Denver Health Medicaid Choice and Child Health Plan Plus (CHP+)

Quality Improvement Program Description

SFY 2020-2021

I. Introduction

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated health care 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 Members enrolled into Denver Health Medicaid Choice (DHMC). In September 2018, the contract with HCPF was transitioned from DHHA to Denver Health Medical Plan, Inc. (DHMP).

DHMP was incorporated on January 1, 1997. The State of Colorado licenses DHMP as a Health Maintenance Organization (HMO). On July 1, 2003, DHMP entered into a contract with HCPF in order to provide comprehensive health care services to Child Health Plan Plus (CHP+)-eligible Members enrolled into DHMP. We may hereinafter refer to DHMC and DHMP as "the Company." The Company offers a full spectrum of health care services for Members through DHHA's integrated health care system. DHMP's Quality Improvement (QI) Program Description outlines the organization's efforts to improve overall quality of care, service and Member safety for the Company's Members on DHHA's behalf.

Mission Statement

The DHMP mission is to: Provide affordable, high quality healthcare coverage for all, in partnership with Denver Health. In partnership with our providers we continually seek to improve the health and well-being of our members by:

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

Quality Statement and Process

The QI Program is designed to support the mission of the Company by promoting the delivery of high-quality, affordable health care 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 and Practitioner experience/satisfaction surveys
- Health Plan Services call data
- Medical record review
- Claims data
- Open Shopper Study data
- Pharmacy data
- Case Management (CM) data
- Utilization Management (UM) data
- Population Health Management (PHM) 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 Members. This approach also allows the Company to focus on opportunities for improving operational processes, increasing Member and Provider and Practitioner experience/satisfaction and effectively providing and managing health outcomes.

The Company uses a continuous improvement cycle where designated staff conduct a measurement of performance indicators, assess and prioritize the indicators upon which the Company may improve and then plan, implement and

evaluate interventions to improve the quality of care, quality of service and 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

Board of Directors

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

Composition:

- DHHA Authority Board Chair Designee
- DHHA CEO
- DHHA Chief Operating Officer (COO)
- DHHA Chief Financial Officer (CFO)
- DHHA Chief Ambulatory Officer
- DHHA Community Health Services (CHS) Board Chairman
- Community Business Leaders

Function:

- Approve the QI Program Description, QI Work Plan and QI Program Evaluation/Impact Analysis
- Review applicable Company quality data such as CAHPS, HEDIS, etc.

Authority and Responsibility

Executive Leadership

1. CEO/Executive Director, Managed Care responsibilities include, but are not limited to:
   - Provide oversight of the Medical Director and department operations
   - Present 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
   - Work in collaboration with the QI Director and QI Intervention Managers on development and assessment of clinical interventions
   - Report findings from clinical interventions to the appropriate groups, such as the Ambulatory Quality Improvement Committee (QIC), QMC and Board of Directors
   - Work with the QI Director on preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, Operations Management Committee, QIC and Board of Directors
   - Design and implement clinical activities in the QI Work Plan
   - Serve on the QMC, AQIC, Pharmacy and Therapeutics (P&T) Committee, Medical Management Committee (MMC), Network Management Committee (NMC), Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee and Denver Health (DH) Physician Executive Committee

- Evaluating and managing the Company's Quality of Care Concerns (QOCCs) and all quality of care related reportables, 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

Quality Improvement Department

1. QI Director responsibilities include, but are not limited to:
   - Develop, lead and monitor the QI Program
   - Report findings from clinical interventions and annual audits to appropriate groups, such as the AQIC, QMC and Board of Directors
   - Complete preparation and dissemination of relevant information obtained on the performance of QI activities to the AQIC, QMC and Board of Directors
   - Directly assume authority and responsibility for the organization and administration of the QI Program, including annual submissions of the QI Program Description, QI Work Plan and QI Program Evaluation/Impact Analysis
   - Direct and provide subject matter expertise and participate in the execution of the QI Program through collaboration with other Company and DH Departments as appropriate for regulatory compliance and QI
   - Tracks the reporting of QOCCs to the DHHA Patient Safety and Quality Department and external network Providers through the Medical Director, as appropriate
   - Serve as the Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
   - Lead LEAN initiatives related to the QI Department, including standard work
   - Provide oversight, supervision and direction to the QI Department, including all regulatory submissions

2. HEDIS Program Manager responsibilities include, but are not limited to:
   - Manage all aspects of HEDIS-related projects, including roadmap submission and annual audits
   - Evaluate opportunities for supplemental data sources to improve HEDIS compliance
   - Provide summation of findings from medical record review process to improve coding and documentation, as well as to inform interventions in collaboration with other managers
   - Evaluate and analyze HEDIS results, recommending measures for targeted improvement
   - Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
   - Work collaboratively with Intervention Managers on interventions related to HEDIS
   - Validate the accuracy and integrity of HEDIS data and all data related to submission

3. QI Project Manager responsibilities include, but are not limited to:
   - Organize all aspects of CAHPS-related projects
   - Evaluate and analyze CAHPS results
   - Lead CAHPS improvement projects, working in collaboration with Intervention Managers
   - Provide project management leadership for a variety of QI Department deliverables
   - Organize data from various sources to support QI activities, serving as the subject matter expert (SME) data advisor
   - Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
   - Provide oversight of QI vendor contracts for CAHPS and Health Outcomes Survey (HOS), along with delegated activities
   - Manage EPSDT standard compliance and improvement efforts
   - Manage activities of the QI Department, including SharePoint sites
   - Lead QI project planning activities related to regulatory and accreditation requirements
   - Lead weekly huddles for the QI Department
   - Coordinate QMC meetings, assuring reporting is meeting standards and deliverable timelines

- Function as the main administrative contact for the QMC
- Work in collaboration with Intervention Managers to maintain timeline deliverables

4. Intervention Managers responsibilities include, but are not limited to:
   - Develop, manage and evaluate all QI interventions related to adults and pediatrics
   - Analyze data and opportunities to develop QI interventions
   - Serve as lead contact and develop interventions with School-Based Health Centers (SBHCs)
   - Lead Performance Improvement Project (PIP) process for Medicaid Choice and CHP+ contract
   - Develop, manage and evaluate QI interventions related to adults
   - Evaluate Race, Ethnicity and Language (R/E/L) data for integrity and culturally- and linguistically-appropriate services (CLAS) purposes
   - Analyze data and opportunities to develop QI interventions
   - Contribute to multicultural health care-related activities including cultural competency training and CLAS use and monitoring

5. QI Registered Nurse (RN) and RN Staff Resource responsibilities include, but are not limited to:
   - Manage Quality of Care Concerns (QOCCs), quality of care reportables, and associated process in a timely and effective matter
   - Provide clinical consultation for the QI Department
   - Conduct Practitioner chart review using HEDIS criteria
   - Develop and update all preventive and clinical guidelines
   - Develop and update all clinical policies and procedures related to the QI Department

III. Committee Structure

Quality Management Committee

The 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, including but not limited to UM, CM, PHM, Pharmacy, Health Plan Services, Provider Relations and Contracts and Credentialing. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC reviews and Member safety initiatives. The QMC includes primary care Providers (PCPs), specialty Providers and behavioral health Practitioners from the HMO network.

Composition:

- Director of QI (Chair)
- Medical Director
- Director of Health Plan Medical Management (HPMM)
- Manager of UM
- Manager of CM
- Director of Compliance
- Director of Health Plan Services
- Manager of Health Plan Services
- Director of Pharmacy
- Director of Provider Relations and Contracts and Credentialing
- Manager of Marketing
- Commercial Product Line Manager
- Government Product Line Manager – Medicare
- Government and Product Line Manager – Medicaid and CHP+
- DHAA Care Coordination Management

- PCPs from DHHA
- Behavioral Health Practitioner from DHHA
- Specialty Care Practitioners from DHHA

Functions:

- Serve as the advisory and action oversight body for quality initiatives and activities.
  - The QI Project Manager 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 PCPs 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 QI activities
- Institute needed actions for improvement based on performance goals
- Ensure follow up of issues and activities
  - When organizational goals are not reached, conduct root cause analyses or barrier analyses
- Review and approve clinical and preventive practice guidelines
- Review Member experience/satisfaction and quality of care results (e.g., CAHPS, HEDIS, Open Shopper Studies)
- Review and evaluate activities that improve Member experience, such as access to care and quality of services, as well as make recommendations about ways to improve these results
- Review findings, themes and opportunities associated with identified QOCCs and all quality of care related reportables
- Review UM, CM, PHM and Pharmacy performance as it funnels up from the MMC
- Review provider relations and credentialing activity from the NMC and Credentialing Committees

- Provide oversight of QI Program deliverables including, but not limited to:
  - QI Program Description
  - QI Work Plan
  - QI Program Evaluation/Impact Analysis
  - Clinical Care Guidelines

Committees Reporting to the QMC include, but are not limited to:

- P&T Committee
- DHHA ACS QIC
- MMC
- NMC
- Credentialing Committee

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 allow for additional performance monitoring information.

Composition:

- CEO/Executive Director
- Medical Director
- Chief Financial Officer (CFO)
- Chief Administration Officer (CAO)
- Director of Medical Management
- Director of Compliance
- Director of Claims
- Manager of Enrollment Services
- Director of Provider Relations and Contracts and Credentialing
- Director of Finance
- Director of Information Systems (IS)
- Director of Health Plan Services
- Director of Pharmacy
- Director of QI
- Commercial Product Line Manager
- Government Product Line Manager – Medicare
- Government Product Line Manager – Medicaid and CHP+
- Manager of Marketing

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 CLAS Program activities, goals, allocation and resources

Medical Management Committee

The Medical Management Committee (MMC) assists the Quality Management Committee (QMC) in overseeing and ensuring quality of clinical care, patient safety, State/CMS/NCQA reporting requirements and program operations provided throughout the organization. The MMC is responsible for assisting the organization to provide oversight, critical evaluation, and delegation of activities essential to promoting the Triple Aim of healthcare: improving the healthcare experience, improving outcomes of populations, and providing optimal care in the most cost effective manner.

Composition:

- Medical Director, DHMP – Committee Chair
- Psych/BH MD - Member
- Utilization Management Director or Manager – Member

- Care Coordination Operations Manager – Member
- Quality Improvement Director – Member
- Accreditation Manager – Member
- Director of Pharmacy or Manager – Member
- Product Line Manager: Commercial– Member
- Product Line Manager: Medicare– Member
- Product Line Manager: Medicaid– Member
- Director of Provider Relations or Manager – Member
- Grievance and Appeals Manager– Member
- Monitoring, Audit and Training Manager– Member
- IS-Member
- Support Staff- Recorder

Functions:

- Oversight, review and approval of documents
  - Policies and Procedures
  - Program Descriptions
  - Program Evaluations (including identification & suggestions of opportunities for improvement)
- Adherence to accreditation and regulatory guidelines
  - NCQA Accreditation requirements
  - State regulations and requirements
  - CMS regulations and requirements
- Collaboration
  - Quality Management Committee
  - Network Management Committee
  - Denver Health and Hospital Association Patient Centered Medical Home
  - DHHA and DHMP Lean Initiatives

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
- Credentialing Coordinator
- Director of Provider Relations and Contracts and Credentialing
- DHHA Representative from the Medical Staff Office
- Primary and Specialty Care Practitioners

Functions:

- Annually review and approve the credentialing and recredentialing criteria and the process used to make credentialing and recredentialing decisions
- Annually review and approve credentialing policies and procedures
- Review results of ongoing monitoring of sanctions and grievances

- Review and determine participating status of Practitioners who, at a minimum, do not meet the established credentialing criteria
- Review the clean files that were approved by the Medical Director
  - Files classified as clean files (i.e., those meeting all criteria with no malpractice claim history) may be reviewed by the Medical Director who determines the file to be approved by sign off
    - Sign off may also be completed by the 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
- 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
- Present "Red Flag" files (i.e., those not meeting the minimum criteria and standards) with detailed information pertaining to malpractice claims or sanctions for a decision
  - The basis for a denial is communicated in writing to the Practitioner, and appeal provisions are offered in accordance with Company policies
- For recredentialing, additionally evaluate Practitioner data such as complaints or quality issues, utilizing the CMS website as appropriate
- Initial assessment and reassessment of organizational credentialing
- Request individual Practitioner file information from the entities with delegated credentialing responsibility for review in response to a potential issue identified during Company oversight

Pharmacy and Therapeutics Committee

The P&T 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
- Formulary Management Clinical Pharmacist
- DHHA Physicians
- DHHA Pharmacists
- Representatives from DHHA and 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 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 program

Compliance Committee

As a licensed health insurer and managed care plan, Denver Health Medical Plan, Inc. (DHMP) operates in a complex, dynamic and highly regulated environment at both the federal and state level. To assist in advising and providing direction to the Chief Compliance and Audit Officer (CCAO) in overseeing DHMP's compliance program for its government and commercial lines of business, DHMP established the DHMP Compliance Committee ("Compliance Committee"), which shall receive reports on compliance matters at least quarterly, or as necessary.

The Compliance Committee is accountable to, and via the CCAO, provides periodic reports on the activities and status of the compliance program to DHMP's Executive Leadership and governing body.

Composition:

- CEO/Executive Director of Managed Care
- Chief Financial Officer
- Chief Administrative Officer
- Medical Director
- General Counsel, DHHA
- Chief Information Security Officer
- Privacy Officer
- Director, Claims
- Director, Compliance & Internal Audit
- Director, Health Plan Services
- Director, Information Systems
- Director, Pharmacy
- Director, Provider Relations & Contracting
- Director, Quality Improvement & Accreditation
- Director, Utilization Management
- Manager, Call Center
- Manager, Commercial Products
- Manager, Compliance
- Manager, Government Products - Medicare
- Manager, Government Products - Medicaid & CHP+
- Manager, Grievance & Appeals
- Manger, Internal Audit
- Manager, Monitoring, Auditing & Training
- Others (as deemed appropriate)

Functions:

- Review and approve the DHMP Compliance Plan and compliance policies and procedures.
- Review and recommend revisions to applicable portions of the Code of Conduct.
- Oversee the implementation of the Compliance Plan.
- Oversee the development and implementation of compliance and Fraud, Waste and Abuse (FWA) training.

- Ensure compliance and FWA training and education are effective and appropriately completed.
- Ensure DHMP has a publicized mechanism for members, employees, vendors and subcontractors to ask compliance questions, report potential compliance and/or FWA concerns and violations confidentially or anonymously without fear of retaliation.
- Ensure DHMP has an effective and timely mechanism for communicating information related to new and revised laws, regulations and guidance applicable to DHMP.
- Review the results of annual and periodic risk assessments.
- Review and approve the compliance and internal audit work plan annually and when revised.
- Ensure appropriate auditing and monitoring activities are conducted to address identified organizational risks and verify adherence to applicable laws, regulations, and guidance.
- Ensure the effectiveness of the compliance program is assessed annually and results are shared with the governing body.
- Ensure DHMP has well-publicized disciplinary standards that encourage good faith participation in the compliance program.
- Review the results of auditing and monitoring activities and ensure timely corrective actions are taken, as necessary, and monitored for effectiveness.
- Ensure timely and reasonable inquiries are made for compliance and/or FWA incidents or issues.

Ambulatory QI Committee

The Ambulatory QI Committee (QIC) is a collaborative group that focuses on integrating quality activities among CHS and the Company. The QIC is a standing subcommittee of the DHHA Ambulatory Care Committee and serves as the QI Committee for the DHHA 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 QIC 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 QIC defines and oversees the efforts of the DHHA QI work groups. This committee is in close collaboration with the CHS Central Management Team (CMT) and the Company's Medical Management group. Together, these entities monitor the implementation of all quality activities. The QIC reports all QI projects to the Company's QMC by way of meeting minutes.

Composition:

- DHHA Director of CHS
- DHHA CHS QI Coordinator
- DHMP Director of QI
- DHMP Medical Director
- DHHA Directors of Pediatric, Internal and Family Medicine Divisions
- DHHA Director of School-Based Health Centers
- DHHA Behavioral Health Practitioners
- DHHA PCPs
- DHHA Specialty Care Physicians
- DHHA Registered Nurse (RN) Clinic Managers

Functions:

- Define a core set of indicators that serve as measures of performance quality for services provided in ambulatory care settings
- Identify methods to measure performance for identified indicators
- Develop annual work plan(s) for review of all performance indicators
- Prioritize areas for performance improvement within the indicators included in the CHS QI Work Plan
- Establish work groups for developing/implementing QI initiatives within ACS and oversee their activities

Network Management Committee

The Network Management Committee is tasked with establishing, maintaining and reviewing network standards and operational processes as required by NCQA, 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) Contract management; (3) Access and availability; (4) Directory audits; and (5) Provider Manual maintenance.

Composition:

- Director of Provider Relations and Contracts and Credentialing (Chair)
- Medical Director
- Director of QI
- Director of HPMM
- Director of Health Plan Services, or designee
- Commercial Product Line Manager
- Government Product Line Manager – Medicare
- Government Product Line Manager – Medicaid and CHP+
- Manager of Provider Relations
- Manager of Appeals and Grievances, or designee
- Manager of Health Plan Services
- QI Staff (optional or as required)
- HPMM Staff (optional or as required)
- Provider Relations and Contracts and Credentialing Staff (optional or as required)
- DHHA Director of Care Coordination (optional or as required)
- DHHA Physicians and Administrators (optional or as required)

Functions:

- Develop Standard Operating 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, contractual requirements and implement accordingly to include the Provider Directory and Provider Manual
- Review Quality of Service Concerns (QOSCs) and develop plans to address

IV. Goals and Objectives

The QI Program seeks to accomplish the following objectives: (1) Assess the quality of care delivered to Members; and (2) Evaluate the manner in which care and services are delivered to these individuals. The QI Department 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.

The QI Program strives to achieve the following goals for all Members:

- Measure, analyze, evaluate and improve the administrative services of DHMP
- 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 experience/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 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 support continuous quality improvement (CQI)
  - The summarized approach to achieve this aim is as follows: (1) Analysis of available data; (2) Trending and barrier/root cause analysis of measures; (3) Implementation of intervention(s); and (4) Remeasurement of targets
- Assure compliance with all State and Federal statutes and regulatory/contractual requirements
- Establish and implement at least one (1) to two (2) PIPs and/or focused studies each year per the Medicaid Choice contractual requirement
  - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated Quality Improvement Committee (IQuIC) and those selected by CMS
- Establish and implement at least one (1) PIP per the CHP+ contractual requirement
  - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated Quality Improvement Committee (IQuIC) and those selected by CMS
- Establish and implement improvement activities to enhance Early and Periodic Screening, Diagnostic and Treatment (EPSDT) performance and compliance
- Objectively and systematically measure and analyze HEDIS, CAHPS and other access/customer service data to promote improvement in Member experience/satisfaction
- Monitor Member experience/satisfaction and identify/address areas of dissatisfaction through an annual review of the following data: (1) CAHPS; (2) Member feedback; (3) Appeals and grievances data; and (4) QOCCs
- Monitor and maintain safety measures and address identified problems
- Monitor an annual Provider and Practitioner experience survey to evaluate satisfaction with the medical management processes 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 (MCOs)

- The annual Program Evaluation/Impact Analysis will describe performance interventions, program outcomes and the overall impact of the Program
- Upon request, this information will be made available to Providers, 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, including but not limited to: (1) Medical record review; (2) PIPs 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; final study specifications shall be at the discretion of the Department
- Integrate Managed Care QI activities with those of the DH ACS and the DHHA Clinical Performance and Safety Improvement (CPSI) Department's QI Committees
- The Company participates in the State IQuiC to provide input and feedback regarding QI priorities, performance improvement and measurement

V. 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 CQI of health care 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
- QOCCs and quality of care related reportables
- Member Experience/Satisfaction
- Provider and Practitioner Experience/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 for Member languages of qualifying prevalence
- 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 needs 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/or audio tape format
- Company will maintain a library of culturally-sensitive health prevention and education materials for use in Member mailings and on the website
- Promote a "plain language culture"
- Bring awareness of communication techniques used between employees and Members
- Educate employees on the use of health literacy readability software to develop Medicaid and CHP+ documents with a readability score of sixth-grade or lower
- Create materials that comply with these regulatory requirements
- Nominate a "champion" of Health Literacy in each DHMP Department, who will serve as the subject matter experts (SMEs) on readability, and who can assist with the use of readability software

Patient Safety

QI works collaboratively with HPMM and Pharmacy to provide clinical quality monitoring and identification of Member safety performance improvement opportunities. QI facilitates the evaluation of QOCCs, all quality of care related reportables, and any resulting CAPs. Additionally, the QI 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 Member education about safety initiatives and preventive approaches.

Safety objectives include:

- Encourage organizational learning about medical and health care errors
- Incorporate recognition of Member safety as an integral job responsibility
- Incorporate Member safety education into job competencies
- Implement corrective, preventative and general medical error reduction education programs to reduce the possibility of Member injury
- Involve Members 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 Member injury occurred or Member safety was impaired
- Review and evaluate actual and potential risk of Member 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 newsletters and/or the DHMP website to help promote and increase knowledge about clinical safety
- Focus existing QI activities on improving Member 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

DH 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 QI studies of clinical and service activities for Denver Community Services and supports evaluation methods for multiple quality studies and other projects within DH CHS

- Continual Readiness: Provides coordination of regulatory reviews, surveys or inquiries to DH, including activities related to Joint Commission, CMS, Office of Civil Rights and The Colorado Department of Public Health and Environment
- Division of Education: Responsible for bringing oversight and organization to the professional education (house staff and student education) occurring within DHHA
- Health Services Research: 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 (e.g., Emergency Medical Services, Clinical Triggers, Soarian Quality Measures)

VI. Care Coordination

Population Assessment

To determine the necessary structure and resources for its PHM Program, DHMP assesses its member population on a continual basis. To do so, DHMP uses a variety of data sources, including but not limited to:

- Medical and behavioral claims or encounters (risk stratification tool)
- Pharmacy claims
- Health Needs Assessment (HNA) results
- Health service programs within the organization (e.g., Utilization Management (UM) data)
- Member responses to health screenings (e.g. SBIRT or DSMQ)
- Data from referrals

DHMP uses the data sources listed above to identify the needs of its population.

Characteristics and Needs

To determine the necessary structure and resources for its PHM Program, DHMP assesses the characteristics and needs of the member population, including:

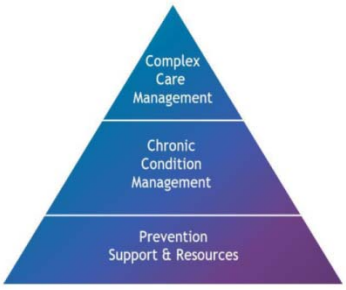
Characteristic	Data Source
Social Determinants of Health	HNA
Federal or State Program Eligibility	Medicaid eligibility
Multiple Chronic Conditions	Claims, referral, HNA
At-Risk Ethnic, Language or Racial Group	HNA, eligibility, member report
Needs of Children and Adolescents 2-20 Years of Age	Gaps in care
People with Special Health Care Needs (PSHCN) and/or People living with Serious and Persistent Mental Illness (SPMI)	Claims, referral, HNA, member report

Activities and Resources

In addition to the Population Assessment, DHMP annually reviews and updates its PHM activities and resources to address member needs and ensure proper integration into Program and Service offerings. This includes evaluating organization resources (e.g., staff, training, etc.) and identifying community resources that correlate with member needs. This review and update occurs at Medical Management Committee (MMC), and is brought to Quality Management Committee (QMC) via MMC Minutes.

Stratification and Segmentation

DHMP has adopted HCPF's new pyramid stratification model and enhances the framework with data driven methodology derived from claims data that includes physical health, behavioral health and pharmacy, as well as health needs surveys. DHMP met with the Cost Control and Quality Improvement Office to review and understand the components driving the risk stratification dashboard that was developed to support the RAEs. Currently, DHMP is in the final process of developing an internal risk stratification dashboard that is based on HCPF's risk dashboard parameters. The dashboard includes data on member physical and mental health and service utilization, including chronic disease, primary care and hospital use and the costs of those services. The information will be used to identify members for more intensive care management. DHMP recently began obtaining the behavioral health data from Colorado Access to include in the dashboard which provides a clear picture of our membership's health status and risk. The dashboard does not currently include SUD data; however, this is a known issue and DHMP has engaged HCPF regarding options and the potential to obtain this data.



DHMP's new risk stratification process is closely aligned with HCPF's pyramid concept of identifying the highest risk members in the complex care management category, followed by identifying members with chronic conditions, and lastly prevention support and resources.

Due to the nature of how DHMP submits encounters versus the fee-for-service process, HCPF is unable to perform this analysis in the same manner as for the Regional Accountable Entities (RAE). As such, DHMP looks forward to collaborating with HCPF program staff regarding the reporting and deliverables associated with the process and tailoring them to fit DHMPs model while assuring alignment with the initiatives of the Accountable Care Collaborative (ACC).

In addition to the risk stratification dashboard, DHMP has engaged a vendor to outreach to all new Medicaid members to complete a Health Needs Assessment (HNA). The HNA is comprised of general questions regarding the member's physical and behavioral status and concerns. The HNA also provides an opportunity to connect the new member to a primary care provider and the call technician has the ability to do a warm transfer to the appointment center to get the member connected.

High Utilizer Medication Management Program

The DHMP pharmacy team monitors members pharmacy utilization and will identify member that are on high cost drugs and will refer them to the care coordination team for review and evaluation for case management services. The care coordination team will outreach to the member to discuss their specific condition and associated pharmacy needs. The care coordinator will attempt to get the member connected to a primary care provider if the member does not already have one.

DHMP participates in the 340b pharmacy program which ultimately results in a lower drug cost for the plan. However, DHMP does not restrict its membership to DHMP pharmacies which stresses the importance of ensuring the member is appropriately connected to the resources available to them within the DH network. The pharmacy does have options to receive medications via mail which allows the member to not have to visit the physical pharmacy locations.

Provider and Practitioner Support

DHMP engages its provider network in a variety of the methods to ensure that they are included and their feedback is heard on key initiatives, goals and processes. In addition to a robust and informative website and provider manual, DHMP develops and sends a Provider Newsletter to the entire network on a bi-weekly basis. The newsletter represents an avenue in which DHMP can interact with providers and describe programmatic changes, highlight key programs (e.g. EPSDT) and requirements, and provide general information. The DHMP marketing team maintains a list/calendar of regularly scheduled content and allows for ad-hoc additions to the newsletter. DHMP is in the process of improving its

provider communications through the development of a centralized provider web portal. This portal will allow providers to, among other things, refer a member for services, file an appeal or grievance, and review DHMP's provider manual

The predominant provider in the DHMP network is the DHHA system which includes the hospital campus, clinics, school based health centers (SBHC) and urgent care facilities. Within the DHHA system is the Ambulatory Care Services (ACS) department and they provide the care coordination and member support specific to the hospital, clinics and SBHCs. DHMP collaborates closely with the ACS team and collaboratively develops initiatives and programs to improve both the member and provider satisfaction and experience. The DHMP Quality Improvement (QI) team is actively involved in multiple initiatives and collaborations with DH ACS providers. The Director of QI participates in several quality committees and workgroups within ACS, including the Ambulatory Quality Improvement Committee (QIC), which combines the previously separate ambulatory quality improvement and the clinical design work group committees and has integrated Member experience performance information into those workgroups. The QIC is responsible for establishing and reviewing indicators of ambulatory care performance, identifying opportunities for quality of care improvement and implementing/disseminating QI interventions. Additionally, members of the QI team staff attend and interact in a variety of ways with ACS chronic disease and prevention quality improvement work groups, led by senior medical leadership of ACS. In these committees and groups, DHMP joins resources with ACS to actively work together to increase the health and well-being of our Members. The QI team also leads targeted interventions in clinic sites through partnership and collaboration with defined clinic leadership and reports on these regularly to the ACS QI workgroup leadership.

DHMP supports the providers and practitioners in its network to achieve its PHM goals by:

- Sharing data with the member's medical home ACS clinic provider and medical home Care Coordinators regarding specific care coordination needs and health plan interventions
- Offering evidence-based or certified decision-making aids
- Sharing this PHM Strategy with DH Ambulatory Care Services (ACS) providers and leadership

The DHMP QI Director also chairs the DHMP Quality Management Committee (QMC) which includes network providers. The QMC is another opportunity for DHMP to collaborate with the network providers and inform and include them on the development and implementation of quality initiatives to support improving the care delivery system.

Care Management Programs

DHMP Medicaid Choice and CHP+ Members benefit from a number of programs and services to support their health goals and outcomes as well as to identify opportunities to address avoidable costs. Our programs include the following:

Care Coordination

For Members identified as needing basic support, including referral coordination, disease management education and support or support with addressing social disparities, like transportation needs, care coordinators can provide the following:

- 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 created and tracked in the medical management platform system. Referrals are also used 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. DHMP care coordinators may also be involved in the provision of disease management and education services. Denver Health's Acute Hospital Care Management team may be involved in

disease prevention education as part of an inpatient admission. Some of the disease management activities at DH include:

- Integrated Behavioral Health
- Tobacco Cessation Clinic
- Diabetes Prevention Program
- Substance Abuse Treatment, Education and Prevention (STEP) Program - The STEP Programs is located on the DH campus and in several Denver Public Schools (DPS), and is a 12-week outpatient treatment program for adolescents and young adults 11 to 24 years of age
- Denver Comprehensive Addictions Rehabilitation and Evaluation Services (CARES) Program - DH Outpatient Behavioral Health Services (OBHS) offers the CARES Program for treatment of non-opiate drug and alcohol substance use disorders. Patients are required to complete a comprehensive substance abuse evaluation and may be referred for treatment through several avenues, including by health care Providers, DHMP Care Coordinators or by self-referral. Hepatology – Hep C Program
- Pharmacotherapy Management

Transitions of Care

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). DHMP has a Transitions of Care (TOC) program that is focused on 30-day readmission avoidance. DHMP uses the LACE assessment tool to identify Members at risk for readmission or death within thirty days of discharge. It incorporates four parameters:

- "L" stands for the length of stay of the index admission.
- "A" stands for the acuity of the admission. Specifically, if the patient is admitted through the Emergency Department vs. an elective admission.
- "C" stands for co-morbidities, incorporating the Carlson Co-Morbidity Index.
- "E" stands for the number of Emergency Department visits within the last 6 months.

DHMP TOC staff identifies and coordinates transitions of care for patients to reduce readmissions, improve quality of care and improve patient and family satisfaction.

TOC for other types of transitions: DHMP Care Coordinators will reach out to known justice-involved Members, Members aging out of Medicaid or CHP+ eligibility and other Members undergoing significant transitions to help coordinate care to support care continuity of medically necessary services.

Complex Case Management

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. DHMP has complex case managers and social workers who can identify Members with complex needs, reach out to identified Members, complete a comprehensive multi-domain assessment with the Member and create a Care Plan with the Member that accounts for opportunities, goals and interventions designed to support the Member in achieving their desired health outcomes. All DHMP-initiated CCM activities and communicated and coordinated with the Members Denver Health PCMH whenever possible.

Denver Health's ACS clinics provide 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.

Care Coordination Program Goals and Objectives

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 operational metrics is part of this initiative with regular review by leadership teams.

DHMP recognizes opportunities for quality improvement in 2020-21 and the following key initiatives are planned with executive support:

- Risk stratification has a new iteration of Member tiering as described in the Population Identification section above.
- 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.
- New configuration of our Medical Management platform, Guiding Care,© is in development and will be fully deployed by October 2020
    - DHMP 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.

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.
Targeted Population	Members who are identified with 5 or more risk factors for high utilization using a risk stratification tool. (that mimics the tool used by HCPF)
Programs/Services	• Medicaid Care Coordination Program- New • Transitions of Care (TOC) Program • Complex Care Management (CCM) program • Health Needs Assessment (HNA) • Ambulatory Care Services Diabetes Prevention Program • Diabetes Self-Management Education Classes • Access to Specially Trained Care Management Teams • Educational and Informational Member Materials campaigns specific to actionable risks
Success Measure	Success is measured by the following: • 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).
Milestones	Phase 1 – Develop an intervention strategy. Plan in progress with target completion date September 2020, Phase 2 – Identify the target population (risk stratification tool is almost complete). Target date for completion of tool, validation and testing is September 2020, Phase 3 – Define program components, build the program and establish improvement goals with a target of October 2020, Phase 4 – Initiate the program and develop baseline with target completion date of November 2020, Phase 5 – Re-measure and repeat as necessary, at least annually.

Goal	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)
Target Population	Members who are pregnant and who deliver while enrolled with DHMP
Program(s)/Service(s)	• Maternity Case Management(MCM) – New program • Complex Care Management (CCM) program • Transitions of Care (TOC) Program • Collaboration with Ambulatory Care Services (ACS) perinatal workgroup • Risk Assessment Screening Tools • Health Needs Assessment (HNA) • Dispatch Health for in home urgent needs • 24/7 NurseLine • EPSDT Outreach • Member Newsletters • New Member Materials (e.g., Quick Reference Guide, Explanation of Coverage, etc.)
Success Measure	Process measure- 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 into the criteria for this measure.
Milestones	Phase 1- Strategy, plan, methodology and goal complete, Phase 2 - Target population identified (with continued efforts to improve early identification) complete, Phase 3 - Define program components and build program. In progress with target date of completion September 2020, Phase 4 - Initiate program with target date for completion October 2020, Phase 5- Re-measure and repeat as necessary, at least annually.

Goal	Increase the percent of children and adolescents (ages 0-21 years) who receive an annual well-child visit.
Target Population	Children and Adolescents ages 0-21 years

Program(s)/Service(s)	• Ambulatory Care Services (ACS) Pediatrics programs and workgroup collaborations • Healthy Heroes – birthday card reminder campaign • Health Needs Assessment (HNA) • School-Based Health Centers • Flu clinics • MyChart • EPSDT Outreach • Emails • Member Newsletters • Employees Newsletters • Community reminders (e.g., TV, radio)
Success Measure	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.
Milestones	Phase 1 Strategy, plan, methodology and goal complete, Phase 2 – Identify the target population complete, Phase 3 – Define program components and build the program goals. Target date for completion is September 2020, Phase 4 – Initiate the program and develop baseline. Target date for completion is October 2020, Phase 5 – Re-measure and repeat as necessary, at least annually.

Goal	Housing is Healthcare Pilot – 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.
Target Population	Chronically Homeless members that meet a defined set of criteria and identified as needing complex care services. Members identified as having alcohol/SUD conditions
Program(s)/Service(s)	• Assertive Community Treatment (ACT) support team • Transitions of Care (TOC) Program • Dispatch Health • Complex Care Management (CCM) program • 24/7 NurseLine • Integrated Care model • Health Needs Assessment (HNA) • Denver CARES
Success Measure	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 • 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.
Milestones	Phase 1 – Strategy development complete; Phase 2 – Identify the target population and criteria for inclusion into pilot complete; Phase 3 – Define additional program components including support from DHMP case management, build the program components and develop improvement goals. Target date of completion is October 2020; Phase 4 – Initiate the program and develop baseline. Target date for completion is January 2021; Phase 5 – Re-measure and repeat as necessary, at least annually.

VII. 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 to 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 Health Plan 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 NMC and QMC to develop opportunities for improvement and CAPs, 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 Practice and Preventive Care Guidelines

On at least an annual basis, the Company will notify all Providers, Practitioners and Members about how to obtain clinical practice and preventive care 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 Department, in the development of clinical practice guidelines, considers the needs of Medicaid Choice and CHP+ Members. In order to improve health, the QI Department ensures that health guidelines are communicated to Providers and Practitioners, Members, non-Members and the public at no cost to the individual or Provider. 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 QI activities/QI projects
- Evaluate the appropriateness of the guidelines annually

Member Experience/Satisfaction

The Company QI Department evaluates and trends Member satisfaction data through the annual CAHPS survey. HCPF performs the CAHPS survey for CHP+ Members. 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 Quality of Care Concerns (QOCC) process and the QI Department continuously monitor and trend all Member QOCC's.

The Health Plan Services Department provides Member-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 basis. Annually, the Company communicates the QI Program goals to its Members through the Member Newsletter, Company website and other mailings.

Provider and Practitioner Experience/Satisfaction

Annually, the Provider Relations and Contracts and Credentialing Department administers a Provider and Practitioner Experience 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 Provider Newsletter, the Company website and other mailings annually. The Provider Relations and Contracts and Credentialing Department monitors Practitioner complaints and makes appropriate improvements.

Credentialing and Delegated Credentialing

The Credentialing Coordinator assures the compliance of credentialing and recredentialing activities align with CMS standards. The Credentialing Coordinator also conducts primary source verification for any direct Credentialed Practitioner. The Credentialing Coordinator will evaluate delegated entity's credentialing compliance with the Company credentialing and recredentialing standards annually. Additionally, the Credentialing Coordinator will conduct site visits for any Practitioner's office site (i.e., 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 Credentialing Coordinator will then report audit results to the Credentialing Committee. Additionally, the Credentialing Coordinator evaluates Practitioner contracts for compliance with credentialing standards' prior contract approval and includes behavioral health practices for CHP+ in credentialing activities. The Credentialing Coordinator conducts an assessment of organizational facilities for contracting compliance, as well as provides ongoing monitoring of Practitioner complaints and sanctions for recredentialing 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.

VIII. QI Program Annual Work Plan and Evaluation

Annual Work Plan

The QI Department will develop a QI Work Plan annually. The QI Work Plan will begin in August of every year. The Work Plan 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 the Medical Management Department
- 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 QI page on the DHMP website

Annual Evaluation

The QI Program submits an annual Program Evaluation/Impact Analysis to the QMC, Board of Directors and HCPF. The QI Program Evaluation/Impact Analysis will begin in August of every year. This document is the basis for the upcoming year's QI Work Plan.

The QI Program Evaluation/Impact Analysis 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 QI Program Descriptions and QI Work Plans will also incorporate advice, recommendations or mandates from external auditors and/or regulatory bodies
- Communication to Members, Providers and the community via the QI page on the DHMP website