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

Quality Improvement Program Description

SFY 2023-2024

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I. Introduction

Denver Health and Hospital Authority (DHHA), a political subdivision of the State of Colorado, is an academic, community-based, integrated health care system that serves as Colorado's primary safety net system. DHHA entered into a contract with the Colorado Department of Health Care Policy and Financing (HCPF) on May 1, 2004, in order to provide comprehensive health care services to Medicaid-eligible Members enrolled into Denver Health Medicaid Choice (DHMC). In September 2018, the contract with HCPF was transitioned from DHHA to Denver Health Medical Plan, Inc. (DHMP).

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

Mission Statement

Denver Health Mission and Vision

- Provide access to the highest quality health care whether for prevention, or acute and chronic diseases,
- Provide life-saving emergency medicine and trauma services to Denver and the Rocky Mountain region;
- Fulfill public health functions as dictated by the Denver Charter and the needs of the citizens of Denver;
- Provide health education for patients;
- Participate in the education of the next generation of health care professionals;
- Engage in research, which enhances our ability to meet the health care needs of Denver Health system patients
- To be the healthiest community in the United States.

DHMP mission is to: deliver 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 equitable access and culturally diverse comprehensive health services, especially to our marginalized members
- Enabling members to play an active role in their health care by ensuring they set prioritized health care goals
- Delivering our services with responsibility and respect to all

Quality Statement and Process

The Denver Health Medical Plan (DHMP) Quality Improvement Program is designed to support the mission of DHMP by promoting the delivery of high quality, accessible health care services that enhance or improve the health of DHMP

members.

The Quality Improvement Program provides a formal process to systematically monitor and evaluate quality and safety of clinical care and service utilizing a multidimensional approach measured through different performance dimensions. These dimensions include appropriateness, efficiency, effectiveness, availability, timeliness and continuity. This approach enables DHMP to focus on opportunities for improving operational processes, member and provider satisfaction as well as health outcomes.

Performance metrics are derived from a variety of data sources, including:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider and Practitioner experience/satisfaction surveys
- Health Plan Services call data
- Medical record review
- Claims data
- Open Shopper Study data
- Pharmacy data
- Case Management (CM) data
- Utilization Management (UM) data
- Population Health Management (PHM) data
- Health Equity/SDOH data

This comprehensive data approach also allows theCompany to target opportunities for improving operational processes, increasing Member and Provider and Practitioner experience/satisfaction and effectively providing and managing health outcomes.

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

II. Quality Improvement Department Structure

Oversight

Board of Directors

The Board of Directors is the governing body for the Company and is responsible for ensuring quality and safety for 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 by the QMC. The Board reviews the QI Program Description, the QI Work Plan and the QI Annual Evaluation

Composition:

Voting Members

- DHHA Authority Board Chair Designee
- DHHA Chief Financial Officer (CFO)
- DHHA Chief Administrative Officer (CAO)
- Five appointed members at Large
- DH community Health Services (CHS) Board Chairman
- Four Community Business Leaders

Non-Voting Members

- DHHA Executive Team
- DHMP Executive Team

Function:

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

Authority and Responsibility

Executive Leadership

1. DHMP CEO/Executive Director responsibilities include, but are not limited to:
   - Provide oversight of the Medical Director and department operations
   - Provide allocation of resources and formal reports to the Board of Directors

2. Medical Director responsibilities include, but are not limited to:
   - Providing direction, support and oversight related to the development, implementation and evaluation of all clinical activities of the QI Department
   - Work in collaboration with the QI Director and QI Intervention Managers on development and assessment of clinical interventions
   - Report findings from clinical interventions to the appropriate groups, such as the Ambulatory Quality Improvement Committee (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
   - Serve on the QMC, AQIC, Medical Management Committee (MMC),) Credentialing Committee, Operations Management Committee, DHHA Patient Safety Committee 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 Grievances (QOC-Gs) while working in conjunction with Quality Care Registered Nurse (RN) designee
   - Report substantiated QOC-Gs to the DHHA Patient Safety and Quality Department and external regulatory agencies, as appropriate
   - Evaluating and managing the Company's substantiated Quality of Care- Grievances (QOC-Gs), working in conjunction with the clinical staff supporting the QIdepartment and DHMP

- 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

Quality Improvement Department

- Functions as a division of Health Outcomes & Pharmacy
- The QI Director position is held by the Senior Director of Health Outcomes and Pharmacy
- Act as QI Department 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
- Serve as Facilitator to the Quality Management Committee (QMC)
- Provide oversight and direction to the QI Department

Currently (1 FTE) Vacant- DHMP Quality Improvement Manager

1. QI Director responsibilities include, but are not limited to:
2. Development, management, and monitoring of the QI Department, including the following teams: Quality Improvement, HEDIS, NCQA (to be moved to the QI Department 8.2023) and Population Health.
3. Coordinate, provide advice and participate in the execution of the QI Program through collaboration withother DHMP and Denver Health departments, as appropriate, for regulatory compliance.
4. Supports the Director with QMC and MMC responsibilities
5. Coordinate, provide advice and participate in the execution of the QI program through collaboration with other DHMP and Denver Health departments for regulatory compliance and performance improvement
6. Annually ensure all policies, procedures and guidelines related to the QI Department are updated appropriately.
7. Overseen QI vendor contracts and delegated activities.
8. Provide management and direction to the QI Department, consisting of the following QI Teams/members:

(1 FTE) HEDIS Team Leader responsibilities include, but are not limited to:

1. Manage all aspects of HEDIS-related projects, including oversight of related projects
2. Evaluate and analyze HEDIS results
3. Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
4. Evaluate and analyze HEDIS results
5. Provide recommendations to the QI Director for cost efficiency, process improvements and quality interventions
6. Work collaboratively with Intervention Manager(s) on process improvements and quality interventions related toHEDIS
7. Validate the accuracy and of HEDIS data and supporting documents

(1 FTE) QI Project Manager responsibilitiesinclude, but are not limited to:

1. Coordinate all efforts related to Work Plans, Evaluations and Program Descriptions
2. Lead activities related to regulatory and accreditation requirements
3. Work in collaboration with Population Health and QI Intervention Project Manager(s) to maintain a

timeline for deliverables
4. Co-direct and work with the QI Director to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording and bi-monthly reporting requirements
5. Function as main administrative contact for the QMC

(1FTE) Population Health Sr. Manager responsibilities include, but are not limited to:

1. Develop the Population Health Strategy to meet all regulatory requirements and align with the broader organizational goals.
2. Engage with and motivate the DHMP network of providers to implement interventions to meet the Population Health goals.
3. Appropriately delegate and oversee responsibilities related to Population Health strategies forstaff assignments, quality assurance monitoring and required reporting.
4. Manage the communications with providers including conflict resolution related to Population Health interventions.
5. Hire, train, motivate and coach staff to support efficient and accurate Population Health Interventions.
6. Hire, train, motivate and coach supervisors to assess employee performance and provide feedback and mentoring opportunities.
7. Monitoring population health activities for quality engagement and timeliness and working with theDirector to ensure the department is properly provisioned and staffed.
8. Analyze qualitative and quantitative monitoring reports to develop more effective or efficient processes and strategies for improving the cost and quality of care.
9. Work with the Director to establish and achieve Population Health department objectives, including improving the cost, quality and experience of care for Members.
10. Generate Population Health outcomes reports and present information to upper-level managers or other parties.
11. Ensure staff members follow company policies and procedures.
12. Other duties as assigned.

RN Staff support for QI Activities responsibilities include, but are not limited to:

1. Review and ensure Quality of Care Grievances (QOC-G), and SRAE events are processed in a timely and effective matter.
2. Provide clinical consultation for the QI Department

III. Committee Structure

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, Health Management, Pharmacy and Provider Relations. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, patient safety initiatives. The QMC includes primary care Providers (PCPs), specialty Providers from DHHA, extended provider network and other staff.

The Denver Health Quality Management Committee:

- Meets Bi-Monthly

- Is Comprised of the following members:
  - DHMP Manager or Director of Quality Improvement (Facilitator)
  - DHMP Medical Director (Chair)
  - DHMP Manager of Compliance
  - DHMP Director of Health Plan Services
  - DHMP Director of Claims, Managed Care
  - HMP Director of Monitoring, Auditing and Training
  - DHMP Director of Utilization Management
  - DHMP Director of Case Management
  - DHMP Director of Insurance Products, Managed Care
  - 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
  - QI Project Manager
  - Intervention Project Managers
  - NCQA Project Manager
  - ACS Care Coordination Manager
  - QOC-G Nurse
  - Pharmacy and Therapeutics Pharmacist
  - Manager of Grievance and Appeals (non-voting unless designated by director)
  - Manager of Health Plan Services (Non-voting unless designated by director)
  - Medicare Products Manager (Non-voting unless designated by director)
  - Medicaid/CHP Product Manager (Non-voting unless designated by director)
  - Commercial Products Manager (Non-voting unless designated by director)
  - Marketing Manager (Non-voting unless designated by director)

Functions of Denver Health Quality Management Committee:

Review of the performance of QI activities.

A. Review summary reports for the QMC subcommittees, ad hoc committees and QA/QI process improvementactivities providing feedback and /or recommendations for improvement.
B. Identify and analyze trends and evaluate the implementation of appropriate focused interventions to improveperformance.
C. Identify and analyze trends and evaluate the implementation of appropriate focused interventions to improveperformance.
D. Review and Approve Quality Improvement Projects (QIPS)
E. Review, evaluate, develop and implement Population Health based QA/QI activities and satisfaction surveyintervention plans.
F. Provide oversight of all clinical and administrative aspects of the QI Program.
G. Review practitioner membership annually or as needed to assure broad representation of primary carepractitioners and specialists.
H. Oversee accurate and clear reporting of QMC minutes and follow up actions.
I. Recommend clinical and safety initiatives relevant to policy decisions. Review and evaluate the results of qualityimprovement activities.
J. Oversee needed actions for improvement upon performance goals.

K. Supervise follow-up of issues and activities, including root cause analysis or barrier analysis when needed.
L. Review, update and approve clinical and preventive practice guidelines annually.
M. Review member satisfaction and quality of care results, such as CAHPS, HEDIS, STARS and findings of OpenShopper studies.
N. Review and evaluate activities that improve member experience, such as access to care and quality of servicesand make recommendations about ways to improve these results.
O. Review, monitor, track and trend, findings of Quality of Care, Quality of Service, and Serious Reportable Eventsand make recommendations for Corrective Action Plans (CAP). Monitoring of CAPS
P. Review of Credentialing Committee (CC), Medical Management Committee (MMC) and Network ManagementCommittee (NMC) minutes for program(s) performance for selection of opportunities
Q. Review and final resolution of practitioner request for reconsideration of credentialing and/or recredentialing determinations and/or issues, termination of practitioner and /or provider contracts for quality-of-care issues, competence, or professional conduct.
R. Provide oversight and recommendations regarding utilization of new technologies and benefit design.
S. Provide oversight of QI Program deliverables including, but not limited to:
T. QI Program Description
U. QI Work Plan
V. QI Evaluation
W. Provide oversight of the Population Health Program
X. Annual PH Program Evaluation
Y. Annual PH Program Strategy
Z. Provide oversight of Utilization Management Program (UM) including:
AA. Annual UM Evaluation
BB. Annual UM Program Description
CC. Work Plan update
DD. Provides ongoing reporting to the DHMP Board of Directors

Operations Management Committee

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

Functions of Denver Health Operations Management Committees:

1. Address, discuss and/or implement actions on presentations, information items and department reports
2. Inform and review annual budget
3. Develop strategic goals for the Company
4. Review financial performance, dashboards, Practitioner and Member service levels, utilization data and otherapplicable information appropriate to the operations of the Company
5. Review new regulatory legislation and contractual requirements and implement, as appropriate

The Denver Health Operations Management Committee

A. Meets Weekly
B. Is Comprised of the following Members:
    - DHMP Manager of Quality Improvement (Facilitator)

- DHMP Medical Director (Chair)
- DHMP Manager of Compliance
- DHMP Director of Health Plan Services
- DHMP Director of Claims, Managed Care
- DHMP Director of Monitoring, Auditing and Training
- DHMP Director of Utilization Management
- DHMP Director of Case Management
- DHMP Director of Insurance Products, Managed Care
- 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
- QI Project Manager
- Intervention Project Managers
- NCQA Project Manager
- ACS Care Coordinator Manager
- Pharmacy and Therapeutics Pharmacist
- Manager of Grievance and Appeals (Non-voting unless designated by director)
- Manager of Health Plan Services (Non-voting unless designated by director)
- Medicaid/CHP Product Manager (Non-voting unless designated by director)
- Commercial Products Manager (Non-voting unless designated by director)
- Marketing Manager (Non-voting unless designated by director)

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:

1. DHMP Medical Director (Chair)
2. DHMP Manager Utilization Management
3. DHMP Manager of Monitoring, Auditing and Training
4. DHMP Manager Case Management
5. DHMP QI Director
6. DHMP NCQA Project Manager
7. DHMP Director of Pharmacy
8. DHHA Behavioral Health Provider (M.D.)
9. Primary and Specialty Care Providers from CHS Provider Network
10. Primary and Specialty Care Providers from the Extended Provider Network

Functions:

11. Provide direction on Health Plan Medical Management Department initiatives
12. Review and approve Program Description and Evaluations

13. Monitor compliance with CMS and State/Federal regulations and mandates
14. Oversee NCQA accreditation deliverables as they relate to UM, Case Management, Health Management, DM/PHM and Pharmacy
15. Analyze utilization data to identify potential areas of over- or under-utilization of health care services and determine appropriate interventions, when necessary
16. Analyze utilization reports to identify significant trends and determine appropriate follow up
17. Report significant findings to the QMC at appropriate intervals, including selection of opportunities, action plans and progress reports
18. Reviews IRR reports at least annually to ensure consistency of UM staff decision making
19. Identify opportunities for utilization and/or cost-savings management
20. Provide strong support and oversight to improve continuity and coordination of care between medical providers and behavioral health providers
21. Work in collaboration with the Network Management Committee (NMC) to ensure adequate medical access to care services
22. Develop improvement initiatives to increase member satisfaction with the plan for Medical Management functions
23. 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

Credentialing Committee

The Credentialing Committee is a subcommittee of the Quality Management Committee and is responsible for evaluating DHMP contracted licensed practitioners, both physicians and non-physicians, who have an independent relationship with the plan. DHMP Medicaid and CHP+ plans comply with Colorado law and current CMS requirements regarding credentialing, re-credentialing, and ongoing monitoring of practitioners. The Credentialing Committee uses active participating practitioners to provide advice and expertise in credentialing decisions.

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

The Denver Health Credentialing Committee:

2. Meets at least Bi -Monthly
3. Is comprised of the following Members:
    1. Medical Director
    2. 3-4 MD/DOs, including at least one PCP, one specialist, and one Behavior Health Provider, and one additional physician; and
    3. 1 Mid-level practitioner

Functions of Denver Health Credentialing Committee:

- Review and approve the Credentialing Charter, Credentialing Policies and Procedures and Credentialing Plan
- Review Practitioner applications, discuss qualifications, and approve or deny the application based on DHMP established criteria.
- DHMP Medical Director reviews all clean files and makes a determination consistent with DHMP Credentialing policies and procedures.

- Provide oversight of all delegated credentialing programs and activities, including but not limited to review of all applications from provider to become a delegated entity and all annual delegated audits.
- Responsible for review and oversight of practitioner quality of care concerns and first level of review for potential disciplinary action consistent with DHMP policies and procedures

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 network drug has any therapeutic advantages in terms of safety and efficacy. Clinical decisions are based onthe 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 thataffect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution and therapeutic interchange protocols.

The Denver Health P&T Committee:

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

<u>The MedImpact P&T Committee:</u>

C. Meets quarterly
D. 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

E. 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
F. A clinical justification is provided if this timeframe is not met; however, for new drugs or newly approveduses for drugs within the six clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic), the Committee will conduct an expedited review and make adecision withing ninety (90) days

Functions of Denver Health and MedImpact P&T Committees:

G. Evaluate and approve formulary drug additions and deletions while ensuring safety and effectiveness
H. Review and approve the Company's formulary drug list at least annually
I. Review and approve the Company's pharmaceutical management procedures annually
J. Evaluate new drugs, drug classes, new clinical indications, therapeutic advantages and new safety information
K. Support educational programs promoting appropriate drug use

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.

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 are appointed by the Chief Compliance and Audit Officer (CCAO) in consultation with the CEO.

The Denver Health Compliance Committee:

L. Meets Quarterly
M. Is comprised of the following Members
    - DHMP CEO
    - DHMP Medical Director
    - DHMP Legal advisor to Committee
    - DHMP Chief Administrative Officer
    - DHMP Chief Financial Officer
    - DHMP Director of Pharmacy
    - DHMP Director of Quality Improvement & Accreditation
    - DHMP Director of information Systems
    - DHMP Director of Health Plan Services
    - DHMP Manager of Health Plan Compliance

- DHMP Manager of Commercial Product
- DHMP Manager of Government Products – Medicare
- DHMP Manager of Government Products – Medicaid & CHP+
- DHMP Privacy Officer
- DHMP Chief Information Security Officer
- DHMP Administrative Assistant, ECS (Scribe)
- DHMP Pharmacy Compliance Analyst
- DHMP Manager of Grievance and Appeals
- DHMP Director of Insurance Products
- DHMP Director, of Compliance & Internal Audit
- DHMP Manager of Utilization Management
- DHMP Manager of Call Center
- DHMP Manager of Payment Integrity

Functions of Denver Health Compliance Committee:

N. Policies, Procedures and Standards of Conduct
   - Review and approve the Enterprise Compliance Program and compliance policies and procedures.
   - Review and recommend revisions to applicable portions of the Code of Conduct.
   - Oversee the implementation of the Enterprise Compliance Program.

O. Training and Education
   - Oversee the development and implementation of compliance and Fraud, Waste and Abuse (FWA) training.
   - Ensure compliance and FWA training and education are effective and appropriately completed.

P. Effective Lines of Communication
   - Ensure DHMP has publicized mechanisms for members, employees, vendors, and subcontractors to ask compliance questions, report potential compliance and/or FWA concerns and violations confidentially or anonymously without fear of retaliation.
   - Ensure DHMP has an effective and timely Mechanism for communicating information related to new and revised laws, regulations, and guidance applicable to DHMP.

Q. Auditing & Monitoring
   - Review the results of annual and periodic risk assessments.
   - Review and approve the compliance and internal audit work plan annually and when revised.
   - Ensure appropriate auditing and monitoring activities are conducted to address identified organizational risks and verify adherence to applicable laws, regulations, and guidance.
   - Ensure the effectiveness of the compliance program is assessed annually and results are shared with the governing body.

R. Enforcement and Discipline
   - Ensure DHMP has well publicized disciplinary standards that encourage good faith participation in the compliance program.
   - Ensure appropriate and consistent discipline is imposed for ethical and compliance violations.

S. Response and Prevention
   - Review the results of auditing and monitoring activities and ensure timely corrective actions are taken, as necessary, and monitored for effectiveness.
   - Ensure timely and reasonable inquiries are made for compliance and/or FWA incidents or issues.

Network Management Committee

The Network Management Committee is tasked with establishing, maintaining and reviewing network standards (and operational processes as required by NCQA for applicable health plans), CMS, Colorado Department of Health Care Policy and Financing (HCPF) andthe Colorado Division of Insurance (DOI). The scope of responsibility includes: (1) Network development and procurement; (2) Provider Contract management, including oversight and (3) Periodic assessment of network capacity.

The Denver Health Network Management Committee:

T. Meets monthly
U. Is comprised of the following Members:
    - DHMP Medical Director
    - DHMP QI Representative, as required
    - DHMP UM Representative, as required
    - DHHA Physicians and Administrators Representative, as required
    - DHMP Provider Relations Representative
    - DHMP Director of QI and Accreditation
    - DHMP Director of Utilization Management
    - DHHA Director of Care Management
    - DHMP Accreditation Manager
    - DHMP Credentialing Manager

Functions of Denver Health Network Management Committee:

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

IV. 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/monitors programs, initiatives and policies 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 State of Colorado ~~and~~ requirements utilizing established, best practice goals and benchmarks to drive performance improvement
- Measure, analyze, evaluate and improve the administrative services and process 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 experience/satisfaction
- Empower Members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic conditions, community outreach efforts and coordination with public/private community

resources

- Promote safe and effective clinical practice by encouraging adherence to established care standards and appropriate practice guidelines
- Educate Members about safety through health promotion activities, Member newsletters and community outreach efforts

The QI PROGRAM OBJECTIVES FOR MEETING THESE GOALS INCULDE THE FOLLOWING:

- Design and maintain the QI structure and processes that support Continuous Quality Improvement (CQI)
    - The summarized approach to achieve this aim is as follows:
        - Analysis of available data; (2) Trending and barrier/root cause analysis of measures; (3) Implementation ofintervention(s); and (4) Remeasurement of targets
- Continuously measure, analyze, evaluate, and improve the clinical care and administrative services of the Plan andhealth care services delivered by contracted practitioners/providers, using HEDIS measures, QI projects and activities and CAHPS member surveys
- Assure compliance with all Colorado State and Federal statutes and regulatory/contractual requirements
- Establish and implement at least one (1) to two (2) PIPs and/or focused studies each year per the Medicaid Choice contractual requirement
    - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated QualityImprovement Committee (IQuIC) and those selected by CMS
- Establish and implement at least one (1) PIP per the CHP+ contractual requirement
    - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated QualityImprovement Committee (IQuIC) and those selected by CMS
- Establish and implement improvement activities to enhance Early and Periodic Screening, Diagnostic and Treatment(EPSDT) performance and compliance
- Objectively and systematically measure and analyze HEDIS, CAHPS and other access/customer service data topromote improvement in Member experience/satisfaction
- Monitor Member experience/satisfaction and identify/address areas of dissatisfaction through an annual review ofthe following data: (1) CAHPS; (2) Member feedback; (3) Appeals and grievances data; and (4) QOC-Gs
- Monitor and maintain safety measures and address identified problems
- Monitor an annual Provider and Practitioner experience survey to evaluate satisfaction with the medicalmanagement processes 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 Monitor and analyze targeted HEDIS measures for health disparitiesand develop appropriate interventions
- Provide multiple avenues for members to obtain Case Management, CCM and Behavioral Health and Wellnessservices
- Collaborate with ACS on the development of initiatives for special needs or racial and ethnic minorities, includingemphasis on cultural competency and health literacy, where appropriate
- Maintain a process for evaluating the impact and effectiveness of the quality assessment and improvementprogram on at least an annual basis
- This evaluation must include sufficient detail for HCPF staff to validate the company's performance accordingto 42 CFR 438.240, External Quality Review of Medicaid Managed Care Organizations (MCOs)
- The annual Program Evaluation/Impact Analysis will describe performance interventions, program outcomesand the overall impact of the Program
    - Upon request, this information will be made available to Providers, Practitioners and Members at no cost

- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes

- Participate in the annual external independent review of quality outcomes, including but not limited to:
-) Medical record review; (2) PIPs and studies; (3) Surveys; (4) Calculation and audit of quality and utilization indicators; (5) Administrative data analyses; and (6) Review of individual cases
    - For external review of activities involving medical record review, the Company will be responsible forobtaining copies of records from the sites in which services occurred
- Participate in the development and design of appropriate external independent studies to assess andassure quality of care; final study specifications shall be at the discretion of the Department
- Integrate Managed Care QI activities with those of the DH ACS and the DHHA Clinical Performance andSafety Improvement (CPSI) Department's QI Committees
- The Company participates in the State IQuiC to provide input and feedback regarding QI priorities,performance improvement and measurement.

V. Program Scope

DHMP is dedicated to ensuring members receive the highest quality health care and customer service. The QI The department 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 performance benchmarks, as well as literature review of best clinical practice research.

QI department structures activities to offer optimal quality and cost effectiveness by ensuring continuous quality improvement (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
- Equitable access to care

Cultural and Linguistic Objectives

BB. The QI Program incorporates ongoing monitoring of the cultural and linguistic needs of it's 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

CC. Identify languages and cultural background of practitioners in provider network to assess whether or not they meet members language needs and cultural preferences

DD. Take action to adjust the provider network if the current network does not meet members language needs and

cultural preferences

EE. Develop, implement and evaluate the culturally- and linguistically appropriate services in collaboration with DHMP staff and other departments and staff, as needed

FF. Ensure interpreter and translation services and auxiliary communication devices will be available to the member at no cost

GG. 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

HH. Evaluate CAHPS questions that relate to interpretation and health literacy satisfaction to identify area for improvement, and implement actions, as needed

II. 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

JJ. Identify annually, using aggregated, using aggregated member Race/Ethnicity/Language (R/E/L) data, languages that must be used in patient materials for quality improvement and marketing activities

KK. 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 members written materials for prevalent populations (>500 members) are translated and made available to members in the respective languages
- These materials appear at a sixth grade reading level and are available, upon request in braille, large print, audio tape format, or other applicable formats to meet member needs

LL. Maintain a library of culturally sensitive health prevention and education materials to be used in member mailings

MM. Participate in DHHA initiatives for reducing health disparities for Plan membership and community Annually, staff diversity training is provided to:

NN. Support the linguistic needs of Denver Health members and the surrounding community by providing Health

OO. Literacy Trainings on-demand to Denver Health and community stakeholder staff and/or providers

Patient Safety

QI works collaboratively with UM, Care Management and Pharmacy to provide clinical quality monitoring and identification of Membersafety performance improvement opportunities. Additionally, the QI Program implements and provides organizational support for ongoing safety and quality performance initiatives. These initiatives relate to care processes, treatments, services and safe clinical practices.

The Medical Director is a Member of the DHHA Patient Safety Committee. To address opportunities to decrease medical errors, the QI Department will offer Member education about safety initiatives and preventive approaches.

Safety objectives include:

1. Incorporate recognition of Member safety as an integral job responsibility
2. Incorporate Member safety education into job competencies
3. Involve Members in decisions about their health care to promote open communication about medical errors and consequences that result
4. Collect and analyze data to evaluate care processes for opportunities to reduce risk and initiate actions
5. Review and investigate serious outcomes where Member injury occurred orMember safety was impaired
6. Report findings and actions internally with a focus on processes and systems to reduce risk
7. Distribute information to Members and Providers via newsletters and/or the DHMP website to help promote and increase knowledge about clinical safety
8. Focus existing QI activities on improving Member safety by analyzing and evaluating data related to clinical safety

9. Trend adverse events reporting in safety practices (e.g. medication errors)
10. Annually review and evaluate clinical practice guidelines to ensure safe practices

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

11. CHS QI: Responsible for the implementation, support and evaluation of effective continuous QI studies of clinical and service activities for Denver Community Services and supports evaluation methods for multiple quality studies and other projects within DH CHS
12. Continual Readiness: Provides coordination of regulatory reviews, surveys or inquiries to DH, including activities related to Joint Commission, CMS, Office of Civil Rights and The Colorado Department of Public Health and Environment
13. Division of Education: Responsible for bringing oversight and organization to the professional education (house staff and student education) occurring within DHHA
14. Health Services Research: An examination of how people get access to health care, how much care costs and what happens to patients as a result of this care
    The main goals of health services research are to identify the most effective ways to organize, manage, finance and deliver high quality care, reduce medical errors and improve patient safety
15. Infection Prevention: Responsible for provision of safe, high-quality health care in the setting of minimizing the risk of acquiring and transmitting infections
16. Medical Biostatistics: This team provides and analyzes data-driven performance measures and tracks quality indicators (e.g., Emergency Medical Services, Clinical Triggers, Soarian Quality Measures)

VI. Care Coordination

Care Management Programs

The overall goal of Care Management and Care Coordination is to help members regain optimum health or improved functional capacity, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources and development and implementation of a care plan with performance goals, monitoring and follow up. Care management programs and activities are an opt-out program, and all eligible members have the right to participate or decline to participate.

The Care Management Team consists of 26 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Clinical, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff.

- Chief Medical Officer
- Director of Health Plan Care Management
- Clinical Manger of Health Plan Care Management
- Operations Manager of Health Plan Care Management
- Care Managers (RN, LPN, MSW, LCSW, RD)
- Licensed Behavioral Health Care Professional
- Transition of Care Nurses (RN, LPN)
- Health Plan Care Coordinators

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is also holistically

supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

Referrals to care coordination and care management can come from a variety of sources, including, but not limited to:

o Health Plan Services (HPS)	o Practitioner/provider	o Inpatient hospital identification via census reports
o Appeals & Grievances (AG)	o Member or caregiver	o Other Care Management programs
o Partner agencies	o Pharmacy	o Community-based organizations (CBOs)
o Claims Data	o Utilization Management (UM)	o Health Screening tools and assessments

Assessment of Member's Health Status includes Health Assessments (HA), Health Risk Assessments (HRA), Health Needs Surveys (HNS), and other functional assessments are completed by the CM team. These assessments collect in-depth information about a member's unique situation and functioning in order to identify their individual needs. The assessments include, but not limited to:

- Identifying an ongoing source of primary care appropriate to the member's needs
- Member's health status, comorbidities, and their current status and member's self-reported status
- Clinical history, inpatient stays, current and past medications
- Activities of daily living (ADL's)
- Behavioral health status including cognitive functions, mental health conditions and substance use disorders
- Social determinants of health
- Life-planning activities (i.e., living wills, advanced directives, powers of attorney
- Evaluation of cultural and linguistic needs, preferred languages, and health literacy
- Evaluation of visual and hearing needs
- Evaluation of the adequacy of caregiver resources
- Evaluation and assessment of community resources

CMs work with the member and/or caregiver to develop a personalized, individualized member and family-centered plan of care. The plan must meet the member needs and include,

- Prioritized goals that consider the member's and family's/caregiver's goals, needs, preferences and desired level of involvement in the care plan
- Timeframes for reevaluating goals
- Resources to be utilized, including appropriate level of care
- Planning for continuity of care, including transition of care and transfers between or across settings
- Development of self-management plan and goals

Barriers are assessed and routinely discussed throughout the care management process to help the member and care manager identify and understand the areas that might prevent a member from meeting their goals or adhering to the plan of care. Barrier analysis includes, but is not limited to:

• Understanding of the	• Level of motivation	• Desire to participate

condition and treatment	for change	
• Belief that participation will improve health	• Ability to participate in achieving goals	• Access to reliable transportation
• Financial or insurance issues	• Language and health literacy level	• Cultural, religious or spiritual beliefs
• Visual or hearing impairments	• Cognitive functioning	• Psychological impairment

Care managers develop and document reasonable timeframes for reevaluation to facilitate a progressive care plan. The CM team maintains contact with the member or family/caregiver, physician(s) and member(s) of the care team based on the member's condition and acuity in order to:

- Assess ongoing needs
- Continue ongoing coaching
- Review progress towards goals
- Inform the member of the next scheduled contact
- Maintain active communication with the PCP, specialty providers and ancillary providers about the member's condition and future needs
- Share ongoing information about choices of settings, providers, treatment options and resources

Care Managers and Health Plan Care Coordinators identify and refer members who could benefit from services available either as part of their health plan benefits or outside of their health plan benefits. CM team members are competent on all the lines of business guidelines and benefit coverages. Resources may include specialty care providers, out-of-network services, social services, government programs, nonprofit organizations, disease-specific foundations and community resources. CM's work with both the provider and the CM team to facilitate the process for resources that require a referral from a provider and/or authorization by the health plan utilization management (UM) team.

Graduation occurs when all care plan opportunities and goals are addressed and re-assessment does not identify need for continued care management, or when a member is able to be transitioned to the next lowest level of care possible based on the member's needs. Members may, at any time, move to a higher level of care management based on changing needs. Discharge from care management or care coordination can occur before care plan goals are met when:

- The member requests to opt out of care management programs and/or care coordination services
- Care Coordinator is unable to reach the member
- The member is no longer eligible for DHMP benefits
- The member is deceased

Additionally, the Care Management team provides disease management services. Services focus on patient education and between-visit care to manage conditions such as asthma, hypertension, diabetes, and depression. DH's primary care staffing model includes an enhanced care team that consists of patient navigators, clinical pharmacists for adults, nurse care coordinators for pediatrics, as well as social workers and behavioral health consultants to optimize clinical visits and support referred patients between visits or after care transitions. DHMP care coordinators may also be involved in the provision of disease management and education services. Denver Health's Acute Hospital Care Management team may be involved in disease prevention education as part of an inpatient admission. Some of the disease management activities at DH include:

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

DHMP Medicaid Choice and CHP+ Members benefit from 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:

Maternal Care Management Program

The DHMP Maternal Care Management Program provides care management services by social workers, registered nurses, and a registered dietitian for high-risk women during pregnancy and for up to a year after delivery. The goal of this program is to ensure healthy pregnancies and healthy babies. The CM staff provide moms and kiddos help in managing access to care, coordination of care, developing individualized plans of care, assist with medication management, help arrange transportation to medical appointments, referrals to other programs like childbirth and breastfeeding education classes, family planning and to the WIC program. The care managers work closely with the members and their providers to meet their needs during their pregnancy. DHMP works in partnership with the providers and services offered at Denver Health including educational classes, virtual and on-site tours of the mom/Baby unit, coordination of care, and assisting in establishing care with DH providers. DH offers several types of prenatal care providers including physicians, midwives, and nurse practitioners.

Diabetes Care Management Program

Implemented in July 2021, the Diabetes Care Management Program is available to Medicaid Choice members. This program is designed to improve quality care of Diabetic members and identification of high risk, poorly controlled, non-adherent members with co-morbidities among the diabetic population. DHMP collaborates with Denver Health Hospital Authority on peer and support groups and access to community programs. Care Managers assist members with accessing screening and access to behavioral health through Denver Health. Care Managers provide additional education and support to increase engagement with the healthcare system, identify changeable SDOH and decrease inequities in care and access to mental health for diabetic members.

Members are identified for outreach for this program through the HNA process, self-referrals, and provider referrals. Additionally, DHMP uses a risk stratification tool which allows DHMP staff to identify members with diabetes and “hone and cone” to outreach members based on known risks. The risk stratification tool was augmented in January 2022 to include

HCPF's 10 identified "winnable" conditions, which includes diabetes. This addition allows for identification and outreach to members who meet this new high-risk criterion.

Controlling Blood Pressure Program

The controlling blood pressure program is offered to DHMP members that are identified as out of control and/or non-adherent with controlling their blood pressure. This program is in collaboration with the DH Pharmacy team and QI/Population Health Team for interventions, including a CBP pilot program to send blood pressure cuffs to Dual Eligible Special Needs members to use in-home for telemedicine visits and personal monitoring. DHMP care managers focus on referring noncompliant members to their PCP/Clinician for management while supporting the member. The CM team will:

- Ensure that a plan of care is in place for members as well as identifying barriers including clinical, nonclinical, and social determinants of health
- Focus on organizing, supporting and arranging resolutions to barriers
- Follow the member until the measure compliance is achieved Once achieved, less frequent outreach will be done to ensure member remains compliant
- Work closely with the member's PCP to offer support and assist in scheduling provider/clinician appointments
- Schedule appointments with clinic PharmD's using EpicCare Link
- Work with the member on medication management and arrange for medication synchronization, scheduled "blister packs" of medication, pillbox organizers and/or other tools if they could be helpful to resolve CBP Compliance barriers

Dual Special Needs Population (DSNP) Program

This is a Comprehensive Care Management program for our Dually Eligible Medicare and Medicaid members. All members in our Medicare Choice plan are enrolled in this program. Members can opt-out to participate in their own care but will still be outreached for Initial Health Risk Assessment (HRA), Transitions of Care (TOC), Change of Condition (COC), and Annual Health Risk Assessments (HRAs). HRA's are completed within 90 days of enrollment and annually thereafter. Individualized Care Plans (ICP) are completed for every member. The ICP is completed upon enrollment, updated at least annually and is an on-going plan of care with members. ICT – Care Plan Meetings are completed on every member, and member involvement is encouraged. ICT Care Plan Meetings are completed upon enrollment, annually, and after a transition of care episode. Any time there is a change in condition with a member, the Individual Care Plan is updated and reviewed by the ICT committee.

Special Health Care Needs Care Management Program

Implemented in June 2021, this program aims to meet the complex needs of members with special health care needs. Services provided for members with special health care needs were previously provided under the Complex Care Medicaid Program. Services are focused on meeting the complex needs of members with SHCN, including benefit coordination and access to services to include child checks, LTSS, and PDN services. Members are identified for outreach through a variety of sources, including MCD reporting, state reporting, provider referrals, and UM referrals. The risk stratification tool is being updated to incorporate multiple data sources for identifying members with SHCN to improve ease of member identification, improve timeliness of outreach, and improve ease of evaluation of member outcomes.

Transitions of Care

The DHMP Transition of Care (TOC) Program is an evidence-based program that focuses on helping reduce preventable readmissions by providing knowledge, confidence, and ability to self-manage health conditions. The goal of this program is to support safe discharge planning, assist IP teams with securing appropriate services post discharge, and to prevent all-cause readmissions by supporting members with obtaining the right care and services at the right time. Members are identified daily, and a comprehensive tracker is managed and updated daily to track members from initial inpatient notification through program enrollment.

Transitions nurses support members and the inpatient care team during the inpatient stay and member discharge, and follow, educate, and support members for 30 days following their hospital discharge. Outreach is done at a minimum of once a week (based on member need) and assessments are completed to determine readmission risk and to develop an individualized care plan with the member. At the completion of the 30 days, the TOC nurse will either graduate the member or refer the member on to our care coordination team or the complex care management team for more follow up and support. The Transitions of Care team has a complex needs process which includes additional monitoring and discharge planning support for members who may experience barriers to discharge, including

- Trach and/or PEG placement during stay
- Length of stay exceeding 14 days, but TOC CM will begin to monitor at 10 days
- Members admitted out of state
- All vent patients
- Medicaid members who will need short- or long-term therapy or LTC placement
- Medical denials that are inpatient pending discharge
- Members experiencing homelessness or unstable housing needing home health care or outpatient IV antibiotics

These members are discussed weekly among internal and external stakeholders to promote safe and effective discharge planning.

Typically, transitions of care fall into two broad categories (planned and unplanned) and may occur between different care sites (e.g., 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. Care coordination activities provided by the TOC include but are not limited to in-network PCP coordination if not already established, appointment reminders – Ensuring timely physician follow-up care, durable medical equipment (DME) Home Health, reviewing medication regimen, disease management education on health conditions and potential “red flags” for readmission, transportation, and connecting members with helpful community resources. 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.

The TOC team has a bi-directional referral system with Colorado Access (COA). Members who are identified as having behavioral health (BH) or substance use disorder (SUD) related need are referred to the TOC team at COA. Members in COA’s TOC program with ongoing physical health needs may be referred to the DHMP TOC team through the DHMP queue. Members may be supported by both programs to address complex medical and BH or SUD related needs. If a member

experiences physical and behavioral barriers to discharge, COA and DHMP will partner with the IP facility, member, caregivers, and any other relevant stakeholders to hold case conferences to overcome barriers, identify appropriate levels of care, and ensure that appropriate wrap around services are in place to support the whole member.

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. Care coordination activities provided by the TOC include but are not limited to:

- In-network PCP coordination if not already established
- Appointment reminders – Ensuring timely physician follow-up care
- DME
- Home Health
- Reviewing mediation regimen
- Disease Management
- Education on health conditions and potential "red flags" for readmission
- Transportation
- Connecting members with helpful community resources

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 Care Medicaid Program

DHMP's Complex Care Program addresses the complex medical, behavioral and/or psychosocial needs of members by providing personalized care management services and goal setting. The program is designed to help members with complex conditions and social situations to obtain access to necessary care and services in a coordinated and cost-effective manner. The program is intended to empower members who have complex medical needs and require a wide variety of resources to manage their health, improve their quality of life and take control of their health care needs. The care managers collaborate with members and providers to set SMART goals and address barriers. This program also assists members with transitions of care across different levels of care. Managing member transitions between care settings is essential for member safety, quality of care, and cost-effective outcomes. Members who are identified as adult members (ages 21+) with 3 or more "winnable" conditions and care costs exceeding $25,000 and adolescent members (ages 0-20) with care costs exceeding $25,000. This definition for adults was updated in November 2022, but members receiving services under the old definition have been retained in the program.

Medicaid/CHP+ Care Coordination

This program is intended to manage Medicaid and CHP+ members with multiple risk factors including chronic diseases,

behavioral health conditions and over and under-utilization patterns that increase risk of poor outcomes. Members are referred to this program through multiple methods, including provider referrals, internal referrals, and through identification of high-risk members using the risk stratification tool. The program will create individualized care plans but will also target specific gaps such as frequent ED utilization or no PCP visit in the last 12 months, with targeted population campaigns.

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:
    6. Integrated Behavioral Health
    7. Tobacco Cessation Clinic
    8. Diabetes Prevention Program
    9. 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
    10. Denver Comprehensive Addictions Rehabilitation and Evaluation Services (CARES) Program - DH Outpatient Behavioral Health Services (OBHS) offers the CARES Program for treatment of non-opiate drug and alcohol substance use disorders. Patients are required to complete a comprehensive substance abuse evaluation and may be referred for treatment through several avenues, including by health care Providers, DHMP Care Coordinators or by self-referral. Hepatology – Hep C Program Pharmacotherapy Management

Complex Case Management (CCM)

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.

High Utilizer Medication Management

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

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

Substance Use Disorder (SUD)

The Substance Use Disorder (SUD) Program is available to all DHMP Members, and DHMP works closely with Colorado Access (COA) to meet the needs of DHMP Medicaid Members who are in need of SUD services. The goal of this program is to assist and equip members in navigating through the recovery process, community resources, education, and programs. This program empowers members to manage their diagnoses and make informed, healthy choices that support physical and emotional well-being, as well as encourage members to engage in creating a foundation of relationships and social networks to provide support. Care Managers provide assistance with housing, transportation, education, resources, and physical and emotional health. Care Managers works closely with Utilization Management to ensure that members are able to access approved treatments, support groups, and/or community programs under existing benefits.

Behavioral Health Care Coordination

The Behavioral Health Care Coordination Program is available to all DHMP members and promotes wellness by helping members access appropriate treatment and community resources. DHMP works closely with Colorado Access to support members in accessing their behavioral health benefits and connecting members to needed care. Care managers assist members in developing goals focused on improving their health. Although behavioral health care managers do not provide counseling or mental health treatment services, they do work with the member to develop a self-management plan, coordinate care with the member's providers, prepare the member for interaction with providers to enhance treatment outcomes, facilitate communication between behavioral health providers and medical providers, identify and direct the member towards community resources, resolve barriers whenever possible, and manage treatment access and follow up

with members with coexisting medical and behavioral disorders.

Continuity of Care

The Continuity of Care Program is available to all DHMP Members and is designed to ensure members have access to out of network (OON) providers due to Transition of Care, Continuity of Care, Network Adequacy or due to a State of Emergency. Care Management and Utilization Management work collaboratively to ensure members have access to care for new members in active treatment with an OON provider at the time DHMP membership becomes effective; continued care is authorized for a defined transitional period as need to minimize disruption of care. Care Managers assist members in choosing an in-network provider. DHMP also provides coordination of care for members based on network adequacy issues for a defined period until a safe transfer of care can be arranged to an in-network provider. Ongoing services are reviewed, and efforts are made to redirect care when able.

Foster Care Program

In 2022, the DHMP CM team implemented a Foster Care Program to support the unique needs of members in foster care. Members in this program are provided care coordination assistance in a direct partnership with the Connections for Kids Clinic (CFKC) at Denver Health's Eastside Clinic, a medical home for children and youth in kinship and foster care. Care Managers assist members and their families with obtaining routine and timely physical and dental exams as well as comprehensive care. The clinic provides the following services:

- Well Child and Sports Exams
- Integrated Behavioral Health
- Dental Care
- Vision and Hearing Screenings
- Developmental Screenings
- Family Planning
- Immunizations
- Case Management
- Sick Visits
- Women, Infant, and Children (WIC) Program on Site
- Pharmacy
- Laboratory Services

DHMP in coordination with the CFKC performs visits/assessments for foster care children. During the first 3 months of care, 3 visits are completed with the member and assessments/evaluations are completed at each of these visits to support member needs. This partnership ensures that foster care children residing within Denver County have access to all DHMP resources and support that is available. This clinic designation allows providers to provide a high level of care coordination and assistance to the child/family.

Other Care Coordination Services

Many DHMP members benefit from Care Coordination services but may not want to opt-in to the programs offered in Care

Management. Care Coordination Activities are available to all DHMP Members. Members are assisted with coordination of but not limited to:

- Applications/Membership Assistance
- Community Resources Assistance
- Condition/Disease Management
- Education
- Health Acuity/Needs
- Medication Management
- Health Care Provider Coordination and DHHA Empanelment
- Transportation
- Appointment Reminders
- Meal Coordination

The DHMP CM team offers support to all members engaged in CM services in order to encourage COVID-19 vaccination and boosters. In 2023, the goal is to normalize COVID-19 vaccinations and encourage members to get routine boosters along with other routine immunizations.

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 early 2023, the DHMP CM team was recognized as a differentiator for the Medical Plan by the Denver Health board for the excellent service provided to members. In 2022-2023, DHMP successfully implemented quality improvement initiatives for Care Coordination activities, including:

- Development and implementation of the Foster Care Program
- Expansion of the Controlling Blood Pressure Program to all lines of business
- Changes to the adult complex care population definition which allowed the CM team to better target members with poor utilization patterns and multiple chronic conditions
- Adults with 3 or more “winnable” conditions and >$25,000 in care costs
- Development of a Complex Care dashboard to track metrics for Complex Care population
- Updates to the risk stratification tool to identify members with special health care needs
- Updates to the risk stratification tool to include an indicator for members with at least 1 inpatient admission in the past year
- Development of a Maternal Care Dashboard to help identify members with high-risk pregnancies and track Care Management outreach and engagement
- Development of a member centric dashboard to easily identify gaps in care, last and next appointments, and ED/inpatient utilization
- Development of a MLR dashboard to track MLR metrics for the Medicaid population
- Enhanced member support during the PHE unwinds, including assisting members with enrollment challenges as well as challenges related to rising SDOH needs

DHMP recognizes opportunities for quality improvement in 2023-2024 and the following key initiatives are planned with

executive support:

- Development of an ADT feed in the Altruista Guiding Care© Medical Management Platform© to track inpatient admissions and observation stays
- Development of an ADT feed in the Altruista Guiding Care© Medical Management Platform© to track ED visits
- Identification of a rising risk population in partnership with SquareML
- Identification of a new Complex Needs definition for pediatric members, which will include potential integration of rising risk data in addition to foster care and special health care needs indicators from the risk stratification tool
- Improved member outcome analytics, including cost and utilization outcomes, in partnership with Square ML
- Ongoing enhanced member support for enrollment and SDOH related needs during the PHE unwind
- Upgrade of the Altruista Guiding Care© Medical Management Platform© including implementation of the Population Health module
- Integration of HEDIS data into the Altruista Guiding Care© Medical Management Platform© Population Health Module
- Automated integration of Health Needs Assessment (HNA) data into the Altruista Tableau Data Warehouse
- Integration of data from the Altruista Guiding Care© Medical Management Platform into DHMP's Risk Stratification tool to improve effectiveness in evaluating member and program outcomes
- Exploration of enhancements to the Altruista Guiding Care© Medical Management Platform which will enhance communication between the CM team and DHMP members, including:
- Robo calls/ Robo texting
- Ability to send members messages through a secure system
- Ability to send member resources and education through a secure system
- Ability for members to complete assessments through a secure system
- Development of a Condition Management dashboard to track member conditions and participation in CM programs

The overall goal of Care Management and Care Coordination is to help members regain optimum health or improved functional capacity, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources and development and implementation of a care plan with performance goals, monitoring and follow up. Care management programs and activities are an opt-out program, and all eligible members have the right to participate or decline to participate.

The Care Management Team consists of 26 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Clinical, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff.

- Chief Medical Officer
- Director of Health Plan Care Management
- Clinical Manger of Health Plan Care Management
- Operations Manager of Health Plan Care Management
- Care Managers (RN, LPN, MSW, LCSW, RD)
- Licensed Behavioral Health Care Professional

- Transition of Care Nurses (RN, LPN)
- Health Plan Care Coordinators

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, improving health outcomes and reducing the cost of care. This strategy presents a cohesive plan for addressing member needs across the continuum of care.

DHMP's PHM Program aims to identify population health needs through segmentation and risk stratification of members and in order to recognize opportunities for intervention. DHMP's Population Health team collaborates and provides support tothe Care Management and Medicaid team to assist in care coordination efforts, evaluate program outcomes, and identify individuals for Care Management outreach.

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

1. Medical and behavioral claims or encounters.
2. Pharmacy claims.
3. Laboratory results.
4. Health Risk appraisal and Health Needs Assessment results.
5. Electronic health records.
6. Health services programs within the organization.
7. Advanced data sources.

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

VII. Adequacy and Availability of Service

The Company will establish, monitor and implement improvement processes to ensure compliance with regulatory and contractual requirements regarding access standards and guidelines for Members. Standards and guidelines include: (1) Geographic distribution of Providers; (2) Provider to Member ratios for PCPs and Specialists; (3) Timeliness of appointments for primary care; (4) Access to after-hours care; and (5) Key elements of telephone service, including responsiveness of the Company's Health Plan Services Department telephone lines.

The Company will continue its Open Shopper Study to evaluate the processes Members undertake to reach a live

representative for availability to schedule appointments and the ease of access to make an appointment. This collection of data is shared with the NMC and QMC to develop opportunities for improvement and CAPs, when appropriate. The Company will assure that female Members are provided with direct access to women's health specialists within the network for covered services.

Clinical Practice and Preventive Care Guidelines

On at least an annual basis, the Company will notify all Providers, Practitioners and Members about how to obtain clinical practice and preventive care guidelines, via DHMP Provider portal (link below). Practice guidelines are based on valid and reliable clinical evidence and/or a consensus of health care professionals in a particular field. The QI Department, in the development of clinical practice guidelines, considers the needs of Medicaid Choice and CHP+ Members. In order to improve health, the QI Department ensures that health guidelines are communicated to Providers and Practitioners, Members, non-Members and the public at no cost to the individual or Provider. The Company will consult with Practitioners to develop and apply evidence-based clinical standards in an annual review/update.
Source: Quality Improvement Program | Denver Health Medical Plan

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

- Developing new clinical guidelines where opportunities for improving clinical practice align with benefits
- Assure Member benefit coverage for any elements of guidelines adopted
- When appropriate, consult guidelines for QI activities/QI projects
- Evaluate the appropriateness of the guidelines annually

Member Experience/Satisfaction

The Company QI Department evaluates and trends Member satisfaction data through the annual CAHPS survey. HCPF performs the CAHPS survey for CHP+ Members. The QI Project Manager assesses CAHPS data to identify opportunities for improvement, new initiatives and activities. Additionally, the Medical Director, and clinical nurse staff support the Quality-of-Care Grievance (QOC-G) process.

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

Provider and Practitioner Experience/Satisfaction

Annually, the Provider Relations Contracts and Credentialing Department administers a Provider and Practitioner Experience Survey to assess the level of satisfaction Practitioners have with Company services and processes. The Company analyzes the results and puts necessary process improvements in place, when deemed appropriate. Additionally, the Company communicates the QI Program goals, processes and outcomes to its DHHA and external Practitioners through the Provider Newsletter, the Company website, and other mailings annually. The Provider Relations and Contracts and Credentialing Department monitors Practitioner complaints and makes appropriate improvements

Credentialing and Delegated Credentialing

The Credentialing Coordinator ensures that the compliance of credentialing and recredentialing activities align with CMS standards. The Credentialing Coordinator also conducts primary source verification for any direct Credentialed

Practitioner. The Credentialing Coordinator evaluates the Practitioner's credentialing materials for compliance against credentialing standards prior to contract approval.

The Credentialing Coordinator will also evaluate the delegated entity's credentialing compliance with the Company credentialing and recredentialing standards annually. Additionally, the Credentialing Coordinator will conduct site visits for any Practitioner's office site (i.e., primary and specialty) that exceeds the acceptable threshold for grievances related to physical accessibility, physical appearance and adequacy of the waiting and exam room space. The Credentialing Coordinator will then report audit results to the Credentialing Committee. The Credentialing Coordinator will conduct an assessment of organizational facilities for contracting compliance, as well as provide ongoing monitoring of Practitioner complaints and sanctions for recredentialing purposes.

Delegation Activities and Oversight

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

VIII. QI Program Annual Work Plan and Evaluation

Annual Work Plan

The QI Department will develop a QI Work Plan annually. The QI Work Plan will begin in August of every year. The Work Plan covers the scope of the QI Program and includes:

- Measurable yearly objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities with the Medical Management Department
- Yearly objectives and planned activities, time frames for completion and responsible staff
- Monitoring of previously identified issues
- Communicated to Members, Providers and the community via the QI page on the DHMP website

Annual Evaluation

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

The QI Program Evaluation/Impact Analysis includes:

- Description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service, including delegated functions
- Trending of quality and safety measures and comparison with established benchmarks
- Analysis of improvement, including barrier analysis when goals are not met.
  - Relevant Practitioners or staff who had direct experience with the process's present possible barriers to improvement and provide recommendations for addressing those barriers
- Evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices, adequacy of resources, committee structure, Practitioner participation, leadership involvement, and any determination of restructure or change(s) to be made for the subsequent year
- The modifications of QI Program Descriptions and QI Work Plans will also incorporate advice, recommendations or mandates from external auditors and/or regulatory bodies
- Communication to Members, Providers and the community via the QI page on the DHMP website.