2025 QUALITY IMPROVEMENT PROGRAM DESCRIPTION

DENVER HEALTH MEDICAL PLAN, INC.

Medicare and Exchange Products

May 13, 2025

DENVER HEALTH MEDICAL PLAN INC.™

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I. 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. The Quality Improvement (QI) Program Description outlines DHMP's efforts to improve the overall quality of care, service, and safety for our Exchange and Medicare members.

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

Mission Statement

DHMP's mission is to provide affordable, high quality healthcare coverage for all. Our vision is to empower members and collaborate with providers to make healthcare simple, personal, and accessible. We achieve this through our common values shared with Denver Health and Hospital Authority (DHHA) of respect, belonging, transparency and accountability.

Quality Statement and Process

The Denver Health Medical Plan (DHMP) Quality Improvement Program is designed to support the mission of DHMP by promoting the delivery of high quality, accessible health care services that enhance or improve the health of DHMP members.. The Quality Improvement Program provides a formal process to systematically monitor and evaluate quality and safety of clinical care and service utilizing a multidimensional approach measured through different performance dimensions. These dimensions include appropriateness, efficiency, effectiveness, availability, timeliness and continuity. This approach enables DHMP to focus on opportunities for improving operational processes, member and provider satisfaction as well as health outcomes.

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

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider and practitioner experience surveys
- Member experience surveys
- Health Plan Services call data
- Medical record review
- Claims data
- Provider access survey data
- Pharmacy data
- Care Management (CM) data
- Utilization Management (UM) data
- Population Health Management (PHM) data
- Social Determinants of Health (SDOH) data

This comprehensive data approach also allows DHMP to target opportunities for improving operational processes, increasing member, provider/practitioner satisfaction, and effectively managing health outcomes.DHMP uses a continuous QI cycle to conduct a measurement of performance indicators; perform quantitative and qualitative analyses, identify and prioritize opportunities for improvement and leverage the Quality Management Committee (QMC), as appropriate. 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 service.

II. Quality Improvement Department Structure

Oversight

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 the Quality Assurance and Performance Improvement (QAPI) documents (which include the QI Program Description, QI Work Plan, and 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 QAPI documents. 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

Executive Leadership

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.

Interim Medical Director* responsibilities include, but are not limited to:

- Providing direction, support and oversight related to the development, implementation and evaluation of all clinical activities of the QI Department.
- Work in collaboration with the 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.
- Delegate components of the QI Work Plan to other members of the Operations Management Committee.

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

Authority and Responsibility (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
- Provide oversight, identify prioritized areas of need for the health plan and direction of the QI Department

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

- Development, management and monitoring of the QI Program
- Serve as Facilitator to the Quality Management Committee (QMC)
- Directly assume responsibility for submission of the QI Program Description, Evaluation and Work Plan annually, all Lines of Business (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 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 Manager

Currently supervised by Sr. Population Health Manager, 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
- 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

(1 FTE) Quality Informatics Program Manager

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

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

- Manage all NCQA readiness and renewal survey preparation with appropriate departments
- Communicate all readiness needs to leaders and their assigned points of contact (POC)
- Ensure health plan is in compliance with NCQA standards, leveraging appropriate committees as needed

(1 FTE) 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) 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 Team to perform HEDIS chart reviews (MRR)

III. Committee Structure

Quality Management Committee (QMC)

DHMP's QMC acts to plan and coordinate organization-wide improvements in quality and safety of clinical care and service to Members. The QMC is charged with responsibility for oversight of all quality related DHMP Medical Management activities and processes, including but not limited to: Utilization Management, Case Management, Health Management, Pharmacy and Provider Relations. Additionally, the Committee oversees the effectiveness of the HEDIS and CAHPS quality outcomes, QI evaluations and interventions, QOCC evaluations, patient safety initiatives. The QMC includes network primary care Providers (PCPs), specialty Providers, and other staff.

The DHMP Quality Management Committee:

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

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 Actuarial Services & Medical Economics
- Director of Claims, Managed Care
- Director of Member and Provider Experience
- 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

- Sr. Manager of Population Health
- QI Project Manager
- Intervention Project Managers
- NCQA Project Manager
- HEDIS Supervisor
- ACS Care Coordination Manager
- QOC Nurse
- Clinical Pharmacist Specialist
- Manager of Medical Economics
- 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)

QMC members will sign a Quality Improvement Confidentiality Statement annually.

- 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. 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, 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 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

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:

- Review of Credentialing Committee (CC), MMC, and Network Management Committee (NMC) minutes for program(s) performance for selection of opportunities
- 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

Operations Management Committee

The Operations Management Committee meets weekly and is comprised of the following members:

- DHMP CEO-Chair
- DHMP CFO-Chair
- DHMP COO-Chair
- DHMP CMO-Chair
- Director of Actuarial & Medical Economics
- Manager of Medical Economics
- 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

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.

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

Medical Management Committee (MMC)

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 (meets bi-monthly):

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

MMC is comprised of the following members:

- Sr. Director of Health Outcomes & Pharmacy, Managed Care – Committee Chair
- Utilization Management Director – Member
- Director of Actuarial & Medical Economics – Members
- Director of Health Plan Care Management – Member
- Manager of Medical Economics – 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 Report
- 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

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
Credentialing Committee

The Credentialing Committee is a subcommittee of the Quality Management Committee and is responsible for evaluating DHMP contracted licensed practitioners, both physicians and non-physicians, who have an independent relationship with the plan.. DHMP's Exchange and Medicare LOBs are NCQA-accredited and comply 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 recredentialing. It is a subcommittee of the QMC and:

- 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

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.

<u>The Denver Health P&T Committee</u>:

- 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

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

- 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
- 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
    - Support educational programs promoting appropriate drug use
    - 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 approveduses for drugs within the six clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic), the Committee will conduct an expedited review and make a decision within ninety (90) days.

Compliance Committee

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

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

1. <u>The Compliance Committee:</u>
    - Meets Quarterly
    - Is comprised of the following members:
        - CEO/Executive Director of Managed Care
        - Chief Financial Officer
        - Chief Operating Officer
        - Chief Compliance and Audit Officer
        - Associate Chief Operating Officer
        - Medical Director
        - Legal Counsel
        - Privacy Officer
        - Director, Care Management
        - Director, Claims

- Director, Member and Provider Experience
- Director, Insurance Products
- Director, Pharmacy
- Director, Utilization Management
- Manager, Commercial Products
- Manager, Government Products - Medicare
- Manager, Government Products - Medicaid & CHP+
- Manager, Health Plan Compliance
- Others (as deemed appropriate)

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- 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

Network Management Committee (NMC)

The Network Management Committee is tasked with establishing, maintaining, and reviewing network standards and operational processes as required by NCQA, CMS, 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 quarterly
- Is comprised of the following Members:
    - Chief Financial Officer - (Chair)
    - Manager of Medical Economics - (Co-Chair)
    - Manager of Marketing, Experience and Provider Relations
    - Medical Director
    - Senior Director of Health Outcomes & Pharmacy
    - Manager of Health Plan Quality Improvement
    - NCQA Project Manager
    - Product Line Managers
    - Director of Health Plan Utilization Management
    - Director of Care Management
    - Director of Member and Provider Experience
    - Manager of Health Plan Services
    - Manager of Appeals & Grievances
    - QI Manager
    - Others as required

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

Member Experience Committee

DHMP's Member Experience Committee was established in Q1-24 to align with the strategic goal of creating, implementing, and continuously improving member onboarding and engagement. The committee meets monthly to review, suggest data-driven changes, and evaluate member experience. The Committee will assess policies and procedures related to member onboarding, experience and engagement, materials, and usability of plan benefits. Primary goals are to:

- Create an onboarding and engagement strategy that:
- Builds rapport with members early, addresses concerns immediately, tailors communication to preferences, empowers members (through integrated technology and education), and improves satisfaction
- Establish metrics to monitor success of onboarding and engagement initiatives
- Form and maintain a member advisory committee
- Must include a diverse, reasonably representative sample of individuals from each product line
- Solicit direct input and feedback on enrollee experiences, member materials, and/or policies
- Help identify barriers to high-quality, coordinated care
- Improve member experience between the member, the plan and the providers

- Enhance member usability and experience of plan benefits and tools
- Comply with all regulatory requirements

The Member Experience Committee:

- Meets Monthly
- The Member Experience Committee will include representation from each of the primary areas related to DHMP Products, not to exceed 15 members:
    - Director of Insurance Products; Co-Chair
    - Director Health Plan Services, Marketing and Engagement; Co-Chair
    - Ad hoc members will include representatives from Product Lines, Health Plan Services, Marketing and Engagement, Pharmacy, Care Management, and Executive Leaders (COO, CMO)

IV. Goals and Objectives

The QI Program seeks to accomplish the following objectives: (1) Assess the quality of care delivered to DHMP members, and (2) Evaluate the way 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. QI program strives to achieve the following goals for all members:

- Ensure quality of care and services that meet the State of Colorado, CMS and NCQA requirements, utilizing established, best practice goals and benchmarks to drive performance improvement.
- Measure, analyze, evaluate and improve the administrative services of the plan.
- Measure, analyze, evaluate and improve the health care services delivered by contracted practitioners.
- Promote medical and preventive care delivered by contracted practitioners that meets or exceeds the accepted standards of quality within the community.
- Empower members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic conditions, community outreach efforts and coordination with public/private community resources.
- Encourage appropriate, safe and effective clinical practice through established care standards and best practice guidelines.
- Improve the health outcomes of our members by providing education to our members on the importance
- of preventive screening, chronic condition care compliance and self-management.
- DHMP's health promotion activities span from monthly campaigns, newsletters, community outreach and Population Health Programs.
- Objectively and systematically measure and analyze HEDIS, CAHPS and other access/customer service data topromote improvement in member experience/satisfaction
- Assess outcomes related to member health care access, quality, cost and 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) Quality of Care Grievances (QOC-Gs)
- Monitor and maintain safety measures and address identified problems
- Monitor an annual Provider and Practitioner experience survey to evaluate satisfaction with the medical management processes and services as they relate to continuity and coordination of care
- Monitor access through 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, Complex Care Management (CCM), Behavioral Health and Wellness services

- Collaborate with ACS on the development of initiatives for health utilization disparities, where appropriate
- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
- Integrate Managed Care QI activities with those of DHHA's Quality Improvement Committee (QIC) and workgroups
- Specific outcome measures QI tracks and monitors include:
    - Well-Child Visits in the First 30 Months of Life
    - Well-Child Visits in the First 30 Months of Life (15 Months - 30 Months)
    - Timeliness of Prenatal Care
    - Breast Cancer Screenings
    - Postpartum Care (7 - 84 days)
    - Asthma Medication Ratio
    - Cervical Cancer Screening
    - Controlling Blood Pressure
    - Eye Exam for Members with Diabetes
    - Colorectal Cancer Screening

V. 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. DHMP QI Program structures to offer optimal quality and cost-effectiveness by ensuring clinical quality improvement (CQI) activities to address the following:

- Health plan medical management
- Preventive health promotion
- Pharmacy management
- Patient safety
- Complex and special health care needs
- Adequacy and availability of services
- Clinical and preventative guidelines
- Continuity and coordination (CoC) of care
- Quality of clinical care
- Member satisfaction
- Provider and practitioner satisfaction
- Credentialing and delegated credentialing
- Delegated activities and oversight
- Access to care

Cultural and Linguistic Objectives

- 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
- Develop, implement, and evaluate the culturally and linguistically appropriate services in collaboration with internal and external stakeholders, as needed
- Ensure interpreter, 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 Care Management Department, 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 member 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 (defined as five percent of the total population or >1,000 individuals, whichever is less) 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
  - Participate in DHHA initiatives for reducing health disparities for plan membership and community
- The QI Program incorporates ongoing monitoring of the cultural and linguistic needs of its membership including but not limited to the following:
    - Cultural preferences
    - Staff diversity training is provided annually to: - All DHHA, including DHMP, all employees and practitioners- DHMP is also expanding cultural competency/humility training to support non-DHHA network practitioners

VI. Care Coordination

Care Management Programs

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

The Care Management Team consists of 33 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Behavioral Health Care Professional, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff.

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

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is holistically supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

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.

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

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

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

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

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

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

- Development of self-management plan and goals

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

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

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

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

Care Managers and Health Plan Care Coordinators identify and refer members who could benefit from services available either as part of their health plan benefits or outside of their health plan benefits. CM team members are competent on all the lines of business guidelines and benefit coverages. Resources may include specialty care providers, out-of-network services, social services, government programs, nonprofit organizations, disease-specific foundations, and community resources. CM's work with both the provider and the CM team to facilitate the process for resources that require a referral from a provider and/or authorization by the health plan utilization management (UM) team.
Graduation occurs when all care plan opportunities and goals are addressed and re-assessment does not identify need for continued care management, or when a member is able to be transitioned to the next lowest level of care possible based on the member's needs. Members may, at any time, move to a higher level of care management based on changing needs. Discharge from care management or care coordination can occur before care plan goals are met when:

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

Additionally, the Care Management team provides disease management services. Services focus on patient education and between-visit care to manage conditions such as asthma, hypertension, diabetes, and depression. DH's primary care staffing model includes an enhanced care team that consists of patient navigators, clinical pharmacists for adults, nurse care coordinators for pediatrics, as well as social workers and behavioral health consultants to optimize clinical visits and support

referred patients between visits or after care transitions. DHMP care coordinators may also be involved in the provision of disease management and education services. Denver Health's Acute Hospital Care Management team may be involved in disease prevention education as part of an inpatient admission. Some of the disease management activities at DH include:

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

At least annually, DHMP evaluates member experience with its Care Management and Care Coordination programs by obtaining feedback from members. Data collected and analyzed includes member feedback about:

- The overall program
- The care management staff
- Usefulness of the information disseminated
- Member's ability to adhere to recommendations
- Percentage of members indicating that the program/services helped them achieve health goals
- In addition, member complaints are analyzed to improve satisfaction with its care management programs/services

Care Management Staff Resources

The Care Management Team consists of 30 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Clinical, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff:

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

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is also holistically supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

Determine, verify, and track eligibility

Denver Health Medical Plan, Inc. (DHMP) has two Medicare Advantage plans: Elevate Medicare Select and Elevate Medicare Choice (HMO D-SNP). DHMP receives enrollment applications from beneficiaries through a variety of enrollment mechanisms: in a face-to-face setting, by mail, by fax, or online. A sales agent meets with a potential member in person, following all Centers of Medicare & Medicaid Services (CMS) guidelines, and enrolls the Medicare beneficiary. If the beneficiary has current Medicaid eligibility and has a current Medicaid identification card, a letter from the State agency confirming entitlement to medical assistance, or verification through a query to the Colorado State Medicaid eligibility data system, the enrollee becomes a member of the Medicare Choice plan. If the beneficiary is not enrolled in Medicaid or is not Medicaid-eligible, they are placed in the Medicare Select plan. If the beneficiary does not meet eligibility requirements under either program, appropriate notification, in accordance with CMS guidelines, is provided.

DHMP utilizes the QNXT™, a Cognizant/TriZetto product, to determine, verify, and track eligibility for the DHMP membership. Cognizant/TriZetto is a nationally recognized leader in managed care software systems, supporting all needs for maintaining member and provider records, benefit rules, pricing, claims payment, billing, and medical management. Administrative, pharmacy and clinical staff access this system to verify member eligibility for care management and coordination processes.

CMS sends daily Transaction Reply Reports (TRR) to Denver Health, and this information is loaded into the QNXT system. The QNXT system performs a nightly data load of member eligibility and demographic data into the Care Management system, Guiding Care. Care Management staff verify members eligibility and demographic information, directly in Guiding Care, to facilitate care coordination for DHMP members.

Unique health needs:

The demographic and health conditions of our population combine to illustrate the unique health needs of DHMP Members:

- Easy to use/understand health education: In 2024, 58.6% the Medicare population identified as high school graduates or less and 55.0% of Exchange members reported that they had completed a college degree. Low levels of education create a significant barrier to member's ability to receive and understand information that can help them become and stay healthy. Individuals with low educational levels are less likely to be knowledgeable about the health effects of some of their behaviors such as smoking or understand the importance and value of preventive health screenings. DHMP employs multiple and varying techniques to support the unique health needs of persons with low education and/or low health literacy levels, which includes but is not limited to: Avoiding medical jargon during conversations with members, breaking down information or instructions into small concrete steps, limiting the focus of a visit to three key points or tasks, and assessing for comprehension by using the teach back cycle. Printed health education information is written at or below sixth grade reading level and includes visual aids, as applicable, to help enhance member understanding.

- Self-management support: Members with multiple and chronic health conditions, as well as those living alone, often need help to understand how to care for themselves, understand their treatment options and how to implement them, and understand how their efforts will impact their health outcomes. Because chronic conditions are complicated and require lots of treatment, follow-up and medication, members can easily become overwhelmed, exhausted, discouraged or simply "checkout" altogether by not taking a role in their health care. DHMP strives to put members in control of their own care with the knowledge, skills and confidence to manage their health, supported by their health care team, and families and caregivers where appropriate to drive optimal health outcomes. DHMP utilizes strategies to engage and support members about ways to stay healthy through education on self-care/management as well as shared decision-making with their health care team.

- Effective and timely care coordination: The social determinants of health for our DHMP population can accelerate progression of chronic disease, create barriers and gaps in care coordination, impact access to treatment and restrict self-management of care. Although most our DHMP members have more than one chronic condition, the health care system is primarily organized to provide care on a disease-by-disease basis. When members see several specialists, the opportunity for confusion escalates and often results in fragmented care. Effective and timely care coordination is often the missing link and when implemented, can help facilitate the medical and social service providers who bring their respective expertise to bear on each member's health problems in the most effective and coordinated manner. Our DHMP members with chronic and complex conditions access, and need ongoing access to, a variety of clinical and non-clinical supports. DHMP utilizes dedicated Care Managers to collaborate with internal and external clinical and non-clinical services to help align members with needed clinical and community services.

- Use of advanced and available technology: Technology can be used to provide our DHMP members with access to flexible care, support, and assistance with self-management by activating member as partners in care. Online platforms are used to educate members on their health needs, while information and communication technology enabled support services may improve member engagement and motivation, and self-monitoring and home-based monitoring devices can provide helpful feedback to members and enable them to make positive behavioral changes to their health. Use of these types of technologies is especially important in the current pandemic situation as it helps promote

access to care while reducing exposure through socially distanced care. While some of our Medicare members have limitations in terms of their ability to access and utilize technology to support their health needs, DHMP evaluates the needs of members as well as their ability to benefit from advanced and available technologies.

- Telehealth: Telehealth services can promote member access to needed services. In 2023, the DHMP Care Management team implemented telehealth services with GLOBO on-demand audio and video remote interpreting for 250 languages. Telehealth video services help CMs to better connect with members and provide opportunities to better assess member needs over telephonic outreach only. Telehealth services promotes continuity of care and helps members avoid additional negative consequences from delayed preventive, chronic, or routine care. Remote access to healthcare services increases participation for DHMP members who are medically or socially vulnerable or who do not have ready access to providers. Remote access helps preserve the patient-provider relationship at times when an in-person visit is not practical or feasible. While some of our members have limitations in terms of their ability to access and utilize telehealth services to support their health needs, DHMP evaluates the needs of members as well as their ability to benefit from telehealth services.

- Culturally and linguistically appropriate care: Our DHMP care managers and providers are trained on being aware of and how to address potential communication difficulties to provide linguistically appropriate and literacy-appropriate information in the member's native language to facilitate effective interactions. Our team of care managers and providers consider the member's needs and preferences within the context of his or her cultural beliefs and practices and understand the importance of these factors in the member's overall treatment plan.

Specially tailored services and resources for DHMP members:

- Dispatch Health: Provides on-demand care in the member's home 7 days/week from 8am – 10pm. Dispatch Health is a mobile healthcare delivery service designed to reduce ER visits for non-emergencies and ensure members with acute healthcare needs get the care they need in a timely manner so they can return to primary care supervision quickly and conveniently. Dispatch health offers Bridge Care, Extended Care, Advanced Care, and Ortho Bridge services. Bridge care includes focused medical interventions to reduce readmissions and is provided in the first week following a discharge. Extended care offers support for complex medical and post-surgical patients after discharge from the hospital. Advanced care options offer high acuity hospital care with up to 30 days of post-acute care management. The Ortho Bridge program supports members with support for orthopedic surgery before and after the surgery, for up to seven days following surgery. Members can be admitted either from the Dispatch Health mobile ER care team or from PCP or specialist clinics as an alternative to direct hospital admission. Services include care coordination, network management, social services, clinical services, and remote monitoring of members. In 2023, Dispatch Health began offering "Bridge" visits for members discharging from an acute care setting. These single visits support members through clinical assessment, medication reconciliation, discharge planning education and support, condition management education and support, assessment of the home setting and other SDOH related needs, coordination of follow up care, and provision of referrals as appropriate. These services direct admissions away from the hospital and helps members transition from an inpatient setting to their home while reducing readmission rates.

- Virtual Urgent Care: Provides members with access to virtual urgent care visits with a DHHA provider via smartphone,

tablet, or computer.

- Denver Seniors' Resource Center: Dedicates its services to older adults and those with developmental disabilities. Employees will do the grocery shopping and deliver to members at their homes. While their day center locations are currently closed to prevent large gatherings, employees are still transporting medical and food goods to members in need.

- Colorado Agency on Aging: Has multiple services available for older adults and persons with chronic health needs, which include:
  - Home Care Allowance: Provides financial resources that are paid directly to a home care provider of the member's choice. The home care provider needs to conduct needed services for the member such as assisting dressing, bathing, transfers, supportive service such as money management and credit counseling, and appointment management.
  - Telephone Reassurance and Friendly Visitors: Provides telephone or personal contact for seniors or older persons who are homebound or who live alone in Colorado.

  Transportation: Provides transportation assistance programs for members to make it possible for members who do not drive to obtain rides for essential trips. Transportation can be provided for medical and doctor appointments, activities such as congregate meals, and errands.

- Social isolation: Call Reassurance (CARE) is an automatic calling system from Database Systems Corporation (DSC) that calls individuals daily to check on their well-being. In addition, Mon Ami is a volunteer phone bank service where volunteers can call members on a daily, weekly, or other regular basis. Services are offered in multiple languages.

- Interpretation services: The LanguageLine is utilized to provide culturally and linguistically appropriate services for any member and/or caregivers in need. This includes virtual and in-person interpreters with all languages available with 48 hours' notice, depending on vendor availability as well as bi-lingual staff. In addition to the LanguageLine, written materials are provided in both English and Spanish. Additionally, the LanguageLine health literacy software is utilized for all written materials to ensure information is communicated with members in a way that is understandable.

- Specialists as PCPs/Direct Access to Specialists: To assist members who use specialists frequently for their health care, DHMP allows members to use specialty providers to serve as PCPs, or the members may be allowed direct access to a standing referral to specialists to facilitate needed care.

- Care Navigators: To reduce and prevent fragmented care and to promote continuity and coordination of care, DHHA has integrated Care Navigators within their specialty practices to support and manage ongoing member referrals. The Care Navigators within the specialty clinics are utilized as an extender of the interdisciplinary team and work to guide patients through and around barriers identified within the complex healthcare system.

- Food Services: Due to the low-income status of some of our members, as well as housing instability, access to healthy and ready-to-eat food is a critical resource need for these members. Food services to support our most-vulnerable members include:
  - Denver Metro Emergency Food Network: One meal box contains four meal portions and is available on a one-

time basis or recurring short-term basis.

- Project Angel Heart: Low sodium, low fat, and highly nutritious meals for our most vulnerable members with heart failure, kidney disease and other life-threatening chronic conditions.
- Metro Caring: Pre-made meals and snacks with ingredients to cook at home for those who want this. One box can feed 1-2 members for a week.

- Geriatric Care Clinic: Provides both primary and behavioral healthcare for members aged 60 and above as well as consultation services. The staff has extensive experience in providing care to members with diverse cultural backgrounds and offer culturally competent and sensitive health care. Staffed by a dedicated and experienced multidisciplinary team, including two board-certified geriatricians, a dedicated RN and social worker, a medical assistant, clerical staff, a navigator, and a pharmacist. In addition, there are behavioral health/mental health specialists and an addiction counselor on site.

- Behavioral Health and Wellness Programs: Behavioral health and wellness coaching and telephonic counseling are available to members suffering from depression and anxiety.

- Pharmacy Services and Resources: Clinical pharmacists are embedded in some of the clinics and at the Denver Health Medical Center (DHMC) available to assist members with medication adherence, multiple drug interactions, and/or medication safety issues.

- MyStrength™: Provides access to self-management tools to help members manage emotional and mental health, motivation, and physical well-being. This evidence-based website offers emotional health modules directed at mindfulness, spirituality, managing depression, controlling anxiety, improving sleep, drug or alcohol recovery, managing chronic pain, opioid recovery, LGBTQ+ resources, and pregnancy and early parenting. Self-management tools directed at physical well-being include weight management, eating well, and physical fitness, getting active and quitting smoking. Additional topics include attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), bipolar disorder, schizophrenia, and spirituality.

- Wellframe: Provides access to self-management programs, digital care management, and biometric trackers to help members manage their health and wellness. Wellframe offers digital care management through an app for the end user, with bi-directional chat features to help members stay more connected with their care managers. Members have the option to participate in self-directed programs on the application, complete well-being check ins and assessments, track medications, communicate and share biometric data with their CM, and exchange information and resources digitally. Wellframe provides alerts to the member's care manager when member needs are identified.

Improving coordination of care through risk stratification

The risk stratification level determines the type and frequency of outreach. The primary objective of our risk stratification process is to identify those members that are at the greatest risk, as well as those in the other risk levels, and prioritizing the coordination of care management interventions to prevent unplanned and uncontrolled costs and poor member outcomes. The risk stratification level enables DHMP staff to identify the right level of care and services, for DHMP members based on their risk level. Members at the highest risk stratification level are prioritized for early engagement by the DHMP Care Manager.

Care Plan Essential components

The development of a care plan is central to establishing and maintaining the relationship between the member and/or caregiver(s) and health management team and is a federal regulatory requirement for Medicare Advantage plans. The care plan is the reference document to maintain transparency and communication between care team members on an on-going basis to ensure completion of goals, to respond to any new issues/conditions, needs and/or barriers, and to collaborate when goals remain unmet. The essential components of the care plan include the following:

- Self-management goals and objectives: The Care Manager works with the member and/or caregiver on developing self-management goals and objectives to facilitate the knowledge, skill, and ability necessary for self-care. This process incorporates the needs, goals, and life experiences of the member and is guided by evidence-based standards. The overall objective of self-management is to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. To accomplish this, the Care Manager reviews assessment findings/draft care plan, initial outreach assessment, TOC assessment, health summary reports and/or changes in the member's health status, with the member to outline the opportunities/problem list and the corresponding self-management goals.

- Personal healthcare preferences: The care plan is developed to promote optimal health outcomes for the member and incorporates the member's personal healthcare preferences. The Care Manager works with the member to determine their preferences and what's important to them such as culture, beliefs, living close to family, attending church, etc. These preferences are incorporated into goals and interventions as appropriate. Member's preferences may also include, for example, care or services that are in accordance with the member's desire to remain in their own home and to maintain their independence and current daily activities. Member's social needs, health needs and personal preferences drive activities, supports and care coordination services.

- Services specially tailored to the member's needs: DHMP members have individually tailored care plans that are specific to their needs and preferences, and the opportunities/problem list provides guidance on the specially tailored services that members will receive. DHMP has the resources available to support and assist DHMP beneficiaries with clinical, behavioral/mental health, social, environmental/housing, financial and other personal health and supportive needs.

- Identification of goals (met or not met): Review of the member's care plan occurs during each member contact and/or transition and the care plan is updated to reflect progress toward goals as well as any barriers and interventions associated with goals or interventions. When a goal is met or completed, this is notated on the member's care plan. For goals that are not met within the stated timeframe, the Care Manager discusses the barriers and challenges to achieving the goal with the member to identify appropriate interventions or changes that need to be made to the goal. The Care Manager utilizes motivational and behavioral interviewing techniques to help members in resetting and achieving their goals. The goal is adjusted and/or the timeframe for achieving the goal may be adjusted based on feedback and input from member. The Care Manager works collaboratively with the member, and treating practitioner, as applicable, to determine appropriate alternative actions and/or reevaluates whether the goals are appropriate for the member in their current state.

Use of Clinical Practice Guidelines and Care Transitions Protocols

DHMP has adopted and utilizes nationally recognized clinical utilization review criteria as (e.g., MCG care guidelines, National Coverage Determinations and Local Coverage Determinations) as well as clinical practice guidelines for preventive and chronic care. UM review criteria is used by UM staff and providers to evaluate the member's clinical picture and care interventions to evidence-based criteria such as MCG care guidelines to determine the appropriateness of the requested service. DHMP's clinical practice guidelines are based on professionally recognized evidence-based standards of care that have been systemically developed through a formal process. Guidelines are developed with input from practitioners and based on authoritative sources including clinical literature and expert consensus. The criteria and guidelines are used to help providers and members make decisions about appropriate health care for specific service requests and clinical circumstances.

The DHMP Medical Management department has several evidence-based criteria resources, tools and protocols available to conduct authorization service review requests. All of these resources are available to DHMP staff, including network providers. These include:

- **Milliman Care Guidelines Health™ Care guidelines:** DHMP licenses the following products which are directly integrated into the GuidingCare™ record:
  - Ambulatory Care
  - Behavioral Health Care
  - Chronic Care
  - General Recovery Care
  - Home Care
  - Inpatient and Surgical Care
  - Multiple Condition Management guidelines
  - Recovery Facility Care

- **Hayes, Inc. Knowledge Center™:** DHMP licenses the following Knowledge Center products:
  - Genetic Test Evaluation
  - Genetic Test Special Reports
  - Health Technology Brief
  - Medical Technology Directory
  - News Service
  - Search and Summary

- **Wolters Kluwer's UpToDate™:** licensed by Denver Health and available to the DHMP UM staff and Medical Director this medical software system provides evidence-based clinical decision support resource information.

- **University of Colorado Health Sciences Library:** The Medical Director has an account with online access that provides access to additional resources and tools that include but are not limited to: PubMed, the Cochrane Library, EMBASE, OVID Medline, PsycINFO, and multiple medical journals.

DHMP utilizes and maintains a comprehensive set of clinical practice guidelines for preventive health, physical health, and

behavioral health. Clinical practice guidelines help providers and members make decisions about appropriate health care for specific clinical circumstances. Members, care management staff and providers have access to clinical practice guidelines on the Denver Health website https://www.denverhealth.org/conditions. Each guideline includes the evidence-based literature and other resources used to develop the guideline. Guidelines available on this website include condition and treatment guidance for numerous conditions.

Care Management Experience Survey

Care Management Satisfaction Surveys were mailed to members in 2023 to increase response rate and provide members with an additional avenue to provide feedback on their CM program. Subsequent follow up calls for members who did not complete surveys are conducted telephonically 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. In the future, DHMP may send surveys to members via mail for those members who prefer not to perform the survey telephonically. 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 GuidingCare 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.

Diabetes Care Management Program

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.

Controlling Blood Pressure (CBP) Program

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. The CM team will:

- Ensure that a plan of care is in place for members as well as identifying barriers including clinical, nonclinical, and social determinants of health
- Focus on organizing, supporting, and arranging resolutions to barriers
- Follow the member until the measure compliance is achieved Once achieved, less frequent outreach will be done to ensure member remains compliant
- Work closely with the member's PCP to offer support and assist in scheduling provider/clinician appointments

Schedule appointments with clinic PharmD's using EpicCare Link

Work with the member on medication management and arrange for medication synchronization, scheduled "blister packs" of medication, pillbox organizers and/or other tools if they could be helpful to resolve CBP Compliance barriers

Dual Special Needs Program (DSNP) – Available to all DHMP Medicare Choice SNP Members

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.

Special Healthcare Needs

The Special Healthcare Needs Program is designed to ensure members that have Special Health Care Needs have access to care, including PCP, specialty, and community resources. The Centers for Medicare and Medicaid (CMS) define SHCN as having a biological, physiologic or cognitive basis, significant limitation in areas of physical, cognitive or emotional function, dependency on medical or assistive devices to minimize limitation of function or activities. In addition, for children, significant limitation in social growth or developmental function, need for psychological, educational, medical or related services over and above the usual for the child's age, or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. The program includes assessments, the development of individual treatment plan, follow-up, accommodate specific cultural and linguistic needs, and input from the member/family and from the member's multidisciplinary team in the development of the treatment plan.

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 implemented 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 (CCM)

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.

High Utilizer Medication Management Program

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.

Substance Use Disorder (SUD)

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

Behavioral Health Care Coordination

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

Continuity of Care

The Continuity of Care Program is available to all DHMP Members and is designed to ensure members have access to out of network (OON) providers due to Transition of Care, Continuity of Care, Network Adequacy or due to a State of Emergency. Care Management and Utilization Management work collaboratively to ensure members have access to

care for new members in active treatment with an OON provider at the time DHMP membership becomes effective; continued care is authorized for a defined transitional period as need to minimize disruption of care. Care Managers assist members in choosing an in-network provider. DHMP also provides coordination of care for members based on network adequacy issues for a defined period of time until a safe transfer of care can be arranged to an in-network provider. Ongoing services are reviewed, and efforts are made to redirect care when able.

Medicare Select Care Management Program

The goal of this program is to support Medicare Select Members to achieve goals outlined by their individual care plan and work through barriers to achieving those goals. The Care Management team provides members support with access to care and disease management, with a specific focus on controlling blood pressure and diabetes management. Members are identified as being appropriate for ongoing care management based upon physical health, behavioral health, and/or social determinants of health criteria. Members are connected with resources for health and wellness, self-management programs, PCP coordination, behavioral health, disease management, medication management, and educational resources.

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.

Care Coordination Activities:

Many DHMP members benefit from Care Coordination services but may not want to opt-in to the programs offered in Care Management. Care Coordination Activities are available to all DHMP Members. Members are assisted with coordination of but not limited to:

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

- Appointment Reminders
- Meal Coordination

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). 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 regulatory bodies which includes CMS and DOI. All QOCCs are tracked, trended, and reported to the DHMP Credentialing Committee. If any QOC is validated for severity and/or frequency, the case is escalated to the QMC. If a QOCC is found to be substantiated, the facility and/or provider are tracked for future occurrences and possible disciplinary action. All reported, substantiated grievances regarding Denver Health providers are sent to the Denver Health Patient Safety and Quality Department.

Care Coordination and Care Management Program Structure

Care Management Programs:

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

The Care Management Team consists of 33 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Behavioral Health Care Professional, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff.

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

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is holistically supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

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.

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

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

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

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

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

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

Barriers are assessed and routinely discussed throughout the care management process to help the member and care manager identify and understand the areas that might prevent a member from meeting their goals or adhering to the plan of

care. Barrier analysis includes, but is not limited to:

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

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

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

Care Managers and Health Plan Care Coordinators identify and refer members who could benefit from services available either as part of their health plan benefits or outside of their health plan benefits. CM team members are competent on all the lines of business guidelines and benefit coverages. Resources may include specialty care providers, out-of-network services, social services, government programs, nonprofit organizations, disease-specific foundations, and community resources. CM's work with both the provider and the CM team to facilitate the process for resources that require a referral from a provider and/or authorization by the health plan utilization management (UM) team.
Graduation occurs when all care plan opportunities and goals are addressed and re-assessment does not identify need for continued care management, or when a member is able to be transitioned to the next lowest level of care possible based on the member's needs. Members may, at any time, move to a higher level of care management based on changing needs. Discharge from care management or care coordination can occur before care plan goals are met when:

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

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

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

At least annually, DHMP evaluates member experience with its Care Management and Care Coordination programs by obtaining feedback from members. Data collected and analyzed includes member feedback about:

- The overall program
- The care management staff
- Usefulness of the information disseminated
- Member's ability to adhere to recommendations
- Percentage of members indicating that the program/services helped them achieve health goals
- In addition, member complaints are analyzed to improve satisfaction with its care management programs/services

Care Management Staff Resources

The Care Management Team consists of 30 team members. The team is multidisciplinary, holding several types of degrees and experience, ranging from Medical Doctor (MD, Registered Nurse/bachelor's in nursing (RN/BSN), Licensed Practical Nurse (LPN) Licensed Clinical, Master Level Social Workers (LCSW/MSW), Registered Dietitian (RD) and experienced non-clinical support staff:

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

The Care Management Team has access to Clinical Pharmacists (PharmD), Certified Pharmacy Technicians (CPhT), Licensed Practical Nurses (LPN), and the DHMP C-level suite of executives as needed. The Care Management Team is also holistically supported by the DHMP organization, and partners with Customer Service, Claims, Utilization Management, Provider Network, and other areas as needed.

Determine, verify, and track eligibility

Denver Health Medical Plan, Inc. (DHMP) has two Medicare Advantage plans: Elevate Medicare Select and Elevate Medicare Choice (HMO D-SNP). DHMP receives enrollment applications from beneficiaries through a variety of enrollment mechanisms: in a face-to-face setting, by mail, by fax, or online. A sales agent meets with a potential member in person, following all Centers of Medicare & Medicaid Services (CMS) guidelines, and enrolls the Medicare beneficiary. If the beneficiary has current Medicaid eligibility and has a current Medicaid identification card, a letter from the State agency confirming entitlement to medical assistance, or verification through a query to the Colorado State Medicaid eligibility data system, the enrollee becomes a member of the Medicare Choice plan. If the beneficiary is not enrolled in Medicaid or is not Medicaid-eligible, they are placed in the Medicare Select plan. If the beneficiary does not meet eligibility requirements under either program, appropriate notification, in accordance with CMS guidelines, is provided.

DHMP utilizes the QNXT™, a Cognizant/TriZetto product, to determine, verify, and track eligibility for the DHMP membership. Cognizant/TriZetto is a nationally recognized leader in managed care software systems, supporting all needs for maintaining member and provider records, benefit rules, pricing, claims payment, billing, and medical management. Administrative, pharmacy and clinical staff access this system to verify member eligibility for care management and coordination processes.

CMS sends daily Transaction Reply Reports (TRR) to Denver Health, and this information is loaded into the QNXT system. The QNXT system performs a nightly data load of member eligibility and demographic data into the Care Management system, Guiding Care. Care Management staff verify members eligibility and demographic information, directly in Guiding Care, to facilitate care coordination for DHMP members.

Unique health needs:

The demographic and health conditions of our population combine to illustrate the unique health needs of DHMP Members:

- Easy to use/understand health education: In 2024, 58.6% the Medicare population identified as high school graduates or less and 55.0% of Exchange members reported that they had completed a college degree. Low levels of education create a significant barrier to member's ability to receive and understand information that can help them become and stay healthy. Individuals with low educational levels are less likely to be knowledgeable about the health effects of some of their behaviors such as smoking or understand the importance and value of preventive health screenings. DHMP employs multiple and varying techniques to support the unique health needs of persons with low education and/or low health literacy levels, which includes but is not limited to: Avoiding medical jargon during conversations with members, breaking down information or instructions into small concrete steps, limiting the focus of a visit to three key points or tasks, and assessing for comprehension by using the teach back cycle. Printed health education information is written at or below sixth grade reading level and includes visual aids, as applicable, to help enhance member understanding.

- Self-management support: Members with multiple and chronic health conditions, as well as those living alone, often need help to understand how to care for themselves, understand their treatment options and how to implement them, and understand how their efforts will impact their health outcomes. Because chronic conditions are complicated and require lots of treatment, follow-up and medication, members can easily become overwhelmed, exhausted, discouraged or simply "checkout" altogether by not taking a role in their health care. DHMP strives to put members in control of their own care with the knowledge, skills and confidence to manage their health, supported by their health care team, and families and caregivers where appropriate to drive optimal health outcomes. DHMP utilizes strategies

to engage and support members about ways to stay healthy through education on self-care/management as well as shared decision-making with their health care team.

- Effective and timely care coordination: The social determinants of health for our DHMP population can accelerate progression of chronic disease, create barriers and gaps in care coordination, impact access to treatment and restrict self-management of care. Although most our DHMP members have more than one chronic condition, the health care system is primarily organized to provide care on a disease-by-disease basis. When members see several specialists, the opportunity for confusion escalates and often results in fragmented care. Effective and timely care coordination is often the missing link and when implemented, can help facilitate the medical and social service providers who bring their respective expertise to bear on each member's health problems in the most effective and coordinated manner. Our DHMP members with chronic and complex conditions access, and need ongoing access to, a variety of clinical and non-clinical supports. DHMP utilizes dedicated Care Managers to collaborate with internal and external clinical and non-clinical services to help align members with needed clinical and community services.

- Use of advanced and available technology: Technology can be used to provide our DHMP members with access to flexible care, support, and assistance with self-management by activating member as partners in care. Online platforms are used to educate members on their health needs, while information and communication technology enabled support services may improve member engagement and motivation, and self-monitoring and home-based monitoring devices can provide helpful feedback to members and enable them to make positive behavioral changes to their health. Use of these types of technologies is especially important in the current pandemic situation as it helps promote access to care while reducing exposure through socially distanced care. While some of our Medicare members have limitations in terms of their ability to access and utilize technology to support their health needs, DHMP evaluates the needs of members as well as their ability to benefit from advanced and available technologies.

- Telehealth: Telehealth services can promote member access to needed services. In 2023, the DHMP Care Management team implemented telehealth services with GLOBO on-demand audio and video remote interpreting for 250 languages. Telehealth video services help CMs to better connect with members and provide opportunities to better assess member needs over telephonic outreach only. Telehealth services promotes continuity of care and helps members avoid additional negative consequences from delayed preventive, chronic, or routine care. Remote access to healthcare services increases participation for DHMP members who are medically or socially vulnerable or who do not have ready access to providers. Remote access helps preserve the patient-provider relationship at times when an in-person visit is not practical or feasible. While some of our members have limitations in terms of their ability to access and utilize telehealth services to support their health needs, DHMP evaluates the needs of members as well as their ability to benefit from telehealth services.

- Culturally and linguistically appropriate care: Our DHMP care managers and providers are trained on being aware of and how to address potential communication difficulties to provide linguistically appropriate and literacy-appropriate information in the member's native language to facilitate effective interactions. Our culturally competent team of care managers and providers consider the member's needs and preferences within the context of his or her cultural beliefs and practices and understand the importance of these factors in the member's overall treatment plan.

Specially tailored services and resources for DHMP members:

- Dispatch Health: Provides on-demand care in the member's home 7 days/week from 8am – 10pm. Dispatch Health is a mobile healthcare delivery service designed to reduce ER visits for non-emergencies and ensure members with acute healthcare needs get the care they need in a timely manner so they can return to primary care supervision quickly and conveniently. Dispatch health offers Bridge Care, Extended Care, Advanced Care, and Ortho Bridge services. Bridge care includes focused medical interventions to reduce readmissions and is provided in the first week following a discharge. Extended care offers support for complex medical and post-surgical patients after discharge from the hospital. Advanced care options offer high acuity hospital care with up to 30 days of post-acute care management. The Ortho Bridge program supports members with support for orthopedic surgery before and after the surgery, for up to seven days following surgery. Members can be admitted either from the Dispatch Health mobile ER care team or from PCP or specialist clinics as an alternative to direct hospital admission. Services include care coordination, network management, social services, clinical services, and remote monitoring of members. In 2023, Dispatch Health began offering "Bridge" visits for members discharging from an acute care setting. These single visits support members through clinical assessment, medication reconciliation, discharge planning education and support, condition management education and support, assessment of the home setting and other SDOH related needs, coordination of follow up care, and provision of referrals as appropriate. These services direct admissions away from the hospital and helps members transition from an inpatient setting to their home while reducing readmission rates.

- Virtual Urgent Care: Provides members with access to virtual urgent care visits with a DHHA provider via smartphone, tablet, or computer.

- Denver Seniors' Resource Center: Dedicates its services to older adults and those with developmental disabilities. Employees will do the grocery shopping and deliver to members at their homes. While their day center locations are currently closed to prevent large gatherings, employees are still transporting medical and food goods to members in need.

- Colorado Agency on Aging: Has multiple services available for older adults and persons with chronic health needs, which include:
  - Home Care Allowance: Provides financial resources that are paid directly to a home care provider of the member's choice. The home care provider needs to conduct needed services for the member such as assisting dressing, bathing, transfers, supportive service such as money management and credit counseling, and appointment management.
  - Telephone Reassurance and Friendly Visitors: Provides telephone or personal contact for seniors or older persons who are homebound or who live alone in Colorado.

  Transportation: Provides transportation assistance programs for members to make it possible for members who do not drive to obtain rides for essential trips. Transportation can be provided for medical and doctor appointments, activities such as congregate meals, and errands.

- Social isolation: Call Reassurance (CARE) is an automatic calling system from Database Systems Corporation (DSC) that calls individuals daily to check on their well-being. In addition, Mon Ami is a volunteer phone bank service where volunteers can call members on a daily, weekly, or other regular basis. Services are offered in multiple languages.

- Interpretation services: The LanguageLine is utilized to provide culturally and linguistically appropriate services for any member and/or caregivers in need. This includes virtual and in-person interpreters with all languages available with 48 hours' notice, depending on vendor availability as well as bi-lingual staff. In addition to the LanguageLine, written materials are provided in both English and Spanish. Additionally, the LanguageLine health literacy software is utilized for all written materials to ensure information is communicated with members in a way that is understandable.

- Specialists as PCPs/Direct Access to Specialists: To assist members who use specialists frequently for their health care, DHMP allows members to use specialty providers to serve as PCPs, or the members may be allowed direct access to a standing referral to specialists to facilitate needed care.

- Care Navigators: To reduce and prevent fragmented care and to promote continuity and coordination of care, DHHA has integrated Care Navigators within their specialty practices to support and manage ongoing member referrals. The Care Navigators within the specialty clinics are utilized as an extender of the interdisciplinary team and work to guide patients through and around barriers identified within the complex healthcare system.

- Food Services: Due to the low-income status of some of our members, as well as housing instability, access to healthy and ready-to-eat food is a critical resource need for these members. Food services to support our most-vulnerable members include:
  - Denver Metro Emergency Food Network: One meal box contains four meal portions and is available on a one-time basis or recurring short-term basis.
  - Project Angel Heart: Low sodium, low fat, and highly nutritious meals for our most vulnerable members with heart failure, kidney disease and other life-threatening chronic conditions.
  - Metro Caring: Pre-made meals and snacks with ingredients to cook at home for those who want this. One box can feed 1-2 members for a week.

- Geriatric Care Clinic: Provides both primary and behavioral healthcare for members aged 60 and above as well as consultation services. The staff has extensive experience in providing care to members with diverse cultural backgrounds and offer culturally competent and sensitive health care. Staffed by a dedicated and experienced multidisciplinary team, including two board-certified geriatricians, a dedicated RN and social worker, a medical assistant, clerical staff, a navigator, and a pharmacist. In addition, there are behavioral health/mental health specialists and an addiction counselor on site.

- Behavioral Health and Wellness Programs: Behavioral health and wellness coaching and telephonic counseling are available to members suffering from depression and anxiety.

- Pharmacy Services and Resources: Clinical pharmacists are embedded in some of the clinics and at the Denver Health Medical Center (DHMC) available to assist members with medication adherence, multiple drug interactions, and/or medication safety issues.

- MyStrength™: Provides access to self-management tools to help members manage emotional and mental health, motivation, and physical well-being. This evidence-based website offers emotional health modules directed at mindfulness, spirituality, managing depression, controlling anxiety, improving sleep, drug or alcohol recovery,

managing chronic pain, opioid recovery, LGBTQ+ resources, and pregnancy and early parenting. Self-management tools directed at physical well-being include weight management, eating well, and physical fitness, getting active and quitting smoking. Additional topics include attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), bipolar disorder, schizophrenia, and spirituality.

- Wellframe: Provides access to self-management programs, digital care management, and biometric trackers to help members manage their health and wellness. Wellframe offers digital care management through an app for the end user, with bi-directional chat features to help members stay more connected with their care managers. Members have the option to participate in self-directed programs on the application, complete well-being check ins and assessments, track medications, communicate and share biometric data with their CM, and exchange information and resources digitally. Wellframe provides alerts to the member's care manager when member needs are identified.

Improving coordination of care through risk stratification

The risk stratification level determines the type and frequency of outreach. The primary objective of our risk stratification process is to identify those members that are at the greatest risk, as well as those in the other risk levels, and prioritizing the coordination of care management interventions to prevent unplanned and uncontrolled costs and poor member outcomes. The risk stratification level enables DHMP staff to identify the right level of care and services, for DHMP members based on their risk level. Members at the highest risk stratification level are prioritized for early engagement by the DHMP Care Manager.

Care Plan Essential components

The development of a care plan is central to establishing and maintaining the relationship between the member and/or caregiver(s) and health management team and is a federal regulatory requirement for Medicare Advantage plans. The care plan is the reference document to maintain transparency and communication between care team members on an on-going basis to ensure completion of goals, to respond to any new issues/conditions, needs and/or barriers, and to collaborate when goals remain unmet. The essential components of the care plan include the following:

- Self-management goals and objectives: The Care Manager works with the member and/or caregiver on developing self-management goals and objectives to facilitate the knowledge, skill, and ability necessary for self-care. This process incorporates the needs, goals, and life experiences of the member and is guided by evidence-based standards. The overall objective of self-management is to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. To accomplish this, the Care Manager reviews assessment findings/draft care plan, initial outreach assessment, TOC assessment, health summary reports and/or changes in the member's health status, with the member to outline the opportunities/problem list and the corresponding self-management goals.

- Personal healthcare preferences: The care plan is developed to promote optimal health outcomes for the member and incorporates the member's personal healthcare preferences. The Care Manager works with the member to determine their preferences and what's important to them such as culture, beliefs, living close to family, attending church, etc. These preferences are incorporated into goals and interventions as appropriate. Member's preferences may also include, for example, care or services that are in accordance with the member's desire to remain in their own home

and to maintain their independence and current daily activities. Member's social needs, health needs and personal preferences drive activities, supports and care coordination services.

- Services specially tailored to the member's needs: DHMP members have individually tailored care plans that are specific to their needs and preferences, and the opportunities/problem list provides guidance on the specially tailored services that members will receive. DHMP has the resources available to support and assist DHMP beneficiaries with clinical, behavioral/mental health, social, environmental/housing, financial and other personal health and supportive needs.

- Identification of goals (met or not met): Review of the member's care plan occurs during each member contact and/or transition and the care plan is updated to reflect progress toward goals as well as any barriers and interventions associated with goals or interventions. When a goal is met or completed, this is notated on the member's care plan. For goals that are not met within the stated timeframe, the Care Manager discusses the barriers and challenges to achieving the goal with the member to identify appropriate interventions or changes that need to be made to the goal. The Care Manager utilizes motivational and behavioral interviewing techniques to help members in resetting and achieving their goals. The goal is adjusted and/or the timeframe for achieving the goal may be adjusted based on feedback and input from member. The Care Manager works collaboratively with the member, and treating practitioner, as applicable, to determine appropriate alternative actions and/or reevaluates whether the goals are appropriate for the member in their current state.

Use of Clinical Practice Guidelines and Care Transitions Protocols

DHMP has adopted and utilizes nationally recognized clinical utilization review criteria as (e.g., MCG care guidelines, National Coverage Determinations and Local Coverage Determinations) as well as clinical practice guidelines for preventive and chronic care. UM review criteria is used by UM staff and providers to evaluate the member's clinical picture and care interventions to evidence-based criteria such as MCG care guidelines to determine the appropriateness of the requested service. DHMP's clinical practice guidelines are based on professionally recognized evidence-based standards of care that have been systemically developed through a formal process. Guidelines are developed with input from practitioners and based on authoritative sources including clinical literature and expert consensus. The criteria and guidelines are used to help providers and members make decisions about appropriate health care for specific service requests and clinical circumstances.

The DHMP Medical Management department has several evidence-based criteria resources, tools and protocols available to conduct authorization service review requests. All of these resources are available to DHMP staff, including network providers. These include:

- **Milliman Care Guidelines Health™ Care guidelines:** DHMP licenses the following products which are directly integrated into the GuidingCare™ record:
  - Ambulatory Care
  - Behavioral Health Care
  - Chronic Care
  - General Recovery Care
  - Home Care
  - Inpatient and Surgical Care

- Multiple Condition Management guidelines
- Recovery Facility Care

- **Hayes, Inc. Knowledge Center™:** DHMP licenses the following Knowledge Center products:
  - Genetic Test Evaluation
  - Genetic Test Special Reports
  - Health Technology Brief
  - Medical Technology Directory
  - News Service
  - Search and Summary

- **Wolters Kluwer's UpToDate™:** licensed by Denver Health and available to the DHMP UM staff and Medical Director this medical software system provides evidence-based clinical decision support resource information.

- **University of Colorado Health Sciences Library:** The Medical Director has an account with online access that provides access to additional resources and tools that include but are not limited to: PubMed, the Cochrane Library, EMBASE, OVID Medline, PsycINFO, and multiple medical journals.

DHMP utilizes and maintains a comprehensive set of clinical practice guidelines for preventive health, physical health, and behavioral health. Clinical practice guidelines help providers and members make decisions about appropriate health care for specific clinical circumstances. Members, care management staff and providers have access to clinical practice guidelines on the Denver Health website https://www.denverhealth.org/conditions. Each guideline includes the evidence-based literature and other resources used to develop the guideline. Guidelines available on this website include condition and treatment guidance for numerous conditions.

Care Management Experience Survey

Care Management Satisfaction Surveys were mailed to members in 2023 to increase response rate and provide members with an additional avenue to provide feedback on their CM program. Subsequent follow up calls for members who did not complete surveys are conducted telephonically 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. In the future, DHMP may send surveys to members via mail for those members who prefer not to perform the survey telephonically. 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 GuidingCare 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.

2025 Care Coordination Activities and Care Management Programs

Program Name: **Complex Case Management (CCM):**

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.

Program Name: **Transitions of Care (TOC)**:

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 implemented 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

Program Name: **High Utilizer Medication Management Program:**

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.

Program Name: **Controlling Blood Pressure (CBP):**

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. The CM team will:

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

Program Name: **Dual Special Needs Program (DSNP) – Available to all DHMP Medicare Choice SNP Members**

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.

Program Name: **Medicare Select Care Management Program**

The goal of this program is to support Medicare Select Members to achieve goals outlined by their individual care plan and work through barriers to achieving those goals. The Care Management team provides members support with access to care and disease management, with a specific focus on controlling blood pressure and diabetes management. Members are identified as being appropriate for ongoing care management based upon physical health, behavioral health, and/or social determinants of health criteria. Members are connected with resources for health and wellness, self-management programs, PCP coordination, behavioral health, disease management, medication management, and educational resources.

Program Name: **Substance Use Disorder (SUD) Care Management Program**

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

Program Name: **Diabetes Care Management Program**

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.

Program Name: **Behavioral Health Care Coordination**

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

Program Name: **Continuity of Care**

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

Program Name: **Special Healthcare Needs**

The Special Healthcare Needs Program is designed to ensure members that have Special Health Care Needs have access to care, including PCP, specialty, and community resources. The Centers for Medicare and Medicaid (CMS) define SHCN as having a biological, physiologic or cognitive basis, significant limitation in areas of physical, cognitive or emotional function, dependency on medical or assistive devices to minimize limitation of function or activities. In addition, for children, significant limitation in social growth or developmental function, need for psychological, educational, medical or related services over and above the usual for the child's age, or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. The program includes assessments, the development of individual treatment plan, follow-up, accommodate specific cultural and linguistic needs, and input from the member/family and from the member's multidisciplinary team in the development of the treatment plan.

Care Coordination Activities:

Many DHMP members benefit from Care Coordination services but may not want to opt-in to the programs offered in Care Management. Care Coordination Activities are available to all DHMP Members. Members are assisted with coordination of but not limited to:

- Applications/Membership Assistance
- Community Resources Assistance
- Condition/Disease Management

- Education
- Health Acuity/Needs
- Medication Management
- Health Care Provider Coordination and DHHA Empanelment
- Transportation
- Appointment Reminders
- Meal Coordination

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, the Director of UM, and UM Manager. 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 our NCQA-accredited LOBs (Elevate/Exchange (HIX), 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.

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.

Goal:
All clinical reviewers must pass each testing module 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

DHMP departments, including but not limited to Pharmacy, UM, and A&G, work collaboratively to provide clinical quality monitoring and identify performance improvement opportunities related to member safety. In addition, the Credentialing Committee 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.

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.)

VII. Adequacy and Availability of Service

DHMP will establish, monitor and implement improvement processes to ensure compliance with regulatory and contractual requirements regarding access standards and guidelines for members. Standards and guidelines include: (1) geographic distribution of providers; (2) practitioner to member required ratios for PCPs, specialty, and behavioral healthcare; (3) timeliness of appointments; (4) Access to after-hours care; and (5) Key elements of telephone service, including responsiveness of DHMP's Health Plan Services Department telephone lines. DHMP conducts an annual provider access survey via Press Ganey to evaluate accessibility/ease of appointment scheduling. This collection of data is shared with the NMC and QMC to develop opportunities for improvement and CAPs, when appropriate.

Clinical Practice Guidelines

DHMP periodically as appropriate reviews select DHHA's clinical 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 contractual recommendations on number and areas of care for guidelines as well as considering those that may best support health plan performance needs.

Provider and Practitioner Experience/Satisfaction

Annually, the Provider Relations Department administers a Provider Experience Survey to assess the level of satisfaction practitioners have with DHMP services, support, and processes. DHMP analyzes the results and puts necessary process improvements in place, when deemed appropriate. Additionally, DHMP communicates the QI Program goals, processes and outcomes to its DHHA and external network practitioners through our Provider Newsletter, DHMP website, and other mailings annually. The PR and A&G teams monitor practitioner complaints and makes appropriate improvements.

BEHAVIORAL HEALTH INTEGRATION AND SERVICE

As DHMP recognizes mental/behavioral health's impact on every aspect of our members' lives, from day-to-day interactions and physical health, we 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 (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. DHMP may collaborate with Denver Health's Center for Addiction Medicine (CAM) on aligned opportunities/goals, as CAM brings a broad range of addiction programs and medical resources into a single place, providing comprehensive treatment options, mindful of the stigma of substance use.

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)
    - In the latter part of 2024/early 2025, DHMP/DHHA are exploring the potential of implementing a universal health-related social needs (HRSN) screening.
- 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:

- SonderMindWellframe is a self mgmt. tool used for HRA assessments for CM. we contracted with Sondermind and they offer talk therapy BH services online. (MCR, HIX and DHHA plans only)
- Most of our contracted BH providers offer on-line and in person appts as does DHHA and First Health BH practitioners.
- DHHA and DHMP staff leverage denverhealth.findhelp.org, recognizing that health care does not end with a member's in-person or virtual visit. A lack of access to social determinants of health – such as quality food, housing, jobs and transportation – can be associated with worse health outcomes and are increasingly the focus of health-related social needs interventions.
- WellPower (formerly known as Mental Health Center of Denver (MHCD)) is also an in-network BH provider equipped to provide a wide range of crisis and recovery services.
- DHHA's outpatient behavioral health services (OBHS) program offers quick intake availability, 24/7 access through the ED, specialized services for pregnant persons and 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. 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 members, as indicated

o. DH's ACS is an NCQA-recognized PCMH which maintains behavioral care in the outpatient primary care clinics via an integrated BH model.

MEMBER EXPERIENCE/SATISFACTION

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

The Health Plan Services Department provides member-focused services. Additionally, DHMP evaluates and trends member appeals, grievances, availability, accessibility, the quality and appropriateness of care for persons with special health care needs. Annually, DHMP communicates the QI Program goals to its members through the Member Newsletter, DHMP website, and other mailings.

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 Member Experience Committee (MEC). 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. DHMP partners with Press Ganey for Member Journey to conduct third-party member satisfaction survey outreach, data collection, and analysis. The results are shared with MEC and CAHPS Workgroup to discuss findings and develop data-driven interventions (SMART goals) for improvement.

DHMP also conducts an annual provider access survey designed to monitor and oversee access to care and services within our network, as a component of member satisfaction. Press Ganey conducts the survey of network providers (e.g. primary, BH, high-volume and high-impact specialty care) to evaluate performance/ease of our members' ability to schedule appointments against our established Access to Care and Services Standards. The findings are then presented at QMC and/or NMC for feedback and intervention.

PROVIDER AND PRACTITIONER EXPERIENCE/SATISFACTION

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

CREDENTIALING AND DELEGATED CREDENTIALING

The Credentialing Coordinator ensures that the compliance of credentialing and recredentialing activities align with CMS/NCQA standards. The Credentialing Coordinator also conducts primary source verification for any direct Credentialed Practitioner. The Credentialing Coordinator evaluates the practitioner's credentialing materials for compliance against credentialing standards in tandem with contract approval.

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

DELEGATION ACTIVITIES AND OVERSIGHT

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 several delegation agreements for the credentialing and re-credentialing of internal and external/expanded networks. These include but are not limited to NCQA accredited First Health, InterMountain (formerly SCL) and Dispatch Health, as well as Columbine Chiropractic, National Jewish, Banner Health, Children's, Common Spirit, CU Medicine, and Sondermind.

VIII. QI Program Annual Work Plan and Evaluation

Annual Work Plan

The QI Department will develop a QI Work Plan annually.
The QI Work Plan will begin in January of every year. The Work Plan covers the scope of the QI Program and includes:
Measurable yearly objectives for the quality and safety of clinical care and quality of service activities scheduled, including all QI collaborative activities
Yearly objectives and planned activities, targeted due dates for completion and responsible staff
Monitoring of previously identified issues
Communicated to Members, Providers and the community via the QI page on the DHMP website

Annual Evaluation

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

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

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. 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.