2024 QUALITY IMPROVEMENT PROGRAM DESCRIPTION

DENVER HEALTH MEDICAL PLAN, INC.

Commercial, Medicare, and Exchange Products

May 14th, 2024

Approved by the Quality Management Committee on: May 14th, 2024.

DENVER HEALTH MEDICAL PLAN INC.™

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INTRODUCTION

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

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

MISSION STATEMENT

To provide affordable, high-quality health care coverage for all in partnership with Denver Health. In partnership with our providers, we continually seek to improve the health and well-being of our members by:

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

QUALITY STATEMENT AND PROCESS

DHMP's QI Program is designed to support the mission of DHMP by promoting the delivery of high-quality, financially sustainable, equitably accessible physical and behavioral health care services that will improve or stabilize the health status of DHMP members. DHMP maintains a comprehensive Quality Improvement (QI) Program to systemically define, evaluate and monitor continuous quality improvement, ensuring high-quality, cost-effective care and services are provided to DHMP Commercial, Exchange and Medicare members. The QI Program incorporates evaluation of key indicators of care and service to identify improvement opportunities, resulting in development and implementation of interventions to increase defined quality metrics. A multidimensional approach is utilized to measure effectiveness. Dimensions evaluated include appropriateness, efficiency, effectiveness, availability, timeliness, continuity and cost of care and services, member satisfaction, health outcomes and provider satisfaction.

Annually, we review ongoing and completed QI activities, including complete analysis of results and evaluation of the overall value of the Program. From this evaluation process, recommendations are developed for the upcoming year, which are incorporated into the QI Program Description and Work Plan. DHMP is able to assess the strengths of the Program and identify opportunities for improvement, incorporating learning from the ongoing activities, including opportunities for increased collaboration to maximize resources and avoid costs resulting from duplicative efforts.

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

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider and practitioner experience surveys

Commented [WIR1]: @Egan, Katie @Ramirez, Jonathan Can we check with Marketing and see if our new name is Elevate

Commented [RJ2R1]: Name change came in summer of 2022 and did not change the 2023 bundle doc. Group is comfortable leaving as is.

Commented [PR3]: Mission Stmt is up to date.

- Member experience surveys
- Health Plan Services call data
- Medical record reviews
- Claims data
- Open Shopper Study data
- Pharmacy data
- Case Management data
- Utilization Management (UM) data
- Population Health Management (PHM) data
- Demographic, health equity and social determinants of health data

These sources provide DHMP with the data collection necessary to improve the appropriateness, efficiency, effectiveness, availability, timeliness, and continuity of care delivered to our members. This approach also allows DHMP to focus on opportunities for improving operational processes, increasing member and practitioner satisfaction, and managing health outcomes. DHMP's mission is to provide the right care at an affordable and equitable cost, high-quality healthcare coverage for all in partnership with DHHA.

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

QI PROGRAM STRUCTURE

OVERSIGHT

DHMP Board of Directors

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

Composition:

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

Function:

- Approve the QI Program Description, QI Work Plan, and QI Annual Evaluation

- Approve Medicare Special Needs Plan (SNP) Model of Care annual goals.
- Review applicable DHMP quality data such as CAHPS, HEDIS, Medicare Stars, etc.

AUTHORITY AND RESPONSIBILITY

DHMP CEO/Executive Director

The CEO/Executive Director supports the QI Program by overseeing the QI Department operations. In addition, the allocation of resources and formal reports to the Board of Directors are coordinated through the CEO/Executive Director.

Medical Director responsibilities include, but are not limited to:

- Provide direction, support, and oversight related to the development, implementation, and evaluation of all clinical and quality improvement activities of the QI Department
- Work in collaboration with the Senior Director of Health Outcomes & Pharmacy (HOP)/QI Director and QI Department managers (QI, NCQA and Population Health) on the development and assessment of clinical and quality improvement 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 Senior Director HOP and QI Managers on the preparation and dissemination of relevant information obtained on the performance of QI activities to the QMC, Operations Management Committee, AQIC, and DHMP Board of Directors
- Provide oversight for clinical activities in the QI Work Plan
- Delegate components of the QI Work Plan to other members of the Operations Management Committee
- Serve on the QMC, AQIC, Medical Management Committee (MMC), Credentialing Committee, Operations Management Committee, and DHHA Patient Safety and Quality Committee
- Serve as the designated physician in the QI Program, including participating in the QMC and related subcommittees, as necessary.
- Provide evaluation and management of DHMP Quality of Care Concerns (QOCCs) related to physical health problems while working in conjunction with QI Registered Nurse (RN) resources
- Report QOCCs to the DHHA Patient Safety and Quality Department and external network Providers as appropriate
- Oversee updates and approval for all DHMP clinical and preventive health guidelines.

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 (QI) Department

- Functions as a division of the Health Outcomes & Pharmacy (HOP) Department

(1 FTE) The Senior Director (HOP) hold QI Director role responsibilities

- 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, identify prioritized areas of need for health plans and direction to the QI Department

(1 FTE) DHMP Manager of QI responsibilities include, but are not limited to:

- Development, management and monitoring of the QI Program
- Directly assume responsibility for submission of the QI Program Description, Evaluation and Work Plan annually, all LOBs

- Identify quality gaps, communicate, and coordinate, provide advice, and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health departments, as appropriate, for regulatory compliance
- Support the QMC activities, meeting agenda, deliverables as annually scheduled and assist with meeting execution
- Annually ensure all policies, procedures and guidelines related to the QI Department are updated appropriately
- Oversee QI vendor contracts as directed by Sr. Dir HOP/QI Director
- Coordinate and/or provide oversight, and/or direction to the QI Department team members, consisting of the following members:

(1 FTE) HEDIS Supervisor

Currently supervised by CMO, responsibilities include, but are not limited to*:*

- Manage all aspects of HEDIS production and data submission support including oversight of related projects, such as HEDIS Roadmap development and timely measure data submission and NCQA measure updates. Communicate all new measure information to appropriate departments and committees.
- Evaluate and analyze HEDIS results and share findings with appropriate committees
- Provide recommendations to the QI Managers for cost efficiency, process improvements and quality interventions
- Work collaboratively with Intervention Manager(s) on process improvements and quality interventions related to HEDIS
- Validate the accuracy of HEDIS data and supporting documents in collaboration with auditor and HEDIS engine vendors
- In cooperation with QI Manager, support medical records review activities, including all related internal process trainings as needed

(1 FTE) NCQA Project Manager

- Manage all NCQA readiness and survey preparation with appropriate departments
- Communicate all readiness needs to leaders and their assigned points of contact (POC)
- Communicate NCQA standards inappropriate committees as these reflect those of HSAG (CMS audit vendor) and flow downstream to become reflected in State contract updates

(2FTE) QI Project Manager responsibilities include, but are not limited to:

- Manage all aspects of CAHPS-related projects
- Evaluate, analyze and report CAHPS results, as well as facilitate improvement efforts
- Analyze the effectiveness of intervention activities
- Coordinate all efforts related to Work Plans, Evaluations, and Program Descriptions
- Lead activities related to regulatory and accreditation requirements
- Work in collaboration with Population Health and QI Intervention Project Manager(s) to maintain a timeline for deliverables
- Co-direct and work with the QI Manager to ensure efficient recruitment of QMC membership, meeting coordination, minute-recording, and bi-monthly reporting requirements
- Function as the main administrative contact for the QMC

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

- Operational oversight of Medicare Stars goals
- Develop the Population Health Strategy to meet all regulatory requirements and align with the broader organizational goals
- Engage with and motivate the DHMP network of providers to implement interventions to meet the Population Health goals
- Appropriately delegate and oversee responsibilities related to Population Health strategies for staff assignments, quality assurance monitoring and required reporting

- Manage the communications with providers including conflict resolution related to Population Health interventions
- Hire, train, motivate and coach staff to support efficient and accurate Population Health Interventions
- Hire, train, motivate and coach supervisors to assess employee performance and provide feedback and mentoring opportunities
- Monitoring population health activities for quality engagement and timeliness and working with the Director to ensure the department is properly provisioned and staffed
- Analyze qualitative and quantitative monitoring reports to develop more effective or efficient processes and strategies for improving the cost and quality of care
- Work with the Director to establish and achieve Population Health department objectives, including improving the cost, quality, and experience of care for Members
- Generate Population Health outcomes reports and present information to upper-level managers or other parties
- Ensure staff members follow company policies and procedures
- Other duties as assigned

(1 FTE) Stars Analyst

- Develop and monitor Stars metrics regulated by CMS- including codified, proposed, display measure and advanced notice changes. Inform leadership and Stars committee of all changes that can and will impact the direction of the plan's Stars strategy. Review all CMS memos and provide communication to department leads.
- Develop and maintain Star Ratings workplan with all department leads with direct impact over Star measures. Work with internal teams to create project initiatives or interventions that will drive timely and effective change to star ratings. Make recommendations, monitors and measure improvements to increase overall ratings.
- Work with business owners to ensure quality metrics are achieved and continuous improvements are made
- Identify and escalate any issues, challenges or barriers to appropriate teams and leadership
- Collaborate with DHHA partners to support, implement, and drive improvements related to Stars rating
- Work with industry expert matter experts (Stars Consultant) to keep informed of industry and regulatory changes. Gather best practice examples, case studies that improve Stars outcomes and strategy.

(1 FTE) Specialist, Clinical Pharmacist, Managed Care – Population Health

- Conduct medication reviews and assessments to identify potential issues and recommend interventions, with a focus on population health. Collaborate with the Supervisor of Pharmacy operations to ensure representation for ICT (Integrated Care Team) meetings.
- Focus on the management of chronic diseases prevalent in the population and develop clinical programs for review
- Work with healthcare teams to design and implement strategies for improving medication adherence in targeted disease management
- Analyze population health data to identify trends and areas for improvement
- Generate reports to support analyses and contribute to evidence-based practices
- Evaluate the effectiveness of population health interventions and make recommendations for improvement
- Oversee the Part D Stars measures to ensure tracking towards Star goals set by the Executive Team

Clinical Staff support for QI Activities includes, but is not limited to:

- Manage QOC-G concerns processes in a timely and effective matter
- Work in collaboration with HEDIS Supervisor to perform HEDIS chart reviews (MRR)
- Develop training materials, facilitate training, or use MRR annual training vendor. Additional DHMP specific data transfers, etc. Training to be supplied by HEDIS supervisor.
- Provide clinical consultation for the QI Department
- Conduct practitioner chart review using HEDIS criteria

Commented [PR4]: IRR is related to UM, not QI, however we are now using Care national to train med record reviewers and certify their competency.

Commented [WIR5R4]: @Pelland, Robin I am in agreement with this shift.

COMMITTEE STRUCTURE

1. QUALITY MANAGEMENT COMMITTEE (QMC)

Commented [WIR6]: @Egan, Katie @Pelland, Robin Changed to follow the QMC policy in PolicyStat.

Commented [PR7R6]: @Egan, Katie I do not know what this ask is referring to. I see there are more than this one in the comments. Do you know what this refers to?

The Quality Management Committee (QMC) acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to members. The QMC is responsible for oversight of all quality related activities and processes, including utilization management, case management, health management, pharmacy, member services, and provider relations. Additionally, the QMC oversees the effectiveness of the healthcare effectiveness data and information set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality outcomes, quality improvement (QI) evaluations and interventions, all quality-of-care evaluations and reporting, and patient safety initiatives. The QMC includes primary care providers and specialty providers from both Denver Health Hospital Authority and extended provider network and other staff.

The DHMP Quality Management Committee:

- Meets Bi-Monthly in the following cadence.
  - January
  - March
  - May
  - July
  - September
  - November

COMMITTEE MEMBERSHIP

Procedure:

The Quality Improvement Manager at DHMP Health Plan shall serve as the QMC Chair.

QMC will include in-network practitioner membership from primary care, behavioral health, and specialist reflective of the plans high volume specialty areas. Practitioner members must hold a current, unencumbered medical license in the state of Colorado, and must also be in good standing with the plan.

Voting Members (and/or their designee)

- Quality Improvement Manager (Chair)
- Chief Medical Director
- DHMP Manager of Compliance
- Director of Claims, Managed Care
- Director of Health Plan Services, Marketing & Engagement, Monitoring, Auditing and Training
- Director of Health Outcomes & Pharmacy
- Director of Utilization Management
- Director of Care Management
- Director of Insurance Products, Managed Care
- Primary Care Providers from Denver Health Hospital Authority (DHHA) and the External Provider Network
- Specialty Care Providers from DHHA and the DHMP External Provider Network (Invited)
- Behavioral Health Provider

Non-Voting Members

- QI Project Manager
- Intervention Project Managers
- NCQA Project Manager
- HEDIS Supervisor
- ACS Care Coordination Manager
- QOC Nurse
- Clinical Pharmacist Specialist
- Manager of Grievance and Appeals (non-voting unless designated by director)

- Manager of Member 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)
- Members presenting to the committee should participate as a nonvoting member unless designated by their director to represent them.
- DHMP Chairperson may invite other DHMP network practitioners, providers, staff and/or other guests on an ad hoc basis for specialty review and/or input.

QMC proceedings are documented by contemporaneous, dated, and signed minutes reflecting committee decisions and actions. Any written information determined to be of confidential nature distributed to QMC members must be stamped as "Privileged and Confidential", be distributed in the meeting packet, collected, at the close of each meeting, and stored in a secured area. All documentation presented at each meeting will be included with the minutes. QMC members will sign a Quality Improvement Confidentiality Statement annually.

The DHMP QMC and subcommittee membership will encompass individuals from DHMP's clinical and administrative leadership staff, DHMP physician-level practitioners in the primary care and specialty care areas of practice, respectively, to provide medical knowledge, clinical, and operational best practice skills, and judgments. The QMC and subcommittee physician members must hold a current, unencumbered medical license and must be credentialed in good standing with DHMP network and the state of Colorado.

Functions of the QMC committee

- Serve as the advisory and action oversight body for quality initiatives and activities for the organization and business partner delegates
- Review of the performance of QI activities
- Review summary reports for the QMC subcommittees, ad hoc committees, and QA/QI process improvement activities providing feedback and/or recommendations for improvement
- Identify and analyze trends and evaluate the implementation of appropriate focused interventions to improve performance
- Review and approve quality improvement projects (QIPS)
- Review, evaluate, develop, and implement population health-based QA/QI activities and satisfaction survey intervention plans
- Provide oversight of all clinical and administrative aspects of the QI program
- Review practitioner membership annually or as needed to assure broad representation of primary care practitioners and specialists
- Oversee accurate and clear reporting of QMC minutes and follow up actions
- Recommend clinical and safety initiatives relevant to policy decisions. Review and evaluate the results of quality improvement activities.
- Oversee needed actions for improvement upon performance goals
- Supervise follow-up of issues and activities, including root cause analysis or barrier analysis when needed
- Review, update and approve clinical and preventive practice guidelines annually
- Review member satisfaction and quality of care results, such as CAHPS, HEDIS, STARS and findings of open shopper studies
- Review and evaluate activities that improve member experience, such as access to care and quality of services and make recommendations about ways to improve these results
- Review, monitor, track, and trend, findings of quality of care, and serious reportable events and make recommendations for CAPs
- Monitoring of CAPs

Commented [WIR8]: Matching PolicyStat

Commented [WIR9R8]: @Ramirez, Jonathan @Egan, Katie Please go through document and clean up formatting and alignment to the paragraph above

- Review of Credentialing Committee (CC), MMC, and Network Management Committee (NMC) minutes for program(s) performance for selection of opportunities
- Review and finalize the 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
- Provide oversight and recommendations regarding utilization of new technologies and benefit design
- Provide oversight of QI program deliverables including, but not limited to:
    - QI program description
    - QI work plan
    - QI evaluation
    - Provide oversight of the Population Health (PH) Program
    - Annual PH program evaluation
    - Annual PH program strategy
- Provide oversight of Utilization Management (UM) Program including:
    - Annual UM evaluation
    - Annual UM program description
    - Work plan update

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

- Ambulatory Care Services QI Committee (AQIC)
- Medical Management Committee (MMC)
- Network Management Committee (NMC)
- Credentialing Committee
- UM Committee

Commented [WIR10]: @Duval, Viv Does these committees roll up through NCQA? Can you provide documentation if they do.

- Member Experience Committee
- CAHPS Committee
- Various Medicare Stars Committee

Commented [RJ11R10]: MEC does not formally report to QMC. CAHPS committee is now part of MEC.

2. OPERATIONS MANAGEMENT COMMITTEE

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

The Operations Management Committee:

- Meets Weekly
- Is Comprised of the following Members:
    - DHMP CEO-Chair
    - DHMP CFO-Chair
    - DHMP COO-Chair
    - DHMP CMO-Chair
    - Director of Health Plan Services
    - Director of Member and Provider Experience
    - Manager of Provider Relations
    - Director of QI/Population Health
    - Sr. Director of Health Outcomes & Pharmacy
    - Director of Information Systems
    - Director of Utilization Management
    - Director of Insurance Products
    - Director of Claims Operations

- Director of Care Management
- Compliance Manager
- Strategic Management Office Manager
- Monitoring Audit and Training Manager

Functions of Operations Management Committee:

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

3. MEDICAL MANAGEMENT COMMITTEE (MMC)

Commented [WIR12]: @Egan, Katie @Pelland, Robin @Ramirez, Jonathan Please match PolicyStat

Commented [PR13R12]: @Winters III, Rule I do not know what that request means, so I will leave this to Katie and Jonathan.

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

The committee meets at least six times a year, or when necessary, at the call of the committee chair. Meeting dates and times will be specified a year in advance and occur during opposite months of the QMC.

Attendance at meetings: Members shall regularly attend or send a designee who is prepared to act on behalf of the appointed member.

Key decisions: The recorder shall prepare a meeting summary that reflects key decisions and required actions to occur subsequent to the meeting. The required actions shall specify what, who, and by when.

Reporting months:

- February
- April
- June
- August
- October
- December

The Medical Management Committee:

- Meets Bi-Monthly
- Is comprised of the following Members:
  - Sr. Director of Health Outcomes & Pharmacy, Managed Care – Committee Chair
  - Utilization Management Director – Member
  - Director of Health Plan Care Management – Member
  - Quality Improvement Manager – Member
  - Accreditation Manager – Member
  - Clinical Manager of Health Plan Care Management – Member

- Operations Manager of Health Plan Care Management – Member
- DHHA Psych MD - Member

The MMC will report up to the QMC bi-monthly. Regular reports will include, but are not limited to the following annual reports:

- Physician Satisfaction Report
- Continuity and Coordination of Care Reports
- Utilization Management Evaluation
- Disease Management Program Evaluation
- Behavioral Health Program Evaluation
- Pharmacy Reports
- Policies and Procedures
- MCD/CHP+ Care Management Program Description and Evaluation
- DSNP Care Management Program Description and Evaluation
- MCR/COMM/EXCH Care Management Program Description and Evaluation
- NCQA Steering Committee
- Annual Committee Goals:
  - Providing strong support and oversight to an initiative to improve continuity and coordination of care
  - Reviewing and updating the current Medical Plan dashboard
  - Works in collaboration with the QMC, which is the oversight committee for the organization
  - Works in collaboration with the Network Adequacy Committee

4. CREDENTIALING COMMITTEE

The Credentialing Committee is a subcommittee of the Quality Management Committee. It is responsible for evaluating DHMP contracted licensed practitioners, both physicians, and non-physicians, who have an independent relationship with the plan. DHMP is an NCQA-accredited plan and complies with Colorado law and current NCQA and 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 re-credentialing. It is a subcommittee of the QMC.

<u>The Credentialing Committee</u>

- Meets at least monthly
- Is comprised of the following Members:
  - Medical Director
  - 3 MD/DOs, including at least one PCP and one specialist
  - 1 Mid-level practitioner

<u>Functions of Credentialing Committee:</u>

- 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 providers to become a delegated entity and all annual delegated audits.

- Responsible for review and oversight of practitioner quality of care concerns and the first level of review for potential disciplinary action consistent with DHMP policies and procedures

5. PHARMACY AND THERAPEUTICS COMMITTEE

DHMP uses the Denver Health Pharmacy and Therapeutics Committee (P&T Committee) for formularies that are maintained internally and the MedImpact P&T Committee for formularies that are delegated to be managed by the pharmacy benefit manager (PBM), MedImpact.

The P&T Committees are tasked with promoting the safe and appropriate use of high-quality, cost-effective pharmaceuticals and 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 on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco-economic studies, outcomes research data, and other such information, as deemed appropriate. In addition, the Committees use appropriate scientific and economic considerations to consider utilization management activities that affect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols.

The Denver Health P&T Committee:

- Meets monthly
- Is comprised of the following members:
  - DHHA Physicians across multiple specialties (e.g., infectious disease, critical care, pediatrics, etc.)
  - DHHA Pharmacists across multiple specialties (e.g., oncology, infectious disease, etc.)
  - Representatives from DHHA and CHS
  - Physicians affiliated with non-Denver Health sites of care (e.g., Rocky Mountain Poison and Drug Center Physicians, University of Colorado, etc.)
  - Director of Pharmacy and Operations Management attend as a non-voting member when request to provide additional details regarding formulary changes to custom formularies.
- Functions of the Committee include:
  - Evaluate and approve formulary drug additions and deletions while ensuring safety and effectiveness
  - Review and approve the Company's formulary drug list at least annually
  - Review and approve the Company's pharmaceutical management procedures annually
  - Evaluate new drugs, drug classes, new clinical indications, therapeutic advantages, and new safety information
  - Support educational programs promoting appropriate drug use

The MedImpact P&T Committee:

- Meets quarterly
- Is comprised of:
  - Physicians and/or practicing pharmacists
  - At least one practicing physician and at least one practicing pharmacist who are independent and free of conflict relative to the Client, MedImpact, and any pharmaceutical manufacturers
  - At least one practicing physician and one practicing pharmacist who are experts regarding the 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

Commented [WIR14]: @Muccioli, Alexa Let me know if anything to add

Commented [MA15R14]: Reviewed. No updates at this time. The only thing I was going to mention was an annual review of P&Ps for formulary management and Drug authorization process but you cover that in another section for functions.

Commented [WIR16]: @Muccioli, Alexa Validate Content and update

Commented [MA17R16]: @Winters III, Rule Reviewed. No changes at this time.

Commented [WIR18]: @Muccioli, Alexa Validate Content and update

- Drug review standards: a reasonable effort is made to review each new chemical entity and new FDA clinical indications within ninety (90) days and make a decision on each within one hundred eighty (180) days of its release onto the market.
    - A clinical justification is provided if this timeframe is not met; however, for new drugs or newly approved uses for drugs within the six clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic), the Committee will conduct an expedited review and decide within ninety (90) days.
- Functions of the Committee include:
    - Evaluate and approve formulary drug additions and deletions while ensuring safety and effectiveness
    - Review and approve the Company's formulary drug list at least annually
    - Review and approve the Company's pharmaceutical management procedures annually
    - Evaluate new drugs, drug classes, new clinical indications, therapeutic advantages, and new safety information
    - Support educational programs promoting appropriate drug use
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6. COMPLIANCE COMMITTEE

Commented [WIR19]: @Grein, Stacy Could you validate this is correct

Commented [GS20R19]: @Winters III, Rufe I updated this section to match the current Compliance Committee Charter

To assist in advising and providing direction to the Chief Compliance and Audit Officer (CCAO) in overseeing DHMP's compliance program for its government and commercial lines of business, DHMP established the DHMP Compliance Committee, which receives reports on compliance matters at least quarterly, or as necessary.

The Committee includes, at a minimum, a cross-section of the members of the Operations Team. Committee members should have the necessary experience and expertise to make decisions and implement changes as recommended by the Compliance 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.

1. <u>The Compliance Committee:</u>
    - Meets Quarterly, or as necessary
    - Is comprised of the following positions (or designee)
        - CEO/Executive Director of Managed Care
        - Chief Financial Officer
        - Chief Operating Officer
        - Medical Director
        - Legal Counsel
        - Chief Information Security Officer
        - Privacy Officer
        - Director, Care Management
        - Director, Claims
        - Director, Health Plan Compliance
        - Director, Member and Provider Experience

- Director, Information Systems
- Director, Insurance Products
- Director, Pharmacy
- Director, Utilization Management
- Manager, Health Plan Services
- Manager, Commercial Products
- Manager, Government Products - Medicare
- Manager, Government Products - Medicaid & CHP+
- Manager, Grievance & Appeals
- Manager, Marketing, Engagement and Provider Relations
- Manager, Monitoring, Auditing & Training
- Manager, Payment Integrity
- Manager, Quality Improvement & Accreditation
- Others (as deemed appropriate)

Functions Of Denver Health Compliance Committee

- 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
- Training and Education
  - Oversee compliance and Fraud, Waste, and Abuse (FWA) training development and implementation
  - Ensure compliance and FWA training and education are effective and appropriately completed
- Effective Lines of Communication
  - Ensure DHMP has publicized mechanism for members, employees, vendors, and subcontractors to ask compliance questions, and 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
- 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 compliance program's effectiveness is assessed annually and results are shared with the governing body
- 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
- 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

7. NETWORK MANAGEMENT COMMITTEE (NMC)

Commented [WIR21]: @Duval, Viv @Egan, Katie Viv does this section match the NMC committee charter?

The Network Management Committee is tasked with establishing, maintaining, and reviewing network standards and operational processes as required by NCQA, CMS, the Colorado Department of Health Care Policy and Financing (HCPF), and the Colorado Division of Insurance (DOI). The scope of responsibility includes: (1) Network development and

procurement; (2) Provider contract management, including oversight; and (3) Periodic assessment of network capacity. (4) Directory Audits, and (5) Provider Manual Maintenance.

The Network Management Committee:

- Meets monthly
- Is comprised of the following Members:
    - DHMP Director of Provider Relations – (Chair)
    - DHMP Product Line Managers
    - 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 Sr Director HOP
    - DHMP NCQA Project Manager
    - DHMP Director of Utilization Management
    - DHHA Director of Care Management
    - DHMP Accreditation Manager
    - DHMP Credentialing Manager

Functions of Denver Health Network Management Committee:

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

GOALS AND OBJECTIVES

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

THE QI PROGRAM STRIVES TO ACHIEVE THE FOLLOWING GOALS:

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

appropriate practice guidelines

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

- Design and maintain the QI structure and processes that support Continuous Quality Improvement (CQI). The summarized approach to achieve this aim is as follows: (1) Analysis of available data; (2) Trending and barrier/root cause analysis of measures; (3) Implementation of intervention(s); and (4) Re-measurement of targets
- Continuously measure, analyze, evaluate, and improve the clinical care and administrative services of the Plan and health care services delivered by contracted practitioners/providers, using HEDIS measures, QI projects and activities, and CAHPS member surveys
- Assure compliance with all Federal and Colorado State statutes and regulatory/contractual requirements
- 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 Wellness services
- 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
- The annual Program Evaluation/Impact Analysis will describe performance interventions, program outcomes and 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 NCQA Health Plan accreditation readiness activities to maintain external 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) Quantitative and qualitative data analyses of all data; and (6) Review of individual cases

PROGRAM SCOPE

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

QI structures activities to offer optimal quality and cost-effectiveness by ensuring CQI of health care 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 Preventative ~~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

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

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

Staff diversity training is provided annually to:

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

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

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.

DHMP uses various methods for risk stratification of members, dependent on the line of business (LOB) and associated regulatory/contractual requirements. Members may be stratified based on primary behavioral or physical health conditions, diagnosis information, over-or under-utilization of services, cost of care, or other factors. DHMP compiles data from several sources, including self-reported data to identify members or populations with high-acuity concerns that can be addressed via care coordination, population health, or care management interventions.

- Care 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. Some care coordination activities and programs at DHMP include:
    - High Utilizer Medication Management Program
    - Medicare Select Care Management
    - Continuity of Care Program
    - COVID Member Outreach/COVID Vaccination Care Coordination
    - Applications/Membership Assistance
    - Community Resources Assistance
    - Education
    - Health Acuity/Needs
    - Medication Management
    - Health Care Provider Coordination and DHHA Empanelment
    - Transportation
    - Appointment Reminders
    - Meal Coordination
- Disease management services include patient education, care coordination, and between-visit care to manage conditions such as asthma, hypertension, diabetes, and depression. DHMP care coordinators are involved in the provision of disease management and education services, and this role has been expanded in 2021 to include the Controlling Blood Pressure and Diabetes Management Programs. Some Disease Management Programs and activities offered by DHMP Care Management include:
    - Controlling Blood Pressure Program
    - Behavioral Health Care Coordination Program
    - Diabetes High-Risk Care Management Program
    - Substance Use Disorder (SUD) Care Management Program
    - Tobacco Cessation Referrals

- Pharmacotherapy Management

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

<u>Dual Special Needs Program (DSNP):</u>

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 on every member. The ICP is completed upon enrollment, updated at least annually and is an on-going plan of care with member. 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. Refer to the Medicare Choice HMP SNP Program Description and SNP Model of Care for additional information on this program.

Transitions of Care

The DHMP 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. Transitions nurses support members and facilities during the 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 are inpatient for more than 14 days, are admitted out of state, or whose medical needs meets complex needs criteria. These members are discussed weekly at a meeting involving UM and CM so that barriers to care and barriers to discharge can be resolved on the side of the hospital system, and repatriation to a Denver Health facility can be supported as appropriate.

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

Complex Case Management

The DHMP CCM Program is available to members enrolled in any of the DHMP plans. The Program addresses the complex medical, behavioral and/or psychosocial needs of members by providing personalized case management services and goal setting. DHMP’s CCM 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. DHMP does so by coordinating quality health care services and optimizing benefits through a case management plan. CCM Care Managers collaborate with members and caregivers to set Specific, Measurable, Attainable, Relevant and Timely (SMART) goals. These Care Managers are Licensed Clinical Social Workers (LCSWs), LPNs and Registered Nurses (RNs); LCSWs and LPNs work under the supervision of an RN.

Denver Health’s ACS clinics also provides 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 Program

This care management program was expanded in 2021 to include members on Medicare, commercial, and exchange plans. The DHMP pharmacy team monitors members pharmacy utilization and will identify members that are on high-cost drugs for care coordination review and evaluation for case management services. The care coordination team will outreach to the member to discuss their specific condition and associated pharmacy needs and connect members to a primary care provider if they are not already established with a provider.

Controlling Blood Pressure (CBP)

Implemented in August 2020, the controlling blood pressure program is offered to DHMP Medicare Advantage 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 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.

Diabetes Care Management Program

Implemented in June 2021, the Diabetes Care Management Program is available to Medicare Choice SNP Members, with services being expanded to include members covered under the Medicare Select HMO, Commercial, and Exchange Lines of Business. 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.

Care Management Member Experience Survey:

The Care Management team conducts a member experience survey annually. Surveys are mailed to members who have participated in a care management program. Telephonic outreach for members who do not complete the survey is conducted by the HPCCs, who are not directly involved with the member's care plan to promote candid and objective feedback from the member. The goal is to reach approximately 25% of DHMP members quarterly and during fourth quarter DHMP strives to ensure that all remaining DHMP members receive a survey. Survey data is collected at the individual member survey results level and at the aggregate level by question type and overall score. Survey data is collected internally by DHMP, and the survey data/results are housed in the Guiding Care system.

Areas of opportunity to improve satisfaction for DHMP members identified through the CMS CAHPS and HOS and DHMP Off-cycle CAHPS/HOS, and the care management surveys are incorporated into cross-departmental quality improvement workplans along with improvement goals, interventions and assigned leads. Progress towards goal attainment and intervention status are reported to various committees. Data from these surveys is analyzed along with pharmacy, appeals and call center data to ensure a global picture of member experience and to evaluate the effectiveness of the DHMP members throughout the year.

QUALITY OF CLINICAL CARE

The QI Department annually collects and reports out HEDIS data according to DHMP's contract requirements. HEDIS

results are analyzed for opportunities to improve all measures with an emphasis on diabetes, cardiovascular conditions, asthma, behavioral health, and preventive care for our members. Every 3 years, QI initiates one Chronic Care Improvement Project (CCIP) for both Medicare Advantage and Medicare SNP populations. This improvement project is directed by CMS per regulations. All DHMP QI activities related to DHMP members undergo the Denver Health "plan, do, study, act" (PDSA) methodology to ensure interventions are handled properly.

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

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. DHMP Care Management continues to strive to identify members who would benefit from Care Management and Care Coordination services to promote improved member outcomes.

DHMP recognizes opportunities for quality improvement in 2023 and the following key initiatives are planned:

- Implementation of face-to-face visits for DSNP members through telemedicine and in-person visits
- Introduction of HRA incentive for members who complete an initial or annual HRA to increase engagement in CM services that support closing gaps in care
- Ongoing collaboration with the DHHA Mobile Vaccination Clinic for enhanced COVID-19 vaccination efforts and normalization of the COVID-19 vaccine into routine immunizations
- Upgrades to inpatient reporting and alert process to improve timeliness of inpatient and discharge notifications
- Upgrades to over/under utilization dashboard to track the impact of Care Management programs on utilization patterns
- Continue expanding the Controlling Blood Pressure and Diabetes Management programs to other lines of business
- Explore and expand into health and wellness and Care Management programs for Commercial and Exchange members
- Implementation of the new Population Health module in Guiding Care, this will allow the care management team to identify areas of opportunities and gaps in care during outreach and program management
- Phase 2 – Guiding Care upgrade – CM Software Platform
- Upgrade to Altruista Tableau Reporting Software

Utilization Management Programs:

DHMP's Utilization Management (UM) Program is designed to support one of the main overall missions of the organization:

ensuring the delivery of high-quality, medically necessary, cost-efficient physical and behavioral health care to members. The UM Program is under the supervision of the Medical Director and the Director of UM. The UM Program Evaluation documents performance by staff, identifies deficiencies, pinpoints opportunities for improvement and describes interventions for the betterment of the UM Program. This Evaluation covers the Elevate/Exchange (HIX), Large Group Commercial (COM), and Medicare (MCR) lines of business (LOBs).

The UM Program strives to achieve the following objectives:

- To coordinate and promote optimal utilization of health care resources
- To promote fair and consistent UM decision making and authorization processing through Inter-Rater Reliability (IRR) testing of physician and non-physician UM staff
- To assist with transition by referring members to the Care Management Department for alternative care when benefits end, should a member no longer be eligible for DHMP benefits
- To educate medical practitioners, providers, and other health care professionals about the utilization management process
- To provide appropriate and timely feedback to members, practitioners, and providers to communicate reasons for treatment denial, as well as methods for appeal and the minimum clinical criteria required for authorization
- To safeguard medical records and all other confidential information through appropriate operation protocols, as well as using physical mechanisms to safeguard Protected Health Information (PHI)

Program Structure and Authority:

The UM Department operates under the direction of the Medical Director, the Director of UM, and Manager of UM. The Medical Director delegates the responsibilities of daily operations to the Director and Manager of UM. The UM Department is a team of licensed Registered Nurses (RNs) and other non-clinical staff who report to the Director or Manager of UM and work to ensure that goals are achieved efficiently and consistently.

Program Development and Approval:

Each year, the Director of UM completes the UM Program Evaluation with the help of the Medical Director and uses the findings in that Evaluation to evaluate the UM Program. Once approved by the Medical Director, the UM Program is updated and will be applied the following year. The Program Documents are brought to the MMC for review and approval, as well as to the QMC via MMC Minutes for additional approval.

Member Satisfaction:
UM staff survey 5 Medicare members every month to assess level of satisfaction with the plan, electronics availability, use of outside networks and satisfaction with the Customer Service Department. Results are presented monthly to the HCAPHS team.

Interrater Reliability Metrics:
Background:

Inter-Rater Reliability (IRR) testing is an annual requirement for all physician and non-physician clinical reviewers for all lines of business at DHMP. Annual testing validates that the guideline criteria are applied consistency and appropriately by all clinical professionals who perform UM organization determinations. Testing is required for all direct hire staff, vendors, and delegates.

The regulatory statutes which outline the need for IRR testing include NCQA accreditation Standard UM2C, 42 CFR 438.210, b.2 and the HCPF contracts Exhibit M-1. This requirement applies to both direct employees and to all UM delegates, and

vendors.

Goal:
All clinical reviewers must pass with a 90% score or higher. If staff fail on the first attempt, one-on-coaching occurs, and the staff are given a second attempt to pass.

POPULATION HEALTH MANAGEMENT

The Population Health Management (PHM) Strategy outlines Denver Health Medical Plan, Inc.'s (DHMP's) strategy for meeting the care needs of its member population, 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 Program aims to identify population health needs through segmentation and risk stratification of members in order to recognize opportunities for intervention. DHMP's Population Health Team provides support to the Care Management 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:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Each area of focus includes the following:

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

The PHM Team maintains a PHM Program description and performs an annual program evaluation. Each year, the PHM team completes the Program Evaluation, and uses the findings in that Evaluation to revise the PHM Program Description. This includes evaluating programs and services offered, organization resources (e.g., staff, training, etc.) and identifying community resources that correlate with member needs. These documents are then brought to the MMC for review and approval, as well as to the QMC via MMC minutes for additional approval.

PATIENT SAFETY

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

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

Patient safety objectives:

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

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

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

ADVOCACY AND AVAILABILITY OF SERVICE

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

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

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

BEHAVIORAL HEALTH INTEGRATION AND SERVICE

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

Behavioral Health assessments are a vital component of the DHMP programs and can include:

- Patient Health Questionnaire (PHQ-2 and PHQ 9)
- Mini-Mental Status Exam
- Social Determinants of Health (SDOH)
- Edinburgh Postnatal Depression Scale (EPDS)
- Generalized Anxiety Disorder (GAD 7)
- Health Risk Assessment (HRA)
- Health Needs Survey (HNS)
- Behavioral Health Cognitive Functioning assessments

Care Management program participants often present with more than a set of medical issues, and psychological or social factors may affect recovery or adherence with treatment. A variety of interdisciplinary care team members conduct assessments that inform the care plan.

DHMP Care management provides a variety of external referral paths for members and providers including email, web-based provider portals, telephone, and fax options. DHMP Care management programs also provide coordination with DHHA and other Health Care Entities for our Members for behavioral health.
These entities include:

- Elevate Mind
- Virtual Mental Health Services for Commercial and Exchange Members
- Employee Assistance Program (EAP) and school counselors for Commercial members
- WellPower (formerly known as Mental Health Center of Denver (MHCD))

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- DHHA has embedded a medical clinic within the WellPower to serve the severe and persistent mental illness population
- DHHA OBHS Programs
- Serves all people, regardless of citizenship or ability to pay
- Offers quick intake availability and 24/7 access to care through the ED
- Offers specialized services for pregnant patients and people with dependent children (same-day access to treatment to all pregnant patients)
- OBHS receives specialized grant funding to enhance recovery efforts and provide wrap-around services, such as support with transportation and childcare
- OBHS serves people on Involuntary Commitments and Emergency Commitments. Programs Include:
    - Opioid Treatment Program (OTP)
    - Denver Health Addiction Recovery Center (DHARC)
    - Women and Family Services (WFS)
    - Substance Treatment Education Program (STEP)
    - ACS Integrated Behavioral Health (Primary Care Providers/Behavioral Health Providers)
    - Specialty Mental Health Providers
    - Colorado Coalition for the Homeless for Medicare and Commercial members, as indicated

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

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

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

CLINCIAL AND PRACTICE GUIDELINES

DHMP annually reviews select DHHA's clinical and practice guidelines. These shared DHHA guidelines are then approved for use by DHMP health plans via the QMC before being distributed to all members and providers via website and/or newsletters.

DHMP, will follow State and NCQA recommendations on number and areas of care for guidelines as well as considering those that may best support health plan performance needs.

MEMBER SATISFACTION

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

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

Member experience is monitored throughout the year in all member facing departments, such as Health Plan Services, Care Management, Pharmacy, etc. Other non-member facing departments report trends/data in the Quality Management Committee (QMC), Network Management Committee (NMC), Medical Management Committee (MMC) and/or CAHPS Committee. This includes member satisfaction survey results, grievances and appeals, prior authorizations, access to care/availability of appointments and members choosing to disenroll. Furthermore, the DHMP QI Department provides annual member communication about their goals, processes and outcomes via the member newsletter, plan website and other creative materials, as applicable.

The Medicare department conducts a monthly mini-CAHPS through a third-party vendor. The monthly results are reviewed, and outreach is conducted via the Marketing and Engagement Department. The results are also rolled up quarterly with projected ratings and shared with the CAHPS Committee for intervention and feedback.

DHMP also conducts quarterly provider access surveys designed to monitor and oversee access to care and services within our network, as a component of member satisfaction. The findings are then presented at NMC for feedback and intervention.

Components of the survey include:

- Member Plan Information
- Member Demographics
- Experience with Member Materials
- Experience with Health Plan Services
- Experience with Accessing Providers and Practitioners
- Experience with UM
- Experience with CCM

PROVIDER SATISFACTION

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

Components of the survey include:

- Overall Satisfaction with DHMP
- Experience with Requests for Durable Medical Equipment (DME)

- Experience with Requests for Home Health Services
- Experience with Requests for Out-of-Network Services
- Experience with Prior Authorization Requests (PARs) for Medication
- Experience with Exchanging Patient Information
- Experience with Quality Improvement (QI) Department
- Experience with Website

CREDENTIALING AND DELEGATED CREDENTIALING

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

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

DELEGATION ACTIVITIES AND OVERSIGHT

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

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

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

Commented [WR23]: @Duval, Viv Should this be First Health @Egan, Katie

QUALITY IMPROVEMENT PROGRAM ANNUAL WORK PLAN AND EVALUATION

ANNUAL WORK PLAN

The QI Department will develop a QI Work Plan at the beginning of January of each year. The Work Plan covers the scope of the QI Program and includes the following:

- Yearly planned activities and objectives, including the times for each activity's completion and the staff. responsible for each activity for improving:
    - Quality of clinical care
    - Safety of clinical care

    - Quality of service
    - Member experience
- Monitoring of previously identified issues
- Evaluation of the QI Program
- Written, measurable objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities with Departments including, but not limited to:
    - Health Plan Medical Management
    - Pharmacy
- Provider Network Adequacy

ANNUAL EVALUATION

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

The Evaluation includes:

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

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Commented [PR25R24]: There is no reason why that could not be added.

Commented [PR26R24]: @Winters III, Rule the website is not part of the evaluation function, but rather a communication tool.

ADMINISTRATIVE FUNCTIONS

CONFIDENTIALITY

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

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

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

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

All confidential information retained by DHMP shall be held in secured and locked files or rooms. DHMP, in accordance

with applicable State and federal laws, shall remain confidential information. While performing its utilization management responsibility, it is the policy of the DHMP Medical Management Department not to record telephone conversations.

CONFLICT OF INTEREST

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

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