2023 QUALITY IMPROVEMENT PROGRAM EVALUATION

DENVER HEALTH MEDICAL PLAN, INC.

Commercial, Medicare, and Exchange Products

May 14th, 2024

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EXECUTIVE SUMMARY

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

- Commercial Employer Group:
  - Denver Health and Hospital Authority (DHHA)
- Commercial Exchange/CO Option:
  - Elevate Health Plans
- Medicare Advantage:
  - Medicare Select HMO
  - Medicare Choice HMO SNP

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

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

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

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

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

these committees and groups, we join quality resources and actively work together to increase the health and well-being of our members.

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

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

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

QUALITY IMPROVEMENT PROGRAM EVALUATION AND WORK PLAN

OVERVIEW

The **QI Program Description** document describes the quality assurance and performance improvement (QAPI) design and scope, governance and leadership and feedback, data systems and monitoring program structure. The **QI Program Evaluation** document describes the quality assurance and performance improvement (QAPI) activities, performance improvement projects, and systematic analyses for one calendar year. Input on projects for improvement, interventions and data analyses on work accomplished during the year is obtained from a variety of sources, to ensure quality is being monitored across the health plans. These include but are not limited to; the DHMP Operations Team, Health Plan Services Department, Utilization Management, Care Management Department staff, QI Department staff, multivariant data sources, Healthcare Effectiveness Data and Information Set (HEDIS) reporting and CAHPS surveys. The Centers for Medicare and Medicaid Services (CMS) and contractual requirements for our Medicare Advantage, Commercial and Exchange lines of business are reviewed annually, for inclusion in the development of a comprehensive and targeted QI Program Evaluation.

Finally, a **QI Work Plan** document is prepared annually using the prior year **QI Program Evaluation** as a guide to identify the response to the analyses and identify actions of focus. The Work Plan for the upcoming year is also prepared for submission to the QMC and DHMP Governing Board of Directors for approval.

The annual **QI Work Plan** includes the following elements:

- Yearly written measurable objectives
- Quality clinical, preventive and service interventions and initiatives
- Overall scope of the QI Program including clinical, safety and service indicators, responsible parties, implementation, review, and time initiatives
- Schedule of reports and planned activities

- Evaluation of the effectiveness of the QI Program
- Evaluation of member experience
- Evaluation of the effectiveness of the CM/UM Programs
- Evaluation and Strategy for the Population Health Programs

QUALITY IMPROVEMENT OBJECTIVES FOR 2024

- Develop a more robust data driven DHMP Quality Improvement Program (QI) which continuously measures, analyzes, and evaluates the quality of care and services provided to our plan members.
- Improve the overall health of our populations by supporting evidence-based interventions to address behavioral, social and environmental determinants of health.
- Promote medical and preventive care delivered by practitioners/providers that meet or exceed the accepted standards/benchmarks of quality in the community.
- Improve the health status of our members by providing high quality, cost-effective, equitable 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.
- Deliver high quality clinical care that meets community standards and offer customer-focused service to our members and practitioners/providers.
- Improve the access to care for all our members by maintaining and increasing a robust provider network with highly qualified professionals.
- Maintain a high level of Provider Satisfaction.
- Evaluate and improve upon the beneficiary experience with care and services.
- Utilize a data-driven approach to improving care, safety, health outcomes and service of beneficiaries through the continuous monitoring and evaluation of industry recognized and internally developed key performance indicators for quality care and service.
- Continuous evaluation of the QI program and implement interventions that improve the administrative services of the Plan and health care services delivered by contracted practitioners/providers, using HEDIS measures, QI projects and activities and CAHPS member surveys.
- Development of improvement 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 Centers for Medicare and Medicaid Services' (CMS) requirements regarding Quality Improvement Program activities.
- Measure and report Quality Improvement and other program performance using standard measures and tools required by CMS and NCQA.
- Adopt national, regional and/or local public health goals and industry performance benchmarks, evaluating available resources for QI to make sustainable decisions.
- 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.
- Continue to build Quality/Pharmacy collaborations for intervention design to drive improved member experience and health outcomes.
- Promote the effectiveness, efficiency, and compliance of all First Tier, Downstream and Related Entities (FDRs) with DHMP contractual and CMS requirements.

- Coordinate delegated activities on behalf of contractual organization.
- Empower members to lead a self-directed healthy lifestyle through health promotion activities, health plan and community outreach efforts and coordination with public and private community resources.
- Encourage safe, effective, and appropriate clinical practice through established care standards and application of appropriate practice guidelines.
- Monitor and evaluate high-volume and/or high-risk services to identify opportunities for improvement.
- Collaborate with ACS on the development of Population Health initiatives for special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate.
- Collaborate with Network Providers to improve 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 HealthPlan Members, ASC Work Groups, QMC and Subcommittees on QI Projects Interventions and Improvement activities.

QUALITY IMPROVEMENT PROGRAM SCOPE

DHMP is dedicated to ensuring members receive the highest quality health care and customer service. The QI Program is responsible for developing, monitoring, and evaluating all quality-related outcomes to ensure these standards are obtained. 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
- Equitable 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 PROGRAM ACCOMPLISHMENTS AND STRENGTHS

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

- Participated in collaborative QI work group activities with ACS, developing QI interventions in disease management and prevention.
- Continued to identify and develop training to assist in appropriate provider documentation and coding to support improvement of HEDIS scores.
- Increased member outreach to encourage preventive health screenings and to support members with chronic disease conditions, such as diabetic eye exams and mammograms.
- Continued enhanced collaboration with DH School Based Health Centers (SBHC) to increase the number of adolescent well-child visits and immunizations within Denver Public Schools.
- Increased member outreach in Covid-19 Vaccination Efforts.
- Continued refinement of member outreach efforts, utilizing EPIC (electronic medical record) implementation for ACS and QNXT (claims processing system) BI and Tableau reports for DHMP.
- Collaborated with Health Plan Medical Management to build a comprehensive Population Health Program to help members improve knowledge and management of health.
- Developed and implemented enhanced patient education materials; focused on health literacy and cultural competency.
- Conducted an annual Provider Satisfaction Survey to evaluate satisfaction with DHMP departments and services, including knowledge of DHMP offerings to support patient care.
- Participated as a member of the Ambulatory Care Quality Improvement workgroup for cardiovascular disease to begin to address health literacy/cultural competency and reduce health disparities through services in DH.
- Supported ongoing inclusion of Culturally and Linguistically Appropriate Services (CLAS) training in required annual training for DH providers and staff to support the delivery of culturally sensitive care and engage fully in participation of a diverse workforce.
- Incorporated data from ACS registries, data warehouse files and outside entity data into supplemental files used for HEDIS reporting.
- Maintained oversight and follow up of delegated and facility credentialing relationships.
- Increased outreach to DHMP members through ACS clinic staff and targeted member outreach, as well as Vendor based screening initiatives.
- Facilitated physician involvement in the development of clinical guidelines, including the streamlining process of guideline development.
- Conducted development, review and revision of policies and procedures annually through electronic tracking process.
- Maintained physician involvement within the QMC structure from the ACS network.
- Maintained VBC for Exchange plans, as part of a Quality Improvement Strategy (QIS) for Elevate, as well as for Commercial and Medicare plans.
- Continued the Medicare Chronic Care Improvement Project (CCIP), to continue through 2024-2026, focused on controlling blood pressure.
- Produced monthly HEDIS runs, and corresponding gaps in care lists for use in quality improvement initiatives.
- Improved the timeliness and accuracy of the annual HEDIS production run.
- QI Manager was recruited and hired as of 2023 Q4.

CHALLENGES AND OPPORTUNITIES

During the 2023 measurement year the QI program faced many challenges.

- The Quality Improvement Department continues to attempt to find strong health plan candidates to fill vacancies.

- QI leadership changed and staff expanded in 2023. Onboarding and reallocation of work ongoing.
- Data challenges continue and work to resolve is ongoing.
- Budgetary constraints have placed a hold on additional QI hires slated to assist with more broad quality health plan efforts. The NCQA health plan accreditation project management moved under the QI Department in Q3 2023.

FUTURE OPPORTUNITIES FOR IMPROVEMENT

- Develop a more rigorous data validation plan for HEDIS measures, confirming that data and counts and sample sizes are accurate, while continuing to increase supplemental sources of data for HEDIS measures.
- Continue efforts to improve the capture and accuracy of provider data for HEDIS, including practice type, specialist coding and provider 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.
- 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.
- Conduct evaluation of member engagement strategy to increase member buy-in and involvement in self-management and preventive care goals.
- Evaluate effective platforms for communication with members.
- Align and partner QI initiatives and interventions with ACS leadership and provider networks to avoid duplication of efforts and to utilize resources more effectively.
- Continue to develop the use of the LEAN framework within quality initiatives to develop A3 problem-solving aligned with the Plan-Do-Study-Act (PDSA) format.
- Utilize the LEAN framework to develop and evolve standard work for the QI Department.
- Integrate with Denver Health ACS health equity efforts, focused on hypertension for African Americans, through the cardiovascular QI workgroup.
- Continue monthly review of HEDIS data to ensure more timely measures and interventions.
- Expand and support QI team opportunities for growth and enhancement of skills, and to automate tasks where possible to increase the functional capacity of the QI team.
- Address known opportunities for NCQA accreditation improvement and an organizational plan for NCQA compliance and accreditation renewal.
- Continue to evolve value-based contracting for enhanced quality improvement outcomes.
- Promote further alignment of DHMP and ACS strategic QI metrics and goals.
- Continue progressing in the evolution of the programs, platforms and staffing of UM, CCM and PHM functions at DHMP.
- Develop internal QOCC education and processes.
- Continue to develop all stakeholder departments' understanding and use of quality data to drive improvement efforts.

ANNUAL CLINICAL AND PREVENTATIVE GUIDELINE REVIEW

Via QMC, a 2023 annual review of the following Guidelines for any nationally recognized updates was completed. The following guidelines were reviewed and approved:

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

Both Clinical and Preventive Guidelines support our contracted providers and provide health plan performance focus areas. Each guideline reflects nationally recognized best practices, as well as community health care standards of care.

QUALITY OF CLINICAL CARE ACTIVITIES

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.

2023 QUALITY IMPROVEMENT ACTIVITIES/INTERVENTIONS

HEDIS metrics are compared to prior year and trended over several years. MY2022 HEDIS rates are based on calendar year 2022 data. For Medicare, Elevate and Commercial lines of business, improvement goals are a 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:

DHMP COMMERCIAL

DHMP Commercial					
Diabetes Indicators (CDC)	**MY2020 HEDIS Results**	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile**	**MY2021-MY2022 HEDIS Change**
HbA1c Testing	85.05%	88.32%	Retired MY2022	N/A	N/A
HbA1c Poor Control >9.0% (lower=better performance) *	45.1%	22.63%	27.49%	50th	4.86%*
HbA1c Control <8.0%	44.07%	63.50%	63.99%	25th	+0.44%
Eye Exam	37.89%	48.91%	52.80%	50th	3.89%
Kidney Health Evaluation	32.96%	52.25%	44.99%	25th	-7.26%
Blood Pressure Controlled <140/90	55.67%	69.10%	72.51%	50th	+3.41%

DHMP MEDICARE

DHMP Medicare					
Comprehensive Diabetes Care (CDC)	**MY2020 HEDIS Results**	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile**	**MY2021-MY2022 HEDIS Change**
HbA1c Testing	89.05%	92.94%	Retired MY2022	N/A	N/A

HbA1c Poor Control >9.0% (lower=better performance) *	26.76%	18.73%	19.46%	New Specifications – No Percentile Available	0.73%*
HbA1c Control <8.0%	57.42%	60.34%	63.99 %	New Specifications – No Percentile Available	+3.65%
Eye Exam	63.02%	75.91%	81.75%	New Specifications – No Percentile Available	+5.84%
Kidney Health Evaluation	40.75%	64.08%	65.35 %	95th	+1.27%
Blood Pressure Control <140/90	60.81%	70.56%	70.56%	New Specifications – No Percentile Available	+0.00%

DHMP EXCHANGE

DHMP Exchange					
Comprehensive Diabetes Care (CDC)	**MY2020 HEDIS Results**	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile***	**MY2021-MY2022 HEDIS Change**
HbA1c Control <8.0%	40.00%	52.08%	51.43%	10th	-0.65%

Eye Exam	31.11%	58.33%	57.14%	50th	-1.19%
Kidney Health Evaluation	Measure did not Exist	Measure did not Exist	64.62%	N/A	N/A

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

SUMMARY OF HEDIS MY2022 DIABETES RESULTS

COMMERCIAL
Comparison of HEDIS MY2022 results against national benchmarks reveals that the HEDIS MY2022 Commercial results improved for all diabetes measures, with the exception of HbA1c Poor Control >9.0, which increased from 22.63% in HMY2021 to 27.49% in HMY2022 (for this measure, a lower percentage means better performance) and Kidney Health Evaluation, which decreased from 52.25% in HMY2021 to 44.99% in HMY2022.

MEDICARE
Comparison of HEDIS MY2021 results to HEDIS MY2022 Medicare results demonstrates improvement for three of the five diabetes measures, with the exception of HbA1c Poor Control >9.0, which increased from 18.73% in HMY2021 to 19.46% in HMY2022 (for this measure, a lower percentage means better performance) and Blood Pressure Control, which remained stable between HMY2021 and HMY2022. Medicare percentiles are not available for this measurement year, as the CDC measures used in previous years were replaced in this measurement year.

EXCHANGE
Comparison of HEDIS MY2021 results to HEDIS MY2022 Exchange results shows rates remained fairly stable for the Eye Exam measure and HbA1c Control <8.0%, with rates decreasing by 1.19% and 0.65% between HMY2021 and HMY2022, 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.

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 2022 and 2023, the QI team worked 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 2023, DHMP began 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. 306 HbA1c test kits were mailed to members, and 30 were processed with results. For KED, 911 test kits were mailed to members, and 73 were processed with results; the KED test kits require both a blood sample and a urine sample to return results, which likely contributed to the lower KED test kit return rate.

ACTION PLAN FOR DIABETES IMPROVEMENT 2024

The DHMP QI team will continue to participate in both the Diabetes Collaborative and Diabetes Collaborative Subgroups and explore additional ways to improve diabetes care for our members, including controlling blood sugar, kidney disease monitoring, and performing eye exams. QI will continue to focus on increasing the Diabetic Eye Exams measure for Medicare, Commercial, and Exchange, which still sits well below the 90th percentile ranking, as well as HbA1c poor control >9.0%. In 2020, DHMP developed and began to implement an integrated Population Health Management program for our Medicare, Commercial, and Exchange population with a focus area on diabetes management for our high-risk patient population. This program aims to improve quality care of diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. DHMP is collaborating with DHHA on peer and support groups and access to community programs.

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

CARDIOVASCULAR SCREENING MY2022 HEDIS CARDIOVASCULAR RESULTS

DHMP COMMERCIAL, MEDICARE AND EXCHANGE CONTROLLING HIGH BLOOD PRESSURE

	Commercial				
	MY2020 HEDIS Results	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile**	**MY2021-MY2022 HEDIS Change**
Controlling High Blood Pressure (CBP)	55.72%	60.83%	65.21%	25th	+4.38%
	Medicare				
	MY2020 HEDIS Results	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile**	**MY2021-MY2022 HEDIS Change**
Controlling High Blood Pressure (CBP)	65.69%	69.83%	69.34%	25th	-0.49%
	Exchange				
	MY2020 HEDIS Results	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentile***	**MY2021-MY2022 HEDIS Change**
Controlling High Blood Pressure (CBP)	61.54%	68.63%	70.00%	50th	+1.37%

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

SUMMARY OF HEDIS MY2022 CONTROLLING BLOOD PRESSURE RESULTS

The rate for Controlling High Blood Pressure (CBP) measure remains well below the 90th percentile across the Commercial, Medicare, and Exchange lines of business. The Commercial rate improved from 60.83% in HMY2021 to 65.21% in HMY2022, and the Medicare rate decreased slightly from 69.83% in HMY2021 to 69.34% in HMY2022. The Exchange rate increased from 68.63% in HMY2021 to 70.00% in HMY2022. Nationally, the Commercial line of business remained in the 25th percentile, while Medicare decreased from the 50th to the 25th percentile, and the Exchange line of business remained in the 50th 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. In 2020, reducing disparities in health related to race, ethnicity and language was identified as a DHHA enterprise opportunity, particularly as the COVID-19 pandemic emphasized the continuing disparities in health outcomes related to race and ethnicity. The QI team continued to work collaboratively with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. Our most recent data 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% and Whites and Hispanics at 61.1% and 64.6%, respectively. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup began an effort to determine root causes of this disparity and create a series of interventions to address it.

In 2022, 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. As a result of this success, DHMP Population Health Management will look at the potential for expanding this intervention into other lines of business for 2024.

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 2023, 497 Medicare members requested and received home blood pressure cuffs. This benefit will continue in 2024 and be expanded to include other lines of business.

ACTION PLAN FOR CARDIOVASCULAR PERFORMANCE IMPROVEMENT 2024

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

The Controlling Blood Pressure Care Management program will continue into 2024 and focus on those Medicare members with hypertension diagnoses whose blood pressure is not under control. Efforts to expand this program for members in the Exchange and Commercial Populations will continue to be a priority for the Population Health Management Team in 2024. In addition, the DHMP QI team will continue to utilize this intervention as our CMS mandated Chronic Condition Improvement Program for the Medicare Choice and Select lines of business.

PREVENTION AND SCREENING HEDIS MEASURE RESULTS

DHMP COMMERCIAL

DHMP Commercial					
Prevention and Screening	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 HEDIS Change
Breast Cancer Screening (BCS)	72.01%	76.61%	82.32%	90th	+5.71%
Cervical (21-64y/o) (CCS)	79.08%	82.73%	78.10%	50th	-4.63%
Colorectal (50-80 y/o) (COL)	59.85%	63.26%	56.20%	25th	-7.06%

DHMP MEDICARE

DHMP Medicare					
Prevention and Screening	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 HEDIS Change
Breast Cancer Screening (BCS)	68.08%	65.00%	77.08%	25th	+12.08%
Colorectal Cancer Screening (COL)	76.16%	68.61%	74.70%	25th	+6.09%

DHMP EXCHANGE

DHMP Exchange					
Prevention and Screening	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 HEDIS Change
Breast Cancer Screening (BCS)	55.56%	54.00%	63.16%	5th	+9.16%
Cervical Cancer Screening (CCS)	56.68%	62.72%	61.31%	5th	-1.41%
Colorectal Cancer Screening (COL)	53.29%	52.66%	48.67%	10th	-3.99%

*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.

COMMERCIAL LINE OF BUSINESS SUMMARY

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

Summary of HEDIS MY2022 Results

The Breast Cancer Screening (BCS) measure rate increased by 5.71% from HMY2021 to HMY2022. The overall rate of Colorectal Cancer Screenings (COL) decreased by 7.06% for HMY2022 compared to HMY2021. Further, Cervical Cancer Screening (CCS) rates decreased by 4.63% in HMY2022.

Interventions 2023

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 in September 2020. This mailer included reminders for members who are overdue for a Breast Cancer Screening. In CY2022, the QI team sent 1682 mailers to Commercial 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 also provided data to support the work.

MEDICARE LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2022 Results

For the Medicare population, percentile rankings remained steady in HMY2021. BCS rates increased by 12.08% in HMY2021, and COL rates increased by 6.09%.

Interventions 2023 – 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 CY2023, the QI team sent 2803 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 2023, they continued to track this rate by clinic.
As mentioned above, ACS also continued mailing Patient Health Summary letters in 2023. This mailer included reminders for members who are overdue for a Breast Cancer Screening.

EXCHANGE LINE OF BUSINESS SUMMARY

Summary of HEDIS MY2022 Results

The Exchange Breast Cancer Screening (BCS) measure rate increased by 9.61% from HMY2021 to HMY2022. Despite the increase in rate, the percentile for BCS remained low, at the 5th percentile. The overall rate of Colorectal Cancer Screenings (COL) decreased by 3.99% for HMY2022 compared to HMY2021, and Cervical Cancer Screening (CCS) rates decreased by 1.41% in HMY2022.

Interventions 2023

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 in September 2020. This mailer included reminders for members who are overdue for a Breast Cancer Screening. In CY2022, the QI team sent 1023 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 ACTION PLAN

PREVENTION AND SCREENING ACTION PLAN FOR 2024

All Commercial, 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 Population Health Analyst will continue to monitor the progress of this intervention. The DHMP QI department maintains a consistent presence at the Ambulatory Care Cancer Screening workgroup. This group provides an open forum for discussion surrounding collaboration with ambulatory care providers and the Women's Mobile Clinic. The QI department will continue participating in this workgroup in 2024. 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 2024, 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.

COLORECTAL CANCER SCREENING

INTERVENTIONS 2023-COLORECTAL SCREENING

In 2023, 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 2024, 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 2023.

The HMY2022 rate for OMW was 60.00%, which was a 16.19% decrease from HMY2021. 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

	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 HEDIS Change
OMW	66.67%	76.19%	60.00%	75th	-16.19%

In 2023, 71 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 2023.

OMW ACTION PLAN FOR 2024

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 2024, 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 2024, the QI Team and the Ambulatory Central Clinical Support (CCS) team will continue to partner with the ACS Geriatric Workgroup to improve performance on this measure. Over the next couple of years, anticipated spec changes to the OMW HEDIS measure may impact this intervention.

PRENATAL/POSTPARTUM CARE

DHMP COMMERCIAL

DHMP Commercial					
	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 Percentile	MY2021-MY2022 HEDIS Change
st Prenatal Care in 1 Trimester	97.87%	96.50%	93.28%	75th	-3.22%
Postpartum care within 7- 84 days after delivery	94.89%	96.50%	95.80%	95th	-0.70%

DHMP EXCHANGE

DHMP Exchange					
	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 Percentile	MY2021-MY2022 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 COMMERCIAL HEDIS MY2022 PRENATAL/POSTPARTUM RESULTS

Numerous changes to the PPC measure in 2020 continue to impact our rates. For Postpartum Care, the period for a visit creating a numerator positive result changed from 21-56 days to 7-84 days. The Timeliness of Prenatal Care measure was also changed to allow for visits that occurred before the enrollment start date to be counted. Additional factors that may have contributed to the improvement in Prenatal Care rates are currently under evaluation by the Denver Health Perinatal Committee. These factors may include changes to provider templates to

improve access to OB Intake visits. The continued improvement in Postpartum Care may also have been impacted by Denver Health's process of scheduling the postpartum visit for patients who deliver at Denver Health before they leave the hospital following delivery. For Commercial HEDIS MY2022, the rate of women who received prenatal care in the first trimester decreased slightly, by 3.99%. The rate of postpartum care within 7-84 days after delivery also decreased slightly, by 0.70%. DHMP Commercial performance remains in the 75th and 95th percentiles when compared to national performance.

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 2024

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

CHILDHOOD PREVENTIVE HEALTH

DHMP COMMERCIAL CHILDHOOD HEDIS METRIC RESULT MY2022

DHMP COMMERCIAL CHILDHOOD HEDIS METRIC RESULTS MY 2022

DHMP Commercial					
Childhood Preventive Measures	**MY2020 HEDIS Results**	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 HEDIS Percentiles**	**MY2021-MY2022 HEDIS Change**
Childhood Immunization Status					
DTaP	94.71%	96.20%	97.95%	95th	+1.75%
MMR	98.24%	97.47%	95.89%	95th	-1.58%
OPV/IPV	97.06%	97.47%	99.32%	95th	+1.85%
HiB	97.65%	97.47%	99.32%	95th	+1.85%
Hepatitis B	97.65%	97.47%	99.32%	95th	+1.85%
Varicella (VZV)	97.65%	97.47%	97.26%	95th	-0.21%
Pneumococcal	95.29%	96.84%	97.95%	95th	+1.11%
Hepatitis A	97.65%	98.10%	97.95%	95th	-0.15%
Rotavirus	94.12%	94.94%	91.78%	90th	-3.16%

Influenza	90.59%	89.87%	88.36%	95th	-1.51%
Combo 2	93.53%	Retired HMY2021	Retired HMY2021	N/A	N/A
Combo 3	93.53%	94.30%	94.52%	95th	+0.22%
Combo 7	91.76%	92.41%	89.73%	95th	-2.68%
Immunizations for Adolescents					
Meningococcal	88.64%	90.80%	95.03%	95th	+4.23%
Tdap/Td	94.32%	95.40%	96.27%	90th	+0.87%
Combo 1	88.64%	89.66%	94.41%	95th	+4.75%
Well-Child Visits					
First 15 months	84.94%	84.43%	77.78%	10th	-6.65%
Ages 3-11	73.90%	79.10%	81.47%	75th	+2.37%
Ages 12-17	57.43%	61.27%	65.06%	50th	+3.79%

DHMP EXCHANGE CHILDHOOD HEDIS METRIC RESULT MY2022

DHMP Exchange					
Childhood Preventive Measures	**MY2020 HEDIS Results**	**MY2021 HEDIS Results**	**MY2022 HEDIS Results**	**MY2022 Percentile**	**MY2021-MY2022 HEDIS Change**
Childhood Immunization Status					
DTaP	N/A	N/A	N/A	N/A	N/A
MMR	N/A	N/A	N/A	N/A	N/A
IPV	N/A	N/A	N/A	N/A	N/A
HiB	N/A	N/A	N/A	N/A	N/A
Hepatitis B	N/A	N/A	N/A	N/A	N/A
VZV	N/A	N/A	N/A	N/A	N/A
Pneumococcal	N/A	N/A	N/A	N/A	N/A

Combo 3	N/A	N/A	N/A	N/A	N/A
Immunizations for Adolescents					
Meningococcal	N/A	N/A	N/A	N/A	N/A
Tdap/Td	N/A	N/A	N/A	N/A	N/A
HPV	N/A	N/A	N/A	N/A	N/A
Combo 3	N/A	N/A	N/A	N/A	N/A
Well-Child Visits					
First 15 months	Measure did not Exist	N/A	N/A	N/A	N/A
Ages 3-11	Measure did not Exist	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 2020, MY2021, and MY 2022 rates were not reportable due to small sample size.

SUMMARY OF HEDIS MY2022 CHILD IMMUNIZATION RESULTS

COMMERCIAL

Immunization rates remain strong for the Commercial line of business, with all Child Immunization Status measures reported in HMY2022 in the 90th or 95th percentile.

Immunizations for Adolescents measures experienced a slight increase in HMY2022, with Meningococcal rates increasing 4.23%, Tdap/Td rates increasing 0.87%, and Combo 1 rates increasing 4.75% from HMY2021. This led to a percentile increase across two of the three measures, with Meningococcal vaccination rates in the 95th percentile of national performance, Tdap/Td rates remaining in the 90th percentile, and Combo 1 vaccination rates in the 95th percentile for HMY2022.

EXCHANGE

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

Interventions 2023

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

ACTION PLAN FOR 2024

For 2024, 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.

COMMERCIAL SUMMARY OF HEDIS MY2022 WELL-CHILD VISITS

COMMERCIAL

HMY2022 well-child visit rates in the first 15 months of life decreased by 6.65% and dropped to the 10th percentile for the Commercial line of business. Well-child visit rates for ages 3-11 were 81.47%, and well-child visit rates for ages 12-17 were 65.06%, at the 75th and 50th percentiles in HMY2022, respectively.

EXCHANGE

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

2023 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 2023, the average monthly mailing was 112 postcards across the Commercial and Exchange lines of business.

Year	Avg. Commercial/Exchange Postcards Mailed/Month
2020	307
2021	120
2022	103
2023	112

ACTION PLAN FOR 2024

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 2024. 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 2024.

ASTHMA

DHMP COMMERCIAL MY2022 ASTHMA INDICATOR RESULTS

Asthma Medication Ratio (AMR)	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 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	61.70%	67.01%	69.62%	<5th	+2.61%

Ages 51-64	*N/A	57.14%	*N/A	*N/A	*N/A
Total	67.86%	66.67%	70.34%	<5th	+3.67%

*N/A=Sample size <30

DHMP EXCHANGE MY2022 ASTHMA MEDICATION RATIO

Asthma Medication Ratio (AMR)	MY2020 HEDIS Results	MY2021 HEDIS Results	MY2022 HEDIS Results	MY2022 HEDIS Percentile	MY2021-MY2022 HEDIS Change
Ages 5-11	Measure Did Not Exist	*N/A	*N/A	*N/A	*N/A
Ages 12-18	Measure Did Not Exist	*N/A	*N/A	*N/A	*N/A
Ages 19-50	Measure Did Not Exist	*N/A	*N/A	*N/A	*N/A[1]
Ages 51-64	Measure Did Not Exist	*N/A	*N/A	*N/A	*N/A
Total	Measure Did Not Exist	*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 MY2022

ASTHMA RESULTS COMMERCIAL

For the Commercial line of business, HMY2022 results showed a slight increase in the Asthma Medication Ratio (AMR) measure. Overall AMR performance (all age groups included) increased by 3.67%, but DHMP remains at <5th percentile nationally. This is especially significant, as NCQA retired the MMA measure in HMY2020, placing increased importance on the AMR metric to assess how well health systems manage asthma moving forward.

EXCHANGE

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

Interventions for 2023

- 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 2024

The DHMP QI department participates regularly in the Ambulatory Asthma Workgroup, which is comprised of Denver Health physicians, nurses, Ambulatory Care Navigators, clinic operations personnel and pharmacists. Additionally, the Asthma Work Group will continue to focus on appropriately identifying and controlling adult asthma in 2024 after identifying a need in 2020 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 2024. 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.

SAFETY AND QUALITY OF CLINICAL CARE

QUALITY OF CARE CONCERNS

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 hospital acquired conditions or never events 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 Product Line Managers and the DHMP QMC. 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. The DHMP Medical Director, along with the RN designee continuously monitor and trend all member QOCCs.

2023 QUALITY OF CARE CONCERN CASES (QOCC) – DHMP COMMERCIAL, EXCHANGE AND MEDICARE

Plan	Total Cases 2023	Unsubstantiated	Substantiated	Inconclusive
Exchange	**0**	**0**	**0**	**0**
Medicare	**5**	**2**	**3**	**0**
Commercial	4	**3**	**1**	**0**

ANALYSIS

COMMERCIAL: A total of 4 cases were submitted for the Employee Commercial Plans for calendar year 2023. Upon review, one complaint was substantiated, and the remaining 3 cases were unsubstantiated. The substantiated complaint involved a local infertility clinic which is outside of our contracted network. After multiple attempts to obtain feedback and clinical records regarding the allegations, nothing was received. The case was therefore deemed substantiated due to lack of evidence.

EXCHANGE: No quality complaints were submitted for this plan for the 2023 calendar year.

MEDICARE: The Medicare line of business had a total of 5 quality of care grievances. Two were deemed unsubstantiated upon review, three were deemed substantiated upon review. All care was appropriate in the two unsubstantiated complaints. Two of the three substantiated complaints were regarding care in contracted Skilled Nursing Facilities. Neither facility would respond to requests for clinicals. Due to lack of information, both were classified as substantiated and will be tracked by the Credentialing Committee. The third substantiated complaint involved a leaking syringe during an ultrasound guided injection. Denver Health's Quality Team was alerted, and an all-provider training notification was sent out.

CULTURAL AND LINGUISTICALLY APPROPRIATE SERVICES PROGRAM (CLAS)

Denver Health Medical Plan (DHMP) provides health coverage to a culturally diverse population; therefore, it is important to educate staff about cultural differences that impact healthcare delivery. As of December 2023, there were nine distinct languages identified that were spoken by our DHMP Medicare Advantage members and 15 distinct languages spoken by our DHMP Commercial population. However, only two languages were spoken by our members at 0.1% or greater, or 500 persons or more, (English and Spanish) for both product lines in 2023.

DHMP MEDICARE ADVANTAGE PLANS LANGUAGE DATA*

Language	Measure	2022	2023
English	Count	3403	3781
	Rate	72.64%	73.53%
Spanish	Count	1235	1318
	Rate	26.36%	25.63%
? /No Language	Count	42	35
	Rate	0.04%	0.68%
Vietnamese	Count	2	2
	Rate	0.04%	0.04%
Chinese	Count	1	2
	Rate	0.02%	0.04%
French	Count	0	2
	Rate	0.00%	0.04%
Danish	Count	0	1
	Rate	0.00%	0.02%
Tagalog	Count	1	1
	Rate	0.02%	0.02%
Tigrigna	Count	1	0
	Rate	0.02%	0.00%
Arabic	Count	1	0
	Rate	0.02%	0.00%
Grand Total	Count	4,790	4,685

**Numbers reflect enrollment as of 12/31/2022*

DHMP MEDICARE ADVANTAGE PLANS RACE/ETHNICITY DATA*

Race/Ethnicity	2021		2022		2023	
	Count	Rate	Count	Rate	Count	Rate
No Ethnicity	0	0.00%	0	0.00%	1	0.02%
Hispanic or Latino	2,402	50.15%	2,446	52.21%	2584	50.25%
White	1,350	28.18%	1,258	26.85%	1395	27.13%
African American/Black	799	16.68%	719	15.35%	847	16.47%
Unknown/Other	141	2.94%	168	3.59%	204	3.97%
Not Hispanic or Latino	0	0.00%	0	0.00%	0	0.00%
Pacific Islander	2	0.04%	2	0.04%	2	0.04%
Alaskan/American Indian	18	0.38%	20	0.43%	28	0.54%
Asian	77	1.61%	71	1.52%	81	1.58%
Native Hawaiian	1	0.02%	1	0.02%	0	0.00%
Other	0	0.00%	0	0.00%	0	0.00%
Grand Total	4,790		4,685		5142	

**Numbers reflect enrollment as of 12/31/2022*

DHMP MEDICARE ADVANTAGE REL SUMMARY

Medicare member race/ethnicity and language data from the December 2022 to December 2023 eligibility files were examined. Based on our analysis for our Medicare line of business in 2023, English was the predominant language of our member population followed by Spanish. Analysis of the race/ethnicity data indicates that the most prevalent race/ethnicity in this population is Hispanic at 50.25%%, followed by White at 27.13% and African American/Black at 16.47%%. 3.97% of members are listed as Unknown/Other, which highlights an improvement in the ability of DHMP to capture race/ethnicity data on our Medicare members.

In late 2021, DHHA initiated a new process for collecting REL data, known as REAL (Race, Ethnicity and Language) Data collection. The REAL data collection process provides standardized tools for collecting more comprehensive and accurate REL data on the patients that DHHA serves. Updates include new data fields in the EMR called "Ethnic Background" with 300+ options for patients to choose as well as updated race and ethnicity drop-down options.

Staff ask all the following questions at least one time for all patients in the DHHA community including many DHMP members.

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

DHMP COMMERCIAL/EXCHANGE LANGUAGE DATA

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

Language	Measure	2022	2023
English	Count	3493	8170
	Rate	23.03%	38.04%
Spanish	Count	402	1209
	Rate	2.65%	5.63%
Unknown	Count	7374	3
	Rate	48.62%	0.01%
Vietnamese	Count	1	18
	Rate	0.01%	0.08%
Korean	Count	1	0
	Rate	0.01%	0.00%
Hungarian	Count	2	2
	Rate	0.01%	0.01%
German	Count	2	1
	Rate	0.01%	0.00%
Egyptian	Count	1	1
	Rate	0.01%	0.00%
Russian	Count	3	2
	Rate	0.02%	0.01%
French	Count	3	5
	Rate	0.02%	0.02%
Amharic	Count	5	5
	Rate	0.03%	0.02%
Arabic	Count	6	8
	Rate	0.04%	0.04%
Karen Languages	Count	1	0
	Rate	0.01%	0.00%
Chinese	Count	1	1
	Rate	0.01%	0.00%
Sicilian	Count	0	1
	Rate	0.00%	0.00%
Thai	Count	0	1
	Rate	0.00%	0.00%
Other	Count	8	7
	Rate	0.05%	0.03%
No Language	Count	3865	3315
	Rate	25.48%	15.43%

Grand Total	**Count**	**15168**	**21479**

DHMP EXCHANGE PLANS RACE/ETHNICITY DATA

Race/Ethnicity	2021		2022		2023	
	Count	Rate	Count	Rate	Count	Rate
No Ethnicity	0	0.00%	0	0.00%	0	0.00%
Hispanic or Latino	3978	26.27%	3995	26.34%	4693	21.85%
White	7325	48.37%	7019	46.28%	8098	37.70%
African American/Black	1086	7.17%	1073	7.07%	1088	5.07%
Unknown/Other	2191	14.47%	2449	16.15%	6624	30.84%
Pacific Islander	30	0.20%	26	0.17%	41	0.00%
Alaskan/American Indian	26	0.17%	31	0.20%	41	0.19%
Asian	499	3.30%	569	3.75%	890	4.14%
Native Hawaiian	9	0.06%	6	0.04%	4	0.02%
Grand Total	15144		15168		21479	

DHMP/DHHA PROVIDER REL DATA

DHMP COMMERCIAL/EXCHANGE REL SUMMARY

Efforts to improve and standardize REL data across lines of business at DHMP is ongoing and changes/progress was made during 2023 to correctly identify member's REL status. In previous years analysis, if member language was missing or listed as ? the member's language was autonomically assigned as English, resulting in English being the listed language spoken by over 97% of the Commercial Population. In 2021, the QI team decided to remove that assignment and report blank/unknown or? in the language field as unknown, which is a more accurate method of categorizing the data.

Commercial member race/ethnicity data from the December 2023 eligibility files were examined. Based on our analysis for our Commercial line of business in 2023, English was the predominant language of our member population followed by Spanish, however, with a vast majority of members language listed as "Unknown". In comparison to 2022, a similar number of languages were spoken among DHMP members, though the number of members speaking languages other than English and Spanish remains relatively low. Analysis of race/ethnicity data indicates that White members were the most prevalent known race among Commercial members at 37.7%, with Hispanic or Latino members comprising 21.85% of the population and Blacks comprising 5.07% of the population. 30.84% of Commercial members identified their race and/or ethnicity as "Other, Unknown" which is an increase from 2022 likely reflecting the increase in membership in the Exchange lines of business for whom REL data has not yet been established.

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

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

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

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

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

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

Due to the importance of CLAS, REL data and language services, these standards are now included in the NCQA standards and guidelines for the accreditation of health plans. DHMP will continue to support, offer and engage in CLAS resources for our members though the health plan standards, and will not renew MHC distinction going forward. As a result of the importance of this work, DHMP has collaborated with DHHA to address REL disparities in health. DHMP will continue to participate with ACS to address identified REL related disparities in health in 2024.

ANALYSIS

Studies show that a member's culture can profoundly impact their health care. As such, it is important to understand the culture of members at DHMP, to ensure the care they receive and the experience they have are positive. "Being culturally sensitive is not limited to providing an interpreter for patients who require one. Many aspects of communication are non-verbal, and culture plays a huge role in medical interactions. Everything from eye contact to whom to address in the exam room can be affected by patients' cultural backgrounds."

Colorado is one of the top ten states with the largest Hispanic or Latino population. This is evidenced at DHMP as % of members reported their ethnicity as Hispanic or Latino. The following has been noted:

- Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance.
- Hispanic populations tend to respect and consult older family members when it comes to health decisions.
- Hispanics have the highest uninsured rates of any racial or ethnic group within the United States.
- 72% of Hispanics speak a language other than English at home.

To ensure providers and staff are aware of and considering culture when providing care, DH has integrated cultural competency into its annual training. In 2023, 8,078 DH staff passed the module, called the 'Denver Health Experience.'

BARRIERS

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

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

OPPORTUNITIES FOR IMPROVEMENT

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

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

INTERVENTIONS

Based on the aforementioned opportunities for improvement, the following interventions have been identified as priorities for 2024:

- Continue to update the DHMP Roster Management Template to include additional languages (i.e., beyond English) spoken by the provider.
- Continue to update the Provider Directory to display additional languages spoken.
- Collaborate with Product Line Managers to ensure culture, race, ethnicity and language questions are included in annual Member Experience Surveys, and leverage any data captured in the regulatory annual CAHPS survey.

DISPARITIES IN HEALTH

In 2020, reducing disparities in health related to race, ethnicity and language was identified as an enterprise opportunity, increasingly so as the COVID-19 pandemic has emphasized the continuing disparities in health outcomes related to race and ethnicity. In 2023, DHMP continued to grow and define its integrated Population Health Management programming for our Medicare, Commercial and Exchange populations with a focus on identifying and eliminating racial and ethnic health disparities. The program will include concerted focus on metrics traditionally associated with high levels of disparities such as, children's wellness exams and immunizations, prenatal care, members with multiple chronic conditions and members with mental health conditions.

Additionally, DHMP will continue to participate in ongoing planning, identification and any initiatives in collaboration with DHHA's Ambulatory Care Services (ACS), ACS quality improvement workgroups, as well as Plan product line management, marketing and health plan services. Initiatives in collaboration with ACS partners include low birth weight for Black women, HbA1c control in Latino members and hypertension control in Black members. More specifically, the QI team will collaborate with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout the Enterprise. The blood pressure under control HEDIS measure monitors the percentage of Members 18–85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup will create an intervention to determine root causes of this disparity and create an intervention to address it.

HEALTH LITERACY

Additional efforts are being made to improve data collection around Member race, ethnicity, and language (see above).

Background

In addition to the need for improving the technical components of care, there is a constant need to support and improve the interpersonal aspects of healthcare. This includes strategies to support culturally sensitive interaction between patient, provider and the health plan. Fostering cultural communication can go a long way in increasing patients' engagement, involvement and adherence to care regimens which ultimately improve health outcomes and member's ratings of their overall health status.

Health literacy, as defined by the Department of Health and Humans Services *Healthy People 2020* is the degree to which individuals have the capacity of obtain, process, and understand basic health information and services needed to make appropriate health decisions. This includes the ability to synthesize health-related information in written and oral form. DHMP's member base includes a population with limited educational backgrounds, varying degrees of English proficiency, cognitive impairments and additional social and medical factors that restrict access to pertinent health information and contribute to low literacy levels. It is the DHMP's commitment to making appropriate efforts to make member-disseminated materials clear and concise in order to improve readability and comprehension, ultimately leading to a member base better equipped to make pertinent health decisions that affect their wellbeing.

In 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. This is also the goal for MCR. All other plans strive to meet 10th Grade Level or lower.

QUALITY OF SERVICE

ACTION PLAN FOR 2024

MEMBER SATISFACTION

Key employees from each department at DHMP have the Health Literacy software installed on his or her 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.

2023 MEMBER SATISFACTION – ANNUAL CAHPS SURVEY AND FEEDBACK

DHMP conducted the Adult Consumer Assessment of Health Plan Providers and Systems (CAHPS) survey in 2023 for the Commercial, Exchange and Medicare plans. CAHPS surveys were conducted under contract with SPH Analytics, an NCQA certified vendor. SPH Analytics follows NCQA protocols and statistically appropriate methodologies to determine member satisfaction scores.

BACKGROUND

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

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

A total of 1,595 Commercial plan members, 1300 Exchange members, and 1600 Medicare members were randomly selected to participate in the CAHPS survey. Survey results summarize the responses of the 251

Commercial plan members, 131 Exchange members and 383 Medicare members who chose to complete the survey.

COMMERCIAL CAHPS RESULTS

In Reporting Year (RY) 2023, the commercial adult sample size was 2164 members with 229 total completed surveys for a 10.6% response rate. Below is a table summarizing Commercial CAHPS results for the past two years.

MEASURE	SUMMARY RATE		CHANGE	2023
	2022	2023		PERCENTILE
How Well Doctors Communicate *(% Always or Usually)*	96.0%	96.5%	0.5%	76th
Rating of Personal Doctor *(% 8, 9 or 10)*	85.2%	86.3%	1.10%	58th
Rating of Health Plan *(% 8, 9 or 10)*	64.3%	61.7%	-2.60%	32nd
Getting Care Quickly *(% Always or usually)*	72.1%	61.3%	-10.80%	<5th
Rating of Health Care (% 8, 9 or 10)	72.5%	72.1%	-0.40%	19th
Customer Service and Claims Processing	**	**	**	**
Rating of Specialist *(% 8, 9 or 10)*	84.5%	79.8%	-4.70%	10th
Getting Needed Care *(% Usually or Always*	70.4%	60.7%	-9.70%	<5th
Ease of Filling out Forms *(% Always or Usually)*	97.6%	96.3%	-1.30%	35th

** **N/A as denoted by NCQA

Key Takeaways:

- Overall CAHPS results for the Commercial line of business decreased from 2022 to 2023, with 6 measures declining in performance during this time period.
- Rating of Health Plan (% 8,9 or 10) Summary Rate score is 61.7% which is a decrease of 2.60% from the RY2022. Getting Care Quickly summary rate score is 61.3%% which is a decrease of 10.8% from RY 2022.
- Only two measures improved year over year, How Well Doctors Communicate (% Always or Usually) and Rating of Personal Doctor (% 8, 9 or 10)

EXCHANGE CAHPS RESULTS

In RY 2023, the Elevate by Denver Health sample size was 936 members with 100 total completed surveys for a 15.4% response rate.

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

MEASURE	SCALED MEAN SCORE		CHANGE	2023 PERCENTILE
	2022	2023		
Rating of Health Plan	65.3	65.7	-0.4	20th
Rating of Health Care	74.1	74.9	0.8	11th
Rating of Personal Doctor	84.1	87.9	3.8	52nd
Rating of Specialist	82.6	79.5	-3.1	<5th
Getting Care Quickly	60.0	56.4	-3.6	<5th
Getting Needed Care	57.2	52.8	-4.4	<5th
Access to Information	47.7	43.6	-4.1	9th
Care Coordination	78.7	79.8	1.1	23rd
Plan Administration	63.9	62.8	-1.1	9th
<Flu Vaccine for Adults 18-64	65.8	69.3	3.5	96th
Medical Assistance with Smoking Tobacco Use Cessation	60.3	66.9	6.6	81st

Key Takeaways:

- Overall DHMP's performance on the 2023 Exchange CAHPS survey saw a similar number of measures improve versus decrease in performance (5 improved, 6 decreased)
- The rating for Getting Needed Care saw the biggest drop of 4.4%for RY2022
- Medical Assistance with Smoking Tobacco Use Cessation saw the biggest increase of 6.6%for RY2022

MEDICARE CAHPS RESULTS

In RY 2023, the Medicare sample size was 1595 with 383 total completed surveys for a 24.0% response rate. Below is a table summarizing Medicare CAHPS results for the past two years.

MEASURE	SCALED MEAN		CHANGE	CURRENT SPH PERCENTILE	2023 STAR RATING
	RY 2022	RY 2023			
Getting Needed Care	75.2	69.8	-5.4	<5th	1
Getting Appointments and Care Quickly	73.3	71.3	-2.0	10th	2
Customer Service	88.3	88.9	0.6	36th	3
Getting Needed Prescription Drugs	88.4	86.9	-1.5	16th	3
Care Coordination	85.0	83.2	-1.8	23rd	4
Rating of Health Care Quality	84.9	83.1	-1.8	21st	3
Rating of Health Plan	85.9	85.1	-0.8	30th	2
Rating of Drug Plan	87.7	87.0	-0.7	56th	2
Annual Flu Vaccine	79.0	82.3	3.3	89th	5

ANALYSIS

Denver Health Medical Plan 2023 Received:

- Four stars for ‘’Care Coordination” and five Stars for “Annual Flu Vaccine”
- Three stars for Rating of “Health Care Quality” and “Getting Needed prescriptions,” and “Customer Service”
- Two stars Rating for “Getting Appointments and Care Quickly”, “Rating of Health Plan” and “Rating of Drug Plan”

DHMP continues to show progress in some MCR Stars CAHPS measures while struggling in others. The largest increases from RY2022 to RY2023 occurred on the “Annual Flu Vaccine” measure, which achieved five Stars. The largest decreases were for the ratings of “Getting Needed Care” and “Getting appointments and care quickly”, which were 1- and 2-Star measures respectively. DHMP continued strong performance in “Care Coordination” and “Customer Service” measures.

GRIEVANCE REPORTING AND TRENDING:

ANALYSIS OF RESULTS AND INDENTIFICATION OF OPPORTUNITIES

The complaint analysis period begins January 1, 2022, and ends October 31, 2023. By looking at two years’ worth of data we have analyzed the number and types of complaints received over time. Denver Health Appeals and Grievances Department uses the software system Guiding Care™ to track grievances and appeals filed by the member and/or their authorized representative. In addition to trending complaints by classification, we monitor for case resolution timeliness, completeness, accuracy, and whether responses are provided in an easy to understand and culturally competent manner. When patterns are identified, they are investigated for performance improvement opportunities by DHMP and/or its affiliate entities and providers. Complaint trends are reported quarterly to the Quality Management Committee and on an ad hoc basis through other informal mechanisms needed to resolve identified issues. As part of the ongoing NCQA monitoring efforts, all resolution letters are monitored prior to mailing to ensure all required elements are included in the letters. Further, the Grievance and Appeals Manager conducts a monthly quality audit of sample cases to ensure all cases are worked and resolved in accordance with internal policies and regulatory requirements. To complete the analysis provided below, every case was reviewed to identify trends.

Aggregate results (quantitative): Please see tables.
Trends over time (quantitative): The number of complaints increased, and this is a trend that is observed consistently throughout this analysis, across all complaint types and lines of business. This is because DHMP experienced an increase in membership, but also, an improved understanding of NCQA reporting methodology expectations and requirements.
Comparison to a standard or goal (quantitative): Recommend goal related to reducing billing/financial and access complaints as they had the highest numbers.
A Conclusion Drawn by The Organization (quantitative): The largest volume of complaints is billing and financial, which are claims or cost share issues, followed by access to care which encompasses network adequacy and wait times for appointments.
Reasons for results, concluded by the organization (qualitative):

> Billing and Financial: Denver Health has been working to improve its claims processing system, and records of contractual and network agreements. Denver Health uses three vendors to assist with claims processing and pricing: Cognizant and Zellis and First Health. The following trends were observed: Sub-contractual relationships resulting in claims denied as out of network. For example, when DHMP is contracted with a lab or radiology facility where services are rendered, but they are not directly contracted with the provider who is interpreting the results.

New contract with First Health beginning 2023. The network is so large that the contract of a specific provider in the network might not be loaded until a claim is received. This created a backlog of contractual updates.
Preventative services not paying with $0.00 member responsibility.
The ranking of diagnoses (first, second, third) on the claim triggers a claim to pay as diagnostic instead of preventative. Provider Relations is doing education with providers as the issues are identified.
Preventative visits that become diagnostic. For example, if a member has a routine colonoscopy, but an issue is found, the service is no longer preventative, and the member has an associated cost.
Pricing and One Time Agreements. For Medicare or Medicaid DHMP has standard contracts. However, for the Commercial line of business, DHMP does not always have specific pricing for a provider or service. Thus, the claim must be reviewed for pricing. Or a provider is out of network, but a one-time-agreement must be negotiated with a provider when services are not immediately available in network.
Member education of plan limitations. Members are not aware that services are not covered when received outside of the DHMP network. Members who are not aware of prior authorization requirements for services. Members who are not aware that they have very high deductibles in some plans.
Pharmacy complaints

The utilization management criteria used by MedImpact is stricter than that which was used by DHMP, so more drugs are denied for medical necessity.
Popularity of new injectable diabetes/weight loss drugs which have a narrow criterion for approval.

ELECTRONIC PAYMENT

Grievances about limitation of electronic premium payment methodologies. In Q1 2023 DHMP did not have an online solution for members to pay their premium. DHMP hears the members' concerns, and an online payment resource was added to the DHMP member portal.

Access: Denver Health has also been working to expand its network of providers throughout the Counties it serves. The following trends were observed:
Unfortunately, long wait times for appointments in some impacted specialties persists. Denver Health Customer Service and Appeals and Grievances Department communicate regularly with the Provider Network team regarding wait times, and specialties with low availability. Denver Health has processes in place to refer members outside of the network and engage in one-time agreements with non-contracted providers when appropriate.
Complaints about the transportation vendor are incorporated in the access category. Denver Health's transportation benefit is popular among members, and while most rides do not incur a complaint, any delay in the cars arrival or missed appointment results in a grievance from the member.

Attitude/Service: Grievances about transportation drivers, enrollment/broker concerns, not receiving materials, or receiving materials that members were not happy with, customer service representatives, hold times and grievances about provider offices.
In the attitude category, the largest sum of complaints is about Access2Care transportation drivers. The complaints most often are because the member was not satisfied with the service that the drivers provided. This ranges from providers being rude, dirty cars, unsafe driving or wait times for the driver to arrive. All concerns about transportation are sent to the vendor for them to investigate and provide feedback about the ride and the members' allegations. Any concerns related to unsafe driving or member safety are immediately addressed and taken very seriously. DHMP holds monthly meetings with Access2Care the transportation vendor to discuss complaint trends and performance improvement opportunities.

Sales, Marketing, Enrollment and Broker complaints also fall into the attitude/service category.
Complaints that members do not remember enrolling or are unhappy with the plan that they were enrolled into. Any allegation of potential enrollment fraud or marketing misrepresentation is triaged to the fraud, waste, and abuse and/or sales team, who review scope of appointments, verify signatures on enrollment forms, and speak with the sales agent to determine if the allegation is substantiated.

DHMP receives requests from members who are unhappy with their enrollment date, desire to change plans, or request to disenroll. Eligibility for enrollment into plans and disenrollment is often circumscribed by regulatory bodies and are outside of the control of the plan. However, DHMP does everything in its power to assist members in finding the best plan for the members specific needs and helps to transition enrollment and disenrollment as expeditiously as possible.

DHMP often receives feedback about our marketing materials and plan documents. Unfortunately, members sometimes find these documents to be unclear and written in legalese, such as the member handbooks or Explanation of Benefits notices. Other members are unhappy about the number of communications the plan sends, such as notifications about wellness programs available to them. Finally other members grieve because they do not receive materials upon request, such as replacement ID cards, the Healthy food Card, or OTC catalogue. DHMP verifies members' addresses before ordering materials and utilizes a print vendor to issue materials. Members also are educated about the opportunity to access some materials online at the DHMP plans website.

The final trend in complaints is about customer service representatives being rude, or excessive hold times. DHMP records all phone calls and can listen back to these grievances to determine if the member's allegation is substantiated, and coaching or disciplinary actions occurs as appropriate. DHMP also monitors its hold times with an effort to adhere to internal and external key performance measures. DHMP extends call center hours during high volume times such as open enrollment and monitors staffing and paid time off/leave of agents to ensure sufficient coverage for the call center.

Quality of Care: The first trend identified is about prescriptions. A member wasn't able to take the medication they were prescribed, and a member didn't feel they were prescribed enough pain medicine. The other trend is that two members had to seek additional care or a second opinion.

Quality of Practitioner Site: There were only two quality of practitioner site complaints, and one was that the member felt discriminated against, and the other that the providers receptionist was rude.

Behavioral Health Complaints: There were 10 behavioral health cases in 2023. Five were for members whose preferred provider is out of the network. This was most often attributed to members who changed from other insurance companies to Denver Health and want continuity of care with their behavioral health providers who are out of network for Denver Health. Three cases were related to inpatient care needing prior authorization but prior authorization not being obtained (retro authorization requests or ER admissions). Two cases were for medication denials as members had not tried formulary alternatives.

Who Participated in the Analysis (qualitative): Melissa Bailey, Appeals and Grievances (A&G) Consultant, Robin Bun, Health Plan Compliance Analyst (HOP), Maria Casaverde Marin, Clinical Quality Operations Manager, DH ACS Clinics (NCQA Accredited PCMH), Andrea Chavez, Pharmacy Technician Supervisor, Cailey Chrissinger, Government Products-Medicare Manager, Jeffery Cole, Health Plan Services (HPS) Manager, Clesson Connelly, Health Plan Compliance Analyst (HOP), Jacqueline De La Torre, Health Outcomes and Pharmacy (HOP) Project Manager, Viv Duval, NCQA Project Manager, Katie Egan, Quality Improvement (QI) Manager, Elizabeth Flood, Population Health (PH) Manager, Chad Frankfather RN, Clinical Manager of Care Management (CM), Katie Gaffney, Lead Health Plan Compliance Analyst (Government Products-Medicaid/CHP+), Cassie Geremaia, Medical Economics Analyst, Annie Giangardella, Compliance Analyst Lead (Government Products-Medicare Advantage), Shannon Godbout, Population Health Project Manager, Marques Haley, Monitoring, Auditing and Training (MAT) Manager, Deb Harris, Credentialing Coordinator, Dr. Kristin Harris MD, DH Psychiatrist, Olivia Herrera, Health Plan Services Supervisor, William Holder, Medical Economics Analyst, Elaina Holland, Director of Member and Provider Service, Anuj Jayakar, Population Health (PH) Analyst, Ashley Leslie, Commercial Products Manager, Linda Manning, Health Plan Compliance Analyst (HOP), Alexa Muccioli, Pharmacy Supervisor, Shaun Owens, Member and Provider Liaison, Robin Pelland, Quality Improvement (QI) Consultant, Alicia Persich, Marketing and Communications, Member and Provider Engagement Manager, Christina Porter RN, HPMM Q and A Training Administer, Jonathan Ramirez, Quality Improvement (QI) Project Manager, Tye Rubin, Medical Economics Analyst, Jeremy Sax, Government Products-Medicaid/CHP+ Manager, Marissa Schillaci-Kayton, Care Management (CM) Operations Manager, Darla Schmidt, Director of Appeals and Grievances (A&G) and Utilization Management (UM), Dr. Christine Seals Messersmith MD, DHMP Medical Director (CMO), Shelly Siedelberg, Quality Improvement (QI) Program Manager, Rebecca Stob, Medical Economics Director, Ruie Winters III, Senior Director of Health Outcomes and Pharmacy (HOP), and David Young, Population Health (PH) Pharmacist.

GRIEVANCES

Table 1: Non-Behavioral Health Complaint volume report - Commercial

Category	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Complaints 2022	Complaints per 1,000 Members (Total: 11,952)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Complaints 2023	Complaints per 1,000 Members (Total: 11,961)
Quality of Care	0	1	0	0	1	<1	0	1	0	1	2	<1
Access	0	3	0	2	5	<1	3	8	2	10	23	1.92
Attitude/Service	3	2	0	2	7	<1	4	4	0	1	9	<1
Billing/Financial	29	35	28	31	123	9.42	26	29	36	24	115	9.61
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	136 total complaints					11.37	149 total complaints					12.4

Table 2: Non-Behavioral Health Complaint volume report - Marketplace

Category	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Complaints 2022	Complaints per 1,000 Members (Total: 2,186)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Complaints 2023	Complaints per 1,000 Members (Total: 8,928)
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	1	0	0	1	<1	5	8	5	6	24	2.68
Attitude/Service	0	0	1	0	1	<1	10	0	2	5	17	1.90
Billing/Financial	7	6	3	9	25	11.43	6	17	22	23	68	7.61
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	27 total complaints					12.35	109 total complaints					12.20

Table 3: Non-Behavioral Health Complaint volume report - Medicare

Category	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Complaints 2022	Complaints per 1,000 Members (Total: 4,664)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Complaints 2023	Complaints per 1,000 Members (Total: 5,185)
Quality of Care	2	1	1	2	6	1.28	1	1	2	2	6	1.15
Access	1	3	4	5	13	2.78	12	11	21	4	48	9.25
Attitude/Service	0	0	0	0	0	0	13	19	31	13	76	14.65

Billing/Financial	8	9	4	6	27	5.77	22	15	23	18	78	15.04
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	2	0	2	<1
TOTAL	40 total complaints					8.57	210 total complaints					40.50

Table 4: Behavioral Health Complaint volume report - Commercial

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Complaints 2022**	**Complaints per 1,000 Members (Total: 11,952)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Complaints 2023**	**Complaints per 1,000 Members (Total: 11,961)**
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	1	1	0	2	<1
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	0	1	1	2	<1
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total complaints					0	4 total complaints					<1

Table 5: Behavioral Health Complaint volume report - Marketplace

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Complaints 2022**	**Complaints per 1,000 Members (Total: 2,186)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Complaints 2023**	**Complaints per 1,000 Members (Total: 8,928)**
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	0	0	0	0	0
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	2	0	0	2	<1
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total complaints					0	2 total complaints					<1

Table 6: Behavioral Health Complaint volume report - Medicare

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Complaints 2022**	**Complaints per 1,000 Members (Total: 4,664)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Complaints 2023**	**Complaints per 1,000 Members (Total: 5,185)**

Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	0	0	0	0	0
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total complaints					0	0 total complaints					0

Appeals

Note that there are no appeals for quality of care or quality of practitioner site for any lines of business. This is because members can only appeal a benefit limitation or cost share. Quality of care and quality of practitioner site are experienced-based events and handled through the complaint process.

Table 7: Non-Behavioral Health Appeal volume report - Commercial

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Appeals 2022**	**Appeals per 1,000 Members (Total: 11,952)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Appeals 2023**	**Appeals per 1,000 Members (Total: 11,961)**
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	4	2	4	0	10	<1
Attitude/Service	11	13	4	6	37	3.09	0	0	0	0	0	0
Billing/Financial	7	1	2	1	11	<1	1	3	13	10	27	2.25
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	48 total appeals					4.01	37 total appeals					3.09

Table 8: Non-Behavioral Health Appeal volume report – Marketplace

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Appeals 2022**	**Appeals per 1,000 Members (Total: 2,186)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Appeals 2023**	**Appeals per 1,000 Members (Total: 8,928)**
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	2	1	1	2	6	<1
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	1	0	0	0	1	<1	0	2	4	3	9	1
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1 total appeal					<1	15 total appeals					1.68

Table 9: Non-Behavioral Health Appeal volume report - Medicare

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Appeals 2022	Appeals per 1,000 Members (Total: 4,684)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Appeals 2023	Appeals per 1,000 Members (Total: 5,185)
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	18	21	24	11	74	14.27
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	12	17	22	23	74	15.79	1	12	3	6	22	4.24
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	74 total appeals					15.79	96 total appeals					18.51

Table 10: Behavioral Health Appeals volume report – Commercial

Note that there are very few behavioral health appeals for all lines of business. This is because the plan has minimal prior authorization or utilization management requirements for behavioral health services, and a wide network for access and availability.

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Appeals 2022	Appeals per 1,000 Members (Total: 11,952)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Appeals 2023	Appeals per 1,000 Members (Total: 11,961)
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	0	0	0	0	0
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	0	1	1	2	<1
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total appeals					0	2 total appeals					<1

Table 11: Behavioral Health Complaint volume report - Marketplace

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Total Appeals 2022	Appeals per 1,000 Members (Total: 2,186)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Total Appeals 2023	Appeals per 1,000 Members (Total: 8,928)
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	0	0	0	0	0

Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total appeals					0	0 total appeals					0

Table 12: Behavioral Health Appeals volume report – Medicare

	PREVIOUS YEAR - 2022						CURRENT MEASUREMENT YEAR - 2023					
Category	**Q1 2022**	**Q2 2022**	**Q3 2022**	**Q4 2022**	**Total Appeals 2022**	**Appeals per 1,000 Members (Total: 4,684)**	**Q1 2023**	**Q2 2023**	**Q3 2023**	**Q4 2023**	**Total Appeals 2023**	**Appeals per 1,000 Members (Total: 5,185)**
Quality of Care	0	0	0	0	0	0	0	0	0	0	0	0
Access	0	0	0	0	0	0	0	1	0	0	1	<1
Attitude/Service	0	0	0	0	0	0	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0 total appeals					0	1 total appeal					<1

CARE COORDINATION

CARE COORDINATION AND CARE MANAGEMENT PROGRAM STRUCTURE

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 30 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 2023 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.
2023 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 Type	Count of Client Patient Id
CCM Benefit Resource Coordination	53
CCM Condition Management	12
CCM Dental Care Coordination	2
CCM Engagement / Enrollment	444
CCM Food Security Coordination	17
CCM Health Care Provider Coordination	23
CCM Language Services	4
CCM LTSS Coordination	4
CCM Member Follow-up	4830
CCM Other Community Resource Coordination	12
CCM Other Follow-up	95
CCM Pharmacy Review	63
CCM Program	271
CCM Provider Follow-up	17
CCM Referral	24
CCM Transportation Coordination	16
Grand Total	**5887**

CCM Activities 2023

CCM Outcome Metrics:

Cost Group	Members in Program at Least 1 Year		Members in Program at Least 60 Days	
	2022	2023	2022	2023
Less than $1,000	0.00%	0.00%	5.26%	0.00%
$1,000-$9,999	40.00%	40.00%	36.84%	26.32%
$10,000-$24,999	10.00%	10.00%	15.79%	15.79%
$25,000-$49,999	10.00%	0.00%	10.53%	10.53%
$50,000-$99,999	10.00%	20.00%	5.26%	10.53%
$100,000-$199,999	20.00%	30.00%	15.79%	26.32%
$200,000-$299,999	10.00%	0.00%	10.53%	5.26%
$300,000+	0.00%	0.00%	0.00%	5.26%
Average Per Member Annual Cost	$66,211.60	$65,625.83	$61,414.59	$90,144.32
Cost Difference (2023-2022 Average Cost)	-$585.77		$28,729.72	

CCM Cost Analysis 2023

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.
- 5887 distinct activities were completed in 2023 for the CCM program.
- Members enrolled in the program for at least 1 year saw decreased costs between 2022 and 2023 (N=10)

        - The average annual cost per member decreased from $66,211.60 in 2022 to $65,265.83 in 2023, for an average per member annual decrease of $585.77 per member.
        - One member saw a decrease in care costs of $85,143.89 between 2022 and 2023 after enrolling in the program in May 2022
        - Cost savings observed for the current assessment period (average $585.77) are smaller than what was observed in the previous assessment period (average $10,707.60)
            - This may be due to changes in utilization as the impact of the COVID-19 pandemic wanes.
                - Members may be more comfortable accessing the ED and similar services in 2023 over 2022.
                - Members may be engaging in services which were delayed because of the COVID-19 pandemic.
        - 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 2022 and 2023 (N=19)
        - The average annual cost per member increased from $61,414.59 in 2022 to $90,144.32 in 2023, for an average per member annual increase of $28,729.72 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.
- Utilization patterns may differ between 2022 and 2023 due to ongoing effects of the COVID-19 pandemic and response, including previously delayed services, appointment availability, and member comfort with accessing the ED.

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.

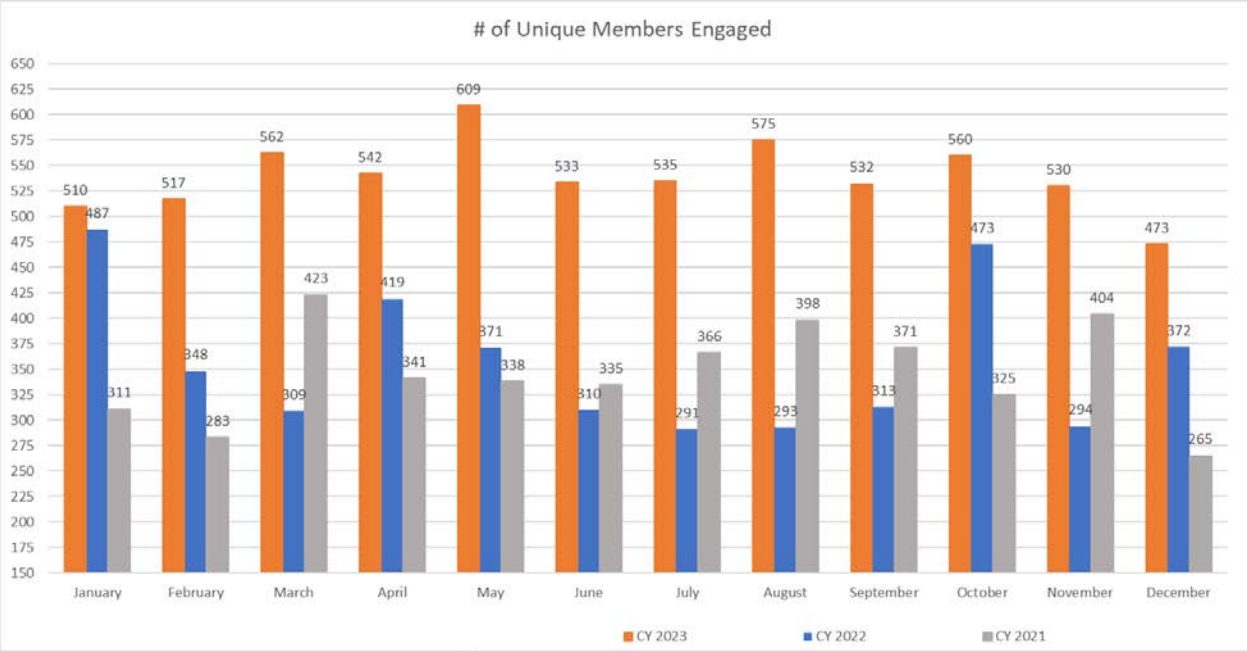
Members are tracked from inpatient notification through the referral process. Once a member is discharged to a home setting, members are referred to a Care Manager for outreach. The current process tracks members through to the conclusion of the referral, indicating whether the member met program criteria 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. The feed is expected to be completed in early 2024. SquareML has also conducted an analysis of potentially avoidable admissions and a high readmission risk. These flags will be included in the ADT feed to help the TOC prioritize and direct services to members.

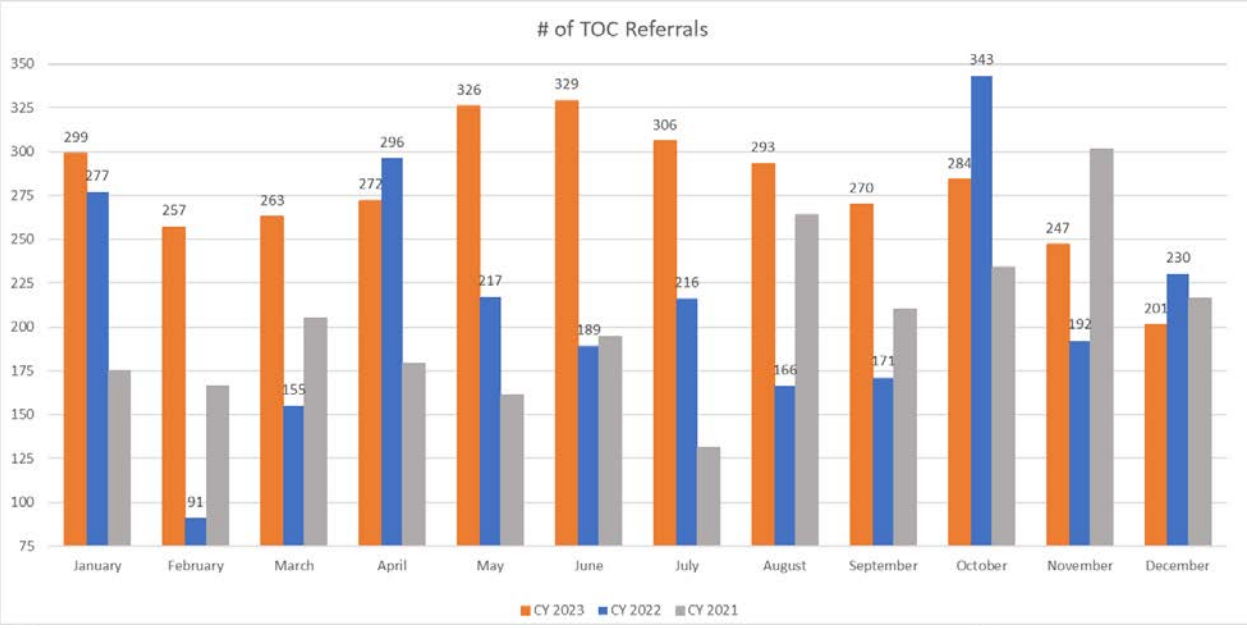
In 2023, the Transitions of Care team expanded its team and added an additional RN Care Coordinator and Health Plan Care Coordinator. This change allowed for improved turnaround times for outreach at each care transition. Additionally, the CM team partnered with Dispatch Health to implement a new Bridge Visit – a single post-acute in-home visit for high-risk members that includes a clinical assessment, medication reconciliation, assessment of ongoing needs, addressing gaps in care, discharge planning support and education, assessing and supporting SDOH needs, and evaluation of the home setting for potential risks.

2023 Transitions of Care (TOC) Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

TOC Program Metrics:



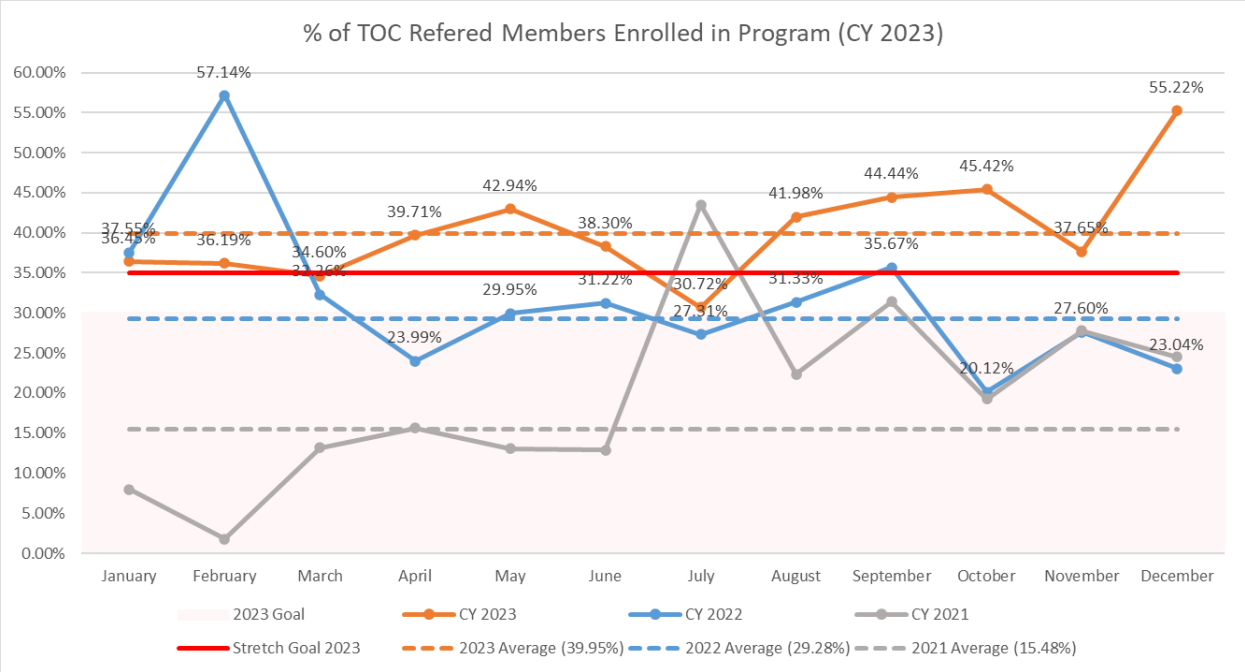
TOC Distinct Members Engaged 2021-2023



TOC Referrals 2021-2023

Enrolled in Program			
Month (CY 2023)	**TOC Referrals**	**Members Enrolled**	**% Members Enrolled**
January	299	109	36.45%
February	257	93	36.19%
March	263	91	34.60%
April	272	108	39.71%
May	326	140	42.94%
June	329	126	38.30%
July	306	94	30.72%
August	293	123	41.98%
September	270	120	44.44%
October	284	129	45.42%
November	247	93	37.65%
December	201	111	55.22%
Total/Avg	**3347**	**1337**	**39.95%**

TOC Enrollment Data 2023



TOC Enrollment Data 2021-2024

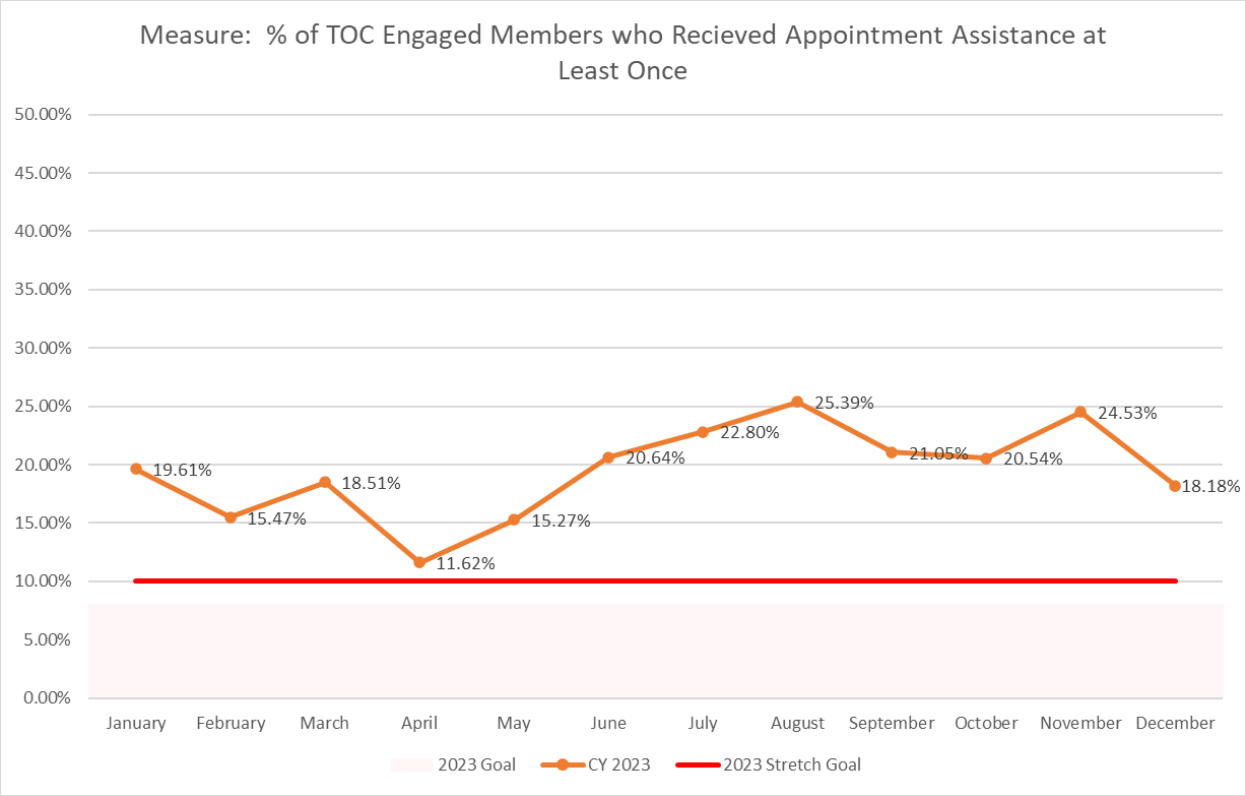
Completed Program			
Quarter (CY 2023)	TOC Enrollment	Members with Completed Outcome	% Members with Completed Outcome
Q1*	293	217	74.06%
Q2	374	280	74.87%
Q3	372	275	73.92%
Q4	333	256	76.88%
Average	**1372**	**1028**	**74.93%**

TOC Program Completion Rates 2023

TOC Activity Metrics:

Month (CY 2023)	TOC Engaged Members	Members With Appointment Assistance	% Members With Appointment Assistance
January	510	100	19.61%
February	517	80	15.47%
March	562	104	18.51%
April	542	63	11.62%
May	609	93	15.27%
June	533	110	20.64%
July	535	122	22.80%
August	575	146	25.39%
September	532	112	21.05%
October	560	115	20.54%
November	530	130	24.53%
December	473	86	18.18%
Total	**6478**	**1261**	**19.47%**

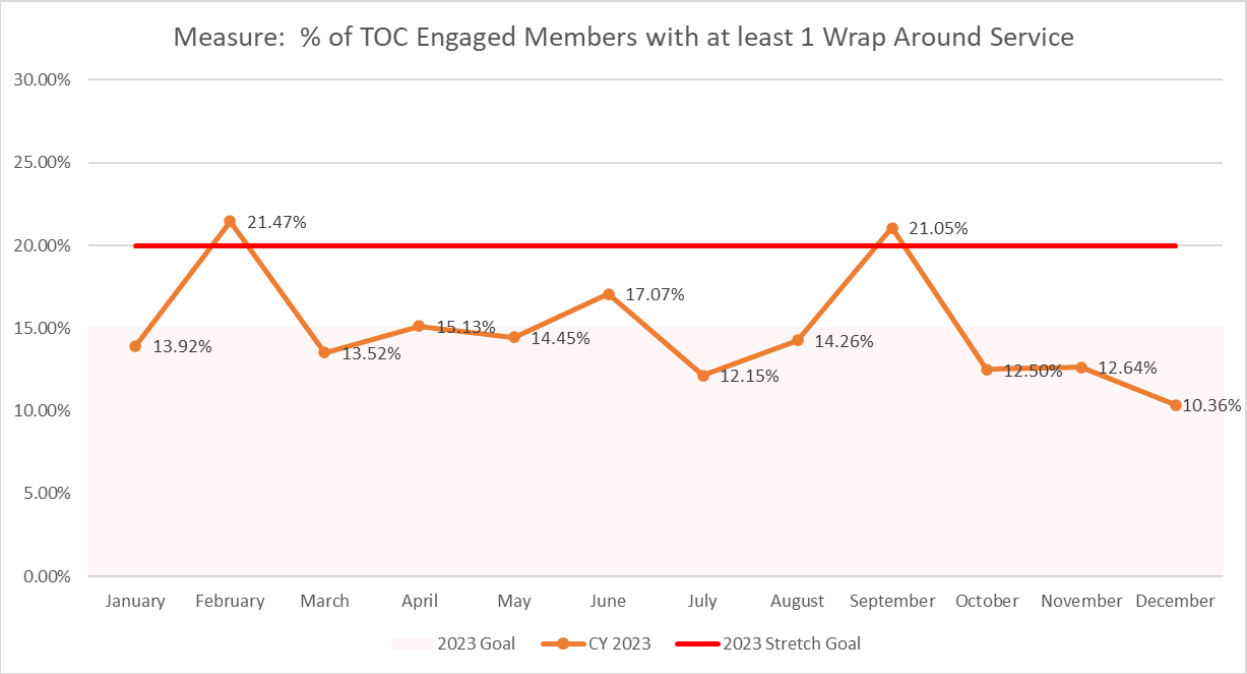
TOC Engaged Members Who Received Appointment Assistance At Least Once 2023



TOC Engaged Members Who Received Appointment Assistance At Least Once CY 2023

Month (CY 2023)	TOC Engaged Members	Members With Wrap Around Services	% Members With Wrap Around Services
January	510	71	13.92%
February	517	111	21.47%
March	562	76	13.52%
April	542	82	15.13%
May	609	88	14.45%
June	533	91	17.07%
July	535	65	12.15%
August	575	82	14.26%
September	532	112	21.05%
October	560	70	12.50%
November	530	67	12.64%
December	473	49	10.36%
Total	**6478**	**964**	**14.88%**

TOC Engaged Members Who Received Wrap Around Services CY 2023

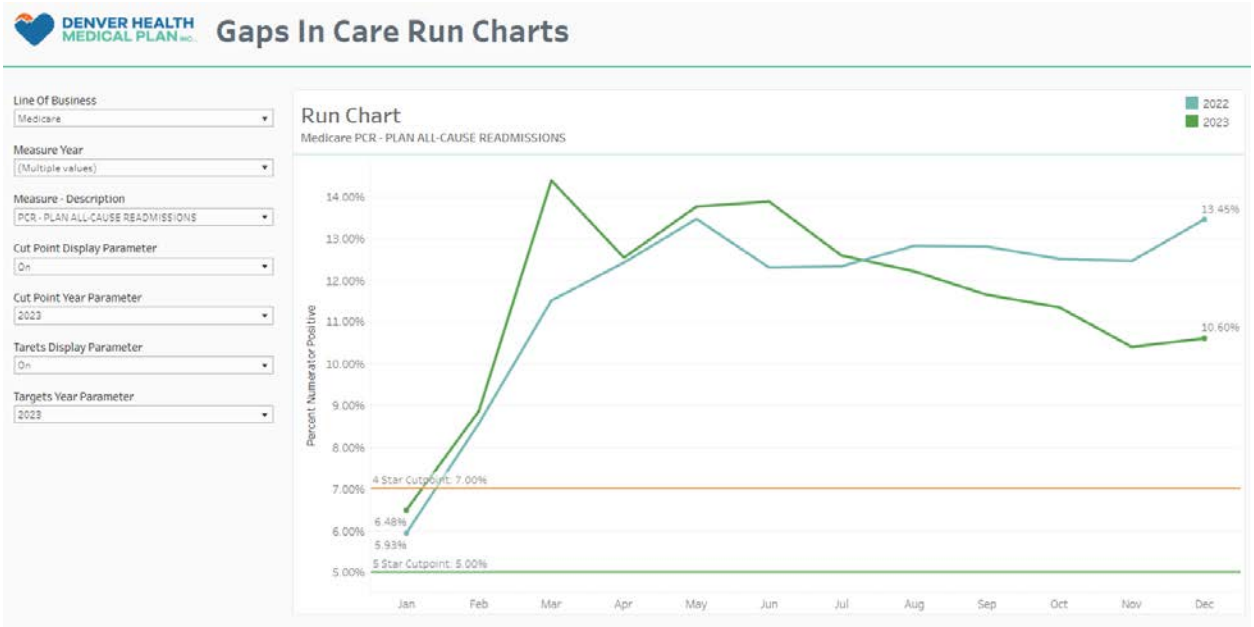


TOC Engaged Members Who Received Wrap Around Services CY 2023

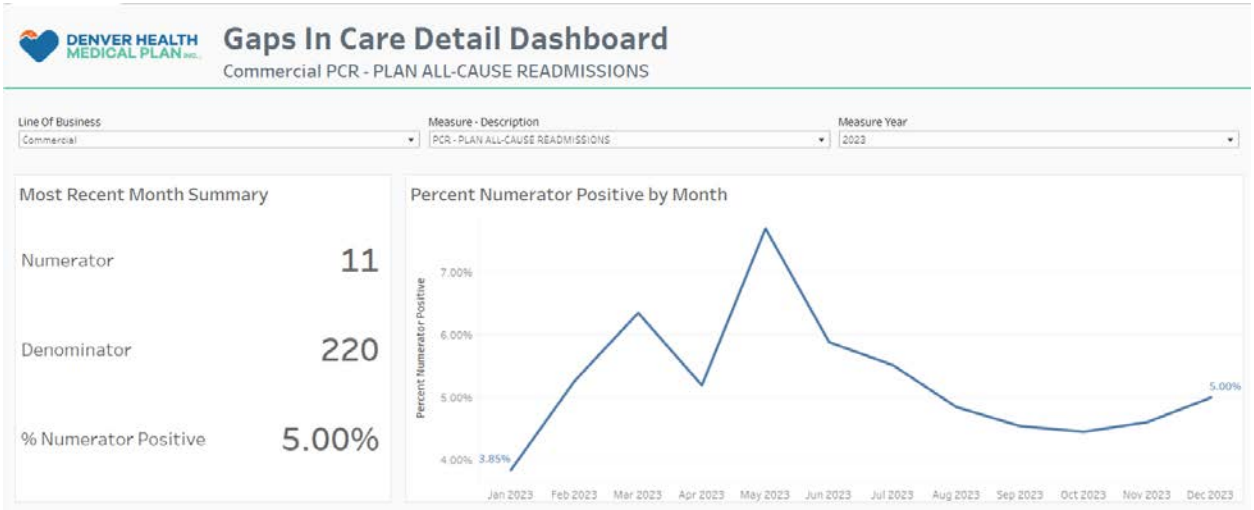
TOC Care Team - Care Activity Outreach	CY 2023	TOC Care Team - Care Activity Outreach	CY 2023
Appointment Reminder	800	DSNP TOC Health Acuity / Needs Assessed	5835
Authorized BP Cuff	17	DSNP TOC ICP Goals / Barriers Communicated to Care Team	8242
BH Care Coordination	14	DSNP TOC Member Follow-up	16125
Care Coordination Task	3	DSNP TOC Referral	1065
Care Plan Review	684	DSNP Transportation Coordination	443
COA Behavioral Health Referral	17	DSNP Utilities Coordination	28
Customer Satisfaction Outreach	9	Face to Face Scripts	30
Dispatch Health Advanced Care Programs	4	Internal Behavioral Health Referral	5
Dispatch Health Follow-up	66	Letter Review	6351
Dispatch Health Referral	185	Member Call	62
DME Coordination Member	4	Member Survey	21
DME Coordination Provider	14	Project Angel Heart Outreach	1130
DSNP - OON Provider	5	TOC Applications/Membership Assistance	764
DSNP Annual HRA Outreach	7	TOC Benefit Resource Coordination	214
DSNP Applications/Membership Assistance	7	TOC Care Plan Update	1508
DSNP Benefit Resource Coordination	261	TOC Dental Care Coordination	4
DSNP Care Plan Update	125	TOC DHHA Assist	13
DSNP Clinical Member Outreach	220	TOC Education Provided	1153
DSNP Clinical Outreach	16	TOC Engagement / Enrollment	14853
DSNP Condition Management	7	TOC Food Security Coordination	369
DSNP Dental Care Coordination	3	TOC Health Care Provider Coordination	4691
DSNP Disenrollment Final Summary	3	TOC Home Health Coordination	301
DSNP Education Provided	11	TOC Housing Resource Coordination	406
DSNP Food Security Coordination	147	TOC Immunization Coordination	6
DSNP Health Care Provider Coordination	541	TOC Initial Assesment	6286
DSNP Home Health Coordination	50	TOC Initial Assessment Outreach	12268
DSNP Housing Resource Coordination	126	TOC IP Discharge Planning	3201
DSNP HRA Initial Assessment	10	TOC IP Provider CM Coordination	68
DSNP ICP Goals / Barriers Communicated to Care Team	69	TOC IP Special Needs Planning	9
DSNP ICT Meeting	2969	TOC Language Services	541
DSNP ICT Pharmacy Review	2255	TOC LTSS Coordination	57
DSNP ICT/TOC Meeting	417	TOC Member Follow-up	15424
DSNP Initial HRA Outreach	7	TOC Other Community Resource Coordination	955
DSNP Language Services	1351	TOC Other Follow-up	4285
DSNP Medication Management	21	TOC Peer/Support Groups	40
DSNP Other Community Resource Coordination	112	TOC Program	11541
DSNP Peer/Support Groups	7	TOC Provider Follow-up	1419
DSNP Pre-ICT Summary	3818	TOC Readmission to Hospital	138
DSNP Provider Follow-up	10836	TOC Referral	3595
DSNP Tobacco Cessation Coordination	54	TOC Safety_DV Coordination	2
DSNP TOC Care Plan Update	6463	TOC Transportation Coordination	1441
DSNP TOC Follow-up	13746	TOC Utilities Coordination	213
Grand Total			**170583**

TOC Activities Performed 2023

TOC Outcome Metrics:



Plan All Cause Readmissions (PCR) - Medicare 2023



Plan All Cause Readmissions (PCR) - Commercial and Exchange 2023

Results/Analysis:

- Plan all cause readmission rates for Medicare decreased by 2.85% in 2023, with a 2023 readmission rate of 10.60% and a 2022 readmission rate of 13.45%
- Plan all cause readmission rates for Commercial and Exchange members decreased from 5.93% in 2022 to 5.00% in 2023.
- Decreases in plan all cause readmission rates started in June 2023 and may be a result of additional staffing on the TOC team as well as improved turnaround times for outreaching members, facilities, and providers at each care transition.
- In 2023, the Transitions team received 3347 distinct member referrals for on-going care transitions management, an increase of 844 referrals from the previous year.
    - Of the 3347 distinct member referrals, 1337 members (39.95%) enrolled in the TOC program, an increase of 604 members / 10.67% from the previous year.
        - The TOC goal of 30% of referred members being enrolled in the program was met for 2023.

        - Of the 1337 members who enrolled in the program, 1028 members (74.93%) of members completed the program, which is slightly below the goal of 75.00%
- 6478 distinct members were outreached/engaged by the TOC team in 2023, an increase of 2206 members from 2022.
    - 1261 distinct members (19.47% of outreached/engaged members) received appointment assistance from the TOC team at least once in 2023.
    - 964 distinct members (14.88% of outreached/engaged members) received support with wrap around services at least once in 2023.

Barriers/Lessons Learned:

- Identifying and tracking members who are inpatient can be difficult due to lag times in the authorization process, and no authorizations being required for tier 1 hospitalizations.
    - In November 2021, a comprehensive tracking and reporting system was implemented to improve the ability to capture inpatient hospitalizations and readmissions.
        - This resulted in earlier referrals to the program and an increased volume of members outreached for and enrolled in the program.
        - Lag times in reporting and inpatient/discharge notifications continue to be a challenge.
- In 2023, DHMP began the process of improving inpatient/discharge reporting timeliness.
    - DHMP is working with SquareML to ingest CORHIO data to develop a “real time” ADT feed.
    - The ADT feed will need to be supplemented with Guiding Care Open Authorization and UM activity data to ensure capture of Skilled Nursing Facilities (SNF), Long Term Acute Care Hospitals (LTACH), Acute Rehabilitation Facilities, and out of state admissions.
    - Improvements in inpatient and discharge notifications and reporting will decrease the administrative burden on the TOC team.
    - The ADT feed will include risk flags to assist the TOC team with prioritizing member outreach:
        - Length of stay greater than or equal to 14 days
        - 3 or more chronic conditions and care costs exceeding $25,000
        - High readmission risk
        - Potentially avoidable admissions
        - Readmission within 30 days
- Calculation of readmission rates for the program is currently not possible; the CM team is working with the DHMP IS team to adjust the DHMP Over/Under Utilization report which will allow the CM team to evaluate readmission rates for members enrolled in the program and to assess program efficacy.
- Engagement via telephonic outreach continues to be a large barrier for the team.
    - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity. Strategies that incorporate other forms of outreach (e.g., in-person, text message, email) and partnerships with community organizations could improve engagement among DHMP members.
    - The DHMP CM team is currently reviewing options for upgrades to the Guiding Care platform which would allow CMs to engage with members via text message, email, and/or through an app.
- Members declining the program has been an ongoing challenge; however, some members are willing to participate in Care Management services even though they do not wish to participate in a program.

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

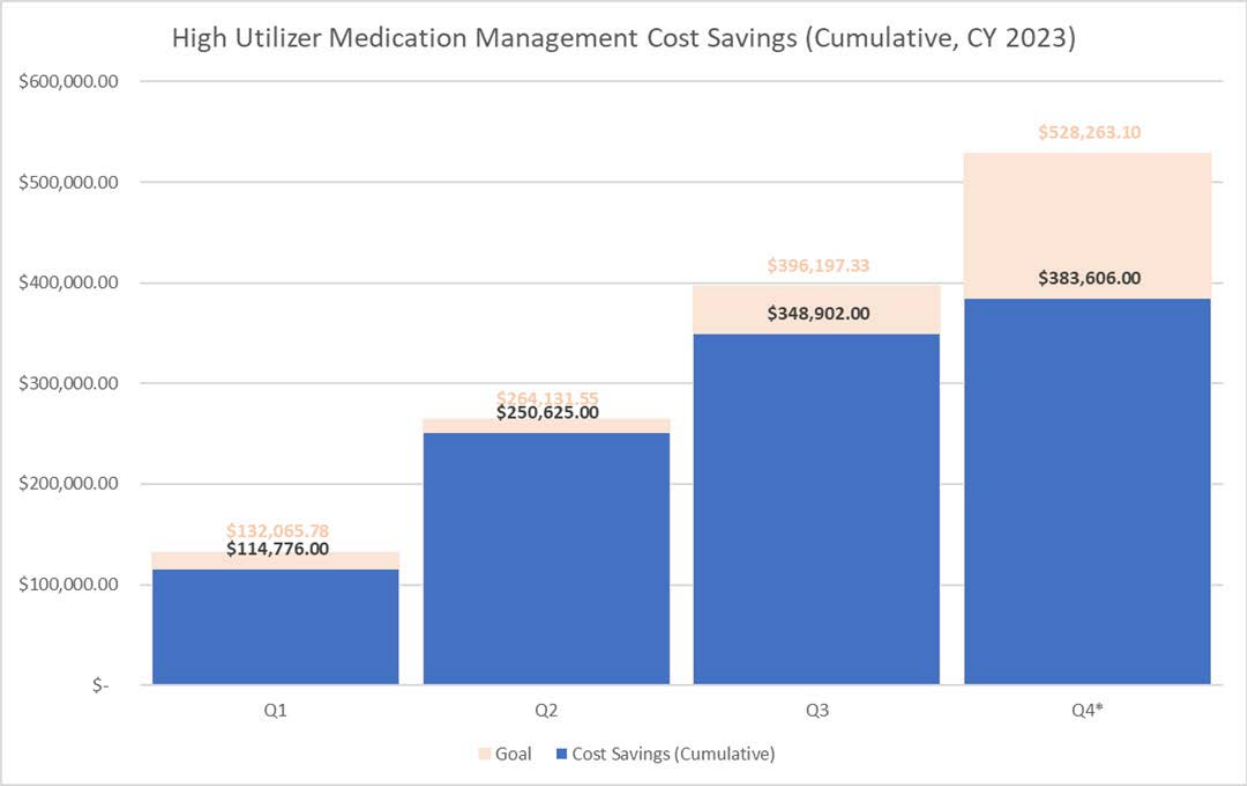
The DHMP pharmacy team monitors members pharmacy utilization and will identify members that are on high-cost drugs for care coordination review and evaluation for case management services. The care coordination team will outreach members to discuss their specific condition and associated pharmacy needs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

2023 High Utilizer Medication Management Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

High Utilizer Medication Management Cost Data:

High Utilizer Med Management Cost Savings		
Quarter (CY 2023)	Quarterly Savings	Cumulative Savings (YTD)
Q1	$ 114,776.00	$ 114,776.00
Q2	$ 135,849.00	$ 250,625.00
Q3	$ 98,277.00	$ 348,902.00
Q4	$ 34,704.00	$ 383,606.00

High Utilizer Medication Management Cost Savings CY 2023



High Utilizer Medication Management Cost Savings CY 2023
**Claims for Q4 Pending*

Results/Analysis:

- A total of 7 distinct members were referred to the program in 2023
- 5 members completed the program in 2023
- The high Utilizer Medication Management Program supports the highest utilizers of IV medications with receiving infusions at home, allowing for greater ease of access to medications while significantly reducing medication costs:
    - In 2023, the program resulted in a total cost savings of $383,686.00, which is below DHMP's goal of $528,263.10 annually.
        - Claims are still pending for Q4 2023

Barriers/Lessons Learned:

- One Option Care pt termed in 2022, which had an impact of >$100,000.
- The program saw a decrease in fills for certain meds.
- In 2022, CM was getting data only for Option Care, but in 2023, cost savings across multiple programs has been combined, making it difficult to fully assess CM's impact.
    - In 2024, CM will work with the pharmacy team to capture pharmacy savings only for those members enrolled in the High Utilizer Medication Management Program
- There have been challenges with CM's ability to access pharmacy referrals.

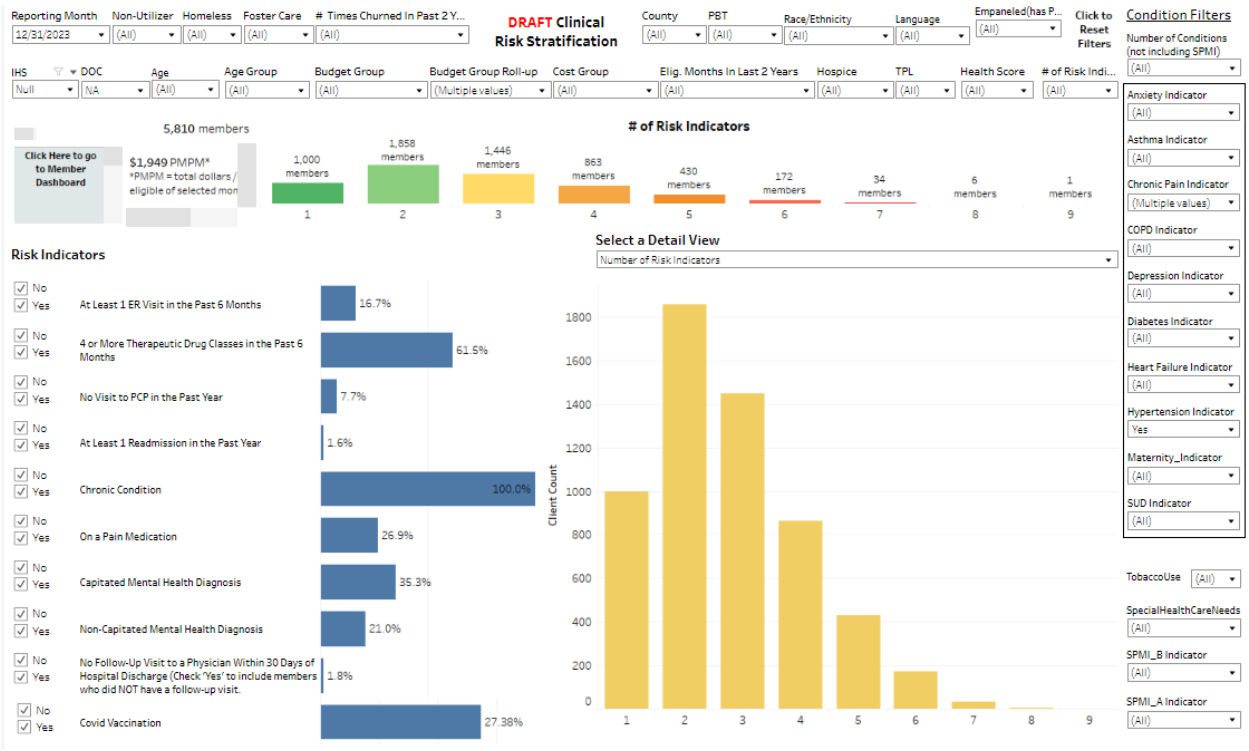
Program Name: **Controlling Blood Pressure (CBP):**

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; 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.

2023 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 (12/31/2023):



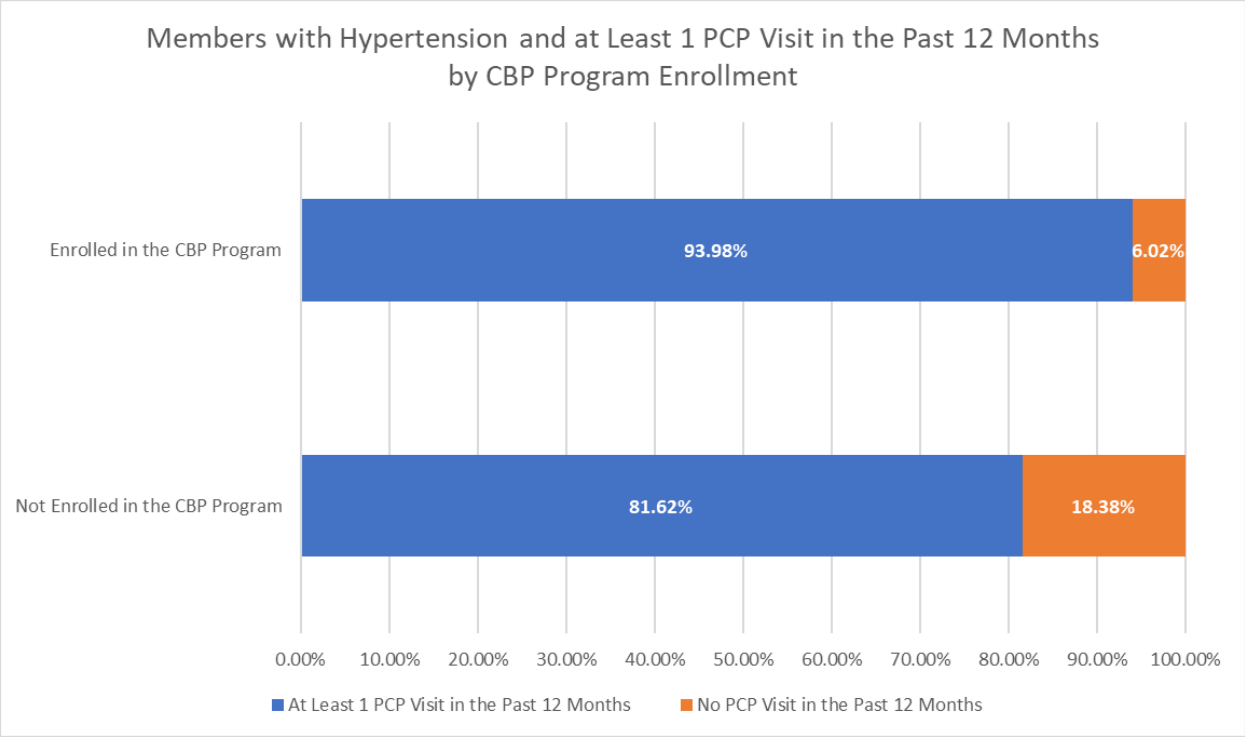
Medicare, Commercial, and Exchange Members with Hypertension as of 12/31/2023 (Risk Stratification Tool)

CBP Care Activities Metrics:

Controlling Blood Pressure Activities	Number of Activities
Authorized BP Cuff	1435
CBP Applications/Membership Assistance	26
CBP Benefit Resource Coordination	284
CBP Care Plan Update	135
CBP Condition Management	2959
CBP Education Provided	229
CBP Engagement / Enrollment	1135
CBP Food Security Coordination	2
CBP Health Acuity / Needs Assessed	4908
CBP Health Care Provider Coordination	566
CBP Housing Resource Coordination	11
CBP Language Services	358
CBP Medication Management	63
CBP Member Outreach	5207
CBP Other Community Resource Coordination	18
CBP Pharmacy Referral	10
CBP Provider Follow-up	155
CBP Tobacco Cessation Coordination	6
CBP Transportation Coordination	16
Does not meet criteria for BP Cuff	30
Member has their own BP Monitor	181
Grand Total	17734

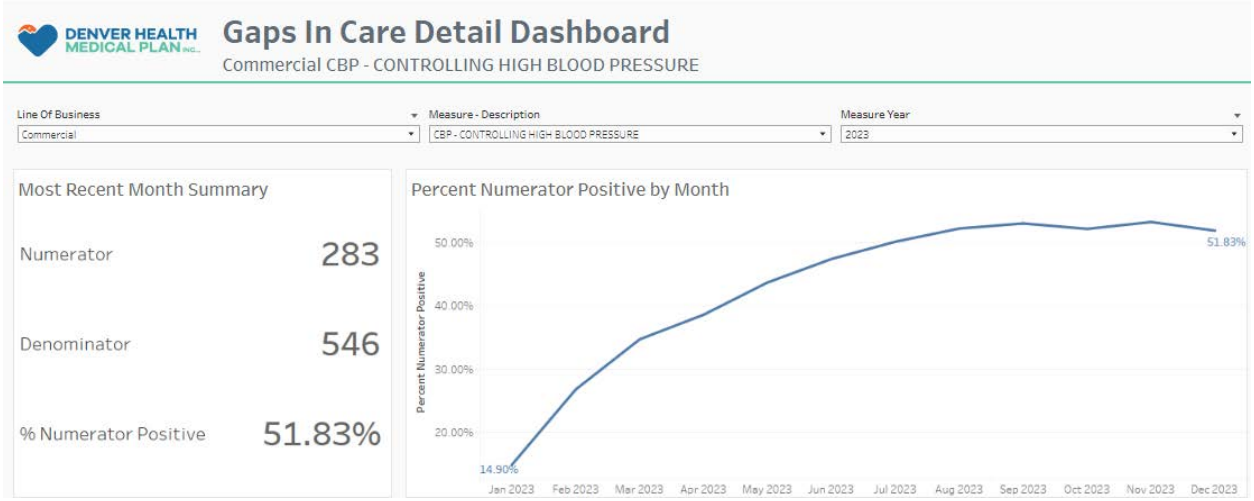
CBP Activities 2023

CBP Outcome Metrics:

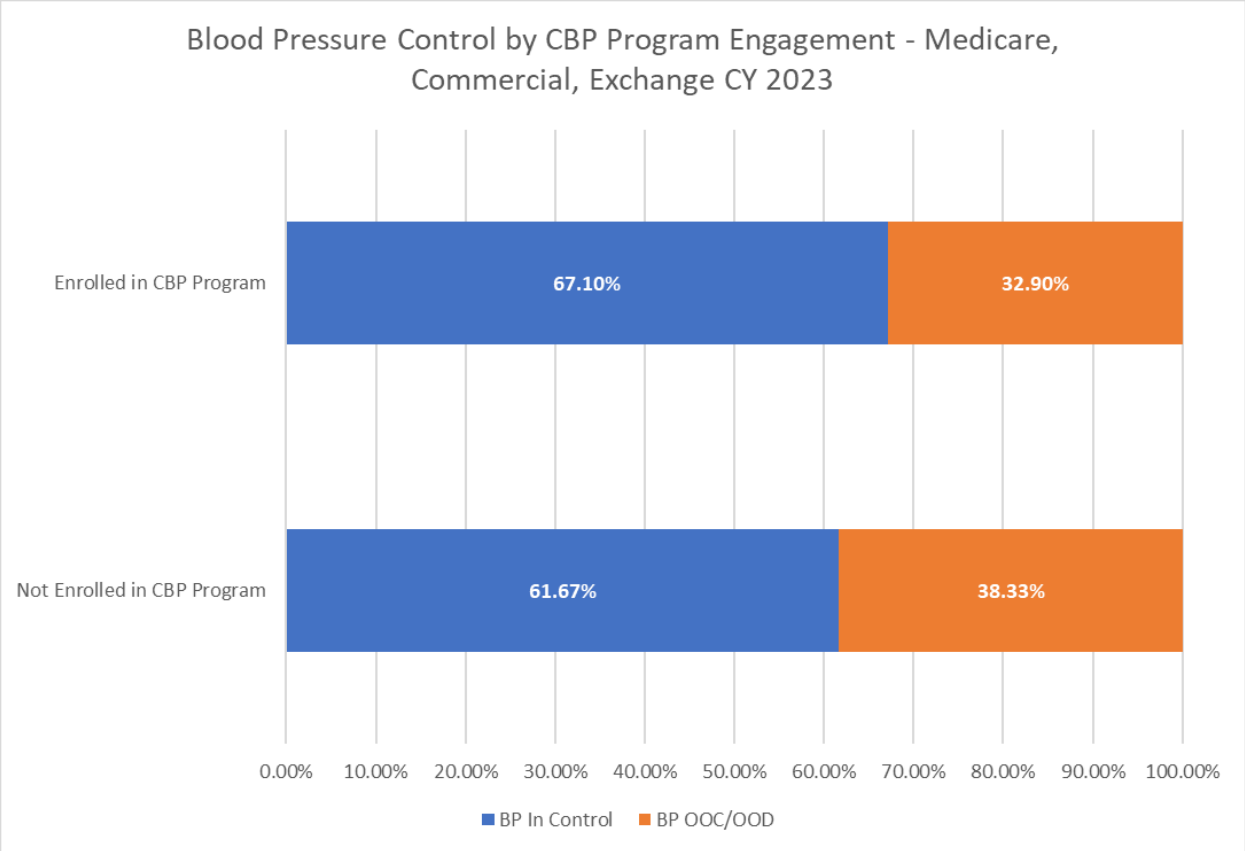


PCP Engagement by CBP Program Enrollment 2023

Controlling Blood Pressure (CBP) Rates - Medicare 2022 and 2023



Controlling Blood Pressure (CBP) Rates - Commercial and Exchange Members 2023



Blood Pressure Control by CBP Program Enrollment 2023

Results/Analysis:

- 5810 distinct members had a diagnosis of hypertension as of 12/31/2023
- 2566 members were enrolled in the CBP program in 2023
    - Members with hypertension who were enrolled in the CBP program were more likely to have a PCP visit in the past 12 months (93.98%) than members who were not enrolled in the CBP program (81.62%)

- 17764 distinct activities were performed for members in the CBP program and for members who were outreached for the CBP program in 2023
    - 303 distinct members were authorized a blood pressure cuff in 2023
        - 9 members did not meet criteria for the BP cuff in 2023
        - 34 members were identified as having their own BP monitor in 2023
    - 119 members received direct support with scheduling an appointment with their provider in 2023
- Rates of blood pressure control for Medicare Members increased by over 4 percent between 2022 (64.80$) and 2023 68.59%)
    - The measure is still below the estimated 4 star cut point of 78%
- Rates of blood pressure control for Commercial/Exchange members was 51.83% in 2023, a decrease of nearly 3 percent from 2022 (54.23%)
- Members enrolled in the CBP program were more likely to have a BP reading in control (67.10%) than those who were not enrolled in the CBP Program (61.67%)

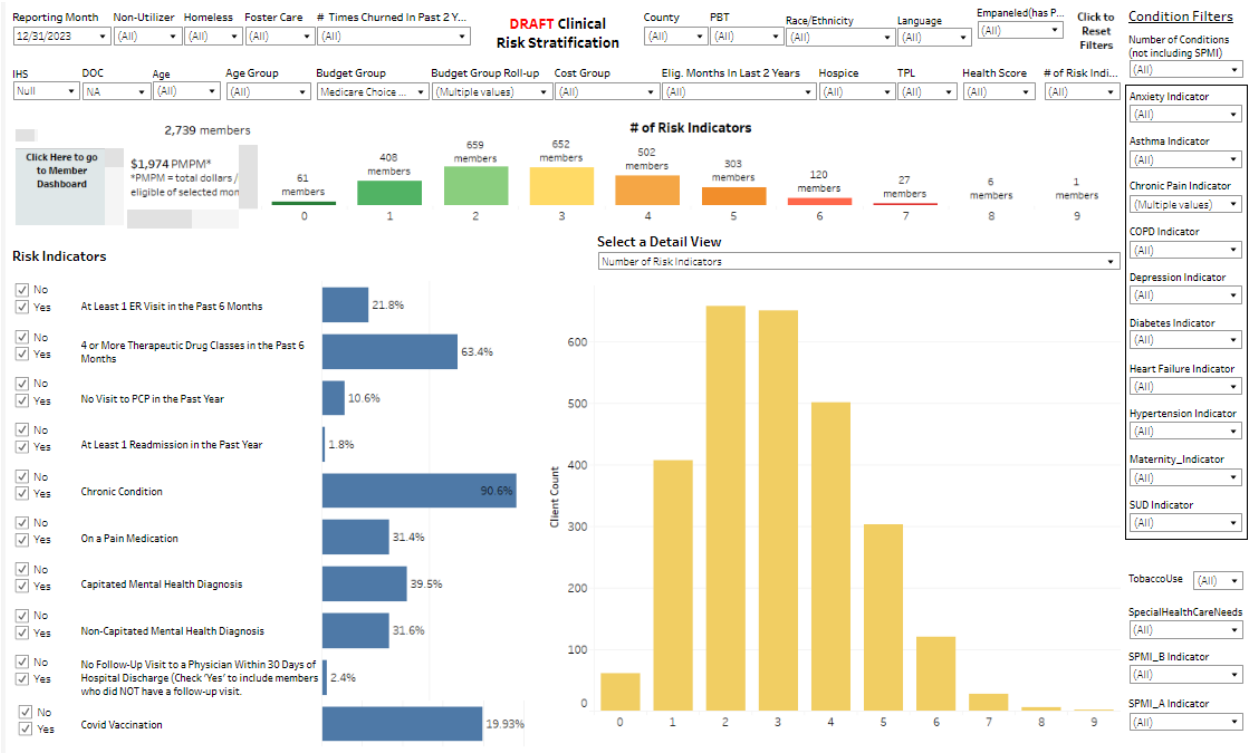
Barriers/Lessons Learned:

- CM can streamline work to close gaps in care with enrolled members
    - The Medicare Member Dashboard was introduced in late 2022 and 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 2024 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
- 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 team will support members with home BP readings
- There is room to improve the 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 partner with SquareML to auto-generate lists based on most recent gaps in care and EPIC lab/appointment data

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 for every member. The ICP is completed upon enrollment, updated at least annually and is an on-going plan of care with members. Interdisciplinary Care Team (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.
2023 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 (12/31/2023):



DSNP Membership as of 12/31/2023 (Risk Stratification Tool)

DSNP Activity Metrics:

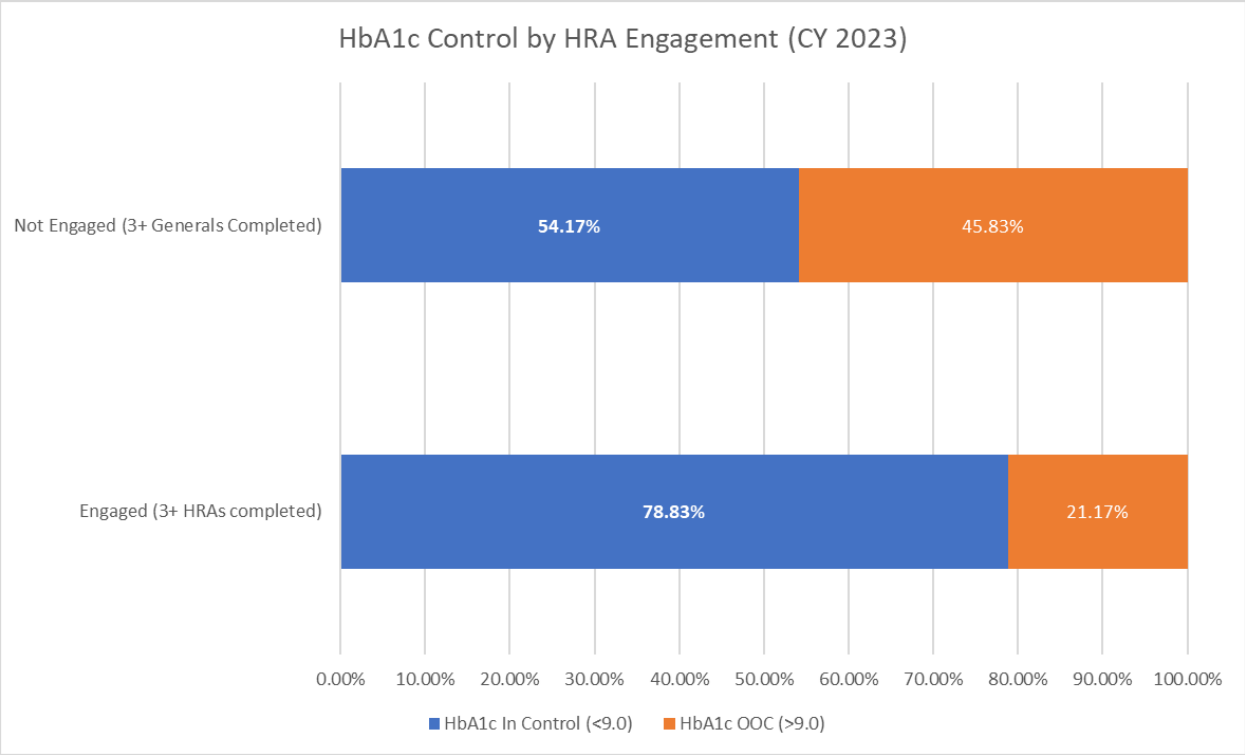
DSNP Activities	Count of Client Patient Id
DSNP - OON Provider	61
DSNP Annual HRA Outreach	14181
DSNP Applications/Membership Assistance	1229
DSNP Benefit Resource Coordination	14972
DSNP Care Plan Update	28330
DSNP Clinical Member Outreach	36409
DSNP Clinical Outreach	6965
DSNP Condition Management	1865
DSNP Dental Care Coordination	823
DSNP Disenrollment Final Summary	3534
DSNP Education Provided	5166
DSNP Food Security Coordination	8831
DSNP General HRA Initial	1746
DSNP General HRA Reassessment	2837
DSNP Health Care Provider Coordination	6066
DSNP Home Health Coordination	242
DSNP Housing Resource Coordination	984
DSNP HRA Initial Assessment	4939
DSNP HRA Reassessment	6768
DSNP ICP Goals / Barriers Communicated to Care Team	1499
DSNP ICT Meeting	20217
DSNP ICT Pharmacy Review	13600
DSNP ICT/TOC Meeting	515
DSNP Immunization Coordination	13
DSNP Initial HRA Outreach	9292
DSNP Language Services	11986
DSNP LTSS Coordination	1732
DSNP Medication Management	4201
DSNP Other Community Resource Coordination	2501
DSNP Peer/Support Groups	16
DSNP Pre-ICT Summary	20083
DSNP Provider Follow-up	52973
DSNP Safety_DV Coordination	31
DSNP Tobacco Cessation Coordination	129
DSNP TOC Care Plan Update	6484
DSNP TOC Follow-up	14070
DSNP TOC Health Acuity / Needs Assessed	5843
DSNP TOC ICP Goals / Barriers Communicated to Care Team	8267
DSNP TOC Member Follow-up	19168
DSNP TOC Referral	1145
DSNP Transportation Coordination	2875
DSNP Utilities Coordination	56
Grand Total	**342644**

DSNP Activities 2023

DSNP Outcome Metrics:

DSNP Metrics	CY 2023
Total Health Risk Assessments Completed	2,644
HRA Completed by Member	1,929
Initial HRA Completed by Member	870
Annual HRA Completed by Member	1,059
Initial HRA General - Unable to Reach	195
Initial HRA General - Member Refused	31
Annual HRA General - Unable to Reach	437
Annual HRA General - Member Refused	52
DSNP HRA Completion Rate	72.96%
Care Plan Meetings (ICT)	4,029
DSNP Enrollment - Medicare Choice DSNP HMO	3,537

DSNP HRA Completion Rate 2023



HbA1c Control by HRA Engagement

Results/Analysis:

- In 2023, a total of 2644 DSNP members were actively engaged in the DSNP CM Program

    - 1929 Total Health Risk Assessments were completed in 2023.
- The HRA completion rate for 2023 was 72.96%, an increase from 2022 (70.52%)
    - 23.90% of members outreached for an initial or annual HRA were unable to be reached.
    - 3.14% of members outreached for an initial or annual HRA declined.
    - The new HRA incentive may have played a role in the increase for HRA participation for members and was heavily promoted in DHMP mailed materials.
- 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)
    - Diabetic members engaged in the HRA process were more likely to have an HbA1c reading that is in control (<9.0, 78.83%) than members who were not engaged in the HRA process (54.17%)
    - Rates for members who were engaged in the HRA process (member completed 3 or more HRAs) were about as likely to have a BP in control (76.07%) as those who were not engaged in the HRA process (member completed 2 or more generals, 76.92%), but the denominator for members who were not engaged in the HRA process and who met criteria for the CBP measure was small (N=26) compared to engaged members who met criteria for the CBP measure (N=163), so it is difficult to assess the full impact of participation in the HRA process

Barriers/Lessons Learned**:**

- Engagement via telephonic outreach failed to reach 23.90% of our members in 2023, which is a lower rate than 2022.
    - Improved rates may be a result of implementing the HRA.
    - DHMP members often have missing or outdated contact information because of numerous barriers including poverty and housing insecurity.
    - Strategies that incorporate other forms of outreach (e.g., in-person, text message, email) and partnerships with community organizations could improve engagement among DHMP members, which would increase opportunities to support members with accessing specialty care.
- 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.
    - Reducing the number of behavioral health related questions and moving them to the end of the assessment may help members complete the HRA more fully.
    - In 2024, the focus will be to reduce barriers for members to complete the HRA by moving behavioral health related questions to the end of the assessment.
- In 2024, DHMP will continue using the HRA incentive to improve member engagement in CM services.

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

This program aims to support Medicare Select Members in achieving goals outlined by their individual care plan and work through barriers to reach them. The Care Management team provides members with access to care and disease management support, with a specific focus on controlling blood pressure and diabetes management. Members are identified as appropriate for ongoing care management based on 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.

2023 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:

Medicare Select Program Activities	Count of Client Patient Id
MCR Select Applications/Membership Assistance	13
MCR Select Benefit Resource Coordination	343
MCR Select Condition Management	3
MCR Select Education Provided	20
MCR Select Food Security Coordination	68
MCR Select Health Care Provider Coordination	81
MCR Select Housing Resource Coordination	4
MCR Select Immunization Coordination	3
MCR Select Language Services	33
MCR Select LTSS Coordination	7
MCR Select Medication Management	20
MCR Select Member Outreach	470
MCR Select Other Community Resource Coordination	27
MCR Select Provider Follow-up	81
MCR Select Transportation Coordination	51
MCR Select Utilities Coordination	13
Medicare Select Annual Outreach	6
Medicare Select Initial Outreach	22
Grand Total	1265

Medicare Select Program Activities 2023

Results/Analysis:

- 122 distinct members received services under the MCR select program
  - 14 members (11.48%) enrolled in the program in 2023
  - 81 outreach calls were completed to assist members with scheduling appointments and accessing care
  - 163 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
- The team identified areas of focus to improve member health and reduce 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 members stay connected to care and have the resources 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.
- Sicker members may be less likely than healthier ones to enroll and participate in programs and/or care coordination activities.
  - Members have voiced not having 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 work closely with Utilization Management to ensure members can access approved treatments, support groups, and/or community programs under existing benefits.
2023 Substance Use Disorder Activity Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

SUD Program	Count of Client Patient Id
SUD Applications/Membership Assistance	3
SUD Benefit Resource Coordination	11
SUD Care Coordination	4
SUD Health Care Provider Coordination	3
SUD Incoming Referral	2
SUD Language Services	3
SUD Member Education Provided	6
SUD Member Outreach	6
SUD Other Community Resource Coordination	2
SUD Transportation Coordination	2
Grand Total	42

SUD Program Activities 2023

Results/Analysis:

- 10 Distinct members were engaged in the SUD program in 2023.
- Members are identified through SUD treatment denials for UM.
    - Care Management attempts to engage with members to provide wrap around services.
    - Referrals dropped off significantly due to changes in SUD coverage which resulted in fewer UM denials.
    - Most members with SUD treatment needs are managed by Colorado Access.
- Despite being a small program, services are necessary.
    - Members with active SUD treatment needs tend to be higher acuity, have higher ED utilization, and are less likely to engage in preventative and primary care services.
    - Successful SUD treatment is often the first step in helping members to engage in preventative care services and reduce incidents and accents that result in ED utilization and hospitalization (i.e., overdoses, falls, other accidents).

Barriers/Lessons Learned:

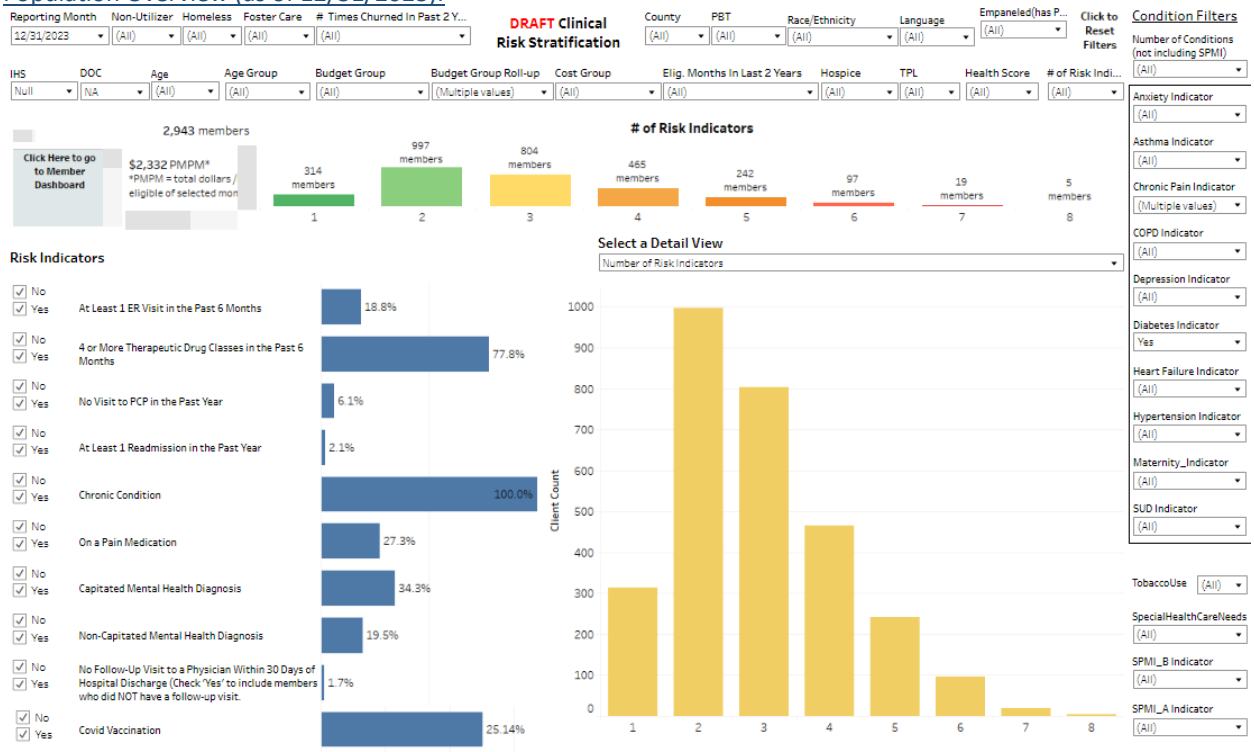
- The program is small, and the number of members outreached represents a small percentage of members who would benefit from SUD service coordination.
    - DHMP is consistently working to improve its ability to identify members who may benefit from SUD services, which may result in an increase in referrals to this program.
    - Care Management will continue to work to identify members in existing programs and during outreach who may benefit from SUD services.
    - 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.

2023 Diabetes Management Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Population Overview (as of 12/31/2023):



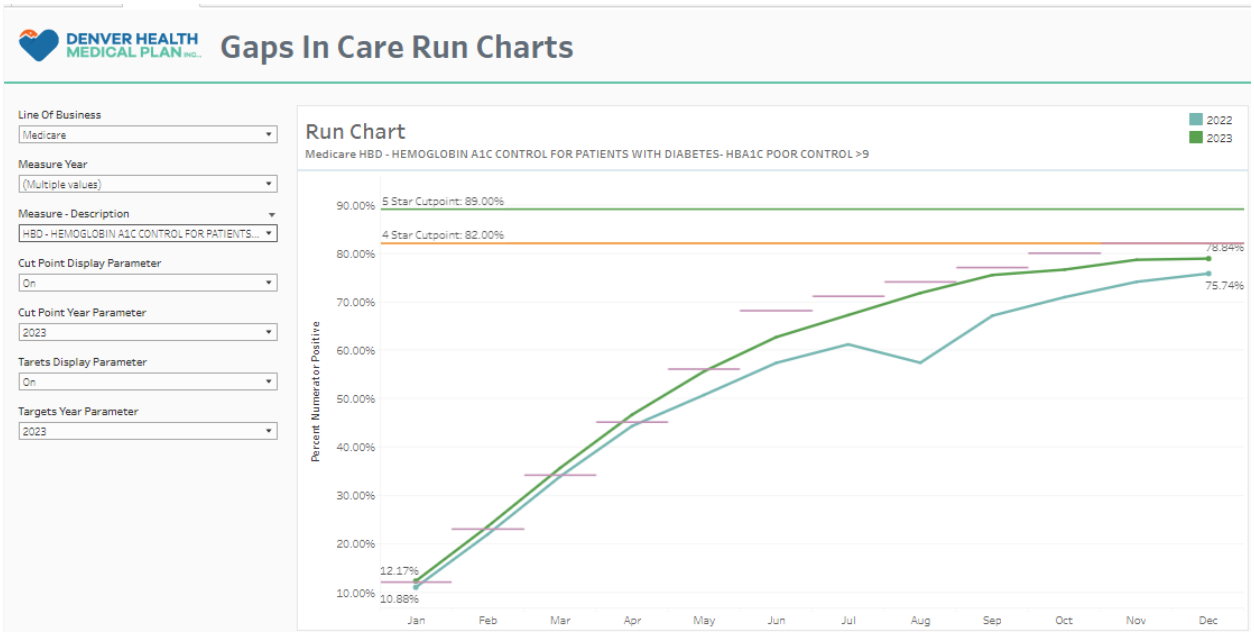
Medicare, Commercial, and Exchange Members with Diabetes as of 12/31/2023 (Risk Stratification Tool)

Diabetes Management Activity Data

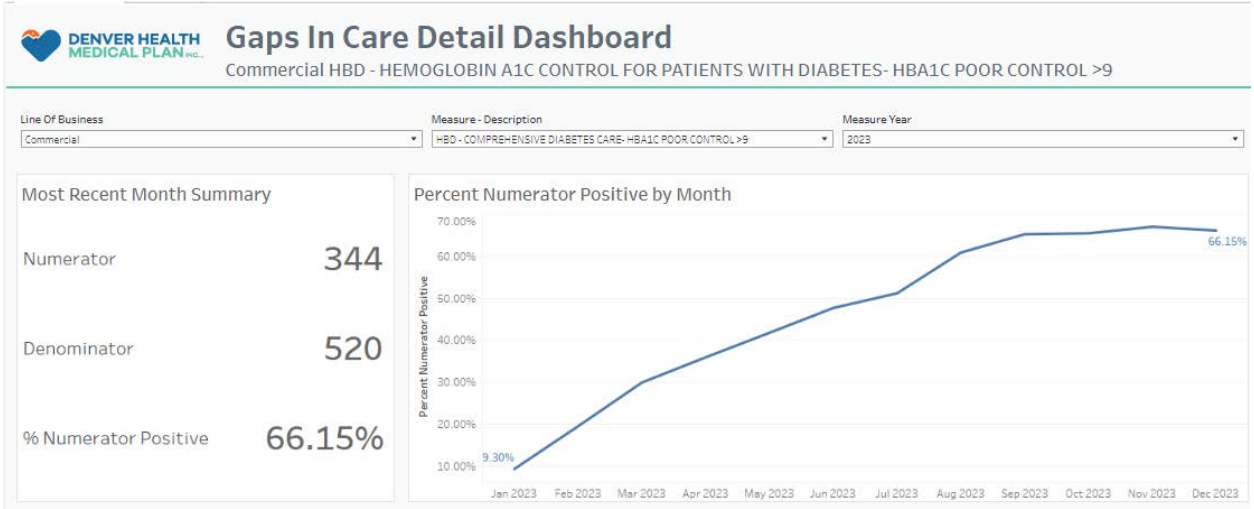
DM Activities	Count of Client Patient Id
DM Applications / Membership	33
DM Assessment	93
DM Benefit Resource Coordination	280
DM Care Plan Update	921
DM Condition Management	703
DM Dental Care Coordination	78
DM Disenrollment Summary	4
DM Education Provided	402
DM Engagement / Enrollment	713
DM Food Security Coordination	51
DM Health Acuity / Needs Assessed	1161
DM Health Care Provider Coordination	1591
DM Housing Resource Coordination	117
DM ICT Meeting	55
DM Internal Activity	518
DM Language Services	794
DM LTSS Coordination	63
DM Medication Management	282
DM Member Outreach	6401
DM Nutritional Support	83
DM Other Community Resource Coordination	254
DM Other Follow-up	53
DM Provider Follow-up	913
DM Referral	92
DM Safety_DV Coordination	3
DM SNAP Coordination	18
DM Transportation Coordination	320
DM Utilities Coordination	12
Grand Total	**16008**

Diabetes Management Program Activities 2023

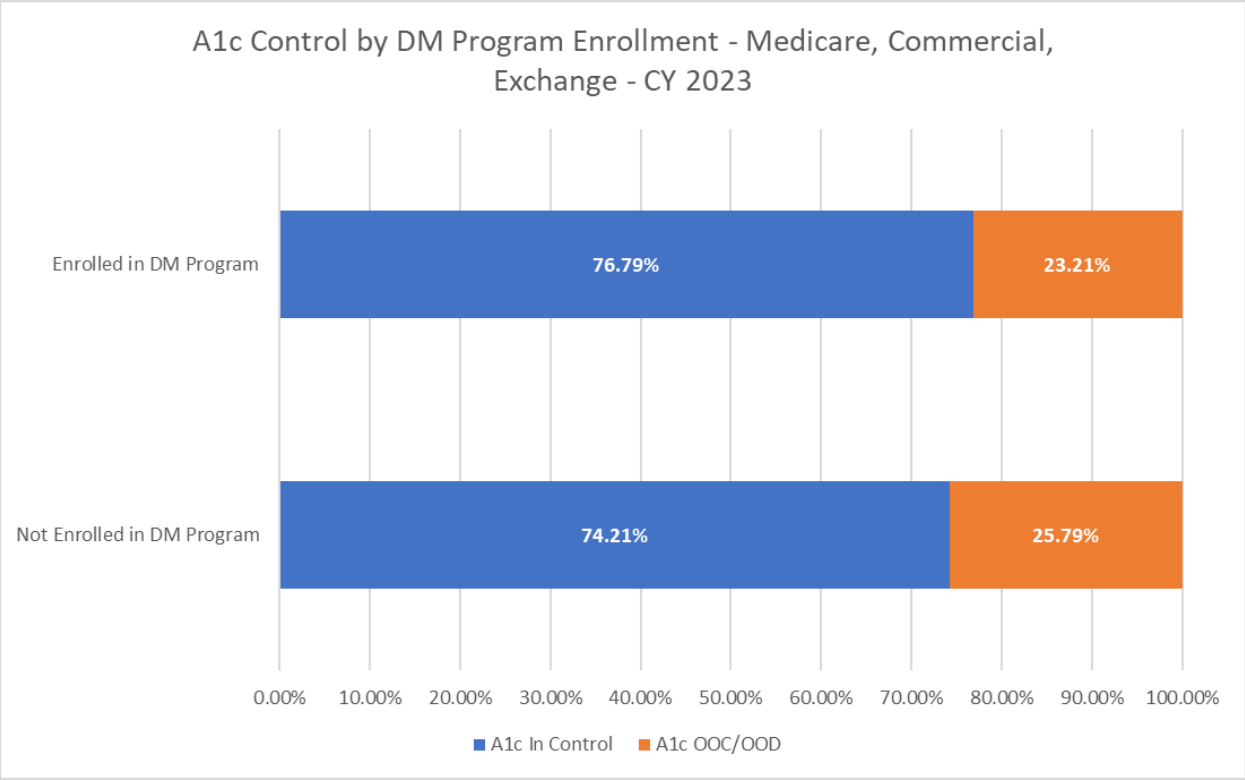
Diabetes Management Outcome Data



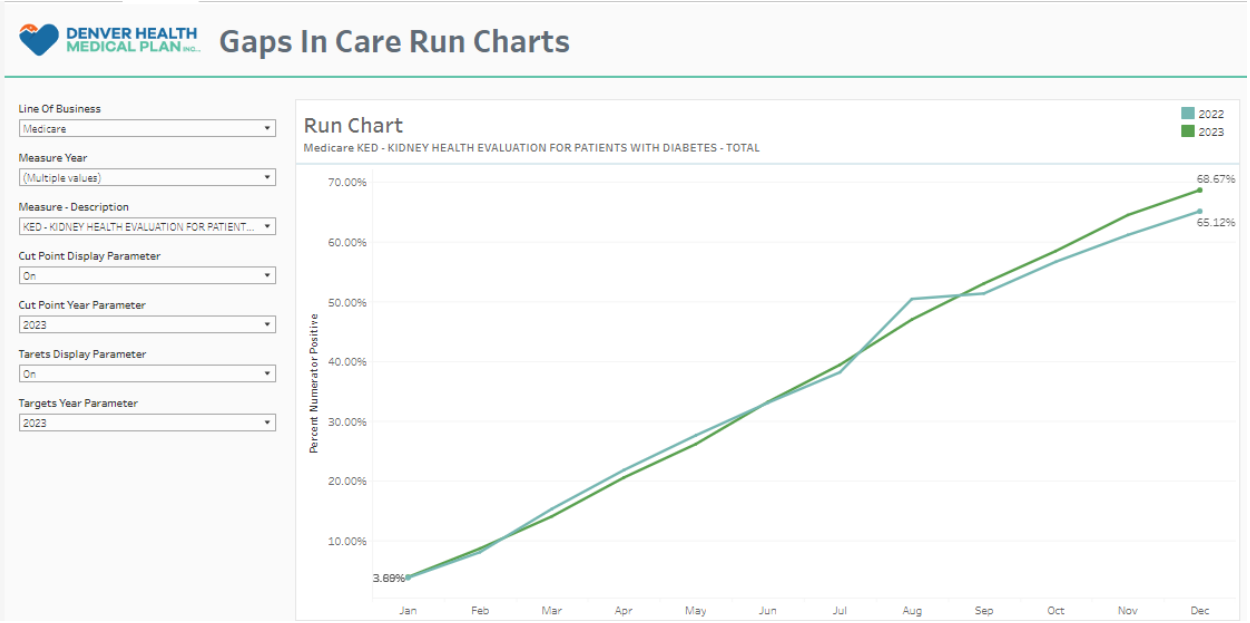
HbA1c Control (HBD) - Medicare 2022 and 2023



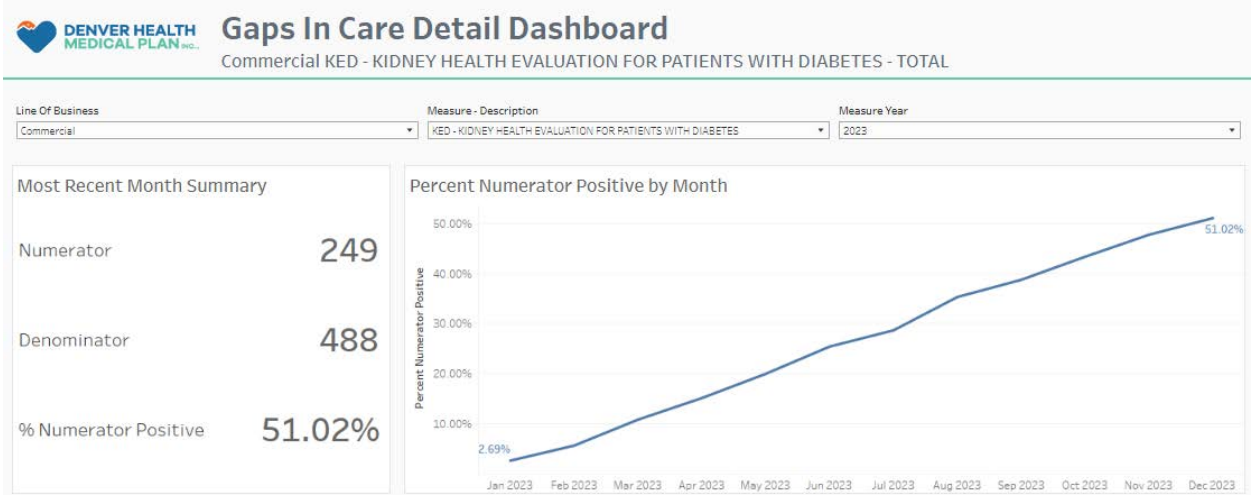
HbA1c Control (HBD) - Commercial and Exchange 2023



HbA1c Control by Diabetes Management Program Enrollment 2023



Kidney Health Evaluation (KED) - Medicare 2022 and 2023



Kidney Health Evaluation (KED) - Commercial and Exchange 2023

Results/Analysis:

- 1293 distinct members participated in the DM program in 2023
    - Members with diabetes who were enrolled in the DM program were more likely to have a PCP visit in the past 12 months (95.53%) than those who were not enrolled in the DM program (93.19%)
- 16008 distinct activities were performed for members enrolled in or outreached for the DM program in 2023
    - 157 members received direct support with scheduling appointments
- In 2023, the Medicare rate for measure HBD – Hemoglobin A1c Control for Patients with Diabetes was 78.84%, an improvement over 2022 rates (75.74%) – estimated 4 stars for 2023
- In 2023, the Commercial/Exchange rate for measure HBD – Hemoglobin A1c Control for Patients with Diabetes was 66.15%, an improvement over the 2022 rate of 63.62%
- 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 2023, CM team members focused on outreaching diabetic members who were numerator negative for the HBD measure
    - The CM team supported members with scheduling appointments to complete their A1c labs
    - The CM team supported members with completing A1c kits from the vendor Let's Get Checked
    - The CM team worked to engage members in the Diabetes Management program for ongoing education, monitoring, and support to manage their condition
- In 2023, the Medicare rate for measure KED – Kidney Health Evaluation for Patients with Diabetes was 68.67%, an improvement over the 2022 rate of 65.12%
- In 2023, the Commercial/Exchange rate for measure KED – Kidney Health Evaluation for Patients with Diabetes was 51.02%, an improvement over the 2022 rate of 44.73%
- The CM team assisted members with scheduling appointments for kidney health evaluation and supported members with completing kidney health evaluation kits from let's get checked

Barriers/Lessons Learned:

- CM can streamline work to close gaps in care with enrolled members.
    - The Medicare Member Dashboard was introduced in late 2022 and 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 2024 to reduce reporting delays of appointment and lab data.
    - The Dashboard will be expanded to all LOB in 2024 to ensure all members in all programs can receive support obtaining necessary screenings.

- 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.
- There is room to improve engagement of members in the HBD denominator.
    - In CY 2024 the CM team will generate outreach lists focused on numerator negative members in this measure, but delays in Gaps in Care reporting is a challenge.
        - The CM team will explore opportunities to partner with SquareML to auto-generate lists based on most recent gaps in care and EPIC lab/appointment data.
- The CM team will implement an intervention in 2024 to ensure that members with severe and persistent mental illness (SPMI) who are also in the numerator for the HBD measure are effectively outreached and engaged in a Diabetes Management program.
    - Factors such as side effects of antipsychotic medications, high SDOH related needs, and the disabling nature of SPMI can impact members' ability to adhere to medication regimens, keep appointments, lose weight, or exercise regularly.
    - The CM team will conduct targeted outreach for members with SPMI who are numerator negative for the HBD measure.

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.

2023 Behavioral Health Care Coordination Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Activity Name	Count of Client Patient Id	Distinct Count of Client Patient Id
BH Care Coordination	471	191
COA Behavioral Health Referral	108	37
DHMP COMM Behavioral Health / SUD Referral	5	3
Internal Behavioral Health Referral	112	24
Grand Total	**696**	**253**

Behavioral Health Care Coordination Activities 2023

Results/Analysis:

- 253 distinct members were engaged in the Behavioral Health Coordination Program
    - 37 members (14.62%) received a behavioral health referral for Colorado Access (COA)
    - 24 members (9.49%) received an internal behavioral health referral to Denver Health
    - 191 members (75.50%) received support with BH care coordination
- 696 outreach calls were made in 2022, and of those, 471 (67.67%) were for BH Care Coordination

Barriers/Lessons Learned:

- 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 2024 for select lines of business.

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 needed 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.

2023 Continuity of Care Program Metrics - DHMP formalized metrics and data collection analysis from our current Care Management Software, Guiding Care, and started identifying what metrics should be tracked and trended.

Activity Name	Count of Client Patient Id	Distinct Count of Client Patient Id
Continuity of Care Language Services	32	14
Continuity of Care Member Coordination	84	38
Continuity of Care Provider Coordination	9	2
Grand Total	**125**	**45**

Continuity of Care Activities 2023

Results/Analysis:

- The Continuity of Care Program supports members with transitioning between in network and out of network providers to meet member needs.
    - Members who are transitioning from an out of network provider can get assistance with transitioning to an in-network provider without gaps in service or care.
    - Care Managers assist with establishing in network providers for members.
    - Care Managers assist members to find services out of network when in-network services are inadequate to meet member needs.
- 146 distinct members were served under this program in 2022.
- 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.

Program Name: **COVID Member Outreach/COVID Vaccination Care Coordination:**

COVID-19 emergency planning and program implementation was initiated across the state of Colorado in 2020. The onset of COVID-19 necessitated Denver Health Medical Plan to pivot and respond to the pandemic, which impacted programming and services across the company. Meetings, interactions, and services with community partners were also impacted. Care Coordination started the outreach program in April 2020. In 2022, in partnership with the Statewide COVID-19 Vaccine Collaborative, DHMP has shifted focus to normalizing the COVID-19 vaccine and boosters and offering

it along with other routine vaccines. Efforts in 2023 focused on the normalization and promotion of COVID-19 vaccinations alongside other routine immunizations. In 2024, the team will continue to support members with accessing COVID-19 vaccines as a part of routine immunizations.

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:

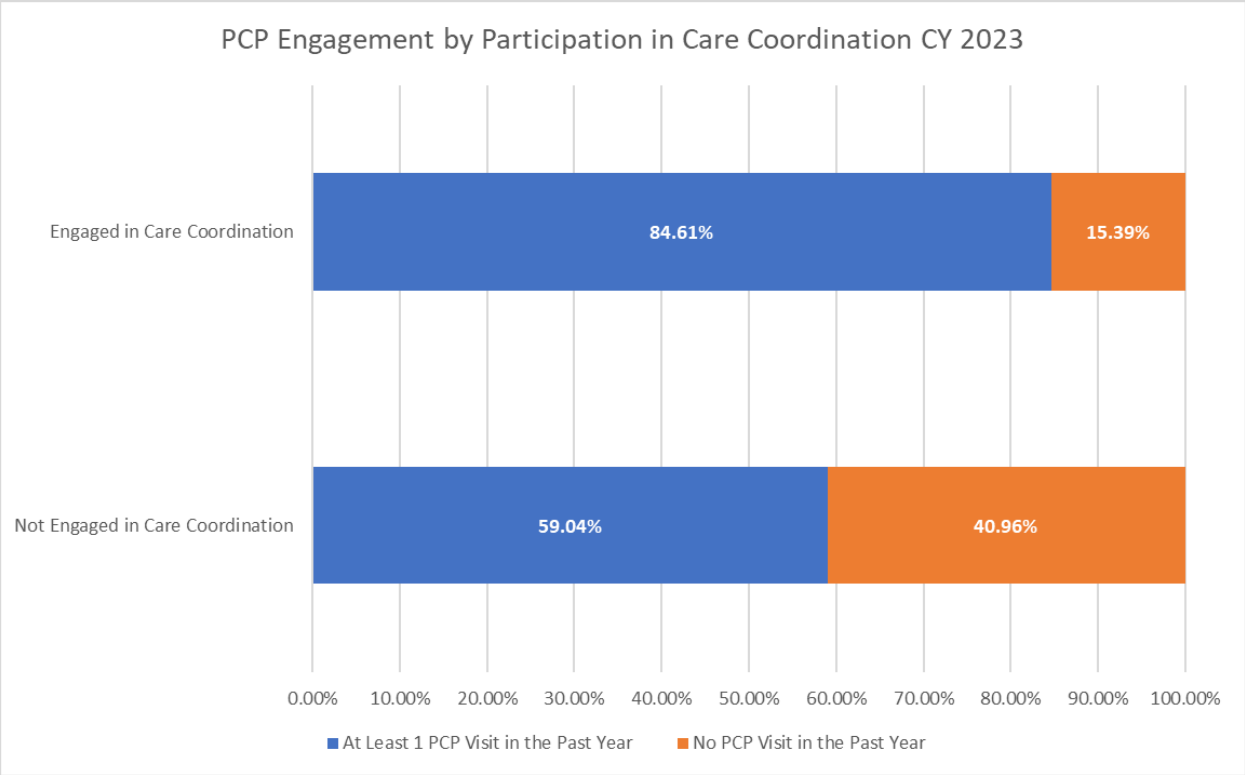
- Applications/Membership Assistance
- Community Resources Assistance
- Condition/Disease Management
- Education
- Health Acuity/Needs
- Medication Management
- Health Care Provider Coordination and DHHA Empanelment
- Transportation
- Appointment Reminders
- Meal Coordination

2023 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:

Activity Name	Count of Client Patient Id
CC Applications/Membership Assistance	11
CC Benefit Resource Coordination	226
CC Care Plan Update	73
CC Condition Management	32
CC Dental Care Coordination	29
CC Education Provided	314
CC Engagement / Enrollment	124
CC EPSDT Member Coordination	6
CC Food Security Coordination	108
CC Health Acuity / Needs Assessed	1488
CC Health Care Provider Coordination	823
CC Housing Resource Coordination	128
CC Language Services	252
CC LTSS Coordination	98
CC Medication Management	338
CC Member Outreach	5128
CC Nutrition Support	14
CC Nutritional Support	5
CC Other Community Resource Coordination	267
CC Other Follow-up	88
CC Provider Follow-up	346
CC Referral	264
CC Safety_DV Coordination	1
CC SNAP Coordination	36
CC Tobacco Cessation Coordination	3
CC Transportation Coordination	248
CC Utilities Coordination	1
CC WIC Coordination	2
Grand Total	**10453**

Care Coordination Activities 2023



PCP Engagement by Engagement in Care Coordination Services

Results/Analysis:

- 1792 unique members engaged in Care Coordination services in 2023
- 10,453 distinct member outreaches were captured in 2022
    - 7.87% of outreach calls were to assist members with scheduling appointments and accessing care
    - 9.97% of outreach calls were to provide members 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 2023.
    - 84.61% of members who engaged in CC services had at least 1 PCP visit in the past 12 months, compared to 59.04% of members who did not engage in these services.
        - These rates are an increase from 2022, where 79.29% of members engaged in CC services had at least 1 PCP appointment in the past year.
- 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:

- There is an ongoing need for the health plan to collaborate with clinical partners to address access to care issues experienced by plan members.
- The organization has enhanced its business continuity protocols to include barriers to care. For example, the use of telemedicine appointments when appropriate.
    - Despite the role of telemedicine in supporting members when appropriate, many members required in-person services.
    - Demand for services continues to outpace appointment availability, which results in lower member satisfaction.

- In 2024, 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 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 to support members with accessing care.

Care Management Member Experience Survey:

A total of 293 members completed the Care Management Member Experience Survey in 2023. Members are contacted by phone following completion of a program, or at year end for those who are continuously enrolled in a program. In 2023, member surveys were mailed to Medicare, Commercial, and Exchange Lines of Business members, providing them with an alternative method for completing surveys. Health Plan Care Coordinators conducted calls for members who did not complete surveys mailed to them.

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

2023 Care Management Member Experience Survey Results

Program Name	Number of Respondents	% Member Response
Complex Case Management	8	2.73%
Controlling Blood Pressure	8	2.73%
Foster Care	3	1.02%
High Utilizer Medication Management	2	0.68%
Maternal Care	14	4.78%
Medicaid Complex Care	20	6.83%
Medicare Choice SNP HMO	208	70.99%
Special Health Care Needs	22	7.51%
Transitions of Care	9	3.07%
Grand Total	**293**	**100.00%**

Care Management Member Experience Survey Responses by Program 2023

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.)	134	126	260	38	51.54%	48.46%

Care Management Member Experience Survey Responses - Behavior Modification - All Programs 2023

Member Satisfaction Survey Results - Behavior Modification - Complex Case Management						
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.)	2	5	7	1	28.57%	71.43%

Care Management Member Experience Survey Responses - Behavior Modification - Complex Case Management 2023

Member Satisfaction Survey Results - Behavior Modification - Medicare Select SNP HMO						
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.)	92	90	182	27	50.55%	49.45%

Care Management Member Experience Survey Responses - Behavior Modification - DSNP Program 2023

Member Satisfaction Survey Results - Behavior Modification - Transitions of Care						
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.)	0	8	8	1	0.00%	100.00%

Care Management Member Experience Survey Responses - Behavior Modification - TOC Program 2023

Member Satisfaction Survey Results - Behavior Modification - Controlling Blood Pressure						
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.)	2	4	6	2	33.33%	66.67%

Care Management Member Experience Survey Responses - Behavior Modification - CBP Programs 2023

Member Satisfaction Survey Results - Behavior Modification - High Utilizer Medication Management						
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.)	0	2	2	0	0.00%	100.00%

Care Management Member Experience Survey Responses - Behavior Modification - High Utilizer Medication Management Program 2023

Behavior Changes Self-Reported by Members	
Reported Behavior Change	# Responses
Smoking Cessation	2
Quit Drinking	1
Medication Adherence	31
Engaged in Treatment	12
Utilized resources	4
Lifestyle Modification - Diet	53
Lifestyle Modification - Exercise	29
Lifestyle Modification - Other	34

Reported Behavior Changes - All Programs 2023

Member Experience Survey Results										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have ccomplaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	3	5	12	68	199		287	6	6.97%	93.03%
How satisfied are you with how the care manager helped you get the care you needed?	3	4	13	56	209		285	8	7.02%	92.98%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	4	3	18	50	282		357	-64	7.00%	93.00%
How satisfied are you with how the care manager treated you?	1	1	8	59	216		285	8	3.51%	96.49%
How helpful was your care manager when you had a question or concern?	3	3	13	52	212		283	10	6.71%	93.29%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	2	5	19	55	189		270	23	9.63%	90.37%
How well did your care manager share important information with you when it was needed?	3	5	19	50	196		273	20	9.89%	90.11%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	4	3	12	47	204		270	23	7.04%	92.96%
How satisfied are you with the timeliness of your care management services?	5	5	15	63	185		273	20	9.16%	90.84%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	7	3	11	52	147	54	274	19	7.66%	92.34%
Overall, how satisfied are you with the care management program?	4	2	11	46	215		278	15	6.12%	93.88%

Member Experience Survey, All Programs, N = 293

Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have Complaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	1	2	6		9	0	11.11%	88.89%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	1	2	6		9	0	11.11%	88.89%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	2	3	4		9	0	22.22%	77.78%
How satisfied are you with how the care manager treated you?	0	0	1	3	5		9	0	11.11%	88.89%
How helpful was your care manager when you had a question or concern?	0	0	1	2	6		9	0	11.11%	88.89%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	1	2	6		9	0	11.11%	88.89%
How well did your care manager share important information with you when it was needed?	0	1	0	2	6		9	0	11.11%	88.89%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	0	3	6		9	0	0.00%	100.00%
How satisfied are you with the timeliness of your care management services?	0	0	0	3	6		9	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	1	1	5	2	9	0	11.11%	88.89%
Overall, how satisfied are you with the care management program?	0	0	1	2	5		8	1	12.50%	87.50%

Member Experience Survey - Transitions of Care Program; N = 9

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 satisfied are you with how the care manager helped you understand your treatment and care plan?	2	5	9	58	132		206	3	7.77%	92.23%
How satisfied are you with how the care manager helped you get the care you needed?	3	4	12	48	139		206	3	9.22%	90.78%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	4	3	15	40	141		203	6	10.84%	89.16%
How satisfied are you with how the care manager treated you?	1	1	7	50	146		205	4	4.39%	95.61%
How helpful was your care manager when you had a question or concern?	3	3	10	46	142		204	5	7.84%	92.16%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	2	5	16	45	124		192	17	11.98%	88.02%
How well did your care manager share important information with you when it was needed?	3	3	16	44	129		195	14	11.28%	88.72%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	4	3	9	39	137		192	17	8.33%	91.67%
How satisfied are you with the timeliness of your care management services?	5	4	10	54	121		194	15	9.79%	90.21%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	7	3	10	46	110	19	195	14	10.26%	89.74%
Overall, how satisfied are you with the care management program?	4	2	9	38	149		201	8	7.46%	93.03%

Member Experience Survey - Medicare Choice SNP HMO Program; N = 209

Member Experience Survey Results - Complex Case Management										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have Complaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	0	0	8		8	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	7		8	0	0.00%	100.00%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	0	0	8		8	0	0.00%	100.00%
How satisfied are you with how the care manager treated you?	0	0	0	0	8		8	0	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	1	0	6		7	1	14.29%	85.71%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	0	0	5		5	3	0.00%	100.00%
How well did your care manager share important information with you when it was needed?	0	0	0	1	6		7	1	0.00%	100.00%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	1	0	6		7	1	14.29%	85.71%
How satisfied are you with the timeliness of your care management services?	0	0	1	0	6		7	1	14.29%	85.71%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	0	1	4	3	8	0	0.00%	100.00%
Overall, how satisfied are you with the care management program?	0	0	0	1	6		7	1	0.00%	100.00%

Member Experience Survey - Complex Case Management Program; N = 8

Member Experience Survey Results - Controlling Blood Pressure										
Survey Question/Results	1 – not at all satisfied	2 – a little satisfied	3 – somewhat satisfied	4 – mostly satisfied	5 – very or always satisfied	Did not have Complaints/ concerns	Total Responses	No Response	Member Not Satisfied (Score of 1,2, or 3)	Member Satisfied (Score of 4 or 5)
How satisfied are you with how the care manager helped you understand your treatment and care plan?	0	0	0	5	2		7	1	0.00%	100.00%
How satisfied are you with how the care manager helped you get the care you needed?	0	0	0	3	5		8	0	0.00%	100.00%
How satisfied are you with how the care manager paid attention to you and helped you with problems?	0	0	0	4	4		8	0	0.00%	100.00%
How satisfied are you with how the care manager treated you?	0	0	0	5	3		8	0	0.00%	100.00%
How helpful was your care manager when you had a question or concern?	0	0	0	3	4		7	1	0.00%	100.00%
How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed?	0	0	0	4	3		7	1	0.00%	100.00%
How well did your care manager share important information with you when it was needed?	0	0	1	1	4		6	2	16.67%	83.33%
How helpful was your care manager in helping you access services (doctors appointments, specialty appointments, etc.)?	0	0	1	2	3		6	2	16.67%	83.33%
How satisfied are you with the timeliness of your care management services?	0	0	1	3	3		7	1	14.29%	85.71%
If you had any complaints, how satisfied are you with how your care manager addressed any complaints or concerns?	0	0	0	2	2	1	5	3	0.00%	100.00%
Overall, how satisfied are you with the care management program?	0	0	0	4	2		6	2	0.00%	100.00%

Member Experience Survey - Controlling Blood Pressure Program; N = 8

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

Member Experience Survey – High Utilizer Medication Management; N = 2

Results/Analysis:

- The overall response rate to the 2023 Care Management Member Experience Survey was higher than 2022, with 293 members completing the survey.
    - In 2022, 208 members responded to the survey.
- Of the 293 members who responded to the survey:
    - 3.07% (9 members) had participated in the Transitions of Care Program
    - 70.99% (208 members) were participants in the Medicare Choice SNP HMO Program
    - 2.73% (8 members) had participated in the Controlling Blood Pressure Program
    - 2.73% (8 members) had participated in the Complex Case Management Program
    - 0.68% (2 members) had participated in the High Utilizer Medication Management Program
    - 59 members (20.13%) had participated in Medicaid focused Care Management programs.
    - Overall satisfaction rates were highest for the Complex Case Management, Controlling Blood Pressure, and High Utilizer Medication Management Programs, 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 an 93.88% 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.
    - This is an improvement over 2022 results, with 88.50% of members reporting being satisfied overall with their care management program and a total score of 4.4/5 for all questions.
    - Complex Case Management was rated at 4.9/5 for all questions (N=8)
    - The DSNP Program was rated at 4.5/5 for all questions (N=208)
    - Transitions of Care was rated at 4.5/5 for all questions (N=9)
    - The Controlling Blood Pressure Program was rated at 4.4/5 for all questions (N=8)
    - The High Utilizer Medication Management Program was rated at 5.0/5 for all questions (N=2)
- Satisfaction rates were highest for the following questions:

        - How satisfied are you with how the Care Manager treated you? (96.49% satisfied)
        - Overall, how satisfied are you with the care management program? (93.88% satisfied)
        - How helpful was your care manager when you had a question or concern? (93.29% satisfied)
    - Satisfaction rates were lowest for the following areas:
        - How well did your care management share important information when it was needed? (90.11% satisfied, an improvement over 2022 when 87.18% of members were satisfied)
        - How helpful was your care manager in communicating your available benefits and referring you to other community resources, if needed? (90.37% satisfied)
        - How satisfied are you with the timeliness of your Care Management services (90.84% satisfied, an improvement over 2022 when 87.50% of members reported being satisfied)
    - Of the 260 respondents to the behavior modification question, 48.46% 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:
            - 2 Members reported engaging in smoking cessation.
            - 1 Member reported that they quit drinking.
            - 31 Members reported greater medication adherence.
            - 12 Members reported engaging in medical care or therapy related to their health condition.
            - 4 members reported utilizing resources provided by the care manager.
            - 53 members reported making changes to their diet.
            - 29 members reported increasing physical activity.
            - 234 members reported other lifestyle changes.

Barriers/Lessons Learned:

- While outreach numbers and response rates to the Member Experience Survey improved in 2023, there is room to improve outreach and response rates:
    - DHMP will continue having Health Plan Care Coordinators who work within specific programs to conduct outreach members who participated in that program each month.
        - This may increase the number of programs that DH is able to receive feedback on.
        - This may increase response rates for individual programs.
    - Improved response rates may allow for more robust program-level analysis, which may lead to additional identified opportunities for improvement.
- 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 2024

- Planned upgrade of the Health Edge Guiding Care© Medical Management Platform from version 8.11 to version 8.17
- Development of an ADT feed to track inpatient admissions and observation stays.
- Development of an ADT feed in to track ED visits.
- Identification of a rising risk population in partnership with SquareML
- Improved member outcome analytics, including cost and utilization outcomes, in partnership with Square ML
- Upgrade of the Health Edge Guiding Care© Medical Management Platform including implementation of the Population Health module
- Integration of HEDIS data into the Health Edge Guiding Care© Medical Management Platform Population Health Module

- Automated integration of Health Needs Assessment (HNA) data into the Health Edge Tableau Data Warehouse
- Integration of data from the Health Edge Guiding Care© Medical Management Platform into DHMP's Risk Stratification tool to improve effectiveness in evaluating member and program outcomes.
- Exploration of enhancements to the Health Edge Guiding Care© Medical Management Platform which will enhance communication between the CM team and DHMP members, including:
    - Robo calls/ Robo texting
    - Ability to send members messages through a secure system.
    - Ability to send member resources and education through a secure system.
    - Ability for members to complete assessments through a secure system.
    - Development of a Condition Management dashboard to track member conditions and participation in CM programs.

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.

Quantitative Analysis—Web
This section assesses interactive components of DHMP's website, specifically the cost estimator tool within the member portal, to determine if the correct information is returned when a request is entered (e.g., a search for a cost estimate for a specific CPT code or treatment by name/provider).

Aggregate results
When a cost estimate was requested via web in February/March 2024 as part of this QA, 12 out of 23 times (52.17%) a cost estimate was requested was available; however, 11 out of 23 times (47.82%), the cost estimate was not available for the requested CPT code (see also Table A). The QA of the cost estimator tool was conducted using codes a member may be likely to request (CMS, 2023; Healthie, 2023).

Table A—Cost Estimator Tool QA

CPT/Treatment	Cost Estimate Available?
78350-Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	**N**
78351-Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	**N**
77080-Bone density study of spine or pelvis	Y
99212-Office visit of established patient requiring a physician, 10-19 minutes	Y
99213- Established patient office or other outpatient visit, typically 15 minutes	Y
99215- Established patient office or other outpatient visit, typically 15 minutes	Y
99203- New patient office or other outpatient visit, typically 30 minutes	Y
99204- New patient office or other outpatient visit, typically 45 minutes	Y
97110- Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes	Y

97140- Manipulation of 1 or more regions of the body	Y
92507- Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	**N**
73521- Radiologic examination, hips, bilateral	**N**
70553- Mri brain stem w/o & w/dye	**N**
77066- Mammography of both breasts	**N**
73080- X–ray exam of elbow; two views	Y
90935-Dialysis outpatient	**N**
90999-Unlisted dialysis procedure inpatient/outpatient	Y
E0601-CPAP Device	**N**
E1390- Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	**N**
E2300-Power seat elevation equipment on wheelchairs	**N**
L3000-Foot insert, removable, molded to patient model	**N**
97124-Massage therapy-1 or more sites, 15 mins	Y
27446-Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	**N**

Of the cost estimates that were available, do note that CPT codes 97124 (massage therapy) and 97140 (physical therapy) produced results of only 1 provider, Karen C Thompson-PT (out-of-network). For the cost estimates that were not available for the requested codes in Table A, 77066 (mammogram of both breasts) and 70553 (MRI brain stem w/o & w/dye) retrieved no results, with a message stating that "The system was unable to process the request." "No results found" for 27446 (total knee), E0601 (CPAP), nor E1390 (oxygen supplies). Finally, for L3000 (foot orthotics) and E2300 (Power seat elevation equipment on wheelchair), the system retrieved no results and advised the tester that "No Treatment includes the term L3000. Check your spelling or click Reset to clear the entry and start over."

Trends over time

In addition to the above trends, sometimes when multiple practitioners were selected for a desired cost estimate, but not all providers had cost estimates available, a warning message appeared with the estimate ID and to contact Health Plan Services; "We are sorry, your estimate cannot be calculated at this time. Please contact Health Plan Services at 800-700-8140 if you should require additional information. Please reference the Estimate ID when contacting Health Plan Services. Estimate ID EST24064000021, EST24064000022, EST24064000020."

Comparison to a standard or goal

DHMP took a multi-faceted approach to determine usefulness of referral/auth and benefit/financial info available on the web. Per DHMP's policy titled Review Of Annual Notice Of Change, Evidence Of Coverage, And Summary Of Benefits Documents, the health plan partners with subject matter experts and vendor(s) to develop benefit documents, including but not limited to the Evidence of Coverage (EOC, A.K.A. member handbooks). These materials provide information to members related to referrals/authorizations, benefits/financial responsibility for a specific service or treatment, based on current models from regulatory bodies including but not limited to CMS.

In order to evaluate the web functionality in regards to determining benefit/financial responsibility for a specific service or treatment from a specified provider or institution, members can view copays/cost shares within the member handbooks, but may also leverage the Cost Estimator Tool within MyDHMP portal (i.e. for out-of-network, member-submitted claims, etc.). Cognizant is the vendor who owns the Cost Estimator Tool, a SaaS solution. The goal of the Cost Estimator Tool is to allow users to generate real-time estimates for covered treatments. While Cognizant does monitor usage statistics of the tool, there is currently not a way to isolate user sessions to singular session records for purposes of tracking single user hits, only roll-up data. However, Cognizant is slated to provide more detailed reporting metrics to

the health plan later in 2024, but that enhancement is still being planned at the time of this analysis. What's more, performance improvement is expected with Cost Estimator Tool version 6.1 R2 deployment. It is currently set to be installed in March 2024 and Cognizant will be conducting joint testing with DHMP's Strategy Management Office (SMO). As for quality checks of the code, testing is run during Cognizant's internal QA process prior to every sprint release. Code is not deployed to customer environments (i.e. DHMP) until QA signoff has been obtained. Updates are made to the base software and are pushed to all clients at the same time What's more, DHMP also conducts an annual analysis of complaints and appeals, to identify opportunities to improve member experience with behavioral and non-behavioral health services. In 2023, DHMP received feedback from our members about our marketing materials and plan documents. Unfortunately, members sometimes find these documents to be unclear and written in legalese, such as the member handbooks or Explanation of Benefits notices. Other members are unhappy about the number of communications the plan sends, such as notifications about wellness programs available to them. Finally other members grieve because they do not receive materials upon request, such as replacement ID cards, the Healthy food Card, or OTC catalogue. DHMP verifies members addresses before ordering materials and utilizes a print vendor to issue materials. Member also are educated about the opportunity to access some materials online at the DHMP plans website. All in all, the volume of complaints about the website were very low, which could be indicative of its usefulness. Additionally, the phone call Q&A section of this report details trends, and there were **no trends indicative of member dissatisfaction with the cost estimator tool**. 2023 A&G trends revealed member grievances about not receiving materials, or receiving materials that members were not happy with. DHMP often receives feedback about our marketing materials and plan documents. Unfortunately, members sometimes find these documents to be unclear and written in legalese, such as the member handbooks or Explanation of Benefits notices. Other members are unhappy about the number of communications the plan sends, such as notifications about wellness programs available to them. Finally other members grieve because they do not receive materials upon request, such as replacement ID cards, the Healthy food Card, or OTC catalogue. DHMP verifies members addresses before ordering materials and utilizes a print vendor to issue materials. Member also are educated about the opportunity to access some materials online at the DHMP plans website.

A conclusion drawn by the organization

The medical plan is committed to ensuring member-centric information related to using their benefits, including but not limited to referral/authorizations, benefits/financial, are understandable, accurate, and easy to locate on our website. This includes quality and accuracy checks of the handbooks, as well as oversight of vendor Cognizant for the Cost Estimator Tool, in alignment with the DHMP Delegation Oversight policy. Processes are being followed.

Qualitative Analysis—Web

Reasons for results

In February 2024, as a result of data collected for this analysis, Ticket INC3010955 was opened with Cognizant (vendor responsible for cost estimator tool) to review / analyze reasons for latency/error messages and correct. Major releases follow the same cadence as QNXT (the system used for viewing claims, practitioner network status), but incremental deployments are released to the Cost Estimator Tool in the form of hot fixes, change packs, etc. as necessary in between releases. In the event bugs are found, they are queued based on severity/priority, and then addressed accordingly by the project organizer and Scrum master. Project managers can influence or say that a certain bug has to be delivered sooner rather or later based on their discretion. Aging is also a factor, so even if there's something medium or low, if it's aging, they will take into consideration as well. If a function/feature appears to be incomplete (i.e. we deliver an admin feature before the functional feature in the member view), we'll indicate that in documentation. For example, Cognizant delivered the Non-binary gender field in profile in support of a product portfolio direction. However, during testing, identified a bug in the QNXT API when testing the non-binary gender, and ended up hiding the non-binary gender by default under Profile section and reported this in the release notes.

Who participated in analysis
DHMP provided enhanced analysis training to key stakeholders in 2023, to better align with NCQA's expectations of the required components of both quantitative and qualitative analyses. Several stakeholders were invited to provide

feedback used in this analysis, including: Cognizant (Vendor of Cost Estimator Tool), QI Consultant, Health Plan Services (HPS) Manager, HPS Supervisor, Lead Applications Analyst, NCQA Project Manager, Website and Marketing Campaigns Manager, DHMP's Medical Management Committee (MMC), and Quality Management Committee (QMC); Primary Care Physician at DH ACS PCMH, Sam Sandos Westside Family Health Center, A&G Consultant, Compliance Analysts, Government Products Manager-Medicare, QI Project Managers, QI Manager, DH Medical Director/Physician for ACS PCMH QI and Research Clinical Scientist, CPC Community Health, Colorado Prevention Center, Professor, Department of Medicine, University of Colorado, Member, State Board of Health, Colorado Department of Public Health and Environment, DHHA Dept of OBGYN Physician, Manager of Population Health (PH), Pediatric Primary Care Physician, Wellington E. Webb Center for Primary Care, Clinical Manager (RN) of Care Management, Government Products Analysts, PH Analyst, Manager of Monitoring, Auditing, and Training (MAT), Credentialing Coordinator, Contracted Behavioral Health Physician, Manager of Commercial Insurance Products, CAHPS Analyst, Manager of Marketing and Provider Relations (PR), Training of Medical Management (RN), Director of CM, Manager of Government Products-Medicaid/CHP+, Operations Manager of CM, Director of A&G and UM, DHMP Medical Director (MD), QI/HEDIS Program Manager, Senior Director of Health Outcomes and Pharmacy (HOP), PH Pharmacist.

Telephone Quality and Accuracy of Information (ME6B&C)

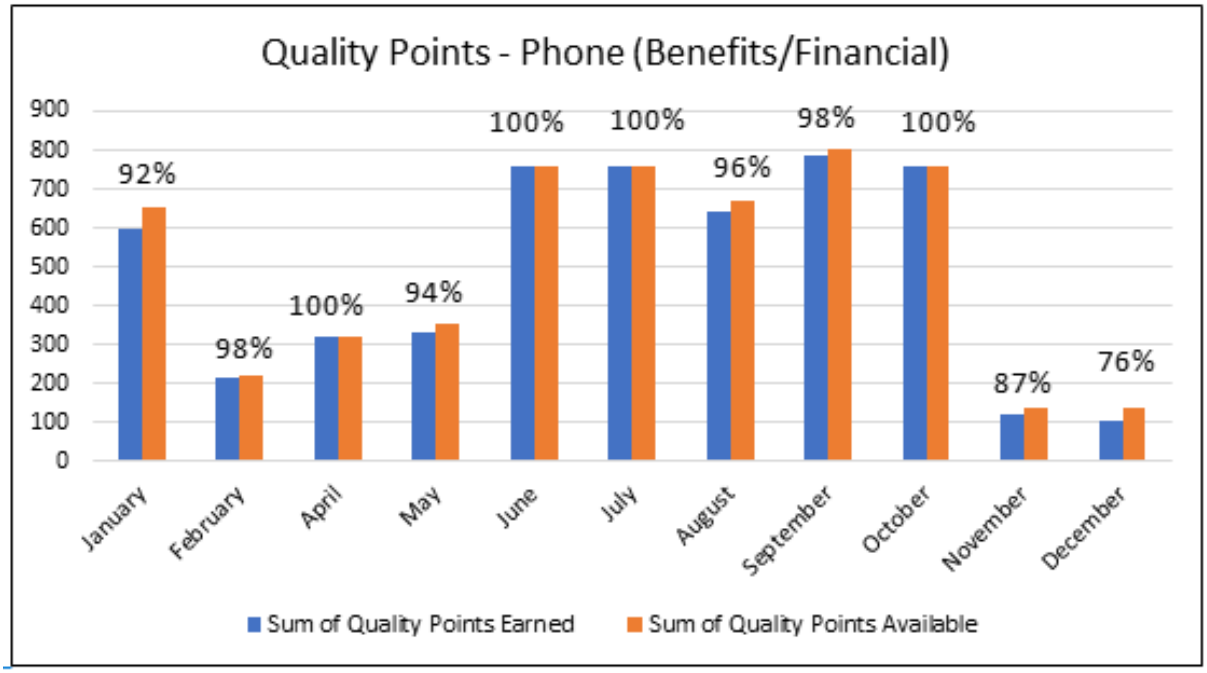
DHMP HPS monitors six telephonic statistics categories to ensure that industry standards are met, specifically: Service Level at or above 80%, Average Delay (speed to answer) of 30 seconds or less or per product line, Abandonment Rate of 5% or less, overall Call Volume, Reasons for calls, and Quality/Accuracy of calls. The Health Plan Services Performance Report monitors these telephonic statistics by Denver Health Medical Plan (DHMP) and Denver Health Hospital Authority (DHHA) lines of businesses. Tracking, comparison, and evaluation occur daily, monthly and annually. HPS Lead/HPS Supervisor/HPS Manager pulls statistical data from the Cisco Unified Intelligence Center Historical Reports and/or Altruista Tableau and/or UCCE and prepares it for the Health Plan Services Manager/Director of Member and Provider Experience/Executive team. The HPSLT ~~Operations Manager/Leads~~ review each report and then provides a summary of monthly activity as well as an analysis of any trends in data, call volume, reason codes, deficiencies, etc. The HPS Manager or designee presents the Performance Report as well as Summary and Analysis at each bi-monthly QMC meeting.

Data Collection

Table B shows QA'd call count by reason (factor 1-benefits & financial, factor 2-referral & auth) by NCQA-Accredited LOBs (MCR, COMM, HIX).

Table B-QA'd Call Count by Reason/LOB

Row Labels	Benefits/Financial	Referral/Auth	Grand Total
January	**32**	**4**	**36**
Commercial	13	1	14
Exchange	7		7
Medicare	12	3	15
February	**10**	**9**	**19**
Commercial	4	6	10



Quality-related deficiency trends included:

1. Authorization and Permission Issues:

- 1 case of no Authorization of Representation (AOR) on file or failure to get member's permission to speak with caller.

2. Protected Health Information (PHI) Compliance:

- 13 cases where not all PHI identifiers were obtained during the call.

3. Call Management and Conduct:

- 3 cases of unsuitable dead air/hold time.
- 3 cases where the blackout function was not used for payment or noted as not working in Caller Label (CL).

4. Procedural Errors and Customer Service Issues:

- Instances of miscommunication regarding 3-way calls and the need for verbal consent for requests.

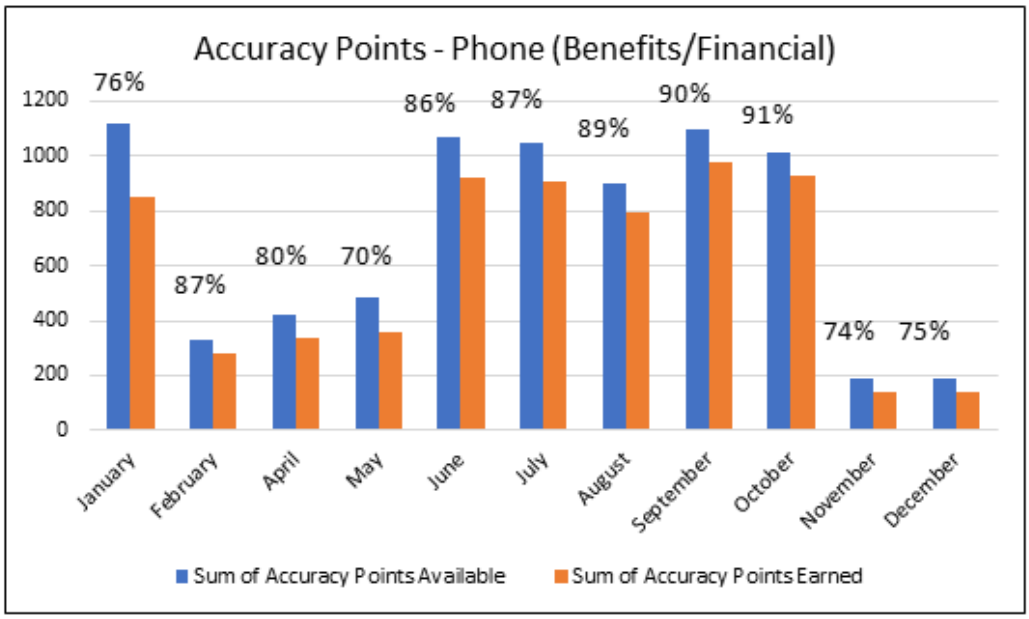
These categories highlight different aspects of quality-related issues observed during the auditing process, including compliance with privacy regulations, call management, and overall customer service quality.

Table D—Benefits/Financial-Accuracy (Phone)

Month	Accuracy Points Available	Accuracy Points Earned	Accuracy Score	Average of Q&A Score
January	1116	851	75.97%	**79.62%**
February	330	282	86.63%	**91.05%**
April	422	340	79.75%	**88.78%**
May	485	361	70.35%	**80.60%**
June	1066	922	86.11%	**91.77%**
July	1046	906	87.00%	**92.38%**
August	899	796	89.06%	**91.73%**

September	1096	979	89.61%	**92.87%**
October	1015	929	91.44%	**95.12%**
November	192	142	73.61%	**79.38%**
December	190	142	74.74%	**75.15%**
Grand Total	**7857**	**6650**	**84.25%**	**88.97%**

Accuracy deficiency trends included (in order of prominence) the call closing not being used (47), missing or incorrect information provided, insufficient documentation, caller type label errors, administrative errors, accuracy concerns, call documentation errors, ensuring correct handbook references, and providing accurate benefit information.



Missing or Incorrect Information Provided:
- 18 cases where there was no CL (Caller Label) on file.
- 17 cases where incorrect information was provided, including wrong locations, missing cost estimates, inaccurate benefits, etc.
- Grocery store locations for Flexcard; review locations at https://www.denverhealthmedicalplan.org/medicare-flexcard

Insufficient Documentation:
- 9 cases where notes lacked sufficient documentation of call discussions or follow-up.

Caller Type Label Errors:
- 2 cases of incorrect caller type labeling.

Administrative Errors:
- 1 case where a phone number wasn't provided prior to transfer.
- 1 case where a grievance wasn't filed despite dissatisfaction.
- 4 cases of HIPAA violations due to missing Authorization of Representation (AOR) on file.

These categories highlight the different areas where accuracy-related issues were observed during the auditing process, including documentation, information provision, and administrative procedures.

Table E—Referral/Auth—Quality (Phone)

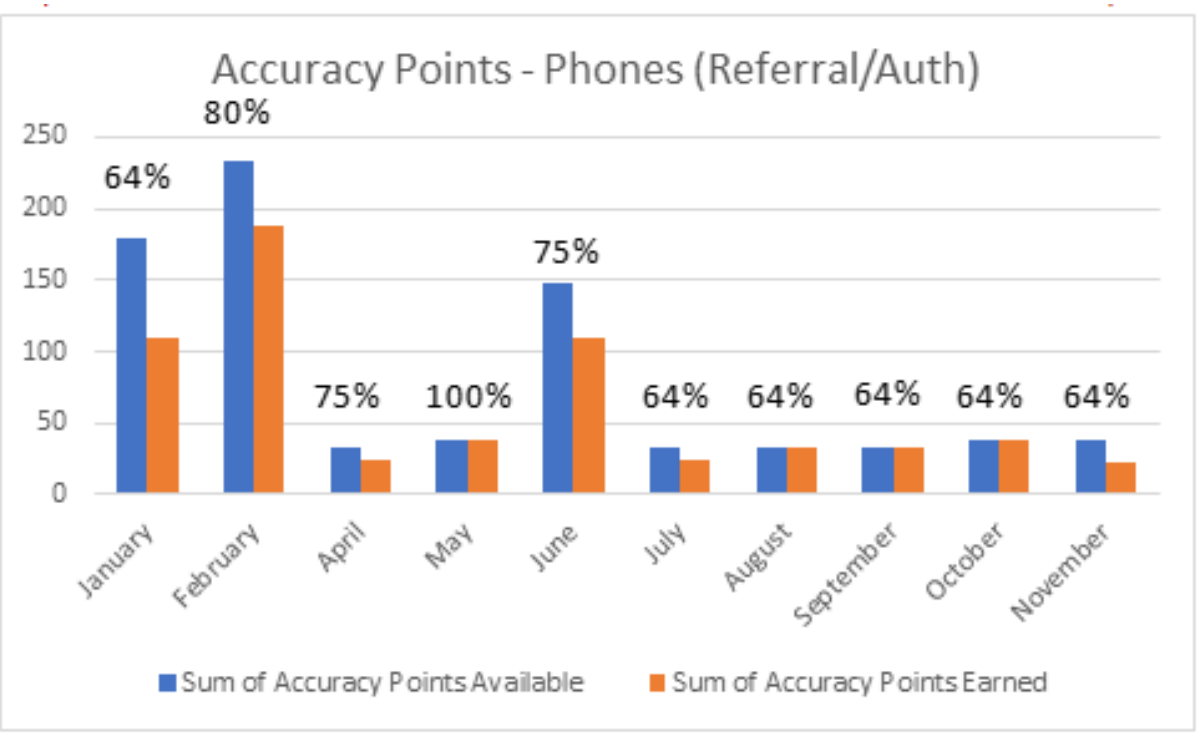
Month	Quality Points Earned	Quality Points Available	Quality Score
January	84	84	**100.00%**
February	0	0	0
April	28	28	**100.00%**
May	18	18	**100.00%**
June	68	84	**80.95%**
July	28	28	**100.00%**
August	28	28	**100.00%**
September	28	28	**100.00%**
October	28	28	**100.00%**
November	18	28	**64.29%**
Grand Total	**328**	**354**	**92.86%**

Various cases of procedural errors, incorrect information given, missed closings, and unfulfilled follow-up promises accounted for the quality deficiencies.

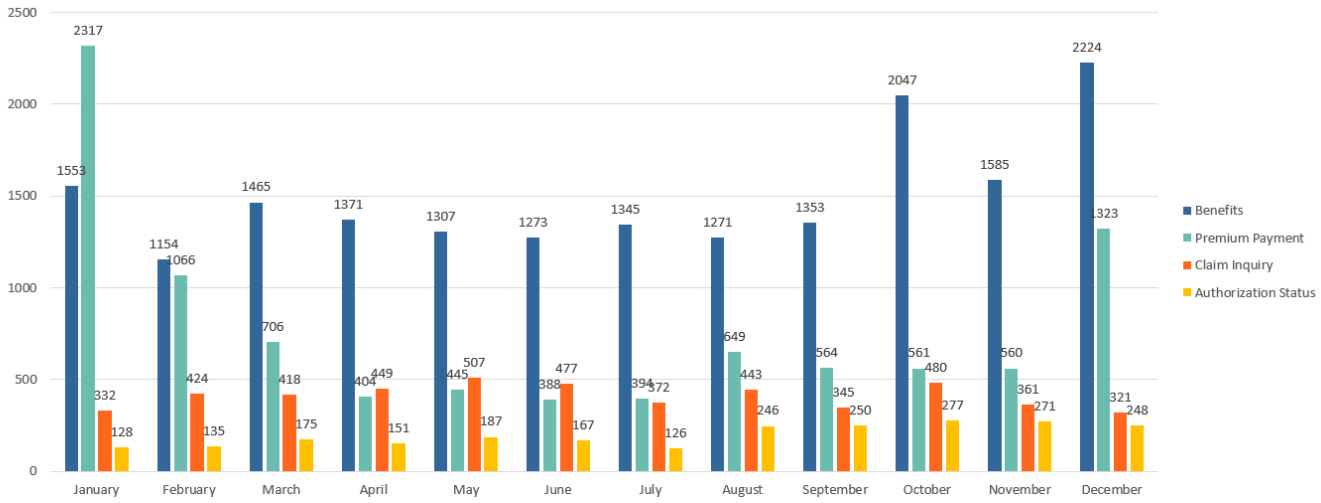
Table F—Referral/Auth—Accuracy (Phone)

Month	Accuracy Points Available	Accuracy Points Earned	Accuracy Score	Q&A Score
January	179	110	**64.45%**	**74.03%**
February	234	188	**80.34%**	**80.34%**
April	32	24	**75.00%**	**86.67%**
May	38	38	**100.00%**	**100.00%**
June	148	110	**74.74%**	**76.82%**
July	32	24	**75.00%**	**86.67%**
August	32	32	**100.00%**	**100.00%**
September	32	32	**100.00%**	**100.00%**
October	38	38	**100.00%**	**100.00%**
November	38	22	**57.89%**	**60.61%**
Grand Total	**803**	**618**	**78.83%**	**81.89%**

Various cases where accuracy issues were noted, such as providing incorrect information, incomplete notes, failing to address specific member inquiries or concerns, and to verify authorization requirements. There was 1 case where the call was not saved in the CRM system.



All LOB: Top 4 Call Reasons 2023



Trends over time

HPS saw an increase of calls and engagement from members in January 2023 and since late November 2023. Common Medicare benefit/financial inquiries were related to Food Card / Flex Card, and over-the-counter (OTC) benefits. Throughout the year, QA'd phone calls had accuracy deficiencies in which some cases the closing was not used.

Comparison to a standard or goal
The KPI is 90% for both accuracy and quality; therefore, the 2023 phone accuracy result of 78.83% did not meet the standard/goal.

A conclusion drawn by the organization
In 2023, the Medicare Advantage LOB combined the OTC benefit with the Food Card benefit, into a one-stop shop, the Flex Card benefit. There were Coffee Talks held for members in Q4-23 around the Flex Card benefit, which sparked an influx of member inquires to HPS around the same. More specifically, members were wondering which supermarkets / stores the Flex Card could be used at, when the quarterly balance would replenish, and other specific inquiries around the Flex Card benefit. As a lesson learned, DHMP should ensure HPS staff receive internal preparation communication to more accurately respond to the influx of related inquiries around the same.

Qualitative Analysis—Telephone
Reasons for results, concluded by the organization
The organization performed as it did due in large part to (1) **specific benefit/financial** inquiries, such as:

- Medicare **food card / Flex card** inquiries. Specifically, HPS received inquiries from members requesting the card itself, to inquire where and what they can use it on, the balance of the food card, how to get a replacement food card, and why food card is not working at SAVE-A LOT.
    a. The FlexCard is a new 2024 benefit combining the OTC and healthy food benefit into one card.
- General benefit inquiries
- OTC card/catalog inquiries
- HRA discrepancies
- Other wellness rewards card inquiries
- Member-submitted reimbursement/claims
- Premium payments/questions
- Vision benefits
- Tetanus vaccine
- Ultrasound benefit
- Cost share for PT services
- Dental benefits/providers
- Other Specific benefit inquiries (e.g., B12 shots, ER benefits, etc.)
- Newborn eligibility/benefits
- Prescription benefits/cost inquiries
- Behavioral health benefits
- Surgical benefits
- Colonoscopy benefits
- Home health services inquiries
- Coverage/providers inquiries in different states (e.g., Florida, California)

Additionally, reasons for **(2) Authorization/Referral inquiries** included:
- Provider calling to request a new auth
- In-network status verification
- Member call to understand referral process
- Authorization/referral inquiries for various services (DME, GI, home health, skilled nursing, urology, etc.)
- Claims issues related to authorization requirements

3. Handbook and Plan Information Requests:
- Member requesting a paper copy of the handbook
- Child call requesting general plan info for father's health plan
- Member calling to check eligibility
- Member new to exchange request ID # and to make premium payment

4. Provider Network Inquiries:
- Member called requesting help in finding in-network providers in Boulder
- Member inquiring on insurance span

5. Billing Inquiries:
- Member call inquiring on a bill
- Member concerned about Shield continuing to bill after meeting MOOP
- Member checking to see if recurring premium has been termed

6. Member ID and Card Requests:
- CM Requesting to replace an ID card

7. Medical Service Inquiries:
- Member called to find out the process for getting a medical bed
- Member called to see if he can be seen at the ER. Member didn't have ID card yet
- New Exchange member on new patient appointment
- Member called to see where he can get his COVID vaccine

8. Administrative Inquiries:
- Address/demographics updates
- ID card/number requests
- Denial letter inquiries
- Do Not Mail requests
- A&G email address inquiries
- Enrollment/eligibility/premium inquiries
- Rx vacation override requests
- Appointment scheduling difficulties
- LEP (Limited English Proficiency) questions
- 1095-A form inquiries (on-exchange)
- Claim status/review
- Parental inquiries (child's provider, premium payments)
- New exchange plan enrollment/reinstatement
- Sibling request for home health services

9. Spanish Language Support:
- (Spanish) non-member request to provide updated address and reinstate Medicare plan

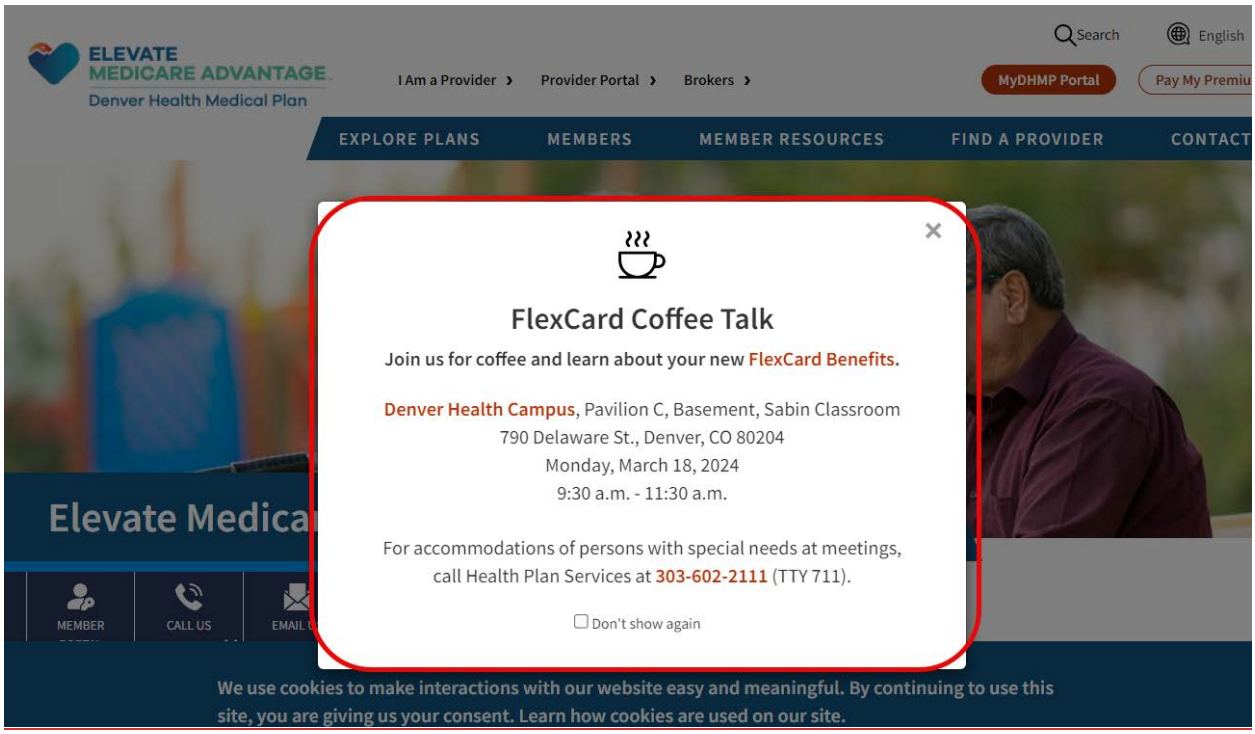
Who participated in analysis
Several stakeholders were invited to provide feedback used in this analysis, including: Cognizant (Vendor of Cost Estimator Tool), QI Consultant, Health Plan Services (HPS) Manager, HPS Supervisor, Lead Applications Analyst, NCQA Project Manager, Website and Marketing Campaigns Manager, DHMP's Medical Management Committee (MMC), and Quality Management Committee (QMC); Primary Care Physician at DH ACS PCMH, Sam Sandos Westside Family Health Center, A&G Consultant, Compliance Analysts, Government Products Manager-Medicare, QI Project Managers, QI Manager, DH Medical Director/Physician for ACS PCMH QI and Research Clinical Scientist, CPC Community Health, Colorado Prevention Center, Professor, Department of Medicine, University of Colorado, Member, State Board of Health, Colorado Department of Public Health and Environment, DHHA Dept of OBGYN Physician, Manager of Population Health (PH), Pediatric Primary Care Physician, Wellington E. Webb Center for Primary Care, Clinical Manager (RN) of Care Management, Government Products Analysts, PH Analyst, Manager of Monitoring, Auditing, and Training (MAT), Credentialing Coordinator, Contracted Behavioral Health Physician, Manager of Commercial Insurance Products, CAHPS Analyst, Manager of Marketing and Provider Relations (PR), Training of Medical Management (RN), Director of CM, Manager of Government Products-Medicaid/CHP+, Operations Manager of CM, Director of A&G and UM, DHMP

Medical Director (MD), QI/HEDIS Program Manager, Senior Director of Health Outcomes and Pharmacy (HOP), PH Pharmacist.

Acting to Improve

DHMP **reached out to Cognizant regarding our findings on the Cost estimator tool** usability in alignment with the DHMP Delegation Oversight policy. A ticket was submitted to DHMP's Managed Care Information Systems (MCIS) Department for cost estimator tool latency, and to see what other common CPT/procedure codes may be able to be added to increase usability for our members. Cognizant assured DHMP that they are working to improve the tool in 2024. We will also look at providing Internal refresher training for HPS Dept. on the cost estimator tool, accurate benefit quoting, and the price transparency page.

In 2023, DHMP hosted an in-person educational event **(Coffee Talks)** for Medicare members to learn about the Flex Card program, other benefits, and how to download/use the online portal/mobile app; leveraged mixed media content with a presentation and phone screen sharing live demo. Communicated awareness through staff when discussing the benefit with members who calls into the plan, and two email blasts. In 2024, additional Coffee Talks took place on February 21 and on March 18 to address member concerns like Flex Card; encouraging Medicare members who call in to remind about the Coffee Talks.



The **Member Experience Committee (MEC)** launched in 2023 and continuing in 2024… is another way DHMP takes proactive action to improve our member experience with benefit/financial and referral/auth inquiries. Additionally, the **IVR phone system** for Medicare members will have a new option for automated Flex Card balance.

Email Response Evaluation (ME6D)

In alignment with DHMP's process titled HPR Quality Assurance Program 1.Has a process for responding to member email inquiries within 1 business day of submission (NCQA ME6D, Factor 1). The same policy outlines DHMP's process for annually evaluating the quality of email responses. (Factor 2). Email was a smaller sample size so included provider inquiries, but not mcd/chp LOB.

Annually collects data on email turnaround time (TAT, Factor 3).
Table G below depicts TAT of QA'd email responses in 2023, for Medicare, Commercial, and Exchange LOBs.

Table G—Email TAT

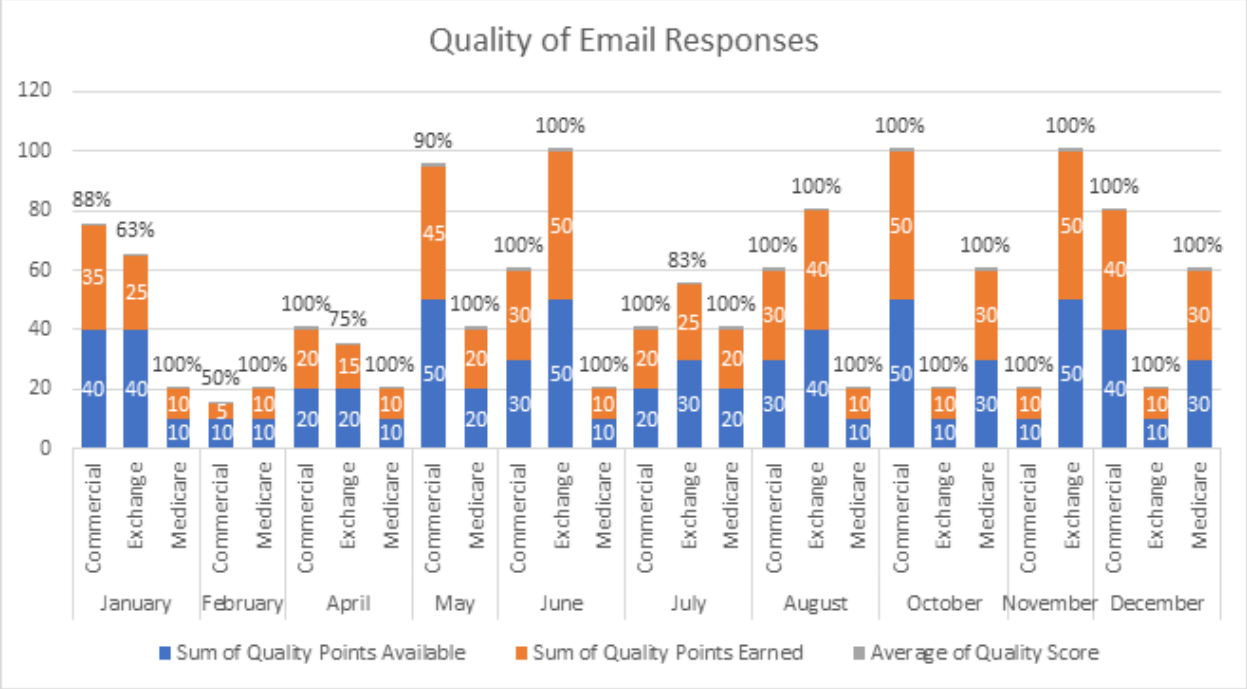
Month	TAT Met	TAT Not Met	TAT %
January	5	4	**55.56%**
February	1	1	**50.00%**
March	NA	NA	NA
April	4	1	**80.00%**
May	6	1	**85.71%**
June	9	0	**100.00%**
July	6	1	**85.71%**
August	8	0	**100.00%**
September	62	8	**88.57%**
October	9	0	**100.00%**
November	6	0	**100.00%**
December	8	0	**100.00%**
2023 Total	**124**	**16**	**85.96%**

The KPI HPS has for email timeliness is within one business day; an associated opportunity would be setting a percentage KPI around email timeliness and adding it to the Health Plan Representative (HPR) Quality Assurance Program Policy.

Annually collects data on the quality of email responses (Factor 4).
Table H below depicts quality trends by month in 2023 for QA'd emails.
Table H—Quality of Email Responses

Month/LOB	Quality Points Available	Quality Points Earned	Quality Score
January	**90**	**70**	**77.78%**
Commercial	40	35	87.50%
Exchange	40	25	62.50%
Medicare	10	10	100.00%
February	**20**	**15**	**75.00%**
Commercial	10	5	50.00%
Medicare	10	10	100.00%
April	**50**	**45**	**90.00%**
Commercial	20	20	100.00%
Exchange	20	15	75.00%
Medicare	10	10	100.00%
May	**70**	**65**	**92.86%**
Commercial	50	45	90.00%
Medicare	20	20	100.00%
June	**90**	**90**	**100.00%**
Commercial	30	30	100.00%

Exchange	50	50	100.00%
Medicare	10	10	100.00%
July	**70**	**65**	**92.86%**
Commercial	20	20	100.00%
Exchange	30	25	83.33%
Medicare	20	20	100.00%
August	**80**	**80**	**100.00%**
Commercial	30	30	100.00%
Exchange	40	40	100.00%
Medicare	10	10	100.00%
October	**90**	**90**	**100.00%**
Commercial	50	50	100.00%
Exchange	10	10	100.00%
Medicare	30	30	100.00%
November	**60**	**60**	**100.00%**
Commercial	10	10	100.00%
Exchange	50	50	100.00%
December	**80**	**80**	**100.00%**
Commercial	40	40	100.00%
Exchange	10	10	100.00%
Medicare	30	30	100.00%
Grand Total	**700**	**660**	**94.29%**



In addition to phone, the KPI goal for email accuracy is also 90%. The quality goal for email was achieved in 2023.

Quantitative Analysis—Email
Annually analyzes data (quant & qual analyses unless otherwise specified)(Factor 5).

Aggregate Results
94.29% was the overall quality score achieved in 2023 for HPS email responses.

Trends over time
January and February were the only months in which email quality was not met in 2023.

Comparison to a standard or goal
The results achieved (94.29%) were above that of the standard/goal of 90%.

A conclusion drawn by the organization
While the quality goal was met for email responses in 2023, an area of opportunity is to provide enhanced contact center staff education prior to the start of a new calendar year (continue re-enforcing benefits education). Additionally, we will continue to monitor both phone calls and email responses to best serve our members in alignment with DHMP's HPR Quality Assurance Program policy.

Qualitative Analysis—Email
Reasons for results, concluded by the organization
This seasonality is reflective of an increase of member inquiries in the beginning of the year, particularly for those who are new to being DHMP members, or enroll in a new plan. Furthermore, we should put ourselves in the member's shoes when it comes to understanding their technical needs, as we have members who are very tech savvy that leverage our website, so we continuously review to ensure we are best ready to serve them. The Medicare population is becoming more and more tech savvy, so we must continue to grow with our members and not hold on to old/often outdated assumptions.

Who participated in analysis
Several stakeholders were invited to provide feedback used in this analysis, including: Cognizant (Vendor of Cost Estimator Tool), QI Consultant, Health Plan Services (HPS) Manager, HPS Supervisor, Lead Applications Analyst, NCQA Project Manager, Website and Marketing Campaigns Manager, DHMP's Medical Management Committee (MMC), and Quality Management Committee (QMC); Primary Care Physician at DH ACS PCMH, Sam Sandos Westside Family Health Center, A&G Consultant, Compliance Analysts, Government Products Manager-Medicare, QI Project Managers, QI Manager, DH Medical Director/Physician for ACS PCMH QI and Research Clinical Scientist, CPC Community Health, Colorado Prevention Center, Professor, Department of Medicine, University of Colorado, Member, State Board of Health, Colorado Department of Public Health and Environment, DHHA Dept of OBGYN Physician, Manager of Population Health (PH), Pediatric Primary Care Physician, Wellington E. Webb Center for Primary Care, Clinical Manager (RN) of Care Management, Government Products Analysts, PH Analyst, Manager of Monitoring, Auditing, and Training (MAT), Credentialing Coordinator, Contracted Behavioral Health Physician, Manager of Commercial Insurance Products, CAHPS Analyst, Manager of Marketing and Provider Relations (PR), Training of Medical Management (RN), Director of CM, Manager of Government Products-Medicaid/CHP+, Operations Manager of CM, Director of A&G and UM, DHMP Medical Director (MD), QI/HEDIS Program Manager, Senior Director of Health Outcomes and Pharmacy (HOP), PH Pharmacist.

Action to Improve Identified Deficiencies
The HPS and QI Teams will collaborate on Q&A in 2024, as the HPS Supervisor was promoted to another position, and the HPS manager will be working to select a back-fill. This will ensure we continue to increase our functionality knowledge of analysis (both quantitative and qualitative) as it relates to honing in on quality and accuracy opportunities to improve member experience. Additionally, HPS leadership will work closer with product line manager to address potential staff knowledge gaps prior to in-person events or mailings which could increase call/email volume for specific types of inquiries.

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 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.

WORKPLAN CONTENT:

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

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.

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