DENVER HEALTH MEDICAL PLAN, INC.
Commercial, Medicare and Elevate Quality Improvement Work Plan
2022

Dept. Section	Structure	Activity/ Regulations	Objective	Requirement/ Planned Activity	Performance Target/Goal	Responsible Party	Reports To	Reporting Frequency											
* Governance -Quality Program	Quality Improvement Program Structure	NCQA QI 1A *2023 QI Program Description	**The QI Program Description** will be annually reviewed and updated according to national and state standards and guidelines with an emphasis on the QI program scope, goals, objectives and structure. This document will clearly outline how the QI program is organized and how it uses its resources to meet program objectives. This will include functional areas and their responsibility and the reporting relationship between the QI Department and the Quality Management Committee (QMC).	**Annually** Program must include: •Program Structure •How patient safety is addressed •How designated physician is involved •How BH practitioner is involved •Oversight of QI functions by QMC •Annual work plan •Olbjectives for serving a culturally and linguistically diverse membership •Objectives for serving members with complex health needs, including behavioral health	**Objective:** •All requirements must be met •Reviewed and updated annually •Submitted for review to the QMC and BOD	QI Manager/ Manager	QMC Board Of Directors	Annually			x	x									
		NCQA QI 1B *2023 Annual QI Work Plan	**The QI Work Plan** schedule is developed after review of previous year's QI Work Plan and Evaluation. The revised Work Plan schedule is crafted after review of annual HEDIS and CAHPS results, along with the overall goals and objectives of QI in the health plan. The work plan is a dynamic document that is frequently updated to reflect progress on DHMP QI activities throughout the year. All yearly objectives must be measurable and analyzed annually during the Program Evaluation.	**Work Plan must address:** •Quality of Clinical Care •Quality of Service •Safety of Clinical Care •Member's Experience •QI Program Scope •Yearly Objectives and planned activities •Tlime Frame in which each activity is to be achieved •The staff member responsible for each activity •Monitoring of previously identified issues Evaluation of the QI Program	**Objective:** •All 9 requirements must be met •Yearly objectives must be measurable •Submitted to and reviewed by the QMC and BOD	QI Manager	QMC Board Of Directors	Annually			x	x									
		NCAQ QI 1C *2022 QI Program Evaluation Report (includes all indicators for the present year.)	**The Program Evaluation** report is written annually to evaluate the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI Work Plan.	**Evaluation includes:** •All description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service •Trending of measures to assess performance in the quality and safety of clinical care and quality of service •Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network-wide safe clinical practices	**For all goals not met:** •QI conducts a root cause or barrier analysis to identify the underlying causes and recommend changes to improve. •Analysis must include organizational staff with direct experience of processes that have presented barriers to improvement. Evaluation Summary must include and address: •Analysis and overall effectiveness •Completed and ongoing activities •Trending of QI measures/results	QI Manager/ Manager	QMC Board Of Directors	Annually			x	x									
* Committees - Work Groups	Quality Improvement Program Operations	NCA QI 1D Quality Management Committee	DHMP's Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members.	**Committee functions include:** •Analyzes and evaluates the results of QI activities •Ensures practitioner participation in the QI program through planning, design, implementation or review •Identifies needed actions •Ensures follow-up, as needed **Meets: Bi- Monthly**	**Objective:** •Committee demonstrates quality oversight activities and participation of required members by presenting clear and accurate records of minutes •Provides oversight to working subcommittees and determines final opportunities for selection for reporting requirements.	QI Manager QI Project Manager	QMC	Bi-Monthly	x		x		x		x		x				
		NCQA QI 1D Medical Management Committee	DHMP's Medical Management Committee (MMC) acts as a working sub-committee to the QMC. The MMC assists the QMC in overseeing and ensuring quality of clinical care, patient safety, State/CMS/NCQA reporting requirements and program operations provided throughout the organization. **Meets:** Bi-Monthly **Reports**: Bi-Monthly QMC	The MMC is responsible for assisting the organization in providing oversight, critical evaluation, and delegation of actions and selection of opportunities while maintaining a constructive relationship with medical staff and approving/overseeing policies and procedures.	**Goals:** •Providing strong support and oversight to an initiative to improve Continuity and Coordination of Care •Reviewing and updating the current medical plan dashboard •Works in collaboration with the QMC •Works in collaboration with the Network Adequacy Committee •Ensure all regulatory and NCQA requirements are reported in a consistent, accurate and reliable manner	MAT Mgr.	QMC	Bi-Monthly	x		x		x		x		x				

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* Commit	Quality Improve	Network Management Committee	**The Network Management Committee (NMC)** is tasked with establishing, maintaining and reviewing network standards and operational processes. **Meets:** Monthly, **Reports**: QMC Bi-Monthly	The scope of the NMC responsibility includes: (1) Network development and procurement; (2) Provider contract management, including oversight; and (3) Periodic assessment of network capacity.	**Goals:** •Develop standard work, policies and procedures for network management. •Review network capacity and develop plans to address opportunities for improvement. •Review provider interest in network participation and evaluate against DHMP network needs. •Review provider terminations and determine continuity of care concerns. •Review new regulatory legislation and contractual requirements and implement, as appropriate. •Review Quality of Service Concerns and develop plan to address, as necessary	Director of Provider Relations	QMC	Bi- Monthly	x		x		x		x		x		x			
* Committees - Work Groups	Quality Improvement Program Operations	NCQA QI 1D Credentialing Committee	Reviewing the credentials, character, licensure status and elgibility for CMS participation for practioners/providers under consideration for plan participation and re-credentialing.	Thee Scope of the Credentialing Committee is to ensure that all Plan practitioners and providers are credentialed and recredentialed in a consistent manner and to demonstrate compliance with NCQA and internal Plan criteria and standards. Meets: At least Monthly Reports: QMC Quarterly	1. Review credentials, licensure, participation status with CMS and Character of participating or potential participating providers. 2. Ensuring the review and approval of files are complete. 3.Ensuring Member safety by reviewing provider (QOC) (HAI)s(HAC) and sanctions. 4. Makes recommendation for (CAP)	Director Credentialing/Network Health Plan Medical Director	QMC	Quarterly	x			x		x			x				
		NCQA PHM 3A Medicare Star Ratings Workgroup	Key plan and ACS representatives work together to identify opportunities and implement interventions to improve our Medicare Star ratings. **Meets: Monthly** **Reports: QMC Quarterly.**	Committee functions include: •Evaluate & identify opportunities •Intervention approval and support •Resource allocation •Review results to evaluate effectiveness	**Objective:** Committee analyzes and targets specific Stars measures for improvement. Interventions are then reviewed with ACS provider network and/or DHMP departments for approval and support. Interventions and data are reported up through the Medicare Stars Program Leadership Committee for review and feedback. All targeted metrics are set up to evaluate effectiveness	Population Health Manager, MCR Stars Analyst	QMC	Quarterly	x			x			x		x				
		NCQA PHM3A Collaborative QI Workgroups	QI health plan representatives sit on several collaborative workgroups led by ACS leadership. **Meets: Monthly** **Reports:** **QMC Quarterly**	**Workgroups QI participates in includes:** •Cancer screening •Pediatric health •CVD •Integrated Behavioral Health •Diabetes •Perinatal Care •Asthma •Transition of Care •Immunizations	**Objective:** •Established active partnership and collaboration in QI work group activities with Ambulatory Care Services (ACS) on several QI interventions in chronic disease management, prevention, screening, annual visits.	Pop Health Manager	QMC	Quarterly	x			x		x			x				

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s -Improvement	Of Clinical Care	NCQA PHM3A QI LEAN Management	Use LEAN practices and tools to identify and research new quality improvement targets. Implement QI strategies (interventions or process improvements) based on findings. **Meets: Ad Hoc Reports: QMC Quarterly**	Objectives including utilizing the use of: •A3 problem solving •PSDA cycle •Chart(s) •Visual Management Boards •Weekly QI team huddle	**Objective:** •Increase collaboration in LEAN efforts •Improve quality of data	QI Manager QI Team	QMC	Quarterly	x			x		x			x					
		NCQA PHM2A, 2C *HEDIS MY2022 Healthcare Effectiveness Data and Information Set (HEDIS) Annual Analysis	HEDIS is a quality requirement program which determines how well health plans perform on a variety of quality processes and outcome variables. HEDIS consists of more than 90 measures across 6 domains of care which allow for comparison of quality performance nationally across health plans.	**Procedure:** •HEDIS data is collected annually through surveys, medical charts, pharmacy data, lab reports and insurance claims for hospitalizations, medical office visits and procedures. •Data validation prior to submission date •Meet submission deadline •Data from the HEDIS project is analyzed to determine areas of intervention and improvement **Reports**: Validated Rates to QMC Annually	**Objective:** Evidence of annual analysis includes: •Presentation to the QMC •Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes. •Increase medical record compliance by improving coding and documentation. •To measure effectiveness of intervention; analysis will be accomplished by comparing previous year results with	QI HEDIS Project Manager PH/QI Project Manager QI Manager	QMC	Annually							x							

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* Performance - HEDIS Metric Projects	Quality Of Clinical Care	*HEDIS Impact: Breast Cancer Screening	To improve HEDIS rates for the Measure Breast Cancer Screening. Every month a list will be drawn from the data warehouse, and run against claims and the active member's list. All Commercial, Exchange and Medicare women 50+ years old, who are in need of a mammogram, will be sent a mailer reminding them to schedule an appointment.	**DHMP's QI Department:** QI will coordinate with WMC staff to post the locations and schedules of BCS screenings (mobile van (WMC)) on the Pulse. Create monthly mailing list of all Commercial, Exchange and Medicare women 50+ years old. PH Project Manager: •Conducts monthly data pull •Defines eligible participants •Distributes member list for mailing **Reports**: Validated Rates to QMC Annually	**Commercial Current HEDIS MY 2021 76.61% (75th percentile)** **Commercial HEDIS MY2023Goal: 78.0% (75th percentile H2020)** **Exchange Current HEDIS 2021: 54% Exchange HEDIS 2023 Goal: 57%** **Medicare Current HEDIS MY2021: 65.0% (25h percentile)** **Medicare Goal HEDIS MY2023: 76% (4 star cut point)**	PH QI Project Managers	QMC	Annually									x							
		*Bone Density Screening (OMW)	To improve HEDIS rates for the measure, Osteoporosis Management in Women who had a Fracture.	Create monthly list of women 67-85 years of age who had a fracture in the last 3 months and who have not had either a bone mineral density test or a prescription for a drug to treat for osteoporosis since the fracture. Provide to ACS Central Clinical Support pharmacy team for follow up monthly. Schedule quarterly meetings to discuss intervention progress and barriers. **Reports:** Validated Rates to QMC Annually QMC Annually	**"Medicare Current HEDIS MY2021: NA (less than 30 in universe)** **Goal Medicare MY 2022 HEDIS Rate: 62% (4star cut point)"**	PH Manger PH Project Managers	QMC	Annually									x							
		*Improving Diabetic Retinal Exams (CDC)	To improve HEDIS rates for the Diabetic Retinal Exam component of the HEDIS CDC measure. Quality team will target members for outreach who meet the following criteria: (1) the member is 18-75 years of age, (2) the member has been diagnosed with diabetes (type 1 and type 2), (3) the member has not had a retinal exam performed is the last year	Create monthly list of members with a diagnosis of diabetes, 18-75 years of age that have not had a dilated retinal exam in the last year. Provide to ACS Eye Clinic Navigators to outreach and schedule the exam. Support ACS Primary Care Clinics in the roll out of Eye Cameras at DH clinics **Reports**: Validated Rates to QMC Annually	**Medicare Current HEDIS 2021: 75.91% (25h percentile*) Goal Medicare 2023 HEDIS Rate: 75% (4 stars)** **Commercial Current HEDIS MY2021: 48.91 % (25th percentile)** **Goal Commercial MY2023 HEDIS Rate: 51.91% (25th percentile)** **Exchange Current HEDIS MY2021: 58.33% (50th percentile)** **Goal Exchange MY2023 HEDIS Rate: 61.33% (50th percentile)**	PH QI Project Managers	QMC	Annually									x							
		* Improving Perinatal Health: HEDIS documentation and coding education	DHMP PH Program Manager and PH/QI Program Managers provide guidance and education on appropriate coding and documentation at the Denver Health Hospital and Ambulatory Care Clinics	**Procedure:** •QI participates in the perinatal workgroup on a monthly basis. QI participates in QI committee activities for improvement of prenatal timeliness and Postpartum Care **Meets**: Monthly **Reports**: QMC Bi-Annual	**Prenatal** **Commercial Current Prenatal MY2021 HEDIS Rate: 96.5% (95th percentile)** **Commercial Prenatal Goal MY2022: 99.5% (>95th percentile)** **Postpartum** **Commercial Current Postpartum MY2020 HEDIS Rate: 96.50% (95th percentile)** **Commercial Postpartum Goal MY2022: 99.5% (>95th percentile)**	PH /QI Project Managers	QMC	Annually										x						
ent Projects	ical Care	NCQA PHM2A, *Improving Well-Child Visits: HEDIS Rates	To improve the Commercial HEDIS Rates for Well-Child Visits the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV) for children ages 3-21.	**The following interventions will be ongoing in 2023:** •Healthy Heroes Birthday Cards, with amendment •SBHC Targeted Lists •SBHC Enrollment Increase **Reported:** Validated Rates to QMC Annually	**HEDIS MY 2021 W30 Rate:** **0-15: 84.43% (50th percentile)** **15-30: 88.96% (25th percentile)** **Goal HEDIS MY2023 Rate** **0-15:87.43% (75th percentile)** **15-30: 91.96 (50th percentile)** **Current HEDISMY2021 WCV Rate: 61.94% (50th percentile)** **Goal HEDIS MY2023: 64.94% (75th percentile)**	PH QI Project Managers	QMC	Annually											x					

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HEDIS Metrics -Improvem	Quality Of Clin	NCQA PHM2A, *Improving Well-Child Visits: Healthy Heroes Birthday Cards	Commercial and Exchange children 2-19 years of age who still require an annual well child visit for the year will receive a birthday card informing them to come for their annual visit. Healthy Heroes includes a checklist of developmental topics the provider will cover in the well-child visit as a way of engaging the member to participate in care.	**Procedure:** •QI pulls list from BI portal monthly •QI cleans data and separates per LOB •QI forwards list to the printer to send out reminder cards **Reports:** Validated Rates to QMC Annually	**Goal:** **Engage children who have not gone in for their annual well child visit through healthy hero birthday reminder cards Commercial** **WCC Counseling for Physical Activity Current HEDIS MY2021 Rate: 82.48% 90th percentile)** **Goal HEDIS MY2023: 85.48% (90th percentile)** **WCC BMI** **Current HEDIS MY 2021 Rate: 92.21% (95th percentile)** **Goal HEDIS MY2023: 95.21% (>95th percentile** **WCC Counseling for Nutrition** **Current HEDIS MY2021Rate: 85.64% (95th percentile)** **Goal HEDIS MY2023: 88.64% (>95th percentile)** **No rates for Exchange due to small sample size**	PH QI Project Managers	QMC	Annually											x					
	cal Care	*Improving Well-Child Visits: School-Based Health Centers Targeted Lists	Twice a year, QI receives a list of all Commercial members enrolled in the SBHC program. QI runs the list against active members and targets all members in need of a well-child visit. **Objective:** Increase the % of Commercial members with a well-child visit by providing targeted lists to SBHCs HCPs	**Procedure:** •SBHC creates list of enrolled members by LOB in DHHA EPIC system •DHMP pull list from EPIC and determines who needs visit and sends list back to clinics so HCPs can complete well visit in SBHC.	**Goal:** AS COVID-19 pandemic allows, assist clinics in targeting students enrolled in a SBHC to complete an annual well child visit. >50% of eligible population receive well visit through SBHC	PH/QI Project Managers	QMC	Annually											x					

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* Performance - H	Quality Of Clini	**Medicare Chronic Care Improvement Program (CCIP)**	CMS requires a 3 year CCIP project that focuses on promoting effective management of chronic disease, slowing disease progression, reducing complications and utilization. In addition, the program should improve care and health outcomes for enrollees, address potential health disparities and produce best practices. For the new three-year cycle beginning January 2021 DHMP has chosen to focus on control of high blood pressure in those MCR members who have a diagnosis of hypertension	**Procedure:** The DHMP Quality Improvement team will work closely with DHMP Care Management and DHHA Ambulatory Care Services to implement a comprehensive chronic disease care management program in order to provide members with poorly controlled blood pressure the support and care they need to more adequately manage their condition.	**Goals:** The 2023 goal of the Controlling Blood Pressure Management program is to increase the percentage of MCR Select members with a diagnosis of hypertension whose BP is in control based on the CBP HEDIS metric from 65% in MY2022 to 76% by December of 2023.	**PH Manager and PH/QI Project Managers**	**QMC**	**Annually**
		***Colorectal Cancer Screening: FIT kit mailing initiative**	**Objective:** To develop interventions to increase the number of FIT kits completed by DHMP MCR members in 2023.	**"Procedure**: In 2022, DHMP collaborated with DHHA ACS to conduct centralized mailing of FIT kits from DH to MCR members and in the later part of the year, DHMP contracted with an outside vendor to mail FIT kits to MCR members who had not completed colorectal cancer screening. For 2023, DHMP will continue to collaborate with DHHA ACS to conduct centralized mailing of FIT kits from DH to MCR members and contract with the same vendor in the latter part of the year if necessary **Reports**: Validated Rates to QMC Annually QMC Annually"	**"Colorectal Cancer Screening (COL) Commercial Current HEDIS MY2021: 63.26% (25th percentile) Commercial HEDIS MY2023 Goal: 66.26% (25th percentile) Exchange Current HEDIS MY2021: 52.66% (25th percentile) Exchange HEDIS MY2023 Goal: 55.66% (25th percentile) Medicare Current HEDIS MY2021 rate: 68.61% (50th percentile) Medicare HEDIS MY2023 Goal: 75% (4-Star cut point)"**	**PH/QI Project Managers Population Health Manager**	**QMC**	**Annually**

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Care Management Population Health	Quality of Care	***Care Management Updates**	DHMP developed an internal comprehensive care management program in 2021. DHMP continues to collaborate with ACS in the provision of care management and quality improvement services and programs for patients and Members. In addition, care management 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 management 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.	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 QMC for review and approval.	**Objective:** **•All requirements must be met** **•Reviewed and updated annually** **•Submitted for review to the QMC**	**Director of Health Plan Medical Management DHMP Medical Director Director of Care Mgmt QI Manager**	**QMC**	**Annually**
		***Promote and improve health outcomes for D-SNP members with chronic conditions**	The D-SNP beneficiary specific performance measures are collaboratively developed in conjunction with DHMP and the DHHA Ambulatory Care Quality Committee (QIC). This SNP-MOC specific set of goals reflect process, impact and outcome measures.	**Procedure:** •DHMP Medical Management department produces an annual SNP MOC program evaluation responsible for the operations of the SNP MOC HRAT, ICP and ICT facilitation, and reporting key metrics. •The results of the MOC annual program evaluation, updated program description, and work plan will be reviewed and approved annually by the QMC •Final approval of program goal is provided by the DHMP Board of Directors •SNP MOC evaluation content is then distributed to the Denver Health Ambulatory care QI Committee (QIC)	2023 SNP MOC Overall Goals: Promote and improve access to primary and specialty care practitioners: •Getting Appointments & Care Quickly- 76 Performance Goal •Ease of Getting Needed Care and Seeing Specialists- 80% Performance Goal Promote and improve affordability of member healthcare needs: •Members who requested and received assistance with food insecurity- 80% Performance Goal •Members who requested and received assistance with transportation costs-80% Performance Goal	**Director of Health Plan Medical Management DHMP Medical Director Director of Care Mgmt QI Manager**	**QMC Board Of Directors DH ACS QIC**	**Annually**
					Promote and improve coordination of care and appropriate delivery of services through the direct alignment of the HRAT, ICP and ICT:III •Members with all ICP goals completed – Initial- 100% Performance Goal •Members with all ICP goals completed – Annual- 100% Performance Goal •Overall member satisfaction with care management program- 3.5/5 Performance Goal •Improving or maintaining member physical health-73% Performance Goal Promote and improve care transitions across all health care settings and providers: •Transitions of Care – Medication Reconciliation Post- Discharge- 85% Performance Goal •Transitions of Care – Receipt of Discharge Information- 90% Performance Goal			
					Promote and improve health outcomes for D-SNP members with chronic conditions: •Diabetes Care – Blood Sugar Controlled- 72% Performance Goal •Controlling High Blood Pressure- 75% Performance Goal Ensure appropriate utilization of services for preventive and chronic health conditions: •Colorectal Cancer Screening (FIT kits) - 71% Performance Goal •Diabetes Care – Kidney Disease Monitoring- 70% Performance Goal			
					Promote appropriate utilization of services: •Rate of emergency department visits/1000 members- 110.70 Performance Goal •Rate of acute inpatient admissions/1000 members- 32.16 Performance Goal Promote member completion of initial and annual HRA: •Initial HRA completion w/in 90 days of enrollment- >=87% Completion Goal •Annual HRA completion w/in 365 days of initial HRA - >=87% Completion Goal			

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Care Management Population Health	Quality of Care	NCQA PHM 2B **Complex Case Management: Population Assessment**	Complex Case Management annually assesses member populations and subpopulations to ensure needs are being met in an appropriate manner.	**Assessment must consider and include the following:** •Relevant characteristics of specific populations •DHMP's total covered population, not just members identified for complex case management •Needs of individuals with disabilities and serious and persistent mental illnesses	**Goals:** •Use multiple data sources, when available, including administrative claims and utilization management data to assess the characteristics and needs of its member population and subpopulations •Reviews and updates its complex case management processes to address member needs, if necessary •Reviews and updates its complex case management resources to address member needs, if necessary	**Director of Care Mgmt.**	**QMC**	**Annually**		x		x										
		NCQA PHM 6A **Complex Case Management: Measuring Program Effectiveness**	Complex Case Management annually measures the effectiveness of its complex case management program using three measures.	For each measure, Complex Case Management: •Illidentifies a relevant process or outcome •Ulll ses valid methods that provide quantitative results •Sllets a performance goal •Clllearly identifies measure specifications •lllCollects data and analyzes results •Illidentifies opportunities for improvement, if applicable	**Goals:** **Member Satisfaction:** **Member Satisfaction will indicate 80% satisfaction with the complex case management program.** **Reduce Per member Spending and Inpatient Utilization** **•Use claims and utilization data to. evaluate annual per member cost for members who have been in the program at least one year and have two or more consecutive years of cost data**	**Director of Care Mgmt.**	**QMC**	**Annually**		x		x										
		NCQA PHM1-6 ***Population Health Management (PHM) Strategy: Program Monitoring**	The Population Health Management Team has a population health strategy for meeting the care needs of its member population.	The strategy describes goals and populations targeted for each of the four areas of focus, Keeping members healthy, Managing members with emerging risk, Patient safety or outcomes across settings, and Managing multiple chronic illnesses, the programs and services offered to members, activities that are not direct member interventions, how member programs are coordinated, and how members are informed about PHM programs.	**2023 PHM Goals:** Establish programming for each of the four population health target areas. •Keeping members healthy •Managing members with emerging risk •Patient safety or outcomes across settings •Managing Multiple Chronic Illnesses The Population Health team has developed the 2023 Population Health Management Strategy for the MCR, COMM and Exchange lines of business. The first step of the strategy is to identify the most often occurring comorbid, disease processes of DHMP's members. The Strategy then then outlines the strategic PH Plan, PH Goal and specific programs that will support these members and also the overall population health strategy.	**Population Health Team** **DHMP Medical Director**	**QMC MMC**	**Annually**		x		x										
		NCQA QI 4B ***Behavioral Health Services**	Follow up for positive depression screening are an ACS strategic quality indicator Ongoing monitoring of CM behavioral health related activities thru current year PIP 2019 - Reports: QMC Annually	**Procedure:** Tracking the completion of "depression screening and follow up visit if positive" at Primary Care visits at DH ACS Tracking of key Case Management team BH related activities	**Goals:** Overall CHS goal is 70% completion Year 1 tracking to establish baselines and determine goals	**Director of Care Management**	**QMC**	**Annually**				x										
		Cultural and Linguistic Appropriate Services (CLAS)	To deliver culturally and linguistically appropriate services to Denver Health membership.	**Objective:** •Ongoing effort to ensure culturally and linguistically appropriate member facing materials and to improve collection of REL membership data to support that work Reports: QMC Annually	**Goal:** •Provide culturally and linguistically appropriate materials and services •Improve collection of REL membership data	**PH QI Project Managers**	**QMC**	**Annually**				x										
		NCQA QI3A-C ***Continuity and Coordination of Medical Care**	DHMP uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.	Annual identification of opportunities to improve coordination of medical care by: •Collecting data on member movement between practitioners and across settings • Conducting qualitative and causal analyses of data to identify improvement opportunities • Identifying and selecting at least 4 opportunities for improvement • Acting on at least 3 opportunities for improvement and measuring effectiveness Reports: MMC bi-montly	**Goals**: •Identify and select at least 4 opportunities to improve the coordination of medical care •Measure the effectiveness of improvement actions taken for at least 3 opportunities •Collaborate with partners at DHHA and EPIC team to provide feedback on provider concerns with EPIC data Restructure Provider Survey to obtain more meaningful provider feedback regarding data sharing issues •Improve capture of inpatient admissions and transfer of members across inpatient care settings	**Director of Care Mgmt., Director of Provider Relations**	**MMC**	**Bi-Monthly**				x								x		
		NCQA QI4A-C ***Continuity and Coordination of Medical Care and Behavioral Health Care**	DHMP uses information at its disposal to facilitate continuity and coordination of medical and behaivoral health care across its delivery system.	Annual identification of opportunities to improve coordination between medical and behavioral health care by: •Collecting data on opportunities for collaboration between medical care and behavioral healthcare • Conducting activities to improve the coordination of behavioral healhtcare and general medical care • Identifying and selecting at least 2 opportunities for improvement • Acting on at least 2 opportunities for improvement and measuring effectiveness Reports: MMC bi-monthly	**Goals**: •Identify and select at least 2 opportunities to improve the coordination of medical care •Measure the effectiveness of improvement actions taken for at least 2 opportunities •Reduce Rate of Plan All Cause Readmissions for members with SPMI	**Director of Care Mgmt**	**MMC**	**Bi-Monthly**														
Care Management Population Health	Quality of Care	FMC **Follow Up After Emergency Department Visit for People with Multiple High-Risk Conditions**	**Objective:** To develop interventions to improve the rate of follow up after emergency department visit for members with multiple high-risk conditions	Procedure: The Care Management team will work with key members of the QI, Population Health, and IS teams to develop a mechanism to identify members who have had a recent ED visit. The Care Management and Population Health teams will work internally and with DHHA and external providers to support members in following up with their PCP. The CM team will use the MCR Member Dashboard to identify and remedy care gaps. **Reports**: Validated Rates to QMC Annually	**Goals:** Improve FMC rates from a 1 star to a 3 star rating in 2023	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**														
		CBP **Controlling Blood Pressure**	**Objective:** To develop interventions to improve the rate of members whose blood pressure is in control	Procedure: The Care Management team has a CBP program to support members with accessing necessary care and resources for managing their blood pressure, as well as support with scheduling appointments with a provider or PharmD for blood pressure checks. Care Managers provide support and education to members for managing their diet, medications, and lifestyle to reduce blood pressure. Care Management will coordiate with Population Health to engage internal and external stakeholders to support members with obtaining annual readings and with accessing necessary supports and resources to get members' blood pressure in control. The CM team will use the MCR Member Dashboard to identify and remedy care gaps. **Reports**: Validated Rates to QMC Annually	**Goals:** Improve CBP rates from a 3 Star to a 4 Star Rating in 2023	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**														
		HBD **Care for Older Adults Pain Assessment**	**Objective:** To develop interventions to improve the rate of members with in control HbA1C reading	Procedure: The Care Management team has a Diabetes Management program to support members with accessing necessary care and resources for managing their diabetes. Care Managers provide support and education to members for managing their diet, medications, and lifestyle to improve A1c contol. Care Management will coordiate with Population Health to engage internal and external stakeholders to support members with obtaining annual A1c labs and with accessing necessary supports and resources to get members'A1c in control. The CM team will use the MCR Member Dashboard to identify and remedy care gaps. Reports: Validated Rates to QMC Annually	**Goals:** Improve HBD rates from a 3 star to a 4 star rating in 2023	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**														

		COA **Care for Older Adults Pain Assessment**	**Objective:** To develop interventions to improve the rate of members who have had a pain assessment	Procedure: The Care Management team will develop an internal process to complete a pain assessment for members aged 66+ in the DSNP and MCR Select Programs **Reports**: Validated Rates to QMC Annually	**Goals:** Improve COA rates from a 2 star to a 3 star rating in 2023	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**												
		PCR Plan All Cause Readmissions	**Objective:** To develop interventions to reduce the number of 30-day plan all cause readmissions in 2023	**Procedure**: The Transitions of Care team is responsible for following Medicare Select and Medicare Choice DSNP members who are admitted to an inpatient setting outside of DHHA, and Medicare Choice DSNP members who are admitted to DHHA. The Transitions of Care team offers support to discharge planners to ensure a safe discharge plan is in place for the member and then follows the member for 30 days upon program enrollment (outreach for enrollment occurs after discharge to a home setting). The DHMP Population Health team will be working with DHHA to evaluate their Transitions of Care interventions for DHMP members admitted at a DHHA facility. **Reports**: Validated Rates to QMC Annually	**Goals:** Improve PCR rates from a 1 star to a 3 star rating in 2023	**Director of Care Mgmt., Manager of Population Health, Manager of Quality Improvement**	**QMC**	**Annually**												

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Care Popul	Qua	***Adoption and Distribution of Clinical Practice and Preventive Health Guidelines**	DHMP is accountable for adopting and disseminating clinical practice guidelines relevant to its members and providers for the provision of non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. Guidelines are adopted from recognized sources or from involvement of board-certified practitioners from appropriate specialties	**CPG's must be updated annually or when the following circumstances exist:** •New scientific evidence or national standards are published prior to the annual review date •National guidelines change prior to the annual review date	**Objective:** **Adoption and dissemination by:** •Establishing the clinical/scientific basis for the guidelines •Review guidelines annually, with updates as needed •Distributing guidelines to appropriate practitioners	**QI Manager** **QI Project Manager**	**MMC**	**Annually**										x		
Utilization Management	Quality of Care	***Evaluating Utilization Management Criteria**	Utilization Management conducts an annual review of the UM criteria and the procedures for applying them, and updates the criteria when appropriate	**DHMP's UM Department has:** •Written UM decision-making criteria that are objective and based on medical evidence • Written policies for applying the criteria based on individual needs •Written policies for applying the criteria based on an assessment of the local delivery system •Involvement of appropriate practitioners in developing, adopting and reviewing criteria **Reports:** MMC MMC reports via Meeting Minutes to QMC	**Objective:** Criteria must consider at least the following when applying criteria to a given individual: •Age •Comorbidities •Complications •Progress of Treatment •Psychosocial situation •Home environment, when applicable	**Director of Utilization Mgmt.** **Medical Director**	**MMC**	**Annually**				x								
		Monitoring Consistency of Applying UM Criteria	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes.	**DHMP's Utilization Management** •Evaluates consistency of health care professionals making UM decisions by applying criteria consistently and appropriately •Acts on opportunities to improve reliability of criteria application when identified **Reports:** MMC, MMC reports to QMC via meeting minutes	**Goal:** •85% Accuracy Rate for Criteria Application	**Director of Utilization Mgmt.** **Medical Director** **Pharmacy Director**	**MMC**	**Annually**				x								
Utilization Managemen	Quality of Care	**Monitoring of Formulary and Pharmaceutical Management Procedures**	Formulary and pharmaceutical management procedures are presented to the Pharmacy and Therapeutics Committee on an annual basis for review and discussion. Minutes from the P&T meeting are presented and reviewed at the QMC on a bi-monthly basis. Review of updated formulary and pharmaceutical management procedures is documented in the P&T minutes.	**Reporting categories:** **Monitoring:** Monthly **Reports:** MMC Bi- monthly, MMC reports to QMC via meeting minutes	**Goal:** •Must present and review all pharmaceutical management procedures annually to address areas for improvement	**Pharmacy Director**	**MMC**	**Bi- Monthly**		x		x		x		x		x		x
		2021 Utilization Management Program Evaluation	The Utilization Management Program Evaluation is conducted annually to review activities from the prior year and measure performance on initiatives to support clinical excellence. A summary of these results is presented to the MMC & QMC that covers overall program effectiveness, performance outcomes, improvement opportunities and changes to the program.	**Evaluation includes:** •Completed and ongoing activities •Quantitative and Qualitative Analysis •Evaluation of effectiveness Reports: Annually QMC	**Presentation to QMC must include:** •Committee discussion and input on program summary •Actions, if applicable •Committee approval UM Program and evaluation of prior year performance	**Medical Director UM Director**	**QMC**	**Annually**			x									
Marketing	Quality of Service	**Member Annual Communication Requirements**	The Marketing Department strives to ensure timely distribution of member communications and materials to promote DHMP membership understanding of current health plan topics related to patient care and service.	**Members receive:** •Information about the quality program goals and outcomes as related to member care and service •Pharmaceutical restriction and preference information, including formulary. **Reports:** QMC annually	**Goals:** •Must provide evidence of annual communication to all members	**Director of Marketing**	**QMC**	**Annually**					x							
		Member Communication Requirements Upon Enrollment and Annually Thereafter	The Marketing Department focuses on timely distribution of member communications and materials to promote DHMP membership understanding of their health plan	**Members are provided the following information, including but not limited to:** •Member rights and responsibilities statement •Subscriber information •PHI use and disclosure information •The process for members to self-refer to case management •How to access staff •An affirmative statement about incentives **Reports:** QMC annually	**Goals:** •Must provide evidence of communication to all commercial members upon enrollment and annually thereafter	**Director of Marketing**	**QMC**	**Annually**					x							
Network	e	**Quality of Service Concerns (QSC)**	The Grievance and Appeals Department appropriately investigates potential Quality of Service Concerns.	**Timeframe requirements:** •Acknowledgment letter: 5 business days. •Standard Response: 30 calendar days. •Extension letter: 15 calendar days (Commercial, Exchange), 14 calendar days (Medicare). •Expedited: 72 hours Monitors Tracks: Monthly **Reports**: QMC Quarterly	Goal: •l00% Timeframe compliance Tracks G&A Types, timeliness, and documents trends, quarterly updates presented to QMC	**Manager of Appeals & Grievances Director of Provider Network Adhoc**	**QMC**	**Quarterly**	x				x		x				x	

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Dept. Section	Structure	Activity/ Regulations	Objective	Requirement/ Planned Activity	Performance Target/Goal	Responsible Party	Reports To	Reporting Frequency											
Credentialing & Provider	Quality Of Servic	NCQA PHM 3A F2 **Practitioner and Provider Communication Requirements**	The Marketing Department provides timely distribution of practitioner and provider communications and materials to promote DHMP practitioner and provider understanding of current health plan topics related to patient care and service.	**Practitioners and Providers are provided the following information, including but not limited to:** •Member rights and responsibilities statement •The process for the practitioner to refer members to case management •Program information •Clinical practice and preventive health guidelines (to appropriate practitioners) •How to obtain UM criteria •How to access staff •An affirmative statement about incentives •Information about the quality program goals and process outcomes related to member care and service •Pharmaceutical management procedure, restriction and preference information, including formulary •Annual Provider Survey •Early Periodic Screening Diagnosis and	**Goal:** •Must provide evidence of communication to all network practitioners and providers upon contracting and annually thereafter •Must provide evidence of annual communication to all network practitioners and providers Reports: NMC Reports QMC via NMC minutes annually	**Director of Provider Relations**	**Network Managemen t Committee QMC**	**Annually**	x											
Credentialing & Provider Network	Quality Of Service	**Physician and Hospital Directory Usability Testing**	At least every three (3) years (36 months), the provider credentialing Department evaluates DHMP's web-based physician and hospital directory for health literacy, understandability and usefulness to members and prospective members.	**Testing considers:** •Font size •Reading level •Intuitive content organization •Ease of navigation •Directories in additional languages, if applicable to membership **Testing occurs:** •When there are significant changes to member demographics •When there are changes to the layout of design of the directory Internal staff who were not involved in the development of the directory participate in testing. **Reports:** QMC every 3years	**Goals:** •There must be a documented process describing how usability testing is performed. •There must be evidence indicating initial usability testing was performed when there were significant changes to member demographics or to the layout or design.	**Provider Credentialing Manager**	**QMC**	**At least every 3 years**												
		***Ongoing Monitoring of Network Practitioners and Providers Site Quality**	Credentialing and Provider Relations has policies and procedures to ensure the quality, safety and accessibility of the offices of all network practitioners meet DHMP's office-site standards. This is achieved by setting performance standards and thresholds for office sites and a clear process for ongoing monitoring of office site quality.	**Provider Relations and Credentialing:** •Sets performance standards and thresholds for office site quality •Establishes a documented process for ongoing monitoring and investigation of member complaints related to practice sites **Reports:** CC Quarterly **Reports:** QMC via CC	**Goals:** •Conduct site visits of offices within 60 calendar days of determining that the complaint threshold was met •Deliver corrective action plans within 30 calendar days of site visit •Repeat site visits are conducted 6 months after delivering corrective action plans to assure compliance	**Director of Provider Relations**	**Credentialin g Committee**	**Quarterly**	x				x	x			x				
Credentialing & Provider Network	Quality Of Service	***Ongoing Monitoring of Practitioner Sanctions, Complaints and Quality Issues**	Credentialing Committee DHMP has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re- credentialing cycles; Appropriate action against practitioners is taken when poor quality concerns are identified. .	Ongoing review and monitoring by: •Collecting and reviewing Medicare and Medicaid sanctions •Collecting and reviewing sanctions or limitations on licensure •Collecting and reviewing complaints •Collecting and reviewing information from identified adverse events **Meets:** Monthly or as often as needed Reports to QMC via Credentialing Committee Minutes	**Goals:** •Review sanction information within 30 calendar days of its release •Implementing appropriate interventions when instances of poor quality are identified	**Medical Director Credentialing Director**	**QMC**				x	x	x	x	x	x	x			
		Monitoring Accessibility of Services	DHMP has established mechanisms to ensure access to primary and specialty care services, along with behavioral health services. DHHA Appointment Center services are responsible for meeting established standards.	**Assessment incorporates:** Self-reported access data from practitioners captured via network adequacy analysis, supplemented with an analysis of complaints related to access.	**Goals:** •Meet urban, suburban standards set in the Access to Care and Services Policy **Reports:** Network Adequacy to NMC and to QMC Annually via Network Committee Minutes	**Director of Provider Relations Product Line Managers**	**NMC**	**Annually**			x									
Marketing rvices	f Service	**Assessing Member Understanding of DHMP Procedures**	The Marketing department has a systematic and ongoing process for assessing new member understanding of DHMP key policies and procedures.	**Assessment includes:** •Monitoring new member understanding of DHMP procedures •Implementing procedures to maintain accuracy of marketing communication •Acting on opportunities for improvement **Reports:** QMC Annually	**Goals:** •There must be evidence of a systematic and ongoing process for assessing new-members ,understanding of DHMP operations and policies. •If DHMP finds that new members have enrolled without an accurate understanding of key DHMP policies and procedures, DHMP must initiate a quality improvement process to correct the possibility of future misrepresentation	**Director of Marketing**	**QMC**	**Annually**						x							

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Operations - Marketing Health Plan Services	Quality Of Service	***Monitoring Satisfaction with Complex Case Management**	Complex Case Management annually evaluates satisfaction with its complex case management services to identify opportunities to improve member satisfaction. Affects member experience	**Satisfaction data is collected through the following methods:** •Obtaining survey feedback from members •Analyzing member complaints for tracking/trending **Reports:** MMC Annually **Reports:**QMC Annually	**Goals:** Members: 100% of the respondents will indicate 80% satisfaction with the program.	**Director of Health Medical Management**	**QMC MMC**	**Annually**				x								
		***Monitoring Member Satisfaction**	DHMP monitors member satisfaction with our services and identifies areas of potential improvement. To assess member satisfaction with our services, DHMP annually evaluates member complaint and appeal data to analyze tracking and trending	**Aggregate member complaints and appeals by reason, showing rates related to:** •Quality of Care •Access •Attitude and Service •Billing and Financial Issues •Quality and Practitioner Office Site **Reports:** QMC Quarterly updates and Annually year and prior year report	**Goals:** Evidence of monitoring includes: •Annual reporting to the QMC •Root-cause analysis provided to identify opportunities for improvement. *Monthly MCR member satisfaction survey *Quarterly provider access survey	**Product Line Managers w/ Marketing**	**QMC**	**Annual (report) Quarterly(updates)**	x				x		x			x			
Operations - Marketing Health Plan Services	Quality Of Service	***2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Analysis**	Assess member satisfaction with quality of clinical care and services provided in practice settings through the CAHPS member satisfaction survey.	**DHMP's QI Department:** •Sends CAHPS surveys out annually to members via random sample. •Validates data before submission •Meets CAHPS submission deadline •Analyzes survey results to determine areas of intervention and improvement **Reports:** Validated Rates to QMC Annually	**Evidence of annual analysis includes:** •Presentation to the QMC •Qualitative and quantitative analysis to identify opportunities for improvement must be documented in the QMC meeting minutes.	**QI Project Manager/ QI Manager/ HEDIS Manager/Product Line Managers**	**QMC**	**Annually**						x						
		Monitoring Satisfaction with the Utilization Management Process	DHMP continually assesses member and practitioner satisfaction with our Utilization Management process to identify areas in need of improvement.	Components of the process: •Collecting and analyzing data on member and practitioner satisfaction to identify improvement opportunities •Taking action designed to improve member and practitioner satisfaction based on assessment of the data	**Goals:** •Members: 90% of the surveyed members (CAHPS) who required an authorization for services will indicate being either "Somewhat or Very Satisfied" with the authorization process. Practitioners: 90% of the surveyed providers will indicate a high level of satisfaction with the UM program by answering each of the Provider UM Satisfaction questions with a rating of either 4 or 5 (on a scale from 1 to 5, with 5 being extremely satisfied)." [Provider, Practitioner Experience Survey]	**Director of Provider Relations (Survey and analysis, action plans) Director of UM**	**QMC**	**Annually**				x									

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Operations - Marketing Health Plan Services	Quality Of Service	**Monitoring Member Services' Benefit Information for Quality and Accuracy**	The Health Plan Services Department has a quality improvement process in place to assess the quality and accuracy of plan benefit information provided to members telephonically and online.	**Components of the process:** •Collecting data on quality and accuracy of information provided •Analyzing data against standards or goals •Determining the cause of deficiencies, as applicable •Acting to correct identified deficiencies **Reporting categories:** • Service Level •Average delay to answer •Calls abandoned •Quality/Accuracy •Call volume **Monitoring:** Monthly **Reported:** QMC Quarterly	**Goals:** •Telephone: 90% accuracy •Online: 90% accuracy •Service level: at or above 80% •Time to answer: 30 seconds or less for Medicare •Time to answer 2 minutes or less Medicaid, Commercial, Elevate Exchange •Time to answer: 250 seconds or less CHP+ •Abandonment rate: 5% or less	**Manager Health Plan Services Health Plan Services Supervisor and Health Plan Services Lead**	**QMC**	**Bi-Monthly**	x			x		x			x					
		Monitoring Pharmacy Benefit Information for Quality and Accuracy	The Pharmacy Department has a quality improvement process in place to assess the quality and accuracy of pharmacy benefit information provided to members telephonically and online	**Components of the process:** •Collects data on quality of service and accuracy of pharmacy benefit information provided both telephonically and online •Analyzes data results •Acts to correct identified deficiencies. * Service Level •Average delay to answer •Calls abandoned •Quality/Accuracy •Call volume **Reports**: MMC Quarterly	Goals: •Telephone: 85% accuracy •Online: 85% accuracy	**Pharmacy Director/Pharmacy Manager/Pharmacy Supervisor/Intervention Manager**	**QMC**	**Quarterly**	x			x		x			x					
Regulatory	Safety Of Clinical Care	**Patient Safety Initiatives**	The Quality Improvement Department works collaboratively with Utilization/Case Management, Population Health, Pharmacy, and G&A Departments to provide clinical quality monitoring and Identification of performance improvement opportunities related to member safety are reviewed and implemented.	**Process:** The Quality Improvement Department facilitates evaluation of quality of care concerns and any corrective action plan that results. QI implements and provides organizational support of ongoing safety and quality performance initiatives that relate to care processes, treatment, service and safety in clinical practice. If opportunities are identified to decrease medical errors, the Quality Improvement Department will work collaboratively with the patient safety committee of the hospital to identify opportunities for improvement and preventive approaches. **Reports:** QMC Quarterly	**Objectives:** •Encourage organizational learning about medical and health care errors •Incorporate patient safety education across organization •Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury in conjunction with patient safety committee. •Involve patients in decisions about their health care and promote open communication about medical errors and consequences which occur as a result •Collect and analyze data, evaluate care processes for opportunities to reduce risk and initiate actions •Review and investigate serious outcomes where a patient injury has occurred or patient	**Manager of QI Director of Utilization Mgmt. G&A Mgr. Pharmacy Director Medical Director**	**QMC**	**Quarterly**	x			x		x			x					
		Quality of Care Concerns (QOCC): MCR, COM, HIX	DHMP Medical Director and RN appropriately investigate potential QOCC's.	**Timeframe requirements:** •Acknowledgment letter: 2 business days. •Expedited Response: 72 hrs. •Standard Response: 30 business days. •Extension letter: 15 business days.	**Goal:** •100% Timeframe Compliance for processing cases within regulatory turn around and reporting time frames. • Report all cases to Quality Management Committee noting substantiated cases which either need track/trending or referral to recredentialing • Allow facility/providers to submit responses on substantiated cases to allow for internal reviews and quality improvement.	**G&A Mgr. RN Case Manager Medical Director**	**QMC**	**Every other Month**	x		x		x		x		x					
Regulatory	Safety Of Clinical Care	***Pharmaceutical Patient Safety Issues**	The Pharmacy Department has information about member pharmaceutical use that may not be available to pharmacies or practitioners. This represents an opportunity to provide added patient safety information to practitioners and patients likely to be affected by drug recalls and withdrawals for patient safety reasons.	**Objectives:** •Identifying and notifying members and prescribing practitioners affected by Class II recall or voluntary drug withdrawals from the market for safety. •An expedited process for prompt identification and notification of members and prescribing practitioners affected by Class I recall. •**Reports**: Compliance Committee Annually and MMC ad hoc	**Goals:** 100% Compliance for: •Class I: Affected members and providers notified no later than seven days of the Food and Drug Administration (FDA) notification. •Class II: Affected members and providers notified within thirty days of the FDA notification. •Class III: Affected members and provider notified within sixty days of FDA notification.	**Pharmacy Director Pharmacy Manager Compliance Analyst**	**MMC Compliance Committee Annually**	**Ad Hoc**													
		Monitoring Privacy and Confidentiality Safety Clinical PH	The Compliance Department has a process for identifying, reporting and taking action on impermissible uses or disclosure of sensitive information.	**The Compliance Department implements procedures for:** •Identifying impermissible uses or disclosure of sensitive information •Reporting impermissible uses or disclosures of sensitive information •Providing education and safeguards in the event of impermissible uses or disclosure of sensitive information	**Goals:** •Annual formal reporting as evidence of ongoing monitoring of privacy and confidentiality. •If instances of impermissible use or disclosure exist, there must be substantive discussion by the Compliance Committee on how to improve protections. Actions to improve protections may include, but are not limited to: Education and training Process/procedural revisions Progressive discipline	**Privacy Officer**	**Board Of Directors**	**Annually**					x								