



University Health Care

University of Utah Health Plans

**QUALITY IMPROVEMENT PROGRAM
DESCRIPTION
FY 2008**

Approval Signature _____(Quality Medical Director)

Date: _____

(Represents approval by the Quality Improvement Committee - Governing Body)

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I. INTRODUCTION

The University of Utah Health Plans support an active, ongoing, and comprehensive Quality Improvement Program with the overarching goal of continually monitoring and improving the quality of care and service delivered to health plan members. This document describes the purpose, scope, goals, strategy, and structure of the program.

II. PROGRAM DESCRIPTION

A. PURPOSE

The purpose of the Quality Improvement Program is to monitor, improve, and evaluate the quality of care and service for our members.

B. SCOPE

The program is designed to improve the service and care received by our members in all health care settings by:

- Assessing and monitoring the delivery of service and care.
- Identifying opportunities for quality improvement initiatives.
- Implementing and tracking quality improvement initiatives that will have the greatest impact on our customers' service and care.
- Measuring the effectiveness of interventions, and using the results for future quality improvement planning.

C. GOALS AND OBJECTIVES

The overarching goal of the Quality Improvement Program is to continually monitor and improve the quality of care and service delivered to health plan members. The goals and objectives are based on an annual assessment of the health plan's quality and operational improvement needs, and represent goals to be achieved by the end of the fiscal year. The annual quality improvement Work Plan details the current-year quality improvement methods to achieve the goals.

1. Diabetes care

- Improve the 2006 diabetes HbA1c testing rate by 1-4% over the 2006 rate, and
- Improve blood pressure control with members who have both hypertension and diabetes by:
 - Educating members about testing through member newsletters, targeted mailings, and phone based education
 - Reminding members about important tests including blood pressure and HbA1c
 - Providing home based tools and resources to members to self-manage their disease (e.g., blood pressure cuffs, home HbA1c kits)
 - Providing care coordination services, including case management, to high-risk members with diabetes
 - Educating staff regarding HbA1c testing to more accurately answer member questions and promote testing.
 - Educating providers regarding the availability of case managers and covered diabetes benefits
 - Exploring the use of incentives to encourage members to complete annual testing

- Promoting and distributing treatment guidelines to providers

2. Member satisfaction

- Maintain service satisfaction to our customers within two standard deviations of the state Medicaid average on the CAHPS question rating the health plan as an 8, 9, or 10 by implementing:
 - Employee skills, training, and tools including the Impact Training course Impact Training.
 - Monthly Training for Claims/Customer Service Reps.
 - Revised call monitoring form and increase amount of call monitoring
 - System flags to notify employees of members with special needs (i.e., only talk to a certain Case Manager)
 - Provider Database – searchable
 - Searchable provider directory on website
 - Provider Network Improvements
 - Benefit Education
 - Monthly staff training on specific benefits
 - Improved visibility of preventive benefits
 - Information about CHEC on the website
 - New CHEC letters and reminder calls

3. Fraud and abuse

- Implement additional fraud and abuse system edits by June 30, 2008.
 - Determine and implement appropriate claims system edits
 - Update policies and procedures
 - Communicate new policies and procedures to staff
 - Integrate updates into annual staff training and new hire training

4. Provider satisfaction

- Improve the percentage of providers ranking the health plan as an 8, 9, or 10 by up to two standard deviations (1-8%) by implementing:
 - On-site visits / face to face
 - EOBs online
 - Improved EOB format (especially with adjustments)
 - EDI – electronic EOB and EFT
 - Call-backs by member service representatives regarding service issues
 - Increase reimbursement
 - Provider communication / education about our processes for pre-payment reviews
 - Review St Marks policy (non par areas)
 - Claims turn around time – manage perception, education/communication
 - Online provider applications
 - Contract / fee schedule audit
 - Provider luncheons
 - Medicare cross-over claims to reduce rebilling

5. Employee satisfaction

- Maintain an overall score of 4 or above on the annual employee satisfaction survey by:
 - Exploring department build out, including plants, pictures, paint, etc.
 - Researching 4, 10hr shifts (longer customer service hours and/or some time off phones for paperwork, emails, CSR's etc.)
 - Increasing recognition in rounding for "extra-specialness"
 - Conducting mid-year evaluations with more specific ways to move from one score to another
 - Improving communication about providers; contracts, status, etc. to staff
 - Organizing the tools and resources folder
 - Researching Interqual or other product to provide additional review support to UM/CM
 - Providing a thank you card in-service at staff meeting
 - Maximizing use of employees' skills and abilities even if outside their job description (cross training)
 - Increasing staff involvement in policy, problem solving, and goals
 - Increasing communication regarding letters/mailers and compilation in tools and resources
 - Continuing the Rewards & Recognition Team
 - Providing monthly in-services from each department area in staff meetings
 - Continuing rounding / one-on-ones
 - Exploring recycling – environmentally responsible
 - Continuing behavior standard nominations

6. Care coordination

- Implement at least three interventions to address identified care coordination barriers.
 - Continue monthly stakeholder meetings to identify and implement provider, member, and policy interventions
 - Conduct baseline measurement by October 1, 2007.
 - Conduct first measurement against baseline by March 1, 2008.
 - Determine additional improvement measurement tools with members and providers

7. CHEC

- Develop and implement a new reminder system for missed CHEC exams by 3.31.07.
 - Determine data pull methodology with Collin Davis by 10.31.06.
 - Create test file with new methodology by 12.31.06.
 - Create mailed reminder scripts and approve through the BMHC by 1.31.07.

8. HIPAA

- Become 100% compliant with the 835 HIPAA transactions by 06/30/07 by
 - Completing internal system testing - late August 2007
 - Developing documentation for internal staff - late August 2007
 - Educating internal staff on changes to existing process via staff meeting - late August 2007
 - Completing pre notification testing with University Physicians and University Hospital - mid October 2007

- Training responsible staff on new procedures for testing, implementing and maintaining trading partners for 835/EFT - mid October 2007
- Going live with University Physicians and University Hospital - early November
- Notifying external trading partners of ability to begin testing 835/EFT - early November
- Updating department web site with information on 835/EFT - early November
- Notifying UHIN of change from internal testing to external testing - early November
- Beginning pre notification testing with external trading partners - mid November
- Going live with external trading partners - early December
- Continuing testing and go lives with external trading partners as they are ready - on going

9. Community Involvement

- UUHP will participate in at least 3 community activities in FY 2008 focused on individuals with disabilities.
 - Promote more legislative advocacy.
 - Support activities offered by the LifeCare Bank..

D. STRATEGY

1. Planning and Implementation

Annually, the Quality Improvement Committee develops a quality improvement Work Plan, which details the current-year Quality Improvement Program initiatives. The Work Plan incorporates the needs, input, and priorities of internal and external stakeholders, and the health care delivery system. Work Plan initiatives are either clinical, or administrative or service related, and include, but are not limited to, monitoring activities, disease-specific interventions, special projects, and quality improvement studies. The Quality Improvement and Operations committees oversee the prioritization and implementation of clinical, or administrative or service Work Plan initiatives, respectively.

To plan and implement quality improvement activities, UUHP uses the Best Care and Administrative Practices (BCAP) improvement model developed by the Centers For Health Care Strategies for Medicaid Managed Care organizations¹, which is based on the Model of Improvement developed by Langley². The model follows an Aim, Measure, and Change planning framework followed by rapid process improvement cycles (Plan, Do, Study, Act).

Planning

- **Aim** - What are we trying to accomplish? Create an Aim Statement.
- **Measure** - How will we know that change is an improvement? Establish Indicators.
- **Change** - What changes can you make that will result in an improvement? Identify Activities.

Implementation/Rapid Process Improvement

- **Plan** (objectives of the cycle, predictions, plan for carrying out the cycle [who, what, where, when]).

¹ Center for Health Care Strategies: *Best Care and Administrative Practices (BCAP) Quality Improvement Model*. www.chcs.org.

² Langley G, Nolan K, Nolan T, Norman C, and Provost L. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass, 1996.

- **Do** (carry out the cycle – document problems, successes, unexpected observations, collect data)
- **Study** (analyze/study data, compare data to predictions, summarize key learning(s))
- **Act** (What changes need to be made? What will be the next PDSA cycle?)

For quality improvement studies undergoing review by an External Quality Review Organization, UUHP also utilizes the protocol established by the Centers for Medicare and Medicaid Services³.

2. Measurement Process

Quality measures are used to regularly monitor and evaluate the effectiveness of quality improvement initiatives, and compliance with internal and external requirements. UUHP measures performance against internal and external baselines and benchmarks when available and applicable, which are derived from the professional literature, national standards, governmental standards, established clinical practice guidelines, best-practice organizations, internal policies and procedures, contractual requirements, and internal trend review.

3. Data Collection, Sources, and Analysis

Data is collected to quantify clinical and service performance against targeted benchmarks, thresholds, or indicators. Sources for data include, but are not limited to, medical records, claims data, customer satisfaction surveys, prospective/concurrent/retrospective utilization management activities, internal databases, complaints and appeals data, pharmacy utilization data, access assessments, observations, interviews, and case management assessments. Data is quantified, analyzed, and interpreted to identify trends, variances, improvements, and improvement opportunities, and a report is made available to the Quality Improvement Committee. Status reports are also provided to regulatory agencies as required.

4. Education, Communication, Feedback, and Provider Profiling

Education and Communication

Ongoing education and communication regarding quality improvement initiatives is accomplished internally through the existing committee structure, regular staff meetings, and ongoing written and electronic communications. Externally, providers and provider organizations are educated regarding quality improvement initiatives via ongoing meetings between health plan management, the provider relations department, and provider organizations, on-site quality visits, provider newsletters and web site availability of the Quality Improvement Work Plan, Work Plan Evaluation, and Program Description.

Feedback

General performance feedback is provided via special mailings, provider newsletters, or meetings with provider organizations. General performance feedback may include, but is not limited to, information about evidence based guidelines, HEDIS and CAHPS results, health management program audits, covered services, and proper coding.

³ Department of Health and Human Services Centers for Medicare & Medicaid Services. Conducting performance improvement projects: a protocol for use in conducting Medicaid external quality review activities. Final Protocol: Version 1.0. May 1, 2002.

Specific performance feedback regarding individual actions or data is communicated directly to providers and/or provider organizations. Specific feedback may include, but is not limited to:

- Listings of members who need specific services.
- Recognition for performance or contributions.
- Discussions regarding the results of chart audits, health management program audits, complaints, appeals, referral patterns, utilization, suspected fraud and abuse, access including wait times, and compliance with contractual requirements, policies, or procedures.

Profiling

Provider profiling within UUHP is: identifying outliers in billing practices or clinical performance and creating appropriate corrective action plans. The primary aim of profiling activities is to identify aberrant behavior including fraud and abuse, and safety and care issues. If identified, UUHP management and the Provider Contracting Committee determine corrective actions plans. If the issue is related to clinical care, safety, competence, or conduct, the Credentialing Committee may also take action including termination of the provider's participation (or application for participation) with UUHP.

UUHP utilizes several types of data for profiling:

- Billing data
 - Pre-programmed edit reports – reviewed to monitor and detect fraudulent billing for Medicaid services.
- Clinical performance data
 - Medical chart audits - UUHP conducts HEDIS and health management program chart audits annually, which serve as opportunities to detect processes and utilization inconsistent with accepted standards.
 - Utilization management data - Utilization Management staff are trained to recognize fraudulent and abusive practices when reviewing claims pended for utilization reviews, and when conducting medical necessity, benefit determination, and benefit exception reviews.
- Customer service data
 - Complaints are logged into a database for tracking and trending purposes and monitored. Complaints regarding providers scheduled for credentialing / recredentialing are forwarded to the credentialing committee.
 - Wait times are reviewed bi-weekly by the contracting committee.

The feedback and profiling matrix in Appendix B displays the indicators/events that identify providers, areas for potential feedback regarding findings, and connections to credentialing / recredentialing.

5. Provider Participation

Participating providers serve on the following health plan committees: quality improvement, contracting, provider advisory, appeals, and credentialing. Through committee activity, participating providers may:

- Review and provide feedback on preventive health standards, clinical protocols, health management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures.
- Review proposed QI study designs.
- Participate in the development of interventions to improve care, service, or safety.

Additional providers are also involved in the quality program on an ad-hoc basis where it will be the most helpful to reach QIP goals while taking into account physicians' interest, appropriate use of their time, and reimbursement requirements. Participating and community providers are involved on an ad-hoc basis for independent peer utilization and appeal reviews, consulting regarding quality initiatives, and focus group feedback to design or evaluate interventions.

6. Evaluation and Update

UUHP conducts ongoing evaluation of the Quality Improvement Program by continually assessing and documenting the progress and effectiveness of Work Plan initiatives. UUHP also evaluates the effectiveness of the Quality Improvement Program annually by preparing the Quality Improvement Work Plan Evaluation, which contains the following information:

- A summary of quality improvement projects and studies.
- The results of each project and study including any constraints that affected the anticipated results.
- Future plans for each project and study.

Health plan management prepares the evaluation and forwards it to the Quality Improvement Committee for review and approval. The results of the evaluation are used for future Quality improvement planning including the development of the Quality Improvement Program Description and the annual Quality Improvement Work Plan.

E. KEY PROGRAM ACTIVITIES SUPPORTING THE QUALITY PROGRAM

To fulfill the overarching program goals and objectives, and Work Plan goals and activities, the quality improvement program functions in an integrated manner with all health plan departments including Information Systems, Provider Relations/Contracting, Member Services, Finance, Utilization/Case Management, and Enrollment. The key activities that support the quality program include:

1. Quality of Care – Health Employer Data Information Set (HEDIS)

HEDIS is a series of standardized, published performance measures designed to ensure that purchasers and consumers have the information necessary to compare the performance of managed care organizations. HEDIS contains performance measures across eight domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction With the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices

- **Health Plan Descriptive Information**

UUHP compares its performance in HEDIS measures against local and national benchmarks to identify potential quality issues and improvement opportunities, and uses HEDIS methodology in to measure the outcomes of many clinical quality improvement activities.

- **2. Member Satisfaction – Consumer Assessment of Health Plan Satisfaction (CAHPS)**

UUHP assesses member satisfaction annually using NCQA’s CAHPS. The survey is administered annually and rotates between adult and child (parent) satisfaction measurement every other year. CAHPS data is used to identify administrative, service, and clinical quality improvement initiatives, monitor health plan performance against local and national benchmarks, and to assess overall member satisfaction as an indicator of whether the UUHP is meeting customer expectations. Member satisfaction is also assessed through reviewing member complaints and appeals by type and frequency to identify trends.

- **3. Health Management Programs**

- U Baby Care – The goal of the U Baby Care program is to ensure healthy pregnancies. Pregnant members are identified through administrative methods and provider and member referrals. All program participants are screened to determine their pregnancy risk status. All participants receive educational information throughout their pregnancy, and those at risk of complications and those with special health care needs receive Case Management/Care Coordination services.
- CHEC - *Child Health Evaluation and Care* is the Utah State Medicaid version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for individuals from birth through age 20. CHEC has three main components; Outreach and Education, Screening and Prevention, and Expanded Services. UUHP also mails well-child visit and immunization reminders to all parents of children eligible for the CHEC program based on the child’s birth date to improve compliance.
- Diabetes – UUHP provides ongoing education to members regarding diabetes care including benefits information, case management/care coordination, and reminders for important diabetes exams. UUHP also actively participates in the Utah Diabetes Prevention and Control Program’s Health Plan Work Group activities, which are aimed at improving diabetes care and knowledge in the community among member and providers.
- Asthma – UUHP’s asthma program is in the initial development stages. UUHP is collaborating with other health plans, the Utah Department of Health, and the American Lung Association to form the Health Systems Asthma Action Group. The group’s initial focus is on improving access to appropriate care.

- **4. Credentialing and Recredentialing**

The University of Utah Health Plans Credentialing Program ensures that providers approved to participate in the University of Utah Health Plan network have met professional and clinical standards that reflect their ability to render quality medical care. The Credentialing Committee also initiates provider audits when a care or safety issue is identified, or when aberrant behavior is identified and is related to clinical competence or conduct.

5. Complaints and Appeals Monitoring

UUHP monitors complaints and appeals to ensure timely resolution, and to identify access, contractual non-compliance, and/or administrative improvement issues. Complaints and appeals involving clinical/quality of care issues are forwarded to the Utilization Management department for review and when necessary, may involve either peer-to-peer review between the provider and UUHP's General Medical Director, or an external same-specialty provider.

6. Utilization / Case Management

The UUHP Utilization / Case Management Department supports processes for delivery of health care services to patients in a way that assures timely access to quality healthcare, patient satisfaction, provider support, and continuous improvement in the quality of that healthcare. Key components of the Utilization / Case Management program include pre-payment review, comprehensive case management, health management program support, and care coordination. In addition, UUHP reviews cost and utilization data regularly to identify over and underutilization trends in the areas of inpatient and outpatient encounters, procedures, procedures by provider type, bed days, and average length of stay.

7. Member Education

Member education is accomplished across several health plan departments including Enrollment, Quality Improvement, and Utilization/Case Management. All new enrollees receive an enrollment form with a health questionnaire used to identify members with special health care needs; high-risk members are referred to Case Management, and receive written self-care education. All new members also receive the Member Handbook and a new enrollee education call to ensure they understand the benefits and services available to them. On a quarterly basis, all members receive the member newsletter, which is aimed at providing members with evidence based health care information, educating members about benefits and services, and linking members to University of Utah and community resources related to their benefits and the newsletter's content. UUHP also continuously updates members' primary language information, which allows us to customize education by language preference for populations representing 5% or more of our covered lives.

8. World Class U

World Class U is a university-wide strategy to improve organizational quality. The University of Utah Hospital and Clinics has committed to three broad goals: 1) To make this the best place for patients to receive care, 2) To make this the best place for staff to work, and 3) To make this the best place for physicians to practice. To attain these goals, the organization has instituted improvement goals and action plans for all departments in key areas: 1) Service, 2) Quality, 3) People, 4) Growth, and 5) Community.

9. Fraud and Abuse Prevention and Detection

This program is designed to prevent and detect fraudulent and/or abusive behavior by providers, members, and other individuals or organizations associated with the operations of the University of Utah Health Plans. Fraud and abuse prevention and detection supports the quality program by ensuring that UUHP credentials, re-credentials, and contracts with only high quality providers. The program is linked to the recredentialing process through regular reviews of the Fraud and Abuse audit log prior to credentialing/recredentialing meetings.

The program goals are to:

1. Ensure compliance with regulations and contract requirements related to fraud and abuse.
2. Utilize controls to prevent and detect fraudulent/abusive behaviors.
3. Educate employees, members, and providers about fraud and abuse prevention, detection, and reporting.
4. Report detected incidents to the appropriate state and federal personnel and agencies after the completion of preliminary internal audits.

10. Member Services

Member Services focuses on meeting customers' needs including answering questions about benefits, services, eligibility, providers, and claims. Member services personnel also play key roles in identifying improvement opportunities, educating members, and identifying and reporting suspected fraud and abuse.

11. Culturally and Linguistically Appropriate Healthcare Services (CLAS)

UUHP ensures that all services are available, accessible, and provided to members in a culturally and linguistically appropriate manner. All providers are required contractually to provide services in a culturally and linguistically appropriate manner. UUHP provides translators for provider offices for free, including attendance at members' medical appointments. UUHP utilizes primary language information in the claims system to provide member materials for all languages making up 3% or more of the enrolled population. In addition, all materials sent in English contain a Spanish sub-header to contact UUHP if the material is needed in Spanish. UUHP also requires all employees to attend CLAS related training annually. All staff are trained to update claims system data to accurately identify members' primary language.

III. PROGRAM STRUCTURE

A. AUTHORITY AND RESPONSIBILITY

The Executive Director for the University Hospital and Clinics has ultimate responsibility for the quality of care and service delivered to members, and is the highest level of oversight for the health plan's Quality Improvement Program. The Executive Director delegates authority and responsibility to the CFO. The CFO delegates operational responsibility to health plan Quality Improvement Committee. The Quality Improvement Committee is responsible for continually improving the quality of care and service and is responsible for summarizing quality improvement activities to the Executive Director via the Director of U Health Plans.

B. ORGANIZATIONAL STRUCTURE

Figure 1 (Appendix A) shows the organizational structure for The University of Utah Health Plans (Healthy U and U of U Employee Health Plan). The health plan reports to the University of Utah Hospital and Clinics' Executive Director through the CFO. The health plan is comprised of the following personnel/departments: Health plan management, Quality, Provider Relations/ Contracting, Enrollment, Information Systems, Utilization Management, and Member Services/Claims.

The Quality Medical Director oversees implementation of the Quality Improvement Program. The Quality Medical Director delegates day-to-day direction, management, and implementation

of the program to the Quality Improvement Manager who is responsible for the following functions:

- Implementation oversight of the Quality Improvement Work Plan.
- Supporting the Quality Improvement Committee's structure and activities.
- Identifying and tracking opportunities for improvement.
- Facilitating quality improvement data collection and analysis.
- Designing quality improvement interventions.
- Facilitating the preparation and completion of the annual Medicaid review.

C. COMMITTEE STRUCTURE AND FUNCTION

UUHP's committees help direct overall health plan operations. The Provider Contracting and Operations committees support the Quality Improvement Program, and the Quality Improvement Committee, by convening and overseeing quality improvement work teams aimed at improvements in their respective areas. The three committees work synergistically to ensure implementation of quality improvement initiatives. The Credentialing / Recredentialing committee works synergistically with the Provider Relations / Contracting Committee to ensure all providers are qualified to provide care to UUHP members. Each committee meets regularly and keeps minutes for each meeting. The following charters outline the purpose, functions, composition, and meeting frequency for each committee:

1. Quality Improvement Committee

Purpose

The Quality Improvement Committee provides the oversight and operational direction necessary to monitor and evaluate the progress of Quality Improvement Program goals. The committee is authorized to request, review, and direct quality improvement activities including problem identification and the formulation of improvement plans, and is charged with overseeing the development and implementation of clinical quality improvement activities.

Functions

- Conducts the annual review and approval of the Quality Improvement Program Description, Work Plan, and Work Plan Evaluation, and recommends revisions to these documents as needed.
- Reviews quality of care (HEDIS), satisfaction (CAHPS), utilization, and health management program data related to quality improvement activities and makes recommendations for improvement.
- Prioritizes annual quality improvement activities

Composition

Quality Improvement Manager - Chair
Quality Medical Director
General Medical Director
Director of Managed Care
Director of Health Plans
Manager of Health Plans
Contracting Manager / Financial Analyst
Enrollment Manager

Information Technology Manager
Quality Improvement Coordinator
Other operations and clinical personnel as appropriate

Meeting Frequency

Monthly

2. Operations Committee

Purpose

The Operations Committee serves as the body that strategically reviews health plan processes and operations.

Functions

- Review operational reporting from the health plan departments including Utilization/Case Management, Member Services, Enrollment, and Product Finances.
- Resource review.
- Recommending process changes as needed, based on patterns and trends over time.
- Actively participating in the development, review, and revision of benefit plan guidelines.
- Overseeing implementation of administrative and service quality improvement initiatives.
- Appeal and grievance trends and process review.

Composition

Director of Health Plans – Chair
Director of Managed Care
Manager of Health Plans
Quality Improvement Manager
Contracting Manager / Financial Analyst
Enrollment Manager
Information Technology Manager
Other operations and clinical personnel as appropriate

Meeting Frequency

Bi-Weekly

3. Provider Contracting Committee

Purpose

The Provider Contracting Committee oversees all provider related functions and activities for the health plan.

Functions

- Assesses the need for new providers.
- Reviews and discusses credentialing/re-credentialing issues.
- Addresses contract claims-system set-up, provider reimbursement, provider directory, and provider manual content issues.
- Drafts contract language where necessary to meet UUHP, Federal, and/or State requirements.
- Monitors provider performance/compliance with contracts, policies, and procedures.

- Reviews access and availability issues including wait times.
- Reviews appeals and grievances related to quality of care/providers and makes recommendations for resolution including risk management.
- Reviews reports of suspected fraud and abuse and directs action plans for fraud and abuse audits.

Composition

Contracting Manager / Financial Analyst - Chair
 General Medical Director
 Quality Improvement Manager
 Director of Managed Care
 Director of Health Plans
 Manager of Health Plans
 Enrollment Manager
 Information Technology Manager
 Other operations and clinical personnel as appropriate

Meeting Frequency

Bi-Weekly

4. Provider Advisory Committee

Purpose

The purpose of the Provider Advisory Committee is to provide 2nd level needs assessment related to network development.

Functions

- Ensures fulfillment of network service and access needs
- Evaluates prospective providers/groups against current UUHP network
- Communicates new University based services to UUHP
- Evaluates need for additional University based services based on UUHP network needs

Composition

UUHP Quality Medical Director
 University Health Care Community Clinics' Medical Director
 University Health Care Physician Contracting Manager
 UUHP Contracting Manager / Financial Analyst
 UUHP Provider Relations Representative
 Director of Health Plans – Chair
 Director of Managed Care

Meeting Frequency

Monthly

5. Credentialing Committee

Purpose

The purpose of the Credentialing Committee is to reasonably ensure that medical professionals applying to be a UUHP network provider are qualified to provide health care services to UUHP members. The credentialing committee is composed of a multi-specialty physicians, legal, and health plan administrative personnel. The Credentials Committee has responsibility and authority for overseeing provider credentials review. In this capacity, the committee acts as the peer review committee to review the credentials of existing and potential network providers.

Functions

- Establishes credentialing standards; approves the UUHP Credentialing Policies & Procedures; reviews and revises the UUHP Credentialing Policies & Procedures as needed, but at least annually to maintain compliance with the credentialing standards of any applicable federal or state regulatory requirements;
- Evaluates completed applications of all providers for initial appointment to the network;
- Reviews and evaluates updated applications and provider performance for reappointment;
- Meets monthly and, when necessary, more frequently;
- Ensures the proceedings of each Credentials Committee meeting are summarized in minutes and reported to the UUHP Provider Committee.

Composition

UUHP General Medical Director – Otolaryngology - Chair
University of Utah - Internal Medicine (2)
University of Utah - OB/GYN
University of Utah - Family Practice
University of Utah - Pediatrics
University of Utah - Surgery – University of Utah
University of Utah - OB/GYN
Private Practice - Pediatrics
University of Utah Risk Management
University of Utah General Council
UUHP Contracting Manager / Financial Analyst
UUHP Provider Relations Representative

Meeting Frequency

Monthly

D. QUALITY IMPROVEMENT WORK TEAMS

UUHP assembles quality improvement work teams to evaluate and implement resolutions to identified quality improvement issues. Teams are cross-functional and include health plan leadership and personnel from departments/programs affected by the initiative. The focus of teams is to implement rapid process improvements, and teams typically last for 3-6 months meeting as frequently as necessary to achieve results. However, some teams convene for longer periods, or are ongoing depending on business needs. Work teams record and file minutes for all meetings, and report to the Quality Improvement Committee or the Operations Committee depending on whether they are working on a clinical, or administrative or service improvement project, respectively. Current quality improvement teams include:

1. Processing Issues and Concerns (PIC)

Purpose

To ensure consistent communication throughout the organization regarding claims-system changes and issues that may affect the staff's ability to accurately provide service. The team uses the following quality improvement process: problem identification → research issue → ID and implement system improvements → policy and procedure update → scripting for staff → staff training and communication.

Composition

Director of Health Plans - Lead
Manager of Health Plans
Claims / Member Services Supervisor
Systems Manager
Claim Lead / Adjuster
Trainer / Auditor

Meeting Frequency

Weekly

2. U Baby Care

Purpose

To ensure quality birth experiences and optimal outcome for mothers and babies.

Composition

Quality Improvement Coordinator - Lead
Quality Improvement Manager
Nurse Case Manager
Case Management Coordinator
Manager of Health Plans

Meeting Frequency

Bi-Monthly

3. Diabetes

Purpose

To design, review, and refine UUHP's Diabetes Management program including educational materials, case management referrals, case management protocols, and outreach efforts.

Composition

Quality Improvement Manager – Lead
Quality Medical Director
General Medical Director
Quality Improvement Coordinator
Nurse Case Manager
Case Management Coordinator

Meeting Frequency
Monthly / as needed

4. Information Services

Purpose

To systematically review and prioritize the Health Plan's information services needs and tasks.

Composition

Director of Health Plans – Lead
Systems Manager
Systems Programmer
Information Services Manager

Meeting Frequency

Weekly

5. Rewards and Recognition

Purpose

To improve department morale, and reward and encourage appropriate and productive behavior.

Composition

Product Manager - Lead
RN, Case Manager
Office Support Coordinator
Claims / Member Services Representative
Enrollment / COB Coordinator

Meeting Frequency

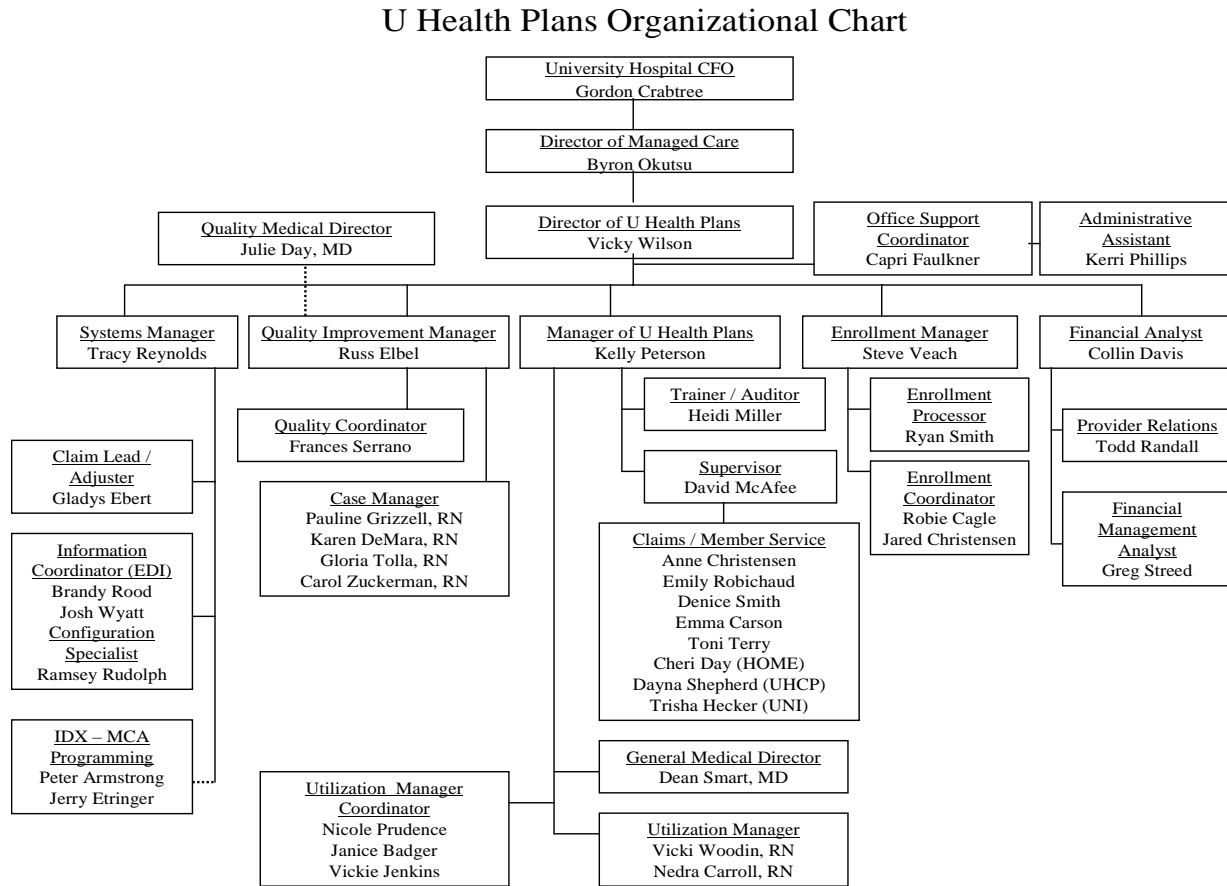
Weekly

IV. CONFIDENTIALITY

All reports, documents, findings, and meeting minutes are confidential information. Access is limited to the Quality Improvement Committee, selected health plan personnel, and the State of Utah, Bureau of Managed Care staff and contractors for the sole purposes of annual Medicaid Reviews and External Quality Reviews, respectively. The Quality Improvement Committee minutes are prepared in a manner to maintain the confidentiality of patients and providers, and stored in a secure manner. Specific information that identifies a patient's health care provider is privileged and may not be disclosed outside of the Quality Improvement Committee.

V. APPENDIX A – ORGANIZATIONAL STRUCTURE

A. FIGURE 1 – ORGANIZATION CHART



Other Resources: *Civil Rights Coordinator-* Russ Elbel, *Complaints Coordinator-* Russ Elbel, *Appeals Coordinator –* Kelly Peterson, *HEDIS Manager -* Collin Davis, *Fraud and Abuse Officer-* Russ Elbel, *HIPPA Transactions-* Vicky Wilson , *HIPPA- Privacy* Kelly Peterson.

VI. APPENDIX B – PROVIDER FEEDBACK / PROFILING MATRIX

Type of Feedback ↓ Event / Profiling Activity	Policies & Procedures	Contract Requirements	Referral Patterns	Utilization	Billing Practices	Federal and State Regulations	Clinical Care Issue and Fraud and Abuse	Best Practices	Frequency	Department
CHEC Audit	X	X	X	X	X	X	X*!	X	Annual	UM/Quality
HEDIS Chart Audits	X	X	X	X	X	X	X*!	X	Annual	UM/HEDIS
Complaints	X	X	X		X	X	X**!		Monthly	Quality
Appeals	X	X	X		X	X	X*!		Monthly	Claims
Wait Times	X	X				X	X**		Bi-weekly	Contracting
Claims Edit Reports	X	X		X	X		X!		Monthly	Claims
Utilization Review Data	X	X	X	X	X		X!	X	Monthly	UM

*Referred directly to Provider Contracting Committee.

!Feedback / referred to Credentialing Committee if the issue is related to care or safety, clinical competence, or professional conduct.

**Information regarding activity reviewed during recredentialing process.