



**University Health Care**

University of Utah Health Plans

**QUALITY IMPROVEMENT PROGRAM  
DESCRIPTION  
FY 2009**

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(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 blood pressure control with members who have both hypertension and diabetes by 2.4%.
- Improve the 2008 HEDIS LDL-C control rate by 2.4%.
  - Direct follow up with clients ID during HEDIS chart audits with elevated BP readings.
  - Identification of medication compliance issues and follow up by phone by case manager / or pharmacist.
  - Development of member profile reports sent every 4 months to members identifying key missed tests including blood pressure and congratulating members on tests completed to date.
  - Continued work with the Health Plan Work Group with a focus on improving hypertension and LDL-C testing.
  - Explore implementation of population based DM program.
  - Continue PCP reminders to members by customer service staff for members with diabetes, hypertension, and hypercholesterolemia (IDX PCP reminder pop up box).

## **2. Member satisfaction**

- Increase service satisfaction by one standard deviation on the CAHPS question for Health Plan Rating
  - Reduce Member CSR's.
  - Improve quality of call interaction.
  - Develop and close provider networks in the north and south counties.
  - Develop internal survey and conduct survey through mail in October and March/April.

## **3. Fraud and abuse**

- Conduct a review on the top three providers profiled as outliers for claims rules violations and practice patterns.
  - Implement provider profiling software (i.e., retrospective review of claims data for patterns of fraud and abuse within the provider network).
  - Refine investigative processes and staff skills
  - Finalize Ingenix iCES implementation.

## **4. Provider satisfaction**

- Increase the percentage of providers rating the health plan as an 8, 9, or 10 by up to 1 standard deviation.
  - Reduce provider CSR's
  - Reduce claims turnaround time.

## **5. Employee satisfaction**

- Maintain the overall average score of the annual employee opinion survey at 4.13 or above.
  - Continue successful programs/tactics: R&R Team, Community service/sub for Santa and thank-you cards.
  - Continue to explore flexible work schedules.

## **6. Care coordination**

- Implement at least three interventions to address identified care coordination barriers.
  - Additional member mailings emphasizing sharing provider contact information with all providers, encouraging communication between providers, and tracking their own medication.
  - HIPAA training /clarification with providers regarding sharing of information among members of the treatment team.
  - Second care coordination measure conducted to measure improvement since baseline.
  - Additional provider workshops – focus on problem solving care and care coordination issues between providers for shared high-risk patients.
  - Identification of high cost / high risk / high utilization enrollees with medical and mental health conditions (SPMI) for Health Plan case management intervention.

## **7. Flu / Pneumonia Shot Campaign**

- All plan enrollees 50 and older will receive a reminder to get their flu and pneumonia vaccinations
  - Member newsletter article

- Focus on Home Health Agencies – Emphasis on encouraging high risk members to get vaccinations.
- Reminder calls to members

## **8. Improved Quality / Patient Care Experience**

- At least two educational sessions with U Hospital Case management Staff regarding plan benefits, resources, and preferred providers.
  - Relationship building and education with U Hospital Case Managers.
    - Educational in-services with U Hospital CM staff
  - Home Health, DME, SNF, LTAC listing to be sent to Case Management Department at the U.

## **9. Quality / Case Management Program Refinements**

- Identify and implement at least one tool or resource to improve the health plan’s ability to manage caseloads.
  - Know more about members’ health risks at the time of enrollment (i.e., health risks). Use info to get members more involved in their care and to help us know where to target our efforts.
    - Get detailed info from Medicaid’s PRA-Plus survey- all questions asked
    - Better idea of HPR role, including HPR alerts
  - Research / identify tools and resources to identify high risk members / manage caseloads (e.g., InterQual, Predictive Modeling, CM Software, internally developed utilization reports).
    - Determine who are highest risk, highest cost, and highest utilizers
  - Understand the availability of services to assist members who have chronic illness and mental health problems before it becomes a crisis situation.

## **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 organizations<sup>1</sup>, which is based on the Model of

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<sup>1</sup> Center for Health Care Strategies: *Best Care and Administrative Practices (BCAP) Quality Improvement Model*. [www.chcs.org](http://www.chcs.org).

Improvement developed by Langley<sup>2</sup>. 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]).
- **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 Services<sup>3</sup>.

## **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

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

<sup>3</sup> 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.

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.

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
  - Claim detail reports - Reports are developed as needed and reviewed to monitor and detect fraudulent billing for Medicaid services. If UUHP determines there may be a system-wide issue, or a particular provider's claims should be reviewed for a period of time, the report is transitioned to the pended claims process to stop and manually review all claims prior to payment.
  - Pended claim process - Claim types that have been identified as potential areas for fraud and abuse are pended for manual review by claims processors and / or utilization management staff. The pended claims process may be applied to all claim types under review, or narrowed to a specific provider or provider type.
  - Ingenix iCes system. Ingenix iCes is a claim editing system that detects improper coding relationships between CPT and HCPCS procedure codes, and ICD-9 diagnosis codes. It can be used as a prevention, identification, and monitoring mechanism.
  - 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.
- Provider profile reports: Claims data is analyzed retrospectively to identify providers with billing patterns that vary from their same specialty peers.
- 
- Customer service data
  - Complaints are logged into a database for tracking and trending purposes and monitored. Complaints regarding access to services are reviewed bi-weekly in the Provider Committee. 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 2<sup>nd</sup> 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

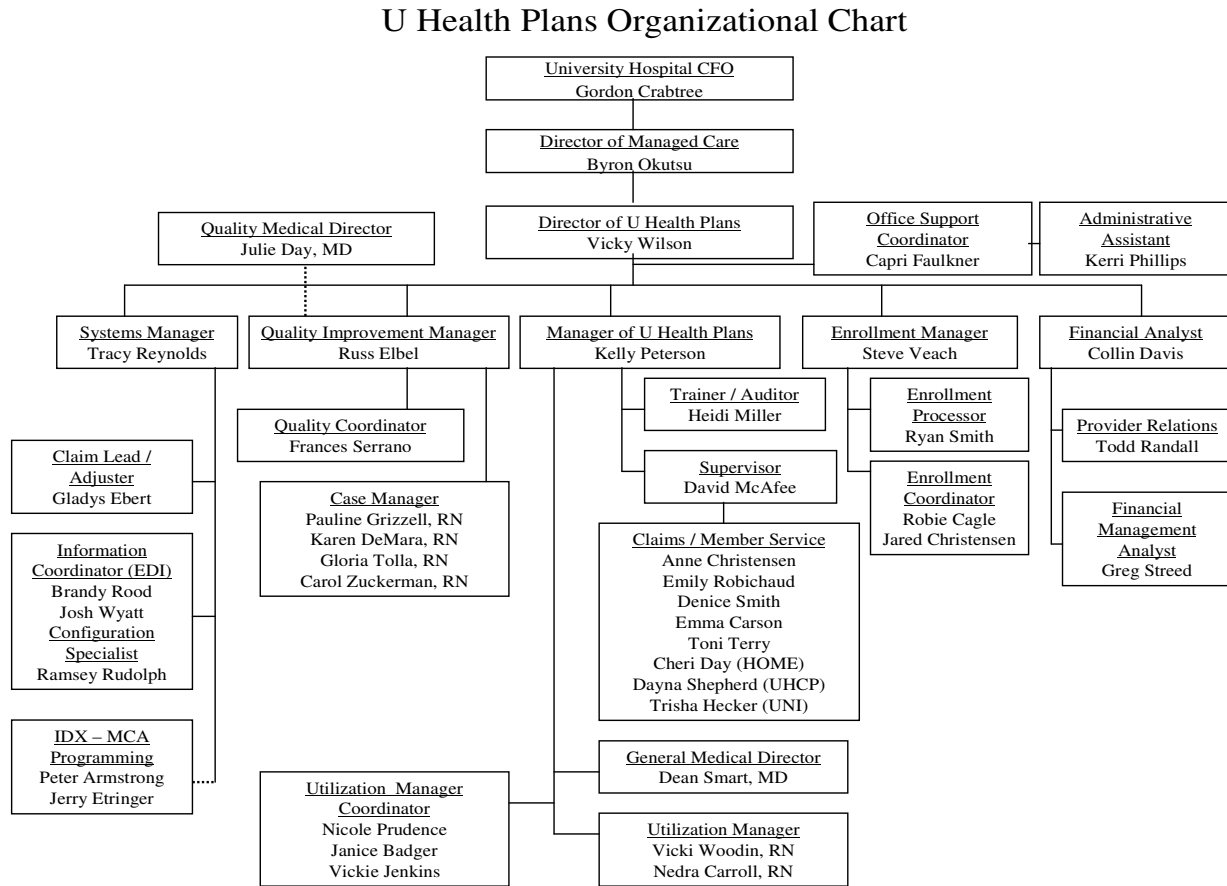
Meeting Frequency  
Weekly

#### **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<br>↓<br>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          |
| Retrospective Provider Profile Data                 | X                     | X                     |                   | X           | X                 |                               | X!                                      | X              | Monthly   | Quality     |

\*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.