEDIS outcome measures and include: diabetes, cardiovascular conditions, asthma, prenatal and postpartum care, behavioral healthcare and preventive health screening measures. Review of these measures is conducted once a year. The results are available after successfully passing the HEDIS audit in June. Results are compared to the previous year and trended over several years.

2016 HEDIS rates are based on measurement year 2015 data, the previous year rate, and the 90th percentile benchmark, which is our goal and considered the gold standard. The following QI initiatives are focused on these clinical indicators with the purpose of improving the quality of clinical care for our members.

2016 QI Activities/Interventions

Adult Interventions

**Diabetes**

2016 HEDIS® Diabetes Results for Commercial Line

<table>
<thead>
<tr>
<th>Diabetes Indicators</th>
<th>2014 HEDIS Results</th>
<th>2015 HEDIS Results</th>
<th>2016 HEDIS Results</th>
<th>2016 HEDIS 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>88.38%</td>
<td>88.38%</td>
<td>89.43%</td>
<td>94.69%</td>
</tr>
<tr>
<td>HbA1c Poor Control &gt;9.0% (lower=better performance)</td>
<td>30.89%</td>
<td>30.89%</td>
<td>37.46%</td>
<td>20.20%</td>
</tr>
<tr>
<td>HbA1c Control &lt;8.0%</td>
<td>57.19%</td>
<td>57.19%</td>
<td>47.73%</td>
<td>66.67%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>45.87%</td>
<td>45.87%</td>
<td>41.39%</td>
<td>70.44%</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>76.15%</td>
<td>76.15%</td>
<td>83.99%</td>
<td>93.40%</td>
</tr>
<tr>
<td>Blood Pressure Controlled &lt;140/90</td>
<td>74.92%</td>
<td>74.92%</td>
<td>75.53%</td>
<td>75.68%</td>
</tr>
</tbody>
</table>

2016 HEDIS® Diabetes Results for Medicare Line

<table>
<thead>
<tr>
<th>Comprehensive Diabetes Care (CDC)</th>
<th>2014 HEDIS Results</th>
<th>2015 HEDIS Results</th>
<th>2016 HEDIS Results</th>
<th>2016 HEDIS 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>93.92%</td>
<td>94.40%</td>
<td>94.40%</td>
<td>97.08%</td>
</tr>
<tr>
<td>HbA1c Poor Control &gt;9.0% (lower=better performance)</td>
<td>20.44%</td>
<td>21.65%</td>
<td>24.09%</td>
<td>12.41%</td>
</tr>
<tr>
<td>HbA1c Control &lt;8.0%</td>
<td>64.96%</td>
<td>60.83%</td>
<td>58.88%</td>
<td>76.72%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>62.53%</td>
<td>64.48%</td>
<td>67.88%</td>
<td>83.10%</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>86.62%</td>
<td>86.13%</td>
<td>89.78%</td>
<td>98.30%</td>
</tr>
<tr>
<td>Blood Pressure Control &lt;140/90</td>
<td>78.59%</td>
<td>75.91%</td>
<td>71.29%</td>
<td>79.32%</td>
</tr>
</tbody>
</table>

HEDIS 2016 Changes for Diabetes Measures
• Added a method and value sets to identify discharges for the applicable required exclusions for the 
  HbA1c Control (<7.0%) for a Selected Population indicator.
• Revised the requirements for urine protein testing for the Medical Attention for Nephropathy
  indicator; a screening or monitoring test meets criteria, whether the result is positive or negative.
• Removed the optional exclusion for polycystic ovaries.
• Added a Note clarifying optional exclusions.
• Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture
  the number of members who met numerator criteria using supplemental data.

Summary of 2016 HEDIS Diabetes Commercial Results
Comparison to the prior HEDIS benchmarks reveals that we are below the gold standard (90th percentile
benchmark) for all diabetes indicators.

DHMP Diabetes Collaborative Quality Improvement Workgroup
DHMP QI staff members as well as representatives from DHHA and Denver Health’s Ambulatory Care Services
(ACS) participate in the Denver Health Diabetes Collaborative QI Workgroup. Participants provide regular
updates on diabetes related initiatives, engage in discussions related to diabetes quality measures, and incorporate
changes in the Diabetes Registry. The workgroup approved a system for the registry to automatically flag patients
who were in need of follow-up testing based on lab results and last dates of service. The collaborative regularly
tracks patients’ outcomes for diabetes control as well as blood pressure and LDL control.

Preventive Health
Preventive health includes the following HEDIS outcome measures:
  • Prenatal and postpartum care
  • Adolescent and childhood immunizations/well visits
  • Preventive cancer screenings: colorectal, breast and cervical cancer screenings.

Each measure is reviewed below with a comparison of the 2016 results to the previous year and to the HEDIS 90th
percentile. In addition, we describe the interventions that occurred during 2016 and the activities planned for
2017.

Summary of 2016 HEDIS Diabetes Results
Comparison to 2016 HEDIS benchmarks reveals that 2016 HEDIS results are below 90th percentile benchmark
for all comprehensive diabetes care measures. Though the measures still fall below the 90th percentile, small
improvements were made in the Medicare rates for Eye Exams. Both Commercial and Medicare rates showed
small improvements in the Medical Attention for Neuropathy measure.

2016 Interventions
In 2016, QI continued the diabetes eye exam outreach project, which was started in 2015. This project is a
collaboration between the formerly used Care Management Assistants in the department of Intensive Case
Management. Care Navigators are now exclusively located in DHHA’s Ambulatory Care Services PCMHs. The
project involves the Care Navigators conducting outreach calls to Medicare, Commercial and Medicaid patients
who have been identified through claims data as needing either a dilated retinal exam or an eye camera screening.
Once contacted, members are scheduled in for an appointment with One Hour Optical or the Denver Health Eye
Clinic.

The intervention initially focused on the Commercial, Medicare and Medicaid lines of business but was later
amended to devote more focus on the Commercial and Medicare plans. Due to the transition in Care Navigation
resources from DHMP to DH ACS, there was a decline observed in the number of total outreach calls and
subsequent success rate in establishing visits with the eye clinic and one-hour optical. However, this decline has been addressed and the Care Navigators, now located in Ambulatory Care Management clinics, will be actively contacting members during the 2017 phase of this intervention. A “successful call” is defined as a call completed by a Care Navigator which resulted in a member being scheduled for an eye exam. The “Completed Exam” column indicates the quantity of appointments kept.

<table>
<thead>
<tr>
<th>LOB</th>
<th>Place of Service</th>
<th>2016 Total Call Volume</th>
<th>Total # of Completed appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>Denver Health Eye Clinic</td>
<td>273</td>
<td>583</td>
</tr>
<tr>
<td></td>
<td>One-Hour Optical</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>Commercial</td>
<td>Denver Health Eye Clinic</td>
<td>223</td>
<td>143</td>
</tr>
<tr>
<td></td>
<td>One Hour Optical</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Total (Medicare &amp; Commercial)</td>
<td></td>
<td>496</td>
<td>820</td>
</tr>
</tbody>
</table>

*due to data pull issues (described below), the efficacy of this intervention cannot be accurately interpreted. A total of 820 Medicare & Commercial members did have eye exams, noted from claims data. 496 individual members were contacted over the course of the year.

For comparison, the 2015 success & completion rate chart is shown below*

<table>
<thead>
<tr>
<th>Call Outcome</th>
<th>Successful Call Count</th>
<th>Completed Exam</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Successful Calls</td>
<td>131</td>
<td>137</td>
<td>93.20%</td>
</tr>
<tr>
<td>DH Eye Clinic Dilated Eye Exam</td>
<td>18</td>
<td>17</td>
<td>94.44%</td>
</tr>
<tr>
<td>DH Eye Camera</td>
<td>79</td>
<td>77</td>
<td>97.47%</td>
</tr>
<tr>
<td>One Hour Optical</td>
<td>50</td>
<td>43</td>
<td>86.00%</td>
</tr>
<tr>
<td>Not Interested/Refused</td>
<td></td>
<td></td>
<td>242</td>
</tr>
<tr>
<td>Total Members Contacted</td>
<td></td>
<td></td>
<td>389</td>
</tr>
</tbody>
</table>

*There were a variety of factors leading to the decline in both numbers and reporting ability of this intervention. The DHMP QI staff experienced turnover in two key areas of intervention management, resulting in the onboarding of new employees and a temporary break in ongoing oversight of this project. Denver Health also completed a major Electronic Medical Records system overhaul with the implementation of Epic, resulting in data pull and documentation difficulties from providers and data analysts across the Denver Health system, including DHMP. DHMP also is in the process of building a new data warehouse where in-house claims data will be housed. The migration from our previous data warehouse necessitated the reconstruction and testing of multiple BI reports, including the identification of members needing DM eye exam. This was another delaying factor in this intervention. Finally, the migration of Care Navigators from DHMP to Ambulatory Care Services resulted in a temporary decrease in the affected members of this intervention. These three issues have been resolved, with the employees of Denver Health now being much more adept at navigation of Epic, with the Intervention Managers now being fully on boarded and with Care Navigators now fully integrated into their new positions.

**Action Plan for 2017**
QI will continue to participate in the Diabetes Collaborative and monitor the activities. Quality Improvement will continue to focus on increasing the Diabetic Eye Exams measure for 2017, which still sits well below the 90th percentile ranking. The Commercial Diabetic Eye Exam component of the Comprehensive Diabetes Care (CDC)
HEDIS measure increased from 64.45-67.88% while the same component for Medicare dropped from 45.87% - 41.39%. but improved from We have applied LEAN methodology to this issue to identify root causes and issues leading to low HEDIS rates for diabetic eye exams. In addition to the aforementioned barriers encountered by the QI department regarding this intervention, there continues to be limited access at the Denver Health Eye Clinic. However, ongoing partnership with the operations personnel with this clinic, combined with the recent expansion of contracted services at One-Hour Optical, extended hours at the Denver Health Eye Clinic and the potential for the utilization of services at the newly-opened Peña Southwest Clinic in Southwestern Denver will be additional resources for this intervention. Turnover in the department of QI created a gap in the ongoing management, which has subsequently been rectified by the full staffing of the QI department, including a full-time Intervention Manager who is actively managing this project. As an organization, Denver Health has made the commitment to improve access for optometry and ophthalmology services. Care Navigators, now located in the Ambulatory Care Services clinics will continue to conduct outreach calls to members with diabetes due for their eye exam informing them of the option to schedule an appointment at Denver Health Clinics or One Hour Optical. In 2017, the project will focus on the Commercial and Medicare Plan members, to reach Commercial Plan members in addition to the current Medicare outreach. The call scripts also include addressing barriers and facilitators to getting to the eye clinic in hopes of decreasing the no show rate. Through this project, QI also plans to expand the calls to cover other diabetes related tests that members are currently due for.

**Cardiovascular Conditions**

**2016 HEDIS Cardiovascular Conditions Measures Results**

<table>
<thead>
<tr>
<th>Cardiovascular Indicators</th>
<th>DHMP Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013 HEDIS</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td>76.64%</td>
</tr>
</tbody>
</table>

**HEDIS 2016 Changes**

Major changes to the CBP Measure for H2016

Revised the definition of adequate control to include two different BP thresholds based on age and diagnosis. Added a Diabetes Flag and corresponding value sets in the event/diagnosis criteria. Revised the Numerator to include the different BP thresholds in the Hybrid Specification.

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

**Summary of 2016 HEDIS CBP**

The rate for Controlling High Blood Pressure (CBP) measure remains below the 90th percentile although there was a significant drop in HEDIS results from 2015 – 2016, with the rate falling from 78.59% in 2015 to 69.34% in 2016. There are currently no active, ongoing interventions targeting this particular measure, though ongoing discussions for future interventions will feature CBP monitoring.

**2016 HEDIS Prevention and Screening Measures Results**

<table>
<thead>
<tr>
<th>HEDIS Measures</th>
<th>DHMP Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 HEDIS</td>
<td>2014 HEDIS</td>
</tr>
</tbody>
</table>
Breast Cancer Screenings (BCS)

All women 50-69 years old, who are in need of a mammogram, are sent a mailer reminding them to schedule an appointment. The QI department uses HEDIS technical specifications and claims data to identify members due for a mammogram. Lists of eligible members are generated on a monthly basis. Members have the option to either get their mammogram from the radiology clinic on the main Denver Health campus or utilize the Denver Health Women’s Mobile Clinic. The Women’s Mobile Clinic provides a private, comfortable and convenient setting to receive a mammogram.

HEDIS 2016 Changes for Breast Cancer Screenings
NCQA Clarified that diagnostic screenings are not included in the measure.

Breast Cancer Screening Analysis
The HEDIS results for Breast Cancer Screenings between HEDIS 2013 and HEDIS 2016 are consistently below the HEDIS 90th percentile for this measure.

In 2015, a total of 796 Medicare members that were due for a mammogram received a Mammogram reminder mailer. Of those that received a mailing, 339 (42.59%) obtained a mammogram. Of members in the Commercial plan that received mailers, 386 completed a mammogram.

In 2016, a total of 1211 Medicare members due for a mammogram received a reminder mailer. Of those that received a mailing, 680 (56%) obtained a mammogram. A total of 819 Commercial members due for a mammogram received a reminder mailer. Of those that received a mailing, 436 (53%) completed a mammogram. This is a vast improvement and we are estimating that our HEDIS 2017 numbers for this category will increase due to this increase in members receiving their exams.

<table>
<thead>
<tr>
<th>LOB</th>
<th>Completed BCS Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMM</td>
<td>436</td>
</tr>
<tr>
<td>MCR</td>
<td>680</td>
</tr>
<tr>
<td>Total</td>
<td>1,116</td>
</tr>
</tbody>
</table>

Breast Cancer Screening Action Plan for FY2017
All Medicare and Commercial female members 50-74 years old, who are due for a mammogram, will continue to receive a mailer reminding them to schedule an appointment. The QI Intervention Manager will continue to monitor the progress of this intervention.

Colorectal Cancer Screenings (COL)

HEDIS 2016 Changes for Colorectal Cancer Screening Measures
There were no significant changes made during measurement year 2016.

Colorectal Cancer Screening Analysis
Though the colorectal cancer screening (COL) for Medicare rates have continued to increase since 2013 and increased again between 2015(66.42%) and 2016(67.40%), although results are still below the 90th percentile
2016 Prevention and Screening Measures QI Activities/Interventions

Preventive Cancer Screening Workgroup: QI collaborates with the cancer screening work group that meets monthly to improve colorectal, breast and cervical cancer screenings. The workgroup consists of members representing Denver Health Ambulatory Care Services, Community Clinics, Women’s Mobile Clinic, GI clinic, radiology, and Denver Health Medical Plan. The workgroup continued to work on:

- Standardized Health Care Partner (HCP) check-in process to include identifying patients lacking breast, cervical, or colorectal cancer screenings.
- HCPs schedule member for an appointment if possible and alert the provider to the tests needed.
- Patient education materials about each cancer and the importance of screenings.
- Developed cancer metrics and implementation of registries to report screening rates on a quarterly basis to clinics.
- Epic optimization and standardization for the identification of patients on DHHA cancer registries.

Action Plan for 2017
QI will continue to participate on the Preventive Cancer Screening Workgroup. COL and Cervical Cancer Screening recommended preventive screening guidelines, per DHHA Cancer Screening Workgroup specs have been added to the monthly Mammogram mailer. In addition, QI will partner with the Denver Health GI clinic to implement a new outreach program targeting members currently due for colorectal cancer screening.

Pediatric Interventions
DHMP submitted a Performance Improvement Project (PIP) in October 2016. PIPs are requested by HCPF every three years for all Managed Care Organizations (MCOs) with a Medicaid and CHP+ contract. This year’s topic was Transitions of Care (TOC) for a pediatric Medicaid population. DHMP partnered with the DHHA pediatric clinics in the three ACS pediatric clinics to institute a program focusing on pediatric members seen in the Emergency Department or admitted for an inpatient stay to either Denver Health hospital or Children’s Hospital Colorado (TCH) for an asthma-related diagnosis. The aim of the program is to identify which DHMP MCD / CHP+ members have been seen in either one of these hospitals and then facilitate a follow-up PCP visit within 30 days via telephonic outreach by an CS Care Navigator within 48 hours of discharge. The Intervention Manager responsible for the overall oversight and ongoing management of this program provides weekly lists of DHMP MCD / CHP+ members admitted to TCH for an asthma-related diagnosis, as per identified by DHMP claims data and daily lists sent by the TCH Informational Systems (IS) department to the ACS Care Navigators at the three pediatric PCMHs. Care Navigators then contact these members and attempt to schedule a PCP visit within two days to address the asthma concern.

Data submission for outreach and scheduling success rates will be submitted to HSAG on a yearly basis. LEAN methodology will be applied during the course of this intervention and multiple PDSA cycles will be completed in order to identify and eliminate waste and streamline data collection. Procedural and data collection feedback will be contributed by HSAG on a yearly basis, which will also assist in the overall process improvement of this.

Prenatal/Postpartum Care Indicators
2016 HEDIS Prenatal/Postpartum Indicator Results

<table>
<thead>
<tr>
<th>DHMP Commercial</th>
<th>2015 HEDIS Results</th>
<th>2016 HEDIS Results</th>
<th>2016 HEDIS percentile</th>
<th>% from Moving up to Next</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

(80.54.17%).
### Summary of 2016 HEDIS Prenatal/Post-Partum Results

For HEDIS 2016, we saw an increase in the rate of women who receive prenatal care in the first trimester, and decrease in the rate of women who receive postpartum care within the 21-56 day timeframe. For the Timeliness of Prenatal Care measure, we are in the 90th percentile. For Postpartum Care, we are above the 50th percentile. There was a 2.68% increase in the Prenatal Care measure and a 2.95% decrease in the Postpartum Care measure. In 2016, the QI department collaborated with Denver Health clinics and marketing for prenatal care incentives and programs through the medical plan attributing to the increase in this measure. Data will continue to be analyzed and addressed for these measures. There are no barriers to identify and DHMP will continue to encourage members to participate in the Mom and Baby program.

### 2017 Action Plan

QI will continue to provide education regarding prenatal and postpartum programs to the members and providers, emphasizing the importance of timely and adequate prenatal and postpartum care. QI will continue marketing’s Mom & Baby benefits. With these incentives, we will continue to monitor our HEDIS rates for improvement. Denver Health Medical Plan, Inc. has also been collaborating with Denver Health Medical Center and partner clinics to increase PPC HEDIS rates through collaboration and education.

### Online Childbirth Education

In 2011, DHMP Marketing and QI worked together to promote *The Gift of Motherhood eLearning Childbirth Education Program*. The program is an interactive, web-based tool that allows expectant mothers to be more prepared for childbirth. A marketing flyer about the program is sent out monthly to women who have been identified as being pregnant through a claims report. Denver Health does not currently offer in-person prenatal classes to new mothers because the Online Childbirth Education Program gives mothers more education specific to their needs at times convenient for them. We continued this outreach in 2016 with additional marketing and promotion of our new benefits for Mom & Baby.

### Mom and Baby Program

In 2011, DHMP worked with the Woman’s Care Clinic to develop a program that offered additional benefits for mothers coming in for prenatal visits at Denver Health. The program, which started in January 2012, provided incentives to women who completed a series of prenatal visits during their pregnancies. This initiative was developed in collaboration with marketing to encourage mothers to keep their prenatal care within the DH system and deliver at our state-of-the-art Labor and Delivery facilities. In 2013, Marketing at Denver Health Medical Plan, Inc. rolled out a program involving additional incentives for keeping well-child visits within the baby’s first year at Denver Health. In 2014, in an effort to streamline incentive programs offered to members and reduce duplicative outreach efforts, DHMP rolled the Quality Improvement Postpartum Flyers into the comprehensive Mom and Baby program.
Moms coming into clinics for their postpartum visits will continue to be eligible for and receive incentives through this program. The language in the mom and baby flyers now reflects the 21-56 day postpartum visit timeframe to align with the medical plan’s HEDIS measure for Postpartum Care. To receive the incentives for these programs, members must request a coupon book from the medical plan and then have the provider place an encounter sticker on the coupon for each visit listed in the flyer.

Since the start of the program, Quality Improvement and Marketing staff made concerted efforts to educate and inform clinics and new mothers and members about the available incentive programs through the Denver Health Medical Plan, Inc. These marketing and outreach efforts will continue throughout 2017, while also evaluating the programs for effectiveness and appropriate reach.

### DHMP Commercial Prenatal Benefits

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>129</td>
<td>49</td>
<td>40</td>
<td>42</td>
<td>46</td>
<td>48</td>
<td>43</td>
<td>32</td>
</tr>
<tr>
<td>2015</td>
<td>137</td>
<td>51</td>
<td>53</td>
<td>52</td>
<td>53</td>
<td>65</td>
<td>52</td>
<td>28</td>
</tr>
<tr>
<td>2016</td>
<td>148</td>
<td>63</td>
<td>50</td>
<td>63</td>
<td>63</td>
<td>62</td>
<td>63</td>
<td>41</td>
</tr>
</tbody>
</table>

There were 191 commercial members who attended one or more prenatal visits in 2016. Denver Health commercial members are mailed prenatal flyers and are provided information on the prenatal and postpartum incentive programs during clinic appointments. In 2016, 148 commercial members requested a coupon book, which is 77% of the 191 members who attended prenatal appointments. Because a percentage of DHMP commercial members do not receive any care at Denver Health, we feel 77% participation is a considerable rate and therefore no barriers are identified.

**2017 Action Plan**

For 2017, we will continue to educate members on the availability of the prenatal incentive program, as well as provide clinics with handouts and education on the availability of the program. We routinely assess clinic participation and understanding of this program, and work to ensure that members are aware of the benefits of commercial membership and the mom/baby program. In partnership with the 123 Health Equity Pledge, the medical plan and the hospital will focus on health disparities as it relates to African-American women receiving post-partum care.

**Baby’s First Year**

In 2013, the “Baby’s First Year” incentive program was started to educate mothers on the importance of completing timely well-child visits and encourage mothers to participate. For each newborn visit completed in the first 12 months of life, members will receive an incentive for their baby. Marketing and QI will continue to monitor and track participation in the program for 2017.
For 2016, 199 commercial members had a live birth (218 commercial members had a live birth in 2015). The percentages here represent the number of requested and completed incentives for 2016 based on the total number of births over the course of the year. We will continue to monitor our rates for participation in Baby’s First Year in 2017, and educate members on the availability of the incentive program and the importance of completing timely well-child visits.

For 2017, we would like to see an average increase of 5% in participation for all incentives in the Baby’s First Year Program. We have been surveying clinics to gain an understanding of the processes that each clinic uses to market the program to patients. We are also working with Marketing to determine the best approach to market the program to members, and what additional steps we can take to better inform and educate members. In addition, we will leverage our participation in the ACS Pediatric workgroup to reiterate program incentives and gather a pediatric provider email list for program marketing efforts.

### Childhood Preventive Health

#### 2016 HEDIS Childhood Preventive Health Indicator Results

<table>
<thead>
<tr>
<th>Childhood Preventive Measures</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014 HEDIS Results</td>
</tr>
<tr>
<td><strong>Childhood Immunization Status</strong></td>
<td></td>
</tr>
<tr>
<td>DTaP</td>
<td>91.60%</td>
</tr>
<tr>
<td>MMR</td>
<td>94.66%</td>
</tr>
<tr>
<td>OPV/IPV</td>
<td>93.13%</td>
</tr>
<tr>
<td>H Influenza Type B</td>
<td>95.42%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>88.55%</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>93.13%</td>
</tr>
<tr>
<td>Pneumococcal Conj</td>
<td>91.60%</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>90.84%</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>85.50%</td>
</tr>
<tr>
<td>Influenza</td>
<td>77.10%</td>
</tr>
<tr>
<td>Combo 2</td>
<td>82.44%</td>
</tr>
<tr>
<td>Combo 3</td>
<td>81.68%</td>
</tr>
</tbody>
</table>

**Immunizations for Adolescents**
Meningococcal | 83.33% | 83.33% | 78.21%* | 89.29%
Tdap/Td | 92.86% | 92.86% | 91.67%* | 94.39%
Combo 1 | 82.54% | 82.54% | 78.21%* | 88.47%

### Well Child Visits

<table>
<thead>
<tr>
<th>Age Group</th>
<th>0-15 months (6+)</th>
<th>3-6 y/o (annual)</th>
<th>12-21 y/o (annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rates</td>
<td>82.64%</td>
<td>77.37%</td>
<td>44.69%</td>
</tr>
<tr>
<td>Percentile</td>
<td>78.15.64%</td>
<td>77.37%</td>
<td>44.69%</td>
</tr>
<tr>
<td></td>
<td>73.55%</td>
<td>74.17%</td>
<td>41.13%</td>
</tr>
<tr>
<td></td>
<td>89.12%</td>
<td>89.74%</td>
<td>64.50%</td>
</tr>
</tbody>
</table>

* For HEDIS 2016, both Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) were rotated from 2014 HEDIS rates. The 2015 immunization numbers listed in the table above are not indicative of true rates.

### HEDIS 2016 Changes

There were no changes made during measurement year 2015.

### Commercial Summary of 2016 HEDIS Child Immunization Results

Denver Health Medical Plan, Inc. continues to demonstrate strong immunization rates for the commercial pediatric members. There was an increase in every CIS HEDIS measure between 2015-2016. The three Immunization for Adolescents metrics all dipped slightly from 2015, but continue to remain in the 50th percentile for MCOs nationwide. For 2017, DHMP will plan to partner with the Medication and Immunization Committee at Denver Health and Hospital Authority, the Pediatric Quality Improvement Work Group, and School Based Health Centers (SBHC) to address any barriers to immunization adherence. Additionally, efforts to increase timely well child visits and newborn visits should have a positive impact on the vaccinations required to complete in the first 2 years of life.

### Commercial Summary of 2015 HEDIS Well-child Visits

**Well Child Visits (W15, W34, AWC)**

Between HEDIS 2015 and HEDIS 2016, the rates for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) decreased; however, the rates for Well-Child Visits within the First 15 Months of Life (W15) and Adolescent Well-Care Visits (AWC) decreased. All well-child visit measures were below the 90th percentile.

DHMP will continue to address well child visit rates and analyze potential interventions to improve them. Through collaboration and education with Denver Health clinics and School Based Health Centers, QI will address concerns of medical record documentation and coding issues that can significantly affect HEDIS well child visit rates. Implementations of a new medical record system and related coding issues have been barriers to greater success this past year. DHMP plans to partner with the pediatric clinics to improve processes around standardized documentation during 2017.

### 2016 Preventive Health QI Activities

**School Based Health Centers (SBHC) Collaboration**

In the fall semester of 2014, a new intervention was implemented to address and improve adolescent well child visits. The intervention was part of a new initiative to encourage adolescents to complete their annual physicals at a Denver Health School-Based Health Center (SBHC). The 17 SBHCs are located in middle schools and high schools with
another 20 satellite elementary schools that feed into the SBHCs. The age range of enrollees in the SBHC is 3 years through 21 years old.

Denver Health Medical Plan and the SBHC worked collaboratively to provide a $10 gift card incentive to members age 12-19 that complete their well child visits at a SBHC. This reduced potential barriers to receiving timely health care by allowing children to attend clinic visits during school hours, without the potential loss of work time for parents and transportation concerns. DHMP QI would send clinics monthly lists of members enrolled in a SBHC who were in need of a well-child visit. After the child attended a visit, the clinic would send their information to QI, who then verified their membership and mailed them a gift card.

In 2016, this intervention was discontinued due to growing concern from the SBHCs that providing gift cards to DHMP members for visits unfairly excluded non-DHMP members. Well visits track overall health, educate students about health concerns such as diet and exercise, and direct students to appropriate services when needed. DHMP will continue to collaborate with SBHC in Denver Public Schools by providing flyers and marketing materials at registration events and attending SBHC events to provide information about the importance of well-child visits.

**Action items for 2017**

DHMP will be conducting a PDSA cycle event to examine the barriers which resulted in the discontinuation of the previous program and design a new program which will better align with the needs of the SBHCs. DHMP will continue to increase collaboration with SBHC in an effort to enroll more health plan members in the SBHCs. When members go to school within Denver Public Schools, they can receive Preventive and acute care quickly and cost-effectively at the SBHCs. The SBHCs have availability when other clinics may not, so increasing the number of members enrolled in these clinics can improve timely access to health care services.

**Healthy Heroes Birthday Cards for DHMP**

In an effort to reach all age groups, we developed an around the world birthday card using our Healthy Heroes Program Logo. Healthy Heroes provides educational materials/health tips for enrolled children 3 to 12 years of age. In addition, birthday cards remind children to come in for their annual well visit. The birthday cards are sent monthly to children ages 2 through 19. Since 2015, we modified our process for selecting eligible children to include only those who have not had a well-child check in the past year in an effort to conserve financial resources. For 2016, the average monthly mailing was 78 postcards in the commercial line of business.

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg. DHMP Postcards Mailed/Month</th>
<th>Avg. Visit Rate within in 2 months of Mailing</th>
<th>Visit at all During Measurement year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>246</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2015</td>
<td>171</td>
<td>27%</td>
<td>63%</td>
</tr>
<tr>
<td>2016</td>
<td>76</td>
<td>13%</td>
<td>31%</td>
</tr>
</tbody>
</table>

In 2014, the QI team amended the Healthy Heroes Birthday cards to include a checklist of developmental
topics the provider will cover in the well-child visit as a way of engaging the member to participate in care. We will continue to track the mailing but do not expect to see an increase in well-child visit rates attributed directly to this mailing. We are partnering with Denver Health Medical Center and the Pediatric Quality Improvement workgroup to increase outreach in order to increase well child visit rates and improve pediatric health outcomes. Barriers identified are incorrect addresses and member lack of attention to the mailing.

Commercial Adult Measures

Preventive Cancer Screenings

<table>
<thead>
<tr>
<th>Cancer Screening Measures</th>
<th>2013 HEDIS Results</th>
<th>2014 HEDIS Results</th>
<th>2015 HEDIS Results</th>
<th>2016 HEDIS Results</th>
<th>2016 HEDIS 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>58.00%</td>
<td>65.22%</td>
<td>67.76%</td>
<td>65.81%</td>
<td>81.53%</td>
</tr>
<tr>
<td>Cervical (21-64y/o)</td>
<td>69.87%</td>
<td>86.62%</td>
<td>78.83%</td>
<td>98.30%</td>
<td>82.24%</td>
</tr>
<tr>
<td>Colorectal (50-80 y/o)</td>
<td>48.42%</td>
<td>53.53%</td>
<td>53.53%</td>
<td>87.83%</td>
<td>73.84%</td>
</tr>
</tbody>
</table>

*Sudden jump in COL screening rates from 2015-2016 attributed to a sampling bias, elevating DHMP’s HEDIS rates to the 95th percentile. A regression to the mean is expected for HEDIS 0217 results.

Commercial Summary of 2016 HEDIS Preventive Cancer Screening Results

The rates for the breast cancer screening measure decreased from 67.76% to 65.81% between 2015 & 2016, both of which continue to remain below the 90th percentile. HEDIS 2017 rates for BCS are expected to rise, as the number of DHMP Commercial members undergoing a mammogram increased by an additional 50 people. Though there are no active interventions specifically CCS or COL rates, the DHMP marketing department, with input from QI, started to put the recommended preventive screening guidelines, as per agreed upon by the Preventive Cancer Screening Group for both of these measures. Cervical Cancer Screening rates also had a significant jump, from 78.83% in 2015 to 98.3% in 2016. The plan for 2017 is to discuss possible interventions with the DH GI department to develop an intervention that will target COL screening rates.

HEDIS 2016 Changes

There were various changes to HEDIS 2016. For BCS, NCQA added new value sets to identify a bilateral mastectomy. “Numerator events by supplemental data” was added to the Data Elements for Reporting tables to capture members who met numerator criteria using supplemental data was added for BCS, COL & CCS rates. Additional changes to COL included a clarification in the Hybrid Specification that FOBT performed in an office setting or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.

2016 Preventive Cancer QI Activities/Interventions

The Mammogram Outreach Reminder Mailing intervention which includes HMO Commercial members, continued in 2016. Specifically, this intervention reminds members to schedule a mammogram exam appointment. The mailing card provides information on how to schedule an appointment for a mammogram through the Denver Health radiology clinic or Women’s Health Mobile Van. A total of n=1200 commercial members were sent postcard reminders in 2016. Of those, n=536 members completed BCS screenings, which is an increase of an additional 150 commercial members who received mammograms in 2015. HEDIS results for this measure are expected to rise as a result of this increase for HEDIS production year 2017.
Preventive Cancer Screening Workgroup

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

- Standardized Health Care Partner (HCP) check-in process to include identifying patients lacking breast, cervical, or colorectal cancer screenings. HCPs schedule members for appointments if possible and alert the provider to the tests needed.
- Patient Navigation regarding colorectal cancer screening options through Denver Health.
- Patient education materials about each cancer and the importance of screenings.
- Review and reporting of cancer screening quality measures through implementation of registries to report screening rates on a quarterly basis to clinics.
- Epic optimization and standardization for the identification of patients on DHHA cancer registries.

Action Plan for 2017

QI will continue to participate on the Preventive Cancer Screening Workgroup. COL and Cervical Cancer Screening recommended preventive screening guidelines, per DHHA Cancer Screening Workgroup specs have been added to the monthly Mammogram mailer. In addition, QI will partner with the Denver Health GI clinic to implement a new outreach program targeting members currently due for colorectal cancer screening.

Asthma

2016 HEDIS Asthma Indicator Results

<table>
<thead>
<tr>
<th>Medication Management for People w/Asthma</th>
<th>DHMP Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014 HEDIS Results</td>
</tr>
<tr>
<td>Ages 5-11</td>
<td>*NA</td>
</tr>
<tr>
<td>Ages 12-18</td>
<td>*NA</td>
</tr>
<tr>
<td>Ages 19-50</td>
<td>47.06%</td>
</tr>
<tr>
<td>Ages 51-64</td>
<td>*NA%</td>
</tr>
<tr>
<td>Total</td>
<td>38.83%</td>
</tr>
</tbody>
</table>

*NA = Sample size < 30

HEDIS 2016 Changes

NCQA made the following changes to the Asthma measures in 2016 related to MMA

- Expanded age range up to 85 years for the commercial product line.
- Added the Medicare product line.
- Added Table MMA-A: Asthma Medications and Table MMA-B: Asthma Controller Medications.
- Deleted all “Long-acting, inhaled beta-2 agonists” from Table MMA-A.
- Replaced all references of Table ASM-C to Table MMA-A in step 1.
- Replaced all references of Table ASM-D to Table MMA-B throughout the measure specification.
- Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.
NCQA made the following changes to the Asthma measures in 2016 related to AMR:

- Expanded age range up to 85 years for the commercial product line.
- Added the Medicare product line.
- Replaced all references of Table ASM-C to Table MMA-A in step 1.
- Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Summary of 2016 HEDIS Asthma Results

Three age groups for the Use of Appropriate Medications for People with Asthma (ASM) measure were not reportable again in 2016 due to sample sizes being less than 30. The only age group that had a sizeable enough denominator to report were the rates for the 19-50 age group. Overall, the rate fell from 42.5% to 39.22% in this age group and from 41.1% to 32.43% overall.

Action Plan for 2017

The DHMP QI department now participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. Meetings are monthly and discuss progress relating to updating ambulatory asthma registries, summaries of current asthma-related interventions and medication change updates. The QI department has been attending and will continue to solicit and contribute feedback about asthma initiatives taking place between ACS and DHMP. Additionally, the DHMP Pharmacy department is planning a telephonic-based intervention designed to improve the AMR of DHMP Medicare patients. The DHMP QI department will assess the possibilities of assisting with this intervention on an ongoing basis.

Behavioral Health & Wellness Programs

STRONG body STRONG mind Disease Management Program Evaluation

Objective and Relevance:
The DHMP STRONG body STRONG mind disease management program is designed to support the mission of DHMP by improving the quality of care and disease outcomes for the plan members. This is achieved through an assessment of member needs, provision of ongoing care monitoring, implementation of culturally appropriate and individually tailored interventions and provision of self-management support so that members are empowered to play an active role in their health care. DHMP, Inc. is targeting depression and diabetes as its two disease management programs.

The DHMP Commercial population totals 13,641 members of which approximately 10,262 or 75% are adults. Of this adult population, 285 (2.8%) of the members have been identified as having diabetes and 1186 (11.6%) have been identified as having depression. The DHMP Medicare population totals 4,411 members of which all are adults. Of this adult population, 828 (18.3%) of the members have been identified as having diabetes and 1038 (23.5%) have been identified as having depression.

Frequency of Reporting:
Members eligible to participate in the STRONG body STRONG mind disease management programs will be identified monthly and reported on at least annually. These members will be stratified by risk level and the interventions provided based on assessment of disease severity will be reported at least annually. The eligible member active participation rate will be calculated and reported on at least annually. Member satisfaction with the disease management services as well as audited HEDIS results specific to depression and diabetes will be reviewed and analyzed at least annually.
Indicators/Metrics:

- Number of members identified as eligible for the **STRONG body STRONG mind** disease management program(s)
- Number and type of interventions provided based on assessment of disease severity
- Number of eligible members who actively participated in the program(s)
- Member satisfaction with the disease management program(s) including:
  - Number of member complaints and inquiries related to the DM program
  - Rating of overall satisfaction with the DM program
  - Rating of DM program staff
  - Rating of usefulness of the information disseminated
  - Rating of member’s ability to adhere to recommendations
- Audited HEDIS results relevant to Depression and Diabetes including:
  - Depression – Antidepressant Medication Management (AMM)
    - Effective Acute Phase Treatment
    - Effective Continuation Phase Treatment
  - Diabetes – Comprehensive Diabetes Care (CDC)
    - HbA1c% Poor control (>9.0%)
    - HbA1c% Poor control (<8.0%)

Commercial Quantitative Analysis:

In total, 1186 commercial members were identified as eligible to participate in our **STRONG body STRONG mind** Depression disease management program and of those 1130 (95.3%) were determined to be low risk, 53 (4.5%) were medium risk, 3 (0.3%) were high risk. Of the 285 members identified as eligible for the **STRONG body STRONG mind** Diabetes disease management program, 165 (57.9%) were determined to be low risk, 75 (26.3%) were medium risk, and 45 (15.8%) were high risk. Please reference the full SBSM Reporting Evaluation Document for specifics.

Of the 1186 members identified for **STRONG body STRONG mind** Depression program, 27 unique members (2.3%) actively participated. Of the 285 eligible members identified for the **STRONG body STRONG mind** Diabetes program, 48 unique members (16.8%) actively participated. Combined, a total of 75 members (5.1% of our eligible commercial membership) were active in our disease management program between January 1, 2016 through December 31, 2016. During this review period, January 1, 2016 through December 31, 2016, there were zero member complaints for the commercial population.

Of the 42 who completed the Satisfaction Survey, the majority rated all items either a 4 or 5. However, there are two areas for improvement based upon the results of the Disease Management Satisfaction Survey given that our goal is to have at least 90% of members rate the items either a 4 or 5. Please reference the full SBSM Reporting Evaluation Document for specifics.

Our performance on the audited HEDIS results related to the Effective Acute Phase Treatment for depression falls into the 75th percentile (2% points needed for the 90th percentile) and 25th percentile for the Effective Continuation Phase Treatment (0.04 % points needed for the 50 % percentile). For the Poor HbA1c Control (>9.0%), DHMP falls just above the 25th percentile. For the HbA1c Control (<8.0%), DHMP falls into the in the 10th percentile, but just below the 25th percentile by 3.5% points.

Medicare Quantitative Analysis:

In total, 1038 Medicare members were identified as eligible to participate in our **STRONG body STRONG mind** Depression disease management program and of those 906 (87.3%) were determined to be low risk, 81 (7.8%) were medium risk, 51 (4.9%) were high risk. Of the 828 members identified as eligible for the **STRONG body STRONG mind** Diabetes management program for diabetes, 430 (51.9%) were determined to be low risk, 248 (30.0%) were medium risk, 150 (18.1%) were high risk. Please reference the full SBSM Reporting Evaluation Document for specifics.
Of the 1038 members identified for the STRONG body STRONG mind Depression program, 191 unique members (18.4%) actively participated. Of the 828 eligible members identified for the STRONG body STRONG mind Diabetes program, 218 (26.3%) actively participated. Combined, a total of 409 unique members (21.9% of our eligible Medicare membership) were active in our disease management program between January 1, 2016 through December 31, 2016.

During this review period, January 1, 2016 through December 31, 2016, there were zero member complaints for the Medicare population.

Of the 47 who completed the Satisfaction Survey, the majority rated all items either a 4 or 5. However, there is one area for improvement based upon the results of the Disease Management Satisfaction Survey given that our goal is to have at least 90% of members rate the items either a 4 or 5. Please reference the full SBSM Reporting Evaluation Document for specifics.

Our performance on the audited HEDIS results related to the Effective Acute Phase Treatment for depression falls into the 25th percentile (2% away from the 50th percentile) and into the 25th percentile for the Effective Continuation Phase Treatment (up from the 25th percentile from 2015). For the diabetes measure Poor HbA1c Control (>9.0%), DHMP falls into the 50th percentile (the same as 2015). For the HbA1c Control (<8.0%) measure, DHMP falls into the 25th percentile (the same as 2015).

Commercial Qualitative Analysis/Barriers/Opportunities for Improvement:
Although we have identified a significant percentage of the adult commercial membership that is eligible to receive disease management services, a relatively low number of these individuals are identified through the UM/CM process, health coaching program or through direct provider and member/caregiver referrals. A recent upgrade to the Guiding Care - Care Management Software platform and data platform should make the ease of referrals less cumbersome and more straightforward.

Future efforts to engage members in the STRONG body STRONG mind disease management programs will continue to focus on outreach calls to the high risk groups. Disease management requires individuals to devote substantial amount of time and effort to improving their health. The Commercial population is often difficult to engage and keep engaged. Efforts to increase engagement will include continuing education for disease management for low patient compliance. Communicating the benefits of disease management to this population is vital and technology enhancements that may enhance the message commercial members receive and encourage them to enroll and remain compliant.

Medicare Qualitative Analysis/Barriers/Opportunities for Improvement:
As with the Commercial population, we have identified a significant percentage of the Medicare membership that is eligible to receive disease management services, a relatively low number of these individuals are identified through the UM/CM process, health coaching program or through direct provider and member/caregiver referrals. A recent upgrade to the Guiding Care - Care Management Software platform and data platform should make the ease of referrals less cumbersome and more straightforward.

Future efforts to engage members in the STRONG body STRONG mind disease management programs will continue to focus on outreach calls to the high risk groups. Disease management requires individuals to devote substantial amount of time and effort to improving their health. This may be difficult for the Medicare population due to other comorbidities and lack of resources. The Medicare populations often require a lot of knowledge about their disease states upon enrollment in the disease management programs. Stigma of having a disease also contributes to compliancy issues.

Commercial and Medicare: Proposed Actions to Address Identified Opportunities for Improvement:
There is significant room for improvement in most of the HEDIS measures and this remains a high priority for the health plan as a whole. The STRONG body STRONG mind disease management program will continue to focus its efforts on the members at highest risk in an attempt to help improve these results and work with the quality improvement team to implement strategies within our department.
Based on our experience with other programs in the Health Management department, members who are directly referred tend to be the most engaged. Therefore, we plan to focus on increasing identification of members for the **STRONG body STRONG mind** disease management programs through direct referral. This may include increasing the number of emails sent to providers to solicit direct referrals as well as outreach to them through telephonic and/or other technology-based programming. Future trainings will include follow-up questions at the end of the calls to determine need so that we can better direct our members to the services they need. The results of the Satisfaction Survey are shared with staff in order to highlight their strengths and also raise awareness of opportunities for improvement. Ongoing training and discussion will occur at team meetings and technology outreach efforts will be evaluated.

**Complex Case Management**

The Intensive Case Management (ICM) Department is made up of three unique programs (i.e., Complex Case Management (CCM) Program, Intensive Care Transition (ICT) Program, and Targeted Case Management (TCM) Program). These programs have been created to target specific patient populations and address a variety of our member’s needs. All three of these programs are considered to be an “opt- out” service available to all plan members.

The CCM Program was created to provide systematic coordination of care to all members enrolled. Members who are enrolled into CCM, have experienced a critical event or diagnosis that requires an extensive use of resources, need help navigating the system to facilitate the appropriate delivery of care, or both. The goal of the CCM program is to help members regain optimum health, improve their functional capabilities, educate them regarding their chronic conditions, and reinforce provider care plans. With these goals in mind, a case manager will complete a comprehensive assessment; identify available benefits and appropriate resources; and create a plan of care with prioritized patient-centered goals and a monitoring plan.

**Evaluation of Complex Case Management**

DHMP performs an evaluation of the CCM Program on an annual basis. Relevant measured processes or outcomes include; Member Self-Management, Adherence to Treatment Plan, Satisfaction with CM services.

**Performance Goal:** At least 75% of commercial members enrolled in Complex Case Management will demonstrate improvement in self-management. Increase the total commercial enrollment by 15% in 2016.

**Eligible Population:** Complex case managers complete a CCM Effectiveness Review every 90 days and/or upon case closure on all members that are assigned to them. During the measurement period (1/1/2016 –09/30/2016), 422 CCM Effectiveness Reviews were completed on 184 unique members enrolled in the CCM program. The Commercial Plan had reviews completed on one unique member and Medicare had reviews completed on 75 unique members. The remaining reviews were completed on 108 members enrolled in either DHMP Medicaid Choice or the State’s Regional Care Collaborative (RCCO) Medicaid.

The following questions will be evaluated.

<p>| During the past 3 months (or since previous effectiveness review), has member evidenced any improvement in self-management? |</p>
<table>
<thead>
<tr>
<th>Option</th>
<th>Total Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>81</td>
<td>19.19%</td>
</tr>
<tr>
<td>Yes</td>
<td>341</td>
<td>80.80%</td>
</tr>
</tbody>
</table>

**Analysis:** Out of those who responded ‘Yes,’ there were two significant areas of improvement:

- Understanding and navigating the health system (n=162, 47.51%)
- Understanding of condition/medications (n=236, 69.21%)

Of those members enrolled into the CCM program, 80.80% of members exhibited an improvement in self-management, whereas 19.19% of members did not. In comparison to 2015 data, there was a 10.8% increase in membership that demonstrated improvement in their self-management skills between the reporting years.

There will be continued focus on patient education, collaboration with the Pharmacy team to identify members eligible for medication benefits (i.e., courier, mail order, and 90-day fill), and utilization of the Case Manager Assistant (CMA) skills to help and teach the member about their transportation resources.

<table>
<thead>
<tr>
<th>During the past 3 months (or since previous effectiveness review), has the member avoided any ED visits because of CCM intervention?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option</strong></td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

| During the past 3 months (or since previous effectiveness review) has member avoided any HOSPITALIZATIONS because of CCM intervention? |
|---------------------------------------------------------------------------------------------------------------------------------
| **Option** | **Total Responses** | **Percentage** |
| No         | 279               | 66.11%        |
| Yes        | 142               | 33.65%        |

**Analysis:** 45.26% of the time a member was identified as having avoided an ED visit due to CCM intervention. Additionally, 33.65% of members were identified as having avoided a hospitalization due to CCM intervention. When reviewing both ED and hospitalization avoidance for members who responded ‘Yes,’ it was noted that:

- 38.74% of members avoided at least one ED visit.
- 20.94% of member avoided at least two ED visits.
- 16.20% of members avoided at least one Hospitalization.
• 24.65% of member avoided at least two Hospitalizations

Additionally, 76.48% of the time the Case Manager provided the member with a tool to utilize the help reduce utilization. Of those members who answered ‘Yes,” to avoiding a visit it was noted that the following tools were the most frequently used:

• Educating the member about the benefits of the 24 hour Nurse Line (20.71%)
• Scheduling a PCP visit to connect the member to their care team (26.02%)
• Referring the member to an applicable specialty service (12.07%)

**Member Satisfaction with CCM performance goal:**

At least 75% of commercial members enrolled in Complex Case Management will elect 4’s and 5’s for the question, “How helpful was your case manager?” on the CCM Member Satisfaction Review. Given that those commercial plan members who were surveyed (i.e., 1 Commercial, 27 Medicaid, 47 Medicare plan members) do not represent a qualifying sample size in which management is able to draw useful conclusions, data from all LOBs will be analyzed.

<table>
<thead>
<tr>
<th>CCM Member Satisfaction Survey Questions</th>
<th>Score of “4 or 5” out of 5</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>How helpful was your Case Manager when you had a question or concern?</td>
<td>78</td>
<td>92.8%</td>
</tr>
<tr>
<td>How helpful was your Case Manager in improving your health?</td>
<td>72</td>
<td>87.8%</td>
</tr>
<tr>
<td>How helpful was your Case Manager in knowing community resources to meet your needs?</td>
<td>73</td>
<td>87.9%</td>
</tr>
<tr>
<td>How helpful was your Case Manager in helping you access services to get the care you need? (i.e.: doctor appointments, specialty appointments, resources)</td>
<td>74</td>
<td>88.1%</td>
</tr>
<tr>
<td>How helpful was your Case Manager in helping you understand your health better?</td>
<td>74</td>
<td>89.1%</td>
</tr>
</tbody>
</table>

**Analysis:**

During the analysis period of 01/01/2016 – 09/30/2016, there were a total of 92 members with a closed case, of those, 84 total members agreed to complete the Satisfaction Survey. Members were asked to rate their case managers ‘helpfulness’ on a satisfaction scale of 1-5 (1=not at all, 2=a little, 3=somewhat, 4=most of the time, 5=always/very). All five of the questions relating to a case manager’s ‘helpfulness’ exceeded the programs goal stating that, “75% of responses...be either option ‘4’ or ‘5’”. Out of the 5 questions relating to ‘helpfulness,’ the question stating, “How helpful was your case manager when you had a question” received the highest marks, with 92.8% of those surveyed selecting a 4 or 5 out of 5.
The remaining areas measuring ‘helpfulness’ received above 80% with considering those members who selected a 4 or 5 out of 5 on the questions relating to helpfulness. During the review period (01/01/2016--09/30/2016), there were no documented member complaints regarding the CCM Program.

**CCM program effectiveness Barrier Analysis:** Several factors contributed to the lack of improvement including cognitive issues/delays preventing improvement, untreated mental health, continued use of alcohol/drugs, lack of adherence, and/or competing priorities. The CCM program did not reach one of its goals of 15% Commercial membership enrollment. Commercial members, many of which are DHHA employees, often decline enrollment reporting the reason being that there is the perception of compromised privacy within the workplace when offered Complex Case Management Services delivered by coworkers.

*Unique members are not considered in the analysis. The n=422 responses were completed by n=184 unique members. Out of those n=184 members, n=75 were Medicare and n=1 was Commercial. These account for 41.3% of the completed responses.*

Although the CCM program saw a 29% increase across all LOB’s in enrollment over 2016, DHHA leadership remained concerned about the value proposition of the CCM Program, as well as the enrollment numbers that continued to remain below industry standards. Therefore, DHHA executive leadership made the decision to integrate all DHMP intensive case management services into Ambulatory Care Services (ACS) and closer to the Patient Centered Medical Home (PCMH) at the end of 2016 (10/1/2016). Finally, industry standards would suggest that such a move would improve patient safety and quality as well as reduce fragmented and duplicative services.

**Opportunities:** CCM believes focusing on patient education is the best way to enhance a member’s health and self-management skills towards their health condition. CCM integration into ACS will focus on creating a meaningful population based program supported by evidenced based and best practice guidelines. DHHA Executive Leadership felt that integrating the CCM program into ACS and moving the case management services closer to the PCMH, was the best way to improve patient care, reduce fragmentation and duplication of services, and improve patient safety and quality.

Defined targets in 2017 for ACS CCM include:

1. At least 75% of patients enrolled will demonstrate improvement in self-management
2. 100% of patients enrolled in CCM will have a comprehensive assessment, care plan, SMAP, and evidence of ongoing care coordination
3. CCM enrollment will enroll at minimum 150 patients across the pediatric and adult populations
4. Reduction of overall member costs

The above measures will be re-evaluated in December 2017 as a part of the annual evaluation of the CCM Program. As part of this evaluation, membership and enrollment will be analyzed. Results of this analysis will continue to drive improvement and development of targeted interventions and special populations for the following year(s). The QMC recommended the addition of objective, quantitative outcome measurements of utilization and health outcomes improvements, not relying on self-reported or CCM reporting improvements, as a component of the future evaluation.

In addition, there is an opportunity to create a DHMP CM program serving those Commercial members not seen, or intended to be seen at ACS, for 2017. This program will be built into the upgraded CM platform, Altruista’s
G7 and will be enrolling members in 2017. This program, designed specifically for Commercial membership, will be evaluated for improvement in Commercial membership enrollment rates in 2017.

**IV. Safety and Quality of Clinical Care**

2016 Quality of Care Concern Cases (QOCC) - DHMP Commercial and Medicare

<table>
<thead>
<tr>
<th>Plan</th>
<th>Total Cases 2016</th>
<th>Unsubstantiated</th>
<th>Substantiated</th>
<th>Inconclusive</th>
<th>Change from 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>3</td>
<td>2*</td>
<td>1*</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Medicare</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>-2</td>
</tr>
</tbody>
</table>

**Commercial Analysis:**
There were a total of three QOCC’s for 2016. This is the same number of reported cases as 2015. *One case was initially found to be Unsubstantiated upon initial review. The case was appealed and overturned.

**Medicare Analysis:**
There were a total of four QOCC’s for 2015. This is a decrease of 2 from the number of cases reported for 2015.

**Cultural and Linguistically Appropriate Services Program (CLAS)**

Denver Health Medical Plan (DHMP) provides health coverage to a culturally diverse population. Thus, it is important to educate staff about cultural differences that impact healthcare delivery. As of December 2016, there were 9 distinct languages identified that were spoken by our DHMP Medicare Advantage members and 4 distinct languages spoken by our DHMP Commercial population. However, only two different languages were spoken by our member at 0.1% or greater as of December 2016 for both product lines. Language prevalence for DHMP has remained consistent for both populations.

**DHMP Medicare Advantage Plans Language Data**

<table>
<thead>
<tr>
<th>Language</th>
<th>Measure</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLISH</td>
<td>Count</td>
<td>3751</td>
<td>3788</td>
<td>3,718</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>88.0%</td>
<td>86.9%</td>
<td>84.78%</td>
</tr>
<tr>
<td>SPANISH</td>
<td>Count</td>
<td>500</td>
<td>560</td>
<td>661</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>11.7%</td>
<td>12.9%</td>
<td>15.07%</td>
</tr>
<tr>
<td>VIETNAMESE</td>
<td>Count</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.1%</td>
<td>0.1%</td>
<td>.09%</td>
</tr>
<tr>
<td>CHINESE</td>
<td>Count</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>KOREAN</td>
<td>Count</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>RUSSIAN</td>
<td>Count</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
DHMP Medicare Advantage Plans Race/Ethnicity Data

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Rate</td>
<td>Count</td>
</tr>
<tr>
<td>NO ETHNICITY</td>
<td>4144</td>
<td>97.23%</td>
<td>4300</td>
</tr>
<tr>
<td>HISPANIC or LATINO</td>
<td>53</td>
<td>1.24%</td>
<td>26</td>
</tr>
<tr>
<td>CAUCASIAN</td>
<td>36</td>
<td>0.84%</td>
<td>12</td>
</tr>
<tr>
<td>AFRICAN AMERICAN</td>
<td>12</td>
<td>0.28%</td>
<td>8</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>11</td>
<td>0.26%</td>
<td>9</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>3</td>
<td>0.07%</td>
<td>2</td>
</tr>
<tr>
<td>ASIAN/PACIFIC</td>
<td>1</td>
<td>0.02%</td>
<td>0</td>
</tr>
<tr>
<td>ALASKAN/AMER INDIAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>5</td>
<td>.11%</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4262</strong></td>
<td><strong>4357</strong></td>
<td><strong>4,386</strong></td>
</tr>
</tbody>
</table>

Medicare member race/ethnicity data from the December 2014 to December 2016 eligibility files were examined. Based on our analysis for our Medicare line of business in 2016 English was the predominant language of our member population at 84.78% followed by Spanish at 15.07%. Analysis of the race/ethnicity data indicates that White/Caucasian members was the most prevalent known race/ethnic group at 15.7%, followed by African American at 4.9%.

DHMP Commercial Language Data

<table>
<thead>
<tr>
<th>Language</th>
<th>Measure</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLISH</td>
<td>Count</td>
<td>15,738</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>99.6%</td>
</tr>
<tr>
<td>SPANISH</td>
<td>Count</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.36%</td>
</tr>
<tr>
<td>HUNGARIAN</td>
<td>Count</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.01%</td>
</tr>
<tr>
<td>GERMAN</td>
<td>Count</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Rate</td>
<td>0.01%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>15,799</strong></td>
</tr>
</tbody>
</table>
DHMP Commercial Race/Ethnicity Data

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
</tr>
<tr>
<td>NO ETHNICITY</td>
<td>6,535</td>
</tr>
<tr>
<td>HISPANIC or LATINO</td>
<td>364</td>
</tr>
<tr>
<td>CAUCASIAN</td>
<td>4,931</td>
</tr>
<tr>
<td>AFRICAN AMERICAN</td>
<td>675</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>2,307</td>
</tr>
<tr>
<td>ASIAN/PACIFIC</td>
<td>166</td>
</tr>
<tr>
<td>ALASKAN/AMER INDIAN</td>
<td>32</td>
</tr>
<tr>
<td>HAWAIIAN</td>
<td>25</td>
</tr>
<tr>
<td>OTHER</td>
<td>764</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>15,799</strong></td>
</tr>
</tbody>
</table>

Commercial member race/ethnicity data from the December 2016 eligibility files were examined. Based on our analysis for our Commercial line of business in 2016, English was the predominant language of our member population at 99.6% followed by Spanish at 0.36%. Analysis of the race/ethnicity data indicates that White/Caucasian members were the most prevalent known race/ethnic group at 31.2%, followed by African American at 4.3%.

Due to the diversity of our Medicare membership, DHMP has remained committed to delivering Culturally and Linguistically Appropriate Services (CLAS) to all eligible members in accordance with our contract with Centers for Medicaid and Medicare (CMS). Furthermore, DHMP Division has policies and procedures to provide cultural and linguistic appropriate services that meet the needs of its members. The Medicare Advantage policies are referred to as the MCR_QI05 v. 02 Cultural and Linguistic Appropriate Services (CLAS) Program Description for Denver Health (DH) Medicare Advantage Plans. Our CLAS program goals have been 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 Distinction for both our Medicaid and Medicare product lines. This prestigious distinction in healthcare quality; 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 joined the DHHA effort for diversity and inclusion and for addressing REL disparities in health through the DHHA’s involvement with American Hospital Association’s 123Pledge for Equity.

2016 CLAS Activities
DHMP Quality Improvement Department annually reviews CLAS policies and procedures, work plan and annual evaluation against contract requirements for updates and quality/process improvements. In addition, program initiatives and interventions are presented to our Quality Management Committee for feedback and suggestions in making process improvements through the QI Workplan.

DHMP’s 2016 activities were focused on the MHC standards guiding the accreditation, and included race/ethnicity and language data, access and availability of language services, practitioner network cultural responsiveness, a CLAS program description and reducing health disparities. An overall accreditation score of 93% indicate successful performance on these standards.
Opportunities for CLAS at DHMP

As a result of the NCQA accreditation audit, opportunities to improve the collection of REL data for members and providers and the ongoing monitoring of language service utilization, including satisfaction of services, were identified. DHMP also considers ongoing training and awareness of staff for CLAS, and involvement with reducing REL related disparities in health to be important, relevant and valuable.

REL data collection improvement efforts:
In an effort to improve understanding of REL related need for members, REL data collection improvement has been identified as an opportunity. Member REL Data is being actively collected from various sources

- The Denver Health Human Resources department will be supplying a monthly list of all new Denver Health employees who have chosen DHMP as their insurance carrier. Part of the application process to Denver Health includes the voluntary submission of the applicant’s self-identification of ‘ethnicity’ in PeopleFluent, the software application used for new applicants applying to work at Denver Health. The HR department will be compiling this voluntary field, removing individual employee/ member identifiers and providing a sum total of the responses.
- Reports run from Denver Health’s Electronic Medical Record, Epic, which has the reporting capabilities to identify members of DHMP and then the voluntary identifying demographic information supplied by patients at the time of check-in to clinic visits.
- Language and race data supplied by the state in monthly enrollment files.
- Voluntary language and race data supplied by members previously enrolled in DHMP’s Complex Case Management and Health Coaching modules during 2015. Members enrolled in these two medical management programs all completed an Initial Comprehensive Assessment where voluntary race and language data was requested.
- Data collected from DH’s Interpretation Services, used during telephonic or in-person clinic visits in Denver Health’s Ambulatory Care Services clinics.
- Results from survey responses collected by DHMP’s Member Services department during introductory new member calls.

These activities are designed to support more complete collection of REL data, across lines of business, to improve our ability to identify need and align services and initiatives to meet those needs.

Disparities in health:
In alliance with DHHA’s 123Pledge for Equity, DHMP is involved with an intervention to improve the post-partum care visit return rates for African-American moms. The DHHA/DHMP analysis indicated a disparity of African American mom’s returning at a rate of 46%, while the Hispanic and White mom’s returning at rates of 59% and 57% respectively. Ongoing planning and barrier analysis, in collaboration with DHHA Ambulatory Care Services (ACS), for intervention development is in process.

Health Literacy Project

Background

In addition to the need for improving the technical components of care, there is a constant need to support and improve the interpersonal aspects of healthcare. This includes strategies to support culturally sensitive interaction between patient, provider and the health plan. Therefore, 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.
In 2015, the Health Literacy Committee (HLC) was reestablished under a new charter. This Committee is currently comprised of employees from the DHMP Marketing and QI Department and is tasked with ensuring consistency in the establishment of activities and training pertaining to the promotion of appropriate Health Literacy levels within DHMP.

Health Literacy, as defined by the Department of Health and Humans Services Healthy People 2010 is the degree to which individual 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 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 HLC’s commitment to DHMP 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.

The HLC actively works toward the goals of making all efforts to ensure that readability standards, per the requisites established per line of business, are met on all member-disseminated documents. The HLC conducts trainings on the use of Health Literacy software (Health Literacy AdvisorTM) 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 2017
In 2017, at least one employee from each department at DHMP has the software installed on his or her computer and is that department’s ‘champion’ for submitting all member materials through the software to ensure that the appropriate Grade Level is obtained. All documents submitted through the software are then recorded and logged on DHMP’s server to create a historical record for future auditing purposes. The HLC conducts training 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.

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Additional trainings on Health Literacy will be conducted by the HLC at multiple times throughout 2017 to new employees, at New Employee Orientation sessions. This includes a presentation of the philosophy and practice of what constitutes Health Literacy, a discussion of the understanding of the importance of improving Health Literacy amongst a diverse member base and practical methods in order to ensure consistency and clarity of language throughout the organization. The trainings will also define Denver Health Medical Plan’s process for reviewing health literacy & readability of member materials, including the submission of documents through the Health Literacy software and the explanation for the process for tracking or logging to meet regulatory requirements.

V. Quality of Service

2016 Member Satisfaction (CAHPS)

Annual CAHPS Survey and Feedback

DHMP conducted the Adult Consumer Assessment of Health Plan Providers and Systems (CAHPS) survey in 2016 for the commercial and Medicare plans. CAHPS surveys were conducted under contract with Morpace, an NCQA certified vendor. Morpace follows NCQA protocols and statistically appropriate methodologies to determine member satisfaction scores.

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

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

A total of 1,527 commercial plan members and 881 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 349 commercial plan members and 328 Medicare members who chose to complete the survey.

Results

Commercial: Table 1 (below) shows the results of the commercial CAHPS survey as compared to health plans nationally. DHMP scored in the

- 75th percentile for ‘How Well Doctors Communicate’,
- 50th percentile for ‘Rating of Personal Doctor’,
- 25th percentile for ‘Rating of Health Plan’,
- 10th percentile for ‘Plan Information on Costs’,

Table 1: Denver Health Medical Plan score comparison to national ratings
Table 2 outlines the CAHPS results reported as part of the CMS Medicare 5-star rating. For the member experience measures, the percent column indicates the percentage of the best possible score the plan earned for the measure. For the screening measure, the percent column indicates the percentage of respondents who received the screening.
Denver Health Medicare members rated the plan at four out of five stars for

- ‘Rating of Drug Plan’.

Additionally, Denver Health Medicare received four stars for the percentage of members who completed an ‘Annual Flu Vaccine’.

The plan received

- Three stars for ‘Rating of Health Plan’, ‘Care Coordination’, and ‘Getting Needed Prescription Drugs’.
- Two stars for ‘Overall Rating of Health Care Quality’ and ‘Customer Service’.
- One star for ‘Getting Needed Care’ and ‘Getting Appointments and Care Quickly’.

**Table 2: Medicare CAHPS Results and 5-Star Ratings**

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**Analysis**

Efforts are under way to improve CAHPS scores across multiple categories for both the commercial and Medicare plans. The QI team completed a comprehensive Open Shopper Study in 2016 to evaluate access to care and followed up on the recommendations. This Open Shopper Study evaluated access by provider type (i.e. primary care, specialty, behavioral health), and outlined findings and recommendations by type. See the Open Shopper Report for detailed findings and recommendations. We actively partner with Ambulatory Care Services (ACS) to facilitate expansion of clinic hours and evaluate ways to increase access to care and availability. A new clinic was
opened in southwest Denver in April, 2016 with expanded hours and weekend access. Productivity is an ongoing focus for the clinics, with pilots looking at four-day work weeks to support expanded hours.

The Patient Experience Group combines collaboration goals and interventions to improve the consumer experience in the ACS clinics. The QI team participates in that group, working to improve customer service and enhance provider and clinic communication. An organization-wide Studer initiative for the past year across all areas of Denver Health involves a concerted effort to improve patient experience. Additionally, an assessment of health plan customer service is underway to identify areas for improvement and implement appropriate strategies.

**Grievance Reporting and Trending**

The complaint analysis report period covers the period of January 1, 2016 to December 31, 2016 and describes the number and types of member grievances and appeals received during the report period. In addition, a summary of activities is provided that demonstrates DHMP’s commitment to quality improvement.

One of the ways DHMP gathers information from members is by tracking grievances filed by members and/or their authorized representatives. Efforts are spent on analyzing not only the timeliness of the problem resolution process, whether regulatory requirements are met, whether member notification of a resolution is provided in an easy to understand and culturally competent manner, but also on identifying patterns of grievances which may suggest the need for further investigation and/or performance improvement opportunities by DHMP and/or its affiliate entities and providers.

It is important to note that the DHMP Grievance and Appeal Department again underwent changes in 2016. In the second quarter of 2016, the Grievance and Appeal Department transitioned from beneath the Director of Member Services to the Call Center Operations Manager. The two existing Grievance and Appeal Coordinators took advantage of other opportunities leaving the two positions open. The Operations Manager was able to fill the vacancies with two individuals with prior knowledge of the department. One of the staff transitioned from the Compliance Department coming with a wealth of knowledge regarding regulatory requirements.

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**ELEVATE (MARKETPLACE) GRIEVANCE DATA—OVERALL HEALTHCARE**

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**MEDICARE APPEAL DATA—OVERALL HEALTHCARE**

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QUALITATIVE ANALYSIS—OVERALL HEALTHCARE

GRIEVANCE DATA:

Access
The Access Category has the third highest number of complaints for the report period. For the commercial plan, 27% of the grievances were related to access. For Medicare, 15% of the grievances were related to access. Both commercial and Medicare members experienced dissatisfaction with the Denver Health Medical Center Appointment Scheduling System, which uses the same processes for all patients/payer sources. There was the inability of members schedule a specialty appointment in a timely manner.

Quality of Service (Customer Service/Attitude)
The Quality of Service Category has the second highest number of complaints for the report period. Within this category, the majority of concerns dealt with member experience of rudeness by a staff member in the hospital or physician clinic setting.

Financial/Billing
The highest category with complaints is Financial Billing. The majority of the complaints stemmed from concerns over having financial responsibility when the member believes they should not owe a copay/coinsurance/deductible. Many members received bills in the mail after accessing services and the bills were incorrect, indicating that the claims system processed the claim incorrectly.

Benefit Package
Benefits accounted for the fourth highest reason for complaints from both Commercial and Medicare members.

Quality of Care
In 2016, Managed Care received 7 complaints regarding Quality of Care.

Provider Network
There no grievances related to the provider network for commercial plans, and there was one provider network grievance for the Medicare plan.

Quality of Practitioner Office Site
During calendar year 2016, there are zero (0) complaints filed with DHMP related to quality of practitioner office site. As a result, no evaluation is provided.

In overall review, timeliness of care, especially for specialty services, is a perceived challenge from members. Specialty care appointments have a longer wait time for services than routine primary care, which members can experience difficulty in understanding and acceptance. Correct claims processing and adjudication is also a pertinent challenge from members.

**APPEAL DATA:**

**Access**
During calendar year 2016, there were no access-related appeals for the commercial plan, and 1 access-related appeal for the Medicare plans.

**Quality of Service (Customer Service/Attitude)**
During calendar year 2015, there were zero (0) appeals filed with DHMP related to Quality of Service. As a result, no evaluation is provided.

**Financial/Billing**
During calendar year 2016, there were ten (10) appeals filed with DHMP related to Financial/Billing. In some of these appeals, DHMP incorrectly processed the member claim and thus the member received a bill for the services. Many of the cases were related to not obtaining a referral or authorization in a timely manner which culminated in a claim denial and member financial responsibility.

**Benefit Package**
During the report period, there were twenty-one (21) appeal cases filed related to Benefit Package. While the cases that were filed each were unique and had different issues, many cases were regarding care that is outside the scope of coverage (e.g. additional physical therapy visits beyond benefit package of 20 visits) or for coverage for a medical treatment that was denied at the initial level.

**Quality of Care**
During calendar year 2016, there was one (1) appeal filed with DHMP related to Quality of Care.

**Provider Network**
During calendar year 2016, there were zero appeals for commercial and Medicare plans.

**Quality of Practitioner Office Site**
During calendar year 2016, there were zero (0) appeals filed with DHMP related to quality of practitioner office site. As a result, no evaluation is provided.

**ELEVATE (MARKETPLACE) OUT-OF-NETWORK DATA**

<table>
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<th>Previous Year Out-of-Network Request, Total</th>
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<td>2016 Out-of-Network Requests</td>
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Twenty-one of the requests were for services not available at Denver Health, which included the following types of care:

- Allergy (2)
- Psychiatry (3)
- Sleep studies (3)
- Transplants (13)

Four requests were due to lack of timely access of services at Denver Health. Type of care included general surgery, pulmonary medicine, urology, and podiatry.

**EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT**

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

Appeals and grievances data (pages 38-40) was compared to CAHPS results (pages 36-37) for both commercial and Medicare product lines. Appeals and grievances data, in addition to requests for out-of-network services, were evaluated for the Elevate Marketplace plan. Additionally, cultural needs and preferences data was considered. DHMP holds an NCQA distinction (2016) in multicultural health care for the delivery of culturally appropriate care.

The 2016 Complex Case Management Population Assessment Report was evaluated for the commercial line, and CAHPS data by race and ethnicity were evaluated for both commercial and Medicare product lines. Supplemental questions were added to the Medicare and commercial CAHPS surveys inquiring about whether physicians and the health plan communicated in a way that was respectful to the member’s cultural background.

- For commercial members, 97% of Denver Health physicians and 96% of the inquiries to the health plan were handled in a way that was respectful to the member’s cultural background. Hispanics responded either the same or more favorably than whites for most CAHPS measures. Likewise, there were not statistically significant differences in CAHPS reporting between white members, African American members, and members of other racial heritage.

- For Medicare members, 93% of Denver Health physicians and 95% of the inquiries to the health plan were handled in a way that was respectful to the member’s cultural background. Hispanics responded either the same or more favorably than whites for most CAHPS measures. Likewise, there were not statistically significant differences in CAHPS reporting between white members, African American members, and members of other racial heritage.

For commercial, Elevate (Marketplace), and Medicare product lines, financial/billing issues, customer service/attitude, and access to care were selected as opportunities for improvement based on appeals/grievances results and corresponding CAHPS and multicultural health data.

- With regard to financial/billing issues, DHMP recognized that there were errors in the claims processing system, and initiated efforts to resolve these systematic problems quickly. The systemic issues were corrected and claims reprocessed for payment. However, the root causes remained ongoing, and as such, DHMP elevated claims processing issues as a key strategic improvement opportunity for 2017. A number of LEAN meetings/problem solving activities were completed, involving key leaders across claims, finance, QI, provider relations, UM, and the Executive Team. An action plan for improvement was developed, and is in progress. Other times, even though the member felt that they did not have a financial responsibility, after review of their benefit package, exclusions, and limitations; it truly was their financial responsibility. The DHMP Grievance and Appeal Department will continue to monitor the data and make the appropriate interventions when necessary.
• Quality improvement efforts for access to care are outlined on pages 37 & 38, in the analysis section of Member Satisfaction. These efforts are pertinent to both commercial and Medicare lines of business because access is the same at Denver Health regardless of payer source.
• With regard to customer service, the grievances dealt with rudeness in the hospital or clinic setting. DHMP works collaboratively with ACS to address these issues as they surface. However, 2016 CAHPS results also indicated that DHMP customer service could use improvement, receiving a ranking in the 5th percentile nationally. DHMP elevated health plan customer service as a strategic imperative for 2017. A workgroup was created to review and make recommendations to improve customer satisfaction. Efforts are underway to implement first call resolution for all incoming member services calls. This includes developing scripting, call monitoring, weekly training, and team coaching. Lastly, there are efforts to improve the level of courtesy and respect given to callers who phone the health plan with questions/needs. AIDET competency training is focal to this effort.

Please see Attachment C_CY 2016 Complaint Data Analysis for full report

QUANTITATIVE ANALYSIS-BEHAVIORAL HEALTHCARE

Commercial Grievance Data

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GRAND TOTAL

GRIEVANCE DATA—BEHAVIORAL HEALTHCARE:

Access
Zero complaints were filed for 2016 for Medicare and commercial product lines.

Financial/Billing
Zero complaints were filed for 2016.

Quality of Service (Customer Service/Attitude)
Zero complaints were filed for 2016.

Quality of Clinical Care
Zero complaints were filed for 2016.

Provider Network
Zero complaints were filed for 2016 for Medicare and commercial product lines.

Quality of Practitioner Office Site
Zero complaints were filed for 2016.

APPEAL DATA—BEHAVIORAL HEALTHCARE:

Access
Zero complaints were filed for 2016 for Medicare and commercial product lines.

Financial/Billing
Zero complaints were filed for 2016.

Quality of Service (Customer Service/Attitude)
Zero complaints were filed for 2016.

Quality of Care
Zero complaints were filed for 2016.

**Provider Network**
Zero complaints were filed for 2016 for Medicare and commercial product lines.

**Quality of Practitioner Office Site**
Zero complaints were filed for 2016.

**Evaluation and Opportunities for Improvement—Behavioral Healthcare**

CAHPS data is not collected for behavioral healthcare independently. Alternatively, DHMP conducts an annual Open Shopper Study, which evaluates access to care for routine, urgent, and emergent behavioral healthcare services, while assessing the quality of the member experience for obtaining services. The Open Shopper results are used, in addition to the appeals and grievances data, to assess service by category and identify opportunities for improvement. Although collected in aggregate for healthcare overall, multicultural health data was also evaluated to identify priorities. DHMP holds an NCQA distinction (2016) in multicultural health care for the delivery of culturally appropriate care. DHMP added supplemental questions to the commercial and Medicare CAHPS surveys, inquiring about whether physicians and the health plan communicated in a way that is respectful to the member’s cultural background. For commercial members, 97% of Denver Health physicians and 96% of the inquiries to the health plan were handled in a way that was respectful to the member’s cultural background. Similarly, for Medicare members, 93% of Denver Health physicians and 95% of the inquiries to the health plan were handled in a way that was respectful to the member’s cultural background. Hispanics responded the same or better than non-Hispanics for most CAHPS measures for both lines of business. Similarly, there were no significant differences in the CAHPS responses between whites, African Americans, and members of other cultural heritages.

Sources for service category evaluation are collected as follows:

- Quality of care (assessed through appeals and grievances)
- Access (assessed through the Open Shopper Study and appeals and grievances)
- Attitude and service (assessed through the Open Shopper Study and appeals and grievances)
- Billing and financial issues (assessed through appeals and grievances)
- Quality of practitioner office site (assessed through appeals and grievances)

The Open Shopper Study identified opportunities for improving access to care and customer service. This included access for routine behavioral healthcare at Outpatient Behavioral Services (OBHS) at Denver Health for both adults and children. The appointment scheduling experience improved significantly from 2015. However, additional opportunities were identified for ongoing improvements in both access and customer experience with appointment scheduling. Results were presented to the QMC for discussion and identification of opportunities. Results were shared with OBHS leaders, and there are ongoing activities to disseminate findings to key stakeholders to improve access and customer experience; these efforts will be re-evaluated in 2017 to assess intervention effectiveness. See full Open Shopper Report for complete findings.

Appeals and grievances data (previous section) found no issues for either Medicare or commercial product lines.
Member Services

Monitoring Member Services’ Telephonic Performance

Member Services has in place a departmental Performance Report that monitors four telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, and overall Call Volume. The Member Services Performance Report monitors these telephonic statistics by each individual Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) line of business. Tracking, comparison, and evaluation occurs on a monthly as well as annual basis. The Member Services Lead Customer Service Representative pulls all telephonic statistical data from the Cisco Telephony System reporting system Cisco Unified CXX Historical Reports and prepares the report for the Call Center Operations Manager. The Operations Manager reviews each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The Operations Manager presents the Performance Report as well as his or her Summary and Analysis at each quarterly Quality Management Committee meeting.

Monitoring Member Services’ Benefit Info for Quality and Accuracy

In order to satisfy regulatory standards and monitor the telephonic quality of DHMP Member Services, the Member Services Quality Assurance Program has instituted reporting occurring on a monthly basis. The MS QA Program allows the Member Services Leadership Team (MSLT) to determine any deficiencies in quality and service provided by the Member Services Representatives (MSRs) as well as work to correct any identified deficiencies. The QA Program serves as a valuable tool in staff development and satisfaction and is also incorporated into the annual MSR evaluation process to ensure that it is meaningful to the team and its individual members.

The QA program entails monitoring and reporting on two components, telephonic productivity and performance as well as quality and accuracy of benefit information provided. Productivity is evaluated on specific metrics from the Cisco Telephony System, specifically Inbound Call Volume, Average Talk Time, Not Ready Time, and Reserved Time. The quality component of the QA Program is evaluated by direct call monitoring and evaluation by the MS Supervisor. The MS Supervisor selects 10 random calls for each MSR that occurred in the specific month out of the Call Copy Call Recording Software. The MS Supervisor will evaluate the call for the quality and accuracy of the information provided based upon various criteria (member information confirmation, identifying issues, knowledge of benefits, documenting the call, tone of voice, etc.) and scores the MSR on a sliding scale dependent upon the accuracy of the information given. The overall evaluation of MSR performance in both areas is compiled, reviewed, and provided to the MSRs on a monthly basis. One on one coaching will occur if deemed necessary. In addition, an overall departmental MS Monthly Call Quality Performance Report is compiled to track the progress of quality maintained by the MSRs from month to month on an individual as well as departmental basis. All MSRs and the department overall must maintain an accuracy rate of 85% or higher. If this is not maintained, corrective actions are taken.

Monitoring the Nurse Advice Line

The primary intent of the Member Services’ Nurse Advice Line Performance Monitoring Program is to track member usage of the provided services and to identify opportunities and establish priorities for improvement. DHMP Member Services receives a monthly Performance Report from the Nurse Advice Line Leadership Team that includes Nurse Advice Line phone metrics such as Service Level, Average Delay, Abandonment Rate, and Call Volume for various DHMP and DHHA lines of business. The Nurse Advice Line is held to the same industry standards as DHMP Member Services, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, and Abandonment Rate of 5%. The Nurse Advice Line Performance Report also includes data on call triage and various member utilization (see Report 1.4). In addition to monitoring the quality and productivity of
the Nurse Advice Line, DHMP Member Services also completes an annual member satisfaction survey call administered by MSRs. This member feedback is recorded and provided directly to the Nurse Advice Line Leadership Team (see Report 1.5).

The Director of Member Services provides the Nurse Advice Line with feedback regarding the reported metrics on a monthly basis after reviewing and analyzing the data provided to him/her. This analysis is intended to be internalized by the Nurse Advice Line Leadership Team in order to help maintain high quality standards and member satisfaction. The Director of Member Services presents the Nurse Advice Line Monthly Performance Report at each quarterly Quality Management Committee meeting. For 2015, most of the above stated goals and standards were met and maintained, however there were challenges during the beginning of the year. The Director of Member Services met with the Nurse Advice Line Leadership Team to discuss the situation and learned that staffing and systems issues were the main causes of the initial challenges in 2015, which were addressed appropriately in the second quarter of year. There was improved performance in the second quarter and it was maintained throughout the remainder of the year.

Please see Attachment B for the full report with graphs

VI. Safety of Clinical Care

Patient Safety

In 2016, DHMP and DHHA were able to actively address the following patient safety objectives:

- Encourage organizational learning about medical and health care errors.
- Incorporate recognition of patient safety as an integral job responsibility.
- Incorporate patient safety education into job competencies.
- Implement corrective, preventative, and general medical error reduction education programs to reduce the possibility of patient injury.
- Involve patients in decisions about their health care to promote open communication about medical errors and consequences that result.
- Collect and analyze data to evaluate care processes for opportunities to reduce risk and initiate actions.
- Review and investigate serious outcomes in collaboration with risk management where patient injury occurred or patient safety was impaired.
- Review and evaluate actual and potential risk of patient safety in collaboration with risk management.
- Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety.
- Focus existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety.
- Trend adverse events reporting in safety practices (e.g. medication errors). Annually review and evaluate clinical practice guidelines to ensure safe practices.

In 2017, DHMP will continue to address patient safety objectives in collaboration with the hospital and ACS to improve the continuity and coordination of care and quality of care delivered to our members.

Privacy and Confidentiality Monitoring

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

At the time of initial hiring, all DHMP personnel shall be informed of confidentiality and the disciplinary action that will result from breach of confidentiality.
At the time of hire, all staff shall sign and acknowledge understanding of the Denver Health and Hospital Authority Confidentiality Agreement on an annual basis. DHMP shall treat all information as confidential to the extent that such information specifically identifies or permits identification of a certain health plan member and describes the physical, emotional, or mental conditions of such person, provided; however, that DHMP may retain and use for its purposes in performance of its obligations any information it obtains relating to costs, charges, procedures, used or treatments employed by a provider in treating any member, to the extent such information does not disclose the identity of the person. Confidential information obtained in the process of performing utilization management services will be used solely for utilization and quality management and will be shared only with parties who are authorized to receive it. Any confidential information, which DHMP finds 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 the federal law.

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

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

VII. Overall Structure of the QI Program

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

1. Medical Director Responsibilities include, but are not limited to:
   - Providing direction and support related to the development, implementation, and evaluation of all clinical activities of the QI department
   - Working in collaboration with the QI Director and the QI Intervention Managers on development and assessment of clinical interventions
   - Designing clinical activities in the QI Work Plan
   - Serving on the QMC, AQIC, Pharmacy and Therapeutics Committee (P&T), Utilization Management Committee, Credentialing Committee, Operations Management Committee, and Denver Health Physician Executive Committee
   - Evaluating and managing DHMP’s Quality of Care Concerns (QOCCs) related to physical health problems, working in conjunction with the QI RN
   - Overseeing DHMP’s clinical and preventive health guidelines
DHMP’s Quality Improvement Department

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

- Development, management, and monitoring of the QI Program
- Acts as staff representative to the DHMP Board of Directors.
- Directly assumes authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation, and Work Plan annually.
- Coordinates, provides advice and participates in the execution of the QI Program through collaboration with other DHMP and Denver Health Departments as appropriate for regulatory compliance.
- Reporting QOCC’s to the appropriate Directors of Service at Denver Health Hospital and Authority (DHHA) and external network providers.
- Serving as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution.
- Annually ensures all policies, procedures, and guidelines related to the QI Department are updated appropriately.
- Oversight of QI vendor contracts and delegated activities.
- Provides oversight and direction to the QI team, consisting of the following:

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

- Manages all aspects of HEDIS production including oversight of related projects.
- Evaluates and analyzes HEDIS results.
- Provides recommendations to QI Director for cost efficiency, process improvements and quality interventions.
- Works collaboratively with Intervention Managers on process improvements and interventions related to HEDIS.
- Validates the accuracy of HEDIS data and supporting documents.

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

- Manages all aspects of Consumer Assessment of Health Providers & Systems (CAHPS) related projects.
- Evaluates and analyzes CAHPS results.
- Provides recommendations to QI Director for cost efficiency, process improvements, and quality
interventions.

- Works collaboratively with Intervention Managers on process improvements and interventions related to CAHPS and Medicare Stars.
- Leading project planning activities related to regulatory and accreditation requirements.
- Facilitates and evaluates open shopper studies related to member experience and access.
- Assists Intervention Managers in data pulls for HEDIS interventions, as needed.

_QI Project Administrator responsibilities include, but are not limited to:_

- Analyzing the effectiveness of intervention activities.
- Coordinates all efforts related to work plans, evaluations and program descriptions.
- Project lead’s activities related to regulatory and accreditation requirements.
- Works in collaboration with Intervention Managers to maintain a timeline deliverables.
- Co-directing and working with QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and obtaining bi-monthly reporting requirements. Functions as main administrative contact for QMC.
- Oversees QI NCQA requirements and functions in conjunction with Director of Quality Improvement.

_**Intervention Managers (2x) responsibilities include, but are not limited to:**_

- Develops, manages and evaluates all quality interventions.
- Works collaboratively with the Medical Director, QI Director, AQIDC, ACS condition-specific work groups, external provider network HEDIS Program Manager, Clinical Project Manager. QI Project Administrator and Data Analyst on all quality interventions.
- Lead healthcare initiatives related to health literacy and cultural disparities.
- Overseeing multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services, and identification of any health disparities.

_RN Staffing support for QI Activities, include but are not limited to:_

- Manages QOCCs and quality of service concerns process in a timely and effective manner.
- Works in collaboration with HEDIS Program Manager to perform HEDIS chart review.
- Develops training materials, facilitating training, testing for inter-rater reliability (IRR), retraining for staff.
- Provides clinical consultation for the QI team.
- Conducts practitioner chart review using HEDIS criteria.
• Develops and updates all preventive and clinical guidelines.

Committee Structure

The Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. The QMC is charged with responsibility for oversight of all quality-related DHMP Medical Management activities and processes, including but not limited to: Utilization Management, Case Management, Behavioral Health and Wellness, Pharmacy, Member Services, and Provider Relations. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, and patient safety initiatives. The QMC includes primary care providers and specialty providers from both Denver Health Hospital Authority and extended practitioner network.

Summary of Future Outcomes

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

VIII. Attachments:

Attachment A_QI Commercial and Medicare Work Plan 2016
Attachment B_Commercial_Monitoring MS Performance_2016 Final
Attachment C_CY 2016 Complaint Data Analysis - Commercial_Medicare Lines of Business Final
## Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Time Frame</th>
<th>Approval</th>
</tr>
</thead>
</table>
| **2016 QI Program Description** | The QI Program Description will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC). | Annually Program must include:  
- Program Structure  
- How patient safety is addressed  
- How designated physician is involved  
- How BH practitioner is involved  
- Oversight of QI functions by QMC  
- Annual work plan  
- Objectives for serving a culturally and linguistically diverse membership  
Objectives for serving members with complex health needs, including behavioral health | Objective:  
- All requirements must be met  
- Reviewed and updated annually  
- Submitted for review to the QMC and BOD | Annually | QI Director | 1/2016 | 2/2016 |
| **2016 Annual QI Work Plan** | The QI Work Plan schedule is developed after review of previous year’s QI Work Plan and evaluation. The revised work plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measurable and analyzed annually during the Program Evaluation. | Work Plan must address:  
- Quality of Clinical Care  
- Quality of Service  
- Safety of Clinical Care  
- Member’s Experience  
- QI Program Scope  
- Yearly Objectives and planned activities  
- Time Frame in which each activity is to be achieved  
- The staff member responsible for each activity  
- Monitoring of previously identified issues | Objective:  
- All 9 requirements must be met  
- Yearly objectives must be measurable  
- Submitted to the QMC and BOD | Annually | QI Director | 1/2016 | 2/2016 |

*Previously monitored*
<table>
<thead>
<tr>
<th>QI PROGRAM OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Management Committee</strong></td>
</tr>
<tr>
<td>DHMP’s Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee functions include:</th>
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</thead>
<tbody>
<tr>
<td>• Analyzes and evaluates the results of QI activities</td>
</tr>
<tr>
<td>• Ensures practitioner participation in the QI program through planning, design, implementation or review</td>
</tr>
<tr>
<td>• Review and make recommendations on policy decisions</td>
</tr>
<tr>
<td>• Identifies needed actions</td>
</tr>
<tr>
<td>Ensures follow-up, as needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective:</th>
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<tbody>
<tr>
<td>• Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QI PROGRAM OPERATIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>Evaluation of the QI Program</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Evaluation includes:</th>
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<tbody>
<tr>
<td>• A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service</td>
</tr>
<tr>
<td>• Trending of measures to assess performance in the quality and safety of clinical care and quality of service</td>
</tr>
<tr>
<td>• Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For all goals not met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• QI must conduct a root cause or barrier analysis to identify the underlying causes and recommend changes to improve.</td>
</tr>
<tr>
<td>• Analysis must include organizational staff with direct experience of processes that have presented barriers to improvement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation Summary must include and address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analysis and overall effectiveness</td>
</tr>
<tr>
<td>• Completed and ongoing activities</td>
</tr>
<tr>
<td>• Trending of QI measures/results</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Period</th>
<th>I/2016</th>
<th>2/2016</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>QI Director</td>
<td>1/2016</td>
<td>2/2016</td>
<td>QMC Board of Directors</td>
</tr>
</tbody>
</table>

*Previously monitored*
| Medicare Star Ratings Workgroup | Committee functions include:  
- Evaluate & identify opportunities  
- Intervention approval and support  
- Resource allocation  
- Review results to evaluate effectiveness | Objective: Committee analyzes and targets specific Stars measures for improvement. Interventions are then reviewed with ACS provider network and/or DHMP departments for approval and support. Metrics are set up to evaluate effectiveness. | Quarterly | Clinical Project Manager  
QI Director | Monthly | Ongoing | QI director |
| Collaborative QI Workgroups | QI health plan representatives sit on several collaborative workgroups led by ACS leadership.  
- Cancer screening  
- Pediatric Preventive Health  
- Diabetes  
- Perinatal Care  
- Asthma  
- Weight Management  
- Practice Transformation | Established active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits. | Monthly | Intervention Managers | Ongoing | Ongoing | QI Director |

### QUALITY OF CLINICAL CARE

| 2016 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis | Procedure:  
- HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures.  
- Data validation prior to submission date  
- Meet submission deadline  
- Data from the HEDIS project is analyzed to determine areas of intervention and improvement. | Objective: Evidence of annual analysis includes:  
- Presentation to the QMC  
- Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.  
- Increase medical record compliance by improving coding and documentation.  
- To measure effectiveness of intervention; analysis will be accomplished by comparing previous year results with current year results. | Annually | QI HEDIS Project Manager  
QI Director | 12/2015 | 6/2016 | QMC |

*Previously monitored*
### HEDIS Impact: Breast Cancer Screening

**Every month a list will be drawn from the data warehouse, and run against claims and the active member’s list. All commercial women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment.**

- Affects member experience

**DHMP’s QI Department:**

- QI will coordinate and advertise employee days and locations of BCS screenings (mobile van) on the pulse and frontlines.
- Conducts monthly data pull
- Defines eligible participants
- Distributes mailings

**Commercial Baseline HEDIS 2014:** 65.22%

**Current HEDIS 2015:** 67.76% (10th percentile)

**HEDIS 2016 Goal:** 69.04% (25th percentile)

**Medicare Baseline HEDIS 2013:** 72.31%

**Current HEDIS 2015:** 73.70% (50th percentile)

**Goal (HEDIS 2016):** 75% (50th percentile)

**Annually**

<table>
<thead>
<tr>
<th>QI Director</th>
<th>1/2016</th>
<th>Ongoing</th>
<th>QMC HEDIS Outreach committee</th>
</tr>
</thead>
</table>

### QI A3 Management

**Use LEAN practices and tools to identify and research new quality improvement targets, Implement QI strategies (interventions or process improvements) based on findings.**

**A3 activities for 2016 include:**

- Improving Health Plan Customer Service
- Developing strategies for improving HEDIS rates in the unenpaneled member population
- Improving race/ethnicity/language (REL) data in the data warehouse
- Improving well child rates for the 3-9 year age group

**Objective:**

- Increase collaboration in LEAN efforts
- Improve quality of data
- Increase overall member satisfaction

**Ongoing**

<table>
<thead>
<tr>
<th>QI team</th>
<th>01/2016</th>
<th>12/2016</th>
<th>QI Director</th>
</tr>
</thead>
</table>

### QUALITY OF CLINICAL CARE

**Improving Perinatal Health: Postpartum and Prenatal Incentives**

**To improve Commercial HEDIS rates for PPC QI works in collaboration with the Marketing Department to incentivize female members, who have a positive pregnancy test or OB intake visit, to encourage expectant mothers to adhere to recommended prenatal**

**Procedure:**

- Claims lists are extracted from the BI portal monthly.
- Marketing department tracks prenatal mailings, prenatal visits, and sends out incentives to members.
- Marketing tracks postpartum

**2015 Prenatal Incentive Average Commercial Participation Rate: 31%**

**2016 Prenatal Incentive Commercial Participation Rate Goal: 35%**

**Annually**

<table>
<thead>
<tr>
<th>QI Pediatric Intervention Manager QI HEDIS Program Manager Director</th>
<th>Ongoing</th>
<th>Ongoing</th>
<th>Outreach Committee QMC</th>
</tr>
</thead>
</table>
### Improving Perinatal Health: HEDIS documentation and coding education

**DHMP QI HEDIS Program Manager and QI Pediatric Intervention Manager** provide guidance and education on appropriate coding and documentation at Denver Health Hospital.

**Procedure:**
- QI participates in the perinatal workgroup on a monthly basis. QI provides guidance and education on appropriate coding and documentation for PPC HEDIS compliance.

<table>
<thead>
<tr>
<th>Year</th>
<th>Measurable Outcome</th>
<th>2015</th>
<th>2016 Goal</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal 2015</td>
<td>93.30% (75th percentile)</td>
<td>96.23% (90th percentile)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum 2015</td>
<td>84.36% (50th percentile)</td>
<td>84.62% (75th percentile)</td>
<td></td>
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</tbody>
</table>

### Improving Well-Child Visits: HEDIS Rates

To improve the Commercial HEDIS Rates for Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34), and Adolescent Well-Care Visits (AWC)

- Affects member experience

<table>
<thead>
<tr>
<th>Year</th>
<th>Measurable Outcome</th>
<th>2015</th>
<th>2016 Goal</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>W15 (6+ visits)</td>
<td>HEDIS 2015: 78.15% (25th percentile)</td>
<td>Goal - HEDIS 2016: 80.99% (50th percentile)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W34</td>
<td>HEDIS 2015: 80.52% (50th percentile)</td>
<td>Goal - HEDIS 2016: 83.43% (75th percentile)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Affects member experience
**DENVER HEALTH MEDICAL PLAN, INC.**  
**Commercial and Medicare Quality Improvement Work Plan 2016**

<table>
<thead>
<tr>
<th><strong>Improving Well-Child Visits: Healthy Heroes Birthday Cards</strong></th>
<th><strong>Education</strong></th>
<th><strong>percentile</strong></th>
</tr>
</thead>
</table>
| Commercial children 2-19- years of age receive a birthday card informing them to come for their annual visit. These mailings have been going out to members since January 2009. Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care. QI will amend the mailing to exclude kids who have already received their well child visit for the year | • QI pulls list from BI portal monthly  
• QI cleans data and separates per LOB  
• QI sends list to Marketing  
• QI proofs the birthday card and sends okay response to Marketing  
• Marketing sends to the printer and they are mailed to members  
• QI monitors response rate on quarterly basis | **Goal:** Engage children who have not gone in for their annual well child visit through the healthy hero birthday cards |
| ✓ Affects member experience | **WCC Counseling for Physical Activity**  
HEDIS 2015: 60.34% (50th percentile)  
Goal HEDIS 2016: 62% (50th percentile) | Quarterly |
| **WCC BMI**  
HEDIS 2015: 81.51% (75th percentile)  
Goal HEDIS 2016: 83.13% (75th percentile) | **WCC Counseling for Nutrition**  
HEDIS 2015: 75.18% (75th percentile)  
Goal HEDIS 2016: 77% (75th percentile) | **Pediatric Intervention Manager**  
1/16  
12/16  
QMC |

*Previously monitored*
### Yearly Planned Activities

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Start</th>
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</thead>
</table>
| Annually   | *Improving Well-Child Visits: Baby’s First Year Incentives* | The Marketing Department has Commercial incentives for the “Baby’s First Year” program. For each newborn visit completed in the first 12 months of life, members will receive an incentive. For 2015, QI has extended the Baby’s first year with Marketing to 15 months to accommodate the W15 measure. Marketing will add a coupon to incentivize members to receive 6 or more visits within the first 15 months with 2 months’ worth of diapers. ✓ Affects member experience | - IS provides Marketing with a monthly report, identifying eligible participants for the program  
- Marketing outreaches to eligible participants  
- Marketing tracks member response and participation rates throughout the program. | For 2015, 218 commercial members had a live birth.  
2015 Overall Average Participation: 22%  
Participation Goal for 2016: 25% | Annually | Marketing Manager | Ongoing | Ongoing | CEO |
| Quarterly  | *Improving Well-Child Visits: School-Based Health Centers Targeted Lists* | Twice a year, QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. Objective: Increase the % of commercial members with a well-child visit by providing targeted lists to SBHC’s HCPs ✓ Affects member experience | Procedure:  
- SBHC sends enrollment lists in October and January, run against active members to determine who is in need of well-child visit  
- Send list back to clinic so HCPs can pull kids out of class and provide well visit in SBHC.  
- Provide updated list on monthly basis back to clinic so they are not providing services to children who may have | Goal: Assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit. | Quarterly | Pediatric Intervention Manager  
School-Based Health Center Administrative Contacts | 10/15 | 5/16 | QMC |

*Previously monitored*
| School Based Health Clinics (SBHC) - Well Child Visit Incentive Program | Procedure (Well Child Visits): We will work with the SBHC to improve the % of children by clinic who complete a well-child visit at the SBHC. Each month QI will send a designated SBHC clinic a list of children on our medical plans that are enrolled in the SHBC program, who still need to complete their annual well visit for the year. Beginning Fall 2014, for children 12 years and older, students who receive their well visit at a SBHC will receive a $10 gift card of their choice (Ross, Subway, Fandango). Clinics will work collaboratively with QI to increase completed and documented Well Child visits. Affects member experience | Well Child Visits: Goal for SBHC Clinics
Commercial: WCC Counseling for Physical Activity
HEDIS 2015: 60.34% (50th percentile)
Goal HEDIS 2016: 62% (50th percentile)
WCC BMI
HEDIS 2015: 81.51% (75th percentile)
Goal HEDIS 2016: 83.13% (75th percentile)
WCC Counseling for Nutrition
HEDIS 2015: 75.18% (75th percentile)
Goal HEDIS 2016: 77% (75th percentile)
AWC HEDIS 2015: 43.07% (525th percentile)
AWC HEDIS 2016 Goal: 45.32% (50th percentile) | Monthly | Pediatric Intervention Manager School Based Health Center – Dr. Sonja O’Leary | 9/2014 | 5/2015 | QI Director QMC |
| Complex Case Management: Population Assessment | Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner. |
| Assessment must consider and include the following: |
| Relevant characteristics of specific populations |
| DHMP’s total covered population, not just members identified for complex case management |
| Goals: |
| Assesses the characteristics and needs of its member population and subpopulations |
| Reviews and updates its complex case management processes to address member needs, if necessary |
| Reviews and updates its complex case management resources to address member needs, if necessary |
| Annually |
| Director of Complex Case Management |
| 11/2016 |
| 1/2017 |

| QUALITY OF SERVICE |
| Complex Case Management: Measuring Program Effectiveness |
| Complex Case Management annually measures the effectiveness of its complex case management program using three measures. |
| For each measure, Complex Case Management: |
| Identifies a relevant process or outcome |
| Uses valid methods that provide quantitative results |
| Sets a performance goal |
| Clearly identifies measure specifications |
| Collects data and analyzes results |
| Identifies opportunities for improvement, if applicable |
| Goals: |
| Readmission Rates: |
| 5% |
| Member Satisfaction: |
| 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied). |
| CCM Effectiveness Review Survey: |
| 90% of members in CCM will exhibit an improvement in self-management. |
| Annually |
| Case Management Director |
| 11/2016 |
| 12/2016 |

*Previously monitored*
### Disease Management: Monitoring Member Participation Rates

The Behavioral Health and Wellness Services Department annually measures active member participation rates.

- The active member participation rate is defined as the number of members who have received at least one interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

**2014 DM Participation Goal:**
1. 5% Commercial member participation among members identified as eligible for either the Diabetes or Depression Disease Management Programs.

### Disease Management: Measuring Program Effectiveness

The Behavioral Health and Wellness Services Department employs and tracks one performance measure for each Disease Management Program. Behavioral Health and Wellness Services will measure program effectiveness for the following programs in 2015:
- Diabetes
- Depression

For each measurement Disease Management:
- Addresses a relevant outcome
- Produces a quantitative result
- Is population based
- Uses data and methodology that are valid for the process or outcome being measured
- Has been analyzed in comparison with a benchmark or goal

#### Current HEDIS 2015 CDC Commercial
- HbA1c >9%: 30.89% (25th percentile)
- HbA1c<8%: 59.19 (25th percentile)%
- Eye Exam: 45.87% (10th percentile)
- MA for Nephrology: 76.15% (0 percentile)
- BP <140/90 mm Hg: 74.92% (95th percentile)

**2016 HEDIS Goals:**
- HbA1c >9%: 31.79% (50th percentile)
- HbA1c<8%: 59.15% (50th percentile)
- Eye Exam: 47.92% (25th percentile)
- MA for Nephrology: 78.01% (5th percentile)
- BP <140/90 mm Hg: 76% (90th percentile)

#### Current HEDIS 2015 AMM Commercial
- Eff. Acute Phase Tmt: 77.7% (95th percentile)
- Eff. Continuation Phase Tmt:
| **2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis** | DHMP’s QI Department: Sends CAHPS surveys out annually to members via random sample. Validates data before submission. Meets CAHPS submission deadline. Analyzes survey results to determine areas of intervention and improvement. | Evidence of annual analysis includes: Presentation to the QMC. Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes. | Annually | QI Clinical Project Manager | Ongoing | QMC |
| Cultural and Linguistic Appropriate Services (CLAS) | To deliver culturally and linguistically appropriate services to Denver Health Members in accordance with Centers for Medicaid and Medicare (CMS) and the Colorado Department of Health Care Policy (HCPF). As well as continuing to train new staff and conduct annual refresher training related to cultural awareness and health literacy. | Function: Cultural Competency Training Trainings will be made available to Denver Health providers and staff. The trainings will educate staff and providers on the health beliefs held by diverse patient populations and raise cultural awareness. Annual analysis will be completed to assess results of the training satisfaction survey. | Goal: Maintain MHC distinction for Medicare Advantage. | Annually | CLAS Program Manager | 1/2015 | Ongoing | Denver Health Diversity Committee |
| | ✓ Affects member experience | CLAS Workgroups Health plan representatives sit on CLAS related cross departmental workgroups under the Community Affairs Program for Denver Health Hospital. Diversity Workgroup LGBTQ Health Committee | | | | | | |

*Previously monitored*
<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
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<th>Primary</th>
<th>Start</th>
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</tr>
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<tbody>
<tr>
<td><strong>QUALITY OF SERVICE</strong></td>
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</table>
| Monitoring Network Availability of Practitioners | DHMP conducts an annual assessment to ensure that it maintains an adequate network of primary care, behavioral health and specialty care practitioners. We monitor effectiveness of the network in meeting needs and preferences of our membership. | Analysis includes:  
- Collecting member complaint data related to cultural, racial, ethnic and linguistic preferences  
- Performance against the number and geographical distribution standards for primary care, behavioral healthcare and specialty care | Goals:  
Meet urban, suburban and rural provider availability standards set in the Access to Care and Services Policy | Annually | Sr. Business Project Manager | 9/2016 | 10/2016 | QMC |
| Commercial Quality of Care Concerns (QOCC) | DHMP Medical Director and QI RN appropriately investigate potential QOCC’s. | Timeframe requirements:  
- Acknowledgment letter: 2 business days.  
- Expedited Response: 72 hrs.  
- Standard Response: 30 business days.  
- Extension letter: 15 business days. | Goal:  
100% Timeframe Compliance | Quarterly | QI Director | Ongoing | Ongoing | QMC |
| Medicare Quality of Care Concerns (QOCC) | DHMP Medical Director and QI RN appropriately investigate potential QOCC’s. | Timeframe requirements:  
- Acknowledgment letter: N/A  
- Expedited Response: 24 hrs.  
- Standard Response: 30 calendar days.  
- Extension letter: 14 calendar days. | Goal:  
100% Timeframe Compliance | Quarterly | QI Director | Ongoing | Ongoing | QMC |
| Monitoring Accessibility of Services | DHMP has established mechanisms to ensure access to primary and specialty care services, along with behavioral health services. DHHA Appointment Center services are responsible for meeting established standards. |  
| Assessment incorporates: Self-reported access data from practitioners captured via Secret Shopper Studies, supplemented with an analysis of complaints related to access. | Goals:  
Meet urban, suburban and rural standards set in the Access to Care and Services Policy | Annually | Sr. Business Project Manager | 1/2016 | 2/2016 | QMC |
| Adoption and Distribution of Clinical Practice and | DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members for the provision of non-preventive acute and chronic care. | Clinical Practice and Preventive Health guidelines must be updated annually or when the following circumstances exist:  
- New scientific evidence or national guidelines | Objective:  
Adoption and dissemination by:  
Establishing the clinical/scientific basis for the | Annually | QI Director | 1/2016 | 12/2016 | QMC |

*Previously monitored
| Preventive Health Guidelines | medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties. | standards are published prior to the annual review date  
- National guidelines change prior to the annual review date | guidelines  
- Review guidelines annually, with updates as needed  
- Distributing guidelines to appropriate practitioners |  
| Performance and Preventive Health Guidelines | DHMP annually measures performance against at least two important aspects of six clinical practice and preventive health guidelines to determine practitioner adherence and to improve the guidelines. | Annually DHMP must:  
- Address and measure two specific aspects of care covered in the guidelines  
  Must consider:  
  - 2 clinical practice guidelines for an acute or chronic medical condition  
  - 2 clinical practice guidelines for a behavioral health condition  
  - 2 preventive health guidelines  
  - Relate provider performance to the clinical process of care within the guidelines | Objective:  
- Data must be collected to determine practitioner adherence to adopted guidelines and improve practitioner performance  
- Collection methodology must be sound to produce valid and reliable results to identify parts of the guidelines that are not being used appropriately  
- Each guideline must have 2 distinct measures | Annually QI Director 9/2016 12/2016 QMC |  
| Performance Measurement of Clinical Practice and Preventive Health Guidelines | DHMP’s UM Department has:  
- Written UM decision-making criteria that are objective and based on medical evidence  
- Written policies for applying the criteria based on individual needs  
- Written policies for applying the criteria based on an assessment of the local delivery system  
- Involvement of appropriate practitioners in developing, adopting and reviewing criteria | Objective:  
- Criteria must consider at least the following when applying criteria to a given individual:  
  - Age  
  - Comorbidities  
  - Complications  
  - Progress of Treatment  
  - Psychosocial situation  
  - Home environment, when applicable | Annually Case Management Director Medical Director 2/2016 3/2016 QMC UMC |  
| Monitoring Consistency of Applying UM Criteria | Utilization Management monitors and reviews application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency. | DHMP’s Utilization Management Department annually:  
- Evaluates consistency of health care professionals making UM decisions | Goal:  
85% Accuracy Rate for Criteria Application | Annually Case Management Director Medical 11/2016 12/2016 QMC UMC |  
| Evaluating Utilization Management Criteria | Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate. | DHMP’s UM Department has:  
- Written UM decision-making criteria that are objective and based on medical evidence  
- Written policies for applying the criteria based on individual needs  
- Written policies for applying the criteria based on an assessment of the local delivery system  
- Involvement of appropriate practitioners in developing, adopting and reviewing criteria | Objective:  
- Criteria must consider at least the following when applying criteria to a given individual:  
  - Age  
  - Comorbidities  
  - Complications  
  - Progress of Treatment  
  - Psychosocial situation  
  - Home environment, when applicable | Annually Case Management Director Medical Director 2/2016 3/2016 QMC UMC |  
| Monitoring Consistency of Applying UM Criteria | Utilization Management monitors and reviews application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency. | DHMP’s Utilization Management Department annually:  
- Evaluates consistency of health care professionals making UM decisions | Goal:  
85% Accuracy Rate for Criteria Application | Annually Case Management Director Medical 11/2016 12/2016 QMC UMC |  

*Previously monitored
**Monitoring of Formulary and Pharmaceutical Management Procedures**

Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes.

**DHMP’s Pharmacy Department annually:**
- Review the procedures
- Review list of pharmaceuticals
- Updates the procedures and pharmaceuticals, as appropriate

**Goal:**
- Must present and review all pharmaceutical management procedures annually to address areas for improvement

<table>
<thead>
<tr>
<th>Quality of Service Concerns (QSC)</th>
<th>The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns.</th>
<th>Timeframe requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Affects member experience</td>
<td>Acknowledgment letter: 5 business days.</td>
<td>Goal:</td>
</tr>
<tr>
<td></td>
<td>Standard Response: 30 business days.</td>
<td>100% Timeframe compliance</td>
</tr>
<tr>
<td></td>
<td>Extension letter: 15 business days.</td>
<td></td>
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<td></td>
<td>Expedited: 72 hours</td>
<td></td>
</tr>
</tbody>
</table>

**Quality of Service**

**Member Annual Communication Requirements**

The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan topics related to patient care and service.

**Members receive:**
- Information about the quality program goals and outcomes as related to member care and service
- Pharmaceutical restriction and preference information, including formulary

**Goals:**
- Must provide evidence of annual communication to all members

<table>
<thead>
<tr>
<th>Member Communication Requirements Upon Enrollment</th>
<th>The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan design and benefits</th>
<th>Members are provided the following information, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Member rights and responsibilities statement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Subscriber information</td>
</tr>
</tbody>
</table>

**Goals:**
- Must provide evidence of communication to all commercial members upon enrollment and annually thereafter

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*Previously monitored
<table>
<thead>
<tr>
<th>and Annually Thereafter</th>
<th>Affects member experience</th>
<th>PHI use and disclosure information</th>
<th>The process for members to self-refer to case management</th>
<th>How to access staff</th>
<th>An affirmative statement about incentives</th>
<th>Goals:</th>
<th>Must provide evidence of annual communication to all network practitioners and providers</th>
<th>Annually</th>
<th>Marketing Manager</th>
<th>1/2016</th>
<th>11/2016</th>
<th>Outreach Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner and Provider</td>
<td>The Marketing Department focuses on timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.</td>
<td>Practitioners and providers are provided the following information:</td>
<td>- Information about the quality program goals and process outcomes related to member care and service</td>
<td>- Pharmaceutical restriction and preference information, including formulary.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Annual Communication Requirements</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner and Provider</td>
<td>The Marketing Department provides timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.</td>
<td>Practitioners and Providers are provided the following information, including but not limited to:</td>
<td>- Member rights and responsibilities statement</td>
<td>- The process for the practitioner to refer members to case management</td>
<td>- Disease Management Program information</td>
<td>- Clinical practice and preventive health guidelines (to appropriate practitioners)</td>
<td>- How to obtain UM criteria</td>
<td>- How to access staff</td>
<td>- An affirmative statement about incentives</td>
<td>Goal:</td>
<td>Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter</td>
<td>Annually</td>
</tr>
</tbody>
</table>
### Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Start</th>
<th>Finish</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY OF SERVICE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and Hospital Directory Usability Testing</td>
<td>The Marketing Department evaluates DHMP’s web-based physician and hospital directory for health literacy, ability for member understanding and usefulness of information to members and prospective members. Evaluation considers: • Font size • Reading level • Intuitive content organization • Ease of navigation • Directories in additional languages, if applicable to membership</td>
<td></td>
<td>Goals: • There must be a documented process demonstrating how usability testing is performed and how testing frequency is determined. • Reports indicating initial usability testing was performed before and after any upgrades to functionality or design that directly affects how members use the site.</td>
<td>Annually</td>
<td>Marketing Manager</td>
<td>3/2016</td>
<td>4/2016</td>
<td>QMC</td>
</tr>
<tr>
<td>Accessing Member Understanding of DHMP Procedures</td>
<td>The Marketing Department has a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures. ✔ Affects member experience Assessment includes: • Monitoring new member understanding of DHMP procedures • Implementing procedures to maintain accuracy of marketing communication • Acting on opportunities for improvement</td>
<td></td>
<td>Goals: • There must be evidence of a systematic and ongoing process for assessing new-member understanding of DHMP operations and policies. • If DHMP finds that new members have enrolled without an accurate understanding of key DHMP policies and procedures, DHMP must initiate a quality improvement process to correct the possibility of future misrepresentation.</td>
<td>Quarterly</td>
<td>Marketing Manager</td>
<td>1/2016</td>
<td>4/2016</td>
<td>7/2016</td>
</tr>
<tr>
<td><strong>Ongoing Monitoring of Network Practitioners and Providers</strong></td>
<td>Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP’s office-site standards. This is Provider Relations and Credentialing: • Sets performance standards and thresholds for office site quality • Establishes a documented process for ongoing monitoring and</td>
<td></td>
<td>Goals: • Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met</td>
<td>Quarterly</td>
<td>QI Director</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Cred. Cmte. QMC</td>
</tr>
</tbody>
</table>

*Previously monitored*
| Site Quality | achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality. | investigation of member complaints related to practice sites | Deliver corrective action plans within 30 calendar days of site visit | Repeat site visits are conducted 6 months after delivering corrective action plans to assure compliance |
| Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues | DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified. | Ongoing review and monitoring by: | Goals: | QI Director | Ongoing | Monthly | Cred. Cmte. QMC |
| | | | | | | | |
| *Monitoring Member Services’ Telephonic Performance | The Member Services Department has a process for monitoring and evaluating telephonic metrics against established thresholds. | Reporting categories: | Goals: | Quarterly | Director of Member Services | Ongoing | Ongoing | QMC |
| | | | | | | | |
| *Continuity and Coordination of Medical Care | DHMP uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. | Annual identification of opportunities to improve coordination of medical care by: | Goals: | Annually | Director of Case Management | Ongoing | 11/2016 | QMC UMC |
| | | | | | | | |

*Previously monitored
| #Continuity and Coordination Between Medical Care and Behavioral Healthcare | During 2014, DHMP will conduct an initial assessment of continuity and coordination of care efforts between medical health care providers and behavioral health care providers (Denver Health and Cofinity providers). DHMP will use the annual provider survey to obtain satisfaction scores and feedback from the providers on the current processes for exchanging patient information between medical and behavioral health care providers. The data will be analyzed by the DHMP Medical Management staff and the Utilization Management Committee. | Annual identification of opportunities to improve coordination of medical and behavioral healthcare by:  
- Collecting data through Provider surveys  
- Conducting qualitative and causal analysis of data to identify improvement opportunities  
Identifying and selecting opportunities for improvement | Goals:  
- At least 80% of the providers surveyed, report a satisfaction rating of at least 4 or 5 (scale of 1 to 5) for the following factors related to the exchange of patient information between behavioral and medical health care providers:  
  - Ease of the process.  
  - Timeliness of the exchange of information  
  - Accuracy of the information.  
  - Completeness of the information. | Annually | Director of Utilization Management | Ongoing | 11/2016 | QMC UMC |
| #Monitoring Satisfaction with Complex Case Management | Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction.  
Affects member experience | Satisfaction data is collected through the following methods:  
- Obtaining survey feedback from members  
- Analyzing member complaints for tracking/trending | Goals:  
- Members: 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied). | Annually | Director of Complex Case Management | 11/2016 | 12/2016 | QMC |
| #Open Shopper Study | Denver Health Medical Plan, Inc. (DHMP) has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is | Objectives:  
- Semi-annually, call all DHMP HMO outpatient clinics (n=9) and a random sample of POS provider clinics (n=50) to assess compliance with DHMP Primary Care Access Standards for routine appointments, urgent after-hours care and acute care access.  
- Semi-annually, call all Behavioral Health providers who see 2 or more of our members to assess | Goals:  
- Emergency Care: 24 hours a day, 7 days a week - Met 100% of the time  
- Emergency Care-Behavioral Health Non-life Threatening: Within 6 hours- Met 100% of the time  
- Urgent Care-Medical and Behavioral Health: Within 24 hours- Met 100% of the time  
- Primary Care-Routine | Semi-Annually | QI Director | 1/2016 | 7/2016 | QMC |

*Previously monitored
<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Description</th>
<th>Goals</th>
<th>Evidence of monitoring includes:</th>
<th>Annually</th>
<th>QI Director</th>
<th>1/2016</th>
<th>2/2016</th>
<th>QMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Satisfaction</td>
<td>DHMP monitors member satisfaction with our services and identifies areas of potential improvement. To assess member satisfaction with our services, DHMP annually evaluates member complaint and appeal data to analyze tracking and trending.</td>
<td>Aggregate member complaints and appeals by reason, showing rates related to:</td>
<td>Quality of Care Access Attitude and Service Billing and Financial Issues Quality and Practitioner Office Site.</td>
<td>Evidence of monitoring includes:</td>
<td>Annually</td>
<td>QI Director</td>
<td>1/2016</td>
<td>2/2016</td>
</tr>
<tr>
<td>Satisfaction with the Utilization Management Process</td>
<td>DHMP continually assesses member and practitioner satisfaction with our Utilization Management process to identify areas in need of improvement.</td>
<td>Components of the process: Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities Taking action designed to improve member and practitioner satisfaction.</td>
<td>Goals: Members: Of the surveyed members (CAHPS) who required an authorization for services, 90% or more reported being either “Somewhat or Very Satisfied” with the process.</td>
<td></td>
<td></td>
<td>12/2016</td>
<td>1/2017</td>
<td>QMC</td>
</tr>
</tbody>
</table>
**DENVER HEALTH MEDICAL PLAN, INC.**  
Commercial and Medicare Quality Improvement Work Plan 2016

<table>
<thead>
<tr>
<th>Monitoring Satisfaction with Disease Management</th>
<th>Satisfaction data is collected through the following methods:</th>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Behavioral Health and Wellness Services Department annually evaluates satisfaction with its disease management services to identify opportunities to improve member satisfaction. ✓ Affects member experience</td>
<td>● Obtaining member survey feedback Analyzing complaints and inquiries</td>
<td>● Members: 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
</tr>
</tbody>
</table>

**QUALITY OF SERVICE**

<table>
<thead>
<tr>
<th>Monitoring Member Services’ Benefit Information for Quality and Accuracy</th>
<th>Components of the process:</th>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Member Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.</td>
<td>● Collecting data on quality and accuracy of information provided ● Analyzing data against standards or goals ● Determining the cause of deficiencies, as applicable ● Acting to correct identified deficiencies</td>
<td>● Telephone: 85% accuracy ● Online: 85% accuracy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring the Nurse Advice Line</th>
<th>Components of the process:</th>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMP has a quality improvement process in place for monitoring the Nurse Advice Line to identify and establish opportunities for improvement.</td>
<td>● Tracks telephone and web statistics monthly ● Tracks member use of the Nurse</td>
<td>● Service Level: at or above 85% ● Time to answer: 30 seconds or less.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

| *Previously monitored |

<table>
<thead>
<tr>
<th><em>Monitoring Satisfaction with Disease Management</em></th>
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<th>Goals:</th>
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<td>● Obtaining member survey feedback Analyzing complaints and inquiries</td>
<td>● Members: 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
</tr>
</tbody>
</table>

**Monitoring Member Services’ Benefit Information for Quality and Accuracy**

**Components of the process:**

- Collecting data on quality and accuracy of information provided
- Analyzing data against standards or goals
- Determining the cause of deficiencies, as applicable
- Acting to correct identified deficiencies

**Goals:**

- Telephone: 85% accuracy
- Online: 85% accuracy

**Quarterly**

Director of Member Services


**Monitoring the Nurse Advice Line**

**Components of the process:**

- Tracks telephone and web statistics monthly
- Tracks member use of the Nurse

**Goals:**

- Service Level: at or above 85%
- Time to answer: 30 seconds or less.

**Quarterly**

Director of Member Services


**QMC**
| Monitoring Pharmacy Benefit Information for Quality and Accuracy | Advice Line | • Evaluates member satisfaction with the Nurse Advice Line  
• Monitors calls periodically  
• Analyzes data at least annually and, if applicable, identifies opportunities and establishes priorities for improvement | • Abandonment rate: 5% or less. |
|---|---|---|---|
| Components of the process: | Collects data on quality of service and accuracy of pharmacy benefit information provided both telephonically and online  
• Analyzes data results  
• Acts to correct identified deficiencies. | Goals: | Semi-annually Pharmacy Director Ongoing Ongoing QMC Compliance Committee |

Results are presented to Compliance Committee and QMC for review and feedback.

| 2015 Utilization Management Program Evaluation | The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the UMC & QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program. | Evaluation includes: | Presentation to QMC must include:  
• Committee discussion and input on program summary  
• Actions, if applicable  
• Committee approval of 2016 UM Program |

| | | Completed and ongoing activities  
• Quantitative and Qualitative Analysis  
• Evaluation of effectiveness | Annually Medical Director 01/2016 02/2016 QMC UMC |

*Previously monitored*
### Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
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</tr>
</thead>
<tbody>
<tr>
<td>SAFETY OF CLINICAL CARE</td>
<td><strong>Patient Safety Initiatives</strong></td>
<td>The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Behavioral Health and Wellness Departments to provide clinical quality monitoring&gt; Identification of performance improvement opportunities related to member safety are reviewed and implemented.</td>
<td>Process: The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches.</td>
<td>Objectives: • Encourage organizational learning about medical and health care errors • Incorporate patient safety education across organization • Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee. • Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result • Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions • Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired under the quality of care concern process. • Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk • Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety.</td>
<td>Annually</td>
<td>Director of QI</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
DENVER HEALTH MEDICAL PLAN, INC.
Commercial and Medicare Quality Improvement Work Plan 2016

### Pharmacuetical Patient Safety Issues

*Previously monitored*

- **Objective:**
  - Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety.
  - An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall.

- **Goals:**
  - **100% Compliance for:**
    - Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification.
    - Class II: Affected members and providers notified within thirty days of the FDA notification.
    - Class III: Affected members and provider notified within sixty days of FDA notification.

- **Annually** | Pharmacy Director | Ongoing | Ongoing | QMC - Semiannually | Compliance Committee - Annually

### Monitoring Privacy and Confidentiality

*Previously monitored*

- **Objective:**
  - Identifying impermissible uses or disclosure of sensitive information.
  - Reporting impermissible uses or disclosures of sensitive information.
  - Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information.

- **Goals:**
  - Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality.
  - If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections.

- **Annually** | Director of Compliance | Ongoing | Ongoing | Compliance Committee | Board of Directors

### SAFETY OF CLINICAL CARE

- **Focus existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety.**
- **Annually review and evaluate clinical practice guidelines against practice guidelines to ensure and improve safe practices.**
may include, but are not limited to:
- Education and training
- Process/procedural revisions
- Progressive discipline
Monitoring Member Services’ Telephonic Performance

Member Services has in place a departmental Performance Report that monitors four telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, Abandonment Rate of 5% or less, and overall Call Volume. The Member Services Performance Report monitors these telephonic statistics by each individual Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) line of business. Tracking, comparison, and evaluation occurs on a monthly as well as annual basis. The Member Services Lead Customer Service Representative pulls all telephonic statistical data from the Cisco Telephony System reporting system Cisco Unified CXX Historical Reports and prepares the report for the Call Center Operations Manager. The Operations Manager reviews each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The Operations Manager presents the Performance Report as well as his or her Summary and Analysis at each quarterly Quality Management Committee meeting.

*Service Level=Percentage of calls answered within 30 seconds. Standard: 80% (Industry) 85% (DMHP/MCD Choice)*
MS Combined Average Delay 12-16

*Average Delay=How long callers wait before agent answers. Standard: 30 seconds (Industry) 30 seconds (DHMP/MCD Choice)

MS Combined Abandonment Rate 12-16

*Abandonment Rate=Percentage of callers that hang up before agent answers. Standard: <5% (Industry) 5<% (DHMP/MCD Choice)
Monitoring Member Services’ Benefit Info for Quality and Accuracy

In order to satisfy regulatory standards and monitor the telephonic quality of DHMP Member Services, the Member Services Quality Assurance Program has instituted reporting occurring on a monthly basis. The MS QA Program allows the Member Services Leadership Team (MSLT) to determine any deficiencies in quality and service provided by the Member Services Representatives (MSRs) as well as work to correct any identified deficiencies. The QA Program serves as a valuable tool in staff development and satisfaction and is also incorporated into the annual MSR evaluation process to ensure that it is meaningful to the team and its individual members.

The QA program entails monitoring and reporting on two components, telephonic productivity and performance as well as quality and accuracy of benefit information provided. Productivity is evaluated on specific metrics from the Cisco Telephony System, specifically Inbound Call Volume, Average Talk Time, Not Ready Time, and Reserved Time. The quality component of the QA Program is evaluated by direct call monitoring and evaluation by the MS Supervisor. The MS Supervisor selects 10 random calls for each MSR that occurred in the specific month out of the Call Copy Call Recording Software. The MS Supervisor will evaluate the call for the quality and accuracy of the information provided based upon various criteria (member information confirmation, identifying issues, knowledge of benefits, documenting the call, tone of voice, etc.) and scores the MSR on a sliding scale dependent upon the accuracy of the information given. The overall evaluation of MSR performance in both areas is compiled, reviewed, and provided to the MSRs on a monthly basis. One on one coaching will occur if deemed necessary. In addition, an overall departmental MS Monthly Call Quality Performance Report is compiled to track the progress of quality maintained by the MSRs from month to month on an individual as well as departmental basis. All MSRs and the department overall must
maintain an accuracy rate of 85% or higher. If this is not maintained, corrective actions are taken.

Monitoring the Nurse Advice Line

The primary intent of the Member Services’ Nurse Advice Line Performance Monitoring Program is to track member usage of the provided services and to identify opportunities and establish priorities for improvement. DHMP Member Services receives a monthly Performance Report from the Nurse Advice Line Leadership Team that includes Nurse Advice Line phone metrics such as Service Level, Average Delay, Abandonment Rate, and Call Volume for various DHMP and DHHA lines of business. The Nurse Advice Line is held to the same industry standards as DHMP Member Services, specifically: Service Level at or above 85%, Average Delay of 30 seconds or less, and Abandonment Rate of 5%. The Nurse Advice Line Performance Report also includes data on call triage and various member utilization (see Report 1.4). In addition to monitoring the quality and productivity of the Nurse Advice Line, DHMP Member Services also completes an annual member satisfaction survey call administered by MSRs. This member feedback is recorded and provided directly to the Nurse Advice Line Leadership Team.
2016 MANAGED CARE NURSELINE REPORT

Abandonment Rate (<5%)

Clinical Quality Audits (%)

Average Speed to Answer (min:sec)
Clinical Dispositions for Standard Triage Calls
(Medicaid Choice Not Included)
<table>
<thead>
<tr>
<th>Activity</th>
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<th>Start</th>
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</tr>
</thead>
</table>
| **2016 QI Program Description- Scope** | The QI Program Description will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC). | Annually Program must include:  
- Program Structure  
- How patient safety is addressed  
- How designated physician is involved  
- How BH practitioner is involved  
- Oversight of QI functions by QMC  
- Annual work plan  
- Objectives for serving a culturally and linguistically diverse membership  
Objectives for serving members with complex health needs, including behavioral health | Objective:  
- All requirements must be met  
- Reviewed and updated annually  
- Submitted for review to the QMC and BOD | Annually | QI Director | 1/2016 | 2/2016 | QMC Board of Directors |
| **2016 Annual QI Work Plan** | The QI Work Plan schedule is developed after review of previous year’s QI Work Plan and evaluation. The revised work plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measurable and analyzed annually during the Program Evaluation. | Work Plan must address:  
- Quality of Clinical Care  
- Quality of Service  
- Safety of Clinical Care  
- Member’s Experience  
- QI Program Scope  
- Yearly Objectives and planned activities  
- Time Frame in which each activity is to be achieved  
- The staff member responsible for each activity  
- Monitoring of previously identified issues | Objective:  
- All 9 requirements must be met  
- Yearly objectives must be measurable  
- Submitted to the QMC and BOD | Annually | QI Director | 01/2016 | 2/2016 | QMC Board of Directors |

*Previously monitored*
**DENVER HEALTH MEDICAL PLAN, INC.**  
**Commercial and Medicare Quality Improvement Work Plan 2016**

### Evaluation of the QI Program

#### Evaluation includes:
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices.

#### For all goals not met:
- QI must conduct a root cause or barrier analysis to identify the underlying causes and recommend changes to improve.
- Analysis must include organizational staff with direct experience of processes that have presented barriers to improvement.

#### Evaluation Summary must include and address:
- Analysis and overall effectiveness.
- Completed and ongoing activities.
- Trending of QI measures/results.

### QI PROGRAM OPERATIONS

| Quality Management Committee | DHMP’s Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. | Committee functions include:
- Analyzes and evaluates the results of QI activities.
- Ensures practitioner participation in the QI program through planning, design, implementation or review.
- Review and make recommendations on policy decisions.
- Identifies needed actions.
- Ensures follow-up, as needed. | Objective: Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes. | Bi-Monthly | QI Director | Ongoing | Ongoing | QMC |
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<td>Annually</td>
<td>QI Director</td>
<td>1/2016</td>
<td>2/2016</td>
<td>QMC Board of Directors</td>
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<table>
<thead>
<tr>
<th>Medicare Star Ratings Workgroup</th>
<th>Key Plan representatives work together to identify opportunities and implement interventions to improve our Medicare Star ratings.</th>
</tr>
</thead>
</table>
| Committee functions include:    | - Evaluate & identify opportunities  
- Intervention approval and support  
- Resource allocation  
Review results to evaluate effectiveness |
| Objective:                      | Committee analyzes and targets specific Stars measures for improvement. Interventions are then reviewed with ACS provider network and/or DHMP departments for approval and support. Metrics are set up to evaluate effectiveness. |
| Quarterly                       | Clinical Project Manager  
QI Director |
| Collaborative QI Workgroups     | QI health plan representatives sit on several collaborative workgroups led by ACS leadership. |
|                                 | - Cancer screening  
- Pediatric Preventive Health  
- Diabetes  
- Perinatal Care  
- Asthma  
- Weight Management  
- Practice Transformation |
|                                 | Established active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits. |
|                                 | Monthly Intervention Managers  
QI Director |

### QUALITY OF CLINICAL CARE

**HEDIS** is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of 80 measures across 8 domains of care which allow for comparison of quality performance nationally across health plans.

**Procedure:**
- HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures.
- Data validation prior to submission date
- Meet submission deadline
- Data from the HEDIS project is analyzed to determine areas of intervention and improvement.

**Objective:** Evidence of annual analysis includes:
- Presentation to the QMC
- Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.
- Increase medical record compliance by improving coding and documentation.
- To measure effectiveness of intervention; analysis will be accomplished by comparing previous year results with current year results.

**HEDIS Project**
- Annually
- QI HEDIS Project Manager  
QI Director
- 12/2015  
6/2016  
QMC

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<tr>
<td>Every month a list will be drawn from the data warehouse, and run against claims and the active member’s list. All commercial women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment.</td>
<td>QI will coordinate and advertise employee days and locations of BCS screenings (mobile van) on the pulse and frontlines.</td>
<td>65.22%</td>
<td>Current HEDIS 2015: 67.76% (10th percentile)</td>
<td>65.22%</td>
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<td>✓ Affects member experience</td>
<td>• Conducts monthly data pull</td>
<td>Current HEDIS 2015: 67.76% (10th percentile)</td>
<td>HEDIS 2016 Goal: 69.04% (25th percentile)</td>
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<td></td>
<td>• Defines eligible participants</td>
<td>Medicare Baseline HEDIS 2013: 72.31%</td>
<td>Medicaid Baseline HEDIS 2016: 73.70% (50th percentile)</td>
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<td>• Distributes mailings</td>
<td>Current HEDIS 2015: 67.76% (10th percentile)</td>
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**QI A3 Management**

Use LEAN practices and tools to identify and research new quality improvement targets. Implement QI strategies (interventions or process improvements) based on findings.

A3 activities for 2016 include:

- Improving Health Plan Customer Service
- Developing strategies for improving HEDIS rates in the unenpanelled member population
- Improving race/ethnicity/language (REL) data in the data warehouse
- Improving well child rates for the 3-9 year age group

**Objective:**

- Increase collaboration in LEAN efforts
- Improve quality of data
- Increase overall member satisfaction

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**QUALITY OF CLINICAL CARE**

**Improving Perinatal Health: Postpartum and Prenatal Incentives**

To improve Commercial HEDIS rates for PPC QI works in collaboration with the Marketing Department to incentivize female members, who have a positive pregnancy test or OB intake visit, to encourage expectant mothers to adhere to recommended prenatal procedures.

**Procedure:**

- Claims lists are extracted from the BI portal monthly.
- Marketing department tracks prenatal mailings, prenatal visits, and sends out incentives to members.
- Marketing tracks postpartum.

2015 Prenatal Incentive Average Commercial Participation Rate: 31%

2016 Prenatal Incentive Commercial Participation Rate Goal: 35%
| Improving Perinatal Health: HEDIS documentation and coding education | DHMP QI HEDIS Program Manager and QI Pediatric Intervention Manager provide guidance and education on appropriate coding and documentation at Denver Health Hospital. | Procedure:  
- QI participates in the perinatal workgroup on a monthly basis. QI provides guidance and education on appropriate coding and documentation for PPC HEDIS compliance. |  
Prenatal 2015: 93.30% (75th percentile)  
Prenatal Goal 2016: 96.23% (90th percentile)  
Postpartum 2015: 84.36% (50th percentile)  
Postpartum Goal 2016: 84.62% (75th percentile)  
Postpartum Incentive Overall Participation Rate 2015: 7%  
Postpartum Participation Rate Goal for 2016: %12% | Marketing Director |
|---|---|---|---|---|
| Improving Well-Child Visits: HEDIS Rates | To improve the Commercial HEDIS Rates for Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34), and Adolescent Well-Care Visits (AWC) | The following interventions will be ongoing in 2016:  
- Healthy Heroes Birthday Cards, with amendment  
- SBHC Targeted Lists  
- SBHC Enrollment Increase  
- Newborn coupon  
- Improving Medical Record Documentation for HEDIS specifications: Provider |  
W15 (6+ visits)  
HEDIS 2015: 78.15% (25th percentile)  
Goal - HEDIS 2016: 80.99% (50th percentile)  
W34  
HEDIS 2015: 80.52% (50th percentile)  
Goal - HEDIS 2016: 83.43% (75th percentile) | QI HEDIS Program Manager  
QI Pediatric Intervention Manager |
### Improving Well-Child Visits: Healthy Heroes Birthday Cards

| Commercial children 2-19- years of age receive a birthday card informing them to come for their annual visit. These mailings have been going out to members since January 2009. Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care. QI will amend the mailing to exclude kids who have already received their well child visit for the year. ✓ Affects member experience |
| Education | AWC HEDIS 2015: 43.07% (525th percentile) Goal – HEDIS 2016: 45.32% (50th percentile) | Quarterly | Pediatric Intervention Manager | 1/16 | 12/16 | QMC |
| • QI pulls list from BI portal monthly | **Goal:** Engage children who have not gone in for their annual well child visit through the healthy hero birthday cards | | | | | |
| • QI cleans data and separates per LOB | WCC BMI HEDIS 2015: 81.51% (75th percentile) Goal HEDIS 2016: 83.13% (75th percentile) | | | | | |
| • QI sends list to Marketing | WCC Counseling for Nutrition HEDIS 2015: 75.18% (75th percentile) Goal HEDIS 2016: 77% (75th percentile) | | | | | |
| • QI proofs the birthday card and sends okay response to Marketing | Marketing sends to the printer and they are mailed to members | | | | | |
| • QI monitors response rate on quarterly basis | | | | | | |
# Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Start</th>
<th>Finish</th>
<th>Approval</th>
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<td><strong>QUALITY OF CLINICAL CARE</strong></td>
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<tr>
<td>Improving Well-Child Visits: Baby's First Year Incentives</td>
<td>The Marketing Department has Commercial incentives for the “Baby’s First Year” program. For each newborn visit completed in the first 12 months of life, members will receive an incentive. For 2015, QI has extended the Baby’s first year with Marketing to 15 months to accommodate the W15 measure. Marketing will add a coupon to incentivize members to receive 6 or more visits within the first 15 months with 2 months’ worth of diapers.</td>
<td>• IS provides Marketing with a monthly report, identifying eligible participants for the program&lt;br&gt;• Marketing outreaches to eligible participants&lt;br&gt;• Marketing tracks member response and participation rates throughout the program.</td>
<td>For 2015, 218 commercial members had a live birth. 2015 Overall Average Participation: 22% Participation Goal for 2016: 25%</td>
<td>Annually</td>
<td>Marketing Manager</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>CEO</td>
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<tr>
<td>Improving Well-Child Visits: School-Based Health Centers Targeted Lists</td>
<td>Twice a year, QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. <strong>Objective:</strong> Increase the % of commercial members with a well-child visit by providing targeted lists to SBHC’s HCPs</td>
<td><strong>Procedure:</strong>&lt;br&gt;• SBHC sends enrollment lists in October and January, run against active members to determine who is in need of well-child visit&lt;br&gt;• Send list back to clinic so HCPs can pull kids out of class and provide well visit in SBHC.&lt;br&gt;• Provide updated list on monthly basis back to clinic so they are not providing services to children who may have</td>
<td>Goal: Assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit.</td>
<td>Quarterly</td>
<td>Pediatric Intervention Manager&lt;br&gt;School-Based Health Center Administrative Contacts</td>
<td>10/15</td>
<td>5/16</td>
<td>QMC</td>
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*Previously monitored*
### School Based Health Clinics (SBHC) - Well Child Visit Incentive Program

As part of the Denver Health Managed Care network, children who are members of Denver Health Medicaid Choice or any Denver Health Medical Plan, Inc. plan, have access to the Denver Health School-Based Health Centers (SBHC). These children can receive health care services at one of the many SBHCs with no cost sharing to the member.

- Affects member experience

**Procedure (Well Child Visits):** We will work with the SBHC to improve the % of children by clinic who complete a well-child visit at the SBHC. Each month QI will send a designated SBHC clinic leads a list of children on our medical plans that are enrolled in the SHBC program, who still need to complete their annual well visit for the year. Beginning Fall 2014, for children 12 years and older, students who receive their well visit at a SBHC will receive a $10 gift card of their choice (Ross, Subway, Fandango). Clinics will work collaboratively with QI to increase completed and documented Well Child visits.

**Well Child Visits: Goal for SBHC Clinics**

**Commercial:**

- **WCC Counseling for Physical Activity**
  - HEDIS 2015: 60.34% (50th percentile)
  - Goal HEDIS 2016: 62% (50th percentile)

- **WCC BMI**
  - HEDIS 2015: 81.51% (75th percentile)
  - Goal HEDIS 2016: 83.13% (75th percentile)

- **WCC Counseling for Nutrition**
  - HEDIS 2015: 75.18% (75th percentile)
  - Goal HEDIS 2016: 77% (75th percentile)

**AWC**

- **HEDIS 2015:** 43.07% (525th percentile)
- **HEDIS 2016 Goal:** 45.32% (50th percentile)

**Monthly**

**Pediatric Intervention Manager School Based Health Center – Dr. Sonja O’Leary**

<table>
<thead>
<tr>
<th>Month</th>
<th>QI Director</th>
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<tr>
<td>9/2014</td>
<td>QMC</td>
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<td>5/2015</td>
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| Complex Case Management: Population Assessment | Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner. | Assessment must consider and include the following:  
• Relevant characteristics of specific populations  
• DHMP’s total covered population, not just members identified for complex case management | Goals:  
• Assesses the characteristics and needs of its member population and subpopulations  
• Reviews and updates its complex case management processes to address member needs, if necessary  
• Reviews and updates its complex case management resources to address member needs, if necessary | Annually | Director of Complex Case Management | 1/2016 | 1/2017 | UMC QMC |

**QUALITY OF SERVICE**

| Complex Case Management: Measuring Program Effectiveness | Complex Case Management annually measures the effectiveness of its complex case management program using three measures. | For each measure, Complex Case Management:  
• Identifies a relevant process or outcome  
• Uses valid methods that provide quantitative results  
• Sets a performance goal  
• Clearly identifies measure specifications  
• Collects data and analyzes results  
• Identifies opportunities for improvement, if applicable | Goals:  
• Readmission Rates:  
• 5%  

• Member Satisfaction:  
• 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied).  

• CCM Effectiveness Review Survey:  
• 90% of members in CCM will exhibit an improvement in self-management. | Annually | Case Management Director | 11/2016 | 12/2016 | UMC QMC |

*Previously monitored*
The Behavioral Health and Wellness Services Department annually measures active member participation rates.

- **Disease Management: Monitoring Member Participation Rates**
  - The active member participation rate is defined as the number of members who have received at least one interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

2014 DM Participation Goal:
1. 5% Commercial member participation among members identified as eligible for either the Diabetes or Depression Disease Management Programs.

For each measurement Disease Management:
- Addresses a relevant outcome
- Produces a quantitative result
- Is population based
- Uses data and methodology that are valid for the process or outcome being measured
- Has been analyzed in comparison with a benchmark or goal

**Current HEDIS 2015 CDC Commercial**
- HbA1c >9%: 30.89% (25th percentile)
- HbA1c<8%: 59.19 (25th percentile)%
- Eye Exam: 45.87% (10th percentile)
- MA for Nephrology: 76.15% (0 percentile)
- BP <140/90 mm Hg: 74.92% (95th percentile)

2016 HEDIS Goals:
- HbA1c >9%: 31.79% (50th percentile)
- HbA1c<8%: 59.15% (50th percentile)
- Eye Exam: 47.92% (25th percentile)
- MA for Nephrology: 78.01% (5th percentile)
- BP <140/90 mm Hg: 76% (90th percentile)

**Current HEDIS 2015 AMM Commercial**
- Eff. Acute Phase Tmt: 77.7% (95th percentile)
- Eff. Continuation Phase Tmt:

<table>
<thead>
<tr>
<th>2014 DM Participation Goal:</th>
<th>Annually</th>
<th>Clinical Director of Behavioral Health and Wellness</th>
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<tbody>
<tr>
<td>1) 5% Commercial member participation among members identified as eligible for either the Diabetes or Depression Disease Management Programs.</td>
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<td>12/2016</td>
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<tr>
<th>Disease Management: Measuring Program Effectiveness</th>
<th>The Behavioral Health and Wellness Services Department employs and tracks one performance measure for each Disease Management Program. Behavioral Health and Wellness Services will measure program effectiveness for the following programs in 2015:</th>
</tr>
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<tbody>
<tr>
<td>• Diabetes</td>
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<td>• Depression</td>
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<td>HbA1c &gt;9%: 31.79% (50th percentile)</td>
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<td>Eff. Continuation Phase Tmt:</td>
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*Previously monitored*
| 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis | Assess member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS member satisfaction survey. | DHMP’s QI Department: Sends CAHPS surveys out annually to members via random sample. Validates data before submission. Meets CAHPS submission deadline. Analyzes survey results to determine areas of intervention and improvement. | Evidence of annual analysis includes: Presentation to the QMC. Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes. | Annually | QI Clinical Project Manager | Ongoing | QM Department |

Cultural and Linguistic Appropriate Services (CLAS) | To deliver culturally and linguistically appropriate services to Denver Health Members in accordance with Centers for Medicaid and Medicare (CMS) and the Colorado Department of Health Care Policy (HCPF). As well as continuing to train new staff and conduct annual refresher training related to cultural awareness and health literacy. | Function: Cultural Competency Training. Trainings will be made available to Denver Health providers and staff. The trainings will educate staff and providers on the health beliefs held by diverse patient populations and raise cultural awareness. Annual analysis will be completed to assess results of the training satisfaction survey. | Goal: Maintain MHC distinction for Medicare Advantage. | Annually | CLAS Program Manager | 1/2015 | QM Department |

CLAS Workgroups | Health plan representatives sit on CLAS related cross departmental workgroups under the Community Affairs Program for Denver Health Hospital. | 56.08% (75th percentile) 2016 HEDIS AMM Goal: Eff. Acute Phase Tmt: 77.7% (95th percentile). Eff. Continuation Phase Tmt: 57.5% (75th percentile). |

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| Monitoring Network Availability of Practitioners | DHMP conducts an annual assessment to ensure that it maintains an adequate network of primary care, behavioral health and specialty care practitioners. We monitor effectiveness of the network in meeting needs and preferences of our membership. | Analysis includes:  
- Collecting member complaint data related to cultural, racial, ethnic and linguistic preferences  
- Performance against the number and geographical distribution standards for primary care, behavioral healthcare and specialty care | Goals:  
Meet urban, suburban and rural provider availability standards set in the Access to Care and Services Policy | Annually | Sr. Business Project Manager | 9/2016 | 10/2016 | QMC |
| Commercial Quality of Care Concerns (QOCC) | DHMP Medical Director and QI RN appropriately investigate potential QOCC’s. | Timeframe requirements:  
- Acknowledgment letter: 2 business days.  
- Expeditied Response: 72 hrs.  
- Standard Response: 30 business days.  
- Extension letter: 15 business days. | Goal:  
- 100% Timeframe Compliance | Quarterly | QI Director | Ongoing | Ongoing | QMC |
| Medicare Quality of Care Concerns (QOCC) | DHMP Medical Director and QI RN appropriately investigate potential QOCC’s. | Timeframe requirements:  
- Acknowledgment letter: N/A  
- Expeditied Response: 24 hrs.  
- Standard Response: 30 calendar days.  
- Extension letter: 14 calendar days. | Goal:  
- 100% Timeframe Compliance | Quarterly | QI Director | Ongoing | Ongoing | QMC |
| Monitoring Accessibility of Services | DHMP has established mechanisms to ensure access to primary and specialty care services, along with behavioral health services. DHHA Appointment Center services are responsible for meeting established standards. | • Assessment incorporates: Self-reported access data from practitioners captured via Secret Shopper Studies, supplemented with an analysis of complaints related to access. | Goals:  
- Meet urban, suburban and rural standards set in the Access to Care and Services Policy | Annually | Sr. Business Project Manager | 1/2016 | 2/2016 | QMC |
| Adoption and Distribution of Clinical Practice and Preventive Health Guidelines | DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members for the provision of non-preventive acute and chronic | Clinical Practice and Preventive Health guidelines must be updated annually or when the following circumstances exist:  
- New scientific evidence or national | Objective:  
Adoption and dissemination by:  
- Establishing the clinical/scientific basis for the | Annually | QI Director | 1/2016 | 12/2016 | QMC |

*Previously monitored
| Preventive Health Guidelines | medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties. | standards are published prior to the annual review date • National guidelines change prior to the annual review date | guidelines • Review guidelines annually, with updates as needed Distributing guidelines to appropriate practitioners | | "Performance Measurement of Clinical Practice and Preventive Health Guidelines | DHMP annually measures performance against at least two important aspects of six clinical practice and preventive health guidelines to determine practitioner adherence and to improve the guidelines. | Annually DHMP must: • Address and measure two specific aspects of care covered in the guidelines. Must consider: ▪ 2 clinical practice guidelines for an acute or chronic medical condition ▪ 2 clinical practice guidelines for a behavioral health condition ▪ 2 preventive health guidelines ▪ Relate provider performance to the clinical process of care within the guidelines | Objective: • Data must be collected to determine practitioner adherence to adopted guidelines and improve practitioner performance. • Collection methodology must be sound to produce valid and reliable results to identify parts of the guidelines that are not being used appropriately • Each guideline must have 2 distinct measures | | "Evaluating Utilization Management Criteria | Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate. | DHMP’s UM Department has: • Written UM decision-making criteria that are objective and based on medical evidence • Written policies for applying the criteria based on individual needs • Written policies for applying the criteria based on an assessment of the local delivery system • Involvement of appropriate practitioners in developing, adopting and reviewing criteria | Objective: Criteria must consider at least the following when applying criteria to a given individual: ▪ Age ▪ Comorbidities ▪ Complications ▪ Progress of Treatment ▪ Psychosocial situation ▪ Home environment, when applicable | | "Monitoring Consistency of Applying UM Criteria | Utilization Management monitors and reviews application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency. | DHMP’s Utilization Management Department annually: • Evaluates consistency of health care professionals making UM decisions | Goal: 85% Accuracy Rate for Criteria Application | | *Previously monitored
DENVER HEALTH MEDICAL PLAN, INC.
Commercial and Medicare Quality Improvement Work Plan 2016

<table>
<thead>
<tr>
<th>Action</th>
<th>Goal</th>
<th>Timeframe</th>
<th>Responsible</th>
<th>Approval Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action is taken to improve the consistency of reviewer determinations.</td>
<td>Must present and review all pharmaceutical management procedures annually to address areas for improvement</td>
<td>Annually</td>
<td>Pharmacy Director</td>
<td>10/2016 11/2016</td>
</tr>
<tr>
<td>Monitoring of Formulary and Pharmaceutical Management Procedures</td>
<td>Monitoring of Formulary and Pharmaceutical Management Procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&amp;T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&amp;T minutes.</td>
<td>DHMP’s Pharmacy Department annually:</td>
<td>Pharmacy Director</td>
<td>Ongoing Ongoing QMC</td>
</tr>
<tr>
<td>Quality of Service Concerns (QSC)</td>
<td>The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns.</td>
<td>Timetable requirements:</td>
<td>Director of Compliance</td>
<td>Quarterly Ongoing</td>
</tr>
<tr>
<td></td>
<td>✓ Affects member experience</td>
<td>Acknowledgment letter: 5 business days.</td>
<td></td>
<td>Ongoing QMC</td>
</tr>
<tr>
<td>Member Annual Communication Requirements</td>
<td>The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan topics related to patient care and service.</td>
<td>Members receive:</td>
<td>Marketing Manager</td>
<td>1/2016 11/2016 Outreach Committee</td>
</tr>
<tr>
<td>Member Communication Requirements Upon Enrollment</td>
<td>The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan design and benefits.</td>
<td>Members are provided the following information, including but not limited to:</td>
<td>Marketing Manager</td>
<td>1/2016 11/2016 Outreach Committee</td>
</tr>
<tr>
<td>QUALITY OF SERVICE</td>
<td></td>
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</tbody>
</table>

*Previously monitored
### Practitioner and Provider Annual Communication Requirements

**Upon Contracting and Annually Thereafter**

The Marketing Department focuses on timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.

Practitioners and providers are provided the following information:

- Information about the quality program goals and process outcomes related to member care and service
- Pharmaceutical restriction and preference information, including formulary.

**Goals:**
- Must provide evidence of annual communication to all network practitioners and providers

**Goal:**
- Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter

<table>
<thead>
<tr>
<th>Practitioners and Providers are provided the following information, including but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member rights and responsibilities statement</td>
</tr>
<tr>
<td>The process for the practitioner to refer members to case management</td>
</tr>
<tr>
<td>Disease Management Program information</td>
</tr>
<tr>
<td>Clinical practice and preventive health guidelines (to appropriate practitioners)</td>
</tr>
<tr>
<td>How to obtain UM criteria</td>
</tr>
<tr>
<td>How to access staff</td>
</tr>
<tr>
<td>An affirmative statement about incentives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practitioner and Provider Communication Requirements</th>
<th>Practitioners and providers are provided the following information:</th>
<th>Goals: Must provide evidence of annual communication to all network practitioners and providers</th>
<th>Goal: Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter</th>
<th>Annually</th>
<th>Marketing Manager</th>
<th>1/2016</th>
<th>11/2016</th>
<th>Outreach Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affects member experience</td>
<td>PHI use and disclosure information</td>
<td>• The process for members to self-refer to case management</td>
<td>• An affirmative statement about incentives</td>
<td></td>
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</tr>
</tbody>
</table>

*Previously monitored*
## Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Start</th>
<th>Finish</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY OF SERVICE</strong></td>
<td></td>
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</tbody>
</table>
| Physician and Hospital Directory Usability Testing | The Marketing Department evaluates DHMP’s web-based physician and hospital directory for health literacy, ability for member understanding and usefulness of information to members and prospective members. | Evaluation considers:  
- Font size  
- Reading level  
- Intuitive content organization  
- Ease of navigation  
- Directories in additional languages, if applicable to membership | Goals:  
- There must be a documented process demonstrating how usability testing is performed and how testing frequency is determined.  
- Reports indicating initial usability testing was performed before and after any upgrades to functionality or design that directly affects how members use the site. | Annually | Marketing Manager | 3/2016 | 4/2016 | QMC |
| Accessing Member Understanding of DHMP Procedures | The Marketing Department has a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures.  
✔ Affects member experience | Assessment includes:  
- Monitoring new member understanding of DHMP procedures  
- Implementing procedures to maintain accuracy of marketing communication  
- Acting on opportunities for improvement | Goals:  
- There must be evidence of a systematic and ongoing process for assessing new-member understanding of DHMP operations and policies.  
- If DHMP finds that new members have enrolled without an accurate understanding of key DHMP policies and procedures, DHMP must initiate a quality improvement process to correct the possibility of future misrepresentation. | Quarterly | Marketing Manager | 1/2016 | 4/2016 | 7/2016 | 10/2016 | QMC |
| *Ongoing Monitoring of Network Practitioners and Providers* | Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP’s office-site standards. This is | Provider Relations and Credentialing:  
- Sets performance standards and thresholds for office site quality  
- Establishes a documented process for ongoing monitoring and | Goals:  
- Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met | Quarterly | QI Director | Ongoing | Ongoing | Cred. Cmte. QMC |

*Previously monitored*
| Site Quality | achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality. | investigation of member complaints related to practice sites | • Deliver corrective action plans within 30 calendar days of site visit  
• Repeat site visits are conducted 6 months after delivering corrective action plans to assure compliance |
|---|---|---|---|
| *Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues* | DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified. | Ongoing review and monitoring by:  
• Collecting and reviewing Medicare and Medicaid sanctions  
• Collecting and reviewing sanctions or limitations on licensure  
• Collecting and reviewing complaints  
• Collecting and reviewing information from identified adverse events | Goals:  
• Review sanction information within 30 calendar days of its release  
• Implementing appropriate interventions when instances of poor quality are identified |
| *Monitoring Member Services’ Telephonic Performance* | The Member Services Department has a process for monitoring and evaluating telephonic metrics against established thresholds. | Reporting categories:  
• Service level  
• Average delay to answer  
• Abandonment rate  
• Call volume | Goals:  
• Service level: at or above 85%  
• Time to answer: 30 seconds or less.  
• Abandonment rate: 5% or less. |
| *Continuity and Coordination of Medical Care* | DHMP uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. | Annual identification of opportunities to improve coordination of medical care by:  
• Collecting data through Provider surveys  
• Conducting qualitative and causal analysis of data to identify improvement opportunities  
• Identifying and selecting opportunities for improvement | Goals:  
• At least 80% of the providers surveyed, report a satisfaction rating of at least 4 or 5 (scale of 1 to 5) for the following factors related to coordination and continuity of care:  
  • Timeliness of information exchanged.  
  • Completeness of information exchange. |

*Previously monitored*
## *Continuity and Coordination Between Medical Care and Behavioral Healthcare*

During 2014, DHMP will conduct an initial assessment of continuity and coordination of care efforts between medical health care providers and behavioral health care providers (Denver Health and Cofinity providers). DHMP will use the annual provider survey to obtain satisfaction scores and feedback from the providers on the current processes for exchanging patient information between medical and behavioral health care providers. The data will be analyzed by the DHMP Medical Management staff and the Utilization Management Committee.

<table>
<thead>
<tr>
<th>Annual identification of opportunities to improve coordination of medical and behavioral healthcare by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Collecting data through Provider surveys</td>
</tr>
<tr>
<td>• Conducting qualitative and causal analysis of data to identify improvement opportunities</td>
</tr>
<tr>
<td>• Identifying and selecting opportunities for improvement</td>
</tr>
</tbody>
</table>

**Goals:**
- At least 80% of the providers surveyed report a satisfaction rating of at least 4 or 5 (scale of 1 to 5) for the following factors related to the exchange of patient information between behavioral and medical health care providers:
  - Ease of the process.
  - Timeliness of the exchange of information
  - Accuracy of the information.
  - Completeness of the information.

## *Monitoring Satisfaction with Complex Case Management*

Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction.

- Affects member experience

<table>
<thead>
<tr>
<th>Satisfaction data is collected through the following methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtaining survey feedback from members</td>
</tr>
<tr>
<td>• Analyzing member complaints for tracking/trending</td>
</tr>
</tbody>
</table>

**Goals:**
- Members: 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied).

## *Open Shopper Study*

Denver Health Medical Plan, Inc. (DHMP) has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is to ensure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is

<table>
<thead>
<tr>
<th>Objectives:</th>
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<tbody>
<tr>
<td>• Semi-annually, call all DHMP HMO outpatient clinics (n=9) and a random sample of POS provider clinics (n=50) to assess compliance with DHMP Primary Care Access Standards for routine appointments, urgent after-hours care and acute care access.</td>
</tr>
<tr>
<td>• Semi-annually, call all Behavioral Health providers who see 2 or more of our members to assess</td>
</tr>
</tbody>
</table>

**Goals:**
- **Emergency Care:** 24 hours a day, 7 days a week - Met 100% of the time
- **Emergency Care-Behavioral Health Non-life Threatening:** Within 6 hours-Met 100% of the time
- **Urgent Care-Medical and Behavioral Health:** Within 24 hours-Met 100% of the time
- **Primary Care-Routine**
### Commercial and Medicare Quality Improvement Work Plan 2016

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Description</th>
<th>Goals</th>
<th>Evidence of monitoring includes:</th>
<th>Annually</th>
<th>Director</th>
<th>QMC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Satisfaction</strong></td>
<td>to determine what percent of clinics within the Denver Health system meet our access standards; what percent of high-volume providers within the expanded Cofinity Network meet our access standards; and what percent of behavioral health providers who serve our members meet our access standards</td>
<td>Goals:</td>
<td>Evidence of monitoring includes:</td>
<td>Annually</td>
<td>QI Director</td>
<td>QMC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence of monitoring includes:</td>
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<tr>
<td></td>
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<td>- Annual reporting to the QMC</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Root-cause analysis provided to identify opportunities for improvement</td>
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<td></td>
<td></td>
<td></td>
<td>- Members: Of the surveyed members (CAHPS) who required an authorization for services, 90% or more reported being either “Somewhat or Very Satisfied” with the</td>
<td></td>
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</tr>
<tr>
<td><strong>Utilization Management Process</strong></td>
<td>DHMP continually assesses member and practitioner satisfaction with our Utilization Management process to identify areas in need of improvement.</td>
<td>Goals:</td>
<td></td>
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</tbody>
</table>

*Previously monitored*
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<table>
<thead>
<tr>
<th>Monitoring Satisfaction with Disease Management</th>
<th>The Behavioral Health and Wellness Services Department annually evaluates satisfaction with its disease management services to identify opportunities to improve member satisfaction.</th>
<th>Satisfaction data is collected through the following methods:</th>
<th>Goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Affects member experience</td>
<td>Obtaining member survey feedback</td>
<td>• Members: 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied).</td>
<td>Annually</td>
</tr>
<tr>
<td>Monitoring Member Services’ Benefit Information for Quality and Accuracy</td>
<td>The Member Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.</td>
<td>Components of the process:</td>
<td>Goals:</td>
</tr>
<tr>
<td></td>
<td>• Collecting data on quality and accuracy of information provided</td>
<td>• Telephone: 85% accuracy</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>• Analyzing data against standards or goals</td>
<td>• Online: 85% accuracy</td>
<td>Director of Member Services</td>
</tr>
<tr>
<td></td>
<td>• Determining the cause of deficiencies, as applicable</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>• Acting to correct identified deficiencies</td>
<td></td>
<td>1/2016 4/2016 7/2016 10/2016</td>
</tr>
<tr>
<td>Monitoring the Nurse Advice Line</td>
<td>DHMP has a quality improvement process in place for monitoring the Nurse Advice Line to identify and establish opportunities for improvement.</td>
<td>Components of the process:</td>
<td>Goals:</td>
</tr>
<tr>
<td></td>
<td>• Tracks telephone and web statistics monthly</td>
<td>• Service Level: at or above 85%</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>• Tracks member use of the Nurse</td>
<td>• Time to answer: 30 seconds or less.</td>
<td>Director of Member Services</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

QUALITY OF SERVICE

*Previously monitored
### Advice Line
- Evaluates member satisfaction with the Nurse Advice Line
- Monitors calls periodically
- Analyzes data at least annually and, if applicable, identifies opportunities and establishes priorities for improvement
- Abandonment rate: 5% or less.

### Monitoring Pharmacy Benefit Information for Quality and Accuracy
The Pharmacy Department has a quality improvement process in place to assess the quality and accuracy of pharmacy benefit information provided to members telephonically and online.

**Components of the process:**
- Collects data on quality of service and accuracy of pharmacy benefit information provided both telephonically and online
- Analyzes data results
- Acts to correct identified deficiencies.

Results are presented to Compliance Committee and QMC for review and feedback.

**Goals:**
- Telephone: 85% accuracy
- Online: 85% accuracy

**Evaluation includes:**
- Completed and ongoing activities
- Quantitative and Qualitative Analysis
- Evaluation of effectiveness

**Presentation to QMC must include:**
- Committee discussion and input on program summary
- Actions, if applicable
- Committee approval of 2016 UM Program

**2015 Utilization Management Program Evaluation**
The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the UMC & QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program.

**Presentation to QMC must include:**
- Committee discussion and input on program summary
- Actions, if applicable
- Committee approval of 2016 UM Program

2016 Utilization Management Program Evaluation  | Semi-annually  | Pharmacy Director  | Ongoing  | Ongoing  | QMC Compliance Committee
--- | --- | --- | --- | --- | ---
*Previously monitored*
<table>
<thead>
<tr>
<th>Yearly Planned Activities</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFETY OF CLINICAL CARE</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Safety Initiatives**

The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Behavioral Health and Wellness Departments to provide clinical quality monitoring. Identification of performance improvement opportunities related to member safety are reviewed and implemented.

- **Affects member experience**

**Process:**

The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches.

**Objectives:**

- Encourage organizational learning about medical and health care errors
- Incorporate patient safety education across organization
- Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee.
- Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result
- Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions
- Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired under the quality of care concern process.
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk
- Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety

- **Annually**
- **Director of QI**
- **Ongoing**
- **Ongoing**
- **QMC**
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<table>
<thead>
<tr>
<th>Pharmacuetical Patient Safety Issues</th>
<th>Objective:</th>
<th>Goals: 100% Compliance for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacists or practitioners. This represents an opportunity to provide patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons. ✓ Affects member experience</td>
<td>• Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety. • An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall. Results are presented to Compliance Committee annually and QMC for review and feedback semiannually.</td>
<td>• Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification. • Class II: Affected members and providers notified within thirty days of the FDA notification. • Class III: Affected members and providers notified within sixty days of FDA notification.</td>
</tr>
</tbody>
</table>

| Monitoring Privacy and Confidentiality | The Compliance Department has a process for identifying, reporting and taking action on impermissible uses or disclosure of sensitive information. ✓ Affects member experience | The Compliance Department implements procedures for: • Identifying impermissible uses or disclosure of sensitive information • Reporting impermissible uses or disclosures of sensitive information • Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information | Goals: • Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality. • If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections |

<table>
<thead>
<tr>
<th>SAFETY OF CLINICAL CARE</th>
<th>Annually</th>
<th>Pharmacy Director</th>
<th>Ongoing</th>
<th>Ongoing</th>
<th>QMC - Semiannually</th>
<th>Compliance Committee - Annually</th>
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<th>may include, but are not limited to:</th>
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<tbody>
<tr>
<td>- Education and training</td>
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<tr>
<td>- Process/procedural revisions</td>
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<tr>
<td>- Progressive discipline</td>
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*Previously monitored*