2021 QUALITY IMPROVEMENT PROGRAM
DESCRIPTION
DENVER HEALTH MEDICAL PLAN, INC.

Commercial, Medicare and Exchange Products

March 9, 2021
INTRODUCTION
Denver Health Medical Plan, Inc. (DHMP) was incorporated on January 1st, 1997 in Colorado as a not-for-profit corporation for the purpose of providing or arranging for the delivery of health care services and related functions through the establishment and operation of a managed care organization (MCO). The purpose of MCO was defined as the delivery of quality, accessible and affordable health care services in and around the City and County of Denver, Colorado. Licensed by the State of Colorado as a Health Maintenance Organization (HMO), the organization is a wholly-owned subsidiary of Denver Health and Hospital Authority (DHHA). Denver Health is an academic, community-based, integrated health care system that serves as Colorado’s primary “safety net” system. DHMP offers a full spectrum of health care services for members through DHHA’s integrated health care system and an expanded network of providers throughout the metro Denver area. The Quality Improvement (QI) Program Description outlines the organization’s efforts to improve the overall quality of care, service and safety for Commercial, including Denver Health Medical Care, HighPoint and Point of Service, Exchange and Medicare benefit members.

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

MISSION STATEMENT

To provide affordable, high-quality health care 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 services with responsibility and respect to all

QUALITY STATEMENT AND PROCESS

DHMP’s QI Program is designed to support the mission of DHMP by promoting the delivery of high-quality, accessible health care services that will improve or stabilize the health status of DHMP members.

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

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider and practitioner experience surveys
- Member experience surveys
- Health Plan Services call data
- Medical record reviews
- Claims data
- Pharmacy data
- Case Management data
- Utilization Management (UM) data
- Population Health Management (PHM) data

These sources provide DHMP with the collection of data necessary to improve the appropriateness, efficiency, effectiveness, availability, timeliness and continuity of care delivered to our members. This approach also allows DHMP to focus on opportunities for improving operational processes, increasing member and practitioner satisfaction and managing health outcomes. DHMP’s 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 service
- Enabling members to play an active role in their health care
- Delivering our services with responsibility and respect to all.

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

### QI PROGRAM STRUCTURE

#### OVERSIGHT

**DHMP Board of Directors**

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

**Composition:**

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

**Function:**

- Approve the QI Program Description, QI Work Plan and QI Annual Evaluation
- Approve Medicare SNP Model of Care annual goals
- Review applicable DHMP quality data such as CAHPS, HEDIS, Medicare Stars, etc.

### AUTHORITY AND RESPONSIBILITY

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

2. **Medical Director** responsibilities include, but are not limited to:
   - Provide direction, support and oversight related to the development, implementation and evaluation of all clinical activities of the QI Department
   - Work in collaboration with the QI Director and QI Team on development and assessment of clinical interventions
   - Report findings from clinical interventions to the appropriate groups, such as the Ambulatory Quality Improvement Committee (AQIC), QMC and DHMP Board of Directors
   - Work with the QI Director on preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, Operations Management Committee, AQIDC and DHMP Board of Directors
   - Provide oversight for clinical activities in the QI Work Plan
   - Delegate components of the QI Work Plan to other members of the Operations Management Committee
   - Serve on the QMC, AQIC, Medical Management Committee (MMC), Credentialing Committee, Operations Management Committee and DHHA Patient Safety and Quality Committee
   - Serve as the designated physician in the QI Program, including participating in the QMC and related subcommittees, as necessary
   - Provide evaluation and management of DHMP Quality of Care Concerns (QOCCs) related to physical health problems while working in conjunction with QI Registered Nurse (RN) resources
   - Report QOCCs to the DHHA Patient Safety and Quality Department and external network Providers, as appropriate
   - Oversee all DHMP clinical and preventive health guidelines

3. **Behavioral Health Care Physician (M.D.) Practitioner** responsibilities include, but are not limited to:
   - Participating in and/or advising the QMC and related subcommittees

4. **Director of Health Plan Medical Management** responsibilities include, but are not limited to:
   - Chair and participate in the MMC
   - Develop, implement and evaluate new and existing complex case management (CCM), chronic care, disease management (DM) and population health management (PHM) Programs, as well as general health and wellness promotion and prevention programs
   - Assist with the development, revision and /or implementation of behavioral health aspects of the QI Program, including behavioral health clinical and preventive health guidelines
   - Collaborate with the QI Department to review medical and behavioral health programs and services offered by network providers to ensure adequate access to meet member needs
   - Develop and oversee the Case Management Program as it effects our external network
   - Author Health Plan Medical Management program description and evaluation, as well as the Special Needs Plan (SNP) Model of Care (MOC) program evaluation, and submits to QMC annually
   - Produce, analyze and present over/under utilization reporting, and action plan development and management to MMC and relevant committees and workgroups
   - Utilize predictive modeling, gaps in care analyses or other data analyses to identify and stratify high-risk members and/or those with special health care needs who could benefit from participation in the programs

5. **Quality Improvement (QI) Department:**

   **DHMP Director of QI** responsibilities include, but are not limited to:
• Development, management and monitoring of the QI Program
• Act as QI staff representative to the DHMP Board of Directors
• Directly assume authority and responsibility for the organization and administration of the QI Program and submission of the QI Program Description, Evaluation and Work Plan annually
• Coordinate, provide advice and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health departments, as appropriate, for regulatory compliance
• Serve as Chairperson for the QMC, including determining the composition of the QMC and coordination of meeting execution
• Annually ensure all policies, procedures and guidelines related to the QI Department are updated appropriately
• Oversee QI vendor contracts and delegated activities
• Provide oversight and direction to the QI Department, consisting of the following members:

**HEDIS Program Manager** responsibilities include, but are not limited to:
• Manage all aspects of HEDIS production, including oversight of related projects
• Evaluate and analyze HEDIS results
• Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
• Work collaboratively with Intervention Manager(s) on process improvements and quality interventions related to HEDIS
• Validate the accuracy of HEDIS data and supporting documents

**QI Project Manager** responsibilities include, but are not limited to:
• Manage all aspects of CAHPS-related projects
• Evaluate, analyze and report CAHPS results as well as facilitate improvement efforts
• Analyze the effectiveness of intervention activities
• Coordinate all efforts related to Work Plans, Evaluations and Program Descriptions
• Lead activities related to regulatory and accreditation requirements
• Work in collaboration with Population Health and QI Intervention Project Manager(s) to maintain a timeline for deliverables
• Co-direct and work with the QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and bi-monthly reporting requirements
• Function as main administrative contact for the QMC

**Population Health and QI Intervention Manager** responsibilities include, but are not limited to:
• Develop, manage and evaluate all quality interventions
• Work collaboratively with the Medical Director, QI Director, AQIDC, Ambulatory Care Services, ACS condition-specific work groups, external provider network HEDIS Program Manager, other applicable staff and Data Analyst on all quality interventions
• Lead health care initiatives related to health literacy and cultural disparities
• Oversee multicultural health care-related activities including cultural competency training, cultural and linguistic appropriate services and identification of any health disparities

**RN Staff support for QI Activities** include, but is not limited to:
• Manage QOCCs and SRAE concerns processes in a timely and effective matter
• Work in collaboration with HEDIS Program Manager to perform HEDIS chart reviews
• Develop training materials, facilitate training, test for inter-rater reliability (IRR) and retrain staff
• Provide clinical consultation for the QI Department
• Conduct practitioner chart review using HEDIS criteria
• Develop and update all preventive and clinical guidelines
 COMMITTEE STRUCTURE

1. QUALITY MANAGEMENT COMMITTEE (QMC)

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

Composition:
- DHMP Director of Quality Improvement (Chair)
- DHMP Medical Director
- DHMP Director of Health Plan Services
- DHMP Health Plan Services Manager
- Manager of Monitoring, Auditing and Training
- DHMP Appeals and Grievances Manager
- DHMP Director of Provider Relations
- DHMP Director of Pharmacy
- DHMP Director of Health Plan Medical Management (UM, CM, Population Health and Medical Management)
- DHMP UM Manager
- DHMP Care Coordination Director
- DHMP Medicare Government Product Line Manager
- DHMP Medicaid Government Product Lines Manager
- DHMP Commercial Products Director/Manager
- DHMP Marketing Manager
- DHMP NCQA Project Manager
- PCP(s) from DHHA and the External Provider Network
- Specialty Care Provider(s) from DHHA and the External Provider Network
- Behavioral Health Physician (M.D) Provider(s) from DHHA or the External Provider Network

Functions:
- Serve as the advisory and oversight body for quality initiatives and activities
- QMC 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
  - Monthly meetings may be held as needed to meet quarterly improvement structural and performance requirements
- Oversee accurate and clear reporting of QMC minutes, including follow-up actions
- Recommend clinical and safety initiatives in regards to policy decisions
- Review and evaluate results of QI activities
- Oversee needed actions for improvement on performance goals
- Supervise follow up of issues and activities when organizational goals are not reached
  - QI Director and Department will conduct root cause analyses or barrier analyses
- Review and approve clinical and preventive practice guidelines
• Review Health Plan Services and Appeals and Grievances performance
• Review member satisfaction and quality of care and quality of service results, such as CAHPS, HEDIS and Open Shopper Studies
• Review and evaluate activities that improve member experience, such as access to care and quality of services, as well as make recommendations about ways to improve these results
  o Review findings of QOCCs and SRAE overview reporting and trending
• Review Health Plan Medical Management and Pharmacy program performance
• Review annual SNP MOC program evaluation and goals
• Provide oversight and recommendations regarding utilization of new technologies and benefit design, as needed
• Provide oversight of QI Program deliverables including, but not limited to:
  o QI Program Description
  o QI Work Plan
  o QI Evaluation
  o Clinical and Preventive Practice Guidelines

Reporting Committees to the QMC include, but are not limited to:
• Ambulatory Care Services QI Committee (QIC)
• Pharmacy and Therapeutics Committee (P&T)
• Medical Management Committee (MMC)
• Network Management Committee (NMC)

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

Composition:
• DHMP CEO/Executive Director
• DHMP CAO (Chair)
• DHMP CFO
• DHMP Medical Director
• DHMP Director of Pharmacy
• DHMP Director of QI
• DHMP Manager of Monitoring, Auditing and Training
• DHMP Director of Information Systems (IS)
• DHMP Director of Health Plan Medical Management
• DHMP Director of Health Plan Services
• DHMP Manager of Appeals and Grievances
• DHMP Medicaid/CHP Product Line Manager
• DHMP Medicare Product Line Manager
• DHMP Manager of Commercial Products
• DHMP Manager of Marketing
• DHMP Director of Compliance
• DHMP Director of Provider Relations

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

3. MEDICAL MANAGEMENT COMMITTEE (MMC)

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

Composition:
• DHMP Medical Director (Chair)
• DHMP Manager Utilization Management
• DHMP Director of Health Plan Medical Management
• DHMP Manager of Monitoring, Auditing and Training
• DHMP Manager Case Management
• DHMP QI Director
• DHMP NCQA Project Manager
• DHMP Director of Pharmacy
• DHHA Behavioral Health Provider (M.D.)
• Primary and Specialty Care Providers from CHS Provider Network
• Primary and Specialty Care Providers from the Extended Provider Network

Functions:
• Provide direction on Health Plan Medical Management Department initiatives
• Review and approve Program Description and Evaluations
• Monitor compliance with CMS and State/Federal regulations and mandates
• Oversee NCQA accreditation deliverables as they relate to UM, Case Management, Health Management, DM/PHM and Pharmacy
• Analyze utilization data to identify potential areas of over- or under-utilization of health care services and determine appropriate interventions, when necessary
• Analyze utilization reports to identify significant trends and determine appropriate follow up
• Report significant findings to the QMC at appropriate intervals, including selection of opportunities, action plans and progress reports
• Reviews IRR reports at least annually to ensure consistency of UM staff decision making
• Identify opportunities for utilization and/or cost-savings management
• Provide strong support and oversight to improve continuity and coordination of care between medical providers and behavioral health providers
• Work in collaboration with the Network Management Committee (NMC) to ensure adequate medical access to care services
• Develop improvement initiatives to increase member satisfaction with the plan for Medical Management functions
• Perform any ad-hoc benefit interpretation for new and existing benefit design and administration and perform ad-hoc technology assessment investigation, analysis and recommendations regarding coverage of new equipment, pharmaceuticals, medical procedures and services

4. CREDENTIALING COMMITTEE

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

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

Functions:
• Annually review and approve the credentialing and recredentialing criteria, as well as the process used to make credentialing and recredentialing decisions
• Annually review and approve credentialing Policy’s & Procedure’s (P&P’s)
• Review results of ongoing monitoring of sanctions and grievances
• Review and determine participating status of practitioners who, at a minimum, do not meet the established credentialing criteria
• Review the clean files that were approved by the DHMP Medical Director (those meeting all criteria with no malpractice claim history)
• Review and approve all delegated approved practitioners
• The Medical Compliance Specialist is responsible for keeping accurate meeting minutes and recording approval or denial for each practitioner presented
• Prevent discriminatory practices by prohibiting any discriminatory factors in its review of practitioners
• Files classified as clean files may be reviewed by the DHMP Medical Director who determines the file to be approved by the sign off of the Medical Director (or Associated Medical Director, or other qualified medical staff member as the designated Medical Director if this individual has equal qualifications as the Medical Director and is responsible for credentialing)
• Present “Red Flag” files (those not meeting the minimum criteria and standards) with detailed information pertaining to malpractice claims or sanctions for a decision
  o 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
• Review SRAE by individual providers and system trend, and take actions as appropriate
• Request individual practitioner file information from the entities with delegated credentialing responsibility for review in response to a potential issue identified during Company oversight

5. PHARMACY AND THERAPEUTICS COMMITTEE

DHMP uses the Denver Health Pharmacy and Therapeutics Committee (P&T Committee) for formularies that are maintained internally and the MedImpact P&T Committee for formularies that are delegated to be managed by the pharmacy benefit manager (PBM), MedImpact.
The P&T Committees are tasked with promoting safe and appropriate use of high-quality, cost-effective pharmaceuticals, as well as ensuring medication use is in compliance with appropriate standards and state and federal regulations. The Committees review clinically effective medications and consider whether the inclusion of a particular drug has any therapeutic advantages in terms of safety and efficacy. Clinical decisions are based on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research data and other such information, as deemed appropriate. The Committees use appropriate scientific and economic considerations to consider utilization management activities that affect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution and therapeutic interchange protocols.

**Functions of Denver Health and MedImpact P&T Committees:**
- Evaluate and approve formulary drug additions and deletions while ensuring safety and effectiveness
- Review and approve the Company’s formulary drug list at least annually
- Review and approve the Company’s pharmaceutical management procedures annually
- Evaluate new drugs, drug classes, new clinical indications, therapeutic advantages and new safety information
- Support educational programs promoting appropriate drug use

**The Denver Health P&T Committee:**
- Meets monthly
- Is comprised of the following members:
  - DHHA Physicians across multiple specialties (e.g., infectious disease, critical care, pediatrics, etc.)
  - DHHA Pharmacists across multiple specialties (e.g., oncology, infectious disease, etc.)
  - Representatives from DHHA and CHS
  - Physicians affiliated with non-Denver Health sites of care (e.g., Rocky Mountain Poison and Drug Center Physicians, University of Colorado, etc.)
  - Director of Pharmacy and Clinical Pharmacist Formulary and Operations Management attend as a non-voting member

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

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

Composition: The Committee includes, at a minimum, a cross section of the members of the Operations Team. Members of the Committee should have the required seniority and comprehensive experience within their respective departments to implement any necessary changes to policies and procedures as recommended by the Committee. In addition, a representative from the DHHA Legal Department shall serve as legal advisor to the Committee. The Committee is chaired by the CCAO or their delegate. The members appointed by the Chief Compliance and Audit Officer (CCAO) in consultation with the CEO, and includes:

- CEO, DHMP
- Chief Compliance and Audit Officer
- Medical Director
- General Counsel, DHHA
- Legal advisor to Committee
- Chief Administrative Officer
- Chief Financial Officer
- Director, Pharmacy
- Director, Quality Improvement
- Director, Health Management
- Director, Provider Relations & Contracting
- Director, Claims Operations
- Director, Information Systems
- Director, Health Plan Services
- Manager Health Plan Services
- Manager, Commercial Product Line
- Manager, Government Products - Medicare
- Manager, Government Products – Medicaid
- Privacy Officer
- Chief Information Security Officer
- Compliance Analyst/Auditor
- Administrative Assistant, ECS (Scribe)
- Pharmacy Compliance Analyst
- Manager, Grievance and Appeals
- Manager, Internal Audit
- Director, Compliance & Internal Audit
- Manager, Compliance

Function: In order to comply with laws, rules and regulations, the members of the Compliance Committee are responsible for advising the CCAO in developing and implementing the following: (please note this list is not all inclusive and may at any time be subject to change):

- Written Policies and Procedures Accountabilities of CCAO and Compliance Committee.
- The CCAO has authority for oversight and monitoring of all compliance reporting functions to the CEO of DHMP, Inc. Executive Director of Managed Care, Compliance Committee, and DHMP Board of Directors.
• Conducting Effective Training and Education
• Develop Effective Lines of Communication
• Auditing & Monitoring Enforcing Standards through Well-Publicized Disciplinary Guidelines
• Responding to Detected Offenses, developing Corrective Action Plans, and Reporting to Government Authorities

6. NETWORK MANAGEMENT COMMITTEE (NMC)

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) Provider contract management, including oversight; (3) Periodic assessment of network capacity; and (4) Development and maintenance of an overall strategic plan for Plan provider relations and contracting.

Composition:
- DHMP Director of Provider Relations – (Chair)
- DHMP Product Line Managers
- DHMP Medical Director
- DHMP QI Representative, as required
- DHMP UM Representative, as required
- DHMP CM Representative, as required
- DHMP DM/PHM Representative, as required
- DHHA Physicians and Administrators Representative, as required
- DHMP Provider Relations Representative
- DHMP Director of QI
- DHMP Director of Health Plan Medical Management
- DHMP Credentialing Manager
- DHMP NCQA Project Manager

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

GOALS AND OBJECTIVES

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

THE QI PROGRAM STRIVES TO ACHIEVE THE FOLLOWING GOALS:
• Ensure quality of care and services that meet CMS, State of Colorado and NCQA requirements utilizing established, best practice goals and benchmarks to drive performance improvement
• Measure, analyze, evaluate and improve the administrative services and processes of the plan
• Measure, analyze, evaluate and improve the health care services delivered by contracted practitioners
• Promote medical and preventive care delivered by contracted practitioners that meets or exceeds the accepted standards of quality within the community
• Achieve outcome goals related to member health care access, quality, cost and satisfaction
• Empower members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic conditions, community outreach efforts and coordination with public/private community resources
• Educate members about patient safety through health promotion activities, member newsletters and community outreach efforts
• Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines

THE QI PROGRAM OBJECTIVES FOR MEETING THESE GOALS INCLUDE THE FOLLOWING:

• Design and maintain the QI structure and processes that support Continuous Quality Improvement (CQI)
  o The summarized approach to achieve this aim is as follows: (1) Analysis of available data; (2) Trending and barrier/root cause analysis of measures; (3) Implementation of intervention(s); and (4) Re-measurement of targets
• Continuously measure, analyze, evaluate and improve the clinical care and administrative services of the Plan and health care services delivered by contracted practitioners/providers, using HEDIS measures, QI projects and activities and CAHPS member surveys
• Assure compliance with all Federal and Colorado State statutes and regulatory/contractual requirements
• Monitor member satisfaction and identify/address areas of dissatisfaction through an annual review of the following data: (1) CAHPS 5.0 H; (2) Member feedback; (3) Grievance and appeals data; (4) Out-of-network requests; and (5) Quality of Care complaint(s) including access to care related QOCC’s
• Monitor and maintain safety measures and address identified problems
• Design and maintain a chronic care improvement program and objectively and systematically measure and analyze its health outcomes and enrollee satisfaction data
• Review any annual provider and practitioner experience survey to evaluate satisfaction with the medical management process and services as they relate to continuity and coordination of care
• Monitor access through CHS and Appointment Center reports and institute improvement processes when opportunities for improvement are indicated
• Provide multiple avenues for members to obtain Case Management, CCM and Behavioral Health and Wellness services
• Provide a comprehensive Health Plan Medical Management Program to identify, track and facilitate care transitions and coordinate care for members
• Collaborate with ACS on the development of initiatives for special needs of racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate
• Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis
• Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes

PROGRAM SCOPE

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

QI structures activities to offer optimal quality and cost effectiveness by ensuring CQI of health care services. Areas targeted for CQI include:

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

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

- Identify language needs and cultural background of members, including prevalent languages and cultural groups using enrollment data
- Identify languages and cultural background of practitioners in provider network to assess whether or not they meet members’ language needs and cultural preferences
- Take action to adjust the provider network if the current network does not meet members’ language needs and cultural preferences
- Develop, implement and evaluate the culturally- and linguistically-appropriate services in collaboration with DHMP staff and other departments and staff, as needed
- Ensure interpreter and translation services and auxiliary communication devices will be available to the member at no cost
- Document and forward member needs identified during member contacts or upon receipt of the member questionnaire to the Health Plan Medical Management Department, as needed
- Evaluate CAHPS questions that relate to interpretation and health literacy satisfaction to identify areas for improvement, and implement action plans, as needed
- Monitor HEDIS measures health disparities and conduct a yearly analysis of the data is to assist in the development of targeted health prevention and education programs that address, identify and reduce health disparities based on available data
- Identify annually, using aggregated member Race/Ethnicity/Language (R/E/L) data, languages that must be used in patient materials for quality improvement and marketing activities
- Assess annually aggregated provider R/E/L data to ensure all materials, including translated materials meet the cultural competency and grade level appropriate for the population
  - All member written materials for prevalent populations (>500 members) are translated and made available to members in the respective languages
  - These materials appear at a 6th-grade reading level and are available, upon request in braille, large print, audio tape format, or other applicable formats to meet member needs
• Maintain a library of culturally-sensitive health prevention and education materials to be used in member mailings
• Participate in DHHA initiatives for reducing health disparities for Plan membership and community

Annually, staff diversity training is provided to:
• Support the linguistic needs of Denver Health members and the surrounding community by providing Health Literacy Trainings on-demand to Denver Health and community stakeholder staff and/or providers
• Support the cultural needs of Denver Health members and the surrounding community by providing cultural competency and responsiveness training to Denver Health and community stakeholder staff and/or providers
• Include annual cultural diversity web course required for all employees

HEALTH PLAN MEDICAL MANAGEMENT SERVICES

Program Structure:
The Health Plan Medical Management Department, operates under the direction of the Medical Director and the Director of HPMM, who is fully involved in the development, implementation, supervision, oversight and evaluation of the HPMM Program. A team of licensed Registered Nurses (RNs) and other non-clinical staff report to the Manager of HPMM and work to ensure that HPMM goals are achieved efficiently and consistently. This department includes the functions of Care Management (CM) and Utilization Management (UM) and Population Health Management (PHM).

The Health Plan Medical Management Department (HPMM) provides evidence-based chronic disease management/chronic care improvement programs, case management, utilization management, wellness and health promotion services and other preventative services to improve member outcomes and reduce costs. These programs and interventions are aimed at helping members develop the skills necessary for making healthy choices and lifestyle changes to effectively self-manage physical and behavioral health conditions. They also help to make sure that members are receiving appropriate health care, by the right providers within the right time frame and are connected with the necessary resources and services. Ongoing programs and interventions include:
• Utilization Management
• Care Management
• Population Health Management
• Health Coaching
• Education and Support Groups
• Support Integrated Primary Care
• Health Communication Strategies
• Wellness and Prevention Strategies
• Dual Eligible Special Needs Plan Model of Care (SNP MOC)

Program Development and Approval
The HPMM department maintains a Program description and performs an annual program evaluation for UM and CM. Each year, HPMM completes a Program Evaluation, and uses the findings in that Evaluation to evaluate and revise the HPMM Program Description. Both documents are brought to the MMC for review and approval, as well as to the QMC via MMC Minutes for additional approval.

Care Management Programs
DHMP COMM and MCR 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 – Hepatitis 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
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 2021 and the following key initiatives are planned with executive support:

- 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,© was developed in 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.

Utilization Management Programs:
The UM Department is a division of the DHMP Medical Management Department, which operates under the direction of the Medical Director who is fully involved in the development, implementation, supervision, oversight and evaluation of the UM Program. The Medical Director delegates the responsibilities of daily operations to the Managers of UM/CM. A team of licensed Registered Nurses (RNs) and other non-clinical staff report to the Managers of UM/CM and work to ensure that UM goals are achieved efficiently and consistently.

The UM Program strives to achieve the following objectives:
• To support the role of the medical provider in the effective provision and management of patient care
• To promote fair and consistent UM decision making and authorization processing
• To assist in the promotion and maintenance of optimally-achievable quality of care
• To educate medical practitioners, providers and other health care professionals about the appropriate use and
cost-effectiveness of health care resources
• To provide a system that monitors the delivery of services in a timely, effective and efficient manner
• To monitor, evaluate and optimize utilization practice patterns of practitioners, providers, contracted hospitals,
ancillary services and specialty providers
• To provide appropriate and timely feedback to members, practitioners and providers in order to communicate
reasons for treatment denial, as well as methods for appeal and the minimum clinical criteria required for
authorization
• To safeguard medical records, treatment authorizations and all other confidential information through
appropriate operation protocols, as well as through the use of physical mechanisms to safeguard Protected
Health Information (PHI)
• To ensure consistency by conducting Inter-Rater Reliability (IRR) testing of physician and non-physician UM staff

Interrater Reliability Metrics:
Background:
Inter-Rater Reliability (IRR) is used to evaluate the consistency with which health care professionals involved in UM apply
criteria in decision making and allow DHMP to act on opportunities to improve consistency, if applicable.
Scope:
The assessment of IRR applies only to determinations made as part of a UM process. All staff using criteria to make
decisions on medical prior authorization (PA) requests receive a test to determine IRR. In Calendar Year 2019 (CY-19),
which ran from January 1st through December 31st of 2019 three existing staff employed greater than 12 months and
nine new clinicians were tested on topics that included:
New Employee Training Modules
• Ambulatory Care
• Behavioral Health Care
• General Recovery Care
• Home Care
• Inpatient and Surgical Care
• Multiple Condition Management
• Recovery Facility Care
For existing staff
• IRR #22-106 Cardio
• IRR #A22-110 GYN
• IRR #22-21 Wound/HH
• IRR A22-127 Behavioral Health
• IRR 22-35 CPCP Pulmonary
Methodology:
At least annually, DHMP assesses the consistency with which physician and non-physician reviewers apply UM criteria,
and evaluates IRR. Staff are provided a test that requires the use of clinical guidelines prior to fulfilling a PA request.
Whether staff are inpatient or outpatient determines which modules are taken, and some modules are not applicable to
a particular clinician. In 2019, DHMP used MCG and DHMP’s PA Approval Criteria to make medical necessity
determinations throughout the IRR. The assessment of IRR applies only to determinations made as part of a UM process, and uses hypothetical UM test cases.

DHMP’s IRR testing methodology for clinicians consists of at least the following:

- Review examples that represent a typical determination decision
- Use standardized, established criterion to determine if medical necessity has been met or not
- Document authorization and rationale for making medical necessity determinations
- Calculate scores based on the accuracy of criteria application

Once complete, the MMC reviews test results for variations in decisions and/or interpretation, and assists with identifying areas of opportunity for improvement.

POPULATION HEALTH MANAGEMENT

The Population Health Management (PHM) Strategy outlines Denver Health Medical Plan, Inc.’s (DHMP’s) strategy for meeting the care needs of its member population, and to present a cohesive plan for addressing member needs across the continuum of care.

DHMP has developed a PHM strategy to meet the care needs of its member population. The PHM Strategy focuses on member needs in four areas of focus.

The four areas of focus are:

1.) Keeping members healthy
2.) Managing members with emerging risk
3.) Patient safety or outcomes across settings
4.) Managing multiple chronic illnesses

Each area of focus includes the following:

- **Goal:** Measurable and specific to the target population
- **Target Population:** Members targeted for intervention
- **Program:** A collection of services or activities to manage member health
- **Service:** An activity or intervention in which members can participate to help reach a specified health goal

The HPMM department maintains a PHM Program description and performs an annual program evaluation. Each year, HPMM completes a PHM Program Evaluation, and uses the findings in that Evaluation to evaluate and revise the PHM Program Description. Both documents are brought to the MMC for review and approval, as well as to the QMC via MMC minutes for additional approval.

PATIENT SAFETY

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

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

**Patient safety objectives:**

- Encourage organizational learning about medical and health care errors
• Incorporate recognition of patient safety as an integral job responsibility
• Incorporate patient safety education into job competencies
• Implement corrective, preventative and general medical error reduction education programs to reduce the possibility of patient injury
• Involve patients in decisions about their health care to promote open communication about medical errors and consequences that result
• Collect and analyze data to evaluate care processes for opportunities to reduce risk and initiate actions
• Review and investigate serious outcomes, in collaboration with risk management, where patient injury occurred or patient safety was impaired
• Review and evaluate actual and potential risk of patient safety in collaboration with risk management
• Report findings and actions internally with a focus on processes and systems to reduce risk
• Distribute information to members and providers via newsletter and/or the website to help promote and increase knowledge about clinical safety
• Focus existing QI activities on improving patient safety by analyzing and evaluating data related to clinical safety
• Trend adverse events reporting in safety practices (e.g., medication errors)
• Annually review and evaluate clinical practice guidelines to ensure safe practices

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

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

ADVOCACY AND AVAILABILITY OF SERVICE

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

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

DHMP will continue to perform Network Adequacy reports to evaluate Denver Health facilities, plus a sample of its extended network of practitioners, to assess the process a member would undertake to schedule a care appointment. This collection of data is shared with the QMC and many other work groups that develop corrective actions, when
deemed appropriate. DHMP will assure that female members are provided with direct access to women’s health specialists within the network for covered services.

**BEHAVIORAL HEALTH INTEGRATION AND SERVICE**

DHMP maintains programs that provide behavioral health support including Transitions of Care (TOC), Care Coordination (CC), Complex Case Management (CCM) and D-SNP Medicare Choice (DSNP) (specifically for Dually Eligible Medicare/Medicaid Special Needs Populations). These programs include RNs (Registered Nurses) and MSWs (Master Level Social Workers) who are trained to complete all depression, anxiety, and other MH assessments and coordination as well as LCSWs (Licensed Clinical Social Workers) and LBHC (Licensed Behavioral Health Counselor) who are licensed and trained in Behavioral Health.

Behavioral Health assessments are an important component of the DHMP programs, and can include Patient Health Questionnaire (PHQ-2 and PHQ 9), Mini-Mental Status Exam, Social Determinants of Health (SDOH), Edinburgh Postnatal Depression Scale (EPDS), Generalized Anxiety Disorder (GAD 7), Health Risk Assessment (HRA), Health Needs Survey (HNS) and Behavioral Health Cognitive Functioning assessments. Care Management program participants often present with more than a set of medical issues, and psychological or social factors may affect recovery or adherence with treatment. A variety of interdisciplinary care team members conduct assessments that inform the care plan.

DHMP Care management provides a variety of external referral paths for members and providers including email, web based provider portals, telephone and fax options. DHMP Care management programs also provide coordination with DHHA and other Health Care Entities for our Members for behavioral health. These entities include Employee Assistance Program (EAP) and school counselors – for Commercial members as well as Mental Health Center of Denver (MHCD) (DHHA has embedded a medical clinic within the Mental Health Center of Denver (MHCD) to serve the severe and persistent mental illness population), DHHA OBHS Substance Use Disorder Rehabilitation Units (that provides medically monitored, interdisciplinary addiction focused treatment to members who have psychoactive substance use disorders) ACS Integrated Behavioral Health (Primary Care Providers/Behavioral Health Providers), Specialty Mental Health Providers and Colorado Coalition for the Homeless for Medicare and Commercial members, as indicated.

Denver Health Hospital Authority, in the Ambulatory Care Services (ACS) division, maintains a variety of care service delivery for the DHMP HMO plan, and in collaboration with DHMP, for the health plan members who receive, or who are assigned to receive, care at Denver Health Medical Center. As part of planned care in ambulatory care, ACS maintains behavioral care in the outpatient primary care clinics in a model call ‘integrated behavioral health’, as well as offering outpatient behavioral health services (OBHS) in a behavioral health specific clinic on the DHHA Campus. DH Ambulatory Care Services is a sister organization, and is a NCQA accredited PCMH.

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

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

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CLINICAL AND PRACTICE GUIDELINES

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

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

Activities related to clinical and practice guidelines include, but are not limited to, the following:
- Develop new clinical guidelines where opportunities for improving clinical practice are identified
- Assure member benefit coverage for any elements of guidelines adopted
- Evaluate compliance with developed clinical guidelines and related clinical outcomes
- When appropriate, use evidence based guidelines for QI activities/projects and member education

CONTINUITY AND COORDINATION OF CARE
Opportunities will be identified for improvement in the coordination of medical care. Staff will facilitate transition of care for all new and existing members across the continuum of care. Opportunities for improvement in the coordination of care include:
- Improve continuity and coordination of care between behavioral and physical health care to assure timely and accurate communication
- Improve continuity and coordination of care between primary and specialty care providers to assure timely and accurate communication

Additional opportunities for improving continuity and coordination of care will be addressed, as identified.

The QI Department works in collaboration with the Health Plan Medical Management department to actively monitor and take action, as necessary, to improve continuity and coordination of care across the health care network. Annually, the MMC identifies opportunities to improve coordination of medical care via data collection and quantitative and causal analysis of this data, as well as implements initiatives for improvement.

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

QUALITY OF CLINICAL CARE
The QI Department annually collects and reports out HEDIS data according to DHMP’s contract requirements. HEDIS results are analyzed for opportunities to improve all measures with an emphasis on diabetes, cardiovascular conditions, asthma, behavioral health and preventive care for our members. Every 3 years, QI initiates one Chronic Care Improvement Project (CCIP) for both Medicare Advantage and Medicare SNP populations. This improvement project is directed by CMS per regulations. All DHMP QI activities related to DHMP members undergo the Denver Health “plan, do, study, act” (PDSA) methodology to ensure interventions are handled properly.

The RN Staffing Support for QI Activities, with oversight from the DHMP Medical Director, investigates any potential QOCCs from members, providers or CMS. All QOCCs are tracked, trended and reported to the DHMP QMC and the DHMP Board of Directors. If a QOCC is found to be substantiated, a CAP will be put in place, if it relates to a system-wide issue. All reported, substantiated grievances regarding providers are sent to the Denver Health Patient Safety and Quality Department or delegated entity, if necessary, for follow up, and if necessary for recredentialing purposes. The DHMP Medical Director, along with the QI RN, continuously monitor and trend all member QOCCs.

MEMBER SATISFACTION
The DHMP QI Department evaluates and trends member satisfaction data through the annual CAHPS member survey. If statistically significant decreases occur in any CAHPS measures, a CAP will be established with regular monitoring of
progress. QI Intervention Managers examine the CAHPS data, in collaboration with the QI Project Manager, and assist in identifying opportunities for improvement to roll out new initiatives/activities.

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

At least annually, the Commercial and Government Products Team collaborate with various stakeholder teams across DHMP to create a member experience survey. Once finalized, this survey is provided to members through a variety of mediums to assess their experience with DHMP during the most recent calendar year (CY). Upon completion, the Teams perform both quantitative and qualitative analyses of data, then work directly with stakeholders to identify barriers, pinpoint opportunities for improvement and propose interventions, if needed, to be implemented. Findings are presented at the QMC.

Components of the survey include:
- Member Plan Information
- Member Demographics
- Experience with Member Materials
- Experience with Health Plan Services
- Experience with Accessing Providers and Practitioners
- Experience with UM
- Experience with CCM

PROVIDER SATISFACTION
At least annually, the Provider Relations Team collaborates with various stakeholder teams across DHMP to create a provider and practitioner experience survey. Once finalized, this survey is emailed to providers and practitioners to assess their experience with DHMP during the most recent CY. Upon completion, the Provider Relations Team performs both quantitative and qualitative analyses of data, then works directly with stakeholders to identify barriers, pinpoint opportunities for improvement and propose interventions, if needed, to be implemented. Findings are presented at the NMC, as well as at the QMC via minutes.

Components of the survey include:
- Overall Satisfaction with DHMP
- Experience with Requests for Durable Medical Equipment (DME)
- Experience with Requests for Home Health Services
- Experience with Requests for Out-of-Network Services
- Experience with Prior Authorization Requests (PARs) for Medication
- Experience with Exchanging Patient Information
- Experience with Quality Improvement (QI) Department
- Experience with Website

CREDENTIALING AND DELEGATED CREDENTIALING
The Provider Credentialing Manager assures the compliance of credentialing and recredentialing activities with CMS standards, and conducts primary source verification for any direct credentialed practitioner. The Provider Credentialing Manager will evaluate the delegated entity’s credentialing compliance with DHMP credentialing and recredentialing standards annually. Site visits will be conducted for any practitioner’s office site (primary and specialty) that exceeds the
acceptable threshold for complaints related to physical accessibility, physical appearance and/or adequacy of waiting and exam room spaces. Audit results will be reported to the Credentialing Committee.

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

DELEGATION ACTIVITIES AND OVERSIGHT
Delegation oversight and vendor/subcontractor management with respect to regulatory, contractual and performance oversight reports are reported to the Compliance Committee on a quarterly basis. The QMC has advisory oversight responsibilities for delegated, quality-related activities. Specific functions of the QMC may be assigned to work groups and subcommittees of the QMC. Furthermore, the Operations Team has administrative responsibility for the implementation, monitoring and maintenance of all delegated activities. Current delegation agreements are in place for Pharmacy PBM, MedImpact (an NCQA UM accredited delegate and for credentialing of selected networks.

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

The Plan maintains seven delegation agreements for the credentialing and recredentialing of internal and external/expanded networks. These include an NCQA-accredited Cofinity Network (Aetna) and the DHHA sister organization, as well as five external networks, Columbine Chiropractic and University of Colorado Medicine (UC Health), Dispatch health, Sisters of Charity of Leavenworth (SCL) and Pop Health.

QUALITY IMPROVEMENT PROGRAM ANNUAL WORK PLAN AND EVALUATION

ANNUAL WORK PLAN
The QI Department will develop a QI Work Plan in the beginning January of each year. The Work Plan covers the scope of the QI Program, and includes:

- Yearly planned activities and objectives, including the time frames for each activity’s completing and the staff responsible for each activity, for improving:
  - Quality of clinical care
  - Safety of clinical care
  - Quality of service
  - Member experience
- Monitoring of previously identified issues
- Evaluation of the QI Program
- Written, measurable, objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities with Departments including, but not limited to:
  - Health Plan Medical Management
  - Pharmacy
- Provider Network Adequacy

See Attachment for the QI Annual Work Plan
ANNUAL EVALUATION

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

The Evaluation includes:

- Description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service, including delegated functions
- Trending of quality and safety measures and comparison with established thresholds
- Measurement and trending of HEDIS and CAHPS data to define opportunities for improvement
- Analysis of whether there was a demonstrated improvement, including barrier analysis when goals were not met
- Evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices, adequacy of resources, committee structure, practitioner participation, leadership involvement and any determination of restructure or change(s) to be made for the subsequent year, based on findings

ADMINISTRATIVE FUNCTIONS

CONFIDENTIALITY

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

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

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

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

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

CONFLICT OF INTEREST

No person may participate in the review, evaluation or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. All DHMP employees, members of committees not employed by the organization and the Board of Directors are required to review and sign the Conflict of Interest statement annually.