Denver Health Medicaid Choice and CHP+

Quality Improvement Program Description

SFY 2018-2019
# Table of Contents

I. Introduction........................................................................................................................................ 2
   The Company’s Mission Statement................................................................................................. 2
   Quality Statement and Process ......................................................................................................... 2

II. QI Program Structure .................................................................................................................... 3
   Oversight ........................................................................................................................................ 3
   Authority and Responsibility ............................................................................................................ 4
   The Company’s Quality Improvement Department ........................................................................ 4
   Committee Structure ....................................................................................................................... 6

III. Goals and Objectives .................................................................................................................... 14

IV. Program Scope ............................................................................................................................... 16
   Cultural and Linguistic Objectives .................................................................................................. 17
   Patient Safety .................................................................................................................................. 17
   Care Coordination .......................................................................................................................... 19
   Adequacy and Availability of Service ............................................................................................... 23
   Clinical and Practice Guidelines ..................................................................................................... 23
   Continuity and Coordination of Care ............................................................................................... 24
   Member Satisfaction ........................................................................................................................ 24
   Practitioner Satisfaction ................................................................................................................. 25
   Credentialing and Delegated Credentialing .................................................................................... 25
   Delegation Activities and Oversight ................................................................................................ 25

V. Quality Improvement Program Annual Work Plan and Evaluation ............................................. 26
   Annual Work Plan ............................................................................................................................ 26
   Annual Evaluation ............................................................................................................................ 26
I. Introduction

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated healthcare system that serves as Colorado’s primary “safety net” system. DHHA entered into a contract with the Colorado Department of Health Care Policy and Financing (HCPF) on May 1, 2004 in order to provide comprehensive health care services to Medicaid eligible’s enrolled into Denver Health Medicaid Choice (DHMC).

Denver Health Medical Plan, Inc. (DHMP) was incorporated on January 1st, 1997. The State of Colorado licenses DHMP as a Health Maintenance Organization. On July 1st, 2003, DHMP entered into a contract with HCPF in order to provide comprehensive health care services to Child Health Plan Plus eligible’s enrolled into DHMP. We will hereinafter refer to DHMC and DHMP as “the Company”. The Company offers a full spectrum of healthcare services for members through DHHA’s integrated healthcare system. The Company’s Quality Improvement (QI) Program Description outlines the organization’s efforts to improve overall quality of care, service, and patient safety for the Company’s members on DHHA’s behalf.

The Company’s Mission Statement

The DHMP mission is to:

Provide affordable, quality healthcare coverage for all in partnership with Denver Health.

Quality Statement and Process

The QI Program is designed to support the mission of the Company by promoting the delivery of high-quality affordable healthcare services that will enhance or stabilize the health of the Company’s 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 metrics. Performance metrics 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 review
- Claims data
- Open Shopper studies
- Pharmacy data
- Case management data
- Utilization management data
- Health management data
These sources allow the Company to collect the data necessary to improve the appropriateness, efficiency, effectiveness, availability, timeliness, and continuity of care delivered to our members. This approach also allows the Company to focus on opportunities for improving operational processes, increasing member and Practitioner satisfaction, and effectively providing and managing health outcomes. The Company’s mission is to deliver the right care or service, at the right time, by the right staff in a safe and suitable setting.

The Company uses a continuous improvement cycle where designated staff conducts a measurement of performance indicators, assesses and prioritizes the indicators upon which the Company may improve, and then plans, implements, and evaluates interventions to improve the quality of care, quality of service, and patient safety of members. Data is collected on a prospective, concurrent, and/or retrospective basis dependent on which type best meets the measurement need. QI data is analyzed, summarized, and presented in a clear manner with trending and comparison against benchmarks, when available, to the Quality Management Committee (QMC). The QMC provides recommendations for improving quality efforts. QI works collaboratively with various Company departments to develop and implement initiatives targeted at improving clinical care, outcomes, safety and service.

II. QI Program Structure

Oversight

The Company’s Board of Directors
The Company’s Board of Directors is the governing body for the Company and is responsible for insuring quality and safety for the Company’s members. The Board holds ultimate authority and responsibility over the Company’s QI Program, CEO/Executive Director, Medical Director, and Quality Management Committee (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 Impact Analysis.

Composition:
- DHHA Authority Board Chair Designee
- DHHA Chief Executive Officer
- DHHA Chief Operating Officer
- DHHA Chief Financial Officer
- DHHA Executive Director of Denver Health Community Health Services
- Community Business Leaders
Function:
- Approves the QI Program Description, QI Work Plan, and Annual Impact Analysis
- Reviews applicable Company quality data such as CAHPS, HEDIS, etc.

Authority and Responsibility

The Company’s Executive Leadership
1. **CEO/Executive Director, Managed Care** responsibilities include, but are not limited to:
   - Provides oversight of the QI Director and department operations
   - Presenting formal reports from the department to the Board of Directors

2. **Medical Director** responsibilities include, but are not limited to:
   - Providing direction, support and oversight related to the development, implementation, and evaluation of all clinical activities of the QI department
   - Working in collaboration with the QI Director and the QI Intervention Managers on development and assessment of clinical interventions
   - Reporting findings from clinical interventions to the appropriate groups, such as the Ambulatory Quality Improvement and Design Committee (AQIDC), Quality Management Committee (QMC), and the Company Board of Directors
   - Working 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 the Company Board of Directors
   - Designing and implementing clinical activities in the QI Work Plan
   - Serving on the QMC, AQIDC, Pharmacy and Therapeutics Committee (P&T), Medical Management Committee, Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee and Denver Health Physician Executive Committee
   - Evaluating and managing the Company’s Quality of Care Concerns (QOCCs) related to physical health problems, working in conjunction with the clinical staff supporting the QI department
   - Overseeing all of the Company’s clinical and preventive health guidelines

The Company’s Quality Improvement Department

1. **Quality Improvement Director** responsibilities include, but are not limited to:
   - Developing, managing, and monitoring the QI Program
   - Acting as staff representative to the Company’s Board of Directors
• Directly assuming authority and responsibility for the organization and administration of the QI Program, including annual submission of the QI Program Description, Evaluation, Work Plan
• Coordinating, providing advice, and participating in the execution of the QI Program through collaboration with other Company and Denver Health Departments as appropriate for regulatory compliance
• Reporting QOCCs to the DHHA Patient Safety and Quality department and external network providers through the Medical Director, as appropriate.
• Serving as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
• Annually updating policies, procedures, and guidelines related to the QI Department
• Providing oversight and direction to the QI team

2. **HEDIS Program Manager** responsibilities include, but are not limited to:
   • Managing all aspects of HEDIS-related projects
   • Evaluating and analyzing HEDIS results
   • Providing recommendations to QI Director for cost efficiency, process improvements, and quality interventions
   • Working collaboratively with Intervention Managers on process improvements and interventions related to HEDIS
   • Validating the accuracy of HEDIS data

3. **Clinical Project Manager** responsibilities include, but are not limited to:
   • Managing all aspects of CAHPS-related projects
   • Evaluating and analyzing CAHPS results
   • Providing recommendations to QI Director for cost efficiency, process improvements, and quality interventions
   • Working collaboratively with Intervention Managers on process improvements and interventions related to CAHPS
   • Oversight of CAHPS vendor contracts and delegated activities
   • Facilitates and evaluates open shopper studies related to member experience and access
   • Managing all aspects of the STARS improvement project

4. **QI Project Manager** responsibilities include, but are not limited to:
   • Analyzing the effectiveness of intervention activities in conjunction with Intervention Managers
   • Coordinates all efforts related to work plans, evaluations and program descriptions, including submissions
   • Project lead’s activities related to regulatory and QI accreditation requirements
   • Works in collaboration with Intervention Managers to maintain timeline deliverables
• Co-directing and working with QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and obtaining bi-monthly reporting requirements
• Functions as main administrative contact for QMC
• Oversees QI NCQA requirements and functions in conjunction with Director of QI

5. **Intervention Managers** responsibilities include, but are not limited to:
   • Developing, managing, and evaluating all quality interventions
   • Working collaboratively with the Medical Director, QI Director, AQIDC subcommittee condition-specific work groups, and QI team
   • Lead healthcare initiatives related to health literacy and cultural disparities
     Contributing to multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services use and monitoring

6. **RN Staffing support for QI Activities includes, but are not limited to:**
   • Managing QOCCs and quality of service concerns process in a timely and effective matter
   • Providing clinical consultation for the QI team
   • Conducting practitioner chart review using HEDIS criteria
   • Developing and updating all preventive and clinical guidelines

**Committee Structure**

1. **The Company’s Quality Management Committee**
The Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. The QMC is charged with responsibility for oversight of all quality-related Company Medical Management activities and processes in collaboration with the Medical Management Committee, including but not limited to oversight of the following: Utilization Management, Case Management, Health Management, Pharmacy, Member Services, and Provider Relations. Additionally, the QMC oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, and patient safety initiatives. The QMC includes primary care providers and specialty providers from both Denver Health Hospital Authority and extended practitioner network. The DHHA Behavioral Health Practitioner also serves as the Behavioral Health Practitioner on the QMC. They assist with the development, revision, and/or implementation of the behavioral health aspects of the QI Program including the 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, review behavioral health cases for appropriateness, especially related to level of care, and in evaluating the Company’s QOCCs related to behavioral health problems, working in conjunction with the clinical nursing staff supporting the QI Department.
Composition:

- Director of QI and Accreditation (Chair)
- Medical Director
- DHMP Director of Health Management
- Director of Compliance
- Director of Government Products
- Director of Member Services
- Director of Pharmacy
- Director of Provider Relations
- Director of Utilization and Case Management
- DHAA Care Coordination Management
- Primary Care Practitioners from Denver Health Hospital Authority (DHHA)
- Behavioral Health Practitioner from Denver Health Hospital Authority (DHHA)
- Specialty Care Practitioners from DHHA

Functions:

- Serve as the advisory and action oversight body for quality initiatives and activities. The QI Project Administrator 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. Bimonthly meetings will be held as needed to meet structural and performance requirements for improvement
- Maintain 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 all quality improvement activities
- Institute needed actions for improvement upon performance goals
- Ensure follow-up of issues and activities. When organizational goals are not reached, conduct root cause analysis or barrier analysis
- Review and approve clinical and preventive practice guidelines
- Review member satisfaction and quality of care 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 identified Quality of Care Complaints (QOCCs)
- Review UM, Health management, and Pharmacy performance as it funnels up from the MMC
- Provide oversight of QI Program deliverables including, but not limited to:
  - QI Program Description
Committees Reporting to the QMC include, but are not limited to:

- Pharmacy and Therapeutics (P&T) Committee
- Ambulatory QI and Design Committee (AQIDC)
- Medical Management Committee (MMC)
- Network Management Committee (NMC)

2. Operations Management Committee

The purpose of the Operations Management Committee is to establish, maintain, and redesign, as needed, the operations of the Company, 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 provided to the Operations Management Committee allow for additional performance monitoring information.

Composition:

- CEO/Executive Director-Denver Managed Health Plan
- Medical Director
- Chief Financial Officer
- Chief Administration Officer
- Director of Health Management
- Director of Government Products
- Director of Compliance
- Director of Claims
- Director of Contracting/Provider Relations
- Director of Finance
- Director of Information Systems
- Director of Commercial Products
- Manager of Marketing
- Director of Member Services
- Director of Pharmacy
- Director of Quality Improvement
- Director of Utilization and Case Management

Functions:

- Address, discuss, and/or implement actions on presentations, information items, and department reports
• Develop annual budget
• Develop strategic goals for the Company
• Review financial performance, dashboards, practitioner and member service levels, utilization data, and other applicable information appropriate to the operations of the Company
• Coordinate and monitor operations and progress toward meeting annual goals and financial objectives
• Review regulatory agency and external audit reports of various Company functions.
• Review new regulatory legislation and contractual requirements and implement as appropriate
• Oversee culturally and linguistically appropriate services (CLAS) program activities, goals, allocation and resources

3. Medical Management Committee
   The Medical Management Committee ensures the delivery of high quality, medically necessary, and cost-efficient physical and behavioral health care to members. The Committee is a subcommittee of the QMC, and provides oversight of the Utilization and Care Management Program.

Composition:
• Medical Director – Chair
• Director of Health Management (Co-Chair)
• Director of Utilization and Case Management
• Director of Quality Improvement
• IS Project Manager
• Director of Compliance
• Director of Pharmacy
• Primary and Specialty Care Practitioners
• DHHA Psych PhD/MD practitioner

Functions:
• Provides direction on utilization management and case management initiatives
• Reviews and approves the UM, ICM, and Pharmacy Program Descriptions and Evaluations
• Monitors compliance with CMS, State/Federal regulations, and mandates
• Annually reviews and approves the clinical criteria set used by UM staff to determine medical necessity
• Analyzes utilization data to identify potential areas of over- or under-utilization of health care services and determines appropriate interventions when necessary
• Analyzes utilization reports to identify significant trends and determine appropriate follow-up
• Reports significant findings to the QMC at appropriate intervals
• Reviews inter-rater reliability (IRR) reports at least annually to ensure consistency of UM staff decision-making
• Identifies opportunities for controlling utilization and/or for cost-savings
• Provide oversight and recommendations regarding utilization of new technologies and benefit design

4. **Credentialing Committee**
The Credentialing Committee acts as the peer review committee for credentialing and recredentialing. It is a subcommittee of the NMC.

**Composition:**
- Medical Director
- Medical Compliance Specialist
- Credentialing Department Manager
- 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 and the process used to make credentialing and recredentialing decisions
- Annually review and approve the credentialing policy and procedures
- Review results of ongoing monitoring of sanctions and grievances
- Review and determining participating status of practitioners who, at a minimum, do not meet the established credentialing criteria
- Review the clean files that were approved by the Medical Director
- Review and approve all delegated approved practitioners
- The Medical Compliance Specialist is responsible for keeping accurate meeting minutes, 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 (those meeting all criteria with no malpractice claim history) may be reviewed by the Company 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 re-credentialing, 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 by the Credentialing Committee in response to a potential issue identified during Company oversight

5. Pharmacy and Therapeutics Committee
The Pharmacy and Therapeutics Committee oversees the process for adding drugs to the Company’s formulary, deleting a drug from the Company’s formulary, and annual review of the Company’s formulary and pharmaceutical management procedures.

Composition:
• Medical Director
• Director of Pharmacy
• DHHA Physicians
• DHHA Pharmacists
• Representatives from DHHA and Community Health Services (CHS)

Functions:
• Review and approve policies and procedures relating to the selection, distribution, handling, use, and administration of drugs for Company-approved practitioners
• Develop an evidence-based formulary of drugs accepted for use by members and provide a platform of ongoing monitoring of approved drugs
• Establish programs and procedures to ensure cost-effective drug therapy
• Participate in quality assurance activities related to the distribution, administration and use of medications
• Oversee, study, and review results of medication-use review programs

6. Compliance Committee
The Compliance Committee serves to promote the highest degree of ethical and lawful conduct throughout the Company 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:
• Director of Compliance
• CEO-Denver Managed Health Plan
• Medical Director
• Director of Finance
• Director of Pharmacy
• Director of Quality Improvement
• Director of Utilization and Case Management
• Director of Information Systems
• Director of Provider Relations
• Director of Health Management
• Director of Member Services
• Government Products Manager
• Director of Marketing/Commercial Product Line Manager
• DHHA Representative from the Legal Department (on ad-hoc basis)

Functions:
• Identify operational areas/topics that will provide the basis for establishing proper business processes, policies and procedures
• Establish a process for creation, approval and periodic review of policies and procedures
• Conduct effective training and education to staff in all areas of compliance and ethics
• Establish mechanisms to detect actual and/or possible compliance violations
• Conduct ongoing auditing and monitoring
• Enforce standards through well-publicized disciplinary guidelines
• Respond to detected offenses, develop corrective action plans, and report compliance issues or offenses to government authorities as needed
• The Compliance Officer, through the efforts of the Compliance Committee and the Compliance Department, is responsible for:
  o Supporting an environment where employees are able to communicate compliance issues and to report suspected fraud and abuse without fear of retribution
  o Promoting that all employees and agents conduct business practices in an ethical and lawful manner
  o Independently investigating and acting on matters related to compliance, including the flexibility to initiate investigations and corrective action plans with all departments and staff, and if necessary, independent contractors
  o Establishing a “chain of command” that employees and agents can follow when reporting actual or possible compliance issues. The “chain of command” details should be communicated to all employees and agents on at least an annual basis
  o Implementing and maintaining a process for tracking and monitoring compliance issues that are reported both anonymously and through the “chain of command”

7. Ambulatory QI and Design Committee
The Ambulatory QI and Design Committee (AQIDC) is a collaborative group that focuses on integrating quality activities among Community Health Services (CHS) and the Company. The AQIDC is a standing subcommittee of the DHHA Ambulatory Care 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
community health system. The 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 their individual locations.

Additionally, the AQIDC defines and oversees the efforts of the DHHA quality improvement 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 the Company’s QMC by way of meeting minutes.

**Composition:**

- DHHA Director of CHS
- DHHA CHS QI Coordinator
- Denver Health Medical Plan Director of Quality Improvement
- Denver Health Medical Plan Medical Director
- DHHA Directors of Pediatric, Internal and Family Medicine Divisions
- DHHA Director of School-based Health Centers
- DHHA Behavioral Health Practitioners
- DHHA Primary Care Physicians
- DHHA Specialty Care Physicians
- DHHA RN Clinic Managers

**Functions:**

- To define a core set of indicators that serve as measures of performance quality for services provided in ambulatory care settings
- To identify methods to measure performance for identified indicators
- To develop annual work plan(s) for review of all performance indicators
- To prioritize areas for performance improvement within the indicators included in the CHS QI work plan
- To establish work groups for developing/implementing QI initiatives within ambulatory care services and to oversees their activities

8. **Network Management 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:
- Director of Provider Relations (Chair)
- Medical Director
- Director of Quality Improvement and Accreditation
- Director of Utilization and Case Management
- Director of Government Products
- Director of Marketing and Commercial Products
- Credentialing Manager
- DHHA Director of Care Coordination
- DHHA Physician Administrator representation

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

The QI Program seeks to accomplish the following objectives: (1) to assess the quality of care delivered to Company members, and (2) to evaluate the manner in which care and services are delivered to these individuals. The QI team is committed to maintaining a standard of excellence and enacts/monitors programs, initiatives, and policies related to this purpose. The subsequent section summarizes our member goals and strategies for meeting these aims.

QI Program strives to achieve the following goals for all members:
- Measure, analyze, evaluate, and improve the administrative services 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 strategy for meeting these goals incorporates:
• Design and maintain the QI structure and processes that supports 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
• Establish and implement at least one to two performance improvement projects (PIPs) and/or focused studies each year per Medicaid Choice contractual requirement
• Establish and implement at least one performance improvement project (PIP) per CHP+ contractual requirement
• Participation for performance improvement projects (PIPs) for clinical and non-clinical care will occur through the State Medicaid Integrated Quality Improvement Committee (IQuIC) and those selected by the Centers for Medicaid and Medicare Services (CMS)
• Establish and implement improvement activities to enhance EPSDT performance and compliance
• Objectively and systematically measure and analyze HEDIS, CAHPS, 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, (2) member feedback, (3) grievance and appeals data and (4) quality of care complaint(s)
• Monitor and maintain safety measures and address identified problems
• Conduct an annual practitioner survey to evaluate satisfaction with the medical management process and services
• Monitor access through CHS and Appointment Center reports and identify improvement opportunities, if needed. 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 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. This evaluation must include sufficient detail for HCPF staff to validate the company’s performance according to 42 CFR 438.240, External Quality Review of Medicaid Managed Care Organizations. The annual Program
Impact Analysis and Report will describe performance interventions, program outcomes and the overall impact of the program. Upon request, this information will be made available to practitioners and members at no cost

- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
- Participate in the annual external independent review of quality outcomes. This includes but is not limited to any or all of the following: (1) medical record review, (2) performance improvement projects and studies, (3) surveys, (4) calculation and audit of quality and utilization indicators, (5) administrative data analyses, and (6) review of individual cases. For external review of activities involving medical record review, the Company will be responsible for obtaining copies of records from the sites in which services occurred
- Participate in the development and design of appropriate external independent studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department
- Integrate Managed Care QI activities with those of the Denver Health Ambulatory Care Services (ACS) and the DHHA Clinical Performance and Safety Improvement (CPSI) Department’s QI Committees
- The Company participates in the State Integrated Quality Improvement Committee (IQuiC) to provide input and feedback regarding QI priorities, performance improvement and measurement

IV. Program Scope

To effectively formulate projects, the QI Department uses clinical and service performance benchmarks established by the State of Colorado and best-practices literature. 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
- Preventive Health Promotion
- Patient Safety
- Health Management
- Adequacy and Availability of Services
- Clinical and Practice Guidelines
- Continuity and Coordination of Care
- Quality of Care Complaints
- Member Satisfaction
- Practitioner Satisfaction
- EPSDT
Cultural and Linguistic Objectives

The QI Program continuously monitors the cultural and linguistic needs of its membership. Objectives include:

- Ensure that limited English proficient (LEP) members receive the same scope and quality of health care services that other non-LEP members receive by providing Linguistic Services (oral and written)
- Ensure the availability and accessibility of cultural and linguistic services including quality interpretation and translation of written materials in members’ preferred language and format
- Promote effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources
- Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the Company’s planning and operations
- Continue to address CLAS, and language need through NCQA standards.

Targeted efforts are performed to address identified CLAS needs:

- All member written materials for prevalent populations (≥ 500 members) are translated and made available to members in their 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
- Company will maintain a library of culturally sensitive health prevention and education materials for use in member mailings and posted on the website
- Promote a “plain language culture”
- Bring awareness of communication techniques used between employees and our members
- Educate employees on the use of health literacy readability software to develop Medicaid and CHP+ documents with a readability score of 6th-grade or lower
- Create materials that comply with these regulatory requirements
- Nominate a “champion” of Health Literacy in each DHMP department who serves as subject material expert on readability and who can assist with the use of readability software

Patient Safety

QI works collaboratively with Utilization and Case Management, Pharmacy, and Health Management to provide clinical quality monitoring and identification of member safety performance improvement opportunities. QI facilitates the evaluation of quality of care complaints and any resulting corrective action plans. Additionally, the Quality program implements and provides organizational support for ongoing safety and quality performance initiatives. These initiatives relate to care processes, treatments, services, 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 quality improvement activities on improving patient safety by analyzing and evaluating data related to clinical safety
- Trend adverse events reporting in safety practices (e.g. medication errors)
- Annually review and evaluate clinical practice guidelines to ensure safe practices

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 continuous quality improvement 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 Denver Health and Hospital Authority
- 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 - This team provides and analyzes data driven performance measures and tracks quality indicators. Examples include Emergency Medical Services, Clinical Triggers, Soarian Quality Measures

Care Coordination

In October 2016, CCM for Medicaid Choice and DHMP CHP+ was moved to the DHHA Ambulatory Care Services (ACS) group to maximize the value proposition of CCM by providing care coordination at the Patient Centered Medical Home (PCMH). ACS and DHMP have collaborated to describe the integrated care coordination approach for patients receiving outpatient services within Denver Health’s care delivery system.

Program Scope

All established patients in primary care are assigned a medical home and primary care team that is responsible for providing panel management services to ensure receipt of appropriate preventive care services, disease management, addressing gaps in care and identifying opportunities for care coordination. The primary care team is acutely aware of each patient’s needs including providing necessary care as well as identifying and outreaching patients about care that they may not know they need. Additionally, DH systems can flag suboptimal lab values, prescriptions that have not been renewed, needed vaccinations or referrals for services that have not been made. In the PCMH model, the patient recognizes the primary care team as their “go to” team for all components of their health care but may need very little support to maintain good health. Denver Health is outreaching to patients within 90 days of enrollment to attempt to complete a health risk assessment and screen for special health care needs. The outcomes of this assessment are forwarded to appropriate care team members for further evaluation and patient outreach when needed.

Patients receiving care at DH interact with providers in a variety of ways and each of these interactions may contribute to the development of a care plan. Care plans provide a patient-focused “road map” of interventions and activities to improve management of health. The essential elements of a care plan may include opportunities/needs gathered through health assessments and screenings, individualized comprehensive needs assessments, assessments from other sources, analytics and utilization data, medical record review and/or input from the patient and their providers. Compiling information from a variety of sources helps to ensure a thorough review and understanding of a patient’s needs. DH staff work with patients and authorized family or caregivers to develop an individualized, patient-centered plan of care that includes personal health care preferences, opportunities, goals, activities and outcomes. Barriers are routinely discussed throughout the care planning process to help patients and care providers understand what areas might prevent successful accomplishment of healthcare goals and/or participation in the care plan process. Social determinants of health are being assessed and all
care coordination is being captured in a longitudinal plan of care which displays in the electronic medical record.

Care plans are developed for patients regardless of risk stratification category. While most pediatric and targeted adult patients receive a low-risk care plan focused primarily on self-management and health maintenance, patients in the Intensive Outpatient Clinic or Children with Special Health Care Needs Clinic receive a high-risk comprehensive individualized care plan that includes more intensive care coordination and case management interventions which includes treatment objectives, treatment follow-up, outcomes monitoring and updating the care plan as necessary.

Referral coordination assists patients requiring health care services from multiple providers, facilities and agencies, to obtain those services and to coordinate with behavioral health organizations, specialty services, and social services provided through community agencies and organizations. Community referrals are being created and tracked in the electronic medical system. Electronic referrals are also being utilized to promote continuity of care and cost-effectiveness of care.

Disease management services include patient education and between-visit care to manage conditions such as asthma, hypertension, diabetes and depression. DH's primary care staffing model includes an enhanced care team that consists of patient navigators, clinical pharmacists for adults, nurse care coordinators for pediatrics, as well as social workers and behavioral health consultants to optimize clinical visits and support referred patients between visits or after care transitions. Other care providers may also be involved in the provision of disease management services. For example, Managed Care has numerous disease management programs that target physical and behavioral health conditions. Similarly, DH's Acute Hospital Care Management team may be involved in disease teaching and education as part of an inpatient admission. Some of the disease management activities at DH may include:

- Integrated Behavioral Health
- Tobacco Cessation Clinic
- Healthy Hearts – Cardiovascular Care
- Hepatology – HepC Program
- Pharmacotherapy Management

Typically, transitions of care fall into two broad categories (planned and unplanned) and may occur between different care sites (hospital, home, skilled-nursing facilities, non-DH providers). DH’s integrated care management model utilizes resources and services to actively identify and coordinate transitions of care for patients to reduce readmissions, improve quality of care and improve patient and family satisfaction. A Care Navigator outreaches justice involved individuals to help coordinate care and provide referrals for Medicaid enrollment to provide better care continuity of medically necessary services.

Patients who are identified as high-risk/medically complex and needing comprehensive care management services have a multidisciplinary care team available for support in managing their health. DH provides these services to patients with the highest risk primarily through high intensity treatment
teams and integrated behavioral health visits. These teams work closely together to provide comprehensive coordination across the continuum of care and assist with ongoing management of complex needs. This coordinated, team-based approach to care is designed to manage comprehensive medical, social, and mental health conditions more effectively. These teams often include primary care providers, nursing, behavioral health clinician (psychology, psychiatry), clinical social worker, certified addictions counselor (CAC), patient navigator and support staff. High risk clinics are the: Children with Special Health Care Needs Clinic; HIV Primary Care Clinic and the Center for Positive Health; Geriatric Clinic; and Intensive Outpatient Clinic.

DHMP’s Health Management Department (HMD) consists of disease management, health and wellness and prevention, and complex case management programs. All of these programs are considered to be an “opt-out” service available to all plan members, placed within the Denver Health and Hospital Authority (DHHA) system and overseen by Denver Health Medical Plan (DHMP). The HMD provides evidence-based wellness and health promotion services to improve patient outcomes and reduce costs. HMD is responsible for the ongoing development and evaluation of:

- Population based disease management
- Chronic care improvement programs
- Health promotion interventions
- Full range of preventative services

These interventions help members to develop the skills necessary for making healthy choices and lifestyle changes to effectively self-manage physical and behavioral health conditions. Ongoing programs include:

- Health coaching
- Education and support groups
- Support integrated primary care
- Health communication strategies

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

Health Coaching
The HMD offers health coaching to members with the following chronic diseases: asthma, depression, diabetes (DM), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and hypertension (HTN). Additionally, health coaching includes a preventive health component to address alcohol, tobacco and substance use and to encourage physical activity for weight reduction and general health.

Emotional Well-Being Program
The Emotional Well-Being Program assists members with depression and/or anxiety. This program assists practitioners in the management of these conditions in the primary care setting by: (1)
performing more comprehensive psychiatric assessments, (2) monitoring depression and anxiety outcomes and providing ongoing medication management recommendations, (3) monitoring and improving medication adherence, and (4) enabling patients to develop and implement a self-care plan. Members can opt to receive this program via telephone and this option reduces barriers to care such as access, lack of transportation, lack of childcare, and financial constraints.

**National Diabetes Prevention Program**
The National Diabetes Prevention Program is available to help our members lose weight and prevent diabetes. The program offers 24 group classes over a full year and one-on-one attention from expert lifestyle coaches.

**Preventive Health Guidelines and Promotion**
In order to improve preventive health, the QI Department ensures that preventive health guidelines are communicated to practitioners, members, non-members and the public at no cost to the individual or provider. The QI Program continues to develop, update and measure compliance with preventive health guidelines annually. The QI Program works collaboratively with other departments on an as-needed basis, determined by population data, HEDIS, and review of health risk assessments.

**Tele-Counseling**
The mission of the Tele-Counseling Program is to provide access to quality behavioral health services to patients regardless of their ability to pay and to those who have barriers to getting care in their medical home. The Tele-Counseling Program provides up to 10 counseling sessions over the phone to patients over the age of 15. Counseling services are provided by bilingual (Spanish/English) master’s level clinicians. Cognitive-behavioral interventions are used to help manage symptoms of depression and anxiety. There is no cost for patients to participate in the program. The duration of each session is 20-30 minutes. Clinical effectiveness is measured using the PHQ-9, GAD-7, and PROMIS.

**Goals and Objectives**
In FY 2018-19, DHMP is assuming responsibility for the Medicaid Choice and Child Health Plan Plus contracts. DHMP will continue to collaborate with ACS in the provision of care coordination and quality improvement services and programs for patients and members. In addition, care coordination was identified as an area of operational excellence for Denver Health in 2018 and additional focus and resources will be allocated to help develop a comprehensive and robust care coordination system that spans across DHMP and ACS for seamless coverage to patients and members. A dashboard with operational metrics is part of this initiative with regular review by leadership teams.

ACS recognizes opportunities for quality improvement in 2018-19 and the following key initiatives are planned with executive support:

- Risk stratification will continue to evolve with a new iteration of patient tiering and efforts underway to DHMP risk stratification data.
- A Transition of Care, Care Coordination and Continuity of Care Policy has been drafted and work
will continue to get this policy updated and implemented for DH.

- A high risk care coordination program is under development in ACS with a program description and 6-month plan for hiring new care coordinators and implementing high risk care coordination initiatives.
- An ACS care services care plan policy has been drafted and training is being created to educate all of ACS on the electronic care plan and its components.
- An onboarding assessment for all DHMP Medicaid Choice members has been automated and calls are automatically going out to new enrollees each month. Results are forwarded to appropriate staff at DHMP and members are offered the opportunity to complete a health needs survey. ACS staff are outreaching based on survey results.

Adequacy and Availability of Service

The Company will establish, monitor, and implement improvement processes to ensure compliance with regulatory and contractual requirements regarding access standards and guidelines for members. Standards and guidelines include: (1) geographic distribution of providers, (2) provider/member ratios for PCPs and specialists, (3) timeliness of appointments for primary care, (4) access to after-hours care, and (5) key elements of telephone service, including responsiveness of the Company’s Members Services Department telephone lines.

The Company will continue its Open Shopper Study to evaluate the processes members undertake to reach a live representative for availability to schedule appointments and the ease of access to make an appointment. This collection of data is shared with the QMC and Network Management Committee to develop opportunities for improvement and corrective actions when appropriate. The Company 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

On an annual basis, the Company will notify all practitioners and members about how to obtain clinical practice guidelines. Practice guidelines are based on valid and reliable clinical evidence and/or a consensus of health care professionals in a particular field. The QI team, in the development of clinical practice guidelines, considers the needs of Medicaid Choice and CHP+ members. The Company will consult with practitioners to develop and apply evidence-based clinical standards in an annual review/update.

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

- Developing new clinical guidelines where opportunities for improving clinical practice align with benefits
- Assure member benefit coverage for any elements of guidelines adopted
- When appropriate, consult guidelines for Quality Improvement Activities/Quality Improvement Projects
• Evaluate the appropriateness and usefulness of the guidelines annually

Continuity and Coordination of Care

Appropriate staff will identify opportunities for improvement in the coordination of medical care. Staff will facilitate transition of care for all new and existing members across the continuum. The following opportunity for improvement in the coordination of care is currently being addressed:

• Improve continuity and coordination of care between unique health care providers to assure timely and accurate communication

Appropriate staff will identify additional opportunities for improving continuity and coordination of care.

The QI Department works in collaboration with the Utilization and Case Management and Care Coordination Departments to actively monitor and improve continuity/coordination of care across the health care network. The Company identifies opportunities to improve coordination of medical care via causal analysis of data and acts upon those opportunities. The QI Department annually collects and reports out HEDIS data according to the Company’s contract requirements. Staff members analyze HEDIS data to identify opportunities to improve all measures. QI places a special emphasis on diabetes, cardiovascular conditions, asthma, behavioral health and preventive care. Each year the quality team initiates or continues 1-2 performance improvement projects (PIP) focused on clinical and/or non-clinical areas to improve member quality of care and service. These two projects are directed by CMS and contract requirements. All Company QI activities related to Company members undergo the Denver Health “plan, do, study, act” methodology to ensure proper intervention handling.

The QI Department, through Clinical Nursing staff, along with the Company Medical Director, investigates any potential quality of care complaints (QOCC) from members, providers, or CMS. QI tracks and trends all QOCCs and reports them to both the Company QMC and the Company Board of Directors. If a QOCC is substantiated, the QI Department will implement a corrective action plan if the concern relates to a system wide issue or with an individual practitioner, as appropriate. The Medical Director reports all substantiated QOCC grievances regarding providers to the Denver Health Patient Safety Committee or other delegated entity for follow-up, as appropriate. If necessary, these groups will evaluate claims for re-credentialing purposes.

Member Satisfaction

The Company 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 measure, a corrective action plan will be established with regular monitoring of progress. The QI Project Manager assesses CAHPS data to identify opportunities for improvement, new initiatives and activities. Additionally, the Medical Director, Clinical Nursing staff
supporting the QOCC process, and the QI Department continuously monitor and trend all member QOCC’s.

The Member Services Department provides customer-focused services. Additionally, the Company evaluates and trends member appeals, grievances, availability and accessibility, and the quality and appropriateness of care for persons with special health care needs. The Company analyzes member enrollment data and reasons for disenrollment on an ongoing base. Annually, the Company communicates the QI program goals to its members through the member newsletter, the Company website, and other mailings.

Practitioner Satisfaction

Annually, the UM Department administers a practitioner survey to assess the level of satisfaction practitioners have with Company services and processes. The Company analyzes the results and puts necessary process improvements in place when deemed appropriate. Additionally, the Company communicates the QI program goals, processes, and outcomes to its DHHA and external practitioners through the practitioner newsletter, the Company website and other mailings annually. The UM Department monitors practitioner complaints and makes appropriate improvements.

Credentialing and Delegated Credentialing

The Medical Compliance Specialist assures the compliance of credentialing and re-credentialing activities align with CMS standards. The specialist also conducts primary source verification for any direct credentialed practitioner. The specialist will evaluate delegated entity’s credentialing compliance with the Company credentialing and re-credentialing standards annually. Additionally, the specialist will conduct site visits for any practitioner’s office site (primary and specialty) that exceeds the acceptable threshold for grievances related to physical accessibility, physical appearance, and adequacy of the waiting and exam room space. The specialist will then report audit results to the Credentialing Subcommittee of the Company QMC. Additionally, the specialist evaluates practitioner contracts for compliance with credentialing standards’ prior contract approval and includes behavioral health practices for CHP+ in credentialing activities. The specialist conducts an assessment of organizational facilities for contracting compliance, as well as provides ongoing monitoring of practitioner complaints and sanctions for re-credentialing purposes.

Delegation Activities and Oversight

Credentialing provides delegation oversight and vendor/subcontractor management with respect to regulatory, contractual, and performance oversight reports, for credentialing and recredentialing, to the Compliance Committee on a quarterly basis. Furthermore, the Operations Team has administrative responsibility for the implementation and maintenance and oversight of all delegated activities.
V. Quality Improvement Program Annual Workplan and Evaluation

Annual Work Plan

QI Department will develop a QI Workplan annually. The QI Workplan will begin in August of every year. The QI Network Adequacy report will begin in July of every year and be conducted quarterly. The Workplan covers the scope of the QI Program and includes:

- Measurable yearly objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities with department such as, but not limited to: Health Management and Utilization and Case Management
- Yearly objectives and planned activities, time frames for completion, and responsible staff
- Monitoring of previously identified issues
- Communicated to members, providers and the community via the Quality Improvement website

Annual Evaluation

The QI Program submits an annual evaluation (Impact Analysis) to the QMC, the Company Board of Directors, and HCPF. The QI Evaluation will begin in August of every year. This document is the basis for the upcoming year’s work plan.

The QI 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 benchmarks
- Analysis of improvement, including barrier analysis when goals are not met. Relevant practitioners or staff who had direct experience with the processes present possible barriers to improvement and provide recommendations for addressing those barriers
- 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
- The modifications of program descriptions and work plans will also incorporate advice, recommendations, or mandates from external auditors and/or regulatory bodies
- Communicated to members, providers and the community via the Quality Improvement website