DENVER HEALTH MEDICAL PLAN, INC. (DHMP) & DENVER HEALTH (DH) MEDICAID CHOICE
Medicaid Choice (MCD) & Child Health Plan Plus (CHP+) Quality Improvement (QI) Work Plan
2020-2021

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
QUALITY IMPROVEMENT PROGRAM STRUCTURE								
***2020-2021 Quality Improvement Program Description**	The QI Program Description is reviewed annually and updated according to national and state standards and guidelines. The QI program scope, goals, objectives and structure are evaluated to assure regulatory compliance. 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, as well as the reporting relationship between the QI Department and the Quality Management Committee (QMC).	**Annually** **Program must include the following requirements:** • Program structure • How patient safety is addressed • How the designated physician is involved • Oversight of QI functions by QMC • Annual work plan • Objectives for serving a culturally- and linguistically-diverse Membership • Objectives for serving Members with complex health needs	**Objective:** • All requirements must be met • Reviewed and updated annually • Submitted to the QMC and the State	Annually	QI Director	8/2020	9/2020	QMC, DHMP Board of Directors
***2020-2021 Quality Improvement Work Plan**	The QI Work Plan is developed after review of previous year's QI Work Plan. The revised Work Plan is crafted after review of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results along with the overall goals, objectives and structure of DHMP. This Work Plan is a dynamic document that is frequently updated to reflect progress on QI activities throughout the year. All yearly objectives must be measureable and analyzed annually during the QI Program Evaluation/Impact Analysis.	**Work Plan must address:** • Quality of Clinical Care (QOCC) • Quality of Service • Safety of Clinical Care • Program Scope • Yearly Objectives • Yearly Planned Activities • Time Frame within which each activity is to be achieved • The staff Member responsible for each activity • Monitoring previously identified issues • Evaluation of the QI Program • Member's Experience/Satisfaction	**Objective**: • All requirements must be met • Yearly objectives must be measureable • Submitted to the QMC and the State	Annually	QI Director	8/2020	9/2020	QMC, DHMP Board of Directors
***2019-2020 Quality Improvement Program Evaluation/Impact Analysis (includes all indicators for the present year)**	The QI Program Evaluation/Impact Analysis 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 safety • Analysis and evaluation of the overall effectiveness of the QI Program, including	**For all goals not met:** • QI must conduct a root cause or barrier analysis to identify the underlying reasons • Analysis must include organizational staff that has direct experience with the processes that have presented barriers to improvement	Annually	QI Director	7/2020	9/2020	QMC, DHMP Board of Directors

***Previously Monitored**

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		progress toward influencing network-wide safe clinical practices						
***2020 CY19-20 Strategic Access Plan**	The Provider Relations and Contracts and Credentialing Department works to ensure the DHMP network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to Members. This access report contains : • Adjustment of availability of practitioners within network, if necessary • Determination of the types of practitioners who serve as high-volume specialty care practitioners and high-volume behavioral health care practitioners • Measurable and quantifiable standards for the number of practitioners of general or family medicine, internal medicine, pediatrics, high-volume specialty care practitioners and high-volume behavioral healthcare practitioners • Quantifiable and measurable geographic distribution of each type of practitioner providing primary care, high-volume specialty care and high-volume behavioral health care • DHMP will analyze annual performance against standards located in our access and availability of practitioner policy and procedure	Comprehensive evaluation of network adequacy. This includes: Primary Care Provider (PCP) to Member Ratio, Specialist Provider to Member Ratio, Access Availability and Geographic Access Availability. **Annually**: • Establish, monitor and implement improvement processes, as necessary, to ensure compliance with access standards for Members	**Objective**: • All contractual requirements are met • Continue to focus on access and availability, monitor grievances and experience/satisfaction surveys	Annually	QI Director Information systems (IS) Department Government Product Line Manager(s) Provider Relations and Contracts and Credentialing Director	8/2020	9/2020	QMC, DHMP Board of Directors

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QI PROGRAM OPERATIONS								
Quality Management Committee (QMC)	The QMC acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to Members.	**Committee functions include:** • Recommends policy decisions • Analyzes and evaluates the results of QI activities • Ensures practitioner participation in the QI Program through planning, design, implementation or review • Identifies needed actions • Ensures follow up, as needed	**Goal**: • Committee demonstrates activities and the participation of required Members (both DHMP employees and providers) by presenting clear and accurate records of minutes	Bimonthly	QI Director	Ongoing	Ongoing	QMC, DHMP QI Director
State QI Meetings: Health Care Policy & Finance (HCPF)	The Integrated Quality Improvement Committee (IQuIC) is a partnership with the physical health organizations, the External Quality Review Organization (EQRO), the Department and community to examine quality within existing and new systems of service and identify potential opportunities for improvement.	**Procedure**: • Bimonthly participation in the HCPF/IQuIC meeting • Work collaboratively with HCPF and other plans on statewide initiatives • Discuss QI initiatives and participate with other Medicaid/CHP+ plans	**Goals**: Increase the quality of care for Members across all quality measures: • HEDIS • CAHPS • Performance Improvement Projects (PIPs) • Technical Reports	Bimonthly	QI Director QI Designee *State Contact: Jerry Ware	Ongoing	Ongoing	QI Director, DHMP Medical Director, HCPF
Ambulatory QI Committee (AQIC) with Community Health Services (CHS)	Discuss collaborative interventions with CHS. Participate in work groups that will focus on diabetes, asthma, hypertension, well visits/preventative screenings, adult and pediatric immunizations, obesity and smoking cessation.	**Functions include**: • Collaborate on interventions to reduce redundancy and increase impact • Review HEDIS, CAHPS, PIPs and focused studies	**Goal**: • Review and recommend actions for collaborative interventions using HEDIS, CAHPS, PIPs, focused studies and appropriate resources • Evaluate resources to reduce redundancy and increase overall impact of interventions	Monthly	QI Director Medical Director	Ongoing	Ongoing	DHMP QI Director
QUALITY OF CLINICAL CARE								
***2021 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis**	HEDIS is a quality requirement program that determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of 92 measures that span six (6) domains of care that allow for comparison of quality performance nationally across health plans.	**Procedure**: • HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures • Data validation prior to submission date	**Objective**: Evidence of annual analysis includes: • Presentation to the QMC • Qualitative and quantitative analysis to identify opportunities for improvement	Annually	QI Director	12/2020	7/2021	QMC

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		• Meet submission deadline • Data from the HEDIS project is analyzed to determine areas of intervention and improvement	must be documented in the QMC Minutes • Decrease medical record non-compliance • To measure effectiveness of intervention, analysis will be accomplished by comparing 2020 results against 2021 results					
***Quality of Care Concerns (QOCCs)**	The Medical Director and Registered Nurse (RN) staffing support appropriately investigate potential QOCC's and all quality of care related reportable events.	**QOCC Timeframe requirements:** • Acknowledgment Letter: Two (2) business days • Expedited Response: 72hrs. • Standard Response: 30 calendar days • Extension Letter: 14 calendar days Review, track, trend all quality of care related reportable events, and perform any needed follow up actions	**Goal**: • 100% Timeframe Compliance	Quarterly	QI Director Medical Director	Ongoing	Ongoing	QMC
Healthcare Effectiveness Data and Information Set (HEDIS) Summer Run	Full HEDIS run for the purpose of creating supplemental data sources for HEDIS 2020 (data year 2019) (Medical record review).	Records will be requested and chased prior to the regular HEDIS season. This will give QI an indication of how HEDIS care measures may score in 2020 (data year 2020)	**Goals**: • Increase eye exam for Comprehensive Diabetes Care(CDC) and well child visits measures • Identify individuals who have not gone in for a doctor's visit for the year and engage in outreach efforts to get them in	N/A	QI Director HEDIS Program Manager (PM) Medical Record Reviewer Staff	8/2020	12/2020	DHMP Medical Director
***External Healthcare Effectiveness Data and**	Annual evaluation of HEDIS processes and data collection according to HEDIS and External Quality Review Organization EQRO protocols.	**Annually**: • Audited by Attest, an NCQA-Accredited audit Vendor	**Goals**: • Pass all quality standards for medical record review	Annually	QI Director HEDIS PM	3/2021	7/2021	DHMP Medical Director, DHMP QI

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Information Set (HEDIS) Audit								Director
***Adoption and Distribution of Clinical Practice and Preventive Health Guidelines**	DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its Members 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 and/or from involvement of board-certified practitioners from appropriate specialties.	**Clinical practice and preventive health guidelines 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	**Objective:** **Adoption and dissemination by:** • Establishing the clinical/scientific basis for the guidelines • Updating the guidelines annually • Distributing guidelines to appropriate practitioners	Annually	QI Director	1/2021	12/2021	QMC
***Evaluating Utilization Management (UM) Criteria**	Utilization Management (UM) conducts an annual review of the criteria and the procedures for applying them, and updates the criteria when appropriate.	**The UM Department has:** • Written UM decision-making criteria that are objective and based on medical evidence • Has written policies for applying the criteria based on individual needs • Has written policies for applying the criteria based on an assessment of the local delivery system involves appropriate practitioners in developing, adopting and reviewing criteria	**Goal**: Criteria must consider at least the following when being applied to a given individual: • Is this a Benefit? • Is this In-Network? • Is this Medically Necessary?	Annually	Director of UM	8/2020	8/2021	QMC Medical Management Committee (MMC)
***Monitoring Consistency of Applying Utilization Management (UM) Criteria**	HPMM monitors and reviews the 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 HPMM Department annually:** • Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making • Acts on opportunities to improve consistency, if applicable	**Goal**: • 80% accuracy rate for Criteria Application	Annually	Director of UM	8/2020	8/2021	QMC MMC
***Monitoring of Formulary and Pharmaceutical Management Procedures**	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee (P&T) on an annual basis for review and discussion. Minutes from the P&T are presented and reviewed at the QMC on a monthly basis. The review of the formulary and pharmaceutical management procedures is documented in the P&T Minutes.	**Pharmacy Department annually:** • Reviews the procedures • Reviews the list of pharmaceuticals • Updates the pharmaceutical management procedures, as appropriate	**Goal**: • Must present and review all pharmaceutical management procedures annually to address areas for improvement	Annually	Director of Pharmacy	11/2020	3/2021	MMC P&T

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Unempaneled Population Strategy for MCD and CHP+	Understand and prioritize opportunity for Clinical Quality Improvement (CQI) in portion of MCD and CHP+ population that has not been seen at DH provider or system in the last 18 months	1. Plan and implement identified opportunities, possibly including: a. Member Roster loading into Epic to create care delivery system record b. Pilot a CHP+ Member prompt for PCP affiliation on inbound calls c. Adding a prompt in the Health Needs Assessment (HNA) process for Members to help them find a PCP d. Member education for helping Members find a PCP e. ACS-based text message outreach campaign for new RAE Members this month; sending a welcome text with the phone number for the appointment line, the phone number for a central Care Navigator, if needed, and a link to schedule directly in MyChart	Reach improvement goals: • Empanelment of CHP+ Members Goal = 63% • Empanelment of MCD Members Goal = 59% per the new process referenced above, this goal is a little different since it was based on members without a PCP visit, goal is outreach to them and get as many as possible empaneled.	Bimonthly	QI Director MCD/CHP product line manager IS Analyst Various Department Leaders ACS Leadership EPICACS Team	8/2020	12/2021	DHMP CEO DHMP Medical Director
***Healthcare Effectiveness Data and Information Set (HEDIS) Impact: Breast Cancer Screening –MCD**	Every month a list will be drawn from the data warehouse, and run against claims and the active Member's list using the BI Portal. All MCD women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment either with Radiology or the DH's Women's Mobile Clinic. In the 2019-2020 FY, 8,328 Medicaid Members were sent Mammogram mailers.	**QI Department:** • Conducts monthly data pull • Defines eligible participants • Works with Marketing Department to distribute mailings	**MCD:** HEDIS 2020- 46.01% 2019 Current Benchmark: <10th Percentile 2021 HEDIS Goal – 49.01% (10th percentile)	Annually	Intervention Manager	7/2020	6/2021	QMC

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***Healthcare Effectiveness Data and Information Set (HEDIS) Impact: Prenatal and Postpartum Care (PPC)**	The DHMP QI Department is collaborating with the DHHA Perinatal Committee on an ongoing basis to identify opportunities and best practice interventions to improve prenatal and postpartum rates.	• Ongoing Perinatal Work Group participation • Perinatal workgroup focus on improving OB intake (OBI) visit timeliness and to improve engagement for ongoing prenatal care	**Post-Partum** • 2020 HEDIS 77.62% (90th percentile) **Goal**: • 2021 HEDIS 80.62% (95th percentile) **Prenatal Care** – Timeliness of Care in 1st Trimester • 2020 HEDIS 91.73% (90th percentile) **Goal**: • 2021 HEDIS 94.73% (95th percentile)	Annually	QI Director ACS Perinatal Work Group	Ongoing	Ongoing	QMC
QUALITY OF CLINICAL CARE								
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – The Centers for Medicare & Medicaid Services (CMS) 416 Report	CMS requires annual reporting of EPSDT screening ratios for children ages 0-20.	Annually, DHMP reports EPSDT screening ratios according to the CMS 416 Form specifications and reports annually to HCPF. EPSDT Screening Ratios are the percentage of Members who had the expected number of initial and periodic screenings per age group, adjusted by the proportion of the year for which they are MCD-eligible for DHMP.	**MCD:** **Percentage of Members 0-20 years who received expected screenings** • 2018-2019 CY 58% **CMS 2019-2020 CY Goal:** • 61%	Annually	Intervention Manager	10/2019	02/2020	HCPF/CMS
EPSDT Detail Report	A DHHA Ambulatory Care Services (ACS) Bright Futures dashboard was created in 2019 to help monitor and improve these metrics. This system-wide pediatric view includes: Pediatric Vaccinations- Combo 10. Pediatric Vaccinations – Combo 7, Adolescent Vaccinations, Dental Visit or Fluoride application once by 18 months, Persistent Asthma on Controller medication 2-18 years, Developmental Screening 12-36 months, MCHAT screening, Six Well-Child visits before 15 months, Well-Child	• Review of current performance • Data analytics mining for potential collaborative intervention opportunities	**MCD:** Pediatric Vaccinations- Combo 10 June 2020 CHS: 55% Pediatric Vaccinations – Combo 7 June 2020 CHS: 72% Adolescent Vaccinations June 2020 CHS: 88% Dental Visit or Fluoride application	Annually	QI Intervention Manager ACS Pediatric Workgroup	2/2019	7/2020	QMC

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	visit rate – 3-6 years of age, Well-Child visit rate – 3-9 years of age, Well-Child visit rate 10-18 years of age, Measles Vaccination Rate at 2-years old, Depression Screening/Monitoring at Visit – Adolescents, Depression Screen and Follow-up Plan if Positive, Hearing Screening – pediatrics, Vision Screening- Pediatrics, Chlamydia Screening – Adolescents, Chlamydia Screening at Visit 14-24 years, HIV Screening – Adolescents, Lead Screening – Pediatrics, Cholesterol Screening-Pediatrics and Anemia Screening – Pediatrics. The dashboard provides a comprehensive view of these metrics for all clinics including provider-level performance on each metric. The DHMP QI team will continue to monitor performance on these metrics and evaluate the data for opportunities for improvement.		once by 18 months June 2020 CHS: 89% Persistent asthma on controller medication 2-18 years June 2020 CHS: 79% Developmental Screening 12-36 months June 2020 CHS: 95% MCHAT screening June 2020 CHS: 90% Six Well-Child visits before 15 months June 2020 CHS: 59% Well-Child visit rate – 3-6 years of age June 2020 CHS: 73% Well-Child visit rate – 3-9 years of age June 2020 CHS: 69% Well-Child visit rate 10-18 years of age June 2020 CHS: 69% Measles Vaccination Rate at 2-years old June 2020 CHS: 95% Depression Screening/Monitoring at Visit – Adolescents June 2020 CHS: 52% Depression Screen and Follow-up					

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			Plan if Positive – June 2020: 68% Hearing Screening – pediatrics June 2020 CHS: 80% Vision Screening- Pediatrics June 2020 CHS: 76% Chlamydia Screening – Adolescents June 2020 CHS: 26% Chlamydia Screening at Visit 14-24 years June 2020: 78% HIV Screening – Adolescents June 2020 CHS: 36% Lead Screening – Pediatrics June 2020 CHS: 52% Cholesterol Screening-Pediatrics June 2020 CHS: 31% Anemia Screening – Pediatrics June 2020 CHS: 55%					
***Child Annual Visit: Birthday Card)**	Children 2-19- years of age receive a birthday card informing them to come for their annual visit. These mailings have been going out to Members since January 2009. This intervention has been shown to increase well-child visit rate within 2 months of the Member's birthday. For FY2019-2020, the Company mailed an average of 2,663 birthday cards a month to Medicaid Choice Members and an average of 387 birthday cards a month to CHP+ Members. As a result of the COVID-	**Monthly Procedure:** • QI team pulls data from custom BI report • QI cleans data and separates by age group to ensure appropriate well child visit messaging • QI sends to the printer and they are mailed to Members	**Medicaid:** **Well-Child Visits:** •HEDIS 2020 W34: 64.53% (<10TH percentile) •HEDIS 2020 AWC: 40.10% (<10th percentile) **GOALS:** •HEDIS 2021 W34 Goal: 67.53%% (25th percentile) •HEDIS 2021 AWC Goal: 43.10%	Annually	QI Intervention Manager	Ongoing	Ongoing	QMC

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	19 pandemic, Healthy Heroes reminder cards were not sent for April and May as most DHHA clinics were not scheduling non-essential visits. QI reviews the postcard annually to ensure that it includes age-appropriate checklist of different things the provider will cover in a well-child visit as a way to engage the patient and ensure all HEDIS components are covered. QI and Marketing redesigned the postcard artwork to include School Based Health Center and to remove reference to Healthy Communities		(25th percentile) **CHP+:** **Well Child Visits** • HEDIS 2020 W34: 71.33% (25th percentile) • HEDIS 2020 AWC: 52.41% (25th percentile) **GOALS:** • HEDIS 2021 W34 Goal: 74.33% (50th percentile) • HEDIS 2021 AWC Goal: 55.41% (55th percentile)					
QUALITY OF CLINICAL CARE								
*** School Based Health Clinics (SBHC) - Well Child Visit support**	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 and are consented to be seen at a school based clinic, 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):** During the school year, QI sends the SBHC Program Manager a list of children on our medical plans that are enrolled in the SHBC program, who still need to complete their annual well visit for the year	**Well Child Visits:** **<u>Medicaid:</u>** **2020 WCC:** • Counseling for Physical Activity : 8.08% (<10th percentile) • BMI Percentile 25.11% (<10th percentile) • Counseling for Nutrition 9.16% (<10th percentile) • **2021 WCC Goal:** • Counseling for Physical Activity 11.08% (<10th percentile) • BMI Percentile 28.11% (<10th percentile)	Monthly	Intervention Manager SBHC Medical Director – Sonja O'Leary	9/2019	3/2020	DHMP QI Director QMC

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			• Counseling for nutrition 12.16% (<10th percentile) • **2020 AWC:** 40.10%% (<10th percentile) • **AWC Goal:** 43.10% (10th percentile) **CHP+:** **2020 WCC:** • Counseling for Physical Activity 7.41% (<10th percentile) • BMI Percentile 23.81% (<10th percentile) • Counseling for Nutrition 8.31% (<10th percentile) **2021 WCC Goal:** • Counseling for Physical Activity 10.41% (>10th percentile) • BMI Percentile 26.81% (>10th percentile) • Counseling for Nutrition 11.31% (>10th percentile) • **2020 AWC**: 52.41% (25th percentile) **2021 AWC Goal**: 55.41% (50th percentile)					

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***Cultural and Linguistic Appropriate Services (CLAS): Medicaid Choice and CHP+**	To deliver culturally and linguistically appropriate services to Denver Health Members in accordance with Centers for Medicaid and Medicare (CMS) and the Colorado Department of Health Care Policy (HCPF). As well as continuing to train new staff and conduct annual refresher training related to cultural competency.	**Cultural Competency Training** • Cultural competency training will be made available, to educate providers and staff on the health beliefs held by diverse patient populations and to raise cultural awareness. • Annual analysis will be completed to assess the percent of providers and staff that receive this cultural competency training **CLAS Program Evaluation** • Will engage in annual assessment of the cultural and language needs of Denver Health Member population and subpopulation. Review on-going DHMP interventions as deemed necessary, identifying opportunities for improvement. Must be documented in meeting minutes. • Participate in DHMP's Member Outreach Committee which reviews and coordinates Member communications and will include the formation of a Member Materials Review Committee which will meet quarterly and review DHMP created Member materials for understanding, cultural appropriateness and ease of use. **<u>Interventions</u>** • In FY20/21, in addition to ongoing system wide work to improve COVID-19 outcomes across racial/ethnic groups, DHMP will develop and implement an integrated Population Health Management program for our MCD population with a focus on identifying and eliminating racial and ethnic health disparities. The program will include concerted focus on metrics traditionally associated with high levels of disparities such as, children's wellness exams and	**Goal**: • Maintain CMS and NCQA CLAS related standards • Reduce system wide racial and ethnic disparities in blood pressure control HEDIS measure	Annually	QI Intervention Manager QI Staff	Ongoing	Ongoing	DHMP QI Director QMC BOD

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		immunizations, prenatal care and members with multiple chronic conditions. • The QI team will collaborate with ACS QI leadership on an initiative to address racial and ethnic disparities in blood pressure management seen widely throughout DHHA. Working together, the DHMP QI team and the Cardiovascular Disease ACS QI workgroup will create an intervention to determine root causes of this disparity and create a culturally appropriate intervention to address it.						
Performance Improvement Project	The most recent PIP cycle, a Rapid-Cycle PIP, began in September 2018, with a total timeframe of 18 months, and was scheduled to conclude on June 30, 2020. Health Services Advisory Group (HSAG) determined the topic to be: providing care for adolescent Members due for an Adolescent Well-Care (AWC) check with DHMP choosing to further focus on Members age 15-18. However, due to the impacts of the COVID-19 pandemic, the PIP was prematurely terminated in April 2020. DHMP's 2018 HEDIS rate for Adolescent Well Care (AWC), which measures annual well care attendance rates, was 36.33% for the MCD population and 37.64% in the CHP+ population, placing us in the 5th percentile and 10th percentile, respectively for all health plans nationwide. For this PIP, DHMP worked with the DHHA Webb Pediatric Clinic.	The QI team tested a series of interventions using PDSA cycles. These interventions included utilizing Healthy Communities to call the parent/guardian of members who had a birthday in that calendar month and were due for an AWC and scheduling an appointment for them and working with DHHA's 17 school-based health centers to have consented members receive their AWC at their assigned clinic. We had also hoped to test an intervention utilizing automated text messages sent to the parent/guardian of all MCD/CHP+ members who were overdue for an AWC but this was put on hold due to the suspension of AWC visits during the COVID-19 pandemic. Intervention testing began in September 2019 and concluded in March 2020. Our key findings were that calls by Healthy Communities navigators resulted in a very modest increase in visits but that outreaching to members who were consented to be seen at one of our 17 school-based health clinics was a key driver in improving our completion rates (CHP+ rates improved from 59.73% to 63.54% in just one	**Goals:** The specific goal for this PIP was, by June 30th, 2020, increase the percentage of DH Medicaid Choice and DH CHP+ Members aged 15-18 assigned to the Webb Pediatrics PCMH who attend at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner per year from 51.06% to 56.93% for the MCD population and from 54.36% to 66.44% for the CHP+ population. At the conclusion of the PIP in April, the AWC completion rate for MCD was 53.51%, below the MCD goal of 56.93% but a 3.42% improvement over our base line of 51.06% and for CHP+ was 62.50%, also below the CHP+ goal of 66.44% but an 8.14% improvement over our base line of 54.36%.	Annually and by PIP Module due date	QI Director and QI Intervention Manager	9/2019	4/2020	DHMP QI Director

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		month). A new rapid cycle (18 months) PIP is scheduled to begin in September 2020.						
QUALITY OF CLINICAL CARE								
Care Coordination Updates	In FY 2019-20, DHMP assumed responsibility for the Medicaid Choice and Child Health Plan Plus contracts. In October 2018, DHMP leadership decided that in 2019, PHM activities would be delegated to an external vendor. The scope of work with the vendor was finalized in January 2019, and preparations were made to transition work. In April 2019, the vendor withdrew from the established scope of work and DHMP leadership made the decision to develop Care Coordination programs in-house after this withdrawal. The Care Coordination programs as described above started in July, 2019 and will be fully developed and operational by October, 2019. DHMP continues 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 have been 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	• Risk stratification has a new iteration of Member tiering • Transition of Care, Care Coordination and Continuity of Care Policies are drafted and work will continue to get this policy updated and implemented for DHMP. DHMP is in the process of establishing an external vendor to perform a health risk assessment, screen for special health care needs and ensure continuity of care for new Members who see a specialist outside of the Denver Health network. The vendor will reach out to DHMP Members within 90 days of enrollment. The outcomes of this assessment are forwarded to the DHMP Care Coordination team and the Member's PCMH further evaluation and patient outreach when needed. The Medical Management Platform, Guiding Care, is being upgraded to a newer version and will be fully deployed by mid-September 2020DHMP will use several of the metrics described in the Population Stratification and Segmentation section of this document as metrics for understanding the success of the programs. Program Development: • Development of new Care Coordination	**Goals:** Four priority metrics include: 1. Improve the health outcomes of members with multiple risk factors including chronic medical conditions, poor follow up or engagement with a PCP, opiate use, and behavioral health diagnosis. **Success is measured by**: decreased ED utilization, improved rate of PCP visit within last year, decreased readmission rate, improved rate of follow up with a physician within 30 days after hospital discharge, improved control of chronic condition- For members in this population with a diabetes diagnosis the goal will be to increase the rate of HbA1c testing , the rate of members receiving medical attention for nephropathy and the percent of members with blood pressure under control (<140/90 mm Hg). 2. Increase the number of pregnant members who receive	Annually	Director of Health Plan Medical Management	7/2020	6/2021	QMC

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
	operational metrics is part of this initiative with regular review by leadership teams.	programs for the Medicaid and CHP+ members to include: • Medicaid Care Coordination Program - New program intended to manage high risk Medicaid members with multiple risk factors including chronic diseases, behavioral health conditions and over and under-utilization patterns that increase risk of poor outcomes. • Maternity Case Management Program - New program intended to improve early prenatal care and identification of high risk pregnancies. • Controlling Blood Pressure Program - New program to improve the blood pressure control of our member's by identifying those that are out of control, moderately out of control, or not engaged in care. • Diabetes Care Management Program - New program to improve quality care of Diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. • The Care Coordination team is working on establishing these new programs for our Medicaid and CHP+ members to be in place by October 1, 2020. We are hiring new staff in care coordination to take on these new programs	their first prenatal visit during the first trimester (or within 42 days of enrollment in the plan) **Success is measured by**: increased number of pregnant women engaged in the MCM program • Intervention measure- increased rate of pregnant women attending and receiving prenatal services in the first trimester • Long term Outcomes measure- Decreased Preterm deliveries Success is measured by DHMP's ability to reduce the gap between the DHMP benchmark and the HEDIS National Average Rate for the measure by 10%. Therefore, DHMP aims to increase the Timeliness of Prenatal Care rate from 71.90% to 72.86%.* *This rate is calculated using HEDIS 2019 national benchmarks and HEDIS 2019 DHMP rates for Timeliness of Prenatal Care. If any changes are made to the criteria for this HEDIS measure, these changes with also be integrated					

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			into the criteria for this measure. 3. Increase the percent of children and adolescents (ages 0-21 years) who receive an annual well-child visit. **Success is measured by**: DHMP's ability to reduce the gap between the DHMP benchmark and the HEDIS National Average Rate for the measure by 10%. Therefore, DHMP aims to increase the Well-Child rate from 48.68% to 49.76%.* *This rate is calculated using HEDIS 2019 national benchmarks and HEDIS 2019 DHMP rates. The metric is designed as a roll-up measure based on a weighted combination of the following HEDIS metrics: *Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life,* and Adolescent Well-Care Visits. Age bands for HEDIS Well-Child visit metrics will change for MY2020 and age bands used in the calculation of this metric will change to incorporate the new metrics once that data is available. 4. Housing is Healthcare Pilot –					

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			Identify, locate, and assist 10 chronically homeless members to be given housing vouchers and support systems to improve health outcomes. For many chronically homeless individuals Substance Use Disorder (SUD) is a key contributing factor; therefore, a component of the program will also focus on IET in primary care with a goal to increase the number of members who initiate and engage in treatment for alcohol and substance use disorder within primary care settings. **Success is measured by**: maintaining 10 active participants in the pilot that have improved health outcomes. Health outcomes measured will include but is not limited to: • Number of ED visits • Number of hospitalizations/rehospitalization • Number of detoxification stays • Number of outpatient visits • Time to first hospitalization, ED visit, detoxification stay					

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			• Total Inpatient day • Average Length of Stay • Additional program goals will be to increase the rate of member Initiation and Engagement in Treatment for Alcohol and Substance Use Disorder in primary care settings.					
Population Health	DHMP's approach to population health aims to improve the health of our entire population by focusing on 3 things: health outcomes, patterns of health determinants and policies and interventions. Our goal is to reduce health inequities among different population groups that are due to many factors including but not limited to social determinants of health (SDOH). The PHM Strategy focuses on member needs in four areas which include managing multiple chronic illnesses, managing members with emerging risk, keeping members healthy, and patient safety or outcomes across settings. Within each focus area we target a specific population group with measurable health inequalities, develop interventions then start by measuring processes, then interventions with a final goal of improving outcomes	In order to ensure a consistent process to tracking the progress of initiatives and projects, DHMP utilizes a five phase approach: • Phase 1 – Develop a strategy plan; • Phase 2 – Identify the target population (risk stratification); • Phase 3 – Define program components and build the program; • Phase 4 – Initiate the program and develop baseline; • Phase 5 – Re-measure and repeat as necessary. Measurements will include: Process, intervention and outcome measures that lead us toward our long term outcome goal	• Improve the health outcomes of members with multiple risk factors including chronic medical conditions, poor follow up or engagement with a PCP, opiate use, and behavioral health diagnosis. • Increase the number of pregnant members who receive their first prenatal visit during the first trimester (or within 42 days of enrollment in the plan) • Increase the percent of children and adolescents (ages 0-20 years) who receive an annual well-child visit. • Housing is Healthcare Pilot – Identify, locate, and assist 10 chronically homeless members to be given housing vouchers and support systems to improve health outcomes • Increase the number of members who initiate and engage in treatment for alcohol and substance use disorder	Quarterly	QI Director Medical Director Population Project Managers CM Manager IS Product Line Manager	August 2020	August 2021	Medical Management Committee Quality Management Committee

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			within primary care settings.					
QUALITY OF SERVICE								
***Monitoring Member Satisfaction**	The Company monitors Member satisfaction/Member concerns regarding its services and identifies areas of potential improvement. To assess Member satisfaction/concerns with its services, the Company evaluates Member complaints and appeals.	**Aggregate Member complaints and appeals by reason, showing volumes related to various categories including but not limited to:** • Access • Attitude and Service • Billing and Financial Issues • Quality and Practitioner Office Site • Quality of Services Concerns	**Evidence of monitoring includes:** • Bi-monthly reporting to the QMC of member complaint and appeal volumes and identified trends. For trends requiring intervention, steps taken to correct the issue are reported.	Bi-monthly	Manager of Grievance and Appeals	7/2020	7/2021	QMC
Annual State Audit	Participate in the annual state audit as well as participate in HCPF activities as requested to determine corrective actions plans and/or opportunities for improvement.	**Objective:** Utilizing the state audit tool, the Medical Plan is responsible for collecting and delivering data/documents as evidence to meet standard specifications. Health Services Advisory Group (HSAG) audits the plan on 3-4 standards each year.	**State Audit Goals**: • Pass State Audit and/or • Implement any Corrective Action Plan as required to meet standard	Annually	Government Product Line Manager Various Departments	11/2020	2/2021	Government Product Line Manager
***2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis**	Assess Member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS Member satisfaction survey.	The QI Department: • Sends CAHPS surveys out annually to Members via random blind sample • Validates data before submission • Meets CAHPS submission deadline • Analyzes survey results to determine areas of intervention and improvement • Present 2019 data to DHMP Leadership in a formal results session late August 2020.	**Evidence of annual analysis includes:** • Presentation to the QMC • Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes	Annually	QI Director	Ongoing	Ongoing	QMC

DENVER HEALTH MEDICAL PLAN, INC. (DHMP) & DENVER HEALTH (DH) MEDICAID CHOICE
Medicaid Choice (MCD) & Child Health Plan Plus (CHP+) Quality Improvement (QI) Work Plan
2020-2021

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
Open Shopper Study	The Open Shopper Study will be completed annually to assess performance against National Committee for Quality Assurance (NCQA) and contractual standards and to evaluate Member experience as it relates to access to care. The results of the study will be used to guide process improvement efforts across the organization. The Open Shopper Study analysis and findings will be presented to the Quality Management Committee (QMC) for oversight and feedback. The report will be shared throughout primary, specialty and behavioral health care departments across Denver Health (DHHA). The Open shopper analysis will be owned by the Medicaid Product Line Management team. With this change, there was an opportunity to reassess the study method, to ensure its relevancy and alignment with the MCD and CHP+ access standards	The results of the open shopper surveys will be provided to the Network Management Committee (NMC) to determine if the network is sufficient to provide services to members on a timely basis; identified provider non-compliance will be addressed through the corrective actions process	The overall goals of the open shopper process include: 1. Ensuring timely access to care and services for DHMP's Medicaid Choice and CHP+ members; 2. Monitoring DHMP's provider network for adherence to required access to care standards; 3. Taking appropriate corrective actions to address identified non-compliance.	Annually,	MCD Product Line Manager	Ongoing	Ongoing	QMC NMC
***Quality of Service Concerns (QSC)**	The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns.	**Timeframe requirements:** • Acknowledgment letter: 2 business days • Standard Response: 15 business days • Extension letter: 14 business days	**Goal:** • 100% Timeframe compliance	Bi-Monthly	Grievance and Appeals Manager	Ongoing	Ongoing	QMC
***Member Annual Communication Requirements**	The Marketing Department strives to ensure timely distribution of Member communications and materials to promote DHMP/DHMC Membership understanding of current health plan topics related to patient care and service.	**Members receive:** • Information about the quality program goals and outcomes as related to Member care and service • Inform Members of CPG's • Pharmaceutical Restriction and Preference information	**Goal**: • Must provide evidence of annual communication to all Medicaid and CHP+ Members	Annually	Marketing Manager	7/2020	6/2021	Outreach Committee
***Member Communication Requirements Upon Enrollment**	The Marketing Department strives to ensure timely distribution of Member communications and materials to promote DHMP/DHMC Membership understanding of current health	**Members are provided the following information:** • Member rights and responsibilities statement	**Goal**: • Must provide evidence of communication to all Medicaid and CHP+ Members	Annually	Marketing Manager	1/2021	11/2021	Outreach Committee

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
and Annually Thereafter	plan topics related to patient care and service.	• 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	upon enrollment and annually thereafter					
***Practitioner and Provider Annual Communication Requirements**	The Marketing Department strives to ensure timely distribution of practitioner and provider communications and materials to promote DHMP/DHMC practitioner and provider understanding of current health plan topics related to patient care and service.	**Practitioners and providers are provided the following information:** • Information about the quality program goals and process outcomes related to Member care and service • Pharmaceutical Restriction and Preference information	**Goal**: • Must provide evidence of annual communication to all network practitioners and providers	Annually	Marketing Manager	1/2021	12/2021	Outreach Committee
QUALITY OF SERVICE								
***Practitioner and Provider Communication Requirements Upon Contracting and Annually Thereafter**	The Marketing Department strives to ensure timely distribution of practitioner and provider communications and materials to promote DHMP/DHMC practitioner and provider understanding of current health plan topics related to patient care and service.	**Practitioners and Providers are provided the following information:** • 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	**Goal**: • Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter	Annually	Marketing Manager	1/2021	12/2021	Outreach Committee
***Ongoing Monitoring of Network Practitioners and Providers Site Quality**	Credentialing and Provider Relations has a process to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP/DHMC'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	Quarterly	Credentialing Department	Ongoing	11/2020-2/2021	Cred. Cmte. QMC

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			delivering corrective action plans					
***Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues**	DHMP/DHMC has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.	**Ongoing review and monitoring by:** • Collecting and reviewing 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 their release. Implementing appropriate interventions when instances of poor quality are identified	Quarterly	Credentialing Department	Ongoing	11/2020-2/2021	Cred. Cmte. QMC
***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 • Call Volume/Abandonment Rate • Customer Service Question- Did you get the help or information you needed? • Facilitate creation of a Customer Service Improvement Plan for review at the QMC	**Goals**: • Phone Statistics: at or above 80% • Average Delay: 30 seconds or less • Abandonment rate: 5% or less • Customer Service Question: >90%	Bi-Monthly Monthly	Manager of Health Plan Services	Bi-Monthly November	Ongoing Ongoing	QMC QMC
SAFETY OF CLINICAL CARE								
***Pharmaceutical Patient Safety Issues**	The Pharmacy Department receives notification of drug recalls from the Pharmacy Benefit Manager and has a process in place to notify affected patients and practitioners in a timely manner. 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.	• 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 a Class I recall	**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	Annually	Pharmacy Director	Ongoing	Ongoing	MMC Compliance Committee

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
Patient Safety Initiatives	The Quality Improvement Department works collaboratively with Utilization/Case Management, Pharmacy, and Health Management Departments to provide clinical quality monitoring and identify performance improvement opportunities related to Member safety.	**Process:** The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that comes from them, and implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service, and safe clinical practice. In addition, the Company Medical Director is a Member of the DHHA Patient Safety Committee. If opportunities are identified to decrease medical errors, the Medical Plan will offer patient education on safety initiatives and preventive approaches.	**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 educational programs to reduce the possibility of patient injury • 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 • Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired in collaboration with DH patient safety • Review and evaluate actual and potential risk of patient safety in collaboration with DH patient safety • Report internally what has	Annually	Medical Director Director of QI Director of Pharmacy Director of UM/CM Director of Health Plan Medical Mgmt	Ongoing	Ongoing	QMC

Yearly Planned Activities								
						Time Frame		
Activity	**Objective/Description**	**Requirement/Planned Activity**	**Performance Target/Goal**	**Reporting**	**Primary**	**Start**	**Finish**	**Approval**
			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 • Trend adverse events reporting in safety practices (e.g. medication errors) • Annually review and evaluate clinical practice guidelines against practice guidelines to ensure and improve safe practices					