### Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Time Frame</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2018 QI Program Description-Scope</strong></td>
<td>The QI Program Description will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC).</td>
<td><strong>Annually Program must include:</strong></td>
<td></td>
<td></td>
<td></td>
<td>1/2018</td>
<td>QMC Board of Directors</td>
</tr>
</tbody>
</table>

### QUALITY IMPROVEMENT PROGRAM STRUCTURE

<table>
<thead>
<tr>
<th>Objective:</th>
<th>All requirements must be met annually submitted for review to the QMC and BOD</th>
</tr>
</thead>
</table>

| **2018 Annual QI Work Plan** | The QI Work Plan schedule is developed after review of previous year’s QI Work Plan and Evaluation. The revised Work Plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measureable and analyzed annually during the Program Evaluation. | **Work Plan must address:** | | | | 1/2018 | QMC Board of Directors |

<table>
<thead>
<tr>
<th>Objective:</th>
<th>All 9 requirements must be met yearly objectives must be measureable submitted to and reviewed by the QMC and BOD</th>
</tr>
</thead>
</table>
DENVER HEALTH MEDICAL PLAN, INC.
Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

**2017 QI Program Evaluation Report** (includes all indicators for the present year.)

The Program Evaluation report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI Work Plan.

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

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

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

---

### QI PROGRAM OPERATIONS

<table>
<thead>
<tr>
<th>Quality Management Committee</th>
<th>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.</th>
<th>Committee functions include:</th>
<th>Objective:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- Analyzes and evaluates the results of QI activities</td>
<td>- Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensures practitioner participation in the QI program through planning, design, implementation or review</td>
<td>- Provides oversight to working subcommittees and determines final opportunities for selection for reporting requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Review and make recommendations on policy decisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identifies needed actions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ensures follow-up, as needed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bi-Monthly</th>
<th>QI Director</th>
<th>Ongoing</th>
<th>Ongoing</th>
<th>QMC</th>
</tr>
</thead>
</table>

---

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
| Medical Management Committee | DHMP’s Medical Management Committee (MMC) acts as a working sub-committee to the QMC. The 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 and selection of opportunities while maintaining a constructive relationship with medical staff and approving/overseeing policies and procedures. | Goals:  
- Providing strong support and oversight to an initiative to improve Continuity and Coordination of Care  
- Works in collaboration with the QMC  
- Works in collaboration with the Network Adequacy Committee  
- Ensure all regulatory and NCQA requirements are reported in a consistent, accurate and reliable manner | Bi-monthly | Medical Director  
Director Health Management | Ongoing | Ongoing | QMC |
| Network Adequacy Committee | The Network Management Committee (NAC) is tasked with establishing, maintaining and reviewing network standards and operational processes. The scope of the NAC responsibility includes: (1) Network development and procurement; (2) Provider contract management, including oversight; and (3) Periodic assessment of network capacity. | Goals:  
- 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 | Monthly | Director of Provider Relations | Ongoing | Ongoing | MMC |
DENVER HEALTH MEDICAL PLAN, INC.
Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

<table>
<thead>
<tr>
<th>Medicare Star Ratings Workgroup</th>
<th>Committee functions include:</th>
<th>Objective:</th>
<th>Quarterly</th>
<th>Clinical Project Manager QI Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key plan and ACS representatives work together to identify opportunities and implement interventions to improve our Medicare Star ratings.</td>
<td>• Evaluate &amp; identify opportunities • Intervention approval and support • Resource allocation • Review results to evaluate effectiveness</td>
<td>Committee analyzes and targets specific Stars measures for improvement. Interventions are then reviewed with ACS provider network and/or DHMP departments for approval and support. Metrics are set up to evaluate effectiveness.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaborative QI Workgroups</th>
<th>Workgroups QI participates in includes:</th>
<th>Objective:</th>
<th>Monthly</th>
<th>QI Interventi on Managers Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI health plan representatives sit on several collaborative workgroups led by ACS leadership.</td>
<td>• Cancer screening • Pediatric Preventive Health • Diabetes • Perinatal Care • Asthma • Transition of CarePeds CMMI • Immunizations • Patient Experience Committee</td>
<td>Established active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALITY OF CLINICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2018 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis</strong></td>
</tr>
<tr>
<td>HEDIS is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of 94 measures across 7 domains of care which allow for comparison of quality performance nationally across health plans.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product
**DENVER HEALTH MEDICAL PLAN, INC.**  
Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

### *HEDIS Impact: Breast Cancer Screening*

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

- Affects member experience

**DHMP’s QI Department:**
- QI will coordinate and advertise employee days and locations of BCS screenings (mobile van) on the Pulse and Frontlines.
- Conducts monthly data pull
- Defines eligible participants
- Distributes member list to PDI for mailing

**Commercial Current HEDIS 2017:** 71.25% (33.33th percentile)
**Commercial HEDIS 2018 Goal:** 72.76% (50th percentile)
**Medicare Current HEDIS 2017:** 71.25% (33.33th percentile)
**Medicare Goal HEDIS 2018:** 72.22% (50th percentile)

### QI LEAN Management

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

- Objectives including utilizing the use of:
  - A3 problem solving
  - PSDA cycle
  - Chart(s)
  - Visual Management Boards
  - Weekly QI team huddle

**Objective:**
- Increase collaboration in LEAN efforts
- Improve quality of data

### *Bone Density Screening (OMW)*

To improve HEDIS rates for the measure, Osteoporosis Management in Women who had a Fracture.

Create monthly list of women 67-85 years of age who had a fracture in the last 3 months and who have not had either a bone mineral density test or a prescription for a drug to treat for osteoporosis since the fracture. Provide to ACS for follow up, as appropriate.

**Current Medicare 2017 HEDIS Rate (2016 data):** 18.18% (10th percentile)
**Goal Medicare 2018 HEDIS Rate:** 25% (25th percentile)
Compliance in 22 of 43 women.

---

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
## Improving Diabetic Retinal Exams (CDC)

To improve HEDIS rates for the Diabetic Retinal Exam component of the HEDIS CDC measure.

Quality will target members for outreach who meet the following criteria: (1) the member is 18-75 years of age, (2) the member has been diagnosed with diabetes (type 1 and type 2), (3) the member has not had a retinal exam performed in the last year.

Create monthly list of members 18-75 years of age that have not had a retinal exam in the last year. Provide to ACS Eye Clinic Navigators to outreach and schedule the exam.

*Previously monitored   **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

### Current Medicare 2017 HEDIS Rate

(2016 data): 68% (3 stars)

Needed 49 additional members to reach most recent 4 star cut point.

#### Goal Medicare 2019 HEDIS Rate

(2018 Data): >=96% (4 stars) Compliance in 1173 of 1222.

---

## QUALITY OF CLINICAL CARE

### Improving Perinatal Health: HEDIS documentation and coding education

DHMP QI HEDIS Program Manager and QI Intervention Manager provide guidance and education on appropriate coding and documentation at the Denver Health Hospital and Ambulatory Care Clinics.

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

#### Commercial Current Prenatal 2017 HEDIS Rate

96.28% (90th percentile)

#### Commercial Prenatal Goal 2018

97.26% (95th percentile)

#### Commercial Current Postpartum 2017 HEDIS Rate

80.17% (50th percentile)

#### Commercial Postpartum Goal 2018

82% (66.67th percentile)

---

*Previously monitored   **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product

---

### Monthly QI HEDIS Program Manager QI Int. Manager 1/2018 12/2018 QMC

---

---
| *Improving Well-Child Visits: HEDIS Rates | To improve the Commercial HEDIS Rates for Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34), and Adolescent Well-Care Visits (AWC) | The following interventions will be ongoing in 2018:  
- Healthy Heroes Birthday Cards, with amendment  
- SBHC Targeted Lists  
- SBHC Enrollment Increase  
- Improving Medical Record Documentation for HEDIS specifications: Provider Education | Commercial W15 (6+ visits)  
Current HEDIS 2017 Rate: 81.15% (25th percentile)  
Goal - HEDIS 2018: 82.81% (50th percentile)  
Commercial W34  
Current HEDIS 2017 Rate: 77.99% (25th percentile)  
Goal - HEDIS 2018: 79.3% (50th percentile)  
Commercial AWC  
Current HEDIS 2017 Rate: 43.21% (25th percentile)  
Goal – HEDIS 2018: 45% (33.33th percentile) | Annually | QI Director, HEDIS Program Manager  
QI Int. Manager | 1/2018 | 12/2018 | QMC |

✓ Affects member experience
### Improving Well-Child Visits: Healthy Heroes Birthday Cards

**Commercial children 2-19 years of age who still require an annual well child visit for the year will receive a birthday card informing them to come for their annual visit.**

Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care.

- **Affects member experience**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Goal</th>
<th>Quarterly</th>
<th>QI Intervention Manager</th>
<th>1/2018</th>
<th>12/2018</th>
<th>QMC</th>
</tr>
</thead>
</table>
| - QI pulls list from BI portal monthly  
- QI cleans data and separates per LOB  
- QI forwards list to the printer to send out reminder cards | Engage children who have not gone in for their annual well child visit through the healthy hero birthday cards | | | | |
| **WCC Counseling for Physical Activity**  
Current HEDIS 2017 Rate: 63.50% (50th percentile)  
Goal HEDIS 2018: 67.38% (75th percentile) | | | | |
| **WCC BMI**  
Current HEDIS 2017 Rate: 91.24% (95th percentile)  
Goal HEDIS 2018: 95% (95th percentile) | | | | |
| **WCC Counseling for Nutrition**  
Current HEDIS 2017 Rate: 80.05% (75th percentile)  
Goal HEDIS 2018: 89.95% (95th percentile) | | | | |

---

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Time Frame</th>
<th>Approval</th>
</tr>
</thead>
</table>
| *Improving Well-Child Visits: School-Based Health Centers Targeted Lists* | Twice a year, QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. | Procedure:  
- SBHC sends enrollment lists to QI  
- QI runs the list against active members and targets who is in need of well-child visit  
- Send list back to clinic so HCPs can complete well visit in SBHC.  
- Provide updated list on monthly basis back to clinic so they are not providing services to children who may have completed well visit elsewhere and as way to track who receives a visit and where. | Goal:  
- Assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit.  
- 50%+ completion of visits for total eligible population | Quarterly | QI Int. Manager School-Based Health Center Administrative Contacts | 10/17 | 5/18 | QMC |
| *School Based Health Clinics (SBHC) - Well Child Visit Incentive Program* | As part of the Denver Health Managed Care network, children who are members of Denver Health Medicaid Choice or any Denver Health Medical Plan, Inc. plan, have access to the Denver Health School-Based Health Centers (SBHC). These children can receive health care services at one of the many SBHCs with no cost sharing to the member. | Procedure (Well Child Visits): QI will reward clinics for every well-child visit completed between 50% and 75% completion of visits for the total eligible population. | Well Child Visits:  
Goal for SBHC Clinics: 50%-75% completion of visits for the total eligible population  
WCC Counseling for Physical Activity  
Current HEDIS 2017 Rate: 63.50% (50th percentile)  
Goal HEDIS 2018: 67.38% (75th percentile) | Monthly | QI Int. Manager School Based Health Center Dr. Sonja O’Leary | 9/2017 | 5/2018 | QI Director QMC |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
**WCC BMI**
Current HEDIS 2017 Rate: 91.24% (95<sup>th</sup> percentile)
**Goal HEDIS 2018**: 95% (95<sup>th</sup> percentile

**Commercial AWC**
Current HEDIS 2017 Rate: 43.21% (25<sup>th</sup> percentile)
**Goal – HEDIS 2018**: 45% (33.33<sup>th</sup> percentile)

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018  ***Collecting HEDIS baseline data in 2018 for Elevate product*
**DENVER HEALTH MEDICAL PLAN, INC.**  
Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

<table>
<thead>
<tr>
<th>Model of Care</th>
<th>Procedure</th>
<th>Measurable Goals and Health Outcomes for the Model of Care</th>
</tr>
</thead>
</table>
| The SNP beneficiary specific performance measures are collaboratively developed in conjunction with DHMP and the DHHA Ambulatory Quality Committee (ACQIDC). This SNP-MOC specific set of goals reflect process, impact and outcome measures. | **DHMP Health Management department produces an annual SNP MOC program evaluation responsible for the operations of the SNP MOC HRAT, ICP and ICT facilitation.**  
**The results of the MOC annual program evaluation, updated program description, and work plan will be reviewed and approved annually by the QMC.**  
**Final approval is provided by the DHMP Board of Directors.**  
**SNP MOC evaluation content is then distributed to the Denver Health Ambulatory QI Committee (ACQIDC).** | **Current 2017 # and % of member for who outreach attempts were completed for HRA completion, initial or annual: 88% 2018 Goal: 90%**  
**Current 2017 # and % of members for whom an Individual Care Plan with identified goals was completed, initial or annual: 38% 2018 Goal: 44.2%**  
**Current 2017 rate of emergency department encounters/1000 members: ** 2018 Goal: **  
**Current 2017 rate of inpatient admissions/1000 members: ** 2018 Goal: **  
**Current 2017 average length of stay index for inpatient admissions: ** 2018 Goal: **  
**Current 2017 rate of 30-day all cause readmissions: 8.5% 2018 Goal: 8.2%**  
**Current 2017 % of patients with pharmacotherapy management of COPD Exacerbation- Systemic Corticosteroid: 71.4% 2018 Goal: 72.14%** |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
<table>
<thead>
<tr>
<th>Complex Case Management: Population Assessment</th>
<th>Current 2017 % of patients with pharmacotherapy management of COPD Exacerbation- Bronchodilator: 91.1% 2018 Goal: 91.1%</th>
<th>Current 2017 % of patients with colorectal cancer screening up to date: 57.9% 2018 Goal: 60.25%</th>
<th>Goals:</th>
<th>Annually</th>
<th>Director of Health Management</th>
<th>11/2018</th>
<th>1/2019</th>
<th>MMC QMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner.</td>
<td>Assessment must consider and include the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Relevant characteristics of specific populations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DHMP's total covered population, not just members identified for complex case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Needs of individuals with disabilities and serious and persistent mental illnesses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assesses the characteristics and needs of its member population and subpopulations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reviews and updates its complex case management processes to address member needs, if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reviews and updates its complex case management resources to address member needs, if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product
QUALITY OF SERVICE

| Complex Case Management: Measuring Program Effectiveness | Complex Case Management annually measures the effectiveness of its complex case management program using three measures. | For each measure, Complex Case Management: • Identifies a relevant process or outcome • Uses valid methods that provide quantitative results • Sets a performance goal • Clearly identifies measure specifications • Collects data and analyzes results • Identifies opportunities for improvement, if applicable | Goals: Member Satisfaction: • 100% of the respondents (former CCM members) will indicate a high level of satisfaction with the program by answering each of the CCM satisfaction survey questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied). | *Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product | Annually | Director of Health Management | 11/2018 | 12/2018 | MMC QMC |

| Population Health Management (PHM) Strategy: Monitoring Member Participation Rates | The Health Management Department has a population health strategy for meeting the care needs of its member population. | • The strategy describes goals and populations targeted for each of the four areas of focus, Keeping members healthy, Managing members with emerging risk, Patient safety or outcomes across settings, and Managing multiple chronic illnesses, the programs and services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about PHM programs. | Goals: 2018 PHM Participation Goal: • Establish baseline data for the four avenues of the population health strategy *Keeping members healthy* Goal: Decrease A1c levels by 2% in members who have a pre-diabetes A1c reading between 5.7 – 6.4 *Target Population:* Members identified as pre-diabetes with an A1c reading between 5.7 – 6.4. *Managing members with emerging risk* Goal: Improve portion of days covered (PDC) rates by 2% from baseline in members who take medications | | Annually | Director of Health Management | 12/2018 | 1/2019 | QMC |
antidepressant medications for depression.

**Target Population:**
- Members who are <80% PDC with medications for depression management.
- Members who are prescribed antidepressant medications for depression.

**Patient safety or outcomes across settings**

**Goal:** Improve medication adherence and knowledge in members who have 8 or more prescriptions and <80% PDC rates for all medications.

**Target Population:**
- Members with =/> 8 prescriptions and < 80% PDC rates

**Managing multiple chronic illnesses**

**Goal:** For members with diabetes and high BMI: lower A1c by 2% or to <9 or lower BMI by 5% or to <25 for members who exceed both measures.

**Target Population:**
- Members with controlled diabetes
- Members who have a BMI >25
**DENVER HEALTH MEDICAL PLAN, INC.**

**Commercial, Medicare and Elevate Quality Improvement Work Plan 2018**

<table>
<thead>
<tr>
<th>2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis</th>
<th>Assess member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS member satisfaction survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Affects member experience</td>
<td>DHMP's QI Department:</td>
</tr>
<tr>
<td></td>
<td>• Sends CAHPS surveys out annually to members via random sample.</td>
</tr>
<tr>
<td></td>
<td>• Validates data before submission</td>
</tr>
<tr>
<td></td>
<td>• Meets CAHPS submission deadline</td>
</tr>
<tr>
<td></td>
<td>• Analyzes survey results to determine areas of intervention and improvement</td>
</tr>
<tr>
<td>Evidence of annual analysis includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Presentation to the QMC</td>
</tr>
<tr>
<td></td>
<td>• Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.</td>
</tr>
<tr>
<td>Anually</td>
<td>QI Clinical Project Manager</td>
</tr>
<tr>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>QMC</td>
</tr>
</tbody>
</table>

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018  ***Collecting HEDIS baseline data in 2018 for Elevate product*
| Cultural and Linguistic Appropriate Services (CLAS) | To deliver culturally and linguistically appropriate services to Denver Health membership.  
✓ Affects member experience | Objective:  
- Ongoing to reduce REL related disparities in health based on available data. Ensure appropriate literacy levels in member materials  
Improvement of REL membership data | Goal:  
- Reduce health care disparities as it relates to REL  
- Improve collection of REL membership data | Annually  
QI Int. Managers | 1/2018 | Ongoing | QMC  
Denver Health Diversity Committee |

### QUALITY OF SERVICE

| Monitoring Network Availability of Practitioners | DHMP conducts an annual assessment to ensure that it maintains an adequate network of primary care, behavioral health and specialty care practitioners. We monitor effectiveness of the network in meeting needs and preferences of our membership. | Analysis includes:  
- Collecting member complaint data related to cultural, racial, ethnic and linguistic preferences  
- Performance against the number and geographical distribution standards for primary care, behavioral healthcare and specialty care | Goals:  
- Meet urban, suburban and rural provider availability standards set in the Access to Care and Services Policy | Annually  
Director of Provider Relations | 9/2018 | 10/2018 | QMC |

**Commercial Quality of Care Concerns (QOCC)**  
DHMP Medical Director and QI RN appropriately investigate potential QOCC's.  

| Timeframe requirements:  
- Acknowledgment letter: 2 business days.  
- Expedited Response: 72 hrs.  
- Standard Response: 30 business days.  
- Extension letter: 15 business days. | Goal:  
- 100% Timeframe Compliance | Quarterly  
QI Director RN Case Manager | Ongoing | Ongoing | QMC |

**Medicare Quality of Care Concerns (QOCC)**  
DHMP Medical Director and QI RN appropriately investigate potential QOCC's.  

| Timeframe requirements:  
- Acknowledgment letter: N/A  
- Expedited Response: 24 hrs.  
- Standard Response: 30 calendar days. | Goal:  
- 100% Timeframe Compliance | Quarterly  
QI Director RN Case Manager | Ongoing | Ongoing | QMC |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product
<table>
<thead>
<tr>
<th>Monitoring Accessibility of Services</th>
<th>DHMP has established mechanisms to ensure access to primary and specialty care services, along with behavioral health services. DHHA Appointment Center services are responsible for meeting established standards.</th>
<th>Assessment incorporates: Self-reported access data from practitioners captured via Secret Shopper Studies, supplemented with an analysis of complaints related to access.</th>
<th>Goals: • Meet urban, suburban and rural standards set in the Access to Care and Services Policy</th>
<th>Annually</th>
<th>Director of Provider Relations</th>
<th>1/2018</th>
<th>2/2018</th>
<th>QMC</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Adoption and Distribution of Clinical Practice and Preventive Health Guidelines</em></td>
<td>DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members and providers for the provision of non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties.</td>
<td>CPG’s must be updated annually or when the following circumstances exist: • New scientific evidence or national standards are published prior to the annual review date • National guidelines change prior to the annual review date</td>
<td>Objective: Adoption and dissemination by: • Establishing the clinical/scientific basis for the guidelines • Review guidelines annually, with updates as needed • Distributing guidelines to appropriate practitioners</td>
<td>Annually</td>
<td>QI Director</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>QMC</td>
</tr>
<tr>
<td><em>Evaluating Utilization Management Criteria</em></td>
<td>Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate.</td>
<td>DHMP’s UM Department has: • Written UM decision-making criteria that are objective and based on medical evidence • Written policies for applying the criteria based on individual needs • Written policies for applying the criteria based on an assessment of the local delivery system • Involvement of appropriate practitioners in developing,</td>
<td>Objective: Criteria must consider at least the following when applying criteria to a given individual: • Age • Comorbidities • Complications • Progress of Treatment • Psychosocial situation • Home environment, when applicable</td>
<td>Annually</td>
<td>Director of UM Medical Director</td>
<td>2/2018</td>
<td>3/2018</td>
<td>QMC</td>
</tr>
</tbody>
</table>

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
# DENVER HEALTH MEDICAL PLAN, INC.
## Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

| *Monitoring Consistency of Applying UM Criteria* | Utilization Management monitors and reviews application of UM criteria to ensure consistency in applying criteria. If reports show there was an inconsistency, action is taken to improve the consistency of reviewer determinations. | DHMP’s Utilization Management Department annually:  
- Evaluates consistency of health care professionals making UM decisions by applying criteria consistently and appropriately  
- Acts on opportunities to improve reliability of criteria application when identified | Goal:  
- 85% Accuracy Rate for Criteria Application | Annually | Director of UM  
Medical Director  
Pharmacy Director | 11/2018 | 12/2018 | MMC  

| *Monitoring of Formulary and Pharmaceutical Management Procedures* | Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes. | DHMP’s Pharmacy Department annually:  
- Review the procedures  
- Review list of pharmaceuticals  
- Updates the procedures and pharmaceuticals, as appropriate | Goal:  
- Must present and review all pharmaceutical management procedures annually to address areas for improvement | Annually | Pharmacy Director | 10/2018 | 11/2018 | P&T – approval  
QMC - review  

## QUALITY OF SERVICE

### Quality of Service Concerns (QSC)
- The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns.  
  ✓ Affects member experience  

**Timeframe requirements:**  
- Acknowledgment letter: 5 business days.  
- Standard Response: 30 business days.  
- Extension letter: 15 business days.  
- Expedited: 72 hours

**Goal:**  
- 100% Timeframe compliance  

**Quarterly**  
- Director of Member Services  
- Ongoing  
- Ongoing  
- QMC

### Member Annual Communication Requirements
- The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan

**Members receive:**  
- Information about the quality program goals and outcomes as related to member care and service

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

**Annually**  
- Director of Marketing  
- 1/2018  
- 12/2018  
- Outreach Committee

---

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
<table>
<thead>
<tr>
<th>Member Communication Requirements Upon Enrollment and Annually Thereafter</th>
<th>Topics related to patient care and service.</th>
<th>Pharmaceutical restriction and preference information, including formulary.</th>
<th>Goals:</th>
<th>ANNUALLY</th>
<th>Director of Marketing</th>
<th>1/2018</th>
<th>12/2018</th>
<th>Outreach Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan design and benefits.</td>
<td>Members are provided the following information, including but not limited to: Member rights and responsibilities statement Subscriber information PHI use and disclosure information The process for members to self-refer to case management How to access staff An affirmative statement about incentives</td>
<td>Must provide evidence of communication to all commercial members upon enrollment and annually thereafter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Affects member experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner and Provider Communication Requirements</td>
<td>The Marketing Department provides timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.</td>
<td>Practitioners and Providers are provided the following information, including but not limited to: Member rights and responsibilities statement The process for the practitioner to refer members to case management Disease Management Program information Clinical practice and preventive health guidelines (to appropriate practitioners) How to obtain UM criteria How to access staff An affirmative statement about incentives</td>
<td>Goal: Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter Must provide evidence of annual communication to all network practitioners and providers</td>
<td>ANNUALLY</td>
<td>Marketing Manager</td>
<td>1/2018</td>
<td>12/2018</td>
<td>Network Adequacy Committee</td>
</tr>
</tbody>
</table>
## Yearly Planned Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Objective/Description</th>
<th>Requirement/Planned Activity</th>
<th>Performance Target/Goal</th>
<th>Reporting</th>
<th>Primary</th>
<th>Time Frame</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY OF SERVICE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician and Hospital Directory Usability Testing</strong></td>
<td>The Marketing department evaluates DHMP's web-based physician and hospital directory for health literacy, ability for member understanding and usefulness of information to members and prospective members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluation considers:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Font size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reading level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intuitive content organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ease of navigation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Directories in additional languages, if applicable to membership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goals:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- There must be a documented process demonstrating how usability testing is performed and how testing frequency is determined.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reports indicating initial usability testing was performed before and after any upgrades to functionality or design that directly affects how members use the site.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician and Hospital Directory Usability Testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Accessing Member Understanding of DHMP Procedures** | The Marketing department has a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures.  
✓ Affects member experience | | | | | | | |
| **Assessment includes:** | | | | | | | |
| - Monitoring new member understanding of DHMP procedures | | | | | | | |
| - Implementing procedures to maintain accuracy of marketing communication | | | | | | | |
| - Acting on opportunities for improvement | | | | | | | |
| **Goals:** | | | | | | | |
| - There must be evidence of a systematic and ongoing process for assessing new-member understanding of DHMP operations and policies. | | | | | | | |
| - If DHMP finds that new members have enrolled without an accurate understanding of key DHMP policies and procedures, DHMP must initiate | | | | | | | |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product*
| Ongoing Monitoring of Network Practitioners and Providers Site Quality | Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP’s office-site standards. This is achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality. | Provider Relations and Credentialing:  
- Sets performance standards and thresholds for office site quality  
- Establishes a documented process for ongoing monitoring and investigation of member complaints related to practice sites | Goals:  
- Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met  
- Deliver corrective action plans within 30 calendar days of site visit  
- Repeat site visits are conducted 6 months after delivering corrective action plans to assure compliance | Quarterly | Director of Provider Relations | Ongoing | Ongoing | Cred. Cmte. |
| Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues | DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified. | Ongoing review and monitoring by:  
- Collecting and reviewing Medicare and Medicaid sanctions  
- Collecting and reviewing sanctions or limitations on licensure  
- Collecting and reviewing complaints  
- Collecting and reviewing information from identified adverse events | Goals:  
- Review sanction information within 30 calendar days of its release  
- Implementing appropriate interventions when instances of poor quality are identified | | Medical Director | Ongoing | Monthly | Cred. Cmte. |
| Monitoring Member Services’ Telephonic Performance | The Member Services Department has a process for monitoring and evaluating telephonic metrics against established thresholds. | Reporting categories:  
- Service level  
- Average delay to answer  
- Abandonment rate  
- Call volume | Goals:  
- Service level: at or above 80%  
- Time to answer: 30 seconds or less.  
- Abandonment rate: 5% or less. | Monthly | Director of Member Services | Ongoing | Ongoing | QMC |
### Continuity and Coordination of Medical Care

Denver Health Medical Plan, Inc. uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

### Annual Identification of Opportunities to Improve Coordination of Medical Care

By:
- Collecting data on member movement between practitioners and across settings
- Conducting qualitative and causal analyses of data to identify improvement opportunities
- Identifying and selecting at least opportunities for improvement
- Acting on at least 3 opportunities for improvement and measuring effectiveness

### Goals

- Identify and select at least 4 opportunities to improve the coordination of medical care
- Measure the effectiveness of improvement actions taken for at least 3 opportunities

<table>
<thead>
<tr>
<th>Goals</th>
<th>Annually</th>
<th>Director of UM</th>
<th>1/2018</th>
<th>12/2018</th>
<th>QMC MMC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Continuity and Coordination Between Medical Care and Behavioral Healthcare** | DHMP will conduct an assessment of continuity and coordination of care efforts between medical health care providers and behavioral health care providers (Denver Health and Cofinity providers). | **Annual identification of opportunities to improve coordination of medical and behavioral healthcare by:**  
- Collecting data on opportunities for collaboration between medical care and behavioral healthcare  
- Conducting qualitative and causal analyses of data to identify improvement opportunities  
- Identifying and selecting at least 2 opportunities for improvement  
- Measuring effectiveness on at least 2 opportunities implemented | **Goals:**  
- Identify and select at least 2 opportunities to improve collaboration between medical and behavioral healthcare  
- Measure the effectiveness of improvement actions taken for at least 2 opportunities | **Annually** | **Director of UM** | **1/2018** | **12/2018** | **QMC MMC** |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018  ***Collecting HEDIS baseline data in 2018 for Elevate product*
# DENVER HEALTH MEDICAL PLAN, INC.
## Commercial, Medicare and Elevate Quality Improvement Work Plan 2018

<table>
<thead>
<tr>
<th>Monitoring Satisfaction with Complex Case Management</th>
<th>Satisfaction data is collected through the following methods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction.</td>
<td>Obtaining survey feedback from members</td>
</tr>
<tr>
<td>✓ Affects member experience</td>
<td>Analyzing member complaints for tracking/trending</td>
</tr>
</tbody>
</table>

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

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

### Goals:
- **Emergency Care**: 24 hours a day, 7 days a week - Met 100% of the time
- **Emergency Care-Behavioral Health Non-life Threatening**: Within 6 hours - Met 100% of the time
- **Urgent Care-Medical and Behavioral Health**: Within 24 hours-Met 100% of the time
- **Primary Care-Routine Symptoms Non-urgent**: Within 7 calendar days - Met ≥ 90% of the time
- **Primary Care-Access to Afterhours Care**: Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician -Met ≥ 90% of the time
- **Specialty Care-Non-Urgent**: Within 60 calendar days-Met ≥ 90% of the time

<table>
<thead>
<tr>
<th>Open Shopper Study</th>
<th>Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver Health Medical Plan, Inc. (DHMP) has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is to determine what percent of clinics within the Denver Health system meet our access standards; what percent of high-volume providers within the expanded Cofinity Network meet our access standards; and what percent of behavioral health providers who serve our members meet our access standards</td>
<td>✓ Affects member experience</td>
</tr>
</tbody>
</table>

### Goals:
- **Annually**
- **Emergency Care**: 24 hours a day, 7 days a week - Met 100% of the time
- **Emergency Care-Behavioral Health Non-life Threatening**: Within 6 hours - Met 100% of the time
- **Urgent Care-Medical and Behavioral Health**: Within 24 hours-Met 100% of the time
- **Primary Care-Routine Symptoms Non-urgent**: Within 7 calendar days - Met ≥ 90% of the time
- **Primary Care-Access to Afterhours Care**: Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician -Met ≥ 90% of the time
- **Specialty Care-Non-Urgent**: Within 60 calendar days-Met ≥ 90% of the time

<table>
<thead>
<tr>
<th>Open Shopper Study</th>
<th>Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver Health Medical Plan, Inc. (DHMP) has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is to determine what percent of clinics within the Denver Health system meet our access standards; what percent of high-volume providers within the expanded Cofinity Network meet our access standards; and what percent of behavioral health providers who serve our members meet our access standards</td>
<td>✓ Affects member experience</td>
</tr>
</tbody>
</table>

### Goals:
- **Annually**
- **Emergency Care**: 24 hours a day, 7 days a week - Met 100% of the time
- **Emergency Care-Behavioral Health Non-life Threatening**: Within 6 hours - Met 100% of the time
- **Urgent Care-Medical and Behavioral Health**: Within 24 hours-Met 100% of the time
- **Primary Care-Routine Symptoms Non-urgent**: Within 7 calendar days - Met ≥ 90% of the time
- **Primary Care-Access to Afterhours Care**: Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician -Met ≥ 90% of the time
- **Specialty Care-Non-Urgent**: Within 60 calendar days-Met ≥ 90% of the time

### Open Shopper Study
- **DHMP** has Access Standards which measure clinic and provider performance for availability of and access to care. To assure appointment availability meets these standards, the Quality Improvement (QI) Department conducts an “Open Shopper” study biannually to determine clinic compliance with access standards for our commercial lines of business (DHMP HMO and DHMP POS). The main purpose of the study is to determine what percent of clinics within the Denver Health system meet our access standards; what percent of high-volume providers within the expanded Cofinity Network meet our access standards; and what percent of behavioral health providers who serve our members meet our access standards.
- **Affects member experience**
<table>
<thead>
<tr>
<th>*Monitoring Member Satisfaction</th>
<th>Aggregate member complaints and appeals by reason, showing rates related to:</th>
<th>Goals: Evidence of monitoring includes:</th>
</tr>
</thead>
</table>
| DHMP monitors member satisfaction with our services and identifies areas of potential improvement. To assess member satisfaction with our services, DHMP annually evaluates member complaint and appeal data to analyze tracking and trending. | • Quality of Care  
• Access  
• Attitude and Service  
• Billing and Financial Issues  
• Quality and Practitioner Office Site. | • Annual reporting to the QMC  
• Root-cause analysis provided to identify opportunities for improvement. |
| ✓ Affects member experience | | |

<table>
<thead>
<tr>
<th>*Monitoring Satisfaction with the Utilization Management Process</th>
<th>Components of the process:</th>
<th>Goals:</th>
</tr>
</thead>
</table>
| DHMP continually assesses member and practitioner satisfaction with our Utilization Management process to identify areas in need of improvement. | • Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities  
• Taking action designed to improve member and practitioner satisfaction based on assessment of the data | • Members: Of the surveyed members (CAHPS) who required an authorization for services, 90% or more reported being either “Somewhat or Very Satisfied” with the authorization process (question 31A).  
• Practitioners: 90% of the surveyed providers will indicate a high level of satisfaction with the UM program by answering each of the Provider UM Satisfaction questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied).” |
| ✓ Affects member experience | | |

| | Routine Behavioral Health Care: Within 10 business days - Met ≥ 90% of the time  
Preventive Visits/Well Visits: Within 30 calendar days- Met ≥ 90% of the time | |

| | 2018 | 2018 | QMC |
| Director of Member Services | 1/2018 | 3/2018 |  |
| Director of UM | 12/2018 | 1/2019 |  |

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product
# Managing Satisfaction with Disease Management

The Health Management Department annually evaluates satisfaction with its disease management services to identify opportunities to improve member satisfaction.  
- Affects member experience

## Satisfaction Data Collection

Satisfaction data is collected through the following methods:
- Obtaining member survey feedback
- Analyzing complaints and inquiries

## Goals

- **Members:** 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied).

### Quality of Service

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Satisfaction with Disease Management</th>
<th>The Health Management Department annually evaluates satisfaction with disease management services to identify opportunities to improve member satisfaction.</th>
<th>Satisfaction data is collected through the following methods:</th>
<th>Goals:</th>
<th>Monitored By:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Obtaining member survey feedback</td>
<td>Members: 95% of the respondents (former DM members) will indicate a high level of satisfaction with the program by answering DM survey questions with a rating of either 4 or 5 (on a 1-5 scale, with 5 being extremely satisfied.)</td>
<td>Director of Health Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Analyzing complaints and inquiries</td>
<td></td>
<td>12/2018</td>
</tr>
</tbody>
</table>
## Utilization Management Program Evaluation

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

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

### Presentation to QMC must include:
- Committee discussion and input on program summary
- Actions, if applicable
- Committee approval of 2018 UM Program

### SAFETY OF CLINICAL CARE

#### Patient Safety Initiatives

- The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Behavioral Health and Wellness Departments to provide clinical quality monitoring.
- Identification of performance improvement opportunities related to member safety are reviewed and implemented.
  - Affects member experience
- Process:
  - The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches.
- Objectives:
  - Encourage organizational learning about medical and health care errors
  - Incorporate patient safety education across organization
  - Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee.
  - Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result
  - Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions

### SAFETY OF CLINICAL CARE

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Frequency</th>
<th>Presenter</th>
<th>Date</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Management Program Evaluation</td>
<td>The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the MMC &amp; QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentation to QMC</td>
<td>Committee discussion and input on program summary, actions, if applicable, and committee approval of 2018 UM Program.</td>
<td>Annually</td>
<td>Medical Director</td>
<td>01/2018</td>
<td>QMC MMC</td>
</tr>
<tr>
<td>Patient Safety Initiatives</td>
<td>The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Behavioral Health and Wellness Departments to provide clinical quality monitoring. Identification of performance improvement opportunities related to member safety are reviewed and implemented.</td>
<td></td>
<td></td>
<td>02/2018</td>
<td>QMC MMC</td>
</tr>
<tr>
<td>DENVER HEALTH MEDICAL PLAN, INC.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial, Medicare and Elevate Quality Improvement Work Plan 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired under the quality of care concern process.
- Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.
- Distribute information to members and providers via newsletter and/or website to help promote and increase knowledge about clinical safety.
- Focus existing quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety.
- Annually review and evaluate clinical practice guidelines against practice guidelines to ensure and improve safe practices.

*Previously monitored **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product
| **Pharmaceutical Patient Safety Issues** | The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacists or practitioners. This represents an opportunity to provide patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons. | Objectives:  
- Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety.  
- An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall.  
- Results are presented to Compliance Committee annually and MMC for review and feedback semiannually. | Goals:  
100% Compliance for:  
- Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification.  
- Class II: Affected members and providers notified within thirty days of the FDA notification.  
- Class III: Affected members and provider notified within sixty days of FDA notification. |  
|  | ✓ Affects member experience | |  
| **SAFETY OF CLINICAL CARE** | The Compliance Department has a process for identifying, reporting and taking action on impermissible uses or disclosure of sensitive information. | The Compliance Department implements procedures for:  
- Identifying impermissible uses or disclosure of sensitive information  
- Reporting impermissible uses or disclosures of sensitive information  
- Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information | Goals:  
- Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality.  
- If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections may include, but are not limited to:  
  - Education and training  
  - Process/procedural revisions  
  - Progressive discipline |  
| **Monitoring Privacy and Confidentiality** | ✓ Affects member experience | |  

*Previously monitored  **TBD; awaiting 2017 claims submissions through end of Feb 2018 ***Collecting HEDIS baseline data in 2018 for Elevate product