Quality Improvement Program Description

2024-2025

SFY Contract July 1, 2024 – June 30, 2025

ELEVATE MEDICAID CHOICE
Denver Health Medical Plan Inc.℠

ELEVATE CHILD HEALTH PLAN *PLUS*
Denver Health Medical Plan Inc.℠

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I. Introduction

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

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

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.

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

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Provider and practitioner experience/satisfaction surveys
- Health Plan Services call data
- Medical record review
- Claims data
- Open Shopper Study data
- Pharmacy data

- Case Management (CM) data
- Utilization Management (UM) data
- Population Health Management (PHM) data
- Health Equity/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 follows a continuous improvement cycle where designated staff measure performance indicators, assess and prioritize areas for improvement, and then plan, implement, and evaluate interventions to enhance care quality, service, and member safety. Data is collected on a prospective, concurrent and/or retrospective basis dependent on which type best meets the measurement need. QI data is analyzed, summarized and presented in a clear manner with trending and comparison against benchmarks, when available, to the Quality Management Committee (QMC). The QMC provides recommendations for improving quality efforts. QI works collaboratively with various departments 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:

Voting Members

- 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.

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.

Medical Director responsibilities include, but are not limited to:

- Providing direction, support and oversight related to the development, implementation and evaluation of allclinical 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 Department

- Functions as a division of 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
- Serve as Facilitator to the Quality Management Committee (QMC)
- Provide oversight, identify prioritized areas of need for health plans and direction to the QI Department

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

- Development, management and monitoring of the QI Program
- Directly assume responsibility for submission of the QI Program Description, Evaluation and Work Plan annually, all LOBs
- Identify quality gaps, communicate, and coordinate, provide advice, and participate in the execution of the QI Program through collaboration with other DHMP and Denver Health departments, as appropriate, for regulatory compliance

- Support the QMC activities, meeting agenda, deliverables as annually scheduled and assist with meeting execution
- Annually ensure all policies, procedures and guidelines related to the QI Department are updated appropriately
- Oversee QI vendor contracts as directed by Sr. Dir HOP/QI Director
- Coordinate and/or provide oversight, and/or direction to the QI Department team members, consisting of the following members:

(1 FTE) HEDIS Supervisor
Currently supervised by CMO, responsibilities include, but are not limited to*:*

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

(1 FTE) NCQA Project Manager

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

(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

(1 FTE) 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

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, HealthManagement, 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 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 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

- QI Project Manager
- Intervention Project Managers
- NCQA Project Manager
- HEDIS Supervisor
- ACS Care Coordination Manager
- QOC Nurse

- Clinical Pharmacist Specialist
- Manager of Grievance and Appeals (non-voting unless designated by director)
- Manager of Member Services (non-voting unless designated by director)
- Medicare Products Manager (non-voting unless designated by director)
- Medicaid/CHP Product Manager (non-voting unless designated by director)
- Commercial Products Manager (non-voting unless designated by director)
- Marketing Manager (non-voting unless designated by director)

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

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
- Review and finalize the resolution of practitioner request for reconsideration of credentialing and/or recredentialing determinations and/or issues, termination of practitioner and/or provider contracts for quality-of-care issues, competence, or professional conduct
- Provide oversight and recommendations regarding utilization of new technologies and benefit design
- Provide oversight of QI program deliverables including, but not limited to: QI program description
- QI work plan
- QI evaluation
- Provide oversight of the Population Health (PH) Program
- Annual PH program evaluation
- Annual PH program strategy
- Provide oversight of Utilization Management (UM) Program including: Annual UM evaluation
- Annual UM program description
- Work plan update

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

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

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 Reports
- Utilization Management Evaluation
- Disease Management Program Evaluation
- Behavioral Health Program Evaluation
- Pharmacy Reports
- Policies and Procedures
- MCD/CHP+ Care Management Program Description and Evaluation
- DSNP Care Management Program Description and Evaluation

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 Medicaid and CHP+ plans comply with Colorado law and current CMS requirements regarding credentialing, re-credentialing, and ongoing monitoring of practitioners. The Credentialing Committee uses active participating practitioners to provide advice and expertise in credentialing decisions.

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

Functions of Credentialing Committee:

- 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

Pharmacy and Therapeutics Committee

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

The P&T Committees are tasked with promoting safe and appropriate use of high-quality, cost-effective pharmaceuticals, as well as ensuring medication use is compliant 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. The Committees use appropriate scientific and economic considerations to consider utilization management activities thataffect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols.

The Denver Health P&T Committee:

- 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 formulary drug list at least annually
- Review and approve 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
- 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)
- 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
- DHMP uses the Denver Health Pharmacy and Therapeutics Committee (P&T Committee) for formularies that are maintained internally and the MedImpact P&T Committee for formularies that are delegated to be managed by the pharmacy benefit manager (PBM), MedImpact.
- The P&T Committees are tasked with promoting the safe and appropriate use of high-quality, cost-effective pharmaceuticals and ensuring medication use is in compliance with appropriate standards and state and federal regulations. The Committees review clinically effective medications and consider whether the inclusion of a particular network drug has any therapeutic advantages in terms of safety and efficacy. Clinical decisions are based on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmaco- economic studies, outcomes research data, and other such information, as deemed appropriate. In addition, the Committees use appropriate

scientific and economic considerations to consider utilization management activities that affect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols.

The MedImpact P&T Committee responsibilities include but are not limited to reviewing:

- "Exclusion list"
- 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 DHMP's formulary drug list at least annually
- Review and approve DHMP'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
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Compliance Committee

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

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

The Denver Health Compliance Committee:

- Meets Quarterly

- Is comprised of the following members:
  - DHMP CEO
  - DHMP Medical Director
  - DHMP Legal advisor to Committee
  - DHMP Chief Operating Officer
  - DHMP Chief Financial Officer
  - DHMP Director of Pharmacy
  - DHMP Director of Member and Provider Services
  - DHMP Manager of Health Plan Compliance
  - DHMP Manager of Commercial Product
  - DHMP Manager of Government Products – Medicare
  - DHMP Manager of Government Products – Medicaid & CHP+
  - DHMP Privacy Officer
  - DHMP Administrative Assistant, ECS (Scribe)
  - DHMP Director of UM/Grievance and Appeals
  - DHMP Director of Insurance Products
  - DHMP Director of Claims

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 the development and implementation of compliance and Fraud, Waste and Abuse (FWA)training.
  - Ensure compliance and FWA training and education are effective and appropriately completed.
- Effective Lines of Communication
  - Ensure DHMP has publicized mechanisms for members, employees, vendors, and subcontractors to ask compliance questions, report potential compliance and/or FWA concerns and violations confidentially oranonymously without fear of retaliation.
  - Ensure DHMP has an effective and timely Mechanism for communicating information related to newand 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 organizationalrisks and verify adherence to applicable laws, regulations, and guidance.
  - Ensure the effectiveness of the compliance program is assessed annually and results are shared with thegoverning body.
- Enforcement and Discipline
  - Ensure DHMP has well publicized disciplinary standards that encourage good faith participation in thecompliance 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

The Network Management Committee is tasked with establishing, maintaining, and reviewing network standards (and operational processes as required by NCQA for applicable health plans), CMS, Colorado Department of Health Care Policy and Financing (HCPF) 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.

The Denver Health Network Management Committee:

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

Functions of Denver Health Network Management Committee:

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

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.
- Establish and implement at least one (1) to two (2) PIPs and/or focused studies each year per the Medicaid Choice contractual requirement.
    - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated QualityImprovement Committee (IQuIC) and those selected by CMS
- Establish and implement at least one (1) PIP per the CHP+ contractual requirement
    - Participation for PIPs for clinical and non-clinical care will occur through the State Medicaid Integrated QualityImprovement Committee (IQuIC) and those selected by CMS
- Establish and implement improvement activities to enhance Early and Periodic Screening, Diagnostic and Treatment(EPSDT) performance and compliance
- Objectively and systematically measure and analyze HEDIS, CAHPS and other access/customer service data topromote improvement in member experience/satisfaction
- 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 Community Health Services (CHS) and Appointment Center reports and institute improvement processes when opportunities for improvement are indicated
- Monitor and analyze targeted HEDIS measures for health disparitiesand develop appropriate interventions
- Provide multiple avenues for members to obtain Case Management, Complex Care Management (CCM), Behavioral Health and Wellness services
- Collaborate with ACS on the development of initiatives for special needs or racial and ethnic minorities, including emphasis on cultural competency and health literacy, where appropriate
- Strengthen the validity of information sources and tools related to quality management to facilitate improvement opportunities and processes
- Participate in the annual external independent review of quality outcomes, including but not limited to:
- Medical record review; (2) PIPs and studies; (3) Surveys; (4) Calculation and audit of quality and utilization indicators; (5) Administrative data analyses; and (6) Review of individual cases
    - For external review of activities involving medical record review, DHMP will be responsible for obtaining copies of records from the sites in which services occurred
- Participate in the development and design of appropriate external independent studies to assess andassure quality of care; final study specifications shall be at the discretion of the

Department

- Integrate Managed Care QI activities with those of DHHA's Quality Improvement Committee (QIC) and workgroups
- DHMP participates in the State Improving Quality in Care (IQuiC) meetings to provide input and feedback regarding QI priorities,performance improvement and measurement.
- 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

- Equitable 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 34 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
- Practitioner/provider
- Member or caregiver
- Pharmacy
- Inpatient hospital identification via census reports
- Discharge Planner Referral
- Other Care Management programs
- Community-based organizations (CBOs)

- Claims Data
- Medical Management Program Referral
- Utilization Management (UM)
- 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
- Level of motivation for change
- Ability to participate in achieving goals
- Desire to participate
- Access to reliable transportation

- Financial or insurance issues
- Visual or hearing impairments
- Language and health literacy level
- Cognitive functioning
- 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

Maternal Care Management Program

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

Diabetes Care Management Program

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

Members are identified for outreach for this program through the HNA process, self-referrals, and provider referrals. Additionally, DHMP uses a risk stratification tool which allows DHMP staff to identify members with diabetes and "hone and cone" to outreach members based on known risks. The risk stratification tool was augmented in January 2022 to include HCPF's 10 identified "winnable" conditions, which includes diabetes. This addition allows for identification and outreach to members who meet this new high-risk criterion.

Controlling Blood Pressure Program

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

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

Dual Special Needs Population (DSNP) Program

This is a Comprehensive Care Management program for our Dually Eligible Medicare and Medicaid members. All members in our Medicare Choice plan are enrolled in this program. Members can opt-out to participate in their own care but will still be outreached for Initial Health Risk Assessment (HRA), Transitions of Care (TOC), Change of Condition (COC), and Annual Health Risk Assessments (HRAs). HRA's are completed within 90 days of enrollment and annually thereafter. Individualized Care Plans (ICP) are completed 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 Health Care Needs Care Management Program

The Special Healthcare Needs Program is available for members across all lines of business. The 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 Care Medicaid Program

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

Medicaid/CHP+ Care Coordination

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

For members identified as needing basic support, including referral coordination, disease management education and support or support with addressing social disparities, like transportation needs, care coordinators can provide the following:

- Referral coordination assists patients requiring health care services from multiple providers, facilities, and agencies, to obtain those services and to coordinate with behavioral health organizations, specialty services, and social services provided through community agencies and organizations. Community referrals are created and tracked in the medical management platform system. Referrals are also used to promote continuity of care and cost-effectiveness of care.

- Disease management services include patient education and between-visit care to manage conditions such as asthma, hypertension, diabetes, and depression. DH's primary care staffing model includes an enhanced care team that consists of patient navigators, clinical pharmacists for adults, nurse care coordinators for pediatrics, as well as social workers and behavioral health consultants to optimize clinical visits and support referred patients between visits or after care transitions. DHMP care coordinators may also be involved in the provision of disease management and education services. Denver Health's Acute Hospital Care Management team may be involved in disease prevention education as part of an inpatient admission. Some of the disease management activities at DH include:
    - Integrated Behavioral Health
    - Tobacco Cessation Clinic
    - Diabetes Prevention Program
    - Substance Abuse Treatment, Education and Prevention (STEP) Program
    - Denver Comprehensive Addictions Rehabilitation and Evaluation Services (CARES) Program
        - DH Outpatient Behavioral Health Services (OBHS) offers the CARES Program for treatment of non-opiate drug and alcohol substance use disorders.
        - Patients are required to complete a comprehensive substance abuse evaluation and may be referred for treatment through several avenues, including by health care Providers, DHMP Care Coordinators or by self-referral. Hepatology – Hep C Program Pharmacotherapy Management

Complex Case Management (CCM)

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

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

DHMP participates in the 340b pharmacy program which ultimately results in a lower drug cost for the plan.

However, DHMP does not restrict its membership to DHMP pharmacies which stresses the importance of ensuring the member is appropriately connected to the resources available to them within the DH network. The pharmacy does have options to receive medications via mail which allows the member to not have to visit the physical pharmacy locations.

Substance Use Disorder (SUD)

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

Behavioral Health Care Coordination

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

Continuity of Care

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

Foster Care Program

In 2022, the DHMP CM team implemented a Foster Care Program to support the unique needs of members in

foster care. Members in this program are provided care coordination assistance in a direct partnership with the Connections for Kids Clinic (CFKC) at Denver Health's Eastside Clinic, a medical home for children and youth in kinship and foster care. Care Managers assists members and their families with obtaining routine and timely physical and dental exams as well as comprehensive care. The clinic provides the following services:

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

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

Other Care Coordination Services

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

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

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

Care Coordination Program Goals and Objectives

DHMP continues to collaborate with ACS in the provision of care coordination and quality improvement services and programs for patients and Members. In early 2023, the DHMP CM team was recognized as a differentiator for the Medical Plan by the Denver Health board for the excellent service provided to members. In 2022-2023, DHMP successfully implemented quality improvement initiatives for Care Coordination activities, including:

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

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

- Development of an ADT feed in the Altruista Guiding Care© Medical Management Platform© to track inpatient admissions and observation stays
- Development of an ADT feed in the Altruista Guiding Care© Medical Management Platform© to track ED visits
- Identification of a rising risk population in partnership with SquareML
- Identification of a new Complex Needs definition for pediatric members, which will include potential integration of rising risk data in addition to foster care and special health care needs indicators from the risk stratification tool
- Improved member outcome analytics, including cost and utilization outcomes, in partnership with Square ML

- Ongoing enhanced member support for enrollment and SDOH related needs during the PHE unwind
- Upgrade of the Altruista Guiding Care© Medical Management Platform© including implementation of the Population Health module
- Integration of HEDIS data into the Altruista Guiding Care© Medical Management Platform© Population Health Module
- Automated integration of Health Needs Assessment (HNA) data into the Altruista Tableau Data Warehouse
- Integration of data from the Altruista Guiding Care© Medical Management Platform into DHMP's Risk Stratification tool to improve effectiveness in evaluating member and program outcomes
- Exploration of enhancements to the Altruista Guiding Care© Medical Management Platform which will enhance communication between the CM team and DHMP members, including:
- Robo calls/ Robo texting
- Ability to send members messages through a secure system
- Ability to send member resources and education through a secure system
- Ability for members to complete assessments through a secure system
- Development of a Condition Management dashboard to track member conditions and participation in CM programs

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

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

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

The Population Health Management (PHM) Strategy outlines Denver Health Medical Plan, Inc.'s (DHMP's) strategy formeeting the care needs of its member population, improving health outcomes and reducing the cost of care.

This strategy presents a cohesive plan for addressing member needs across the continuum of care.

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

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

- Medical and behavioral claims or encounters.
- Pharmacy claims.
- Laboratory results.
- Health Risk appraisal and Health Needs Assessment results.
- Electronic health records.
- Health services programs within the organization.
- Advanced data sources.

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

The four areas of focus are:

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

Each area of focus includes the following:

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

VII. Adequacy and Availability of Service

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 will continue its Open Shopper Study to evaluate accessibility/ease of appointment scheduling. This collectionof 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.

Member Experience/Satisfaction

DHMP's QI Department evaluates and trends Member satisfaction data through the annual CAHPS survey. HCPF performs the CAHPS survey for CHP+ Members. The QI Project Manager assesses CAHPS data to identify opportunitiesfor 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. DHMP monitors member enrollment data and reasons for disenrollment on an ongoing basis. Annually, DHMP communicates the QI Program goals to its members through the Member Newsletter, DHMP website, and other mailings.

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 relatedto 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.

VIII. QI Program Annual Work Plan and Evaluation

Annual Work Plan

The QI Department will develop a QI Work Plan annually. The QI Work Plan will begin in August of every year. The WorkPlan 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/Impact Analysis to the QMC, Board of Directors and HCPF. The QIProgram Evaluation/Impact Analysis will begin in August of every year. This document is the basis for the upcoming year's QI Work Plan.

The QI Program Evaluation/Impact Analysis includes:

- Description of completed and ongoing QI activities that address quality and safety of clinical care and quality ofservice
- 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 subsequentyear
- The modifications of QI Program Descriptions and QI Work Plans will also incorporate advice, recommendations ormandates from external auditors and/or regulatory bodies