

Denver Health Medical Plan, Inc.

# Quality Improvement Program Description

Commercial, Medicare and Exchange Products 2018

Reviewed by the QMC in March 13, 2018

## Table of Contents

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I. Introduction.....	3
Mission Statement .....	3
Quality Statement and Process.....	3
II. QI Program Structure.....	4
A. Oversight.....	4
B. Authority and Responsibility.....	5
C. Committee Structure .....	7
III. Goals and Objectives .....	15
IV. Program Scope.....	17
Cultural and Linguistic Objectives .....	17
Health Management Services .....	18
Complex Health Needs.....	19
Preventive Health Promotion .....	21
Patient Safety .....	21
Adequacy and Availability of Service .....	22
Clinical and Practice Guidelines .....	22
Continuity and Coordination of Care .....	23
Quality of Clinical Care .....	23
Member Satisfaction.....	24
Provider Satisfaction .....	24
Credentialing and Delegated Credentialing .....	24
Delegation Activities and Oversight.....	24
V. Quality Improvement Program Annual Work Plan and Evaluation.....	25
A. Annual Work Plan.....	25
B. Annual Evaluation .....	25
VI. Administrative Functions.....	26
A. Confidentiality .....	26
B. Conflict of Interest.....	26

## I. Introduction

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The Denver Health Medical Plan, Inc. (DHMP) was incorporated on January 1<sup>st</sup>, 1997 in Colorado as a not-for-profit corporation for the purpose of providing or arranging for the delivery of healthcare services and related functions through the establishment and operation of a managed care organization (MCO). The purpose of MCO was defined as the delivery of quality, accessible and affordable healthcare services in and around the City and County of Denver, Colorado. Licensed by the State of Colorado as a Health Maintenance Organization (HMO), the organization is a wholly owned subsidiary of Denver Health and Hospital Authority (DHHA). Denver Health is an academic, community-based, integrated healthcare system that serves as Colorado's primary "safety net" system. DHMP offers a full spectrum of healthcare services for members through DHHA's integrated healthcare system and an expanded network of providers throughout the metro Denver area. The Quality Improvement Program Description outlines the organization's efforts to improve the overall quality of care, service, and safety for the Commercial product members, including Denver Medical Care and Point of Service and Medicare benefit members.

*\*Unless specifically called out for differences, Commercial and Medicare product lines will be known as DHMP, Inc.*

## Mission Statement

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*To provide quality, accessible, and affordable healthcare services in the Denver area. In partnership with our providers, we continually seek to improve the health and well-being of our members by:*

- Promoting wellness and disease prevention
- Providing access to culturally diverse, comprehensive health services
- Enabling members to play an active role in their health care
- Delivering services with responsibility and respect to all

## Quality Statement and Process

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DHMP's Quality Improvement (QI) Program is designed to support the mission of DHMP by promoting the delivery of high-quality, accessible healthcare services that will improve or stabilize the health status of DHMP members.

The QI Program provides a formal structure and process designed to monitor and evaluate the quality and safety of care and service through defined performance and outcome metrics. Measureable objectives are derived from a variety of data sources, including:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider satisfaction surveys
- Member Services call data
- Medical record reviews
- Claims data
- Open Shopper studies
- Pharmacy data
- Case management data
- Utilization data

- Health Management data

These sources provide DMHP with the collection of data necessary to *improve the appropriateness, efficiency, effectiveness, availability, timeliness, and continuity of care delivered to our members*. This approach also allows DMHP to focus on opportunities for improving operational processes, increasing member and practitioner satisfaction, and effectively providing and managing health outcomes. DMHP's mission is to deliver the right care or service, at the right time, by the right staff, in a safe and suitable setting.

DHMP uses a continuous quality improvement cycle where designated staff conducts a measurement of performance indicators; assess and prioritize the indicators which DMHP may improve; and plan, implement, and evaluate interventions to improve the quality of care, quality of service, and/or patient safety of members. Data is collected on a prospective, concurrent, and retrospective basis, dependent on which type best meets the measurement need. Measurable objectives such as HEDIS, CAHPS, and HOS, quantitative and qualitative data sets are defined, trended and evaluated. QI data is analyzed, summarized, and presented in a clear manner with trending, and compared against benchmarks, when available, to the Quality Management Committee (QMC). The QMC provides recommendations for improving quality benchmarks, initiatives and oversight. QI works collaboratively with DMHP departments and provider networks to develop and implement initiatives targeted at improving clinical care, outcomes, safety, and service.

## II. QI Program Structure

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### A. Oversight

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#### DHMP Board of Directors

DMHP's Board of Directors is the governing body for DMHP and is responsible for ensuring quality and safety for DMHP's members. The Board holds ultimate authority and responsibility over DMHP's QI Program, Chief Executive Officer (CEO), Medical Director, and QMC, as well as the development and ongoing monitoring of the QI Program. All QI initiatives and interventions are reviewed through the QMC. The Board reviews the QI Program Description, the QI Work Plan and the QI Annual Evaluation.

#### Composition:

- DHHA Authority Board Chair Designee
- DHHA Chief Executive Officer (CEO)
- DHHA Chief Operating Officer (COO)
- DHHA Chief Financial Officer (CFO)
- DHHA Chief Ambulatory Officer (CAO)
- DH CHS Board Chairman
- Five Community Business Leaders

#### Function:

- Approve the QI Program Description, QI Work Plan, and QI Annual Evaluation
- Review applicable DHMP quality data such as CAHPS, HEDIS, Stars, etc.

## **B. Authority and Responsibility**

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### **1. DHMP CEO/Executive Director**

The CEO/Executive Director supports the QI Program through oversight and supervision of the QI Department staff and operations. The allocation of resources and formal reports to the Board of Directors are coordinated through the CEO/Executive Director.

### **2. Medical Director responsibilities include, but are not limited to:**

- Provide direction, support, and oversight related to the development, implementation, and evaluation of all clinical activities of the QI department
- Work in collaboration with the QI Director and the QI Intervention Managers on development and assessment of clinical interventions
- Report findings from clinical interventions to the appropriate groups, such as the Ambulatory Quality Improvement and Design Committee (AQIDC), QMC, and DMHP Board of Directors
- Work with the QI Director on preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, Operations Management Committee, AQIDC, and DMHP Board of Directors
- Work with the QI Director on preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, Operations Management Committee, AQIDC, and DHMP Board of Directors
- Provide oversight for clinical activities in the QI Work Plan
- Delegate components of the QI Work Plan to other members of the Operations Management Committee
- Serve on the QMC, AQIDC, , Medical Management Committee (MMC), Credentialing Committee, Operations Management Committee, and the DHHA Patient Safety and Quality Committee
- Provide evaluation and management of DHMP Quality of Care Concerns (QOCCs) related to physical health problems while working in conjunction with the QI Registered Nurse (RN) resources
- Oversee all DHMP clinical and preventive health guidelines

### **3. Director of Health Management Services responsibilities include, but are not limited to:**

- Participate in the MMC
- Develop, implement, and evaluate new and existing complex case management, chronic care, and disease management programs, and also general health and wellness promotion and prevention programs
- Assist with the development, revision, and /or implementation of the behavioral health aspects of the QI Program including behavioral health clinical and preventive health guidelines
- Collaborate with QI to review behavioral health programs and services offered by network providers to ensure adequate access to meet member needs
- Develop and oversee the case management program as it effects our external network
- Authors Health Management program description and evaluation, and the SNP MOC program evaluation, and submits to QMC annually.
- Utilize predictive modeling, gaps in care analyses, or other data analysis to identify and stratify high-risk members and/or those with special health care needs who could benefit from participation in the programs

#### 4. Quality Improvement Department:

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

- Development, management, and monitoring of the QI Program
- Act as staff representative to the DHMP Board of Directors
- Directly assume authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation, and Work Plan annually
- Coordinate, provide advice, and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health departments, as appropriate, for regulatory compliance
- Report QOCCs to the appropriate Directors of Service at DHHA and external network providers
- Serve as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
- Annually ensure all policies, procedures, and guidelines related to the QI Department are updated appropriately
- Oversee QI vendor contracts and delegated activities
- Provide oversight and direction to the QI team, consisting of the following members:

*HEDIS Program Manager responsibilities include, but are not limited to:*

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

*Clinical Project Manager Responsibilities include, but are not limited to:*

- Manage all aspects of Consumer Assessment of Health Providers & Systems (CAHPS) related projects
- Evaluate and analyze CAHPS results
- Provide recommendations to QI Director for cost efficiency, process improvements, and quality interventions
- Work collaboratively with Intervention Managers on process improvements and interventions related to CAHPS and Medicare Stars
- Lead project planning activities related to regulatory and accreditation requirements
- Facilitate and evaluate Open Shopper studies related to member experience and access
- Assist Intervention Managers in data pulls for HEDIS interventions, as needed

*QI Project Administrator responsibilities include, but are not limited to:*

- Analyze the effectiveness of intervention activities
- Coordinate all efforts related to Work Plans, Evaluations, and Program Descriptions
- Lead activities related to regulatory and accreditation requirements
- Work in collaboration with Intervention Managers to maintain a timeline for deliverables
- Co-direct and work with the QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording, and bi-monthly reporting requirements
- Function as main administrative contact for QMC
- Oversee QI NCQA requirements and functions in conjunction with QI Director

*Intervention Manager responsibilities include, but are not limited to:*

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

*NCQA Project Manager responsibilities include, but are not limited to:*

- Oversight of the NCQA accreditation project and manages all deliverables.
- Serves as a single point of contact for department directors, consultants and NCQA.
- Builds all NCQA project deliverables, working closely with Managed Care's Operations Team.
- Directs, monitors, and validates NCQA project team member performance; drives project work efforts to ensure adherence to project scope, schedule, and consulting budget.
- Identifies risk and develops appropriate response strategies in conjunction with applicable department directors.

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

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

## **C. Committee Structure**

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### **1. DHMP Quality Management Committee**

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

#### **Composition:**

- DHMP Director of Quality Improvement (Chair)
- DHMP Medical Director
- DHMP Director of Member Services
- DHMP Director of Provider Relations
- DHMP Director of Pharmacy

- DHMP Director of Utilization Management/Case Management
- DHMP Director of Health Management
- Government Products Manager
- Primary Care Providers from DHHA and the External Provider Network
- Specialty Care Providers from DHHA and the External Provider Network

Functions:

- Serve as the advisory and action oversight body for quality initiatives and activities
- QI team is responsible for the preparation and dissemination of relevant information obtained on the performance of QI activities
- Provide oversight of all clinical and administrative aspects of the QI Program
- Review practitioner membership annually or as needed to assure broad representation of primary care practitioners and specialists
- Meet quarterly at a minimum. (Monthly meetings may be held as needed to meet quarterly improvement structural and performance requirements)
- Oversee accurate and clear reporting of QMC minutes, including follow-up actions
- Recommend clinical and safety initiatives in regards to policy decisions
- Review and evaluate the results of QI activities
- Oversee needed actions for improvement upon performance goals
- Supervise follow up of issues and activities when organizational goals are not reached. QI Director and team will conduct root cause analysis or barrier analysis
- Review and approve clinical and preventive practice guidelines
- Review Member Services and Appeals and Grievances performance
- Review member satisfaction and quality of care and quality of service results, such as CAHPS, HEDIS, and Open Shopper studies
- Review and evaluate activities that improve member experience, such as access to care and quality of services, and make recommendations about ways to improve these results. Review findings of QOCCs
- Review CCM, Health Management, and Pharmacy program performance
- Review annual SNP MOC program evaluation
- Provide oversight and recommendations regarding utilization of new technologies and benefit design
- Provide oversight of QI Program deliverables including, but not limited to:
  - QI Program Description
  - QI Work Plan
  - QI Evaluation
  - Network Adequacy Report
  - QI Policies and Procedures
  - Clinical and Preventive Practice Guidelines

Report Committee's to the QMC include, but are not limited to:

- AQIDC
- Pharmacy and Therapeutics Committee (P&T)
- Medical Management Committee (MMC)
- Network Adequacy Committee (NAC)



## 2. Operations Management Committee

The purpose of the Operations Management Committee is to establish, maintain, and redesign, as needed, the operations of DHMP as requested by the CEO and Board of Directors. Departmental information and reports are reviewed to identify improvement opportunities in service to members. Issues may be referred from the QMC for follow up as appropriate. Financial, marketing, claims and utilization data, as well as enrollment reports furnished to the Operations Management Committee provide additional performance monitoring information.

### Composition:

- DHMP CEO/Executive Director
- DHMP Medical Director
- DHMP Director of Pharmacy
- DHMP Director of Quality Improvement
- DHMP Director of Utilization/Case Management
- DHMP Director of Information Systems
- DHMP Director of Health Management
- DHMP Director of Member Services
- DHMP Manager of Appeals and Grievances
- DHMP Government Product Manager for Medicaid/CHP+ and Medicare
- DMHP Medicare Operation/Applications Manager
- DHMP Director of Commercial Products
- DHMP Manager of Marketing
- DHMP Director of Compliance
- DHMP Director of Finance
- DHMP Director of Contracting/Provider Relations

### Functions:

- Address, discuss, and/or implement actions on presentations, information items, and department reports
- Develop annual budget
- Develop strategic goals for DHMP
- Review financial performance, dashboards, provider and member service levels data, utilization data, and other applicable information appropriate to the operations of the Plan
- Coordinate and monitor operations and progress toward meeting annual goals and financial objectives
- Review regulatory agency and external audit reports of various DHMP functions
- Review new regulatory legislation and contractual requirements and implement as appropriate

## 3. Medical Management Committee

The Medical Management Committee (MMC) assists the QMC in overseeing and ensuring quality of clinical care, patient safety, State/CMS/NCQA reporting requirements, and program operations provided throughout the organization. The MMC is responsible for assisting the organization in providing oversight, critical evaluation, and delegation of actions, as well as selection of opportunities while maintaining a constructive relationship with medical staff and approving/overseeing policies and procedures.

### Composition:

- DHMP Medical Director (Chair)
- DHMP Director of Utilization/Case Management (Member)

- DHMP Director of Health Management (Member)
- DHMP Program Manager, Case Management (Member)
- DHMP QI Director (Member)
- DHMP Accreditation Manager (Member)
- DHMP Director of Pharmacy (Member)
- DHHA Psych PhD (Member)
- Primary and Specialty Care Providers from Community Health Services (CHS) Provider Network
- Primary and Specialty Care Providers from the Extended Provider Network

Functions:

- Provide direction on Utilization Management (UM) and Medical Management department initiatives
- Review and approve Program Description and Evaluations
- Monitor compliance with CMS and State/Federal regulations and mandates
- Oversee NCQA accreditation deliverables as it relates to UM, Case Management, Disease Management, and Pharmacy
- Analyze utilization data to identify potential areas of over or under utilization of health care services and determine appropriate interventions, when necessary
- Analyze utilization reports to identify significant trends and determine appropriate follow up
- Report significant findings to the QMC at appropriate intervals, including selection of opportunities
- Reviews IRR reports at least annually to ensure consistency of UM staff decision making
- Identify opportunities for controlling utilization and/or cost-savings
- Provide strong support and oversight to improve Continuity and Coordination of care between medical providers and behavioral health providers
- Work in collaboration with the Network Adequacy Committee (NAC) to ensure adequate medical access to care services
- Develop member improvement initiatives to increase satisfaction with the plan

4. Credentialing Committee

The Credentialing Committee acts as the peer review committee for credentialing and re-credentialing. It is a subcommittee of the NAC.

Composition:

- DHMP Medical Director
- DHMP Manager of Credentialing
- DHMP Medical Compliance Specialist
- DHHA Representative from the Medical Staff Office
- DHHA providers from primary care and various specialties

Functions:

- Annually review and approve the credentialing and recredentialing criteria, as well as the process used to make credentialing and recredentialing decisions
- Annually review and approve credentialing policy and procedures
- Review results of ongoing monitoring of sanctions and grievances
- Review and determine participating status of practitioners who, at a minimum, do not meet the established credentialing criteria

- Review the clean files that were approved by the DHMP Medical Director (those meeting all criteria with no malpractice claim history)
- Review and approve all delegated approved practitioners
- The Medical Compliance Specialist is responsible for keeping accurate meeting minutes and recording approval or denial for each practitioner presented
- Prevent discriminatory practices by prohibiting any discriminatory factors in its review of practitioners
- Files classified as clean files may be reviewed by the DHMP Medical Director who determines the file to be approved by the sign off of the Medical Director (or Associated Medical Director, or other qualified medical staff member as the designated Medical Director if this individual has equal qualifications as the Medical Director and is responsible for credentialing)
- Present “Red Flag” files (those not meeting the minimum criteria and standards) to the Credentialing Committee with detailed information pertaining to malpractice claims or sanctions for a decision. The basis for a denial is communicated in writing to the practitioner and appeal provisions are offered in accordance with Company policies
- For recredentialing, additionally evaluate practitioner data such as complaints or quality issues, utilizing the CMS website as appropriate
- Initial assessment and reassessment of organizational credentialing
- Request individual practitioner file information from the entities with delegated credentialing responsibility for review in response to a potential issue identified during Company oversight

#### 5. Pharmacy and Therapeutics Committee

DHMP uses the Denver Health Pharmacy and Therapeutics Committee (P&T Committee) for formularies that are maintained internally and the MedImpact P&T Committee for formularies that are delegated to be managed by the pharmacy benefit manager, MedImpact.

The P&T committees are tasked with promoting safe and appropriate use of high quality, cost effective pharmaceuticals, as well as ensuring medication use is in compliance with appropriate standards and state and federal regulations. The Committees review clinically effective medications and considers whether the inclusion of a particular drug has any therapeutic advantages in terms of safety and efficacy. Clinical decisions are based on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research data, and other such information as deemed appropriate. The Committees use appropriate scientific and economic considerations to consider utilization management activities that affect access to drugs, such as access to non-Formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols.

Functions of Denver Health and MedImpact P&T Committees:

- Evaluate and approve formulary drug additions and deletions while ensuring safety and effectiveness
- Review and approve the Company’s formulary drug list at least annually
- Review and approve the Company’s Pharmaceutical Management Procedures annually
- Evaluate new drugs, drug classes, new clinical indications, therapeutic advantages, and new safety information
- Support educational programs promoting appropriate drug use

The Denver Health P&T Committee:

- Meets monthly
- Is comprised of the following members:
  - DHHA Physicians across multiple specialties (e.g. infectious disease, critical care, pediatrics, etc.)

- DHHA Pharmacists across multiple specialties (e.g. oncology, infectious disease, etc.)
- Representatives from DHHA and CHS
- Physicians affiliated with non-Denver Health sites of care (Rocky Mountain Poison and Drug Center Physicians, University of Colorado)
- Director of Pharmacy and Clinical Pharmacist Formulary and Operations Management attend as a non-voting members

#### The MedImpact P&T Committee

- Meets quarterly
- Is comprised of:
  - Physicians and/or practicing pharmacists
  - At least one practicing physician and at least one practicing pharmacist who are independent and free of conflict relative to the Client, MedImpact, and any pharmaceutical manufacturers
  - At least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals
  - Members that are not on the HHS Office of the Inspector General “exclusion list”
  - A representative of the DHMP Pharmacy Department who calls in to attend Committee meetings as a guest in listen-only mode. All approved P&T Committee meeting minutes are provided to DHMP QMC on a quarterly basis through MMC minutes
- Drug review standards: a reasonable effort is made to review each new chemical entity and new FDA clinical indications within ninety (90) days, and make a decision on each within one hundred eighty (180) days of its release onto the market. A clinical justification is provided if this timeframe is not met; however, for new drugs or newly approved uses for drugs within the six clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic), the Committee will conduct an expedited review and make a decision within ninety (90) days

#### 6. Compliance Committee

The Compliance Committee serves to promote the highest degree of ethical and lawful conduct throughout the Plan by examining, evaluating, and coordinating processes that demonstrate compliance with all applicable rules and regulations, as well as all federal, state, and local laws.

Composition: The Committee consists of four or more members, appointed by the Compliance Director in consultation with the CEO, and includes individuals that have varying responsibilities within the organization who are able to represent the interests of the Company, including:

- DHMP Director of Compliance
- DHMP CEO/Executive Director
- DHMP Medical Director
- DHMP CFO
- DHMP Director of Pharmacy
- DHMP Director of QI
- DHMP Manager of Member Services
- DHMP Director of Government Products
- DHMP Director of Marketing/Commercial Product Line Manager
- DHMP Director of Provider Relations
- DHMP Claims Manager

Functions:

- Maintain written policies, procedures, and standards of conduct
- Designate a Compliance Officer and Compliance Committee who report directly and are accountable to the CEO or other senior management, including the Board of Directors. Establish, implement, and provide effective Compliance Program, Fraud, Waste, and Abuse, and HIPAA privacy training and education for employees
- Establish and implement effective and accessible lines of communication through an anonymous hotline or other methods of reporting, for all employees to report compliance concerns and actual/suspected violations of the Compliance Program, Code of Conduct, and/or laws and regulations without fear of retaliation. Have well-publicized disciplinary guidelines
- Establish and implement an effective system for routine monitoring and auditing for the identification of compliance risks
- Establish a system for promptly responding to compliance issues and implementing appropriate corrective actions

7. Benefit Interpretation Committee

The responsibility of the Benefit Interpretation Committee (BIC) is to create, revise, interpret, and disseminate benefit information in a uniform and organized fashion for the use by Plan employees, providers, and members. The BIC will serve as a clearinghouse for all benefit issues, for all lines of business. The Committee is charged with analyzing the clinical, financial, marketing, legal, ethical, and administrative aspects for the determination, development, and deployment of benefit coverage decisions, and Plan administration.

Composition:

- DHMP Medical Director
- DHMP Pharmacy Representative
- DHMP Utilization/Case Management Representative
- DHMP Claims Representative
- DHMP Provider Relations Representative
- DHMP Member Services Representative
- DHMP Information Systems Representative
- DHMP Compliance Representative
- DHMP Grievance/Appeal Representative
- Applicable DHMP Product Line Managers

Functions:

- Review, research, and make determinations on new and existing benefit design interpretation and administration
- Identify benefits in need of uniformity for benefit design and interpretations
- Monitor proposed legislation /regulation for impact on benefit coverage requirements and compliance
- Solicit employer's expectations regarding the inclusion or exclusion of certain services in the benefit plan and how this affects DHMP market positions and image within the local healthcare industry
- Define the service and determine the efficacy/ appropriateness of the service after review of clinical research, medical, and other literature
- Assess and determine needs for services, formulate policy decisions, and distribute approved policies for implementation and communication with each department and service partner
- Evaluate which services are generally accepted in medical practice or are currently considered experimental/ investigational

- Evaluate recommendations from the ad hoc Technology Assessment Committee regarding coverage of new equipment, pharmaceuticals, medical procedures, and services
- Construct adequate safeguards to assure appropriate billing and administration for covered services
- Determine the all-inclusive cost of service to the plan
- Monitor and coordinate the successful implementation of changes resulting from Committee decisions
- Develop and maintain the benefit interpretation materials for the Commercial, Medicare, Medicaid, and CHP+ lines of business

#### 8. Ambulatory Quality Improvement and Design Committee

The Ambulatory Quality Improvement and Design Committee (AQIDC) is a collaborative group that focuses on integrating quality activities among CHS and the Company. AQIDC is a standing subcommittee of the DHHA Patient Safety and Quality Committee, and serves as the QI Committee for the Denver Health CHS Board of Directors. This group monitors CHS quality and safety measures, in addition to providing oversight to units and programs within the scope of the CHS. AQIDC is responsible for establishing and reviewing indicators of ambulatory care performance, identifying opportunities for quality of care improvement, and implementing/disseminating QI interventions. They will carry out their efforts through quality workgroups that develop tools and processes for improvement. Staff from the workgroups will work with clinical site staff to better performance at individual locations.

Additionally, the AQIDC defines and oversees the efforts of the DHHA QI work groups. This Committee is in close collaboration with the CHS Central Management Team (CMT) and the Company's Medical Management group. Together, these entities monitor the implementation of all quality activities. The AQIDC reports all QI projects to DHMP's QMC by way of meeting minutes.

#### Composition:

- DHHA Director of CHS
- DHHA ACS QI Associate Medical Director
- DHMP Director of QI
- DHMP Medical Director
- DHHA Directors of Pediatric, Internal, and Family Medicine Divisions
- DHHA Director of School-Based Health Centers
- DHHA ACS Chief Nursing Officer
- DHHA Director of ACS Data and Analytics
- DHHA Integrated Behavioral Health
- DHHA Primary Care Physicians
- DHHA Specialty Care Physicians
- DHHA RN Clinic Managers

#### Functions:

- Identify a core set of indicators that serve as measures of quality of performance for services provided in ambulatory settings
- Establish methods of measurement of performance for identified indicators
- Establish an annual work plan(s) for review of performance for all indicators
- Prioritize areas for performance improvement within the indicators included in the CHS QI work plan

- Establish workgroups for developing and implementing QI initiatives within ambulatory services and oversees their activities

#### 9. Network Adequacy Committee

The Network Management Committee is tasked with establishing, maintaining, and reviewing network standards and operational processes as required by National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), Colorado Department of Health Care Policy and Financing (HCPF), and the Colorado Division of Insurance (DOI). The scope of responsibility includes: (1) network development and procurement; (2) Provider contract management, including oversight; and (3) Periodic assessment of network capacity.

#### Composition:

- DHMP Director of Provider Relations - Chair
- DHMP Product Line Managers
- DHMP Medical Director
- DHMP QI Representative, as required
- DHMP UM Representative, as required
- DHHA Physicians and Administrators Representative, as required
- DHMP Provider Relations Representative
- DHMP Director of QI
- DHMP Director of UM
- DHMP Credentialing Manager
- DHHA Director of Care Management

#### Functions:

- Develop standard work, policies, and procedures for network management
- Review network capacity and develop plans to address opportunities for improvement
- Review provider interest in network participation and evaluate against DHMP network needs
- Review provider terminations and determine Continuity of Care concerns
- Review new regulatory legislation and contractual requirements and implement, as appropriate
- Review Quality of Service Concerns and develop plan to address, as necessary

### **III. Goals and Objectives**

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The QI Program seeks to accomplish the following objectives: (1) Assess the quality of care delivered to DHMP members; and (2) Evaluate the manner in which care and services are delivered to these individuals. The Quality QI Department is committed to maintaining a standard of excellence, and enacts and monitors programs, initiatives, policies, and processes related to this purpose. The subsequent section summarizes goals and strategies for meeting these aims.

QI Program strives to achieve the following goals:

- Ensure quality of care and services that meet CMS, State of Colorado, and NCQA requirements utilizing established, best practice goals and benchmarks to drive performance improvement
- Measure, analyze, evaluate, and improve the administrative services and processes of the plan
- Measure, analyze, evaluate, and improve the health care services delivered by contracted practitioners

- Promote medical and preventive care delivered by contracted practitioners that meets or exceeds the accepted standards of quality within the community
- Achieve outcome goals related to member health care access, quality, cost, and satisfaction
- Empower members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic conditions, community outreach efforts, and coordination with public/private community resources
- Encourage safe and effective clinical practice through established care standards and best practice guidelines
- Educate members about patient safety through health promotion activities, member newsletters, and community outreach efforts

The QI Program objectives for meeting these goals include the following:

- Design and maintain the QI structure and processes that support continuous quality improvement (CQI). The summarized approach to achieve this aim is as follows: (1) Analysis of available data; (2) Trending and barrier/root cause analysis of measures; (3) Implementation of intervention(s); and (4) Re-measurement of targets
- Assure compliance with all Federal and Colorado State statutes and regulatory/contractual requirements
- Objectively and systematically measure and analyze HEDIS, CAHPS 5.0 H, and other access/customer service data to promote improvement in member satisfaction
- Monitor member satisfaction and identify/address areas of dissatisfaction through an annual review of the following data: (1) CAHPS 5.0 H; (2) Member feedback; (3) Grievance and appeals data; and (4) Quality of Care complaint(s)
- Monitor and maintain safety measures and address identified problems
- Design and maintain a chronic care improvement program and objectively and systematically measure and analyze its health outcomes and enrollee satisfaction data
- Conduct an annual practitioner survey to evaluate satisfaction with the medical management process and services as they relate to Continuity and Coordination of care
- Monitor access through CHS and Appointment Center reports and institute improvement processes when opportunities for improvement are indicated
- Provide multiple avenues for members to obtain Case Management, Complex Case Management, and Behavioral Health and Wellness services
- Provide a comprehensive Utilization/Case Management Program to identify, track, and facilitate care transitions and coordinate care for members
- Monitor and analyze targeted HEDIS measures for health disparities and develop appropriate interventions
- Empower members to lead a healthy lifestyle through health promotion activities, community outreach efforts, and coordination with public and private community resources
- Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines
- Facilitate the participation of providers, the Interdisciplinary Care Team (ICT) and members in the QI Program
- Communicate improvements in the QI Program to all stakeholders
- Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis
- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes



## IV. Program Scope

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DHMP is dedicated to ensuring members receive the highest quality health care and customer service. The QI Program is responsible for the development, monitoring, and evaluation of all quality-related outcomes to make certain these standards are obtained. The scope of the QI Program includes developing improvement opportunities and intervention/activities throughout DHMP and DHHA. The QI Department uses clinical and service performance benchmarks, as well as review of best practice literature and research.

QI structures activities to offer optimal quality and cost effectiveness by ensuring Continuous Quality Improvement (CQI) of healthcare services. Areas targeted for CQI include:

- Cultural and Linguistic Member Needs
- Health Management
- Preventive Health Promotion
- Pharmacy Management
- Patient Safety
- Complex Health Needs
- Adequacy and Availability of Services
- Clinical and Practice Guidelines
- Continuity and Coordination of Care
- Quality of Clinical Care
- Member Satisfaction
- Provider Satisfaction
- Credentialing and Delegated Credentialing
- Delegated Activities and Oversight

### Cultural and Linguistic Objectives

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The QI Program incorporates ongoing monitoring of the cultural and linguistic needs of its membership including but not limited to the following:

- Identify language needs and cultural background of members. Including prevalent languages and cultural groups using enrollment data
- Identify languages and cultural background of practitioners in provider network to assess whether or not they meet members' language needs and cultural preferences
- Take action to adjust the provider network if the current network does not meet members' language needs and cultural preferences
- Develop, implement, and evaluate the culturally and linguistically appropriate services in collaboration with DHMP staff and other departments and staff, as needed
- Ensure interpreter and translation services and auxiliary communication devices will be available to the member at no cost
- Document and forward member needs identified during member contacts or upon receipt of the member questionnaire to the Health Management or Utilization/Case Management Departments as needed
- Evaluate CAHPS questions that relate to interpretation and health literacy satisfaction to identify areas for improvement. Action plans are implemented, as needed
- Monitor HEDIS measures health disparities, and conduct a yearly analysis of the data is to assist in the development of targeted health prevention and education programs that addresses, identifies and reduces health disparities based on available data

- Identify annually, using aggregated member Race/Ethnicity/Language (R/E/L) data, languages that must be used in patient materials for quality improvement and marketing activities
- Assess annually aggregated provider R/E/L data to ensure all materials, including translated materials meet the cultural competency and grade level appropriate for the population. (All member written materials for prevalent populations ( $\geq 500$  members) are translated and made available to members in the respective languages. These materials appear at a sixth-grade reading level and are available (upon request) in braille, large print, and in audio tape format)
- Maintain a library of culturally-sensitive health prevention and education materials to be used in member mailings
- Participate in DHHA initiatives for reducing health disparities for Plan membership and community

Annually, staff diversity training is provided to:

- Support the linguistic needs of Denver Health members and the surrounding community by providing Health Literacy Trainings on demand to Denver Managed Health Plan and community stakeholder staff and/or providers
- Support the cultural needs of Denver Health members and the surrounding community by providing cultural competency & responsiveness training to Denver Health and community stakeholder staff and/or providers
- Include Annual cultural diversity Web course required for all employees

## Health Management Services

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The Health Management Department (HMD) provides evidence-based chronic disease management/chronic care improvement programs, case management, wellness and health promotion services and other preventative services to improve member outcomes and reduce costs. These programs and interventions are aimed at helping members develop the skills necessary for making healthy choices and lifestyle changes to effectively self-manage physical and behavioral health conditions. They also help to make sure that members are receiving appropriate health care, by the right providers within the right time frame and are connected with the necessary resources and services. Ongoing programs and interventions include:

- Disease Management
- Complex Case Management
- Health Coaching
- Education and Support Groups
- Support Integrated Primary Care
- Health Communication Strategies
- Wellness and Prevention Strategies

When applicable, the HMD staff use incentives to promote engagement in health and wellness programs and/or to promote successful health behavior change.

### Disease Management and Health Coaching

Disease Management interventions are offered to members with chronic diseases such as asthma, depression, anxiety, diabetes (DM), chronic obstructive pulmonary disease (COPD), chronic pain management, congestive heart failure (CHF), and hypertension (HTN). Health coaching also includes preventive health measures for alcohol, tobacco and other substance use as well as increasing physical activity and reducing weight. Our Health Coaches work one-on-one with members and/or the member's caregiver, if applicable. Health Coaches provide

individualized support and tailored interventions to help members self-manage their chronic illnesses and other health conditions by enhancing motivation and providing support and encouragement to individuals as they address chronic health care needs or lifestyle changes. Initial assessments are conducted to gain a better understanding of the whole person, the barriers that might be preventing them from achieving their health goals, and to help inform the Health Coach of appropriate interventions for each individual. Readiness to change is assessed and a diverse array of psychological and behavioral change tools are employed to empower individuals to become better self-managers of their health. Interventions may include, but are not limited to, motivational interviewing for health behavior change, skills-based training, provision of patient education, provision of information and resources, and facilitation of support groups focused on medical and behavioral issues.

Health Coaches have diverse educational backgrounds and offer a wide range of clinical expertise. At a minimum, they receive specialized training in the following areas: (1) Motivational interviewing for health behavior change; (2) Disease education/management; (3) Behavior change strategies; (4) Cultural competency and diversity; (5) Community resources.

### Complex Case Management

Complex Case Management is intended to empower members to take control of their health care needs across the care continuum by coordinating quality health care services and the optimization of benefits through a realistic, cost-effective, and timely case management plan. By collaborating with members and their care team, complex case managers are able to facilitate access to health care services and provide support for health-related decisions, which may allow members to obtain the highest quality of care, maximize their health care coverage, and potentially save money. As such, high-risk members eligible for the program would include those with 1) advanced chronic diseases with multiple co-morbid conditions, 2) complicated acute diseases, 3) high utilization rates, and/or 4) severe psychological, and/or social issues or needs who require complex care coordination, as well as assistance obtaining a wide range of resources.

### myStrength™ Online Self-Help Program

In the myStrength™ self-help program, members can energize their mental and wellness health with proven online tools and tailored resources. These tools and resources are designed to improve their mood every day. myStrength™ serves as a platform for many programs such as depression, anxiety, and alcohol/drug abuse. To enroll in the myStrength™ program, members are asked to fill out a wellness profile through a secure online program. All members' information is kept private. Patients can then access eLearning tools, read articles, watch videos, or simply be inspired by daily quotes and pictures.

### Education Classes

As needed, and when resources are available, the Health Management Department offers education classes on a variety of health education topics. Topics offered include, but are not limited to: smoking cessation, heart health, chronic pain management, diabetes management, depression and/or anxiety, and weight management.

### Complex Health Needs

Complex case management is an approach to service delivery, which strives to ensure that patients with complex needs receive timely coordinated services. In addition, members understand and are able to effectively carry out their individualized care plans, and that resource links are made and utilized to maintain the patients' ability to function independently in a community of their choice as long as it remains appropriate. Additionally, it encourages collaboration, cost efficiency, and service integration to avoid service duplication.

ACS maintains the responsibility for CCM service delivery for the DHMP HMO plan, per NCQA requirements and in collaboration with DHMP, for the health plan members who receive, or who are assigned to receive, care at Denver Health Medical Center. DHMP, however, is still required to provide these same services to its members whose medical home is not Denver Health (i.e., POS, HighPoint HMO, DPS, and Medicare). Therefore, DHMP will provide overall high quality Health Management Services (i.e., Complex Case Management, Disease Management, Health Coaching, and Wellness and Prevention programs) for those members who are not intended to be seen by a Denver Health provider.

The regulatory obligation by CMS to offer Disease Management for the Medicare population remains with the health plan as responsibility for these programs and services did not move to ACS. In addition, the CCM services delivery moved back from ACS to DHMP for the Medicare line of business in 2017.

#### DHMP Complex Case Management Program

The DHMP Complex Case Management (CCM) Program is designed to provide intensive, personalized case management services for members who have complex medical and social needs and require a wide variety of resources. Members with complex needs can include individuals with physical or developmental disabilities, severe mental illnesses, multiple chronic conditions and complex medical needs. The goal of the program is to help members regain optimum health or improved functionality capacity in the right setting, utilizing the right providers, in the right time frame and in a cost effective manner.

Complex Case Managers have expertise in training in a variety of approaches in the management of health including case management concepts, principles and strategies, insurance benefits , cost containment and savings strategies, transitional care, cognitive behavioral and strengths perspective in order to provide patient-centered, whole person care.

The program is designed to achieve the following objectives:

- Assist members in regaining an optimal health status
- Improved functional status of members with chronic conditions, complex medical and psycho-social needs
- Proactively identify and engage members for the program
- Develop effective case management care plans that meet member health needs with timely, evidence based care and service
- Provide interventions to positively impact the target population
- Identify and refer to community resources to maximize support
- Improve and increase access to care

In addition to the CCM program, there are additional programs and resources available to members with complex needs who may/may not be enrolled in the program. Those include but are not limited to:

#### Clinical Social Workers

Denver Health Medical Center employs graduate-level clinical social workers to provide services to the population served at Denver Health. Social workers are employed across the continuum of care and in various settings including community health, public health, school-based clinics, managed care, acute, and primary care. Members with complex needs are often referred to a social worker for intervention. Social work services include but are not limited to assessment of need, counseling, case management and/or care coordination and provision of community resources.

### Intensive Outpatient Clinic (IOC)

The intensive outpatient clinic provides a multi-disciplinary, comprehensive team approach to addressing the needs of patients who are identified as high risk (e.g. high utilizers, frequent ED/hospital admissions and readmissions, multiple chronic conditions and/or presence of MH/substance abuse). The team consists of primary care physicians, nurses, social worker, psychologist, psychiatrist, CAC (certified addictions counselor), navigator and pharmacist. Their clinic location provides a 'one-stop' approach for members at most risk.

### Preventive Health Promotion

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In order to improve preventive health, the QI Department ensures that preventive health guidelines are readily available to practitioners, members, non-members, the public, and members with disabilities at no cost. The QI Program will continue to develop, measure compliance with updated preventive health guidelines annually, and provide outreach activities to targeted member groups according to risk factors, to urge the use of preventive services. QI staff will develop new interventions to promote disease prevention and health promotion as necessary, in collaboration with other departments, based on analysis of population data, HEDIS, and review of health risk assessments.

HMD provides a full range of preventive health of services including health coaching, education, and support groups for smoking cessation and weight reduction, educational services on a variety of preventive health topics, and an online preventive and disease management program.

### Patient Safety

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The QI Department works collaboratively with Utilization/Case Management, Pharmacy, and Health Management Departments to provide clinical quality monitoring and identify performance improvement opportunities related to member safety. The QI Department facilitates evaluation of quality of care concerns and any corrective action plan that comes from them, and implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service, and safe clinical practices.

The Medical Director is a member of the DHHA Patient Safety Committee. To address opportunities to decrease medical errors, the QI Department will offer patient education about safety initiatives and preventive approaches.

#### Patient safety objectives:

- Encourage organizational learning about medical and health care errors
- Incorporate recognition of patient safety as an integral job responsibility
- Incorporate patient safety education into job competencies
- Implement corrective, preventative, and general medical error reduction education programs to reduce the possibility of patient injury
- Involve patients in decisions about their health care to promote open communication about medical errors and consequences that result
- Collect and analyze data to evaluate care processes for opportunities to reduce risk and initiate actions
- Review and investigate serious outcomes in collaboration with risk management where patient injury occurred or patient safety was impaired
- Review and evaluate actual and potential risk of patient safety in collaboration with risk management.
- Report findings and actions internally with a focus on processes and systems to reduce risk
- Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety

- Focus existing QI activities on improving patient safety by analyzing and evaluating data related to clinical safety
- Trend adverse events reporting in safety practices (e.g., medication errors).
- Annually review and evaluate clinical practice guidelines to ensure safe practices

Denver Health also has a Department of Patient Safety and Quality which oversees the following divisions for DHHA:

- CHS QI - Responsible for the implementation, support, and evaluation of effective CQI studies of clinical and service activities for Denver Community Services and supports evaluation methods for multiple quality studies and other projects within Denver Community Health Services
- Continual Readiness - Provides coordination of regulatory reviews, surveys, or inquiries to Denver Health. This includes activities related to Joint Commission, CMS, Office of Civil Rights, and The Colorado Department of Public Health and Environment
- Division of Education - Responsible for bringing oversight and organization to the professional education (house staff and student education) occurring within DHHA
- Health Services Research – This research is an examination of how people get access to health care, how much care costs, and what happens to patients as a result of this care. The main goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety
- Infection Prevention - Responsible for provision of safe, high-quality health care in the setting of minimizing the risk of acquiring and transmitting infections
- Medical Biostatistics – Responsible for providing and analyzing data-driven performance measures, and for tracking quality indicators. Examples include Emergency Medical Services, Clinical Triggers, and Soarian Quality Measures

### Adequacy and Availability of Service

DHMP will establish, monitor, and implement improvement processes as necessary to ensure compliance with the State access standards and guidelines for members, including:

- Geographic distribution of providers
- Provider/member ratios for PCP's, high impact and high-volume specialists
- Timeliness of routine, regular, and urgent care appointments for primary care appointments
- Timeliness of non-urgent, urgent, and routine behavioral health appointments
- Access to after-hours care
- Key elements of telephone service including responsiveness of DHMP's Members Services Department telephone lines and responsiveness of Appointment Center telephone lines

DHMP will continue its Open Shopper study that evaluates Denver Health facilities plus a sample of its extended network of practitioners to assess the process a member would undertake to schedule a care appointment. This collection of data is shared with the QMC and many other workgroup committees that develop corrective actions when deemed appropriate. DHMP will assure that female members are provided with direct access to women's health specialists within the network for covered services.

### Clinical and Practice Guidelines

DHMP clinical and practice guidelines are developed, analyzed, and distributed annually to all members and providers. DHMP will consult with practitioners to develop and apply evidence-based clinical practice guidelines and involve practitioners in annual review and update of established guidelines.

DHMP, in collaboration with relative network providers, will develop and update at least six clinical and preventive guidelines, with two of the six being relevant to behavioral health. One of the behavioral health guidelines may be a behavioral health component of a clinical guideline, DHMP will involve behavioral health practitioners in developing guidelines for behavioral health care.

Activities related to clinical and practice guidelines include, but are not limited to the following:

- Develop new clinical guidelines where opportunities for improving clinical practice are identified
- Assure member benefit coverage for any elements of guidelines adopted
- Evaluate compliance with developed clinical guidelines and related clinical outcomes
- When appropriate, use guidelines for QI Activities/Projects

### Continuity and Coordination of Care

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Opportunities will be identified for improvement in the coordination of medical care. Staff will facilitate transition of care for all new and existing members across the continuum of care. Opportunities for improvement in the Coordination of Care include:

- Improve Continuity and Coordination of care between behavioral and physical health care to assure timely and accurate communication
- Improve Continuity and Coordination of care between primary and specialty care providers to assure timely and accurate communication

Additional opportunities for improving Continuity and Coordination of Care will be addressed, as identified.

The QI Department works in collaboration with the UM and CCM departments to actively monitor and take action, as necessary, to improve Continuity and Coordination of Care across the health care network. Annually, the MMC identifies opportunities to improve coordination of medical care via data collection and quantitative and causal analysis of this data.

Additionally, members are notified within 30 calendar days prior to practitioner termination and are offered assistance to select a new practitioner during this time of transitional care. If a practitioner notifies DHMP of their termination less than 30 calendar days prior to the effective date, DHMP will notify the affected member(s) as soon as possible, but no later than 30 calendar days after receipt of the notification. If practitioner contracts are discontinued, DHMP allows affected members continued access to the practitioner under certain conditions.

### Quality of Clinical Care

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The QI Department annually collects and reports out HEDIS data according to DHMP's contract requirements. HEDIS results are analyzed for opportunities to improve all measures with an emphasis on diabetes, cardiovascular conditions, asthma, behavioral health and preventive care for our members. Every three years QI initiates one Quality Improvement Project (QIP) focused on clinical and/or non-clinical areas to improve member quality of care and service and one Chronic Care Improvement Project (CCIP) for both Medicare Advantage and the Medicare SNP populations. This improvement project is directed by CMS per regulations. All DHMP QI activities related to our DHMP members undergo the Denver Health "plan, do, study, act" methodology to ensure interventions are handled properly.

The *RN Staffing Support for QI Activities*, with oversight from the DHMP Medical Director, investigate any potential Quality of Care Concerns (QOCC) from members, providers, or CMS. All QOCC's are tracked, trended, and reported to the DHMP QMC and the DHMP Board of Directors. If a QOCC is found to be substantiated, then

a Corrective Action Plan (CAP) will be put in place, if it relates to a system-wide issue. All report substantiated grievances regarding providers are sent to the Denver Health Risk Management Department or delegated entity for follow up, and if necessary for recredentialing purposes. The DHMP Medical Director, along with the QI RN, continuously monitor and trend all member QOCC's.

### Member Satisfaction

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The DHMP QI Department evaluates and trends member satisfaction data through the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey. If statistically significant decreases occur in any CAHPS measures, a corrective action plan will be established with regular monitoring of progress. QI Intervention Managers examine the CAHPS data, in collaboration with the Clinical Project Manager and assist in identifying opportunities for improvement to roll out new initiatives/activities.

DHMP's Member Service Department provides customer-focused services, as well as member claims processing and payments. Additionally, DHMP evaluates and trends member appeals, grievances, availability, and accessibility, the quality and appropriateness of care for persons with special health care needs, and makes correction to the system when is necessary. Member enrollment data reasons for disenrollment are analyzed on an ongoing base. Annually, DHMP communicates to its members regarding the QI program goals, processes, and outcomes through the member newsletter, DHMP Website, and other mailings.

### Provider Satisfaction

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Annually, the Medical Management Project Manager administers a practitioner survey inquiring to the level of satisfaction the practitioners have with DHMP Utilization Management (UM) services and processes. These results are analyzed and process improvements are put in place when deemed appropriate. DHMP annually communicates to its DHHA and external practitioners regarding the QI program goals, processes, and outcomes through the provider newsletter, the DHMP Website, and other mailings. The UM Department monitors practitioner complaints and makes appropriate improvements as related to Continuity and Coordination of Care.

### Credentialing and Delegated Credentialing

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The Medical Compliance Specialist assures the compliance of credentialing and recredentialing activities with CMS standards and conducts primary source verification for any direct credentialed practitioner. The Medical Compliance Specialist will evaluate the delegated entity's credentialing compliance with DHMP credentialing and recredentialing standards annually. Site visits will be conducted for any practitioner's office site (primary and specialty) that exceeds the acceptable threshold for complaints related to physical accessibility, physical appearance, and adequacy of waiting and exam room spaces. Audit results will be reported to the Credentialing Subcommittee of the DHMP QMC.

The Compliance Specialist evaluates provider contracts for compliance with Credentialing standards prior to contract approval and include behavioral health practices in credentialing activities. An assessment is conducted of organizational facilities for contracting compliance and ongoing monitoring of provider complaints and sanctions for recredentialing purposes.

### Delegation Activities and Oversight

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Delegation oversight and vendor/subcontractor management with respect to regulatory, contractual, and performance oversight reports are reported to the Compliance Committee on a quarterly basis. The QMC has advisory oversight responsibilities for delegated, quality-related activities. Specific functions of the QMC may be assigned to workgroups and subcommittees of the QMC. Furthermore, the Operations Team has administrative responsibility for the implementation, monitoring, and maintenance of all delegated activities. Current



delegation agreements are in place for Pharmacy PBM, MedImpact (NCQA UM accreditation pending), and for credentialing of selected networks.

MedImpact's agreement is a combination of partial and fully delegated functions. Some of these elements are portions of a standard, or specific to a line of business or population, (e.g., providing PA and UM decision for Medicare and Exchange.) Other elements are provided for whole standards, such as maintaining appropriate providers, or for selected elements for all lines of business, such as standards for the use appropriate clinical information. The Plan maintains the requirements in complement, for either the lines of business, or specific elements to support compliance, timeliness, and service for members. A complete grid of responsibility is maintained in the PBM delegation agreement.

The Plan maintains four delegation agreements for the credentialing and recredentialing of internal and external/expanded networks. These include an NCQA-accredited Cofinity Network (Aetna) and the DHHA sister organization, as well as two external networks, Columbine and University of Colorado Medicine.

## **V. Quality Improvement Program Annual Work Plan and Evaluation**

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### **A. Annual Work Plan**

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The QI Department will develop a QI Work Plan annually beginning January of each year. The Work Plan covers the scope of the QI Program and includes:

- Written, measurable, yearly objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities with departments including, but not limited to:
  - Health Management,
  - Pharmacy Management
  - Utilization Management
- Member experience activities and measurements
- Yearly objectives and planned activities, time frames for achieving, and those responsible
- Monitoring of previously identified issues
- QI Network Adequacy

*See Attachment for the QI Annual Work Plan*

### **B. Annual Evaluation**

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An annual written evaluation of the QI Program is submitted to the QMC and DHMP Board of Directors and is the basis for the upcoming year's Work Plan.

The Evaluation includes:

- Description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service, including delegated functions
- Trending of quality and safety measures and comparison with established thresholds
- Measurement and trending of HEDIS and CAHPS data to define opportunities for improvement

- Analysis of whether there has been a demonstrated improvement, including barrier analysis when goals are not met.
- Evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices, adequacy of resources, committee structure, practitioner participation, leadership involvement, and any determination of restructure or change(s) to be made for the subsequent year, based on findings

## **VI. Administrative Functions**

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### **A. Confidentiality**

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

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

At the time of hire, all staff shall sign and acknowledge understanding of the DHHA Confidentiality Agreement on an annual basis. DHMP shall treat all information as confidential to the extent that such information specifically identifies or permits identification of a certain Plan member and describes the physical, emotional, or mental conditions of such person, provided; however, DHMP may retain and use for its purposes in performance of its obligations any information it obtains relating to costs, charges, procedures, used or treatments employed by a provider in treating any member, to the extent such information does not disclose the identity of the person.

Confidential information obtained in the process of performing UM services will be used solely for utilization and quality management, and will be shared only with parties who are authorized to receive it. Any confidential information that DHMP finds necessary to disclose, in the performance of utilization management services, shall not be disclosed to any unauthorized entity without prior consent of the member or as required by the federal law.

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

### **B. Conflict of Interest**

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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.