2024 QUALITY IMPROVEMENT PROGRAM EVALUATION

DENVER HEALTH MEDICAL PLAN, INC.

Medicare and Exchange Products

May 13, 2025

Table of Contents

EXECUTIVE SUMMARY

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated healthcare system that serves as the primary "safety net" system for the City and County of Denver. Denver Health Medical Plan, Inc. (DHMP) was originally incorporated on January 1st, 1997. DHMP is licensed by the State of Colorado Division of Insurance as a Health Maintenance Organization (HMO). DHMP offers two Medicare Advantage plans with Elevate marketing plan name referred to as our (1) Elevate Medicare Select (HMO) and (2) Elevate Medicare Choice (HMO D-SNP*) plans. *Elevate Medicare Choice members are dually-eligible for both Medicare and Medicaid Choice.
DHMP established and maintains a comprehensive Quality Improvement (QI) Program to systemically define, evaluate, monitor, and provide continuous quality improvement. The QI Program aims to ensure high-quality, cost-effective care and services are provided to DHMP's Elevate Exchange and Medicare Advantage members.

Quality Improvement Program

The QI Program incorporates evaluation of key indicators of care and safety of 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, member satisfaction, health outcomes and provider satisfaction.

DHMP's Quality Improvement (QI) Program Description outlines our plan to improve quality of care and ensure member safety, describes the various committee structures, and quality activities which are based on data-driven outcomes. The QI team systemically monitors and evaluates the delivery of health care services, with a focus on improving member outcomes. Utilizing QI interventions based on a continuous improvement cycle of PDSA – plan, do, study, act and incorporating LEAN methodology, QI interventions are planned, implemented, and assessed with targets of improving functional outcomes for members, delivering culturally competent care and service; and increasing member satisfaction with services.

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

Annually, DHMP's QI Team reviews ongoing and completed QI activities. This evaluation includes a complete analysis of performance improvement metric results, effectiveness of QI projects and evaluation of the overall value of the QI Program. Out of this evaluation process, recommendations for quality improvements are developed and planning begins for the upcoming calendar year. Additionally, DHMP assesses the strengths of the QI Program and identifies opportunities for improvement, incorporating learning from the ongoing activities. The QI Evaluation, QI Program Description and QI Work Plan are crafted, and presented to DHMP's QMC and DHMP's Governing Board of Directors for approval.

Provider Network

- Our Exchange provider network includes **Denver Health** providers and facilities in the Denver Metro area and the Denver Health Winter Park clinic, as well as
  10 Family Health Centers
  18 School-Based Health Centers (SBHCs)

Denver Health Medical Center
Denver Health Outpatient Medical Center

- **Banner Health** providers and facilities in Larimer, Weld and Morgan Counties
- In-network providers include these and more
- 4 Corners Children's Clinic
- CommonSpirit Health facilities (formerly Centura)
- Durango Surgery Center
- Middle Park Health
- Pagosa Springs Medical Center
- Pediatric Partners of the Southwest
- St. Vincent General Hospital District
- Summit Community Care Clinic
- In-network hospitals and medical facilities include these and more
- Animas Surgical Center at Escalante
- Kremmling Memorial Hospital
- Longmont United Hospital
- Mercy Regional Medical Center
- Middle Park Health
- OrthoColorado Hospital
- Pagosa Springs Medical Center
- Penrose Hospital
- St. Anthony North Hospital
- St. Anthony Summit
- St. Elizabeth Hospital
- St. Francis Hospital
- St. Mary-Corwin Hospital
- St. Thomas More Hospital
- St. Vincent General Hospital
- First Health is only INN for outpatient BH for HIX.

As for DHMP's Medicare Advantage plans, both Medicare Select and Medicare Choice share the same network, which consists of DHHA, DHMP, Dispatch Health, Columbine Chiropractic, CU Medicine, First Health (formerly Cofinity for BH), InterMountain (formerly SCL), and National Jewish. This includes Denver Health Ambulatory Care Services (ACS)/Community Health Services (CHS), which consists of nine NCQA-recognized PCMH primary care clinics which provide focused care for children, adults and geriatrics. Our providers, care teams, and free 24/7 Nurseline strive to meet members where they're at, working to assure care is received in the right place, at the right time, with the right provider, in a way that best suits a member and their family's needs.

We collaborate with CHS on QI initiatives through the Ambulatory Quality Improvement Committee (QIC), and ACS disease and prevention-specific quality improvement work groups. In these committees and groups, we join quality resources and actively work together to increase the health and well-being of our members. Together, DHMP and ACS focus on raising the overall quality of services to achieve measurable outcomes and to use resources more productively.

QUALITY IMPROVEMENT PROGRAM EVALUATION SUMMARY

DHMP's 2024 QI Program objectives were focused on advancing the quality of care and services delivered to members through a comprehensive approach. Over the course of the year, DHMP's QI Program made notable progress in improving care, enhancing member experience, and advancing strategic initiatives. Several efforts were launched to streamline data management and improve operations. efficiency. The Centers for Medicare and Medicaid Services (CMS) and contractual requirements for our Medicare Advantage and Exchange lines of business are reviewed annually, for inclusion in the development of a comprehensive and targeted QI Program Evaluation. The scope of the QI Program includes developing improvement opportunities and intervention/activities throughout DHMP. The QI Department uses clinical and service performance benchmarks and a review of best practice literature and research. QI organizes activities to ensure optimal quality and cost-effectiveness in healthcare by focusing on Continuous Quality Improvement (CQI) targeting the following areas:

- Cultural and Linguistic Member Needs
- Health Plan Medical Management
- Preventive Health Promotion
- Pharmacy Management
- Patient Safety
- Complex Health Needs
- Adequacy and Availability of Services
- Clinical and Preventative Guidelines
- Continuity and Coordination of Care
- Quality of Clinical Care
- Member Satisfaction
- Provider and Practitioner Satisfaction
- Credentialing and Delegated Credentialing
- Delegated Activities and Oversight
- Appropriate access to care

The DHMP QI 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 health plan members.

QUALITY IMPROVEMENT OBJECTIVES FOR 2025

- Maintain a Quality Improvement Program which continuously measures, analyzes, and evaluates the quality of care and services provided to our plan members.
- Improve the overall health of our populations by supporting evidence-based and data-driven interventions to address behavioral, social and environmental determinants of health.
- Promote preventive care delivered by practitioners/providers that meet the accepted standards of quality in the community.
- Improve the health status of our members by providing access to high quality, cost-effective and affordable care.
- Improve member satisfaction and experience by focusing on improvements in the delivery of clinical care and services.
- Enhance the improvement of beneficiary health outcomes through nationally recognized evidence- based clinical practice guidelines that incorporate individual beneficiary health care needs and preferences, including cultural, ethnic, linguistic, and other social determinants of health.
- Empower members to lead a healthy lifestyle through health promotion activities, care support outreach
- Measure and report Quality Improvement and other program performance using standard measures and tools required by CMS, DOI, and NCQA.
- Measure and evaluate interventions to address continuity and coordination of care.

- Develop efforts to improve reporting race/ethnicity/language data.
- Support staff and provider training on working with various cultural, ethnic and medically underserved populations.
- Review language utilization and provider language reports to evaluate network responsiveness to provide culturally appropriate care.
- Improve transitions of care across health care settings and practitioners.
- Develop and implement pharmaceutical quality assurance measures and systems to identify and reduce medication errors, adverse drug interactions and improve medication use through retrospective and concurrent drug utilization review systems, as well as pharmaceutical policies and procedures.
- Assure that culturally appropriate, health literate communication, education and health care services are provided to members in all areas we serve.
- Improve data collection for quality management metrics to evaluate and improve HEDIS, Star Measures, Core Measure scores, including improvement of coding and documentation for clinical care services.
- Improve data extraction for quality management metrics to improve the accuracy and completeness of HEDIS and Core Measures.
- Collaborate with internal DHMP departments to improve quality of care and services to our members.
- Develop interventions in response to results from the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the Health Outcomes Survey (HOS®), beneficiary inquiry, grievance, and appeal data.
- Comply with the CMS and HHS requirements regarding Quality Improvement Program activities.
- Improve pharmaceutical quality measure performance and systems to identify and reduce adverse drug interactions and improve medication access and adherence through retrospective and concurrent drug adherence data review systems, as well as pharmaceutical policies and procedures.
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- Promote the effectiveness, efficiency, and compliance of all First Tier, Downstream and Related Entities (FDRs) with DHMP contractual and CMS requirements.
- Ensure delegation oversight in alignment with NCQA health plan accreditation standard (e.g. PBM and Credentialing oversight).
- Encourage safe, effective, and appropriate clinical practice through established care standards and application of appropriate practice guidelines.
- Analyze high-volume and/or high-impact specialty care services to identify opportunities for improvement.
- Collaborate with Network Providers to improve access and delivery of care and services to our members.
- Collaborate with internal DHMP departments to improve health plan quality and services to our members.
- Maintain the health information system to comply with professional standards of health information management, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security laws and state privacy standards.
- Incorporate feedback from Health Plan Members, ASC Work Groups, QMC and Subcommittees on QI Projects Interventions and Improvement activities.

ACCOMPLISHMENTS

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

- The diligence and commitment of the A&G staff resulted in NCQA Corrective Action Plan (CAP) for NCQA Standard UM9D ending (meaning DHMP is back in good standing with NCQA), with emphasis on member understandability/usability in appeal and denial letters.

- Implemented the Wellframe App to better enable members to stay connected with their DHMP Care Management Team.
- Credentialing moved from a manual process to a more automated process by leveraging the functionality of MD Staff platform more, which has increased productivity and efficiency.
- Obtained a contract with Gaines, a new provider data management warehouse (PDMW) solution, which will allow for DHMP to have more accurate and detailed record of providers aiding our efforts for more accurate reporting of NA indicators.
- DHMP's Credentialing Department facilitated reporting of cultural competency training completion status on the online provider directory.
- DHMP's Credentialing Department worked with delegated providers and outside vendors to enhance our provider directory, by including hours of operation, webpage URLs, virtual visits, and accommodations for persons with disabilities.
- Implemented new credentialing vendor that made the new provider contracting processing faster and easier for the provider groups to get credentialing done for their practitioners.
- Maintained oversight and follow up of delegated and facility credentialing relationships with OneCred and 3Won.
- Expanded Culturally and Linguistically Appropriate Services (CLAS) training for non-Denver Health network providers (DH providers already took training about delivering culturally appropriate care annually along with DHMP staff), developed enhanced member and staff education materials, to support the delivery of culturally appropriate care.

- Participated as a member of the Ambulatory Care Quality Improvement workgroup to continue to address health literacy, and delivering high-quality, culturally appropriate care.
- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention.
- Maintained physician involvement within the QMC structure from the ACS network.
- Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase the number of adolescent well-child visits and immunizations within Denver Public Schools.
- Increased outreach to DHMP members through ACS clinic staff and targeted member outreach, as well as Vendor based screening initiatives.
- Continued refinement of member outreach efforts, utilizing EPIC (electronic medical record) implementation for ACS and QNXT (claims processing system) BI and Tableau reports for DHMP

- Continued to identify and develop training to assist in appropriate provider documentation and coding to support improvement of HEDIS scores.
- Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting.
- Produced monthly HEDIS runs, and corresponding gaps in care lists for use in quality improvement initiatives.
- Improved the timeliness and accuracy of the annual HEDIS production run.
- Increased member outreach to encourage preventive health screenings and to support members with chronic disease conditions, such as diabetic eye exams and mammograms.
- Pharmacy technicians assisted with HEDIS GAP closure
- Pharmacy team provided additional adherence outreach for Medicare patients
- After-call surveys were implemented for CAHPS measures
- Pharmacy work processes were improved, and efficiencies were established specifically related to administrative tasks as well as the prior authorization process
- An electronic form was created to streamline pharmacy issues to resolve problems at the Denver Health pharmacies quickly and efficiently to avoid delays in care

- Medicare Select has preferred pharmacies for 2025 to provide savings opportunities for members
- UM enhanced the inpatient review process to ensure greater accuracy in reflecting length of stay to incorporate more detailed reviews, improving the determination of medical necessity while balancing cost containment and ensuring care is provided at the appropriate level.
- Conducted an annual Provider Satisfaction Survey to evaluate satisfaction with DHMP departments and services, including knowledge of DHMP offerings to support patient care.
- Continued the Medicare Chronic Care Improvement Project (CCIP), to continue through 2024-2026, focused on controlling blood pressure.
- Completed the first year of our three-year Chronic Care Improvement Program (CCIP) cycle, planning and implementing our Controlling Blood Pressure (CBP) initiatives to improve hypertension control rates.
- Implemented a Quality Improvement Strategy (QIS) initiative to improve HIV medication adherence by deploying an Interactive Voice Response (IVR) medication refill reminder program, developing refill reporting and creating a Tableau dashboard to capture adherence rates.
- Developed a dashboard, with a machine learning vendor, to produce reporting for our mini-CAHPS survey, which previously had been a manual process. Trending information is now available from Q3 2022 to Q4 2024.

CHALLENGES/BARRIERS

During the 2024 calendar year the QI program faced many challenges.

- Underwent a NCQA Corrective Action Plan (CAP, UM9D) and Resurvey (NET) audit in fall of 2024.
- DHHA has financial pressures as the city's safety net hospital, supporting vulnerable populations.
- DHMP faced impact of the Public Health Unwind and two Exchange products (Friday and Bright defunct) led to a reduction in workforce, increased workloads, and structural adjustments.
- Discontinuation of mini-CAHPS member surveys (formerly quarterly) due to budgetary restrictions
- Expansion into Peak counties with unknown claims experience for Exchange.
- Acquired new software for more accurate and detailed network adequacy (NA) reporting for all line of business. This has introduced the challenge of learning to operate the new software and extrapolate meaningful data.
- Create reporting from scratch for measurement of MCR equivalence on Exchange and Commercial benefit plans to accurately compare against hospital rate floors.
- Pharmacy call center is having difficulty utilizing the courtesy call back feature and it had to be suspended due to technical issues that prevented members from receiving a call back
- Exchange members had issues with non-self-injectables processing correctly at the pharmacy, which required manual overrides and investigation
- Change Healthcare was compromised and had to shut down resulting in many pharmacy claims having to be overridden and processed later.
- Call center turnover was high resulting in being short-staffed and there was re-training required
- Many cost savings initiatives were started in 2024 leading to practitioner and member abrasion
- Exchange plan was not being appropriately monitored by the pharmacy benefit manager (PBM) and required frequent oversight from the pharmacy team to ensure compliance

- Inpatient Medical Necessity Review
- Home blood pressure cuff vendor's ability to send orders out in a timely fashion
- Struggled with technical data challenges related to our HIV medication adherence Tableau dashboard and staff turnover in our IS department supporting with the fix.

OPPORTUNITIES FOR IMPROVEMENT

- Continue auditing and monitoring A&G letters to ensure continued full compliance with contractual and regulatory requirements, with emphasis on specific denial reason(s), reference to the benefit provision, guideline, or protocol on which decision(s) are based, and the reviewer's title and qualifications (UM9D).
- A&G continues to work closely with the Claims Department to determine root cause to continuously improve and reduce potential member/provider abrasion (e.g. leverage Inter-Departmental Collaboration meeting).
- A&G on-going training and re-training of staff related to policies and procedures, in order to uphold NCQA standards related to understandability, usability, as well as accurate logging of appeals and grievanes in A&G system.
- Increase member awareness and usage of the Wellframe App to enhance support from the member's DHMP CM team
- Continually evaluate effective platforms for communication with members, including but not limited to Wellframe, MyChart, Portal, Directory, and member materials.
- Implement a new PDMW system in early 2025 to enhance the accuracy and efficiency of provider data.
- Enhanced credentialing delegation training to include the importance of why we are asking for provider REL data.
- Reduce manual data pull for network provider REL data and enhance more comprehensive reporting.
- Work with ACS and DH leadership in patient experience initiatives throughout DH, focusing on improving member experience metrics and educating staff to improve CAHPS measure scores.
- Continue developing strategies with ACS QI leadership to address gaps in care with year-round interventions and activities.
- Align and partner QI initiatives and interventions with ACS leadership and provider networks to avoid duplication of efforts and to utilize resources more effectively.
- Continue to evolve value-based contracting for enhanced quality improvement outcomes.
- Promote further alignment of DHMP and ACS strategic QI metrics and goals.
- Develop a more rigorous data validation plan for HEDIS measures, confirming that data and counts and sample sizes are accurate, while continuing to increase supplemental sources of data for HEDIS measures.
- Continue efforts to improve the capture and accuracy of provider data for HEDIS, including practice type, specialist coding and provider location, and build out electronic clinical data system (ECDS) reporting per NCQA requirements.
- Evolve the real-time quality data availability and usability (following the launch of the DHMP data warehouse, efforts to integrate EPIC-based encounter data, and launch of Tableau reporting software) through ongoing IS collaboration.
- Increase engagement and training of providers in HEDIS and CAHPS metrics and provide meaningful, provider-centric education and training to increase plan experience ratings, MA Star ratings, HEDIS scores and risk adjustment scores through appropriate medical record documentation and coding.
- Continue monthly review of HEDIS data to ensure more timely measures and interventions.
- Pharmacy needs to review the configurations and determine if benefits and current configurations are appropriate. There are many outdated configurations from 12-13 years ago that may no longer be applicable.
- Pharmacy to continue to improve prior authorization criteria and formulary management for the commercial self-funded plan

- Pharmacy to continue collaboration with the Pharmacy Benefit Manager (PBM) to ensure compliance with state and federal regulations
- Integration of IVR data into Tableau dashboard to enable analysis of the impact of IVR outreach on adherence.
- Monitor opportunities to reduce provider/member abrasion and appeals with the recently updated UM inpatient review process.
- Assess CCIP CBP intervention with quality in addition to quantity through conversion rate analysis, member-level data analysis and increase provider engagement alignment.
- Increase utilization of virtual visits to improve access, and address other access issues impacting CAHPS scores.
- Partnership with DHHA and Press Ganey is underway to implement Member Journey platform in replacement of mini-CAHPS survey (a relationship between DHMP and Press Ganey as an innovation collaborator free of charge)
- Conduct evaluation of member engagement strategy to increase member buy-in and involvement in self-management and preventive care goals.
- Continue to develop the use of the LEAN framework within quality initiatives to develop A3 problem-solving aligned with the Plan-Do-Study-Act (PDSA) format.
- Utilize the LEAN framework to develop and evolve standard work for the Health Outcomes and Pharmacy Department.
- Expand and support QI team opportunities for growth and enhancement of skills, and to automate tasks where possible to increase the functional capacity of the QI team.
- Address departmental and key stakeholder-specific opportunities for NCQA accreditation to ensure compliance with organizational plan for NCQA renewal.
- Continue to develop all stakeholder departments' understanding and use of quality data to drive improvement efforts.

I. QUALITY OF CLINICAL CARE

DHMP strives to continually evaluate, monitor and improve the quality of care for our members. Quality improvement activities consisted of the following activities:

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

Quality of care and service audits and key performance metrics are tracked and trended. The results are regularly reported to the QMC and are trended by comparing year over year performance. The QMC makes recommendations to help improve performance as needed. Yearly statistics are included in the Grievance data in the Evaluation.

Credentialing and Recredentialing

The Credentialing Committee, comprised of a Peer Review Board, reviews newly credentialed and reappointed practitioners and providers, as well as any reported sanctions, in accordance with established policies and procedures. In collaboration with this bi-monthly committee, DHMP's Credentialing Department ensures clinical quality by assessing practitioner applications, verifying qualifications, and approving or denying candidates based on DHMP criteria. As part of both the annual delegation audit review and internal credentialing process, the Credentialing Department produces detailed reports on credentialing information integrity (formerly called system controls), ensuring alignment with compliance standards.

All provider files are reviewed for accuracy and completeness, including the Colorado State and DHMP Facility Applications. Primary Source Verifications (PSVs) are performed on every application, drawing on sources such as the National Practitioner Data Bank (NPDB), OIG, GSA, NPPES, and Quality of Care Concerns (QOCC).

Over the course of the last year, Credentialing collaborated across departments to implement a new provider data management warehouse (PDMW), improved our capabilities of collecting REL data, and enhanced our provider directory. During 2024, various DHMP departments worked to obtain a contract with Gaines, a PDMW solution. This work involved assessment and planning, budgeting, vendor demos, reviewing proposals, system integration and data mapping capabilities.

DHMP expects the implementation of this new PDMW system, slated for early Q3-2025, to significantly enhance the accuracy and efficiency of provider data for our health plan. Members will benefit from having access to accurate information about their healthcare providers, which streamlines the process of finding in-network services. Overall, this information technology infrastructure improvement will enhance DHMP operations and processes.

Additionally, the new PDMW will reduce manual data pull for network provider race, ethnicity, and language (R/E/L). The Credentialing Department's role in the project includes but may not be limited to delegate education regarding the importance of why we are asking for provider REL data with the ability to opt-out (e.g. NCQA HPA NET1A).

The work conducted with regard to provider directory encompassed adding key information such as hours of operation and disability accommodations, working with both delegated providers and external vendors.

HEDIS Measures

HEDIS metrics are compared to prior year and trended over several years. MY2023 HEDIS rates are based on calendar year 2023 data. For Medicare and Exchange lines of business, improvement goals are a three percent (3%) increase year over year.
The following QI initiatives are focused on clinical indicators with the purpose of improving the quality of clinical care and health outcomes for our members.

Diabetes Measures

DHMP MEDICARE

DHMP Medicare					
Diabetes Measures	**MY 2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2023 HEDIS Results**	**MY2023 HEDIS Percentile**	**MY2022-MY2023 HEDIS Change**

HbA1c Poor Control >9.0% (lower=better performance) *	18.73%	19.46%	17.52 %	33rd	9.97%
HbA1c Control <8.0%	60.34%	63.99%	72.02 %	33rd	12.55%
Eye Exam	75.91%	81.75%	72.99%	33rd	-10.72%
Kidney Health Evaluation	64.08%	65.35%	72.59 %	90th	11.08%
Blood Pressure Control <140/90	70.56%	70.56%	75.18%	50th	6.55%

DHMP EXCHANGE

DHMP Exchange					
Diabetes Measures	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2023 HEDIS Results**	**MY2023 HEDIS Percentile***	**MY2022-MY2023 HEDIS Change**
HbA1c Control <8.0%	52.08%	51.43%	61.80%	NA	20.16%
Eye Exam	58.33%	57.14%	52.27%	67th	-8.52%
Kidney Health Evaluation	Measure did not Exist	64.62%	56.32%	67th	-12.84%

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

SUMMARY OF HEDIS MY2023 DIABETES RESULTS

MEDICARE

Comparison of HEDIS MY2022 results to HEDIS MY2023 Medicare results demonstrates improvement for four of the five diabetes measures, with the exception of Eye Exams for Members with Diabetes, which decreased from 81.75 percent in HMY2022 to 72.99 percent in HMY2023.

EXCHANGE

Comparison of HEDIS MY2022 results to HEDIS MY2023 Exchange results shows rates improved for HbA1c Control <8.0%, from 51.43% in HMY2022 to 61.80% in HMY2023. In that same time period, rates of Eye Exams and Kidney Health Evaluation decreased, from 57.14% in HMY2022 to 52.27% in HMY2023 and 64.62% in HMY2022 to 56.32% in HMY2023, respectively.

DIABETES COLLABORATIVE QUALITY IMPROVEMENT (QI) WORKGROUP

DHMP QI staff members and representatives from Denver Health's Ambulatory Care Services (ACS) participated in a monthly Diabetes Collaborative QI Workgroup. Participants provided regular updates, engaged in discussions related to diabetes metrics, and incorporated changes to ongoing diabetes interventions. The collaborative tracked patient outcomes for diabetes control, blood pressure, nephropathy, and diabetic eye exams. In July 2024, the Diabetes Collaborative QI Workgroup merged with the Cardiovascular Disease QI Workgroup to streamline efforts that impact overlapping populations.

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

In 2024, the QI team continued to work with DH Ambulatory Care Services (ACS) to conduct outreach to those members who needed to complete an HbA1c test or who were in poor control (HbA1c >9.0%) and schedule them for PCP appointments at DH clinics through a combination of routine patient health summary letter mailings and select efforts with central QI support staff for telephonic outreach.

In 2024, DHMP continued sending Medicare members whose HbA1c was out of control or out of date home test kits to complete and return in the mail to test their HbA1c levels and kidney function. 304 HbA1c test kits were mailed to members, and 30 were processed with results. For KED, 985 test kits were mailed to members, and 199 were processed with results.

ACTION PLAN FOR DIABETES IMPROVEMENT 2025

The DHMP QI team will continue to participate in the Diabetes and Cardiovascular Disease QI Workgroup and explore additional ways to improve diabetes care for our members, including controlling blood sugar, kidney disease monitoring, and performing eye exams. QI will continue to focus on increasing HbA1c poor control >9.0%. DHMP continues to collaborate with DHHA on peer and support groups and access to community programs.

DHMP will provide additional education and support to increase engagement with the healthcare system, identify changeable social determinants of health and decrease inequities in care and access to mental health across our spectrum of diabetic members.

CARDIOVASCULAR SCREENING MY2023 HEDIS CARDIOVASCULAR RESULTS

DHMP MEDICARE AND EXCHANGE CONTROLLING HIGH BLOOD PRESSURE

	Medicare				
	MY2021 HEDIS Results	**MY2022 HEDIS Results**	**MY2023 HEDIS Results**	**MY2023 HEDIS Percentile**	**MY2022-MY2023 HEDIS Change**
Controlling High Blood Pressure (CBP)	69.83%	69.34%	73.97%	33rd	6.68%
	Exchange				

	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 HEDIS Percentile*	MY2022-MY2023 HEDIS Change
Controlling High Blood Pressure (CBP)	68.63%	70.00%	60.78%	10th	-13.15%

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

SUMMARY OF HEDIS MY2023 CONTROLLING BLOOD PRESSURE RESULTS

The rate for Controlling High Blood Pressure (CBP) measure remains well below the 90th percentile across the Medicare and Exchange lines of business. The Medicare rate increased from 69.34 percent in HMY2022 to 73.97 percent in HMY2023. The Exchange rate decreased from 70.00 percent in HMY2022 to 60.78 percent in HMY2023. Nationally, the Medicare line of business increased from the 25th to the 33rd percentile, and the Exchange line of business decreased from the 50th to the 10th percentile.

The DHMP QI team participates in the DHHA ACS Cardiovascular Disease (CVD) Workgroup recognizing the need to collaborate on data collection and interventions to improve HEDIS rates across populations and address disparities in blood pressure control outcomes. The QI team continued to work collaboratively with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. Our most recent data shows that Black members have a lower rate of blood pressure control than their White or Hispanic counterparts' system wide with adequate control for Blacks at 58.9 percent and Whites and Hispanics at 61.1 percent and 64.6 percent, respectively. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup began an effort to determine root causes of this disparity and create a series of interventions to address it.

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

In 2023, DHMP began offering our members at home blood pressure cuffs to monitor their hypertension more closely. This allowed members to report their blood pressure during outreach calls from Care Management and Pharmacy staff as they followed up on Medicare members with hypertension. Over the course of 2024, 311 Medicare members requested and received home blood pressure cuffs. This benefit will continue in 2025.

In July 2024, the Diabetes Collaborative QI Workgroup merged with the DHHA Cardiovascular Disease Workgroup to streamline efforts that impact overlapping populations.

ACTION PLAN FOR CARDIOVASCULAR PERFORMANCE IMPROVEMENT 2025

The QI team will continue to participate in the Diabetes/CVD workgroup and monitor activities and data collection related to Control of High Blood Pressure. Additionally, we will work closely with the workgroup to continue the

implementation of an intervention to address racial and ethnic disparities in blood pressure management seen widely throughout the enterprise including working with community partners and conducting patient focus groups.

The Controlling Blood Pressure Care Management program will continue into 2025 and focus on those Medicare members with hypertension diagnoses whose blood pressure is not under control. In addition, the DHMP QI team will continue to utilize this intervention as our CMS mandated Chronic Condition Improvement Program for the Medicare Choice and Select lines of business.

PREVENTION AND SCREENING HEDIS MEASURE RESULTS

DHMP MEDICARE

DHMP Medicare					
Prevention and Screening	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2023 HEDIS Results**	**MY2023 HEDIS Percentile**	**MY2022-MY2023 HEDIS Change**
Breast Cancer Screening (BCSE)	65.00%	77.08%	80.19%	75th	4.03%
Colorectal Cancer Screening (COLE)	68.61%	74.70%	68.77%	33rd	-7.94%

DHMP EXCHANGE

DHMP Exchange					
Prevention and Screening	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2023 HEDIS Results**	**MY2023 HEDIS Percentile**	**MY2022-MY2023 HEDIS Change**
Breast Cancer Screening (BCSE)	54.00%	63.16%	74.03%	NA	17.21%
Cervical Cancer Screening (CCS)	62.72%	61.31%	54.01%	33rd	-11.91%
Colorectal Cancer Screening (COL)	52.66%	48.67%	51.65%	33rd	6.12%

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

PREVENTATIVE CANCER SCREENING WORKGROUP

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

- Standardized Health Care Partner (HCP) check-in process to include identification of patients lacking breast, cervical or colorectal cancer screenings.
- Healthcare Partners (HCPs) schedule members for appointments, if possible, and alert the provider to the tests needed
- Patient Navigation regarding colorectal cancer screening options through DH

- Review and report cancer screening quality measures screening rates quarterly to clinics through implementation of registries.
- Coordinated outreach for DHMP Medicare members who have outgoing FIT tests and no return.
- Revised cancer metrics and implementation of registries to report screening rates quarterly to clinics.

MEDICARE LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2023 Results

For the Medicare population, BCS rates increased by 4.03 percent in HMY2023, and COL rates decreased by 7.94 percent.

Interventions 2024 – BCS

All women 50-74 years old who need 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 monthly. In CY2024, the QI team sent 2287 mailers to Medicare members. Members have the option to either get their mammogram from the radiology clinic on the main Denver Health campus or utilize the Denver Health Women's Mobile Clinic. The Women's Mobile Clinic provides a private, comfortable, and convenient setting to receive a mammogram.

ACS continued to work to improve implementation of Medical Assistant standard work to include scheduling patients due for a mammogram during their physician visit. In 2024, they continued to track this rate by clinic.
As mentioned above, ACS also continued mailing Patient Health Summary letters in 2024. This mailer included reminders for members who are overdue for a Breast Cancer Screening.

EXCHANGE LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2023 Results

The Exchange Breast Cancer Screening (BCS) measure rate increased by 17.21 percent from HMY2022 to HMY2023. The overall rate of Colorectal Cancer Screenings (COL) decreased by 11.91 percent for HMY2023 compared to HMY2022, and Cervical Cancer Screening (CCS) rates increased by 6.12 percent in HMY2023.

Interventions 2024

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

To improve the rate of BCS, monthly mammogram mailers are sent to members due for mammography. The mailer includes information on scheduling an appointment and a calendar link for the women's mobile clinic. All women 50-74 years old, who need a mammogram, are sent a mailer reminding them to schedule an appointment. As mentioned above, ACS also continued mailing Patient Health Summary letters. This mailer included reminders for members who are overdue for a Breast Cancer Screening. In CY2024, the QI team sent 4351 mailers to Exchange members.

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

Breast Cancer Screening

PREVENTION AND SCREENING ACTION PLAN FOR 2025

All Medicare and Exchange female members 50-74 years old who are due for a mammogram will continue to receive a mailer every six months reminding them to schedule an appointment. The DHMP QI department maintains a consistent presence at the Ambulatory Care Cancer Screening workgroup. This group provides an open forum for discussion surrounding collaboration with ambulatory care providers and the Women's Mobile Clinic. The QI

department will continue participating in this workgroup in 2025. ACS is anticipating the implementation of a variety of technology interventions to improve BCS rates. For example, patient self-scheduling in MyChart and automated text message and MyChart reminders. ACS will also continue their Patient Health Summary letter intervention in 2025, which contains BCS reminders.

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

Cervical Cancer Screening

Exchange Cervical Cancer Screening HEDIS Rates**				
MY2021	MY2022	MY2023	MY2022 HMO Percentile	MY2022- MY2023 Change
39.36%	39.42%	41.44%	5th	+5.12%

*This is the last year we can report and then it moves to ECDS.

Analysis

The rates for Cervical Cancer Screening (CCS) increased by 6.12 percent in HEDIS MY2023. The QI team continues to collaborate with the DH Women's Mobile Clinic and maintains a presence at the ambulatory Cancer Screening Committee, where similar metrics are discussed. In addition, ACS is anticipating the implementation of a variety of technology interventions to improve Women's health screening rates including cervical cancer screening rates (e.g., patient self-scheduling in MyChart and automated text message reminders.)

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

Action Plan for 2025

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

COLORECTAL CANCER SCREENING

INTERVENTIONS 2024-COLORECTAL SCREENING

In 2024, DHMP continued their relationship with an external vendor (Let's Get Checked, formerly BioIQ) to mail fecal immunochemical test (FIT) kits, test the samples, and mail result letters to Medicare patients and providers. 850 FIT kits were mailed to members, 142 kits were returned, and 112 kits were processed. Based on the success of this intervention, DHHA also continued mailing FIT kits to patients who were due for a colorectal cancer screening and eligible for FIT screenings. Staff then followed up with members who needed to return the FIT kits with reminder letters and phone calls. Additionally, ACS began sending Colorectal Cancer screening reminders as part of the Patient Health Summary Letter intervention (see description above).

PREVENTIVE CANCER SCREENING ACTION PLAN

QI will continue to participate in the Cancer Screening Workgroup and explore innovative ways for DHMP Medicare members to receive and return FIT kits. In 2025, ACS will send FIT kits to DHMP Medicare members due for their screening and integrate the results into members EMR. This intervention involves reminder letters for unreturned FIT kits, with the potential to make outreach reminder calls as part of this intervention are being discussed.

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

OSTEOPOROSIS MANAGEMENT FOR WOMEN WHO HAD A FRACTURE (OMW)

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

In 2020, DHMP QI was invited to collaborate with the Geriatrics Workgroup and attend the monthly workgroup meetings. As part of this collaboration, CCS began to connect members in the intervention with the ACS fracture liaison service. This collaboration continued through the Geriatric Workgroup in 2024.

The HMY2023 rate for OMW was 73.33 percent, which was a 22.17 percent increase from HMY2022. This metric is also a measure in Medicare Stars, but DHMP has not reported on OMW as a Star measure due to the small population size.

DHMP MEDICARE MEMBERS OMW RESULTS

	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 HEDIS Percentile	MY2022-MY2023 HEDIS Change
OMW	76.19%	60.00%	73.33%	90th	22.17%

In 2024, 30 women were identified for targeted outreach. Once identified for outreach, there is a 6-month window in which a member can undergo a BMD or receive an Rx for osteoporosis in order to meet the measure. Because some women had fracture dates that have yet to reach the 6-month expiration dates and due to claims run-out, not all eligible members have a reported outcome. However, preliminary non-validated results from our monthly HEDIS runs indicate continued high performance in 2024.

OMW ACTION PLAN FOR 2025

The DHMP Population Health Project Manager meets intermittently with the CCS team to discuss project updates, clarify metrics and review workflow, discuss barriers and their root causes, and opportunities for improvement. Despite the small population size for Medicare Stars, the plan is to continue with this intervention through 2025, with the longer- term goals of ensuring that all eligible women receive the appropriate treatments and reaching a 4-Star rating on this measure. In 2025, the QI Team and the Ambulatory Central Clinical Support (CCS) team will continue to partner with the ACS Geriatric Workgroup to improve performance on this measure. Over the next couple of years, anticipated spec changes to the OMW HEDIS measure may impact this intervention.

Prenatal/Postpartum Care

DHMP EXCHANGE

DHMP Exchange					
	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 Percentile	MY2022-MY2023 HEDIS Change
st Prenatal Care in 1 Trimester	N/A	N/A	N/A	N/A	N/A
Postpartum care within 7- 84 days after delivery	N/A	N/A	N/A	N/A	NA

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

SUMMARY OF HEDIS MY2023 PRENATAL/POSTPARTUM RESULTS

The DHMP QI team continued to participate in the ACS Perinatal Workgroup. The ACS Perinatal Workgroup completed a key driver analysis of the Timeliness of Prenatal Care metric and determined that a lack of access to appointments was a key driver of DH performance on this metric. Several clinics in the Denver Health system started piloting mother/baby dyad visits to improve postpartum care follow-up, though how these visits are billed remains a challenge to ensure these visits are identified appropriately as postpartum care visits. Additionally, Denver Health clinics are in the process of implementing changes in workflow and documentation to improve performance on these metrics.

PRENATAL/POSPARTUM CARE ACTION PLAN FOR 2025

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

Well Child Visits
Applicable to Exchange, not Medicare.

DHMP EXCHANGE CHILDHOOD HEDIS METRIC RESULT MY2023

DHMP Exchange					
Childhood Preventive Measures	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 Percentile	MY2022-MY2023 HEDIS Change
Well-Child Visits					
First 15 months	N/A	N/A	N/A	N/A	N/A
Ages 3-21	N/A	N/A	54.05%	N/A	N/A

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^MY 2021, MY2022, and MY 2023 rates were not reportable due to small sample size.

Childhood Preventive Measures

DHMP EXCHANGE CHILDHOOD HEDIS METRIC RESULT MY2023

DHMP Exchange					
Childhood Preventive Measures	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 Percentile	MY2022-MY2023 HEDIS Change
Childhood Immunization Status					
DTaP	N/A	N/A	N/A	N/A	N/A
MMR	N/A	N/A	N/A	N/A	N/A
IPV	N/A	N/A	N/A	N/A	N/A
HiB	N/A	N/A	N/A	N/A	N/A
Hepatitis B	N/A	N/A	N/A	N/A	N/A
VZV	N/A	N/A	N/A	N/A	N/A
Pneumococcal	N/A	N/A	N/A	N/A	N/A
Combo 3	N/A	N/A	N/A	N/A	N/A
Immunizations for Adolescents					
Meningococcal	N/A	N/A	N/A	N/A	N/A

Tdap/Td	N/A	N/A	N/A	N/A	N/A
HPV	N/A	N/A	N/A	N/A	N/A
Combo 3	N/A	N/A	N/A	N/A	N/A

*National percentiles not calculated for the Exchange line of business. Commercial line of business percentiles used.
^MY 2021, MY2022, and MY 2023 rates were not reportable due to small sample size.

Immunizations

EXCHANGE

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

Interventions 2024

In 2024, the DHMP QI team participated in the Denver Health Pediatric Quality Improvement Work Group. Many of the interventions in 2024 were continuations of interventions that began in 2019 and 2020.

Denver Health has historically and consistently performed well in immunization scores. ACS Providers and staff are diligent in reviewing immunization records with members and educating them on the benefits of prevention. Data collection issues between State databases, Epic and claims data have been readily acknowledged and collaborative solutions between multiple DHHA departments were initiated. The DHMP QI department attends the ACS Medical Immunization Workgroup and has brought to light these data challenges and vaccine schedule variability.
ACS has implemented a variety of interventions aimed at improving immunization rates. These interventions included reminder calls and letters to members coming due or overdue for childhood vaccinations. As part of the continued work on this subject, ACS transitioned to a two dose Rotavirus series, which began in January 2021. The goal of this change is to support patient completion of the Rotavirus series and improve Combo 7 rates.

ACS also continued sending a Patient Health Summary letter to pediatric patients who are overdue on vaccines throughout 2024. Additional planning for interventions to improve these metrics is ongoing.

ACTION PLAN FOR 2025

For 2025, the DHMP QI team will continue to partner with the Denver Health Pediatric Quality Improvement Work Group and School Based Health Centers (SBHC) to address any barriers to immunization adherence. Efforts to increase timely well-child visits should also have a positive impact on the vaccinations required to complete in the first 2 years of life (particularly IPV and Combo 7 rates). ACS will continue sending letters to all patients who were non-compliant for Combo 7 at 15 months, followed by telephone outreach to patients who are 21 months old and have not yet completed their Combo 7 vaccines. ACS will also continue sending a Patient Health Summary letter to pediatric patients (other age groups) who are overdue on vaccines. Efforts to capture changes to immunization naming and coding changes in EPIC and mapping to HEDIS data tables are also ongoing.

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

EXCHANGE

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

2025 PREVENTATIVE HEALTH QUALITY IMPROVEMENT ACTIVITIES

SCHOOL BASED HEALTH CENTERS (SBHC) COLLABORATION

DHMP and DHHA continue to encourage eligible members particularly adolescents to complete their annual well-care visit at a Denver Health SBHC. There are 18 SBHCs located in middle schools and high schools with another 20 satellite elementary schools that feed into the SBHCs. SBHCs provide a variety of services such as well child visits, sport physicals, immunizations, chronic disease management, primary care and behavioral health care services. DHHA and DHMP continue to encourage eligible members to access care through our network of SBHCs. This information is sent directly to Member households in newsletters and is also available on the DHMP Member website. DHHA also promotes receiving care through an SBHC and in 2020 added electronic parental consent forms to their website to facilitate the consent process. In addition, the DHHA appointment center utilizes a process that alerts schedulers of a SBHC enrolled student which will prompt them to schedule the child at a SBHC for their clinic needs. For our adolescent population, collaboration with the DPS School Based Health Centers to identify and see members for Well Child visits during school hours has been highly successful in the past. In 2023, siblings of students enrolled at a Denver Public School were also able to receive medical care at SBHCs, expanding access to more of our member population.

BIRTHDAY CARDS FOR DHMP MEMBERS

In an effort to reach members of all age groups who are eligible for a well-child or adolescent well-care visit, DHMP sends Commercial and Exchange members a birthday card that provides educational information regarding the need for wellness visits and what services to expect their child to receive. In addition, the birthday cards remind parents that it is time to bring their children in for their annual well-visit. The cards are sent monthly to parents of children ages 2 through 19. In 2024, the average monthly mailing was 57 postcards across the Exchange lines of business.

Year	Avg. Exchange Postcards Mailed/Month
2021	120*
2022	103*
2023	112*
2024	57

*Averages include both Exchange and Commercial lines of business

ACTION PLAN FOR 2025

QI staff will continue to collaborate with the DHHA ACS Pediatric Quality Improvement Workgroup and SBHC team to develop interventions to improve health care outcomes for pediatric members. DHMP hopes to continue piloting and potentially expanding the SBHC intervention described above in 2025. In addition, the DHMP QI team continues to have discussion with the ACS SBHC teams around developing incentive programs to drive adolescent well-care rates for DHMP members who attend a Denver Public School. DHMP will also continue to mail Healthy Heroes birthday postcards each month to remind members' parents/guardians to schedule their annual well-child visit.

In Q4 2020, ACS began sending Patient Health Summary letters to pediatric patients who are overdue for a Well Child Visit and/or immunizations. In December 2020, this initiative was expanded to send these alerts through MyChart for patients who have a MyChart account. Both of these initiatives will continue in 2025.

Asthma Medication Ratio Measure

*N/A=Sample size <30

DHMP EXCHANGE MY2023 ASTHMA MEDICATION RATIO

Asthma Medication Ratio (AMR)	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2023 HEDIS Results	MY2023 HEDIS Percentile	MY2022-MY2023 HEDIS Change
Ages 5-11	*N/A	*N/A	*N/A	*N/A	*N/A
Ages 12-18	*N/A	*N/A	*N/A	*N/A	*N/A
Ages 19-50	*N/A	*N/A	*N/A	*N/A	*N/A[1]
Ages 51-64	*N/A	*N/A	*N/A	*N/A	*N/A
Total	*N/A	*N/A	*N/A	*N/A	*N/A

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

SUMMARY OF HEDIS MY2024

ASTHMA RESULTS EXCHANGE

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

Interventions for 2024

- The AWG and RN line utilizes a DHHA asthma-only telephonic line for Members needing assistance with asthma medication refills and triage. Members are also informed about the need to make an asthma assessment appointment with their PCP if they've refilled their rescue medication without refilling the appropriate number of controllers medications.
- ACS continues to utilize DHHA PNs to conduct a follow-up phone call within 48 hours of discharge from the ED or IP for pediatric Members with an asthma-related concern. PNs are tasked with addressing needs and attempting to schedule a follow-up PCP appointment or complete a TOC flowsheet.
- Prior pharmacy refill and HEDIS data demonstrated that many asthmatics fill rescue asthma medications without filling the appropriate number of controller medications.

ACTION PLAN FOR 2025

The DHMP QI department participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. Additionally, the Asthma Work Group will continue to focus on appropriately identifying and controlling adult asthma in 2025 after identifying a need to address the asthma needs more uniformly of members in this age group.

The DHMP QI team will continue to highlight to the ACS QI team and the Asthma Work Group, specifically, the importance of focusing on the AMR for our MCR, COMM and EXCH populations. The collaboration with the DHMP Pharmacy team to analyze these metrics and develop interventions to address medication adherence will continue into 2025. Priorities will include collaborating with DHMP Pharmacy and ACS on a process to obtain more complete pharmacy fill data for the Asthma Medication Ratio Metric, proactively identifying members who have been filling rescue medications but not their prescribed controller medications.

Performance Improvement Projects (PIPs)

Medicare and Exchange LOBs did not have any PIPs in 2024, but did overcome NCQA Corrective Action Plan and Resurvey.

Quality Improvement Strategy (QIS): HIV Medication Adherence

DHMP's QIS initiative focuses on improving HIV medication adherence through a Medication Refill Reminder program to help ensure members take their medications consistently.

DHMP implemented the Interactive Voice Response (IVR) Refill Reminder Program, which uses MedImpact's tracker to identify members who are 3 days past due picking up their meds, then IVR contacts the members via automated calls with a refill reminder. Success is measured by members filling prescriptions within two weeks of the reminder. So reporting was developed to show how successful the IVR system is in assisting members in refilling their HIV medication.

- The table below shows we have really good success in refill rates for the 3 LOBs in the program. The figures reflect consistent efforts in outreach and engagement, with nearly 60 percent of members who were contacted filling their medication within two weeks.

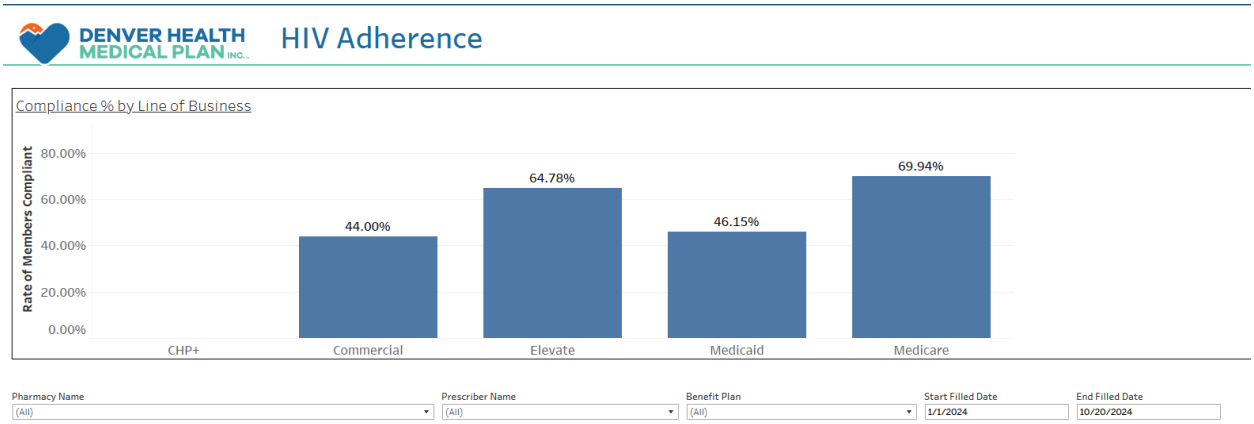
Table 1. IVR Program Success Rates

LOB	Members Outreached	Members who Refilled Med	Success Rate
Medicare	763	467	61.21%
On Exchange	1227	698	56.89%
Off Exchange	1329	793	59.67%
TOTAL	**3319**	**1958**	**58.99%**

- Program data includes start date of *February 2023 through September 2024*
- Unique member identification resets each month – members can be included multiple times if they show up in multiple months

The Quality Improvement and Population Health teams worked with the IS Department to develop a Tableau dashboard to capture the adherence rates of members taking these HIV medications across the different lines of business. Our goal was to achieve an adherence rate to HIV medications among our

Exchange population of 65 percent by 12/31/24. This data below is pulled through 10/20/24 and reflects we were at 44 percent at that time. Due to data challenges with our dashboard, we are awaiting a fix to gather final results. DHMP plans to integrate the IVR data into the Tableau dashboard in 2025, enabling analysis of the impact of IVR outreach on adherence.



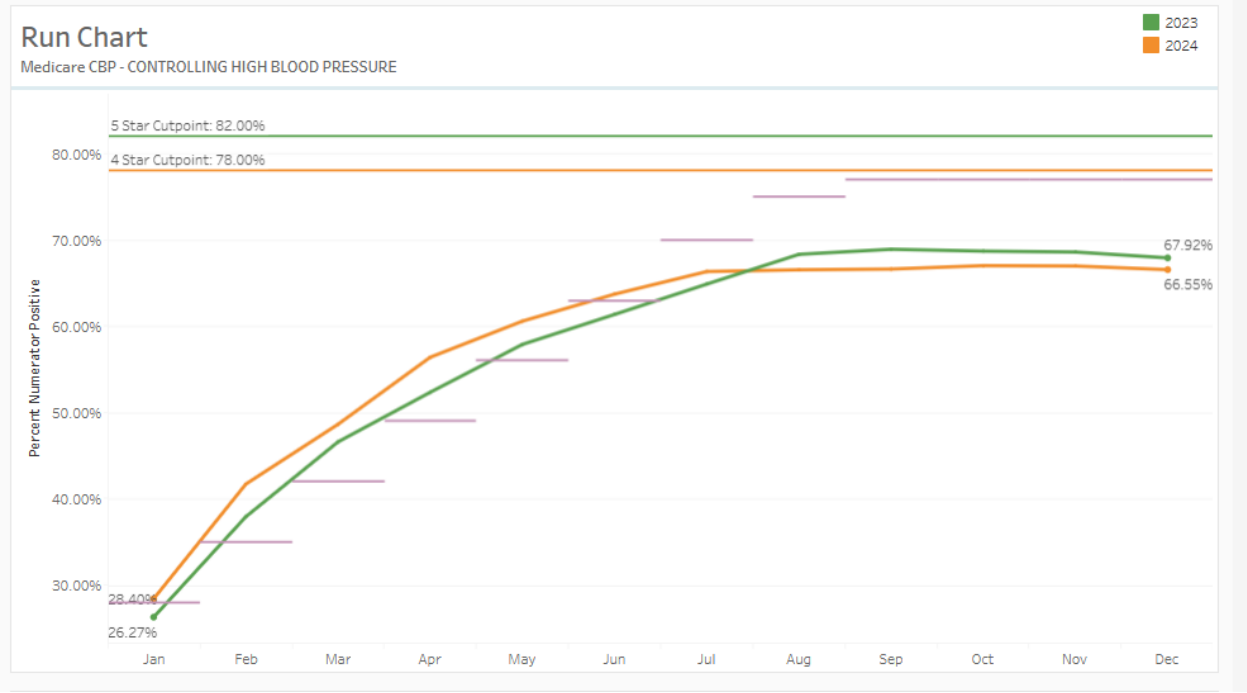
Medicare Chronic Care Improvement Program (CCIP)

The Chronic Care Improvement Program (CCIP) is a required component of Medicare Advantage plans' Quality Improvement Programs, governed by CMS regulations. Its purpose is to enhance chronic disease management, improve care outcomes for enrollees, and reduce healthcare costs. The CCIP's timeline spans three years. The first year focuses on planning and implementation, the second year on monitoring and adjusting, and the third year on final evaluation and reporting.

Denver Health Medical Plan's Medicare Advantage CCIP initiative is on Controlling Blood Pressure (CBP), targeting members with uncontrolled hypertension. This initiative uses the HEDIS Controlling High Blood Pressure metric (<140/90 mm Hg) to identify and support members through outreach, medication adherence interventions and care coordination. Our program's goal is to improve hypertension control rates from 2023's 3-star performance (68.92%) to a 4-star, which we anticipate could be around or greater than 84 percent by 2026.

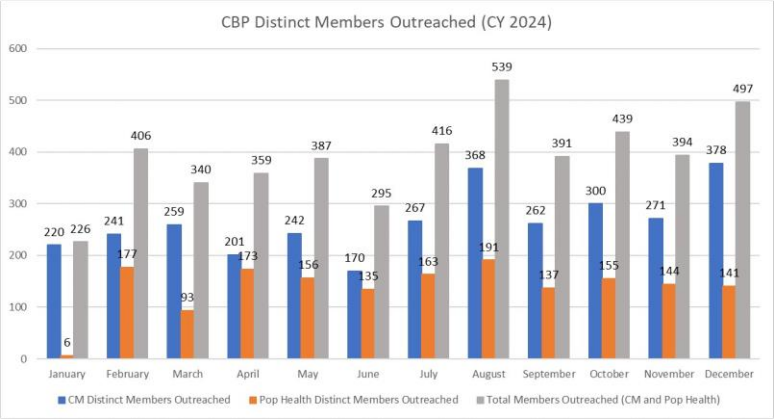
2024 is the first year of this three-year cycle (2024-2026), but this project is a continuation of our previous CCIP initiative. Continuing with CBP is a strategic decision, as the metric remains challenging due to increasing target rates. To ensure progress, we monitor key metrics and intervention effectiveness during our monthly Population Health 3x meetings. These meetings provide a collaborative platform to review month-over-month performance trends, member engagement and care management.

The chart below tracks our 2024 Medicare CBP performance month over month, comparing data for 2023 (green line) and 2024 (orange line) in terms of the percentage of members achieving controlled blood pressure. Note, the updated 2024 3 Star cut point is 79 percent and 4 Start cut point is 84 percent, which is not reflected on the dashboard. Both years start with relatively low percentages in January (26-28%), there is steady growth in both years, with 2024 showing a slight improvement over 2023 for most moths, around June to August the 2023 and 2024 trends converge maintaining similar performance. The growth flattens out from September onward and by December, 2023 ends slightly higher at 67.92 percent, while 2024 is at 66.55 percent indicating a small decrease in performance compared to the previous year. Both years fall short of the 4 star cut point.



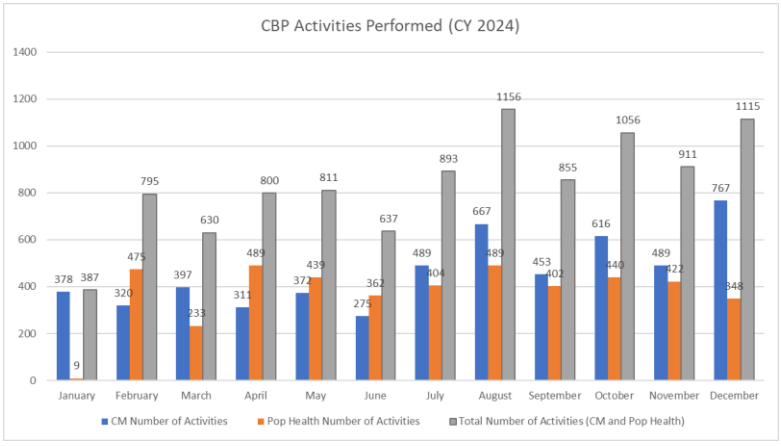
The below CBP Intervention chart reflects Case Management outreach (blue bars) which involves more personalized, high-touch interventions and Population Health outreach (orange bars) which involves more broad-scale outreach efforts and total outreach is the sum of both (gray bars). Case Management outreach is lower than Population Health outreach throughout the year, but both contribute to total interventions. Outreach increases steadily from January to August, peaking in August. This suggests a positive correlation to the performance trend. Outreach drops slightly in September and October, which corresponds with performance plateaus. Outreach rises again in December, but performance remains stalled. Need for sustained consistent outreach through Q4 in the future. Opportunity to compare how many outreached members actually improved BP control, not just how many were contacted.

CBP Interventions



The below CBP Intervention chart reflects the number of Case Management actions, such as care coordination, medication reviews, or coaching (blue bars) and Population Health actions, such as education efforts (orange bars), total activities together are the sum (gray bars). Activity levels increase steadily from January to August, peaking in August. A slight drop occurs in September and October, rebounding in December.

CBP Interventions



The distinct members outreached peaked in August but later decreased slightly. December also saw a strong outreach effort. The number of CBP-related activities follows a similar trend, peaking in August and rebounding in December. This suggests that outreach efforts are translating into tangible activities, which is a good sign of operational efficiency. Performance on the run chart plateaued after August despite high outreach and activities in August, September and October there was no corresponding improvement in performance. This suggests a disconnect between interventions and actual blood pressure control. August had the highest outreach and activities, yet performance stalled at 67 percent. This could mean higher outreach and activities don't necessarily lead to better BP control. There is opportunity to look at assessing this intervention with quality in addition to quantity through conversion rate analysis. Meaning report how many members who were contacted improved BP control and which actions had the most successful impact. More targeted, personalized follow-ups may be needed instead of just increasing outreach volume. Provider engagement to align efforts and review best practices for BP control could also improve performance lag. A deeper analysis into member-level data in 2025 could help identify the break down.

DHMP also partnered with a home blood pressure cuff vendor in 2024 to mail cuffs for eligible Medicare members, with results below.

CBP Blood Pressure Cuff

	BP Status			
BPCuff	BP Normal not out of date	BP Reading out of date	Moderate OOC	OOC
At home	84 45.41%	48 25.95%	21 11.35%	32 17.30%
Declined	3 37.50%	2 25.00%	1 12.50%	2 25.00%
DHMP	92 49.20%	44 23.53%	14 7.49%	37 19.79%
No	442 43.29%	268 26.25%	141 13.81%	170 16.65%

Key

At home = reading was obtained at home

Declined = member was offered a home cuff but opted not to get one

DHMP = provided through our blood pressure cuff vendor

No = no blood pressure cuff at home, results received at encounter-level

Intervention Success
In 2024, 47.31 percent of Medicare members who had a cuff at home from DHMP/vendor had BP Normal Not out of Date (176/372), compared to 43.25 percent (445/1,029) who did not have a BP cuff at home (a 4.06 percent difference between BP compliance).

Clinical and Preventative Guidelines

The intent of DHMP's Clinical and Preventive Health Care guidelines is to support providers with evidence-based care guidelines for adoption in consultation with DH and disseminate to network

providers and members. We reviewed contractual and regulatory specifications with consideration to the needs of our membership to determine which guidelines would be most appropriate, and determined the following:

- Antenatal and Postpartum Care Guideline
- Pediatric and Adolescent Preventive Healthcare Guidelines
- Diabetes Management for Non-Pregnant Adults in the Outpatient Setting Guideline
- Asthma Care Guideline
- Adult Depression Guideline
- Management of Hypertension in Adult Outpatients Guideline
- Pediatrics Early Intervention, Child Find or Developmental Delay Clinical Referral Guideline (related to persons with special health care needs).

This effort is in collaboration with DHMP's QI team, Medical Director, DH's Chief Quality, Safety, and Transformation Officer, Enterprise Compliance, Legal, Medical Management Committee (MMC), and QMC. We are proud of this alignment to reduce unnecessary duplication of efforts (LEAN waste). These guidelines are not intended to set legal standards of care or replace independent clinical decision making.

Pharmacy Review and Notification of Drug Recalls

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

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

Table 1: Drug Recalls by Quarter

Report Quarter	Members Affected	Notification Timely
1Q2024	N/A	N/A
2Q2024	0	N/A
3Q2024	0	N/A
4Q2024	N/A	N/A

On April 4, 2024, there was a market withdrawal of Relvyrio (sodium phenylbutyrate/taurursodiol). Amylyx Pharmaceuticals, Inc voluntarily discontinued the marketing authorizations for this product and removed the product from the US market based on the Phase 3 PHOENIX trial results. There were no members impacted, and thus no notification was required.

In September 2024, Pfizer, Inc. started the process with the FDA of voluntarily withdrawing the medication Oxbryta (Voxelotor) from the market, ceasing distribution, and discontinuing all active clinical trials and expanded access programs based on the outcomes of ongoing clinical trials showing a higher rate of vaso-occlusive crisis in patients with sickle cell disease receiving Oxbryta compared to placebo. There were 0 members impacted, and thus no notification was required.

Quality of Care Complaints (QOCC)

Member submitted concerns regarding the quality of care are classified as member grievances. These member grievances are processed by the Grievance and Appeal Department. If a member submitted quality concern is deemed significant or high risk for a member's health and safety, it can be reviewed by a nurse and escalated to the Medical Director for review. The Medical Director must agree to escalate the case to a quality-of- care concern.

Any concern submitted by a provider, or any concern deemed significant when annually reviewing the conditions will be reviewed by the Medical Director for possible acceptance as a quality-of-care concern. An RN Designee, with direction from the DHMP Medical Director, investigates any potential QOCCs. All QOCCs are tracked, trended, and reported to the DHMP Credentialing Committee; if trends are identified by the Credentialing Committee, QOCC may also be escalated/presented to QMC for oversight. Provider feedback is sought during the investigation for insight into the details of the case. Substantiated QOCC's regarding providers or a facility are sent to the Credentialling Committee for further tracking and trending or action if appropriate.

2024 QUALITY OF CARE CONCERN CASES (QOCC) – DHMP EXCHANGE AND MEDICARE

2024 Quality of Care Concern Cases (QOC)				
Plan	**Total Cases**	**Unsubstantiated**	**Substantiated**	**Inconclusive**
Exchange	1	0	1	0
Medicare	6	5	0	1

ANALYSIS

Exchange: There was one (1) quality of care concern for calendar year 2024. The case was discovered to be iatrogenic (provider harm) with an out-of-network provider. The care was not authorized and was discovered after the fact on claims review. The case was validated for member harm and reviewed by the Credentialling Committee. A unanimous decision to submit to the Colorado State Licensure Board was determined.

Medicare: A total of six (6) quality of care concern cases occurred for calendar year 2024. One (1) case was determined to be inconclusive. It was regarding lost personal items during a hospital stay. Five (5) cases were determined to be unsubstantiated. No member harm occurred on any case and all care was found to be given within the normal standards of care. Two cases occurred during a hospital stay. Two cases were for outpatient/clinic care. One case occurred in the Emergency Department.

No trends were identified for all 6 cases.

Access to Care and Services

DHMP evaluates access standards primarily through the provider access survey, complaints, and monitoring of disenrollments. As part of DHMP's comprehensive QI program, maintains quality standards to identify, evaluate, and remedy opportunities relating to access of care. Exchange and Medicare members can access primary care on Saturday mornings at three Denver Health locations (Montbello Health Center, Denver Health main campus and at the Westside Family Health Center on Federal Boulevard).

- DHMP provide all members with information on how to access the care they need through the Provider Directory, Member Handbook, and Member Newsletters.
  - New DHMP Members are sent a welcome packet including their ID card and Quick Reference Guide. DHMP also provides Orientation Videos in English and Spanish on the website for Members. These videos inform our members about their benefits and provide information on how the plan works.
  - DHMP maintains a 24-hour NurseLine that is available for members if the appointment center is closed and when members are experiencing specific symptoms. The NurseLine is capable of discussing the member's symptoms and concerns assisting the member in understanding the urgency of their need and can assist with deciding the best course of action based on the urgency to see their primary care provider or going to the urgent care or emergency department. Additionally, the NurseLine nurses can write prescriptions for some illnesses and can also schedule a Dispatch Health visit.
  - DHMP continues to contract with Dispatch Health to support our membership. Dispatch Health is a mobile urgent care provider that can go directly to the home of the member to provide services. DHMP has expanded the use of Dispatch Health to include SNF at home, Hospital at home and Bridging services to assist in early discharges.
  - MyChart is a user-friendly application/website with multiple capabilities available to members to enhance and support their experience. The capabilities include but are not limited to scheduling appointments, requesting pharmacy refills, review lab results, communicate directly with providers, and a centralized location for tracking their health outcomes and programs. It was used to send mass messages about the availability of Covid and flu vaccines, as requirements changed rapidly.
  - DHHA has recently begun utilizing an e-consult process that allows for providers to refer members for an e-consult with a specialist who can review the case and provide recommendations for care without, in many cases, having to see the member for a visit. E-consults are generally acted on within 3 business days. This results in less wait times for specialty access. In the event that a follow up visit is needed the specialty provider can order a visit.
  - Telehealth visits continue to offer expanded access for Members. Members can schedule telehealth visits including urgent care via MyChart.

Provider Access Survey

The provider access survey will be completed annually to analyze performance of network practitioner/provider accessibility against DHMP's Access to Care and Service standards. The results are used to identify deficiencies/opportunities, and take action to improve network adequacy, as applicable. The annual network adequacy analysis and findings will be presented to the Network Management Committee (NMC) for oversight and feedback to determine if the network is sufficient to provide services to members on a timely basis. The overall goals of the provider access survey process include:

- Ensuring adequate access to primary, behavioral, and high-volume/high-impact specialty care and services for DHMP's members.
- Monitoring DHMP's provider network for adherence to required access to care standards.
- Act on opportunities to improve access, as appropriate.

HEDIS Access Measures

Below is the Adults' Access to PCP (AAP) performance for DHMP's Elevate Medicare Advantage (MA) line of business (LOB).

Access Measures	Medicare				
	HEDIS MY2021 Results	HEDIS MY2022 Results	HEDIS Measurement Year MY2023 Results	MY2022HEDIS MCD Percentile	HEDIS MY2022-MY2023 Percent Change
Adults' Access to PCP (AAP)					
Ages 20-44	90.05%	88.89%	92.09%	50th	+3.47%
Ages 45-64	95.09%	94.39%	94.45%	25th	+0.06%
Ages 65+	91.99%	91.93%	92.55%	10th	+0.67%
Total	92.61%	92.33%	92.91%	25th	+0.62%

AAP is not a HEDIS measure for Exchange, therefore it is not reported above.

Analysis

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

- DHMP receives and monitors a new and existing patient waitlist summary report from DHHA on a weekly basis. The DHHA Access to Care team works to reduce the waitlists for Primary and Specialty care, including with calling people from the appointment center to offer appointments and by scrubbing the data to reduce duplicates.
- DHMP continued focused collaborative efforts with network providers in 2024

to address access, more specifically waitlists (could be for a preferred/sooner appointment day/time) to significantly reduce new patient waitlists by 81.3 percent from November 2024 to March 2025.

- Improvements are related to staffing up for Derm and Urology and other areas, working the waitlists (appt center outreach), etc. A new large-scale Access/Scheduling project has just kicked off with ECG which will focus on many areas including standardized scheduling of appointments. Additional detail on waitlist reduction performance are detailed below.

Access to Care – 2024 Waitlist Reduction Insights

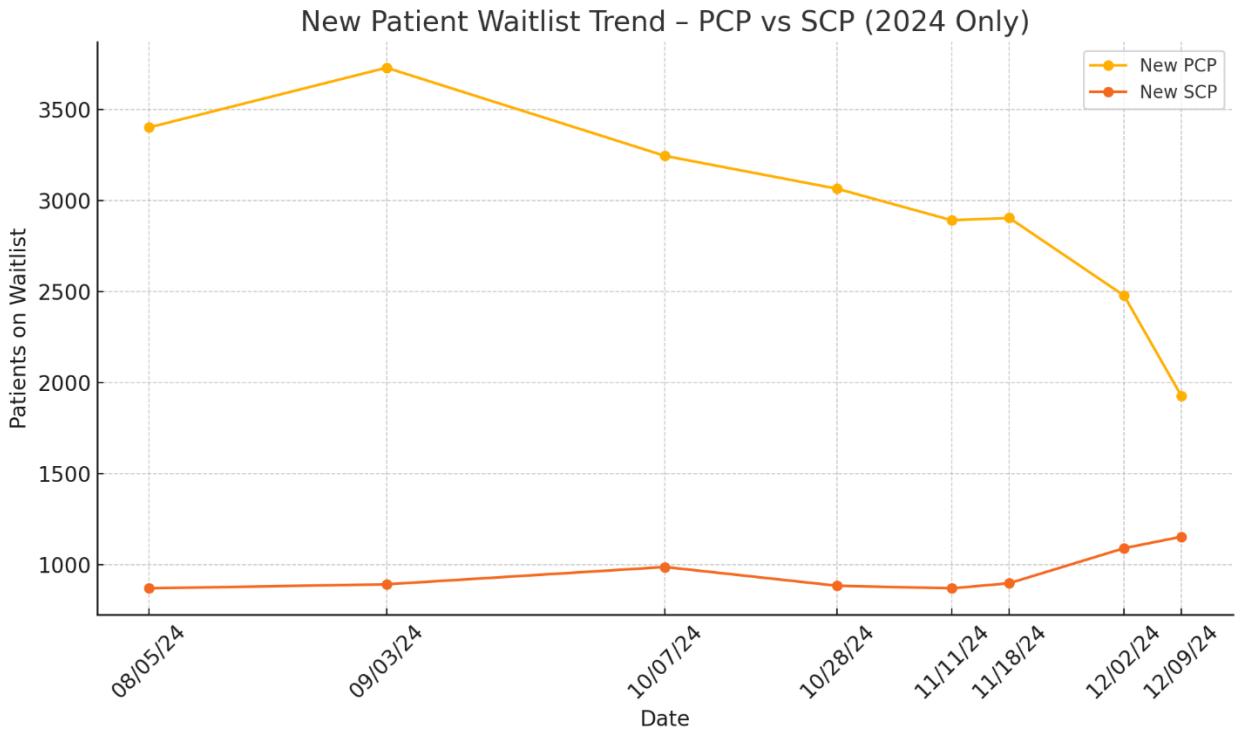
As part of Denver Health's systemwide focus on Access Transformation and Quality, targeted work was conducted in Fall 2024 to reduce patient waitlists across both primary and specialty care. The goal is to build a long-term strategy that sustains access improvement, stabilizes the waitlist workdown process, and maintains low volumes of patients awaiting care.

The first step toward achieving this goal was to establish a consistent method for waitlist tracking in 2024, followed by evaluating the data to identify root causes and implementing targeted process improvements in 2025. Waitlist tracking began in Fall 2024, and the table below reflects the data collected as the foundation for the following analysis. It includes both new and existing patient waitlists, broken out by Primary Care (PC) and Specialty Care (Spec).

	New Patient Waitlist		Existing Patient Waitlist		
Date	**PC**	**Spec**	**PC**	**Spec**	**Total**
8/5/2024	3400	872	N/A	N/A	**4272**
9/3/2024	3728	894	N/A	N/A	**4622**
10/7/2024	3244	989	N/A	N/A	**4233**
10/28/2024	3064	886	1665	2417	**8032**
11/11/2024	2891	872	1749	2455	**7967**
11/18/2024	2904	900	1874	2259	**7937**
12/2/2024	2478	1092	1864	2077	**7511**
12/9/2024	1927	1155	1803	2101	**6986**

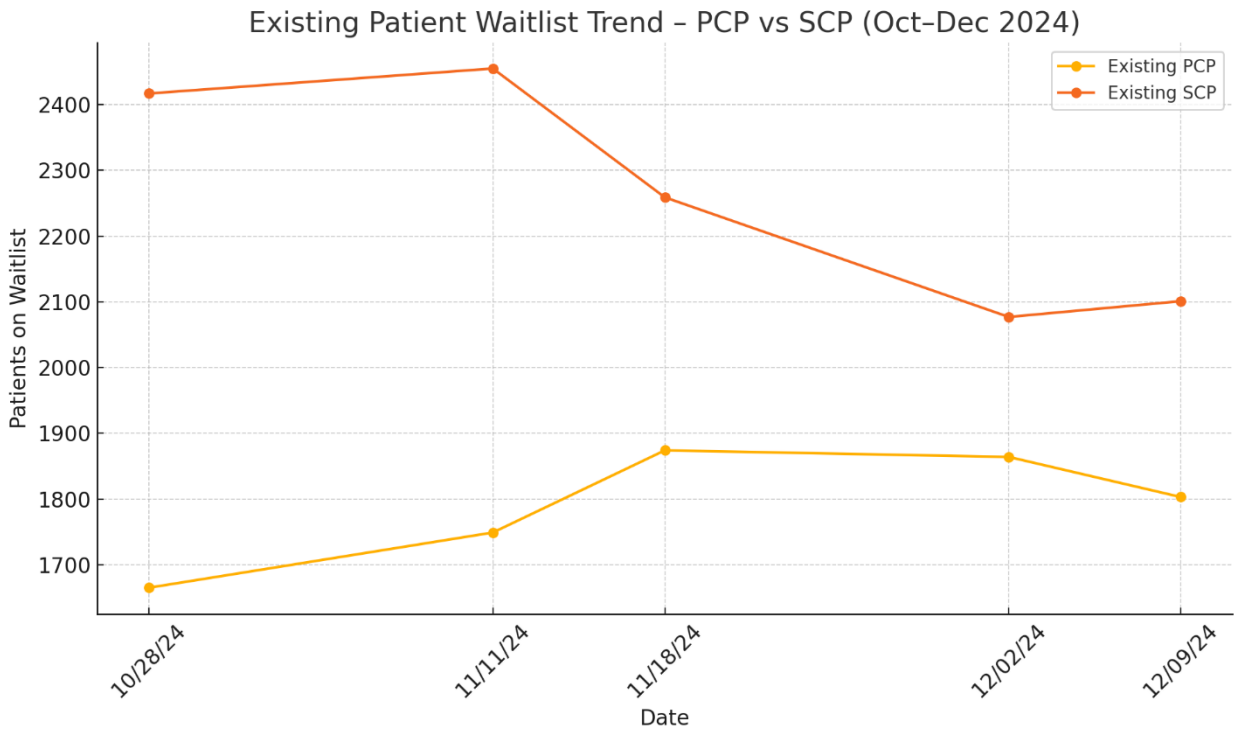
New Patient Waitlist

Primary Care Providers (PCPs) averaged 2,955 patients on the waitlist, with a notable decrease of 1,473 from the first to last data point. This reflects meaningful gains in appointment availability and access for new primary care patients. In contrast, Specialty Care Providers (SCPs) averaged 958 patients on the waitlist and saw a modest increase of 283, highlighting an area where continued support and capacity planning may be needed.



Existing Patients Waitlist

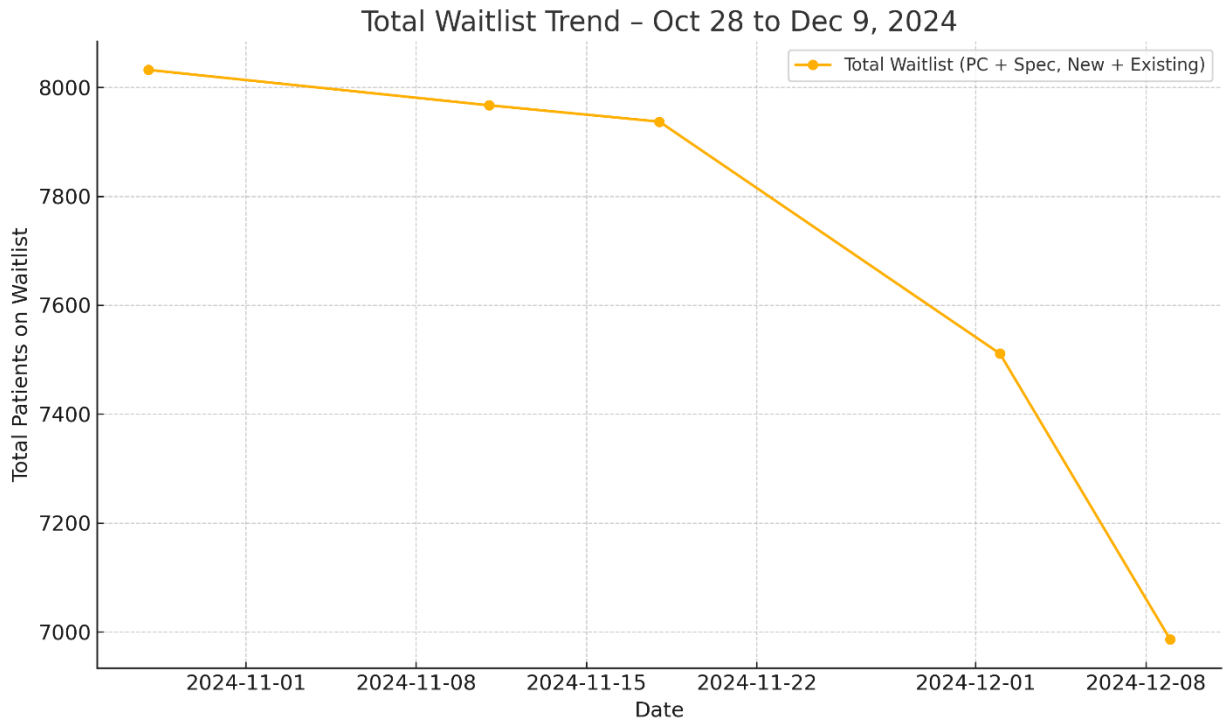
Data was only available beginning in late October through December 2024. During this period, PCP waitlists averaged 1,791 patients, with a slight increase of 138, suggesting consistent demand for follow-up and chronic care management. Meanwhile, SCP waitlists averaged 2,262 and saw a decrease of 316, indicating progress in improving specialty care continuity.



Combined Waitlist (New + Existing)

During the final months of 2024, Denver Health tracked the total waitlist volume across all provider types. This combined view offers insight into overall scheduling pressure and capacity trends.

- Primary Care Providers (PCPs) averaged 4,444 patients on the waitlist.
    - From late October to December, the total PCP waitlist decreased by 999, suggesting meaningful improvement in primary care access and throughput.
- Specialty Care Providers (SCPs) averaged 3,243 patients on the waitlist.
    - The total SCP waitlist saw a slight decrease of 47, indicating relative stability with minor improvement in specialty scheduling capacity.
- Overall, the total waitlist (PCP + SCP, new + existing) averaged 7,687 patients.
    - The system experienced a net decrease of 1,046 patients over the reporting period, pointing to positive progress in access transformation efforts.



- These findings are being used to inform 2025 planning and to stabilize long-term access improvement strategies.

Cultural and Linguistically Appropriate Services Program (CLAS)

DHMP has processes in place for evaluating language needs. In addition, DHMP shall make a reasonable effort to provide health care services that respect a member's individual health care attitudes, beliefs, customs and practices from diverse, ethnic, religious, age, gender, sexual orientation, physical and mental disability groups through its cultural and linguistic competency programs. The Culturally and Linguistically Appropriate Services (CLAS) Program Objectives are aligned with the National CLAS Standards, the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, improve quality and help eliminate health care disparities for DHMP's member population.

Previous Year Aggregate Results

Below are the aggregated results from the CY 2024 NCQA Network Management report, completed in CY2025.

Exchange HMO

Race and Ethnicity

Race/ Ethnicity	Count	Rate
AFRICAN AMERICAN	141	1.2%
ALASKAN/AMER INDIAN	18	0.2%
ASIAN/PACIFIC	184	1.5%
CAUCASIAN	575	4.8%

HISPANIC OR LATINO	350	2.9%
Other	849	7.1%
UNKNOWN	9,843	82.3%
Grand Total	**11,960**	**100.0%**

Language Count Rate

ENGLISH	9,173	76.7%
MANDARIN	10	0.1%
NEPALI	25	0.2%
OTHER	86	0.7%
RUSSIAN	15	0.1%
SPANISH	1,737	14.5%
UNKNOWN	819	6.8%
VIETNAMESE	95	0.8%
Grand Total	**11,960**	**100.0%**

Medicare HMO

Race and Ethnicity

Race/ Ethnicity	Count	Rate
AFRICAN AMERICAN	202	3.7%
ALASKAN/AMER INDIAN	5	0.1%
ASIAN/PACIFIC	19	0.3%
CAUCASIAN	1,039	19.0%
HISPANIC OR LATINO	6	0.1%
Other	4,143	75.9%
UNKNOWN	44	0.8%
Grand Total	**5,458**	**100.0%**

Language

Language	Count	Rate
ENGLISH	4,088	74.9%
OTHER	13	0.2%
SPANISH	1,336	24.5%
UNKNOWN	21	0.4%
Grand Total	**5,458**	**100.0%**

Current Year Aggregate Results

Race

Race	HIX Member Count	HIX Rate	MA Member Count	MA Rate	Grand Total	Overall Rate
AFRICAN AMERICAN	141	1.2%	202	3.7%	**343**	**2.0%**
ALASKAN/AMER INDIAN	18	0.2%	5	0.1%	**23**	**0.1%**
ASIAN/PACIFIC	184	1.5%	19	0.3%	**203**	**1.2%**
CAUCASIAN	575	4.8%	1,039	19.0%	**1,614**	**9.3%**
HISPANIC OR LATINO	350	2.9%	6	0.1%	**356**	**2.0%**
Other	849	7.1%	4,143	75.9%	**4,992**	**28.7%**
UNKNOWN	9,843	82.3%	44	0.8%	**9,887**	**56.8%**
Grand Total	**11,960**	**100.0%**	**5,458**	**100.0%**	**17,418**	**100.0%**

Ethnicity

Ethnicity	HIX Memb Count	HIX Rate	MA Member Count	MA Rate	Grand Total	Overall Rate
DECLINE TO ANSWER	314	2.6%	43	0.8%	**357**	**2.0%**
HISPANIC, LATINO, OR SPANISH ORIGIN	2,781	23.2%	2,721	49.9%	**5,502**	**31.6%**
MEXICAN, MEXICAN AMERICAN, OR CHICANO/A	1	0.0%			**1**	**0.0%**
NOT HISPANIC, LATINO, OR SPANISH ORIGIN	5,650	47.2%	2,579	47.3%	**8,229**	**47.2%**
UNKNOWN	3,214	26.9%	115	2.1%	**3,329**	**19.1%**
Grand Total	**11,960**	**100.0%**	**5,458**	**100.0%**	**17,418**	**100.0%**

Overall, Hispanic, Latino, or Spanish (HLS) Origin is a significant part of DHMP membership (31.6 percent or 5,502 covered lives) in 2024.

Linguistic Needs Assessment

A prevalent non-English language is defined by our policy titled Cultural and Linguistic Appropriate Services (CLAS) as five percent of the total population or 1,000 individuals, whichever is less, in a line of business speaking a

specific language. Based on the results of our most recent annual linguistic analysis, coupled with language and interpreter services available for the diverse population we serve, we are compliant as we currently have written member materials, handbooks, newsletters, and marketing materials available in both English and Spanish (prevalent languages).

REL Summary

We acknowledge that the majority of network practitioners have no ethnicity data available, and have selected to act upon the opportunity (intervention) of more comprehensive REL data, by educating network practitioners/provider groups and implement a new provider data management warehouse for more detailed reporting. While DHMP's network does not indicate a gap in meeting the cultural, ethnic, racial, and linguistic needs of the members we serve, the organization will work to further refine network practitioner REL data by implementing a new provider data management warehouse in 2025, as well as educate on providing more comprehensive data for rosters. Findings from the Colorado Health Access Survey (CHAS) also reveal that the primary reason for Coloradans seeking culturally appropriate care is due to a disability; with nearly 40 percent of those disabled respondents also expressing a correlation between their past experiences with abuse, domestic violence, or other trauma and their healthcare needs (CHI, 2023). As Colorado is a diverse state with diverse needs, it is also important to consider the culturally appropriate needs of multi-racial members (Snyder & Truitt, 2020).

Health Literacy

It is the DHMP's commitment to making appropriate efforts to make member-disseminated materials clear and concise in order to improve readability and comprehension, ultimately leading to a member base better equipped to make pertinent health decisions that affect their wellbeing. In addition, DHMP works toward the goal of ensuring that readability standards, per the requisites established per line of business, are met on all member-disseminated documents. The Marketing Department provides support on the use of health literacy *software (Health Literacy Advisor™)* installed on multiple computers at DHMP. Documents submitted through the software are reviewed and then awarded a reading grade level concurrent with the readability level. It is a regulation of Medicaid and CHP+ to have all member-disseminated materials at a 6th Grade Level or lower–which is also the goal for Medicare. All other plans (such as Exchange) strive to meet 10th Grade Level or lower.Key employees from each department at DHMP have the Health Literacy software installed on their computer and serve that department's 'champion' for submitting all member materials through the software to ensure that the appropriate Grade Level is obtained. All documents submitted through the software are then recorded and logged on DHMP's server to create a historical record for future auditing purposes. The Marketing Department provides support on the appropriate and optimal usage of this software to ensure consistency in Grade Level dissemination and in order to meet contractual requirements per LOB.

QUALITY OF SERVICE

Provider Survey Insights

Every September Provider Relations works with the Marketing department to deploy an annual provider survey. The survey consists of 23 questions pertaining to the provider experience working with DHMP. In 2024 we had over 60 providers participate which was a 47 percent increase from only 28 in 2023; key insights:

1. DHHA providers are majority of participants. We would like to increase participation outside of DHHA to contracted provider groups.
2. Majority of our providers are in an OP setting or hospital.

3. Providers responded they are meeting access to care standards.
4. Providers are generally satisfied with DHMP and would recommend us to other practitioners as well as patients.
5. Majority of our providers are using EPIC for health record access and find data sharing easy. We are projected to have a similar or slightly higher participation rate in 2025 due to lower contracting activity with our network.

Appeals & Grievances (A&G) Reporting and Trending

DHMP annually analyses A&G complaints and appeals (in alignment with NCQA ME7—separate report) to identify opportunities to improve behavioral healthcare (BH) and non-BH member experience, with respect to the five required NCQA reporting categories.

Aggregate Results

Exchange HMO

Table 1: Exchange Non-BH Complaint Volume

Category	PREVIOUS MEASUREMENT YEAR 2023		CURRENT 2024	
	Total Complaints	Complaints per 1,000 Members (Total: 8,928)	Total Complaints	Complaints per 1,000 Members (Total: 9,764)
Quality of Care	0	0	2	<1
Access	24	2.68	20	2.04
Attitude/Service	17	1.90	28	2.86
Billing/Financial	68	7.61	194	19.86
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	109	12.20	244	24.98

Non-behavioral complaints for DHMP's Exchange LOB increased year-over-year, largely due to higher membership and a rise in billing and financial concerns. While access complaints declined and provider service concerns remained low, the plan continues to enhance member support and financial transparency to improve the overall experience.

Table 2: Exchange Non-BH Appeal Volume

Category	PREVIOUS 2023		CURRENT 2024	
	Total Appeals	Appeals per 1,000 Members (Total: 8,928)	Total Appeals	Appeals per 1,000 Members (Total: 9,764)
Quality of Care	0	0	0	0
Access	6	<1	27	2.76
Attitude/Service	0	0	0	0
Billing/Financial	9	1	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Average	15	1.68	27	2.76

. Exchange non-BH appeals increased from 15 (1.68 per 1,000 members) in 2023 to 27 (2.76 per 1,000 members) in 2024, driven entirely by access-related concerns. While billing and financial appeals declined to zero, indicating some improvement, the plan continues to address access challenges to enhance timely care.

Medicare HMO

Table 3: Medicare Non-BH Complaint Volume

Category	PREVIOUS MEASUREMENT YEAR 2023		CURRENT 2024	
	Total Complaints	Complaints per 1,000 Members (Total: 5,185)	Total Complaints	Complaints per 1,000 Members (Total: 4,945)
Quality of Care	6	1.15	11	2.22
Access	48	9.25	45	9.10
Attitude/Service	76	14.65	54	10.92
Billing/Financial	78	15.04	40	8.08
Quality of Practitioner Office Site	2	<1	1	<1
Total/Number per 1,000	210	40.50	151	30.32

Medicare non-BH complaints decreased by 25 percent, from 210 (40.50 per 1,000 members) in 2023 to 151 (30.32 per 1,000 members) in 2024, driven by significant reductions in billing/financial and attitude/service concerns. While access complaints remained stable and quality of care complaints increased slightly, the overall decline reflects improvements in financial processes and member experience.

Table 4: Medicare Non-BH Appeal Volume

Category	PREVIOUS 2023		CURRENT 2024	
	Total Appeals	Appeals per 1,000 Members (Total: 5,185)	Total Appeals	Appeals per 1,000 Members (Total: 4,945)
Quality of Care	0	0	0	0
Access	74	14.27	101	20.42
Attitude/Service	0	0	0	0
Billing/Financial	22	4.24	124	25.07
Quality of Practitioner Office Site	0	0	0	0
Total/Average	96	18.51	225	45.50

Non-BH Medicare appeals rose from 96 (18.51 per 1,000 members) in 2023 to 225 (45.50 per 1,000 members) in 2024, driven by increases in billing/financial appeals related to claims and FlexCard use at certain Merchants, as well as access-related appeals. While no appeals were reported for quality of care, attitude/service, or practitioner office sites, the data highlights a shift toward financial and access concerns. DHMP is prioritizing staff training on complex benefit inquiries and expanding virtual visit options to improve access and reduce systemic barriers.

Table 5: Exchange BH Complaint Volume

Category	PREVIOUS MEASUREMENT YEAR 2023		CURRENT 2024	
	Total Complaints	Complaints per 1,000 Members (Total: 8,928)	Total Complaints	Complaints per 1,000 Members (Total: 9,764)
Quality of Care	0	0	0	0
Access	0	0	0	0
Attitude/Service	0	0	0	0
Billing/Financial	2	<1	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	2 Complaints	<1	0	0

No BH cases in CY2024 based on research/analysis. Exchange BH complaints were minimal in 2023, with only two billing and financial concerns (<1 per 1,000 members), and dropped to zero across all categories in 2024. This may indicate improved processes and member experience in behavioral health services.

Table 6: Exchange BH Appeal Volume

Category	PREVIOUS 2023		CURRENT 2024	
	Total Appeals	Appeals per 1,000 Members (Total: 8,928)	Total Appeals	Appeals per 1,000 Members (Total: 9,764)
Quality of Care	0	0	0	0
Access	6	<1	0	0
Attitude/Service	0	0	0	0
Billing/Financial	9	1	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Average	15	1.68	0	0

No BH cases in CY2024 based on research/analysis.

Medicare HMO

Table 7: Medicare BH Complaint Volume

Category	PREVIOUS MEASUREMENT YEAR 2023		CURRENT 2024	
	Total Complaints	Complaints per 1,000 Members (Total: 5,185)	Total Complaints	Complaints per 1,000 Members (Total: 4,945)
Quality of Care	0	0	0	0
Access	0	0	0	0
Attitude/Service	0	0	0	0
Billing/Financial	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	0	0	0	0

No BH cases in CY2024 based on research/analysis.

Table 8: Medicare BH Appeal Volume

Category	PREVIOUS 2023		CURRENT 2024	
	Total Appeals	Appeals per 1,000 Members (Total: 5,185)	Total Appeals	Appeals per 1,000 Members (Total: 4,945)
Quality of Care	0	0	0	0
Access	0	0	0	0
Attitude/Service	0	0	0	0
Billing/Financial	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Average	0	0	0	0

No BH cases in CY2024 based on research/analysis.

Exchange BH complaint and appeal ratios remained at zero per 1,000 members in 2024, well within the DOI goal of fewer than 10 to 15 per 1,000 members. The decline from 1.68 appeals per 1,000 members in 2023 to zero may reflect improved claims adjudication, clearer benefit communication, and expanded virtual visit options reducing barriers to care. While past complaints were linked to appointment access, prescription denials, and billing disputes, no formal complaints were reported in 2024. This suggests enhanced provider capacity and pharmacy processes but may also indicate underreporting due to network limitations or administrative complexity. The perceived efficiency gap between DHMP and competitors like Anthem in claims visibility remains a challenge, highlighting opportunities for continued provider and member education on claims processing and cost-sharing expectations.

Medicare BH complaint and appeal ratios also remained at zero per 1,000 members in 2024, meeting CMS goals. While no formal complaints were filed, member feedback highlighted concerns with customer service accessibility, grievance resolution transparency, and pharmacy benefit navigation. Reports of non-emergency medical transportation delays and pharmacy denials for controlled substances suggest ongoing challenges that may require improved formulary education and prior authorization support. The lack of billing disputes suggests effective claims processing, though clearer communication on cost-sharing and reimbursement expectations could further enhance member experience. DHMP remains focused on service improvements, provider engagement, and expanding virtual visit access to support timely and high-quality behavioral healthcare across all modalities.

In 2025, DHMP's Member and Provider Experience Director's org. (including the Monitoring, Auditing and Training, Health Plan Services, Marketing/Provider Relations Departments) in collaboration with the QI Team will implement key **non-BH interventions** to enhance member education and service quality. This includes developing an **internal tip sheet** to empower HPS staff in addressing billing, claims, and benefit inquiries based on A&G trends. Additionally, DHMP will host a **Words Matter** Lunch & Learn with the Center for Addiction Medicine (CAM) and integrate this content into an **enhanced Culture of Yes training**, required for all DHMP staff and new hires, to better equip them for complex member interactions. To further improve service delivery, DHMP will **expand the Culture of Yes training** to reinforce a member-centered approach and deploy targeted communications to **promote virtual visits**, particularly behavioral health services, through newsletters and other outreach channels.

For **behavioral health interventions**, DHMP will focus on increasing virtual visit utilization and ensuring all staff receive **Words Matter** training as part of the required **Culture of Yes** curriculum, embedding principles that foster compassionate and effective member engagement.

Care Coordination Annual Evaluation CY2024

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

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

  Referrals to care coordination and care management can come from a variety of sources, including, but not limited to:

  - Health Plan Services (HPS)
  - Appeals & Grievances (AG)
  - Partner agencies
  - Claims Data
  - Practitioner/provider
  - Member or caregiver
  - Pharmacy
  - Utilization Management (UM)
  - Inpatient hospital identification via census reports
  - Other Care Management programs
  - Community-based organizations (CBOs)
  - Health Screening tools and assessments

Assessment of Member's Health Status includes Health Assessments (HA), Health Risk Assessments (HRA), Health Needs Surveys (HNS), and other functional assessments are completed by the CM team. These assessments collect in-depth information about a member's unique situation and functioning to identify their individual needs. The assessments include, but not limited to:

- Identifying an ongoing source of primary care appropriate to the member's needs
- Member's health status, comorbidities, and their current status, and member's self-reported status
- Clinical history, inpatient stays, current and past medications
- Activities of daily living (ADL's)
- Behavioral health status including cognitive functions, mental health conditions and substance use disorders

- Social determinants of health
- Life-planning activities (i.e., living wills, advanced directives, powers of attorney
- Evaluation of cultural and linguistic needs, preferred languages, and health literacy
  - Evaluation of visual and hearing needs
  - Evaluation of the adequacy of caregiver resources
  - Evaluation and assessment of community resources

CMs work with the member and/or caregiver to develop a personalized, individualized member and family-centered plan of care. The plan must meet the member needs and include,

- Prioritized goals that consider the member's and family's/caregiver's goals, needs, preferences, and desired level of involvement in the care plan
- Timeframes for reevaluating goals
- Resources to be utilized, including appropriate level of care
- Planning for continuity of care, including transition of care and transfers between or across settings
- Development of self-management plan and goals

Barriers are assessed and routinely discussed throughout the care management process to help the member and care manager identify and understand the areas that might prevent a member from meeting their goals or adhering to the plan of care. Barrier analysis includes, but is not limited to:

- Understanding of the condition and treatment
- Belief that participation will improve health
- Financial or insurance issues
- Visual or hearing impairments
- Level of motivation for change
- Ability to participate in achieving goals
- Language and health literacy level
- Cognitive functioning
- Desire to participate
- Access to reliable transportation
- Cultural, religious, or spiritual beliefs
- Psychological impairment

Care managers develop and document reasonable timeframes for reevaluation to facilitate a progressive care plan. The CM team maintains contact with the member or family/caregiver, physician(s) and member(s) of the care team based on the member's condition and acuity to:

- Assess ongoing needs
- Continue ongoing coaching
- Review progress towards goals
- Inform the member of the next scheduled contact
- Maintain active communication with the PCP, specialty providers and ancillary providers about the member's condition and future needs
- Share ongoing information about choices of settings, providers, treatment options and resources

Care Managers and Health Plan Care Coordinators identify and refer members who could benefit from services available either as part of their health plan benefits or outside of their health plan benefits. CM

team members are competent on all the lines of business guidelines and benefit coverages. Resources may include specialty care providers, out-of-network services, social services, government programs, nonprofit organizations, disease-specific foundations, and community resources. CM's work with both the provider and the CM team to facilitate the process for resources that require a referral from a provider and/or authorization by the health plan utilization management (UM) team.

Graduation, Transition or Discharge from Care Management and Care Coordination services. Graduation occurs when all care plan opportunities and goals are addressed and re-assessment does not identify need for continued care management, or when a member is able to be transitioned to the next lowest level of care possible based on the member's needs. Members may, at any time, move to a higher level of care management based on changing needs. Discharge from care management or care coordination can occur before care plan goals are met when:

- The member requests to opt out of care management programs and/or care coordination services
- Care Coordinator is unable to reach the member
- The member is no longer eligible for DHMP benefits
- The member is deceased

At least annually, DHMP evaluates member experience with its Care Management and Care Coordination programs by obtaining feedback from members. Data collected and analyzed includes member feedback about:

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

- Care Management Staff Resources: The Care Management Team consists of 33 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Clinical, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff.
  - Chief Medical Officer
  - Director of Health Plan Care Management
  - Clinical Manger of Health Plan Care Management
  - Operations Manager of Health Plan Care Management
  - Care Managers (RN, LPN, MSW, LCSW, LPC, RD)
  - Transition of Care Nurses (RN, LPN)
  - Health Plan Care Coordinators

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is also holistically supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

Summary of 2024 Care Coordination Activities and Care Management Programs

Program Name: **Complex Case Management (CCM):**

The DHMP CCM Program is available to members enrolled in any of the DHMP plans. The Program addresses the complex medical, behavioral, and/or psychosocial needs of members by providing personalized case management services and goal setting. DHMP's CCM Program is intended to empower members who have complex medical needs and require a wide variety of resources to manage their health, improve their quality of life and take control of their health care needs. DHMP does so by coordinating quality health care services and optimizing benefits through a case management plan. CCM Care Managers collaborate with members and caregivers to set Specific, Measurable, Attainable, Relevant and Timely (SMART) goals. These Care Managers are Licensed Clinical Social Workers (LCSWs), LPNs and Registered Nurses (RNs); LCSWs and LPNs work under the supervision of an RN.
2024 CCM Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

CCM Program Metrics:

Activity Name	Number of Activities	Distinct Members Served
CCM Applications/Membership Assistance	1	1
CCM Benefit Resource Coordination	5	3
CCM Condition Management	3	2
CCM Dental Care Coordination	1	1
CCM Engagement / Enrollment	45	22
CCM Food Security Coordination	1	1
CCM Housing Resource Coordination	1	1
CCM Language Services	1	1
CCM Member Follow-up	1028	75
CCM Other Follow-up	13	9
CCM Pharmacy Review	10	9
CCM Program	58	13
CCM Provider Follow-up	2	2
Grand Total	**1169**	**88**

CCM Activities 2024

CCM Outcome Metrics:

Cost Group	Members in Program at Least 60 Days		Members in Program at Least 1 Year	
	2023	2024	2023	2024
$1,000-$9,999	27.78%	27.78%	28.57%	35.71%
$10,000-$24,999	27.78%	27.78%	21.43%	28.57%
$25,000-$49,999	5.56%	16.67%	7.14%	7.14%
$50,000-$99,999	22.22%	16.67%	21.43%	21.43%
$100,000-$199,999	16.67%	0.00%	21.43%	0.00%
$200,000-$299,999	0.00%	11.11%	0.00%	7.14%
Average Per Member Annual Cost	$ 46,821.33	$ 58,549.25	$ 57,414.17	$ 42,609.57
Average Per Member Cost Difference	$	11,727.92	$	(14,804.60)
Total Cost Difference (2024 - 2023)	$	222,830.49	$	(207,264.38)

CCM Cost Analysis 2024

Results/Analysis:

- A total of 25 distinct clients participated in the CCM program in 2023
  - All members were still actively enrolled as of 12/31/2023
  - 14 members (56.00%) were newly enrolled in 2023
- 1169 distinct activities were completed in 2024 for the CCM program across 88 members
- Members enrolled in the program for at least 1 year saw decreased costs between 2023 and 2024 (N=14)
  - The average annual cost per member decreased from $57,414.17 in 2023 to $42,609.57 in 2024, for an average per member annual decrease of $14,804.60 per member, or a total savings of $207,264.38

        - The CCM program employs mechanisms to support decreases in utilization and spending:
            - Improved management of medical, social, and behavioral risk factors may have prevented acute exacerbations of chronic disease
            - Improved self-management and adherence
            - Social and behavioral stabilizations to facilitate safe discharge planning, reducing the need for, or duration of, inpatient admissions
        - A smaller cost savings was identified during the current assessment period
    - Members enrolled in the program for at least 60 days saw increased costs between 2023 and 2024 (N=19)
        - The average annual cost per member increased from $46,821.33 in 2023 to $58,549.25 in 2024, for an average per member annual increase of $11,727.92 per member
    - The cost difference between members who have been enrolled in the program for at least one year compared to members who have been enrolled in the program for at least 60 days indicates that new members are driving cost while the program appears to be successful in containing cost in the long term

Barriers/Lessons Learned:

- Evaluating cost savings can be difficult due to changing membership, lack of year over year cost data, and challenges with cost of members upon entry into the program
    - Outreach lists build caseloads that come from the DHMP Top 10 High Utilizer report, which are the most expensive members
    - There may be an opportunity to partner with SquareML to develop a formal cost analysis for members in CCM in the future
    - Members require extensive support to change utilization patterns, such as members who frequently use the emergency department (ED) as their PCP

Program Name: **Transitions of Care (TOC)**:

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

Care coordination activities provided by the TOC include but are not limited to:

- In-network PCP coordination if not already established
- Appointment reminders – Ensuring timely physician follow-up care

- DME
- Home Health
- Reviewing mediation regimen
- Disease Management
- Education on health conditions and potential “red flags” for readmission
- Transportation
- Connecting members with helpful community resources

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

The Transitions of Care team has a complex needs process which includes additional monitoring and discharge planning support for members who are inpatient for more than 14 days, are admitted out of state, or whose medical needs meets complex needs criteria. These members are discussed weekly among internal and external stakeholders to promote safe and effective discharge planning for complex needs members.

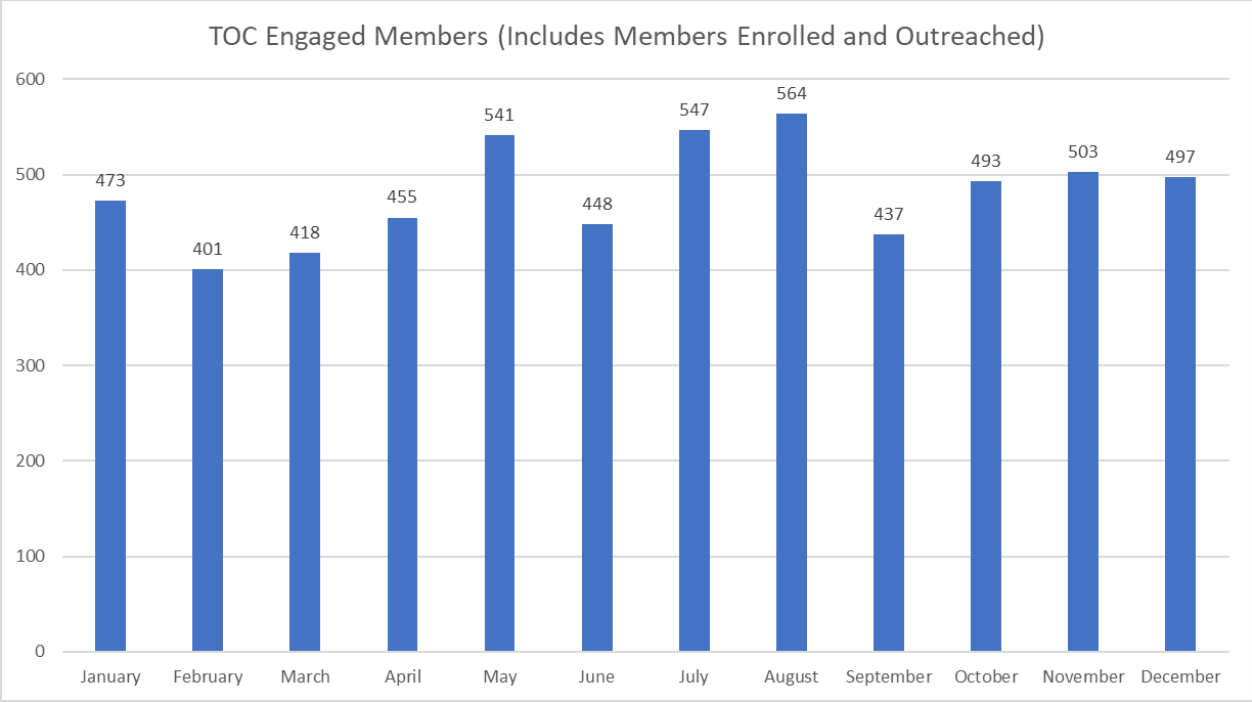
Members are tracked from inpatient notification through the referral process. Once a member is discharged to a home setting, members are referred to a Care Manager for outreach. The current process tracks members through to the conclusion of the referral, indicating whether the member met program criteria or opted to enroll in the program.

In CY 2023, the CM team partnered with SquareML, a data analytics company. In 2023, SquareML began development of an admission, discharge, and transfer (ADT) feed which will provide more “real time” data to the Transitions of Care team. This feed was completed in 2024 and went live in August 2024. SquareML has also conducted an analysis of potentially avoidable admissions and a high readmission risk. These flags are used to risk stratify members being assigned to Care Managers. The ADT feed has additional risk flags for stratification, including:

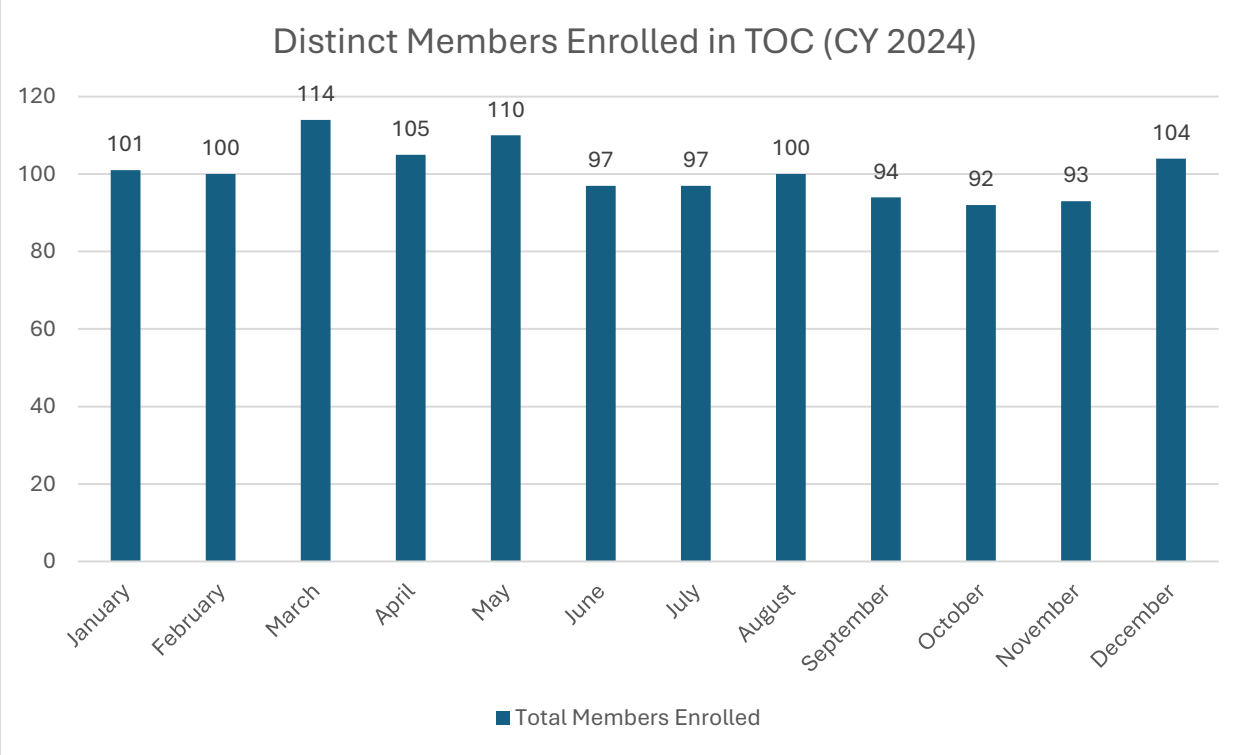
- Length of stay greater than or equal to 14 days
- Total care costs exceeding $25,000
- 3 or more chronic conditions

2024 Transitions of Care (TOC) Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

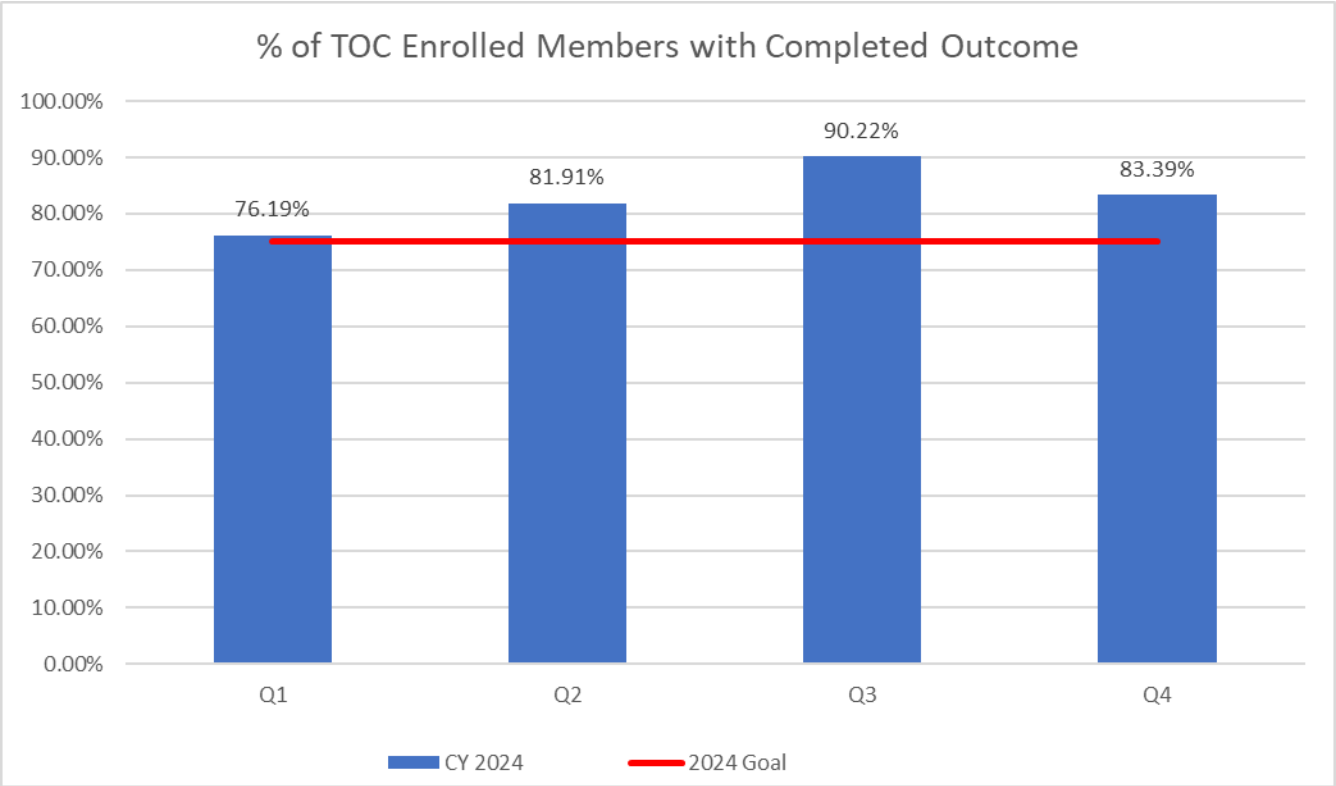
TOC Program Metrics:



TOC Distinct Members Engaged 2024



TOC Enrollments 2024



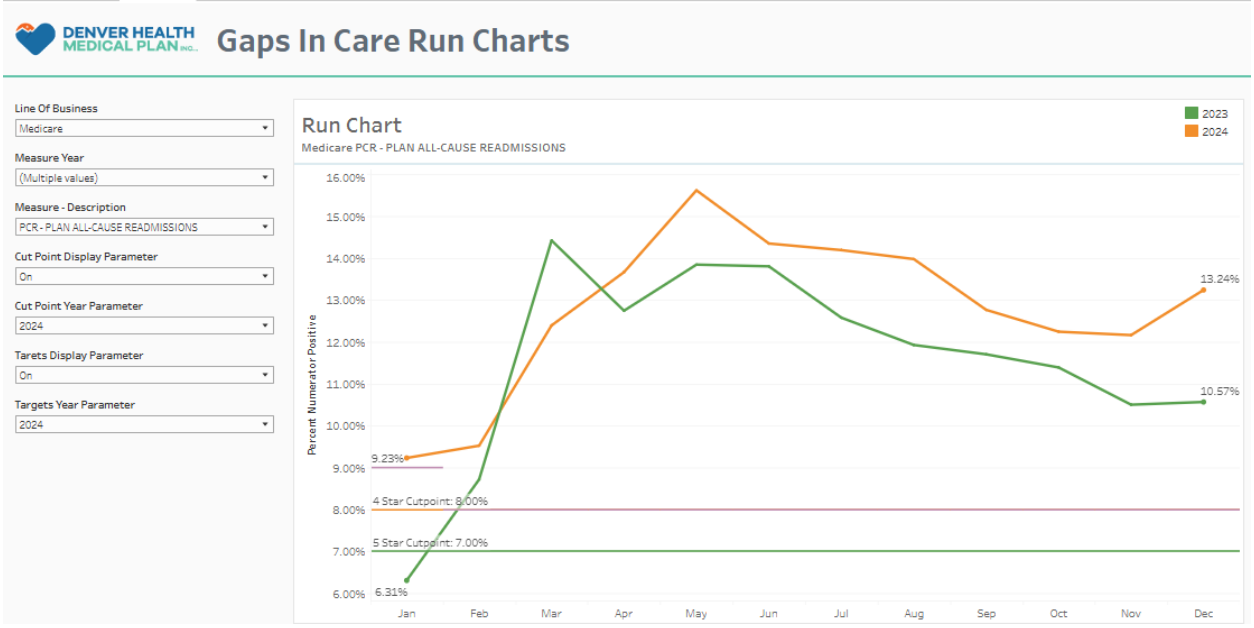
TOC Program Completion Rates 2023

TOC Activity Metrics:

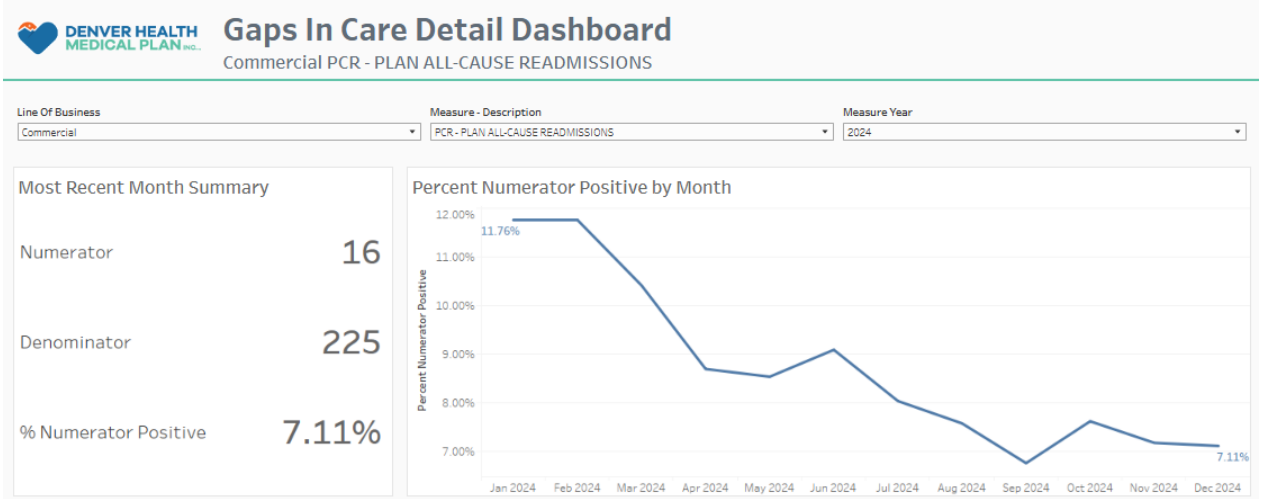
Care Activity Type	Number of Activities	Members Served
CCM TOC Member Follow Up	26	26
CCM TOC Other Follow-Up	5	5
CCM TOC Provider Follow-Up	7	7
DSNP ICT/TOC Meeting	107	100
DSNP TOC Care Plan Update	2645	744
DSNP TOC Follow-up	2278	492
DSNP TOC Health Acuity / Needs Assessed	2389	677
DSNP TOC ICP Goals / Barriers Communicated to Care Team	2684	696
DSNP TOC Member Follow-up	6018	798
DSNP TOC Referral	579	323
TOC Applications/Membership Assistance	25	18
TOC Benefit Resource Coordination	76	53
TOC Care Plan Update	67	55
TOC DHHA Assist	9	4
TOC Education Provided	33	29
TOC Engagement / Enrollment	2611	1408
TOC Food Security Coordination	10	9
TOC Health Care Provider Coordination	402	226
TOC Home Health Coordination	61	36
TOC Housing Resource Coordination	11	10
TOC Initial Assesment	1288	875
TOC Initial Assessment Outreach	2481	1385
TOC IP Discharge Planning	1497	615
TOC IP Provider CM Coordination	395	219
TOC IP Special Needs Planning	29	12
TOC Language Services	358	168
TOC LTSS Coordination	3	3
TOC Member Follow-up	4872	1444
TOC Other Community Resource Coordination	73	52
TOC Other Follow-up	312	183
TOC Peer/Support Groups	1	1
TOC Program	1875	971
TOC Provider Follow-up	264	158
TOC Readmission to Hospital	16	14
TOC Referral	804	644
TOC Transportation Coordination	83	50
TOC Utilities Coordination	1	1
TOC Wellframe Digital CM Assessment	4	4
Grand Total	**34399**	**2586**

TOC Activities and Members Served 2024

TOC Outcome Metrics:



Plan All Cause Readmissions (PCR) - Medicare 2024



Plan All Cause Readmissions (PCR) - Commercial and Exchange 2024

Results/Analysis:

- Plan all cause readmission rates for Medicare increased by 2.67% in 2024, with a 2023 readmission rate of 10.60% and a 2024 readmission rate of 13.24%
- Plan all cause readmission rates for Commercial and Exchange members increased from 4.95 % in 2023 to 7.00% in 2024
    - Few DHMP exchange members were in the PCR denominator in 2023 and 2024
        - 17 members were included in the PCR measure in 2023 with 0 readmits (0.00%)
        - 25 members were included in the PCR measure in 2024 with 2 readmits (8.00%)

        - Smaller denominators for this measure mean that we may see larger changes in rates, but that these changes are not likely to be statistically significant
    - The TOC team implemented the new ADT feed in August 2024, with an immediate 1.21% decrease in PCR rates between August and September 2024
    - There were challenges with the contexture data feed in September, October, and December which impacted the timely delivery of ADT notifications to the TOC team
    - Staffing changes and challenges in September 2024 through the end of the year further impacted the TOC team in managing this measure
        - The team previously outreached facilities for all admissions to support safe discharges, but in September 2024, outreach efforts to facilities were focused on DSNP members, referrals from facilities, members in LTACH, and members with open authorizations for 12 days or greater
        - Previously, the team provided two outreach calls and a letter to all members, but for our Medicare Select and our Exchange members, this was decreased to one outreach call
            - DSNP members still receive two calls and a letter
        - The TOC team previously followed all exchange members who were admitted, but in 2024, the team focused on members:
            - With a length of stay exceeding 14 days
            - Referrals from members, providers, and facilities
            - Members at LTACH
            - Members predicted to readmit using Square ML's predictive analytics
            - Members with a potentially avoidable admission:
                - COPD
                - Heart Failure
                - Hypertension
                - Diabetes
                - Asthma
    - 2586 distinct members were outreached/engaged by the TOC team in 2024
        - A total of 876 distinct members (33.88%) outreached by the TOC team engaged in the program in 2024 across 1259 total enrollments
            - 3 members opted into the new Wellframe digital care management platform for a self-directed TOC program
                - This option became available in November 2024
        - Of all members who enrolled in the program, 82.49% of members completed the program, which is exceeding the goal of 75.00%
        - 206 distinct members (8.74% of outreached/engaged members) received appointment assistance from the TOC team at least once in 2024

Barriers/Lessons Learned:

- Calculation of readmission rates for the program is currently not possible
  - The CM team is working with SquareML to develop a TOC dashboard which will allow the CM team to evaluate readmission rates for members enrolled in the program and to assess program and team member efficacy
- Engagement via telephonic outreach continues to be a large barrier for the team
  - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
    - The Wellframe application also offers:
      - Sending of resources, educational materials, and letters digitally
      - Biometric tracking that can be shared with the member's care manager
      - Self-management programs, including the opportunity for members to engage in a self-directed TOC program
      - Member assessments
      - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
  - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
- Members declining the program has been an ongoing challenge; however, some members are willing to participate in Care Management services even though they do not wish to participate in a program
  - As of November 2024, members also have the option to participate in a TOC self-management program through the Wellframe Application

Program Name: **High Utilizer Medication Management Program**

The DHMP pharmacy team monitors members pharmacy utilization and will identify members that are on high-cost drugs for care coordination review and evaluation for case management services. The care coordination team will outreach to the member to discuss their specific condition and associated pharmacy needs and connect members to a primary care provider if they are not already established with a provider.

2024 High Utilizer Medication Management Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

High Utilizer Medication Management Program Data

High Utilizer Medication Management Program	
Program Status	**Distinct Member Count**
Changed Programs	1
Completed Program	79
Member Engagement	1
Member Enrolled in Program	5
Unable To Reach	5
Grand Total	**91**

High Utilizer Medication Management Cost Data:

High Utilizer Medication Management Program				
Begin Month	**Savings**	**Frequency**	**Savings annualized**	**LOB**
January	$12,909.21	Monthly	$154,910.52	Exchange/CO Option
April	$20,546.12	q 90 days	$61,638.36	Exchange/CO Option
June	$16,794.40	Monthly	$117,560.80	Exchange/CO Option
July	$8,276.58	q 90 days	$16,553.16	Medicare Advantage
October	$17,790.82	Monthly	$35,581.64	Medicare Advantage
YTD			**$386,244.48**	

High Utilizer Medication Management Cost Savings CY 2024 Medicare and Exchange

Results/Analysis:

- The High Utilizer Program saved the plan $2,116,784.83 in 2024 across all lines of business
  - The 2024 cost savings for Medicare and Exchange members in this program was $386,244.48
- 91 distinct members were served under the program in 2024
- The high Utilizer Medication Management Program supports the highest utilizers of high cost medications and considers alternative medications and pharmacy changes to bring down the cost of treatment

Barriers/Lessons Learned:

- Some members referred to the program have been unreachable by the CM conducting outreach, making it difficult to support members with getting costs down
  - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
    - The Wellframe application also offers:
      - Sending of resources, educational materials, and letters digitally
      - Biometric tracking that can be shared with the member's care manager

        - Self-management programs, including the opportunity for members to engage in a self-directed program
        - Member assessments
        - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
    - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
- Some members referred to the program are already on the lowest cost option and their cases may need to be re-evaluated in the future for additional opportunities

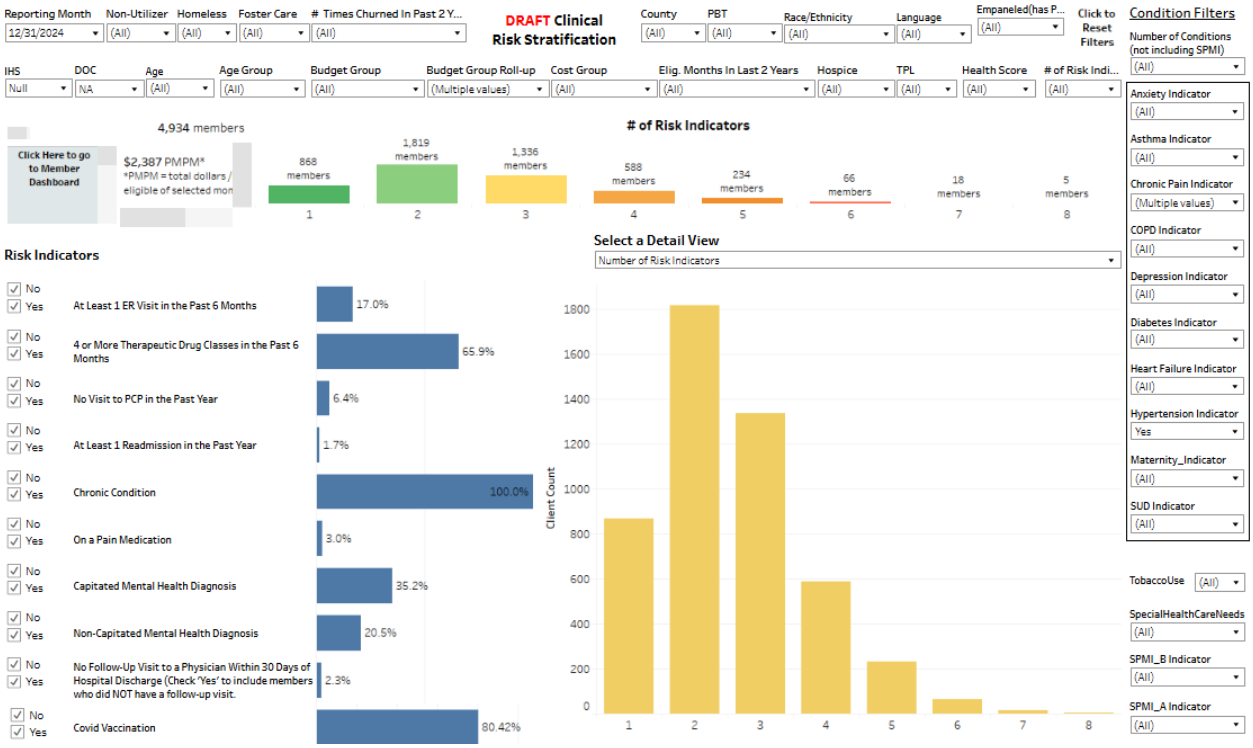
Program Name: **Controlling Blood Pressure (CBP):**

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

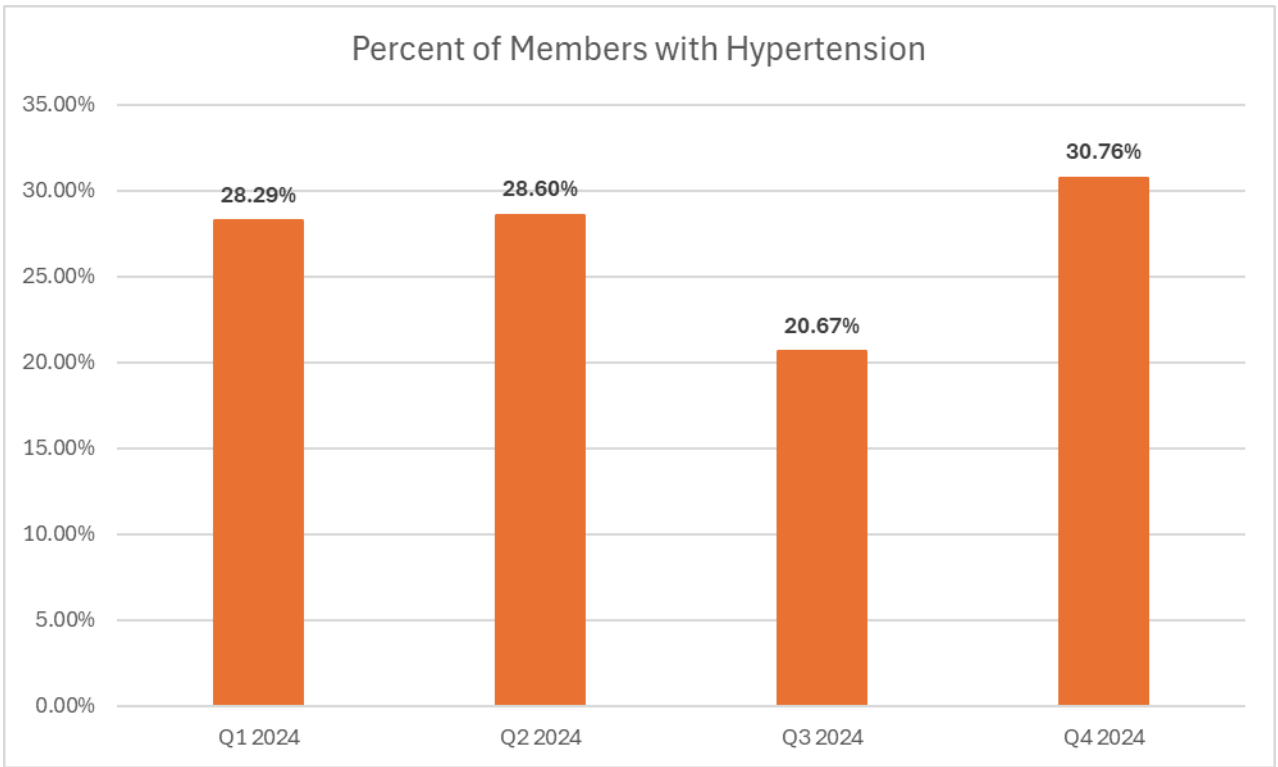
- Ensure that a plan of care is in place for members as well as identifying barriers including clinical, nonclinical, and social determinants of health
- Focus on organizing, supporting, and arranging resolutions to barriers
- Follow the member until the measure compliance is achieved Once achieved,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

2024 CBP Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Population Overview (12/31/2024):

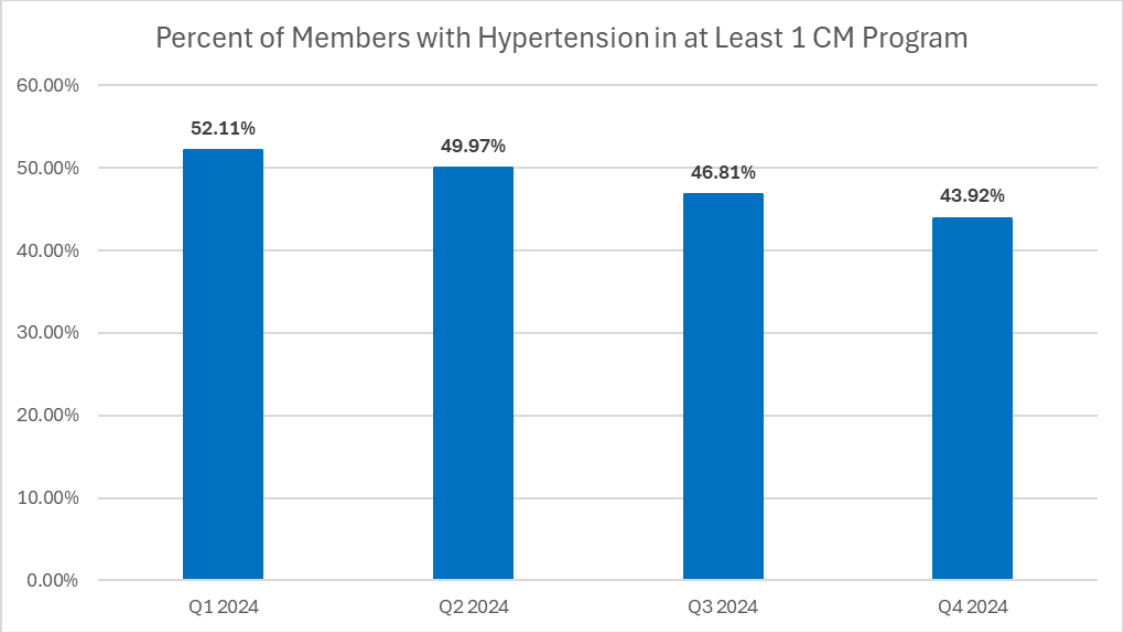


Medicare and Exchange Members with Hypertension as of 12/31/2024 (Risk Stratification Tool)



Percent of Members with Hypertension 2024

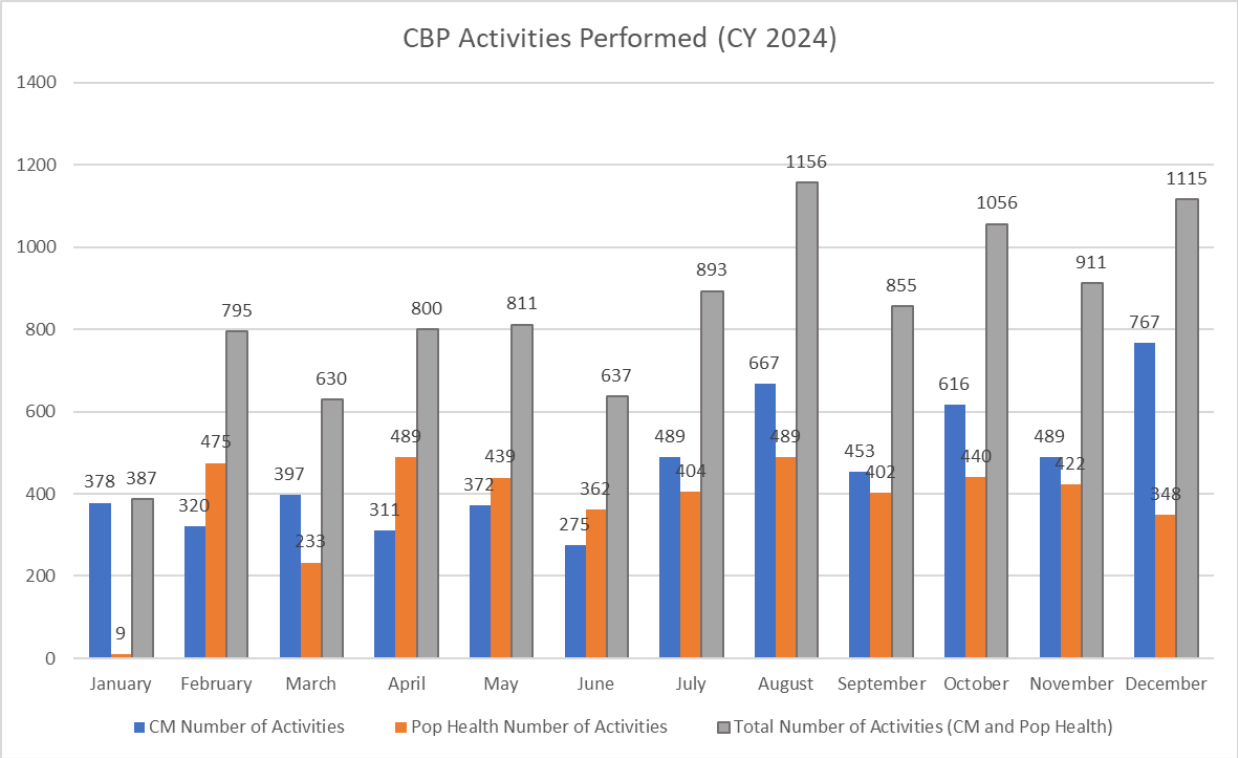
CBP Care Activities Metrics:



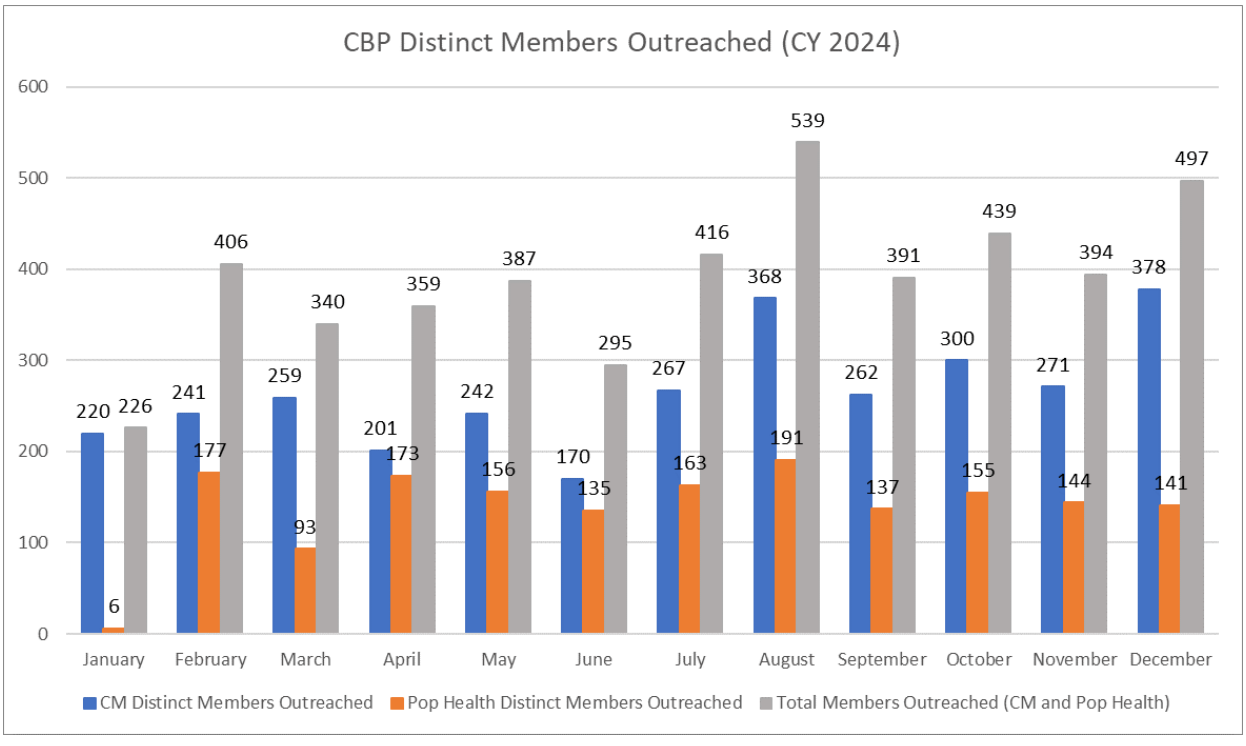
Percent of Members with Hypertension in at least 1 CM program 2024

Care Activity Type	Number of Activities	Members Served
Authorized BP Cuff	200	176
CBP Applications/Membership Assistance	2	2
CBP Benefit Resource Coordination	68	64
CBP Care Plan Update	30	28
CBP Condition Management	875	370
CBP Education Provided	83	82
CBP Engagement / Enrollment	179	171
CBP Food Security Coordination	3	3
CBP Health Acuity / Needs Assessed	1689	750
CBP Health Care Provider Coordination	59	54
CBP Language Services	88	57
CBP Medication Management	370	261
CBP Member Outreach	2139	658
CBP Other Community Resource Coordination	2	2
CBP Pharmacy Referral	1	1
CBP Provider Follow-up	8	8
CBP Tobacco Cessation Coordination	1	1
CBP Transportation Coordination	4	3
Does not meet criteria for BP Cuff	2	2
GIC Blood Pressure Outreach	893	465
PH CBP Medication Management	1510	890
PH CBP Member Outreach	1881	1001
PH CBP Provider Outreach	49	48
Grand Total	**10136**	**2215**

CBP Activities 2024

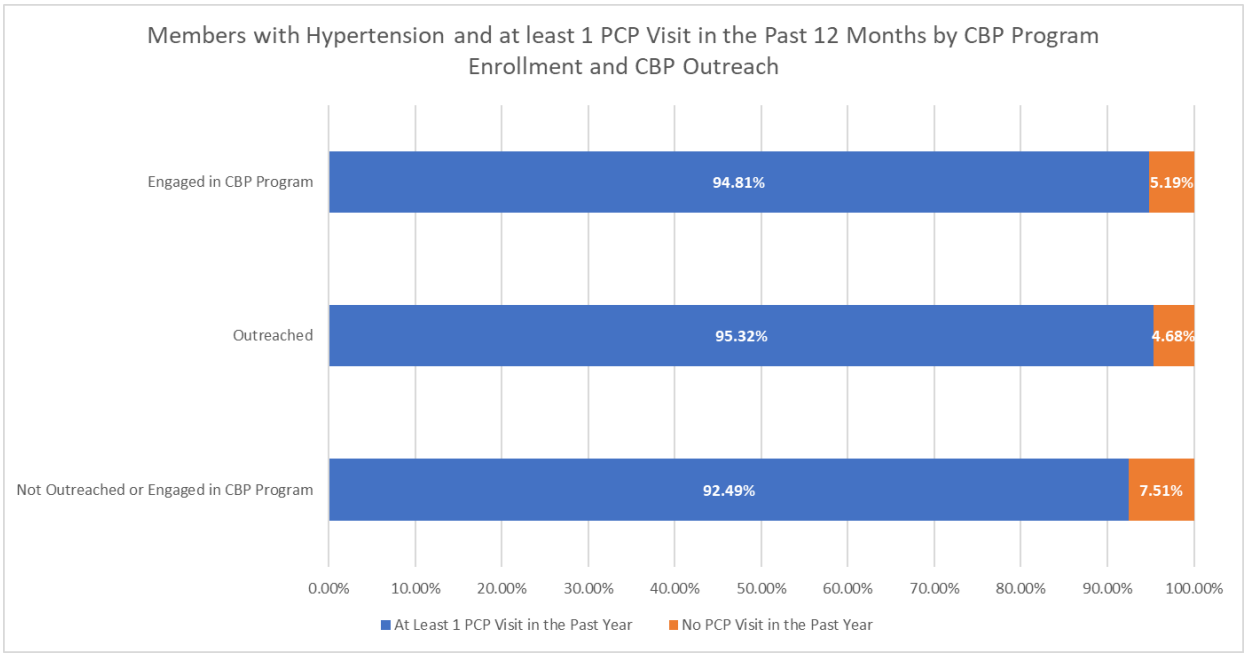


CBP Activities Performed 2024

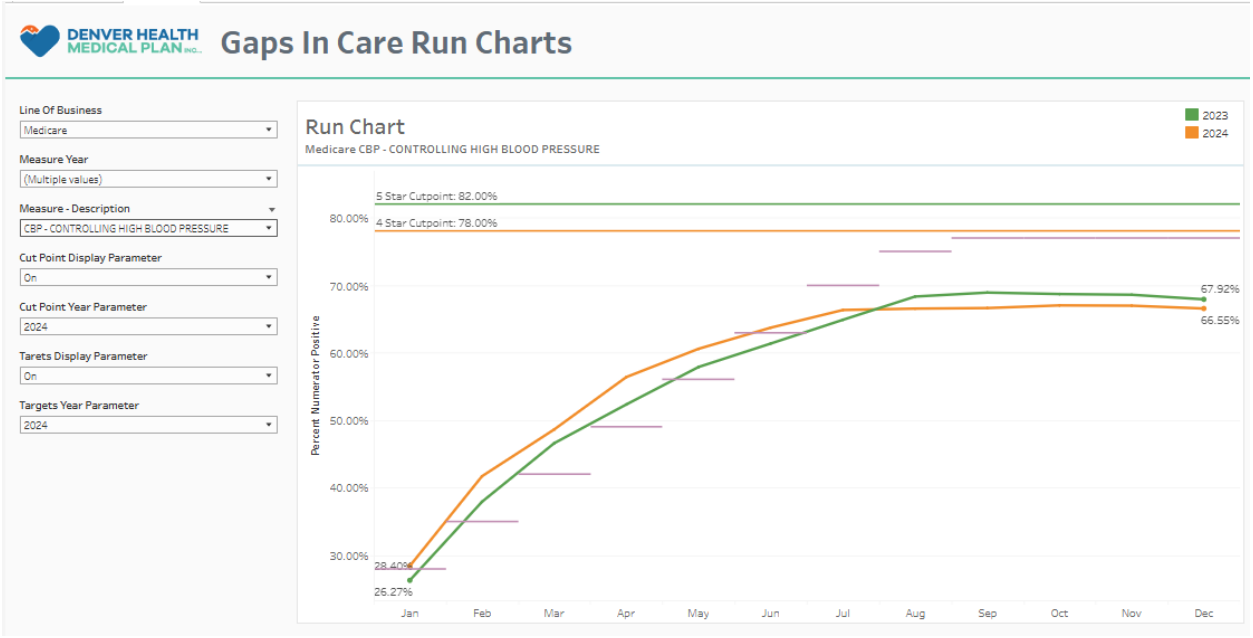


CBP Members Outreached 2024

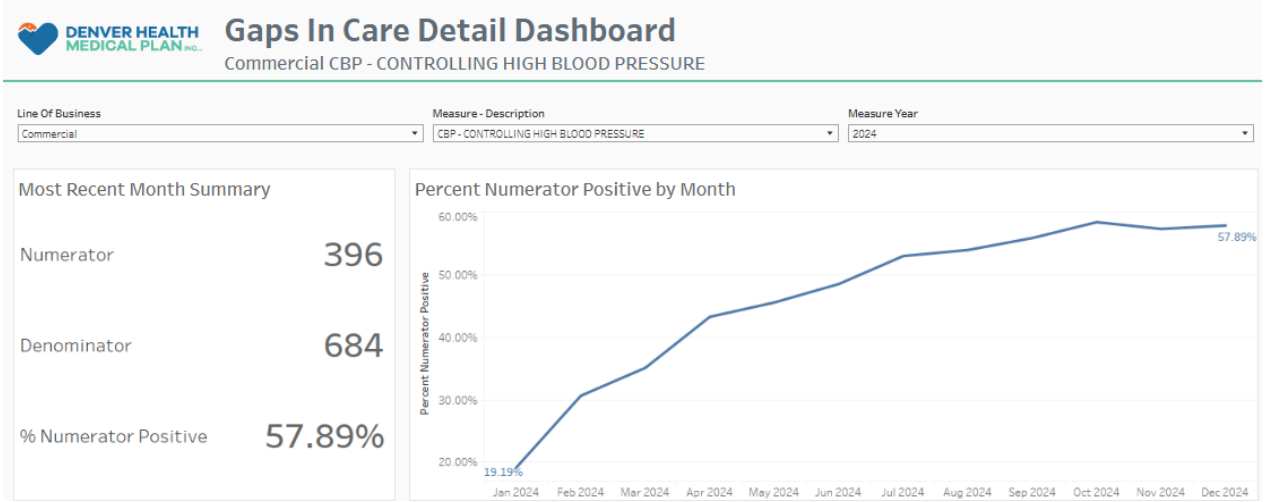
CBP Outcome Metrics:



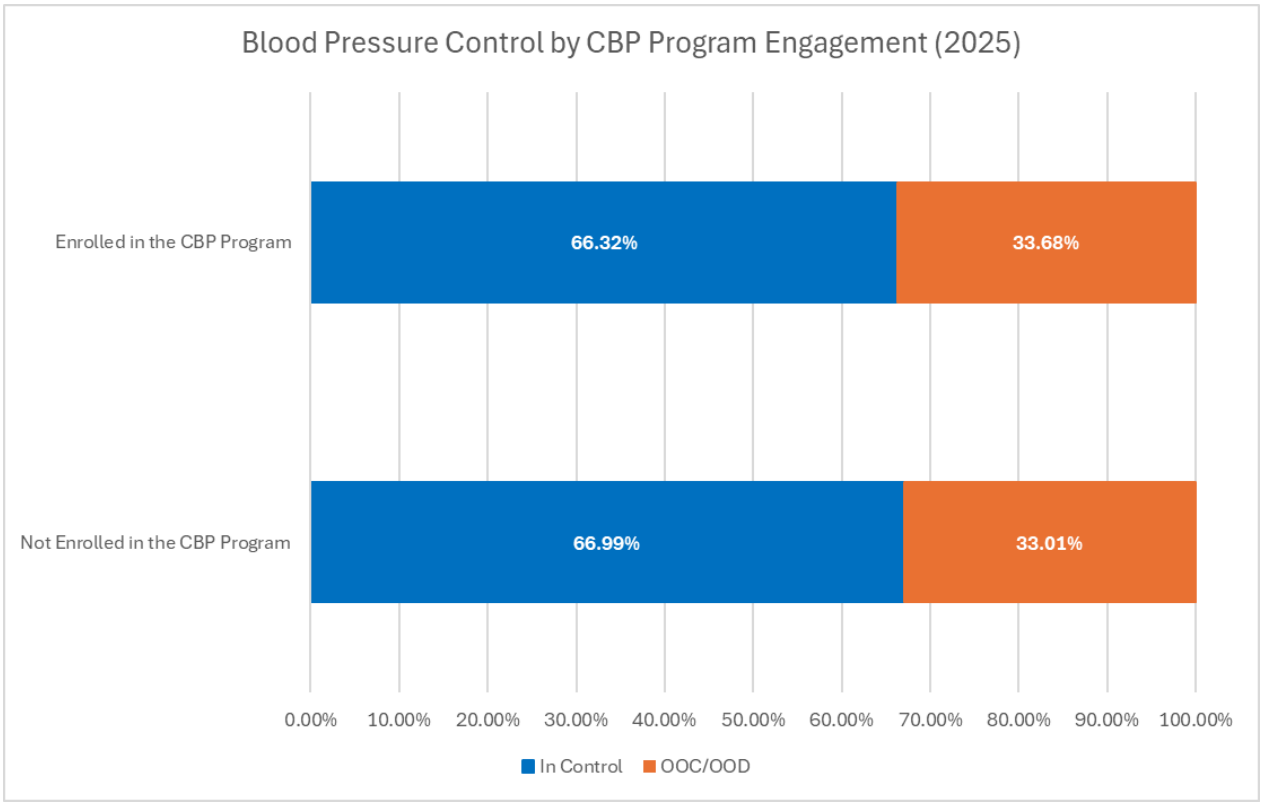
PCP Engagement by CBP Program Enrollment and CBP Outreach 2024



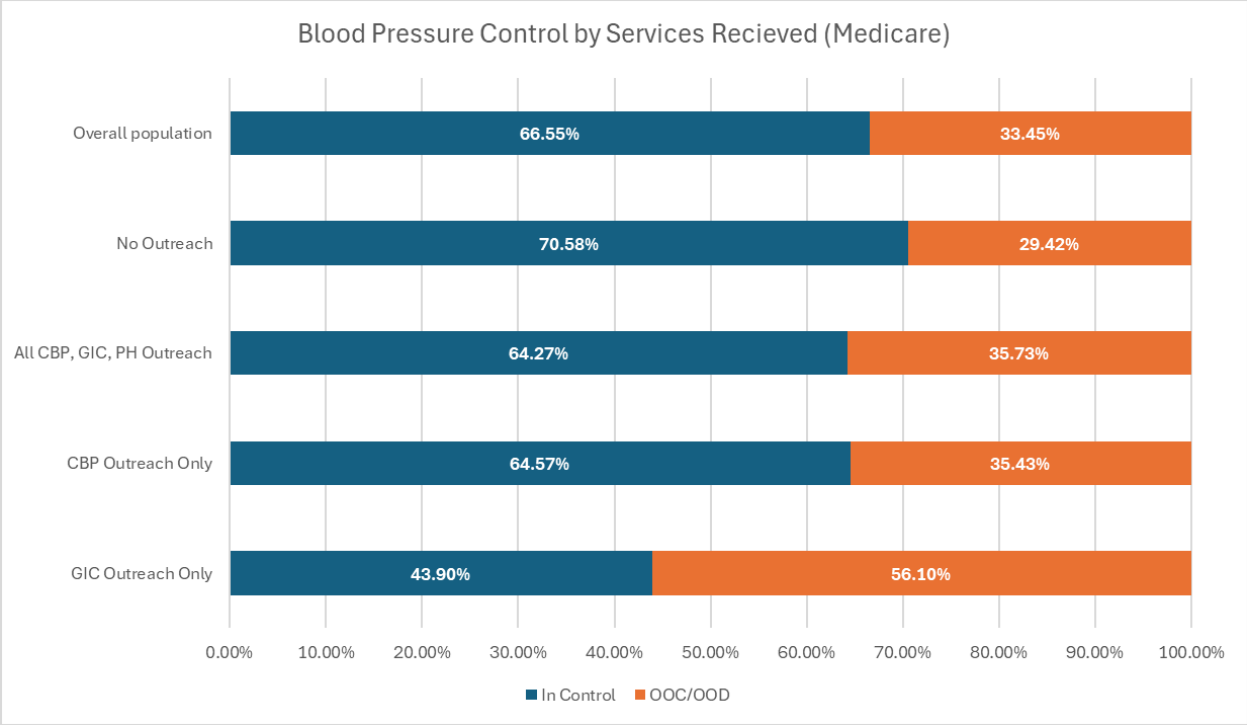
Controlling Blood Pressure (CBP) Rates - Medicare 2023 and 2024



Controlling Blood Pressure (CBP) Rates - Commercial and Exchange Members 2024



Blood Pressure Control by CBP Program Engagement 2024 (Medicare)



Blood Pressure Control by CBP, Population Health, and Gaps in Care (GIC) Outreach 2024 (Medicare)

Results/Analysis:

- 2215 Members were served under the CBP Program, CBP Gaps in Care Outreach, and Population Health outreach in 2025 across 10136 activities
  - 2044 members were enrolled in the CBP program in 2024
  - 465 Distinct Members received gaps in care outreach to support them with getting their blood pressure in control and their reading current
  - 176 members received support with getting a blood pressure cuff
  - 54 members received direct support with scheduling an appointment
- Members with hypertension who were enrolled in the CBP program (94.81%) or directly outreached by the CM or Population Health teams (95.32%) were more likely to have a PCP visit in the past 12 months than members who were not enrolled in the CBP program (92.49%)
- An average of 27.80% of Medicare and Exchange members had a diagnosis of hypertension in 2024
  - Of those diagnosed with hypertension, an average of 48.20% were enrolled in at least 1 CM program in 2024
    - Members with this condition may receive services outside of the CBP program
- Rates of blood pressure control for Medicare Members decreased between 2023 (67.92%) and 2024 66.55%).
  - Medicare Members enrolled in the CBP program were about as likely to have an in-control reading (66.32%) as those who were not enrolled in the program (66.99%)

        - The Care Management team targets our most vulnerable and high needs members for program services
    - Medicare members outreached for the CBP Program, Population Health, and Gaps in Care were less likely to have BP readings in control (64.27%) than those who received no outreach (70.58%)
        - Outreach efforts often focus on members whose BP readings are OOC/OOD, which may explain this discrepancy
            - 348 members outreached under CBP, Population Health, and Gaps in Care Outreach changed from out of control/out of date to in control reading
            - Members outreached only for gaps in care CBP outreach were more likely to have an out of control (OOC) or out of date (OOD) reading (56.10%) than an in-control reading (43.90%)
                - 82 members who received this outreach changed from OOC/OOD to in control
                - This was a new activity configured in August 2024 and does not represent efforts for the entire year
- Rates of blood pressure control for Commercial/Exchange members was 57.89% in 2024, an increase of nearly 6 percentage points from 2023 (51.92%)
    - A total of 33 Exchange members met criteria for the CBP measure in 2024, with 18 members (54.55%) having an in-control reading
    - A total of 24 Exchange members met criteria for the CBP measure in 2023, with 17 members (70.83%) having an in-control reading

Barriers/Lessons Learned:

- Compliance with this measure often “dips” towards the end of the year, which is influenced by multiple factors including seasonal illnesses, visits to urgent care, holiday stress, and poor compliance with diet during the holidays
    - The DHMP Care Management team will provide ongoing efforts to provide ongoing support and services to members with high blood pressure, including monthly chart reviews, supporting eligible members with obtaining a blood pressure cuff for home monitoring, and supporting members with follow up readings and visits after an out-of-control reading
    - The DHMP Care Management and Population Health teams will support members with home BP readings
- Engagement via telephonic outreach continues to be a large barrier for the team
    - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
        - The Wellframe application also offers:
            - Sending of resources, educational materials, and letters digitally
            - Biometric tracking that can be shared with the member’s care manager

- Self-management programs, including the opportunity for members to engage in a self-directed program
- Member assessments
- Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal

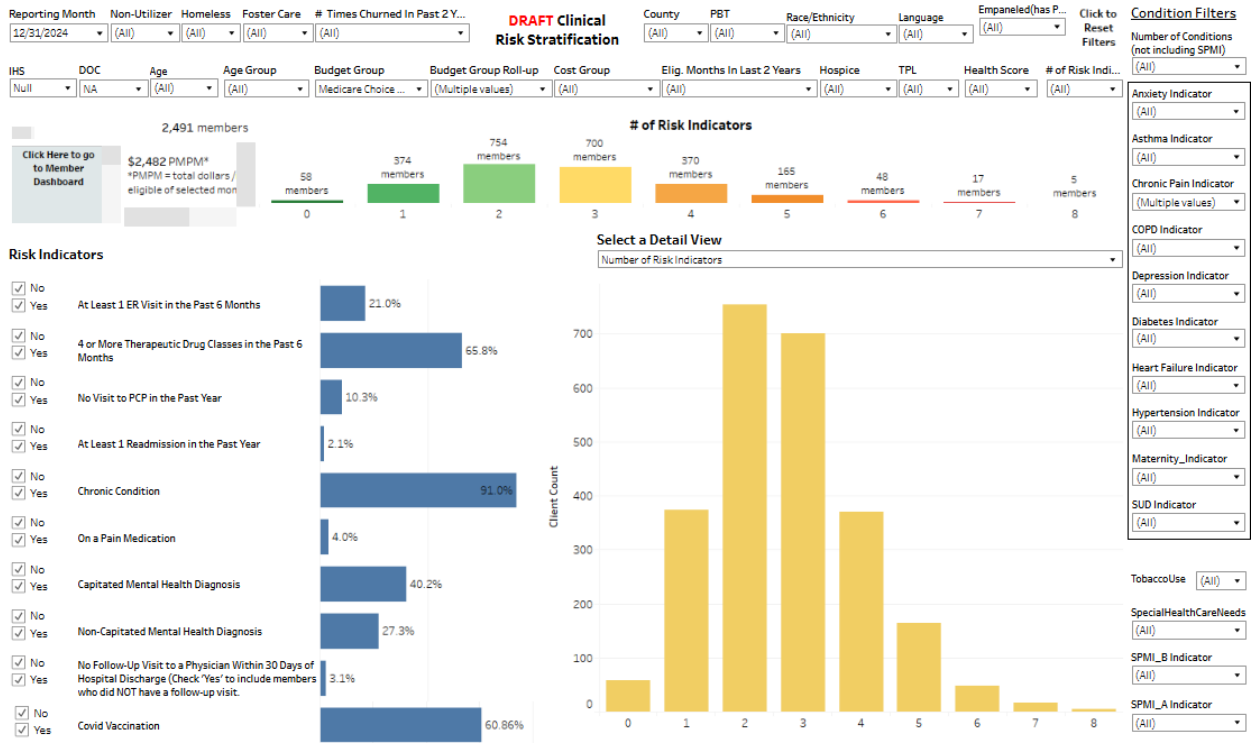
        - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
    - In 2024, DHMP's vendor for blood pressure cuffs under their Medicare benefit saw a backlog and delays in delivery
        - Members are encouraged to use their over-the-counter benefit to purchase a blood pressure cuff to prevent delays in monitoring and care
    - Program enrollment for members with hypertension trended downward throughout the year
        - We are seeing higher overall attribution and rates of members with this condition without additional resources to support these members
        - The number of members enrolled in at least 1 CM program has remained relatively stable
        - The CM team will look for alternative ways to engage these members in 2025, such as through the Wellframe application and self-management programs
    - There is room to improve engagement of members in the CBP denominator
        - In CY 2024 the CM team will generate outreach lists which focus on numerator negative members in this measure, but delays in Gaps in Care reporting is a challenge
            - The CM team will explore opportunities to obtain more real-time data to support members

Program Name: **Dual Special Needs Program (DSNP) – Available to all DHMP Medicare Choice SNP Members:**

This is a Comprehensive Care Management program for our Dually Eligible Medicare and Medicaid members. All members in our Medicare Choice plan are enrolled in this program. Members can opt-out to participate in their own care but will still be outreached for Initial Health Risk Assessment (HRA), Transitions of Care (TOC), Change of Condition (COC), and Annual Health Risk Assessments (HRAs). HRA's are completed within 90 days of enrollment and annually thereafter. Individualized Care Plans (ICP) are completed on every member. The ICP is completed upon enrollment, updated at least annually and is an on-going plan of care with member. ICT – Care Plan Meetings are completed on every member, and member involvement is encouraged. ICT Care Plan Meetings are completed upon enrollment, annually, and after a transition of care episode. Any time there is a change in condition with a member, the Individual Care Plan is updated and reviewed by the ICT committee.

2024 DSNP Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Population Overview (12/31/2024):



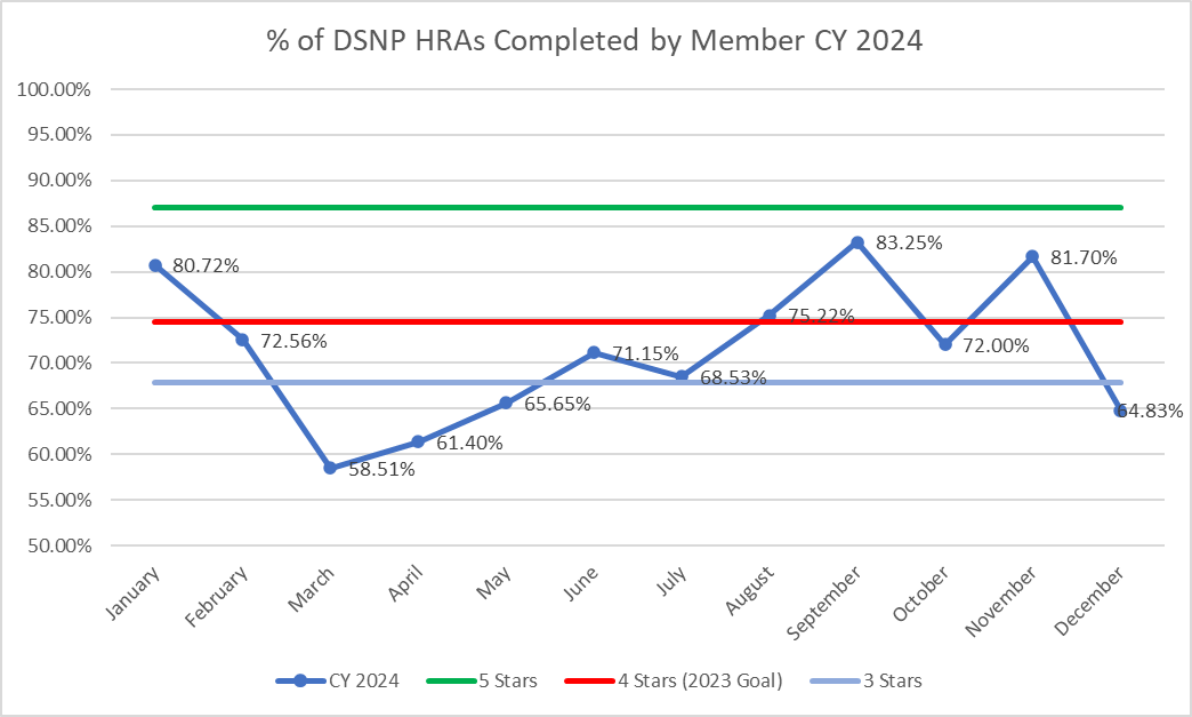
DSNP Membership as of 12/31/2024 (Risk Stratification Tool)

DSNP Activity Metrics:

Activity Name	Number of Activities	Members Served
DSNP - OON Provider	35	27
DSNP Annual HRA Outreach	3520	1367
DSNP Applications/Membership Assistance	239	146
DSNP Benefit Resource Coordination	2592	1126
DSNP Care Plan Update	10484	3157
DSNP Clinical Member Outreach	10692	2978
DSNP Clinical Outreach	799	362
DSNP Condition Management	208	141
DSNP Dental Care Coordination	171	107
DSNP Disenrollment Final Summary	1261	1205
DSNP Education Provided	1243	784
DSNP Food Security Coordination	558	318
DSNP General HRA Initial	391	381
DSNP General HRA Reassessment	647	644
DSNP Health Care Provider Coordination	1434	783
DSNP High Risk	273	189
DSNP Home Health Coordination	45	33
DSNP Housing Resource Coordination	205	110
DSNP HRA Initial Assessment	803	781
DSNP HRA Reassessment	1783	1638
DSNP ICP Goals / Barriers Communicated to Care Team	16	14
DSNP ICT Meeting	4540	3051
DSNP ICT Pharmacy Review	2977	2185
DSNP ICT/TOC Meeting	107	100
DSNP Immunization Coordination	1	1
DSNP Initial HRA Outreach	1570	641
DSNP Language Services	3649	935
DSNP Low General Risk	959	865
DSNP Low Risk	1901	1538
DSNP LTSS Coordination	460	156
DSNP Medication Management	1176	836
DSNP Moderate Risk	1075	824
DSNP Other Community Resource Coordination	395	203
DSNP Peer/Support Groups	2	2
DSNP Pharmacy Member Outreach	283	191
DSNP Pre-ICT Summary	4423	3080
DSNP Provider Follow-up	12500	3182
DSNP Tobacco Cessation Coordination	32	14
DSNP TOC Care Plan Update	2645	744
DSNP TOC Follow-up	2278	492
DSNP TOC Health Acuity / Needs Assessed	2389	677
DSNP TOC ICP Goals / Barriers Communicated to Care Team	2684	696
DSNP TOC Member Follow-up	6018	798
DSNP TOC Referral	579	323
DSNP Transportation Coordination	817	261
DSNP Utilities Coordination	7	7
PH DSNP ICT Pharmacy Review	568	380
PH DSNP Medication Management	1245	763
PH DSNP Pharmacy Member Outreach	1449	831
PH DSNP Pharmacy Provider Outreach	101	94
Grand Total	**94229**	**3948**

DSNP Activities 2024

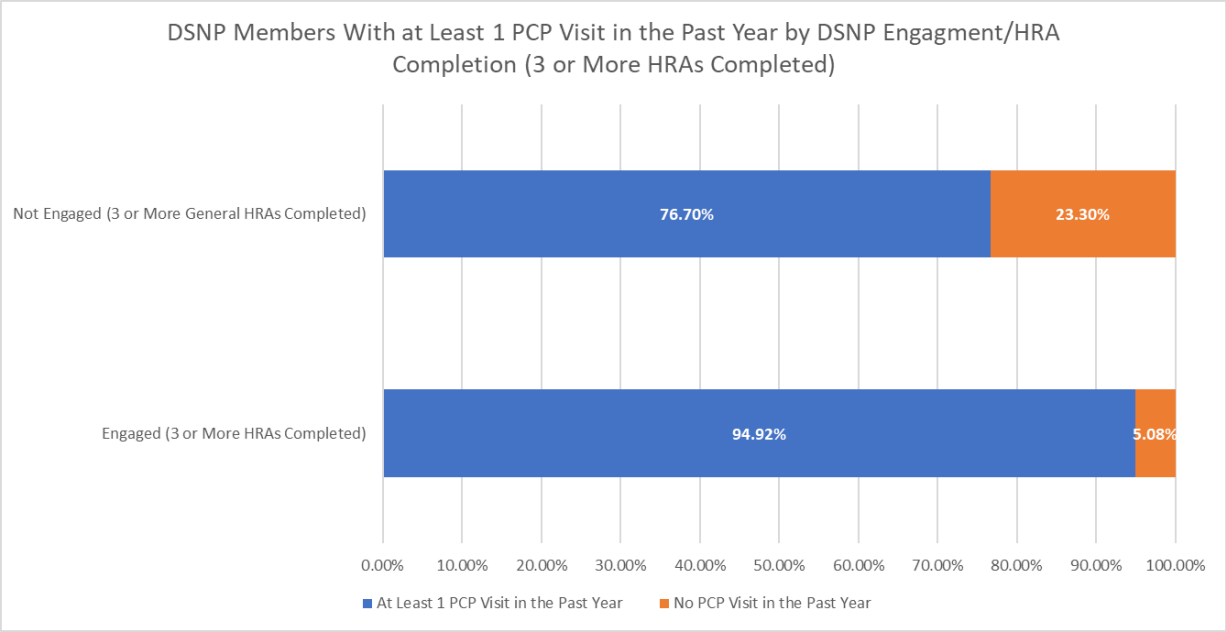
DSNP Outcome Metrics:



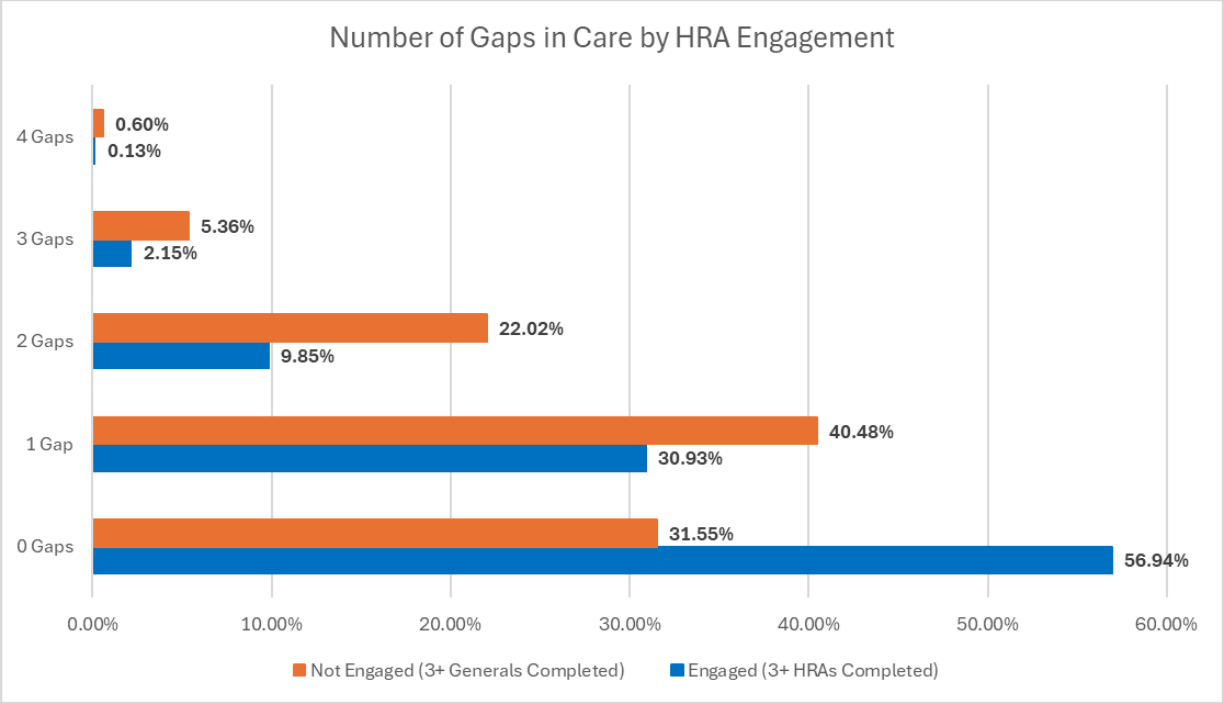
DSNP HRA Completion Rate 2024

DSNP Metrics	CY 2024
Total Health Risk Assessments Completed	3,606
HRA Completed by Member	2,550
Initial HRA Completed by Member	769
Annual HRA Completed by Member	1,801
Initial HRA General - Unable to Reach	331
Initial HRA General - Member Refused	61
Annual HRA General - Unable to Reach	577
Annual HRA General - Member Refused	87
DSNP HRA Completion Rate	71.29%

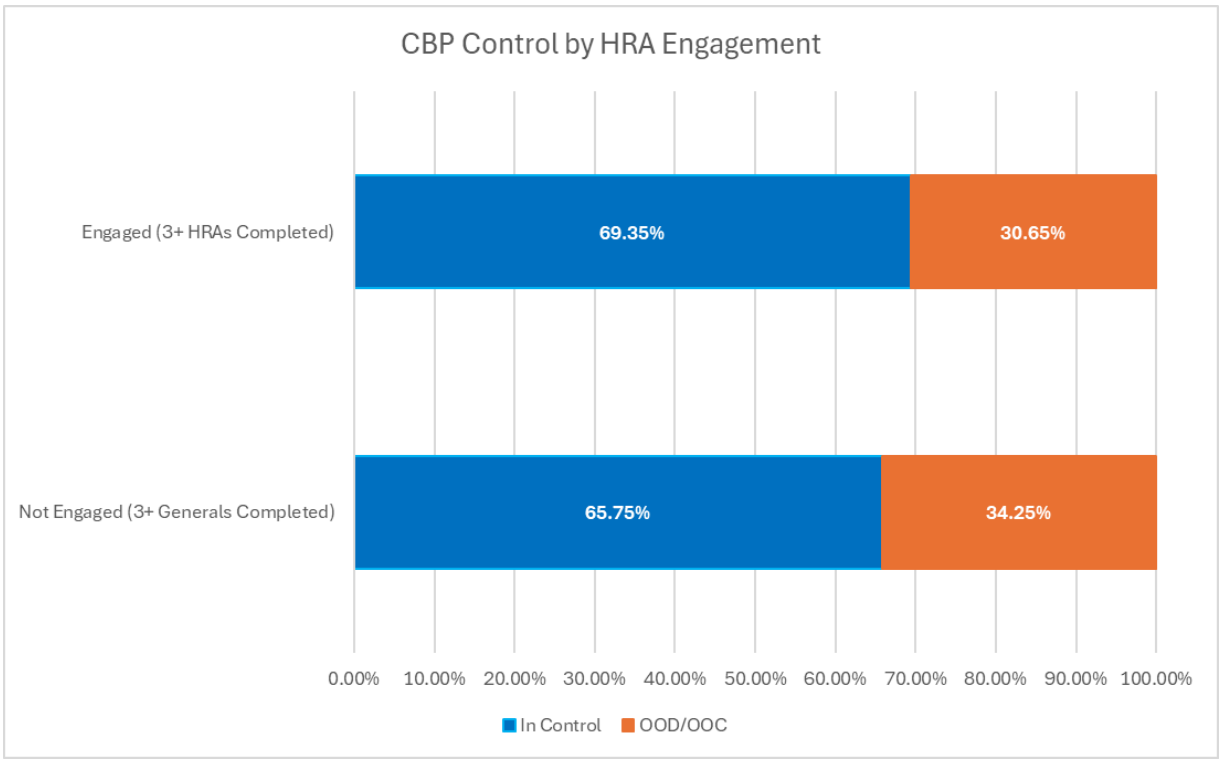
DSNP HRA Completion Rate 2024



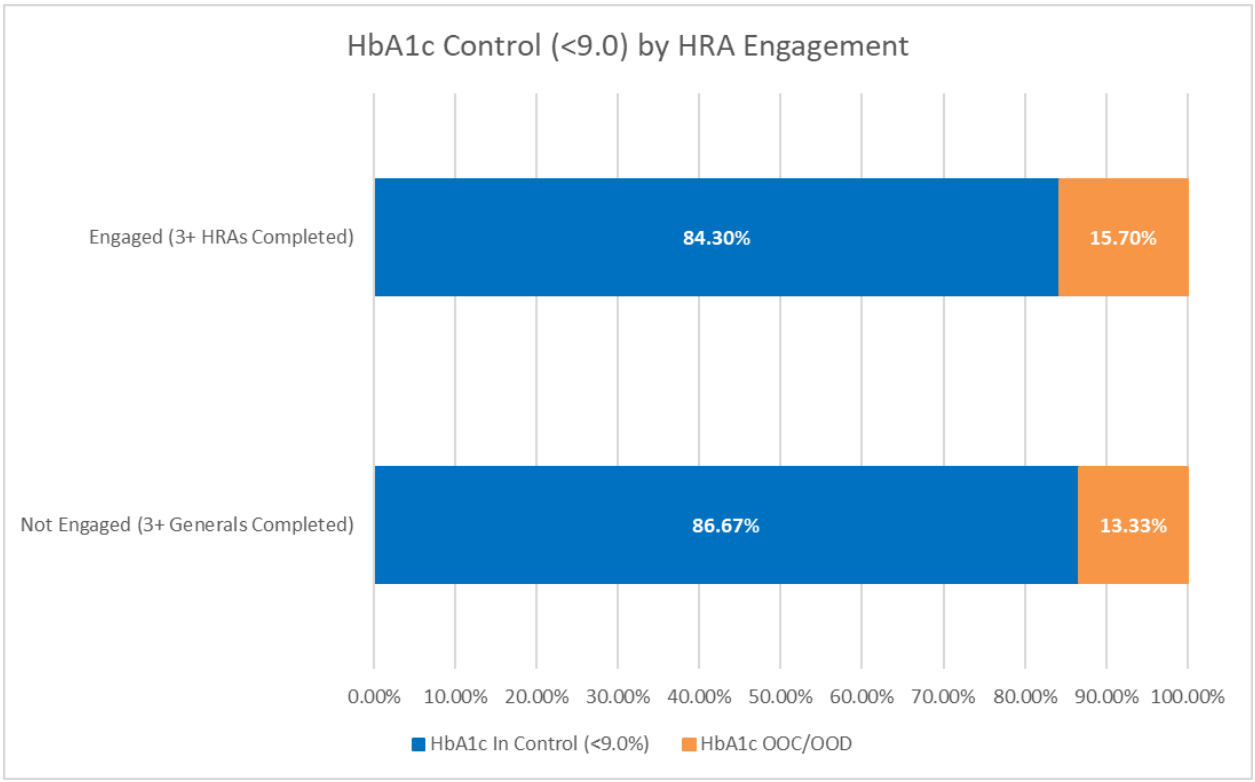
PCP Engagement by DSNP Engagement, 2024



Number of HEDIS Gaps in Care (GIC) by HRA Engagement, 2024



Blood Pressure Control by HRA Engagement, 2024



HbA1c Control by HRA Engagement (2024)

Results/Analysis:

- In 2024, a total of 3606 DSNP members were actively engaged in the DSNP CM Program
  - 2550 Total Health Risk Assessments were completed in 2024
- The HRA completion rate for 2024 was 73.33%, an slight increase from 2023 (72.96%)
- Members who are engaged in the DSNP Program (have participated in 3 or more HRAs) were more likely to have at least 1 PCP visit in the past year (94.92%) than those who were not engaged in the DSNP program (3 or more generals completed; 76.70%)
- Members who are engaged in the HRA process (have participated in 3 or more HRAs) tend to have fewer gaps in care than members who were not engaged in the HRA process (member has 3 or more general HRAs)
  - 56.94% of members engaged in the HRA process had 0 gaps in care, compared to 31.55% of members who were not engaged in the HRA process
  - Rates for members who were engaged in the HRA process (member completed 3 or more HRAs) were more likely to have a BP in control (69.35%) as those who were not engaged in the HRA process (member completed 3 or more generals, 65.75%)
  - Diabetic members engaged in the HRA process were slightly less likely to have an HbA1c reading that is in control (<9.0, 84.30%) than members who were not engaged in the HRA process (86.67%)
    - Rates for 2024 are estimated due to a data integrity issue with December 2024 data
      - Rates were estimated using November and December 2024 data
    - The rate of in control HbA1c reading for members engaged in the HRA process increased from 2023 rates (78.83%)
    - The number of members in the GSD measure who were not engaged in the HRA process is small (N=45), while 293 members were engaged in the process, making it difficult to compare rates

Barriers/Lessons Learned:

- Engagement via telephonic outreach for the HRA failed to reach 25.18% of our members in 2024
  - In November 2024, DHMP implemented the Wellframe application to offer bi-directional encrypted messaging between CMs and their members
    - The Wellframe application also offers:
      - Sending of resources, educational materials, and letters digitally
      - Biometric tracking that can be shared with the member's care manager
      - Self-management programs
      - Member assessments
      - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
  - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the

team's ability to engage members both Telephonically and through the Wellframe Application

- Many members stopped participating in the HRA process when they are asked questions about their behavioral health, meaning that the HRA cannot be counted as complete
  - In 2024, the DHMP CM team reduced the number of behavioral health related questions and moving them to the end of the assessment may help members complete the HRA more fully
    - The focus is to reduce barriers for members to complete the HRA by moving behavioral health related questions to the end of the assessment
- In 2024, the medical plan had an issue with mail which impacted timely delivery of HRAs from May through August 2024
  - The issue has been resolved; however, this impacted the overall HRA rate for 2024
- In 2025, DHMP will continue using the HRA incentive to improve member engagement in CM services

Program Name: **Medicare Select Care Management:**

The goal of this program is to support Medicare Select Members to achieve goals outlined by their individual care plan and work through barriers to achieving those goals. The Care Management team provides members support with access to care and disease management, with a specific focus on controlling blood pressure and diabetes management. Members are identified as being appropriate for ongoing care management based upon physical health, behavioral health, and/or social determinants of health criteria. Members are connected with resources for health and wellness, self-management programs, PCP coordination, behavioral health, disease management, medication management, and educational resources.

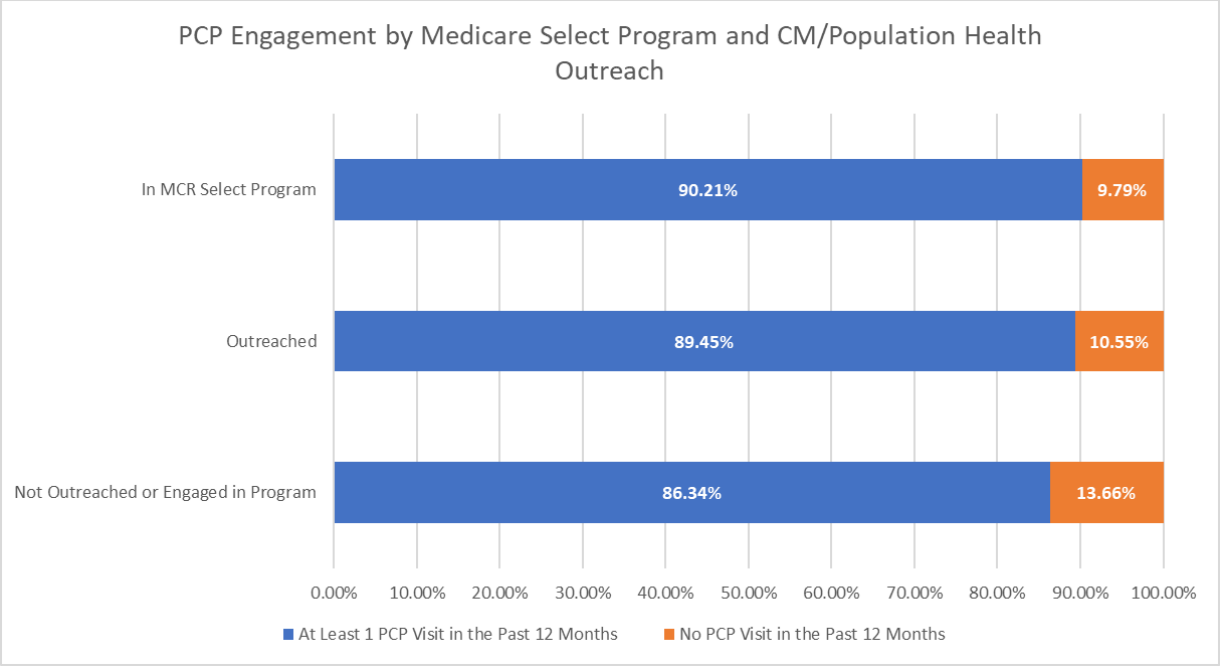
2024 MCR Select Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Medicare Select Activity Metrics:

Activity Name	Activities Performed	Members Served
MCR Select Applications/Membership Assistance	16	13
MCR Select Benefit Resource Coordination	240	121
MCR Select Care Plan Update	10	9
MCR Select Condition Management	13	13
MCR Select Education Provided	33	27
MCR Select Food Security Coordination	16	9
MCR Select Health Acuity / Needs Assessed	43	35
MCR Select Health Care Provider Coordination	105	65
MCR Select Housing Resource Coordination	9	4
MCR Select Language Services	249	137
MCR Select LTSS Coordination	5	3
MCR Select Medication Management	70	45
MCR Select Member Outreach	408	230
MCR Select Other Community Resource Coordination	14	8
MCR Select Pharmacy Member Outreach	6	5
MCR Select Pharmacy Referral	2	2
MCR Select Provider Follow-up	361	224
MCR Select Transportation Coordination	13	11
Medicare Select Annual Outreach	4	4
Medicare Select Initial Outreach	5	5
PH MCR Select Medication Management	709	416
PH MCR Select Member Outreach	661	398
PH MCR Select Pharmacy Member Outreach	921	478
PH MCR Select Provider Outreach	41	39
Grand Total	**3954**	**951**

Medicare Select Program Activities 2024

Medicare Select Outcome Metrics:



Results/Analysis:

- 951 distinct members received services under the MCR select program (552 members) and through population health Medicare Select outreach (523 members)
  - A total of 217 members (22.82%) were actively enrolled in the Medicare Select program in 2023
  - A total of 105 outreach calls were completed to assist members with scheduling appointments and accessing care
  - A total of 52 outreach calls were completed to assist members with SDOH related needs, such as food security, transportation, housing resources, utility resources, language services, and other community benefits
- Members who were enrolled in the Medicare Select Program were more likely to have visited their PCP in the past year (90.21%) than members who were outreached but not engaged in the Program (89.45%) or members who were not outreached or engaged in the program (86.34%)
- The team identified areas of focus to improve member health and reducing health care costs by improving member adherence to treatment recommendations, improving communication and coordination among health care providers, and increasing access to support services
  - Health Care Provider Coordination and assistance for SDOH related needs are the two most frequently used services in the program
  - These services are crucial to ensure that members stay connected to care and have the resources that they need to manage their health and well-being

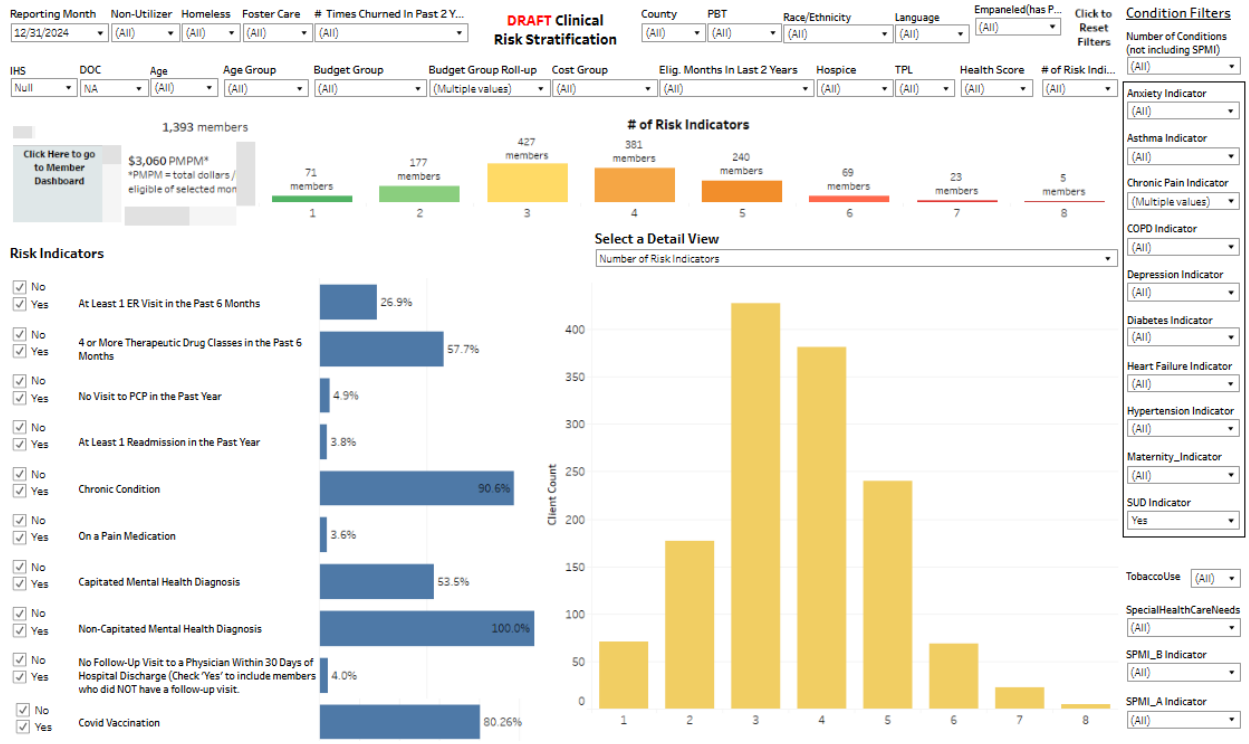
Barriers/Lessons Learned:

- Many Medicare Select members receive services under other programs, such as Transitions of Care and Condition Management Programs
- Engagement via telephonic outreach continues to be a large barrier for the team
  - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
    - The Wellframe application also offers:
      - Sending of resources, educational materials, and letters digitally
      - Biometric tracking that can be shared with the member's care manager
      - Self-management programs, including the opportunity for members to engage in a self-directed program
      - Member assessments
      - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
  - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
- Sicker members may be less likely than healthier ones to enroll and participate in programs and/or care coordination activities
  - Members voice they did not have the energy to deal with another health care provider despite the team's efforts to convince these members that care coordination could be most beneficial precisely during these times

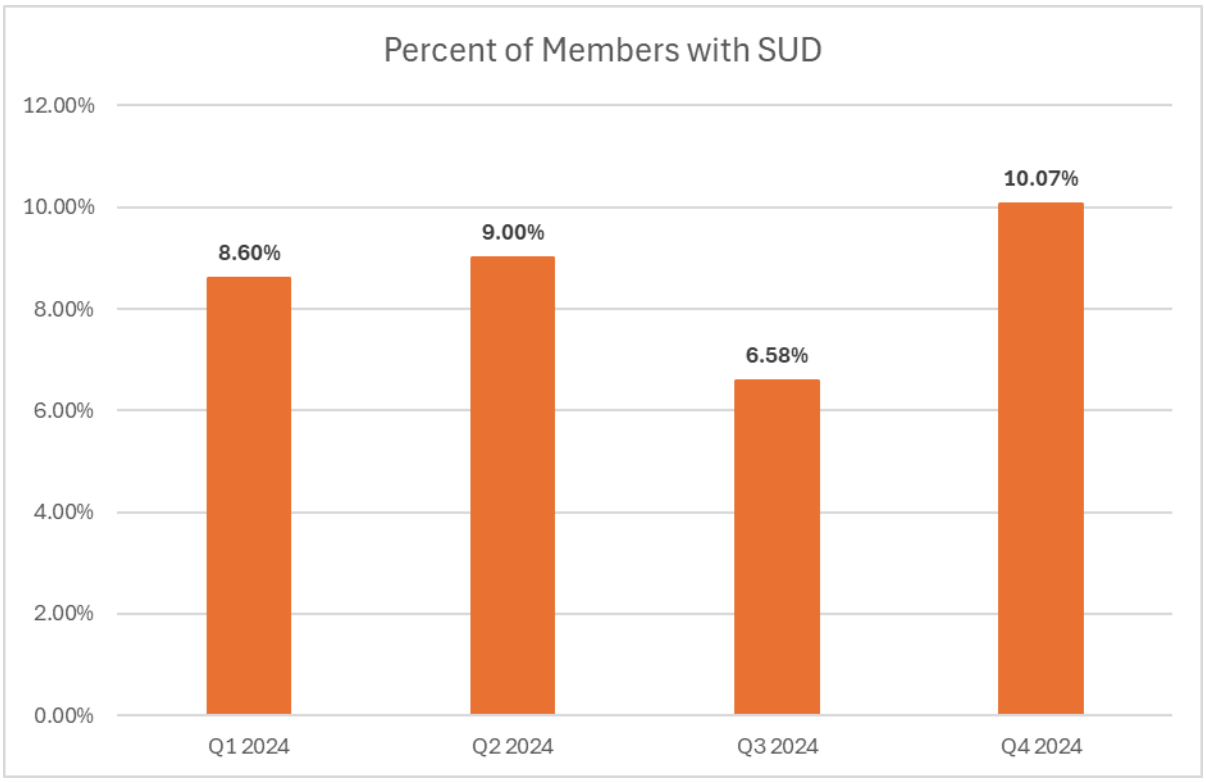
Program Name: **Substance Use Disorder (SUD) Care Management Program:**

The Substance Use Disorder (SUD) Program is available to all DHMP Members. The goal of this program is to assist and equip members in navigating through the recovery process, community resources, education, and programs. This program empowers members to manage their diagnoses and make informed, healthy choices that support physical and emotional well-being, as well as encourage members to engage in creating a foundation of relationships and social networks to provide support. Care Managers provide assistance with housing, transportation, education, resources, and physical and emotional health. Care Managers works closely with Utilization Management to ensure that members can access approved treatments, support groups, and/or community programs under existing benefits.
2024 Substance Use Disorder Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Population Overview (as of 12/31/2024):



Medicare and Exchange Members with SUD as of 12/31/2024 (Risk Stratification Tool)

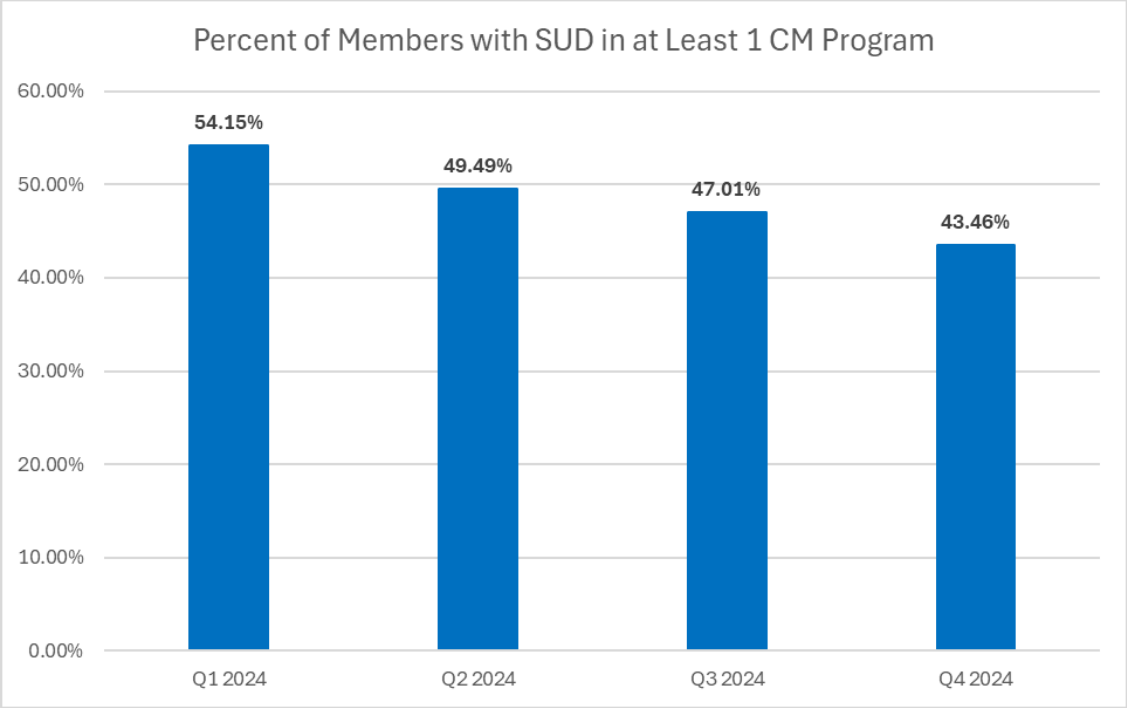


Percent of Members with SUD Diagnosis 2024

Substance Use Disorder Activity Metrics 2024:

Activity Name	Activities Performed	Members Served
DHMP COMM Behavioral Health / SUD Referral	7	2
SUD Applications/Membership Assistance	1	1
SUD Benefit Resource Coordination	309	196
SUD Care Coordination	4	4
SUD Health Care Provider Coordination	1	1
SUD Member Education Provided	2	2
SUD Member Outreach	959	587
Grand Total	**1283**	**761**

SUD Program Activities 2024



Percent of members with SUD in at least 1 CM program 2024

Results/Analysis:

- 761 Distinct Members were outreached for SUD services in 2024
- In 2024, an average of 8.56% of all Medicare and Exchange members had a SUD diagnosis
  - Of those members with SUD, an average of 48.52% were engaged in at least 1 CM program in 2024
    - Members with this condition can receive services in programs outside of the SUD program

- Members are identified through SUD treatment denials for UM, as well as through the Center for Addiction Medicine for Population Health initiation and engagement in treatment outreach
- Despite being a small program, services are necessary
    - Members with active SUD treatment needs tend to be higher acuity, have higher ED utilization, and are less likely to engage in preventative and primary care services
    - Successful SUD treatment is often the first step in helping members to engage in preventative care services and reduce incidents and accents that result in ED utilization and hospitalization (i.e., overdoses, falls, other accidents).

Barriers/Lessons Learned:

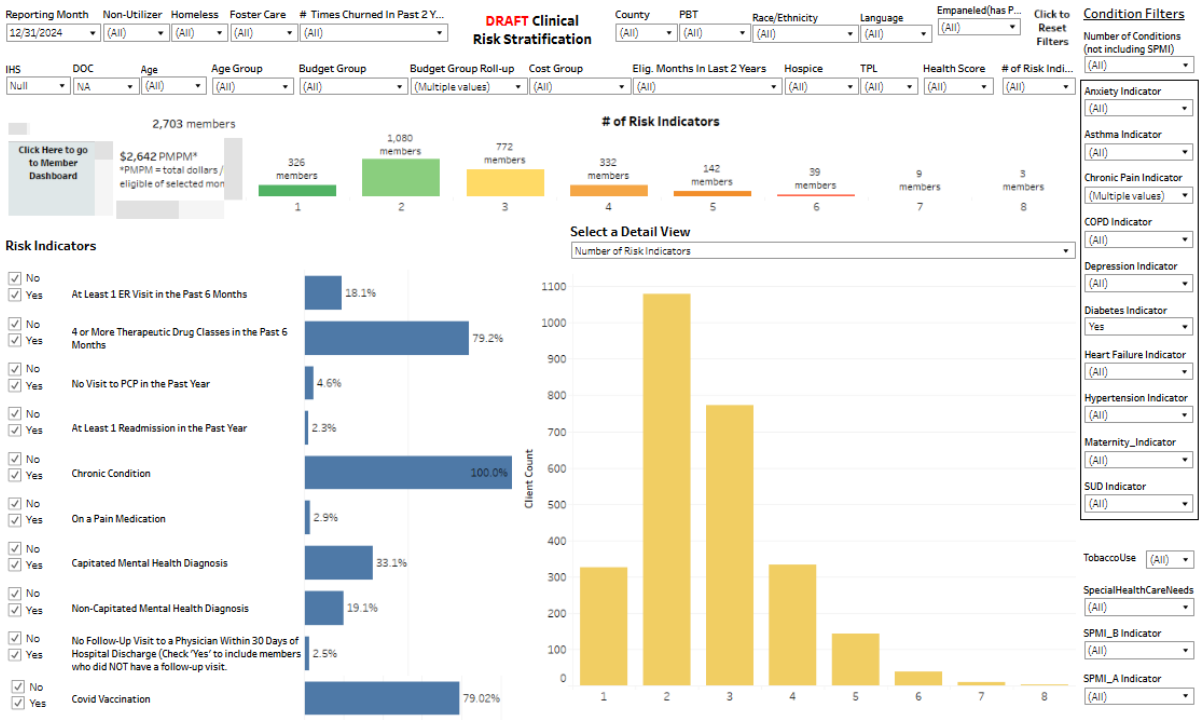
- Engagement via telephonic outreach continues to be a large barrier for the team
    - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
        - The Wellframe application also offers:
            - Sending of resources, educational materials, and letters digitally
            - Biometric tracking that can be shared with the member's care manager
            - Self-management programs, including the opportunity for members to engage in a self-directed program
            - Member assessments
            - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
    - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
- Program enrollment for members with SUD trended downward throughout the year
    - We are seeing higher overall attribution and rates of members with this condition without additional resources to support these members
    - The number of members enrolled in at least 1 CM program has remained relatively stable
    - The CM team will look for alternative ways to engage these members in 2025, such as through the Wellframe application and self-management programs
- Identification of members with a new SUD diagnosis can be challenging
    - DHMP is consistently working to improve its ability to identify members who may benefit from SUD services, which may result in an increase in referrals to this program
    - Care Management will continue to work to identify members in existing programs and during outreach who may benefit from SUD services
    - Many members may not be ready to receive SUD services through the CM team

Program Name: **Diabetes Care Management Program:**

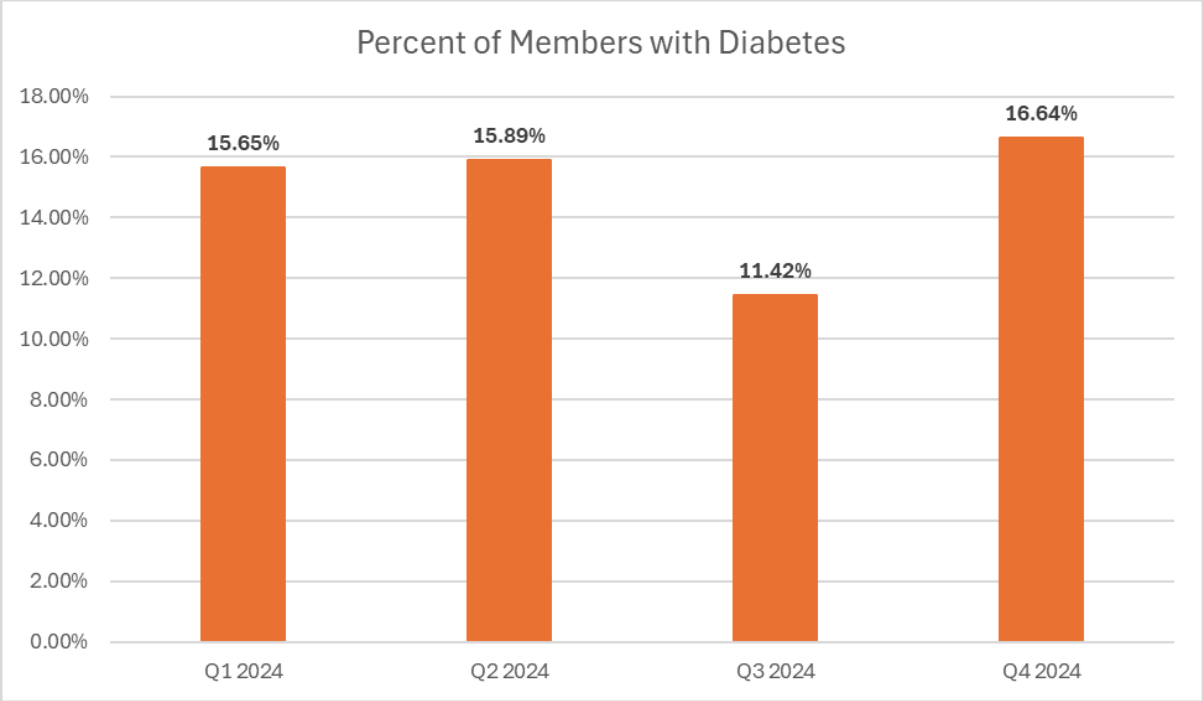
The Diabetes Care Management Program is available to members across all lines of business. This program is designed to improve quality care of Diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. DHMP collaborates with Denver Health Hospital Authority on peer and support groups and access to community programs. Care Managers assist members with accessing screening and access to behavioral health through Denver Health. Care Managers provide additional education and support to increase engagement with the healthcare system, identify changeable SDOH and decrease inequities in care and access to mental health for diabetic members.

2024 Diabetes Management Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

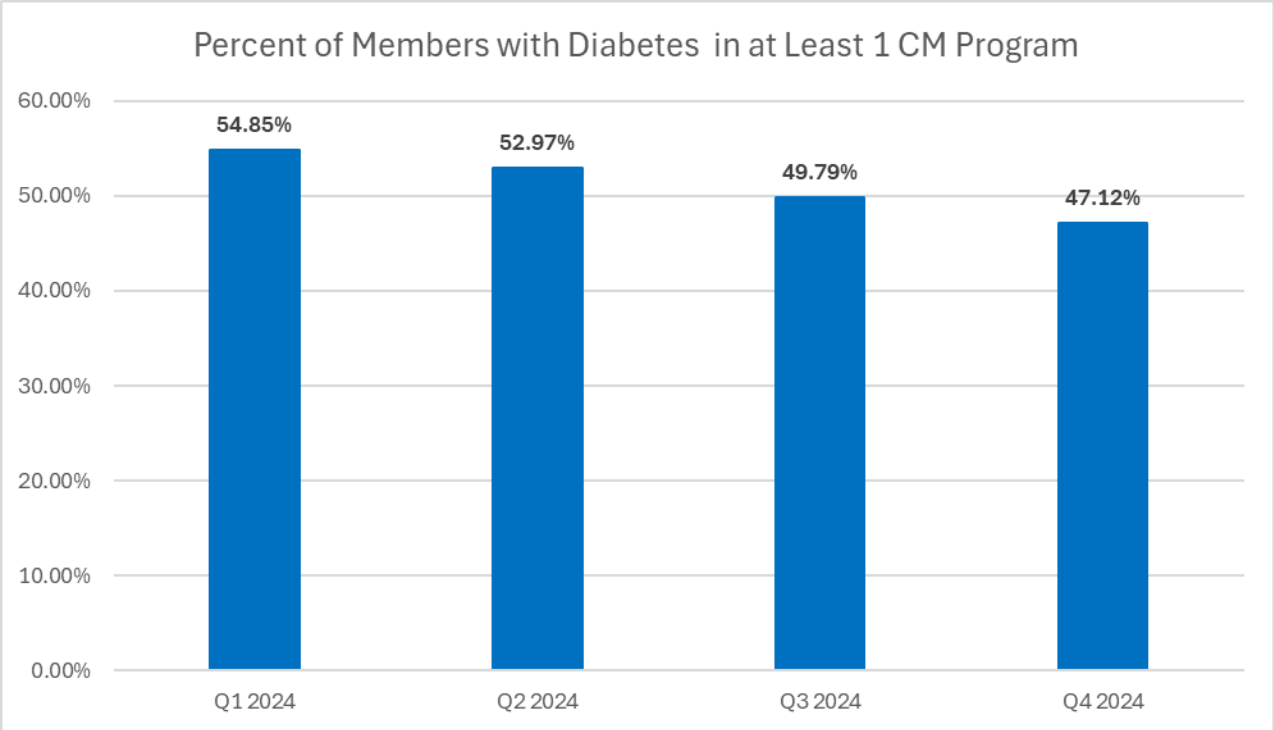
Population Overview (as of 12/31/2024):



Medicare and Exchange Members with Diabetes as of 12/31/2024 (Risk Stratification Tool)



Percent of Members with Diabetes 2024



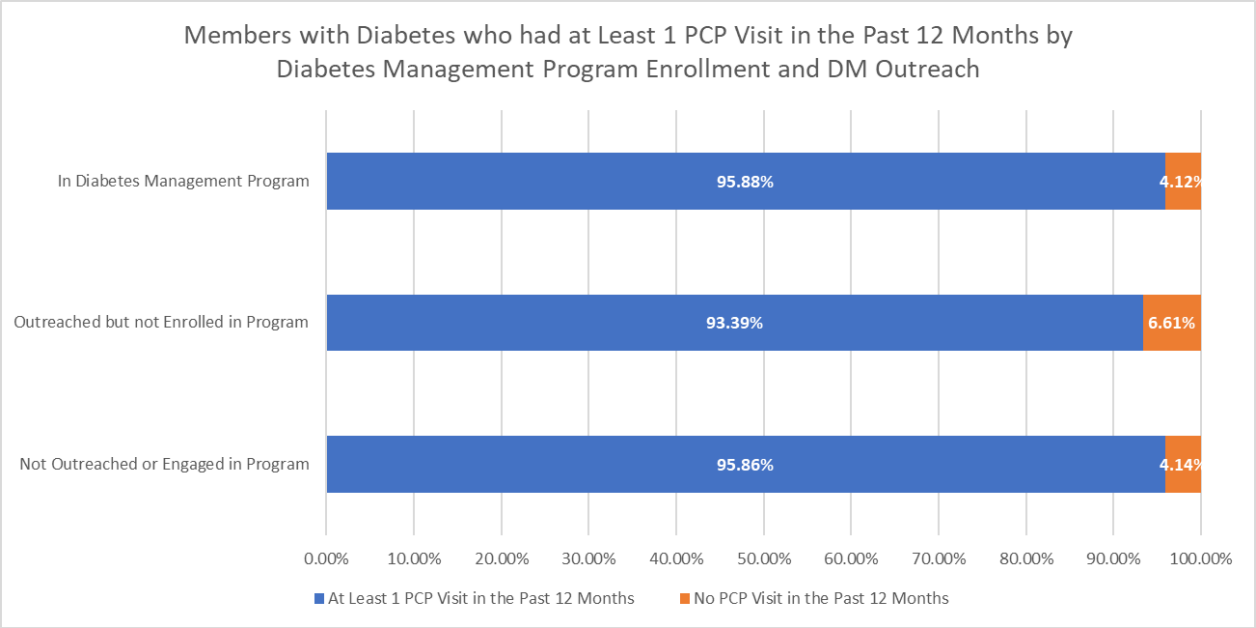
Percent of Members with Diabetes in at Least 1 CM Program (2024)

Diabetes Management Activity Data

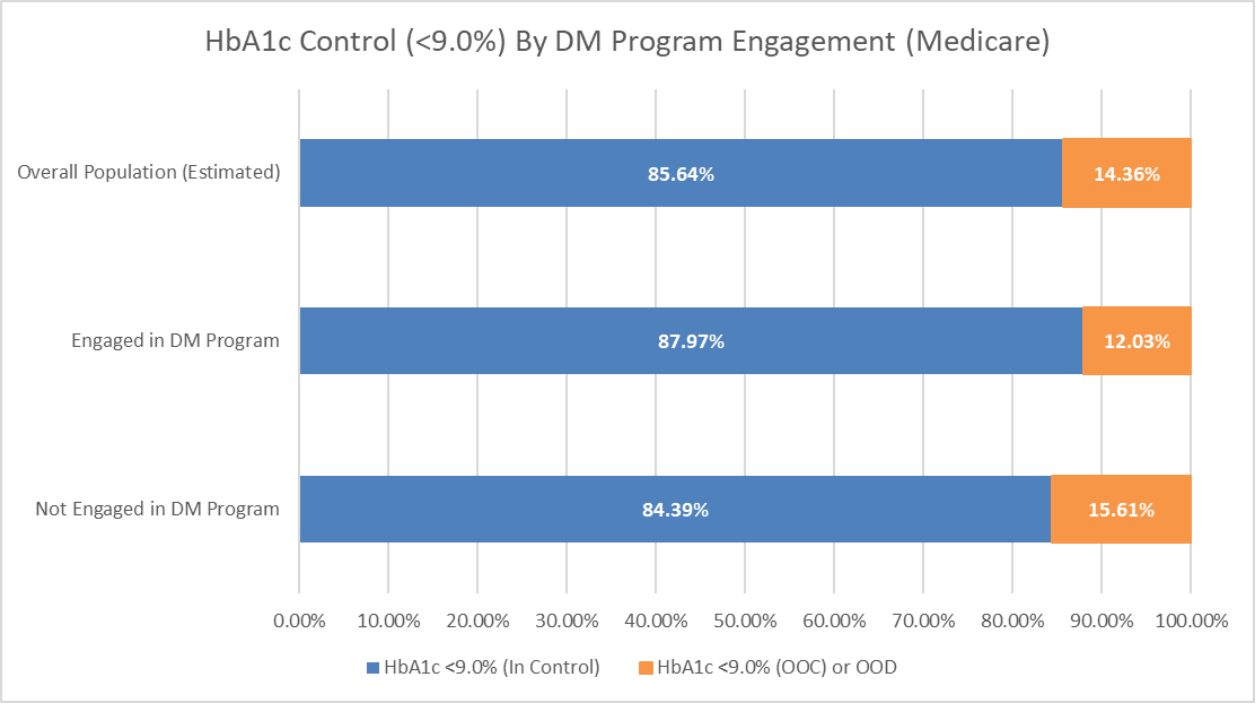
DM Activities	Activites Performed	Members Served
DM Assessment	7	7
DM Benefit Resource Coordination	77	31
DM Care Plan Update	143	108
DM Condition Management	194	156
DM Dental Care Coordination	11	8
DM Disenrollment Summary	12	12
DM Education Provided	96	54
DM Engagement / Enrollment	82	80
DM Food Security Coordination	3	2
DM Health Acuity / Needs Assessed	914	406
DM Health Care Provider Coordination	220	92
DM Housing Resource Coordination	20	5
DM ICT Meeting	2	2
DM Internal Activity	83	66
DM Language Services	105	35
DM LTSS Coordination	14	6
DM Medication Management	199	128
DM Member Outreach	1001	282
DM Nutritional Support	11	7
DM Other Community Resource Coordination	37	15
DM Other Follow-up	18	9
DM Provider Follow-up	160	73
DM Referral	19	15
DM Transportation Coordination	56	17
GIC DM Eye Exam Outreach	1036	453
GIC DM HBA1c Outreach	1156	582
GIC DM Kidney Health Eval Outreach	1623	781
PH DM Medication Management	568	360
PH DM Member Outreach	674	389
PH DM Provider Outreach	63	60
Referral to Diabetes Prevention Program (DPP)	2	2
Grand Total	**8606**	**1671**

Diabetes Management Program Activities 2024

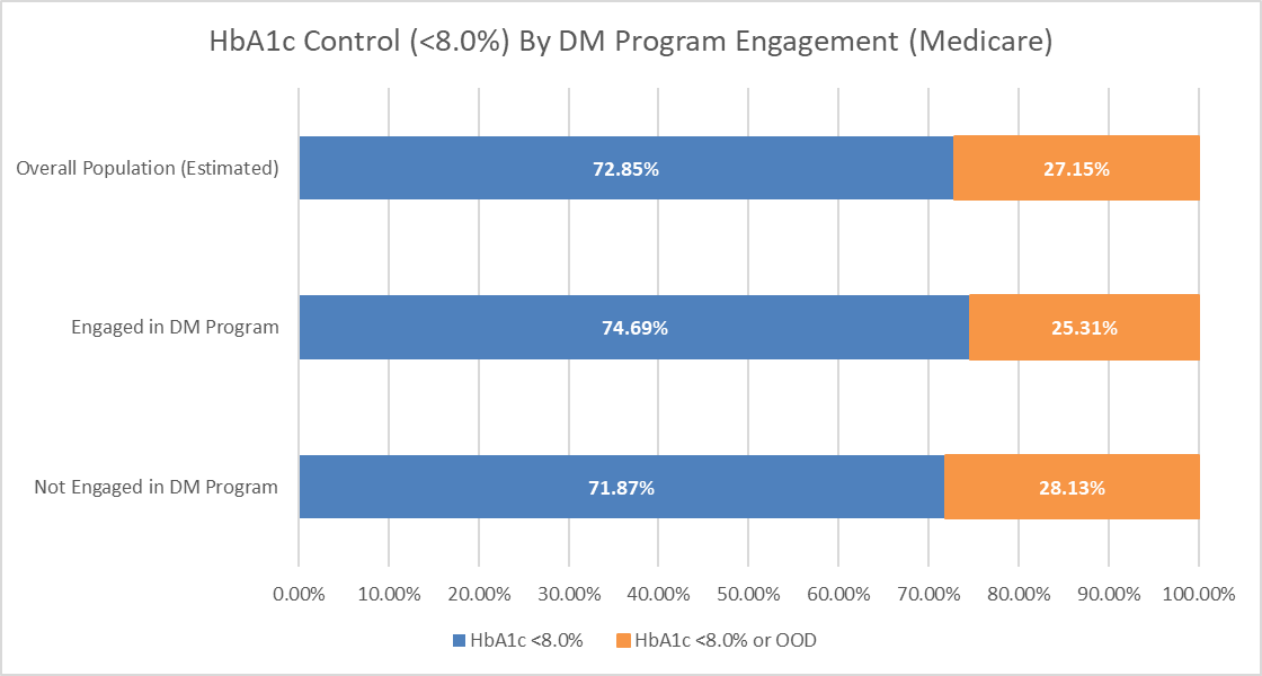
Diabetes Management Outcome Data



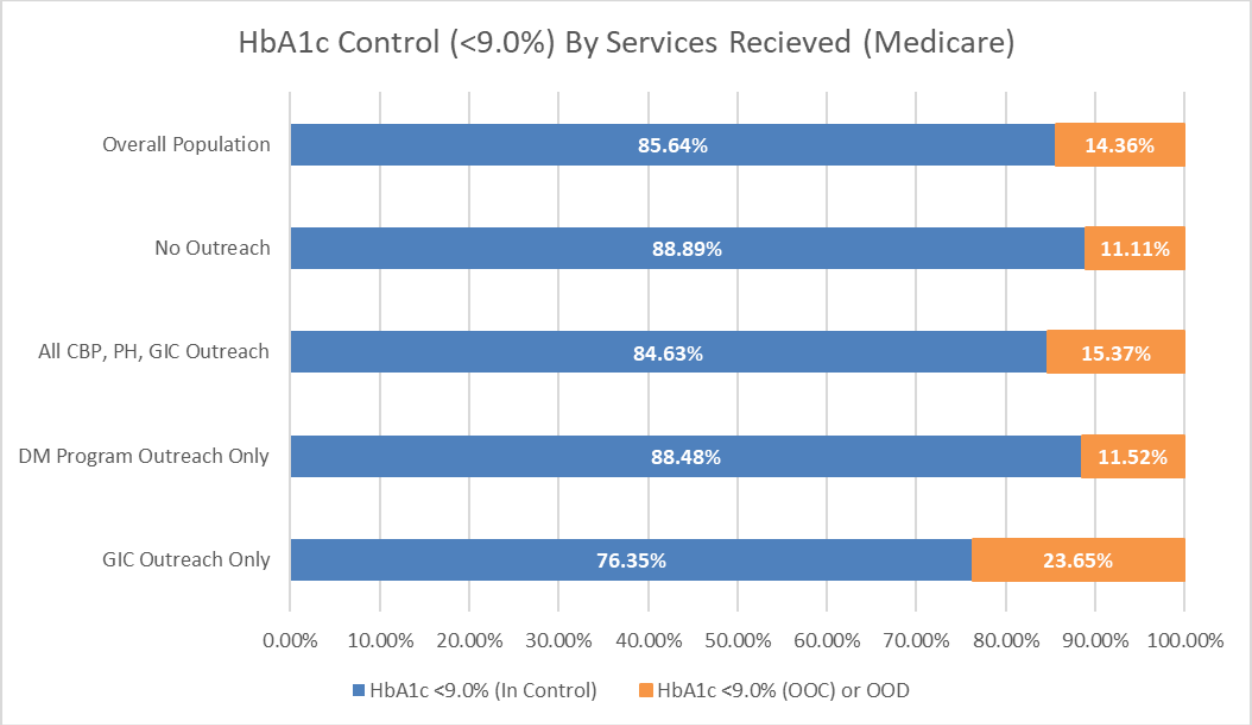
PCP Engagement by Diabetes Management Program Engagement and Outreach 2024



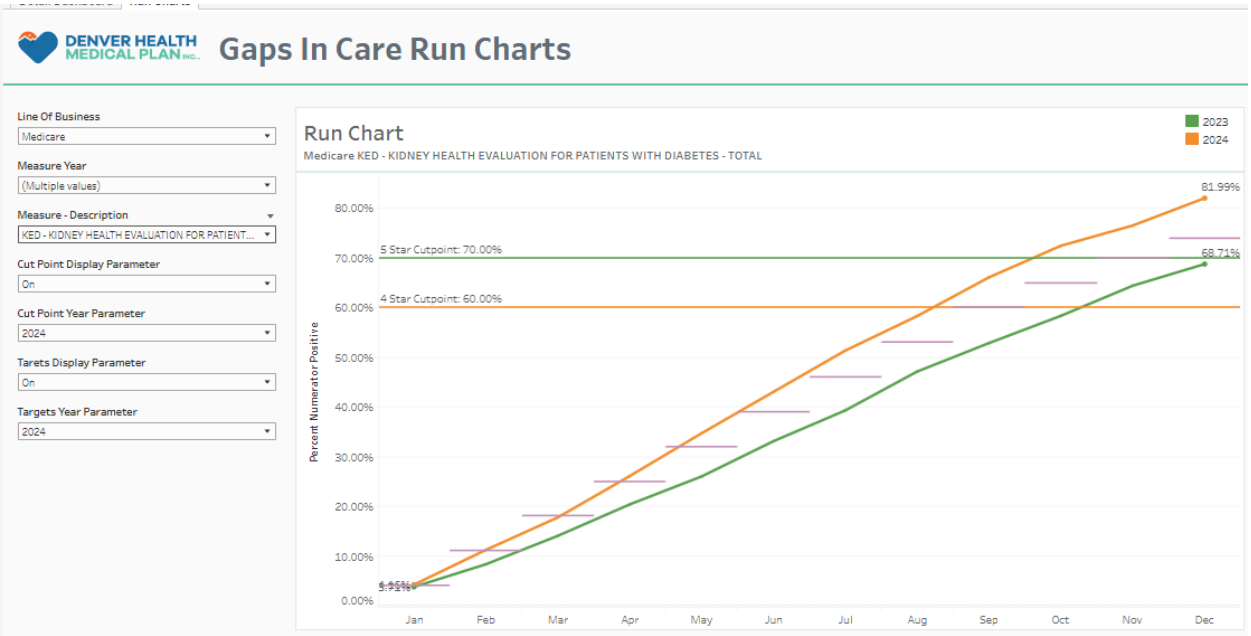
HbA1c Control (<9.0%) by Diabetes Management Program Enrollment 2024 (Medicare)



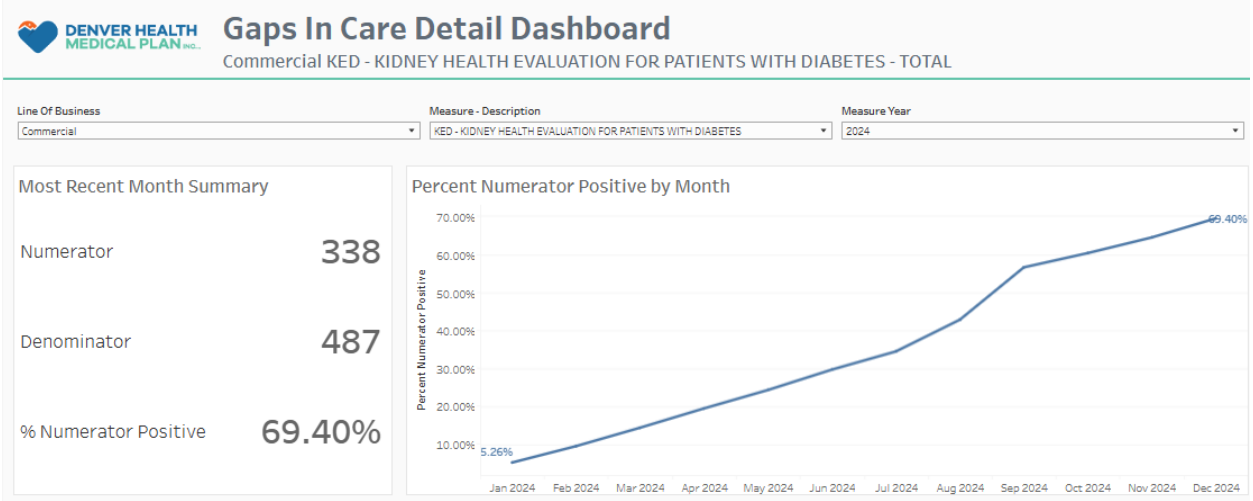
HbA1c Control (<8.0%) by Diabetes Management Program Enrollment 2024 (Medicare)



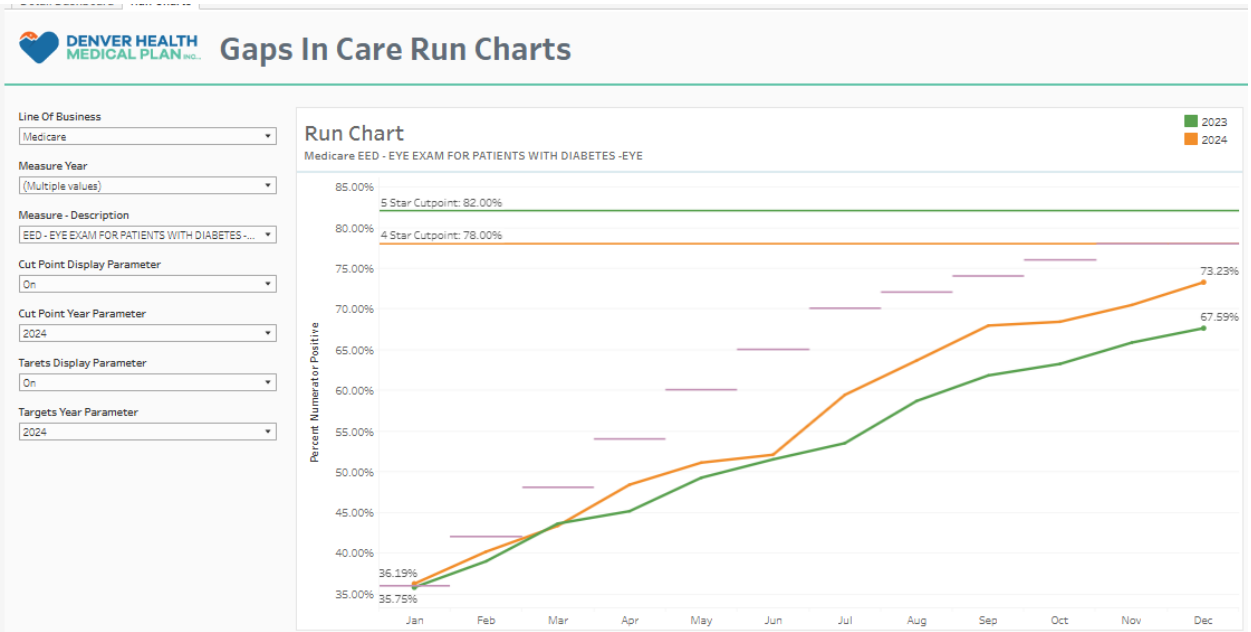
HbA1c Control by Services Provided (DM Outreach, Population Health (PH) Outreach, and Gaps in Care (GIC) HbA1c Outreach 2024 (Medicare)



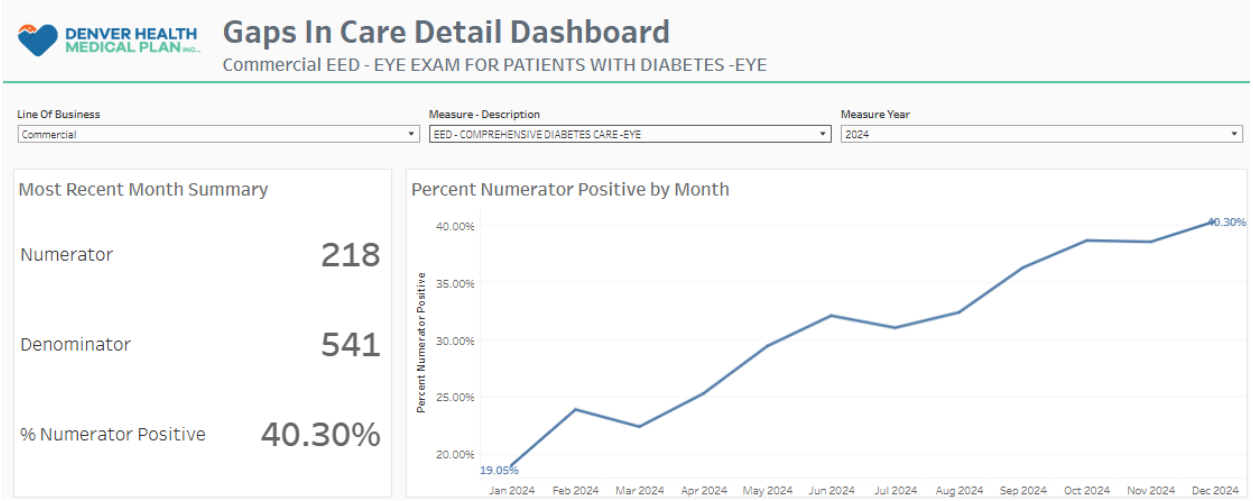
Kidney Health Evaluation (KED) - Medicare 2023 and 2024



Kidney Health Evaluation (KED) - Commercial and Exchange 2024



Eye Exam for Patients with Diabetes (EED) - Medicare 2023 and 2024



Eye Exam for Patients with Diabetes (EED) – Commercial and Exchange 2024

Results/Analysis:

- A total of 1671 members were served under the Diabetes Management Program, gaps in care diabetic outreach, and population health outreach across 8606 distinct activities
  - 453 members received support with scheduling diabetic eye exams
  - 582 members received support with HbA1c control
  - 781 members were outreached to complete kidney health evaluations
  - A total of 1117 Medicare and Exchange members were enrolled in the Diabetes Management Program in 2024
- An average of 14.90% of Medicare and Exchange Members had a diagnosis of diabetes in 2024

        - Of those members diagnosed with diabetes, an average of 45.48% of members were enrolled in at least 1 CM program in 2024
            - Members with this condition can receive services under other CM programs
    - Members who were enrolled in the diabetes management program showed slightly higher rates of PCP engagement (95.88%) than members who were not outreached or engaged in a program (95.86%)
    - Members who were outreached but not engaged in the diabetes management program showed lower rates of PCP engagement (93.39%) than those who were not outreached
    - In 2024, the Medicare rate for Hemoglobin A1c Control (<9.0%) for Patients with Diabetes was estimated to be 85.64%, an improvement over 2023 rates (78.98%), and an estimated 72.85% of Medicare members had a Hemoglobin A1c reading of <8.0%
        - Members engaged in the DM program were more likely to have an HbA1c reading of <9.0% (87.97%) or <8.0% (74.69%) than members not engaged in the program (84.39% and 71.87%)
        - There were data integrity issues for the December 2024 data; this data is based on best estimates using available November and December 2024 data
    - Medicare members outreached for the DM Program, Population Health, and Gaps in Care were less likely to have HbA1c readings in control (<9.0; 84.63%) than those who received no outreach (88.89%)
        - Outreach efforts often focus on members whose HbA1c readings are OOC/OOD, which may explain this discrepancy
            - Members outreached only for gaps in care HbA1c outreach were less likely to have an in-control reading (76.35%) than members who received outreach under the diabetes management program (88.48%)
                - GIC outreach specifically targets members with an OOC/OOD reading
                - Data is not available to assess the effectiveness of this intervention for 2024 (members changed from OOC/OOD to in control)
                - This was a new activity configured in August 2024 and does not represent efforts for the entire year
    - In 2024, the Commercial/Exchange rate for HbA1c Control for Patients with Diabetes was estimated to be 69.23%, an improvement over the 2023 rate of 59.15%
        - Estimated rates for the Exchange population for 2024 is 60.59%
            - There is an opportunity to engage this population in services
        - There were data integrity issues for the December 2024 data; this data is based on best estimates using available November and December 2024 data
    - Rates of A1c in control were higher for members enrolled in the DM program (76.79%) than for members who were not enrolled in the DM program (74.21%)
    - In 2024, the Medicare rate for measure KED – Kidney Health Evaluation for Patients with Diabetes was 81.99%, an improvement over the 2023 rate of 68.71%
        - DHMP exceeded the estimated 5-star cut point for this measure in 2024

        - Members enrolled in the Diabetes Management program were more likely to have completed a kidney health evaluation (84.20%) than those not engaged in the program (79.12%)
    - In 2024, the Commercial/Exchange rate for measure KED – Kidney Health Evaluation for Patients with Diabetes was 69.40%, an improvement over the 2023 rate of 51.03%
        - A total of 27 Exchange members met criteria for this measure in 2024
            - Of those members, 62.96% of members had completed a kidney evaluation in 2024
            - There may be an opportunity to expand care coordination services for these members in the future
    - In 2024, the Medicare rate for measure EED – Eye Exams for Patients with Diabetes was 73.23%, an improvement over the 2022 rate of 67.59%
        - Members enrolled in the Diabetes Management program were more likely to have completed an eye exam (77.14%) than members not engaged in the program (67.84%)
    - In 2024, the Commercial/Exchange rate for EED – Eye Exams for Patients with Diabetes was 40.30%, an improvement over the 2023 rate of 42.17%
        - A total of 51 members met criteria for this measure in 2024
            - Of those, 43.14% of members had completed a diabetic eye exam in 2024
            - There may be an opportunity to expand care coordination services for these members in the future

Barriers/Lessons Learned:

- CM can streamline work to close gaps in care with enrolled members
    - The Medicare Member Dashboard displays gaps in care that can be reviewed by a Care Manager when they are working with a member
        - The CM team will continue to work with IS in 2025 to reduce reporting delays of appointment and lab data
    - The Dashboard will be expanded to all LOB in 2024 to ensure that all members in all programs can receive support with obtaining necessary screenings
- Exchange members often decline to participate in CM services
    - There may be an opportunity to engage these members in self-management programs through the Wellframe application
- Compliance with this measure often plateaus towards the end of the year, which is influenced by multiple factors including appointment access
    - The DHMP Care Management team will provide ongoing efforts to provide ongoing support and services to members with high blood pressure, including monthly chart reviews, supporting eligible members with obtaining a blood pressure cuff for home monitoring, and supporting members with follow up readings and visits after an out-of-control reading
    - The DHMP Care Management team will support members with home BP readings
- Engagement via telephonic outreach continues to be a large barrier for the team

        - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
            - The Wellframe application also offers:
                - Sending of resources, educational materials, and letters digitally
                - Biometric tracking that can be shared with the member's care manager
                - Self-management programs, including the opportunity for members to engage in a self-directed program
                - Member assessments
                - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
        - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity, which impacts the team's ability to engage members both Telephonically and through the Wellframe Application
    - Program enrollment for members with diabetes trended downward throughout the year
        - We are seeing higher overall attribution and rates of members with this condition without additional resources to support these members
        - The number of members enrolled in at least 1 CM program has remained relatively stable
        - The CM team will look for alternative ways to engage these members in 2025, such as through the Wellframe application and self-management programs

Program Name: **Behavioral Health Care Coordination:**

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

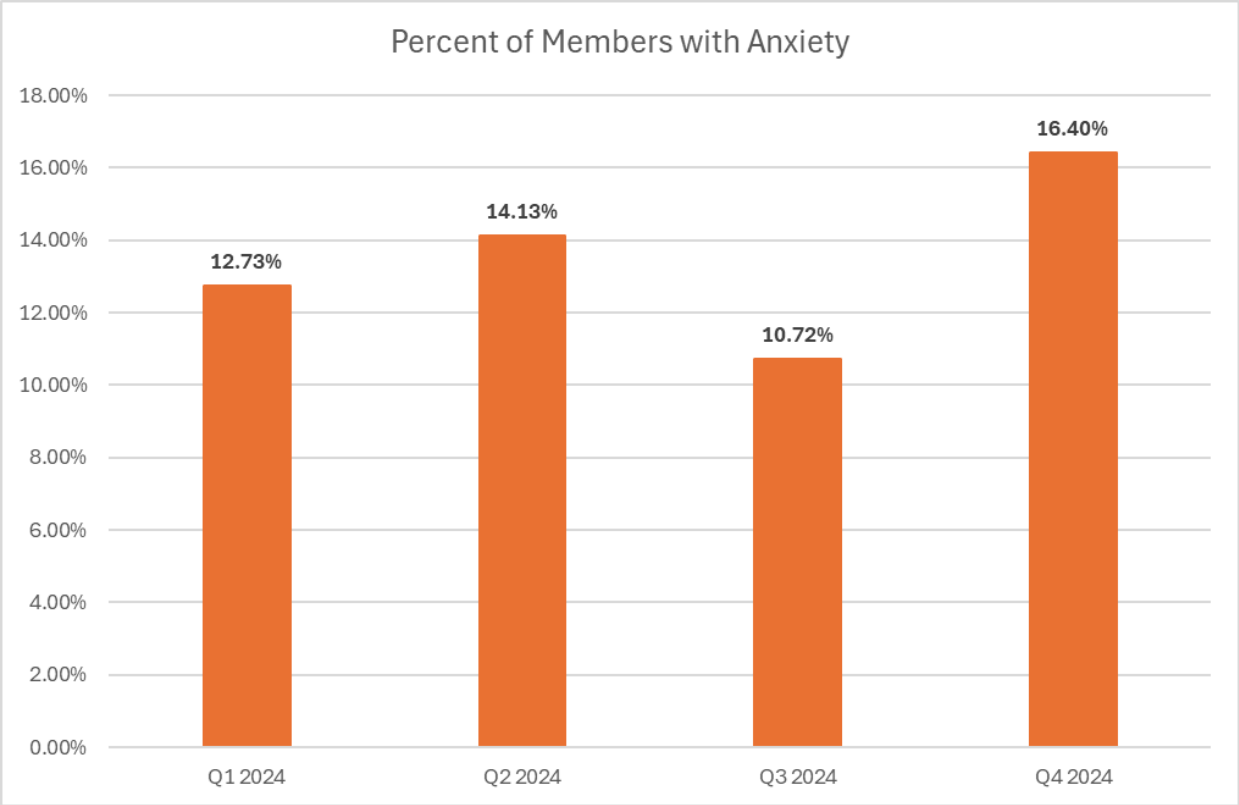
2024 Behavioral Health Care Coordination Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Behavioral Health Activity Data:

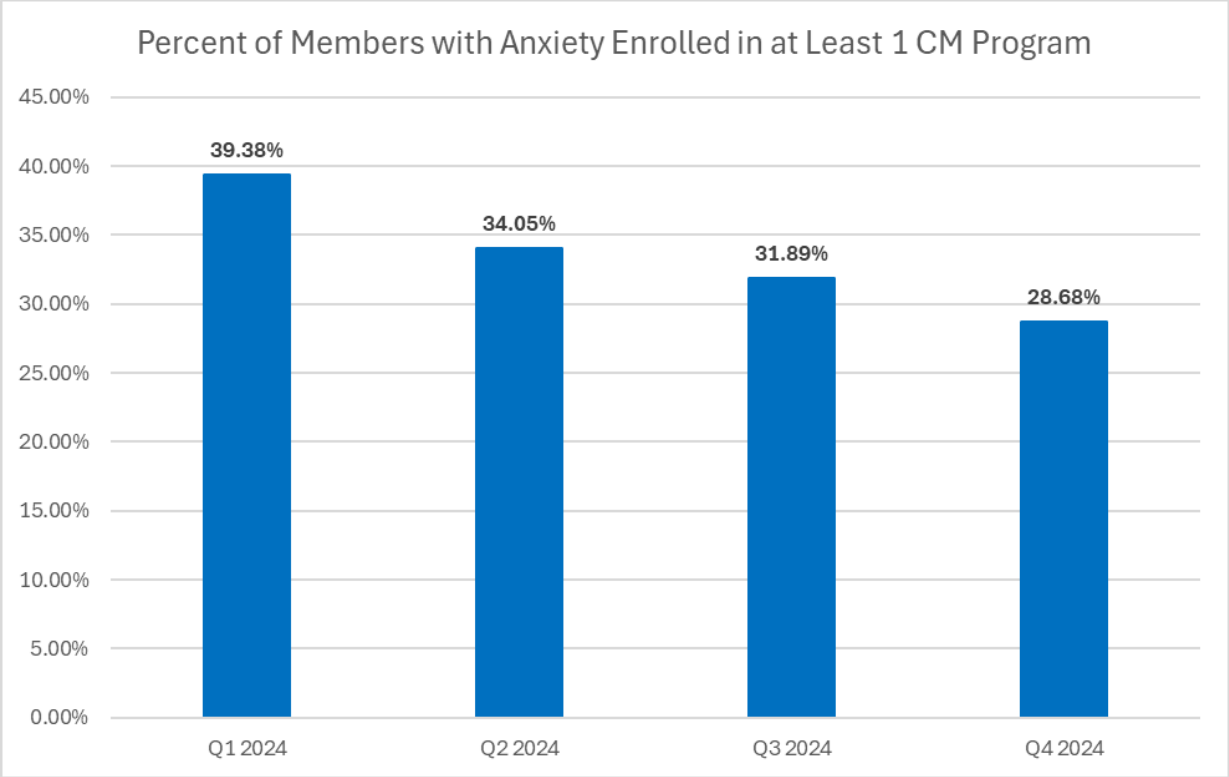
Activity Name	Activities Performed	Members Served
BH Care Coordination	102	72
COA Behavioral Health Referral	30	22
DHMP COMM Behavioral Health / SUD Referral	7	2
Internal Behavioral Health Referral	9	9
Grand Total	**148**	**101**

Behavioral Health Care Coordination Activities 2024

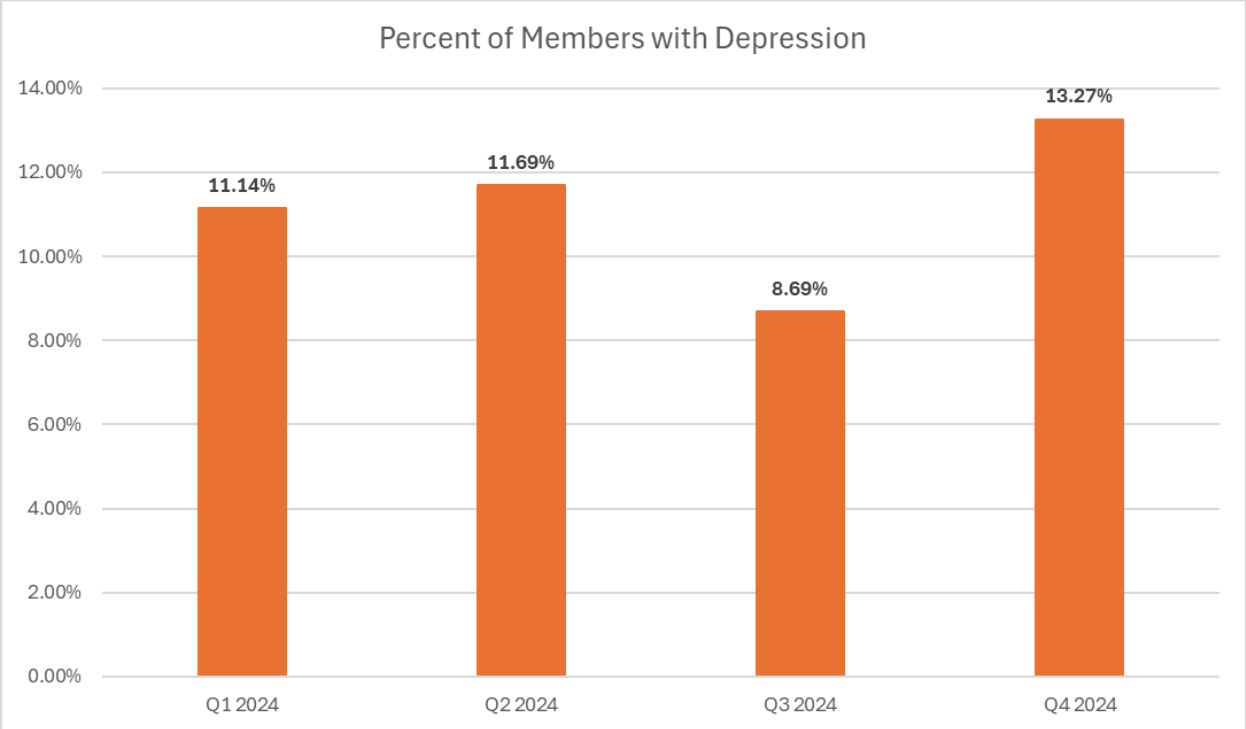
Behavioral Health Population and Program Data:



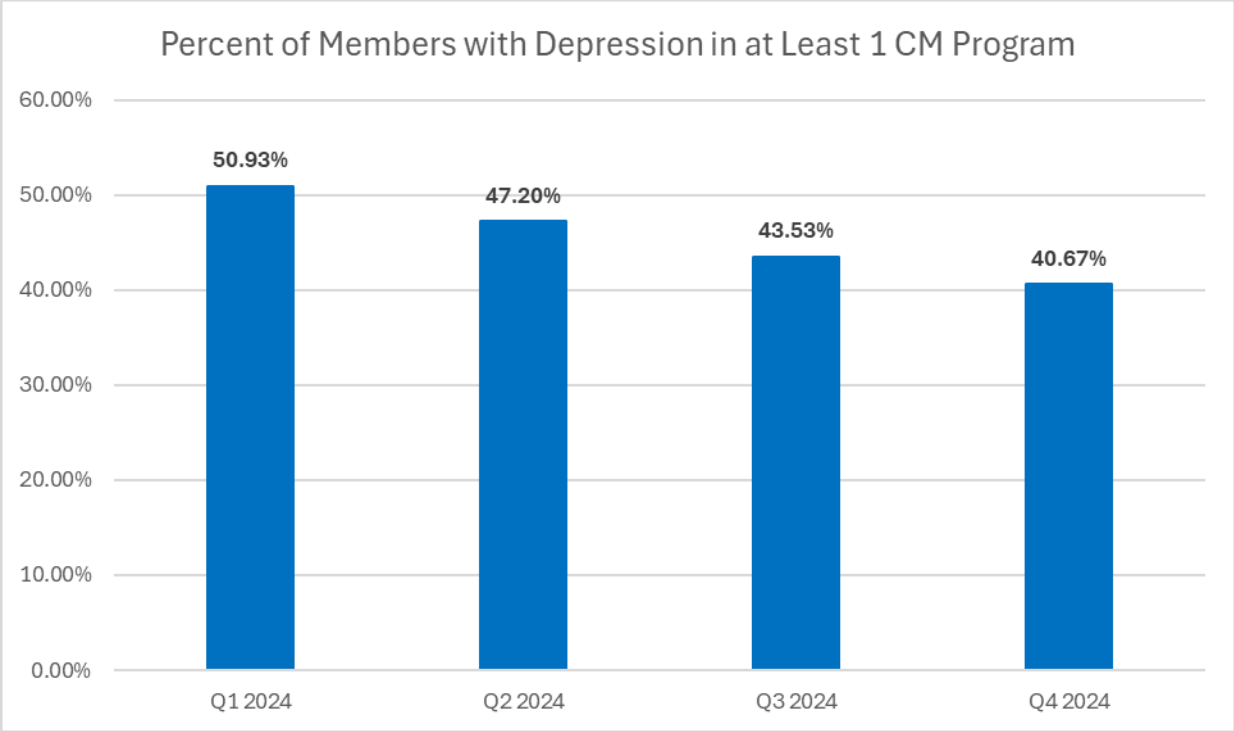
Percent of Members with Anxiety 2024



Percent of Members with Anxiety in at least 1 CM program 2024

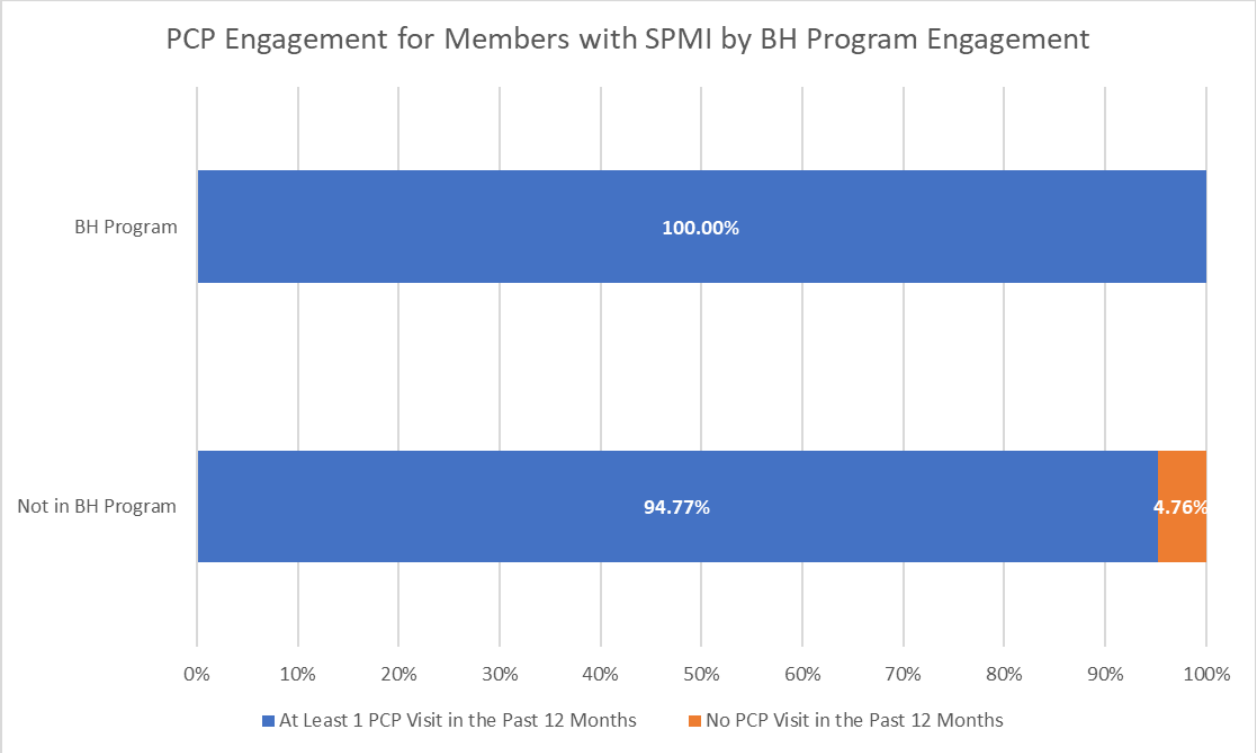


Percent of Members with Depression 2024

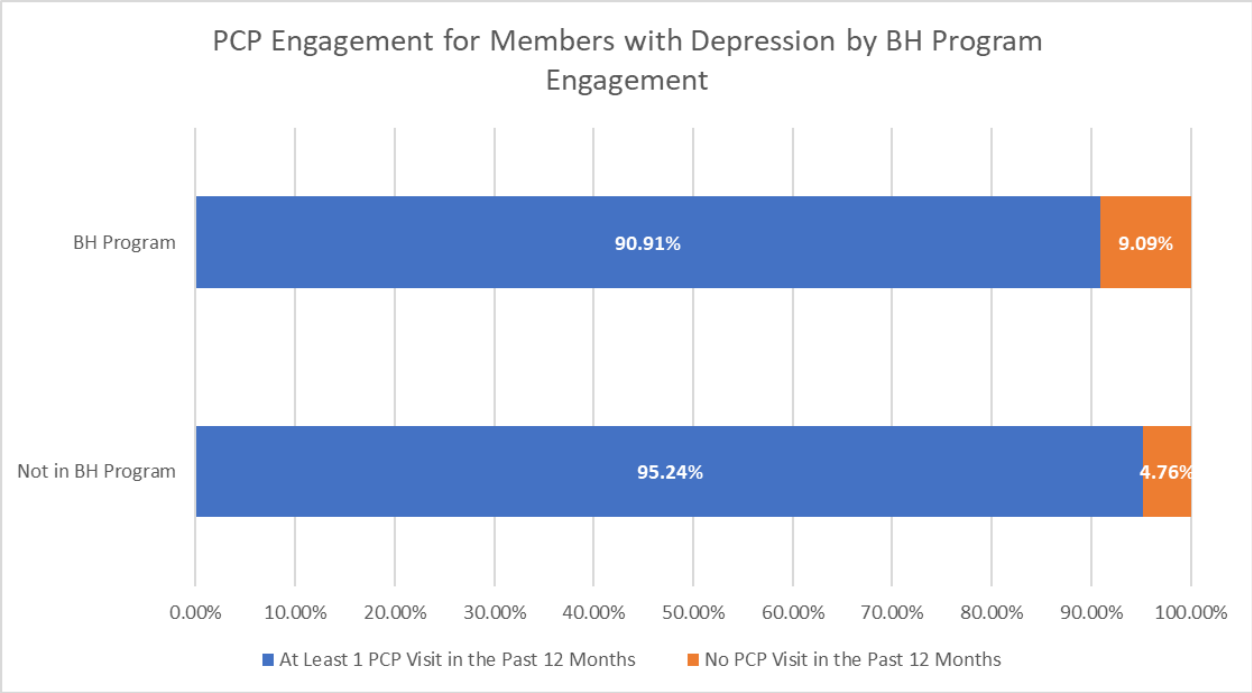


Percent of Members with Depression in at least 1 CM Program 2024

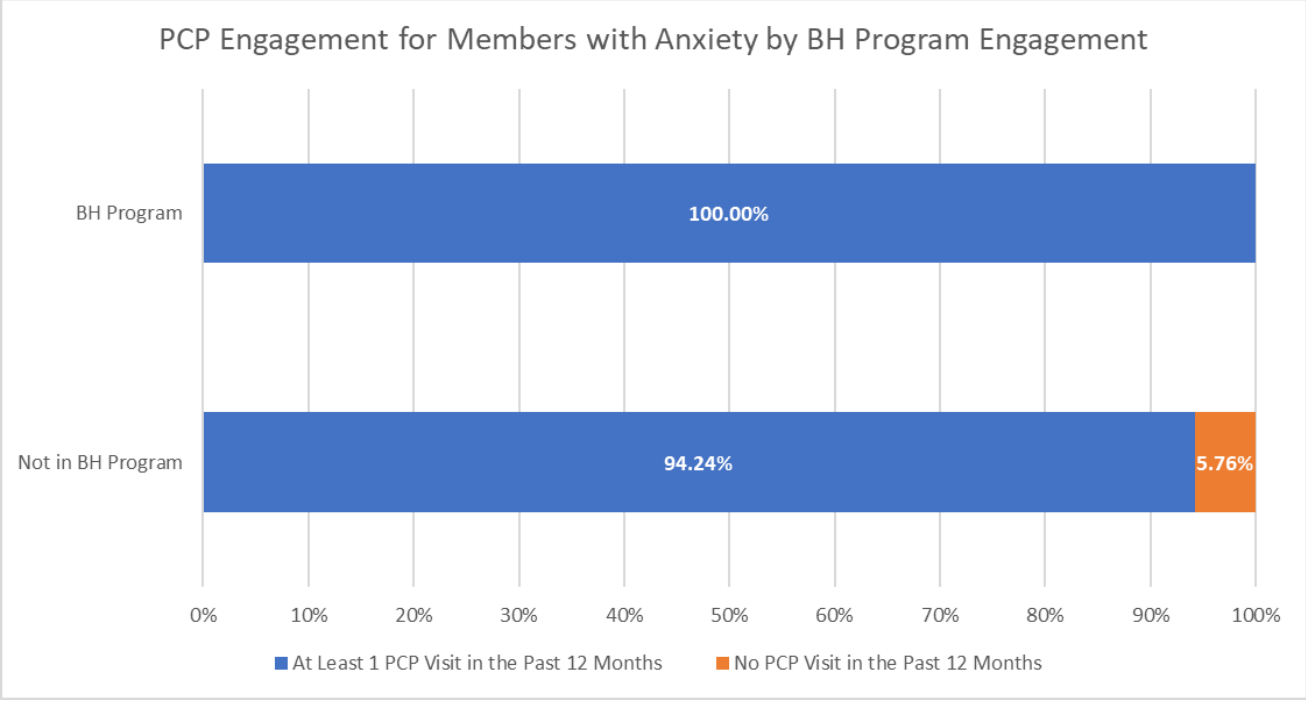
Behavioral Health Outcome Data:



PCP Engagement for Members with SPMI 2024



PCP Engagement for Members with Depression 2024



PCP Engagement for Members with Anxiety 2024

Results/Analysis:

- 101 distinct members received support under Behavioral Health Coordination Program across 148 activities

        - Of all members with SPMI, 100% of members outreached for BH Care Coordination had at least 1 PCP visit in the past 12 months, compared to 94.77% of members who were not outreached
        - Of all members with depression, 90.91% of members who were outreached for BH Care Coordination had at least 1 PCP visit in the past 12 months, compared to 95.24% of members who were not outreached
        - Of all members with anxiety, 100% of members outreached for BH Care Coordination had at least 1 PCP visit in the past 12 months, compared to 94.24% of members who were not outreached
    - An average of 13.50% of Medicare and Exchange members had a diagnosis of anxiety in 2024
        - Of members with a diagnosis of anxiety, an average of 33.50% of members were enrolled in at least 1 CM program in 2024
            - Members with BH concerns may be served under programs outside of the Behavioral Health Care Coordination Program
    - An average of 11.20% of all Medicare and Exchange members had a diagnosis of depression in 2024
        - Of all members with a diagnosis of depression, an average of 45.58% of members were enrolled in at least 1 CM program in 2024
            - Members with BH concerns may be served under programs outside of the Behavioral Health Care Coordination Program

Barriers/Lessons Learned:

- Engagement via telephonic outreach continues to be a large barrier for the team
    - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
        - The Wellframe application also offers:
            - Sending of resources, educational materials, and letters digitally
            - Biometric tracking that can be shared with the member's care manager
            - Self-management programs, including the opportunity for members to engage in a self-directed program, including behavioral health programs
            - Member assessments
            - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
- There continues to be an increased demand for Behavioral Health services but wait times can be long and services can be difficult to obtain
    - Telehealth continues to be an option for members to access behavioral health services
    - Many members have expressed ongoing interest in receiving telehealth behavioral health services

- In 2022, DHMP implemented telehealth behavioral health services in response to the rising demand for timely behavioral health services and members' requests to receive these services via telehealth, and this service will be continued into 2025 for select lines of business

- Program enrollment for members with anxiety and depression trended downward throughout the year
  - We are seeing higher overall attribution and rates of members with these conditions without additional resources to support these members
  - The number of members enrolled in at least 1 CM program has remained relatively stable
  - The CM team will look for alternative ways to engage these members in 2025, such as through the Wellframe application and self-management programs

Program Name: **Continuity of Care:**

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

2024 Continuity of Care Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Activity Name	Activities Performed	Members Served
Continuity of Care Language Services	26	17
Continuity of Care Member Coordination	231	103
Continuity of Care Provider Coordination	62	37
Grand Total	**319**	**117**

Continuity of Care Activities 2024

Results/Analysis:

- The Continuity of Care Program supports members with transitioning between in network and out of network providers to meet member needs
  - Members who are transitioning from an out of network provider can get assistance with transitioning to an in-network provider without gaps in service or care

        - Care Managers assist with establishing in network providers for members
        - Care Managers assist members to find services out of network when in-network services are inadequate to meet member needs
    - A total of 117 distinct members were served under this program in 2024
    - This program is necessary for ensuring that members do not experience gaps in care

Barriers/Lessons Learned:

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

Care Coordination Activities:

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

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

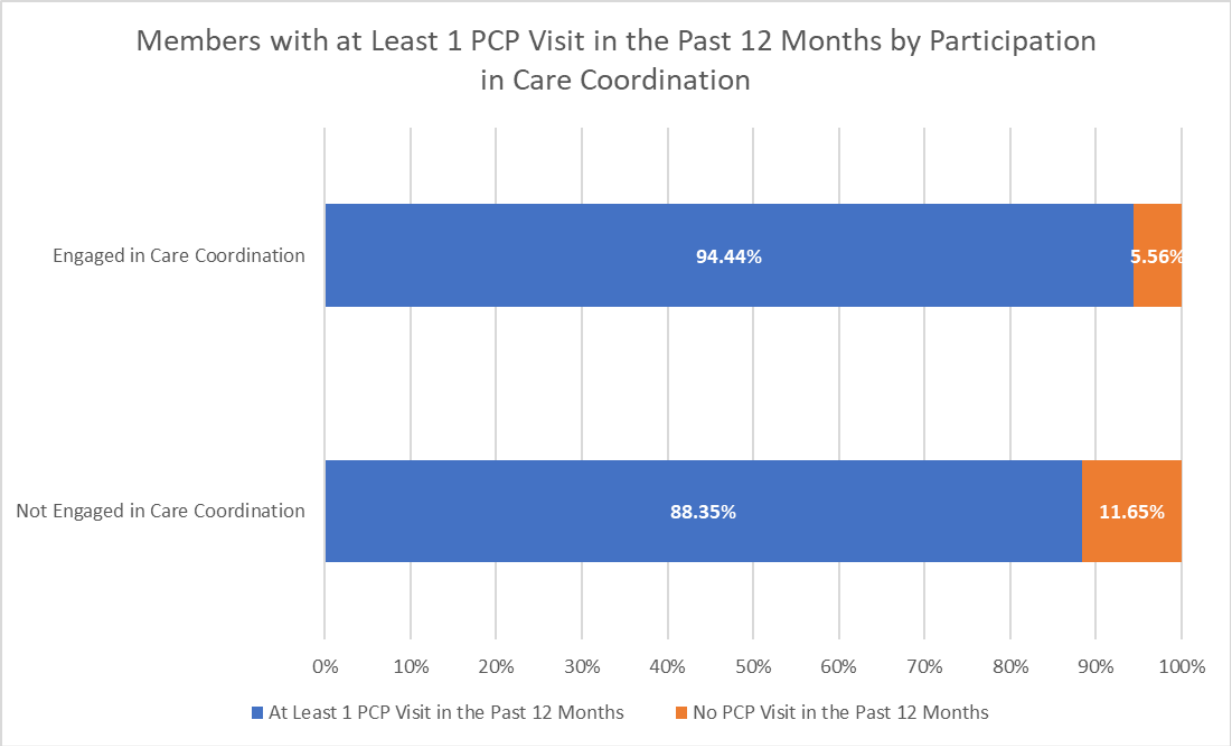
2024 Care Coordination Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Care Coordination Activity Metrics:

CC Activity	Activities Performed	Members Served
CC Applications/Membership Assistance	4	2
CC Benefit Resource Coordination	164	72
CC Care Plan Update	26	21
CC Condition Management	22	16
CC Dental Care Coordination	12	9
CC Disenrollment Summary	10	9
CC Education Provided	127	108
CC Engagement / Enrollment	3	3
CC EPSDT Member Coordination	21	21
CC EPSDT Provider Coordination	2	2
CC Food Security Coordination	61	60
CC Health Acuity / Needs Assessed	1264	1132
CC Health Care Provider Coordination	394	206
CC Housing Resource Coordination	72	70
CC ICP Goals / Barriers Communicated to Care Team	2	2
CC Internal Activity	105	82
CC Language Services	85	48
CC LTSS Coordination	24	7
CC Medication Management	254	120
CC Member Outreach	1891	847
CC Nutrition Support	1	1
CC Other Community Resource Coordination	96	77
CC Other Follow-up	32	32
CC Provider Follow-up	135	47
CC Referral	83	74
CC SNAP Coordination	24	23
CC Tobacco Cessation Coordination	2	2
CC Transportation Coordination	144	70
CC Utilities Coordination	10	10
CC WIC Coordination	2	2
Grand Total	**5072**	**1764**

Care Coordination Activities 2024

Care Coordination Outcome Metrics:



PCP Engagement by Engagement in Care Coordination Services 2024

Results/Analysis:

- A total of 1764 unique members engaged in Care Coordination services in 2024
- 5,072 distinct member outreaches were captured in 2024
  - 11.68% of members engaged in Care Coordination were assisted with scheduling appointments and accessing care
  - 12.76% of members were assisted with services to support SDOH needs, such as housing assistance, utility assistance, food security, WIC/SNAP benefits, language assistance, transportation, and access to community resources
- Members who engaged in Care Coordination services had higher rates of attending at least 1 PCP visit in the past year compared to members who did not engage in Care Coordination services in 2024
  - 94.44% of members who engaged in CC services had at least 1 PCP visit in the past 12 months, compared to 88.35% of members who did not engage in these services
- These services help bridge the gap for members who only want or need a small number of services and who do not wish to participate fully in a CM program

Barriers/Lessons Learned:

- Engagement via telephonic outreach continues to be a large barrier for the team
  - In November 2024, the DHMP CM team went live with the Wellframe application, which allows for encrypted bi-directional text messaging communication
    - The Wellframe application also offers:
      - Sending of resources, educational materials, and letters digitally
      - Biometric tracking that can be shared with the member's care manager
      - Self-management programs, including the opportunity for members to engage in a self-directed program
      - Member assessments
      - Alerts to be sent to the Care Manager if an assessment response or biometric reading is abnormal
- There is an ongoing need for the health plan to collaborate with clinical partners to address access to care issues experienced by plan members
  - In 2025, DHMP is continuing to partner with DHHA and other contracted clinics to assess access to care issues on a systemic level
  - The CM team continues to work with members to schedule appointments and participate in telemedicine services when appropriate
    - It has been essential for Care Management to provide communication and education to members about the availability, safety, and importance of participating in medical care and not delaying necessary screening services and to support members with accessing essential services
    - Care Management continues to work with members to continue to utilize home screening services as necessary
    - The DHMP Care Management team is pivotal in assessing the efficacy of systemic changes by reporting back any issues or barriers experienced by members or the CM team while attempting to coordinate care, and by responding to member and provider referrals to the Care Management team regarding issues with access to care
    - The CM team continues to utilize the appointment backline and EPIC scheduling to support members with accessing care

Care Management Member Experience Survey:

A total of 32 members completed the Care Management Member Experience Survey in 2024. Members are contacted by phone following completion of a program, or at year end for those who are continuously enrolled in a program. In 2024, member surveys were completed through outreach calls and through the mail.

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

question to assess changes to member health behaviors because of their participation in the care management program.

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

2024 Care Management Member Experience Survey Results

Program Name	Number of Respondents	% Member Response
Medicare Choice SNP HMO	29	90.63%
Transitions of Care	3	9.38%
Grand Total	**32**	**100%**

Care Management Member Experience Survey Responses by Program 2024

Member Satisfaction Survey Results - Behavior Modification						
Survey Question/Responses	**No**	**Yes**	**Total**	**No Response**	**% No**	**% Yes**
Have you made any changes to your behavior as a result of participating in this program? (Behavior changes could include: taking your prescribed medication every day, starting a workout program, eating healthier etc.)	20	11	31	1	64.52%	35.48%

Care Management Member Experience Survey Responses - Behavior Modification - All Programs 2024

Member Response	Number of Members
"Exercising more, taking meds in timely manner"	1
Eating better food that's good for me. Walking more and taking care of my B/P	1
I guess I have made a few watching my sugars and watching what I eat.	1
I take my medicine as prescribed	1
I take my prescribed medication as directed.	1
Increased exercise	1
Member is eating healthier	1
New workout program for seniors.	1
PT on my own and regular OHBS therapy	1
Work out more regularly	1
Member declined to respond	1
Grand Total	**11**

Reported Behavior Changes - All Programs 2024

Member Experience Survey Results										
Survey Question/Results	**1 – not at all satisfied**	**2 – a little satisfied**	**3 – somewhat satisfied**	**4 – mostly satisfied**	**5 – very or always satisfied**	**Did not have Complaints/ concerns**	**Total Responses**	**No Response**	**Member Not Satisfied (Score of 1,2, or 3)**	**Member Satisfied (Score of 4 or 5)**
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	1		3	7	20		31	1	12.90%	87.10%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	1		2	9	19		31	1	9.68%	90.32%
How helpful was your care manager when you had a question or concern?	1			7	24		32	0	3.13%	96.88%
How satisfied are you with how the care manager helped you get the care you needed?		1	2	6	23		32	0	9.38%	90.63%
How satisfied are you with how the care manager helped you understand your treatment and care plan?		1		8	23		32	0	3.13%	96.88%
How satisfied are you with how the care manager paid attention to you and helped you with problems?		1	2	7	22		32	0	9.38%	90.63%
How satisfied are you with how the care manager treated you?			1	6	25		32	0	3.13%	96.88%
How satisfied are you with the timeliness of your care management services?	1		1	10	19		31	1	6.45%	93.55%
How well did your care manager share important information with you when it was needed?		1	1	10	19		31	1	6.45%	93.55%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?		1	1	5	18	5	30	2	6.67%	93.33%
Overall, how satisfied are you with the care management program?	1			8	22		31	1	3.23%	96.77%

Member Experience Survey 2024, All Programs, N = 32

Member Experience Survey Results - Transitions of Care										
Survey Question/Results	**1 – not at all satisfied**	**2 – a little satisfied**	**3 – somewhat satisfied**	**4 – mostly satisfied**	**5 – very or always satisfied**	**Did not have Complaints/ concerns**	**Total Responses**	**No Response**	**Member Not Satisfied (Score of 1,2, or 3)**	**Member Satisfied (Score of 4 or 5)**
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	0	0	3		3	0	0.00%	100.00%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	0	0	3		3	0	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	0	1	2		3	0	0.00%	100.00%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	0	1	2		3	0	0.00%	100.00%
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	0	1	2		3	0	0.00%	100.00%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	1	0	2		3	0	33.33%	66.67%
How satisfied are you with how the care manager treated you?	0	0	0	1	2		3	0	0.00%	100.00%
How satisfied are you with the timeliness of your care management services?	0	0	0	0	3		3	0	0.00%	100.00%
How well did your care manager share important information with you when it was needed?	0	0	0	0	3		3	0	0.00%	100.00%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	0	0	3	0	3	0	0.00%	100.00%
Overall, how satisfied are you with the care management program?	0	0	0	0	3		3	0	0.00%	100.00%

Member Experience Survey 2024 - Transitions of Care Program; N = 3

2023 Member Experience Survey Results - Medicare Choice SNP HMO										
Survey Question/Results	**1 – not at all satisfied**	**2 – a little satisfied**	**3 – somewhat satisfied**	**4 – mostly satisfied**	**5 – very or always satisfied**	**Did not have Complaints/ concerns**	**Total Responses**	**No Response**	**Member Not Satisfied (Score of 1,2, or 3)**	**Member Satisfied (Score of 4 or 5)**
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	1	0	3	7	17		28	1	14.29%	85.71%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	1	0	2	9	16		28	1	10.71%	89.29%
How helpful was your care manager when you had a question or concern?	1	0	0	6	22		29	0	3.45%	96.55%
How satisfied are you with how the care manager helped you get the care you needed?	0	1	2	5	21		29	0	10.34%	89.66%
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	1	0	7	21		29	0	3.45%	96.55%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	1	1	7	20		29	0	6.90%	93.10%
How satisfied are you with how the care manager treated you?	0	0	1	5	23		29	0	3.45%	96.55%
How satisfied are you with the timeliness of your care management services?	1	0	1	10	16		28	1	7.14%	92.86%
How well did your care manager share important information with you when it was needed?	0	1	1	10	16		28	1	7.14%	92.86%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	1	1	5	15	5	27	2	7.41%	92.59%
Overall, how satisfied are you with the care management program?	1	0	0	8	19		28	1	3.57%	96.43%

Member Experience Survey 2024 - Medicare Choice SNP HMO Program; N = 29

Results/Analysis:

- The overall response rate to the 2024 Care Management Member Experience Survey was lower than in 2023, with 32 members completing the survey
    - The CM team was unable to conduct a mass mailing of surveys in 2024, which significantly impacts response rates

- Of the 32 members who responded to the survey:
- 9.38% (3 members) had participated in the Transitions of Care Program
- 90.62% (29 members) were participants in the Medicare Choice SNP HMO Program
- Overall satisfaction rates were highest for the Transitions of Care Program, with 100% overall satisfaction rates reported for the question "Overall, how satisfied are you with your care management program?"
- Results of the survey were largely favorable, with a 96.77% overall satisfaction rate, with an average score of 4.6 across all questions asked
- The CM team exceeded their goal of 4.5/5 overall satisfaction
- The DSNP Program was rated at 4.6/5 for all questions (N=29)
- Transitions of Care was rated at 4.8/5 for all questions (N=3)
- Satisfaction rates were highest for the following questions:
- How satisfied are you with how the Care Manager treated you? (97.06% satisfied)
- How satisfied are you with how the care manager helped you understand your treatment and care plan? (97.06% satisfied)
- How helpful was your care manager when you had a question or concern? (97.06% satisfied)
- Satisfaction rates were lowest for the following areas:
- How helpful was your care manager in helping you access services (doctors' appointments, specialty appointments, etc.? (87.88% satisfied)
- How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed? (87.88% satisfied)
- How satisfied are you with how the care manager paid attention to you and helped you with your problems (99.24% satisfied)
- Of the 31 respondents to the behavior modification question, 34.48% of members reported making a change in their behavior because of participating in a care management program
- Members were encouraged to provide more information about the lifestyle changes they have made, and respondents reported the following changes:
- Exercising more
- Eating better
- Taking medications as prescribed
- Engaging in care

Barriers/Lessons Learned:

- Response rates for the survey were lower in 2024 than in 2023 as the Care Management team was unable to conduct a mass survey mailing as they have in previous years
- DHMP will continue having Health Plan Care Coordinators who work within specific programs to conduct outreach members who participated in that program each month

- Improved response rates may allow for more robust program-level analysis, which may lead to additional identified opportunities for improvement
  - The current survey does not require members to report why they are satisfied or dissatisfied with services
- While some members provided feedback in the comments section, very few members explained their rating to the team, making it difficult to understand the specific issues they were experiencing

Care Management and Care Coordination Plans for 2025

- Increased member participation on the Wellframe Application
- Integration of Denver Health Hospital Authority EPIC data into the ADT feed
- Continued work to improve the accuracy of the Readmission Risk model in the ADT feed
- Explore options for direct data sharing between SquareML and Guiding Care to enhance integration of the ADT feed
- Development of a TOC dashboard in SquareML using data from the ADT feed
- Cost benefit analysis of an ADT feed in to track ED visits
- Continued work to identify of a rising risk population in partnership with SquareML
- Explore improved member outcome analytics, including cost and utilization outcomes, in partnership with Square ML
- Automated integration of Health Needs Assessment (HNA) data into the Health Edge Tableau Data Warehouse

II. MEMBER EXPERIENCE

Member Experience Committee (MEC)

Established in Q1 2024, DHMP's Member Experience Committee meets monthly to apply data-driven insights (analyses and collaborative work) that refine onboarding, engagement policies, and benefit materials, directly closing identified gaps in member satisfaction.

Primary Goals

- Create an onboarding and engagement strategy that:
- Builds rapport with members early, addresses concerns immediately, tailors communication to preferences, empowers members (through integrated technology and education), and improves satisfaction
- Establish metrics to monitor success of onboarding and engagement initiatives
- Form and maintain a member advisory committee
- Must include a diverse, reasonably representative sample of individuals from each product line
- Solicit direct input and feedback on enrollee experiences, member materials, and/or policies
- Help identify barriers to high-quality, coordinated care
- Improve member experience between the member, the plan and the providers
- Enhance member usability and experience of plan benefits and tools
- Comply with all regulatory requirements

Annual CAHPS Surveys

Consumer Assessment of Health Plan Providers and Systems (CAHPS) surveys are conducted on behalf of DHMP by NCQA certified vendor Press Ganey (formerly SPH Analytics). These surveys cover topics that are important to healthcare consumers and focus on aspects of quality that our members are best qualified to assess, such as the communication skills of providers and ease of access to services.

Randomly selected Exchange and Medicare 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 1,300 Exchange members and 1,596 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 133 Exchange members and 264 Medicare members who chose to complete the survey.

EXCHANGE CAHPS RESULTS

In RY 2024, the Elevate by Denver Health sample size was 1,300 members with 133 total completed surveys for a 17.4% response rate.

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

MEASURE	SCALED MEAN SCORE		CHANGE	2024 PERCENTILE
	2023	2024		
Rating of Health Plan	65.7	66.8	1.1	24th
Rating of Health Care	74.9	77.2	2.3	21st
Rating of Personal Doctor	87.9	87.7	-0.2	42nd
Rating of Specialist	79.5	81.6	2.1	6th
Getting Care Quickly	56.4	60.7	4.3	<5th
Getting Needed Care	52.8	57.8	5.0	<5th
Access to Information	43.6	41.4	-2.2	<5th
Care Coordination	79.8	81.1	1.3	27th
Plan Administration	62.8	66.1	3.3	19th
Medical Assistance with Smoking Tobacco Use Cessation	66.9	69.1	2.2	88th

Key Takeaways:

- Overall improvement: DHMP saw improvements in 8 out of 11 scored measures compared to the previous year, signaling progress in several areas of member experience.
- Greatest improvement: Getting needed care improved by 5.0 points, followed by Getting Care Quickly (+4.3 points), and Plan Administration (+3.3 points), indicating positive strides in member access and service delivery.

- Stable high performance: Medical Assistance with Smoking/Tobacco Use Cessation increased by 2.2 points, now in 88th percentile.
- Biggest decline: Access to Information decreased by 2.2 points and remains in the lowest percentile tier (<5th), highlighting a continued opportunity for targeted improvement in this area.
- Mixed results in provider rating: Rating of Personal Doctor decreased slightly (-0.2), while Rating of Specialist and Rating of Health Care saw increases (+2.1 and +2.3, respectively), reflecting variable experiences with providers.

MEDICARE CAHPS RESULTS

In RY 2023, the Medicare sample size was 1,595 with 383 total completed surveys for a 24.0% response rate. In RY 2024, the Medicare sample size was 1,596 with 264 total completed surveys for a 16.5% response rate. Below is a table summarizing Medicare CAHPS results for the past two years.

MEASURE	SCALED MEAN		CHANGE	CURRENT SPH PERCENTILE	2024 STAR RATING* (Case mix adjusted)
	RY 2023	RY 2024			
Getting Needed Care	69.8	78.1	8.3	27th	3
Getting Appointments and Care Quickly	75.5	76.2	0.7	5th	1
Customer Service	88.9	89.3	0.4	37th	3
Getting Needed Prescription Drugs	86.9	89.8	2.9	69th	4
Care Coordination	83.2	87.2	4.0	66th	4
Rating of Health Care Quality	83.1	86.0	2.9	50th	4
Rating of Health Plan	85.1	85.5	0.4	31st	2
Rating of Drug Plan	87.0	90.6	3.6	87th	4
Annual Flu Vaccine	82.3	80.4	-1.9	91st	5

ANALYSIS

- Overall gains: DHMP improved in 7 out of 8 scored measures, reflecting meaningful enhancements in member experience and care delivery.
- Most significant improvement: Getting Needed Care increased by 8.3 points, the largest year-over-year gain, moving from a 2-Star to a 3-Star rating.
- Notable advancements: Annual Flu Vaccine remained strong despite a slight drop (-1.9 points), holding at the 91st percentile and retaining a 5-Star rating.
- Ongoing challenges: Getting Appointments and Care Quickly remains a key aera for improvement, showing only a marginal increase (+0.7 points) and holding at 1 star and the 5th percentile, its lowest performing domain.
- Mixed results in plan ratings: Rating of Health Plan and Customer Service improved slightly (+0.4 points each), but stayed in the 2-Star and 3-Star tiers, indicating room for further enhancement.

Despite performance improvement or stability, our star ratings dropped in the following two measures due to increased rate targets.

- Getting care quickly: Performance increased YOY, but the star rating dropped due to cut point increases and removal of a historically strong question.
- Customer Service: Performance remained flat, but the star rating dropped due to higher cut points.

Analysis reflects intervention is needed in Getting Appointments and Care Quickly, Rating of the Health Plan and Getting Needed Care in 2025 to improve our overall Official CAHPS score. Four questions on the Official CAHPS survey drive the scores for these domains, and they are all related to access.

Getting Needed Care

10. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
O Never
O Sometimes
O Usually
O Always

29. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?
O Never
O Sometimes
O Usually
O Always

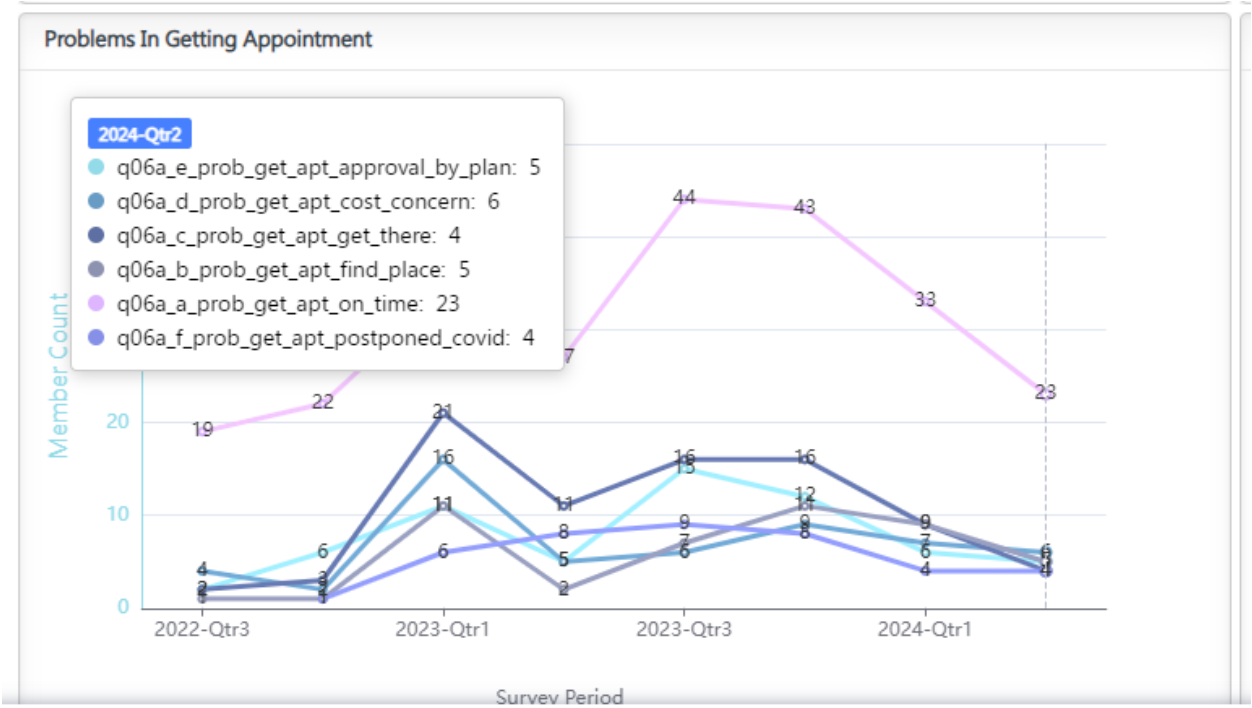
Getting Appointments & Care Quickly

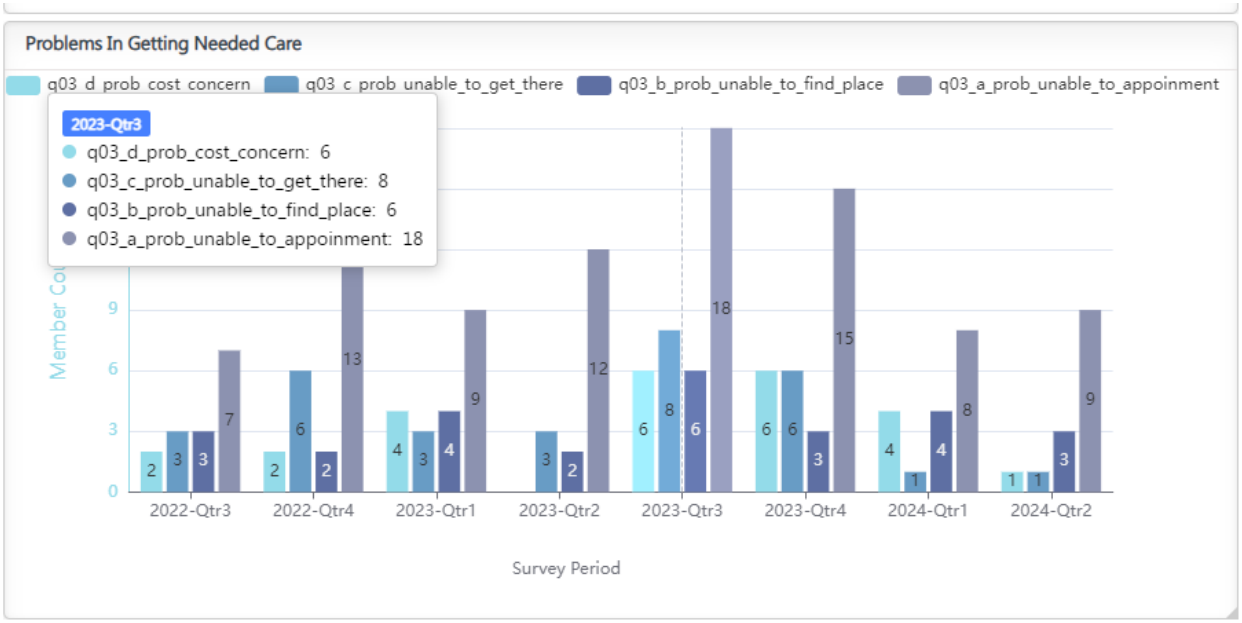
4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
O Never
O Sometimes
O Usually
O Always

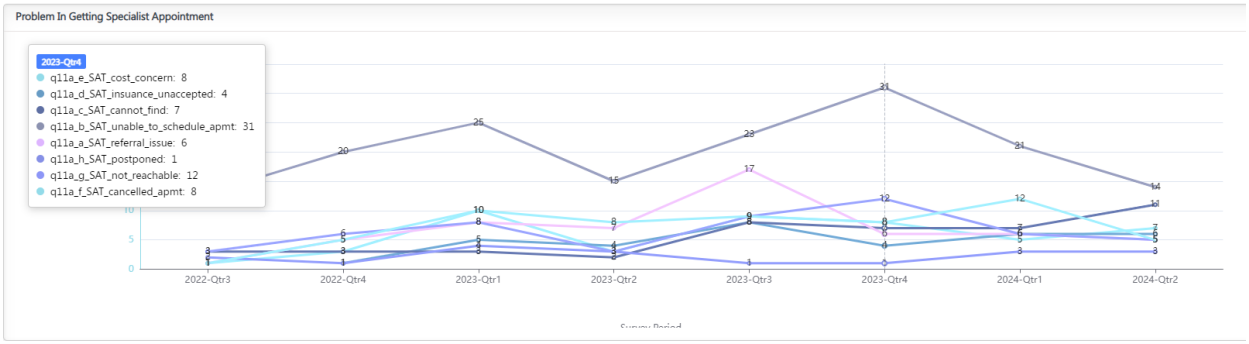
6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
O Never
O Sometimes
O Usually
O Always

8. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
O Never
O Sometimes
O Usually
O Always

This trend regarding access concerns is further reinforced by the data from our newly developed mini-CAHPS survey dashboard, where our quarterly surveys also reflect members reporting difficulties in scheduling timely appointments.







The QI and Pop Health teams have worked on developing this dashboard weekly for the past year with Square ML, a machine learning vendor. Producing reporting for our mini-CAHPS surveys was previously a manual process. It contains trending information dating back to Q3 2022 and through Q4 2024.

We updated our mini-CAHPS survey for Q3 and Q4 of 2024 to have fewer questions, in an effort to increase response rates, and ask more open-ended questions to better understand our members challenges related to access. Work was recently completed with Square ML to trend the Q3 and Q4 member comments and finish development of our dashboard, so we can create targeted interventions for 2025. Based on our analysis, the interventions we plan to implement in 2025 to address access issues are:

1. Increasing virtual visits to decrease strain on in-person access
2. Review online scheduling functionality, all in partnership with Denver Health.

Health Plan Services

Health Plan Services (HPS) has in place departmental Performance Report that is responsible for Website, telephone and email quality and accuracy. Each will be addressed in this document.

DHMP's website functionality allows our members to complete the following in one attempt or contact: (1) change a primary care practitioner, as applicable, and (2) determine how and when to obtain referrals and authorizations for specific services, as applicable, and (3) determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable.

Aggregate results

Table C depicts the quality and accuracy telephonic result by NCQA-accredited LOB for call reasons referral/auth and benefit/financial for CY2024. The KPI goal is 90% for both quality and accuracy.

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Table C—Phone Q&A (CY2024)

LOB/Primary Inquiry Reason	Quality % Achieved	Quality (Points Earned/Points Available)	Accuracy % Achieved	Accuracy (Points Earned/Points Available)
Exchange—Auth/Referral	85.39%	3706/4340	98.03%	13732 /14008
Exchange—Benefit/Financial	88.71%	23536/26530	91.90%	31282/34038
Medicare—Auth/Referral	85.92%	11848/13790	94.04%	15171/16133
Medicare—Benefit/Financial	90.91%	19832/21814	98.03%	24111/24595
Total	87.73%	58922/66474	95.50%	84296/88774

While the CY2024 accuracy goal of 90 percent or greater was achieved, the quality result was nearly three percent below goal. Main reason for not achieving quality score was due to HPS Representatives missing turning on the blackout feature when obtaining personal credit/debit card information for taking payment and/or not turning off the blackout feature after credit/debit card information obtained. During instances of these misses, HPS Representatives were provided additional training and coaching regarding the requirements of and protecting PHI. 98.3 percent was the overall quality score achieved in 2024 for HPS email responses. The KPI goal for email accuracy is also 90%. The quality goal for email was achieved in 2024. CY2024 email TAT was 100 percent met, out of 115 audited emails.

CY2024 average speed (delay) of answer (ASA) KPI % achieved for Elevate Exchange was 71.33% compared to goal of 80% for 2024 and abandonment rate ended at 12%, missing KPI of <=5%. It was noted there was an approximate 40% increase in call volume for Elevate Exchange 2024 compared to 2023 (increase in membership). For Medicare, KPI of ≤ 30 seconds ASA was met at 30 seconds, abandonment rate <=5 % was met at 3% and call volume increased by approximately 25% in 2024 compared to 2023. In December 2024, augmented call center support for Medicare and prioritized Elevate Exchange member calls to help support achieving KPIs in 2025. In addition, to enhance the member experience, in April 2024, DHMP updated online payment options in Member Portal to include seeing balances and choosing option of recurring or one-time payments. Also, permissions were granted to HPS Representatives to be able to cancel recurring/one-time payment upon members request, eliminating the need for rep to submit ticket.

If additional detail is desired, see also ME6 analysis (separate report).

Acting to Improve

For non-behavioral member experience related interventions in 2025, HPS (based on ME6 analysis) will be updating internal facing process flow document that staff references to make it more clear that rep should end the blackout function after they finish processing payment for Exchange premium calls; to address the trend of points being missed due to forgetting to stop the black out and the HPS Supervisor not hearing the call closing due to the blackout feature not ending trend. Additionally, to address opportunities member experience such as Medicare member understanding of Flexcard benefits, DHMP will continue in-person educational events known as CoffeeTalks in 2025. These events are designed to enhance the member experience by offering valuable resources and tools to help members understand and maximize their benefits. After each session, members completed a standard survey, providing DHMP with feedback to inform and improve future events. Furthermore, members who identified specific issues were contacted after the event for a follow-up 1:1 session with a staff member to ensure their concerns were addressed.

As for acting to improve behavioral health care (BH) in 2025, DHMP's Member and Provider Experience Director in collaboration with the Monitoring, Auditing and Training (MAT) and HPS Departments to develop an internal tip sheet for staff to better empower them to answer complex claims and benefit questions, as well as enhance DHMP's internal Culture of Yes training with Center for Addiction Medicine (CAM) *Words Matter* campaign content (in alignment with both ME7 and ME6 analyses). The Words Matter campaign and pledge are a **call to action** that we all commit to using non-judgmental language in interactions and documentation regarding our members. The Words Matter campaign alignment in 2025 will include but may not be limited to dissemination of person-centered, de-stigmitizing language guide, training materials, Lunch and Learn, and internal re-enforcement communications.

MONITORING HEALTH PLAN SERVICES' BENEFIT INFORMATION FOR QUALITY AND ACCURACY

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

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

INTERVENTIONS

To continue process improvements to serve the DHMP members to the best of our ability, the HPS team has taken on a number of new initiatives to increase customer service satisfaction levels. The HPS team continues to proactively work to enhance onboarding, data sharing and internal collaboration for new and existing staff, to include all DHMP Product Lines. DHMP MAT team assist in training new hires for all HPS employees. The MAT works with everyone to onboard new staff and be available to address real-time questions and concerns. Secondly, HPS Leadership continue to post all staff performance statistics around call volume, time and performance to allow transparency in identification of strength and challenges. These efforts are ongoing and remain a priority.

While providing quality assurance and utilization management services, DHMP may receive protected health information (PHI) and other confidential information. DHMP will receive, use, disclose, retain and safeguard such information in accordance with state and federal laws.

At the time of hire and on an annual basis, all staff shall receive comprehensive privacy and security training and acknowledge an understanding of the Denver Health privacy and security policies. DHMP shall treat all information as confidential to the extent that such information meets the definition of PHI as specified in 45 CFR Part 160. Confidential information obtained in the process of performing utilization management services will be used solely to perform the obligations concerning utilization and quality management and will be shared only with parties who are authorized by law or by the member to receive it, unless otherwise required by law.

All confidential information retained by DHMP shall be held in a secure manner consistent with statutory requirements and Denver Health policy. DHMP shall retain all confidential information for a period of time in accordance with applicable State of Colorado and federal laws. While performing its utilization management responsibility, it is the policy of the DHMP's Medical Management Department not to record telephone conversations.

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

Privacy and Confidentiality

In the course of providing quality assurance and utilization management services, DHMP receives confidential information from members and from providers which may include Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). DHMP will use and share such information in accordance with applicable state and federal laws. Policies are in place at DHMP to ensure the confidentiality of the information, including the following:

- DHMP maintains a policy requiring a Notice of Privacy Practices which complies with all requirements mandated by HIPAA. Such notice is offered to all members and is accessible online.
- The Notice of Privacy Practices describes the process for members to request restrictions to the uses and disclosures of their PHI, obtain copies of their PHI, request an amendment, or receive an accounting of disclosures.
- Access to PHI is restricted to those with a need to access PHI, and all access is logged and monitored for appropriate use.
- All employees with access to PHI are trained on proper handling of such information upon initial hiring, and annually thereafter.
- Policies are in place requiring the secure storage of all confidential information, including PHI, in accordance with applicable state and federal guidelines.

V. OVERALL STRUCTURE OF THE QI PROGRAM

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

Medical Director responsibilities include, but are not limited to:

- Providing direction and support related to the development, implementation and evaluation of all clinical activities of the QI department.
- Working in collaboration with the QI Director and the QI Intervention Managers on development and assessment of clinical interventions
- Delegating components of the QI Work Plan to other Members of the Operations Management Committee
- Serving on the QMC, AQIC, Pharmacy and Therapeutics Committee (P&T), Medical Management Committee, Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee and Denver Health Physician Executive Committee
- Evaluating and managing DHMP's Quality of Care Grievances (QOC-Gs working in conjunction with the QOC RN, and reporting to the PSQC as indicated for the reporting of QOC-Gs to the appropriate regulatory entities as appropriate. Overseeing DHMP's clinical and preventative health guidelines
- Serving as the chairperson of the Credentialing Committee

DHMP's Quality Improvement Department

Quality Improvement Department functions as a division of the Health Outcomes and Pharmacy (HOP). DHMP's Director of Quality Management is held by the Senior Director of HOP who provides oversight and direction to all QI members, QI department program work and direct supervision of QI department leaders. Responsibilities include, but are not limited to:

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

Denver Health Departments, as appropriate, for regulatory compliance.

- Serve as facilitator for the QMC, including determining the composition of the QMC and coordination of meeting execution.

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

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

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

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

Privacy and Confidentiality Monitoring

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

- At the time of initial hiring, all DHMP personnel shall be trained in the proper handling of confidential information and informed of disciplinary action that will result from a breach of confidentiality.
- All staff shall be trained annually in the proper handling of confidential information as part of their mandatory training

curriculum.

- DHMP shall treat all information as confidential which specifically identifies or permits identification of a certain health plan Member and describes the physical, emotional, or mental conditions of such person.
- DHMP may retain and use such confidential information in the performance of its obligations relating to costs, charges, procedures, or treatments employed by a Provider in treating any Member.

Confidential information obtained in the process of performing utilization management services will be used solely for utilization and quality management and will be shared only with parties authorized to receive it. Any confidential information which DHMP finds it necessary to disclose in the performance of utilization management services shall not be disclosed to any unauthorized entity without prior consent of the Member or as required by law.
All confidential information, whether physical or digital, retained by DHMP shall be held in a secure manner. All confidential information will be retained in accordance with applicable state and federal laws.

In the course of performing its utilization management responsibility, it is the policy of DHMP Medical Management Department not to record telephone conversations.
In the event of a Conflict of Interest, no person may participate in the review, evaluation, or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. All Company employees, any members of committees not employed by the organization, and the board of directors are required to review and sign the Conflict-of-Interest statement annually.

Quality Management Committee Structure (QMC)

DHMP's Quality Management Committee (QMC) plans and coordinates improvements in quality and safety of clinical care and service for our members. The QMC is charged with responsibility for oversight of all quality related DHMP Medical Management activities and process, including but not limited to: Utilization Management, Case Management, Health Management, Pharmacy, Population Health Management, Member Services, Appeals and Grievances, Provider Relations, Marketing, Compliance, and Product Line Managers. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, and SNP MOC annual program evaluation and goals The QMC includes primary care Providers and specialty Providers from both DHHA and the extended practitioner network and other staff.

The Quality Management Committee:

- Meets Bi-Monthly
- Is comprised of the following **Voting Members** (and/or their designee):
    - Quality Improvement Manager (Chair)
    - Chief Medical Director
    - DHMP Manager of Compliance
    - DHMP Director of Actuarial & Medical Economics*
    - DHMP Director of Member and Provider Experience
    - DHMP Director of Claims
    - DHMP Director of Monitoring, Auditing and Training
    - Manager of Medical Economics*
    - DHMP Director of Pharmacy
    - DHMP Director of Utilization Management
    - DHMP Director of Case Management
    - DHMP Director of Insurance Products
    - PCP(s) from DHHA and the External Provider Network
    - Specialty Care Provider(s) from DHHA and the External Provider Network
    - Behavioral Health Physician (M.D) Provider(s) from DHHA or the External Provider Network

- *Medical Economic's supports QMC goals due to their role in data analytics, NMC/Contracting efforts, and supporting benefit design with data gathering and comparison.

Non-Voting Members:

- QI Project Manager
- Intervention Project Managers
- NCQA Project Manager
- HEDIS Supervisor
- ACS Care Coordination Manager
- QOC Nurse
- Clinical Pharmacist Specialist
- Manager of Grievance and Appeals (non-voting unless designated by director)
- Manager of Health Plan Services (Non-voting unless designated by director)
- Medicare Products Manager (Non-voting unless designated by director)
- Medicaid/CHP Product Manager (Non-voting unless designated by director)
- Commercial Products Manager (Non-voting unless designated by director)
- Manager of Provider Relations and Marketing (Non-voting unless designated by director)

- DHMP Chairperson may invite other DHMP network practitioners, providers, staff and/or other guests on an ad hoc basis for specialty review and/or input.

Functions of QMC:

- Review of the performance of QI activities.
- Review summary reports for the QMC subcommittees, ad hoc committees and QA/QI process improvement activities providing feedback and /or recommendations for improvement.
- Identify and analyze trends and evaluate the implementation of appropriate focused interventions to improve performance.
- Review and Approve Quality Improvement Projects (QIPs)
- Review, evaluate, develop and implement Population Health based QA/QI activities and satisfaction survey intervention plans.
- Provide oversight of all clinical and administrative aspects of the QI Program.
- Review practitioner membership annually or as needed to assure broad representation of primary care practitioners and specialists.
- Oversee accurate and clear reporting of QMC minutes and follow up actions.
- Recommend clinical and safety initiatives relevant to policy decisions. Review and evaluate the results of quality improvement activities.
- Oversee needed actions for improvement upon performance goals.
- Supervise follow-up of issues and activities, including root cause analysis or barrier analysis when needed.
- Review, update and approve clinical and preventive practice guidelines annually.
- Review member satisfaction and quality of care results, such as CAHPS, HEDIS, STARS and findings of Open Shopper studies.
- Review and evaluate activities that improve member experience, such as access to care and quality of services and make recommendations about ways to improve these results.
- Review, monitor, track and trend, findings of Quality of Care, Quality of Service, and Serious Reportable Events and make recommendations for Corrective Action Plans (CAP). Monitoring of CAHPS

- Review of Credentialing Committee (CC), Medical Management Committee (MMC), Network Management Committee (NMC), and Pharmacy and Therapeutics (P&T) Committee minutes for program(s) performance for selection of opportunities
- Review and final resolution of practitioner request for reconsideration of credentialing and/or recredentialing determinations and/or issues, termination of practitioner and /or provider contracts for quality-of-care issues, competence, or professional conduct.
- Provide oversight and recommendations regarding utilization of new technologies and benefit design.
- Provide oversight of QI Program deliverables including, but not limited to:
    - QI Program Description
    - QI Work Plan
    - QI Evaluation
- Provide oversight of the Population Health Program
    - Annual PH Program Evaluation
    - Annual PH Program Strategy
- Provide oversight of Utilization Management Program (UM) including:
    - Annual UM Evaluation
    - Annual UM Program Description
    - Work Plan update
- Provides ongoing reporting to the DHMP Board of Directors

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

- Ambulatory Care Services QI Committee (AQIC) as needed
- Medical Management Committee (MMC)
- Network Adequacy Committee (NMC)
- Credentialing Committee (CC)
- Utilization Management (UM) Committee

QI Activities Summary

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

Results from QI activities for 2024 have been outlined throughout this impact analysis and are also contained in the 2023-24 work plan and strategic access plan. QI will continue to work collaboratively with other departments and the ACS Provider network to improve HEDIS and CAHPS scores. We will strive to increase access to needed care and access to getting care quickly, while focusing on member experience and engagement.