Fiscal Year 2018
Quality Improvement Program Description

Signed By: Russell Vinik, MD
Chief Medical Officer
Quality Improvement Council Chair

Date: 10/25/2017
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I. Introduction and Philosophy

University of Utah Health Plans (Health Plans) supports an active, ongoing, and comprehensive Quality Improvement Program based on and aligned with the National Quality Strategy, the Triple Aim®, the Institute of Medicine aims, the State of Utah Managed Care Quality Strategy, CMS guidelines and University of Utah Healthcare Strategic Goals.

It is our belief that the Quality Improvement Program is an integral part of business operations and it is embedded throughout all Health Plans departments and applies to all lines of business. Quality Improvement staff work with all Health Plans staff in developing programs, monitoring progress, assisting with care coordination, and providing technical assistance for process improvement.

A. National Quality Strategy

The overarching aims of the National Quality Strategy⁴ build on the Institute for Healthcare Improvement’s Triple Aim®, supported by six priorities. The strategy outlines nine levers to align core organizational functions to drive improvement. In keeping with the spirit of the Strategy, the Quality Improvement Program focuses on these priorities:

- Reducing harm in care delivery (appropriate care without over- or under-utilization).
- Engaging members and their families, to promote wellness, shared decision making regarding care, and member safety.
- Promoting effective communication and coordination of care
- Promoting effective prevention and treatment practices.
- Working in the community to promote healthy living.
- Applying innovative delivery and payment models designed to make quality care more affordable.

We employ these levers to achieve our quality improvement goals:

- Performance feedback
- Public reporting
- Technical assistance and education
- Consumer incentives
- Invest in staff who are innovative, able to facilitate adoption of improved processes, and who value using data to drive improvement.

B. Triple Aim®

The Health Plans Quality Improvement Program is based on the Triple Aim®⁵

- Improving the experience of care (quality and satisfaction)
- Improving the health of populations
- Reducing health care costs

⁴ http://www.ahrq.gov/workingforquality/about.htm
⁵ http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
C. **Institute of Medicine Improvement Aims**

The Institute of Medicine (IOM)\(^6\) defines quality as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The IOM, in 2001, proposed six aims intended to provide a framework for narrowing the gap between what we know is good healthcare and the healthcare that is actually delivered. The IOM’s six ‘Aims for Improvement’ are to provide healthcare that is:

1. Safe: No one should be harmed by healthcare.
2. Effective: Care should be evidence-based and not over- or under-used.
3. Patient-centered: The patient should be an active partner in healthcare decision making.
4. Timely: Care should be delivered without excessive waiting.
5. Efficient: The system should constantly work to reduce waste.
6. Equitable: High quality care should be equally available to all.

The UUHP applies this definition of quality and fully subscribes to the IOM aims which remain relevant even today.

D. **Quality Strategy and Strategic Goals**

Health Plans’ Quality Strategy is based on the National Quality Strategy, the Triple Aim\(^6\), the University of Utah Health mission to serve the people of Utah and beyond by continually improving individual and community health and quality of life, and its vision to be patient-focused, distinguished by collaboration, excellence, leadership, and respect. Health Plans fully supports these strategies.

Health Plans Strategic Goals are focused on patient experience, quality, and financial strength in both the medical and behavioral health care realms. To support these Strategic Goals, the Quality Improvement focuses on:

- **Patient Experience**
  - Improve access
  - Improve care transitions
- **Quality**
  - Improve quality of care
  - Provide exceptional value
- **Financial Strength**
  - Monitor under- and over-utilization

The Quality Improvement Program’s alignment with these strategies and goals is evidenced in our provider selection, ongoing measurement and feedback, quality improvement initiatives, and our overall structure.

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\(^6\) [http://www.ihi.org/resources/Pages/ImprovementStories/AcrosstheChasmSixAimsforChangingtheHealthCareSystem.aspx](http://www.ihi.org/resources/Pages/ImprovementStories/AcrosstheChasmSixAimsforChangingtheHealthCareSystem.aspx)
II. Program Structure

A. Governance

The Quality Improvement Council, chaired by the Chief Medical Officer, has ultimate responsibility for the quality and safety of care and service delivered to members, and is the highest level of oversight for the Quality Improvement Program.

The Quality Improvement Council oversees implementation of the Quality Improvement Program and delegates day-to-day management and implementation of the program to the Clinical Operations Director and the Quality Improvement Manager, who are responsible for:

- Oversight and implementation of the Quality Improvement Work Plan
- Support for the Quality Improvement Council
- Identifying and tracking opportunities for improvement
- Facilitating quality improvement data collection and analysis
- Conducting causal analysis in order to identify opportunities for improvement and to address unmet goals
- Designing quality improvement interventions
- Facilitating the preparation and completion of the annual Medicaid review, Centers for Medicare & Medicaid Services (CMS) reviews, and NCQA accreditation

B. Organizational Structure

Appendix A Figure 1 shows the Health Plans overall organizational structure and its relationship to University of Utah Health. Health Plans departments include: Health Plans Management, Operations (Enrollment, Claims, Customer Service), Clinical Operations (Care Management, Utilization Management, Quality Improvement), Provider Network, Information Systems, Compliance, Actuarial Services, Finance, and Programs and Marketing.

Appendix A Figure 2 shows the Clinical Operations structure. Primary responsibility for the implementation and maintenance of the Quality Improvement Program is within Clinical Operations, under the direction of the Chief Medical Officer, who also serves as chair of the Quality Improvement Council. The Chief Medical Officer acts as a change agent who drives continuous quality improvement by working collaboratively with all departments to implement innovative, value driven improvements. As a member of the Operations and Strategy Committees the Chief Medical Officer conveys quality improvement activities, findings, and recommendations to the committees. As the leadership committees of UUHP, they are responsible to ensure recommendations are carried out in all appropriate departments.

The Behavioral Health Practitioner (Psychiatry Addiction Medicine Medical Director) is a board certified psychiatrist who reports to the Chief Medical Officer. The Behavioral Health Practitioner (Practitioner) works as a team member to assist us in providing behavioral health care consistent with evidence-based practice and with appreciation
of, and sensitivity to, diverse populations. The Practitioner is actively engaged with the Behavioral Health Care Management Team to ensure appropriate care is delivered, and with the Quality Improvement Team in analyzing data and identifying opportunities for improvement.

The Quality Improvement Team supports program development, designs improvement interventions, facilitates provider-directed improvement interventions, conducts process and outcomes measurement and remeasurement, and provides performance feedback. Under the direction of the Chief Medical Officer the Quality Improvement Team has primary responsibility for driving outcomes measurement and improvement.

The team is comprised of a Quality Improvement Manager, Quality Improvement Specialists, and an Accreditation Specialist, supported by analysts from the Systems Team.

The Quality Improvement Manager:
- Manages and implements the Quality Improvement Program for all UUHP lines of business.
- Focuses on quality health outcomes, member experience, and cost of care.
- Leads and directs UUHP-wide assessment and improvement initiatives in support of the UUHP strategic initiatives.
- Coordinates performance improvement activities in concert with the care management and disease management programs, utilization management, and pharmacy services.
- Develops, implements and maintains a standardized quality management plan and program to ensure compliance with external regulatory and accreditation requirements.
- Manages complex projects, people, and business priorities to achieve member and provider satisfaction.
- Serves as a subject matter expert regarding measurement, quality improvement opportunities and approaches, analytics, interventions and initiatives and evaluation of improvement activities.
- Builds relationships with internal and external customers. Communicates progress and results through presentations to key stakeholders, including senior leadership.
- Influences stakeholders to support key quality projects/programs to ensure results. Consults with internal/external customers on solutions that impact quality.

Quality Improvement Specialists:
- Act as facilitators and consultants for Health Plans quality improvement initiatives, providing expert input regarding problem identification and resolution, continuous quality improvement, process mapping and redesign, and regulatory requirements.
• Partner with leadership, providers and staff to design and implement strategies for identified quality improvement opportunities.
• Facilitate communication and collaboration across providers and the continuum.
• Perform audits, chart review, and prepare reports to assess and improve Health Plan compliance with HEDIS measures, operational goals, State Medicaid, CMS and accreditation requirements.
• Review and interpret patient care information, from the medical record and other data sources used to identify quality of care issues, transforms these facts into actionable information for improvement work.
• Provide education to the organization regarding quality and patient safety topics, performance improvement, and other regulatory metrics and standards.
• Review and interpret claims and medical record data, and population management analytics, to develop actionable information to facilitate improvement. Use these data to facilitate change, to develop goals, and determine progress toward relevant evidence-based benchmarks.
• Collaborate with care management teams on program design and outcome monitoring.
• Provide technical assistance to providers in quality assessment, monitoring, and improvement. Develop collaborative projects and work with care management teams, a variety of public and private providers, policymakers, and researchers to facilitate improvement in population health.
• Lead staff in identifying, prioritizing, and developing action plans to respond to emerging population and service needs. Lead and/or participate in performance improvement initiatives.
• Perform internal audits and prepare reports to assess and improve organizational compliance with new or existing quality metrics, standards, operational goals, and/or improvement initiatives.

The Accreditation Specialist is responsible for coordinating all activities related to NCQA accreditation, for all UUHP departments. The Accreditation Specialist

• Coordinates all activities related to NCQA accreditation.
• Acts as a facilitator and consultant, providing expert input regarding NCQA requirements, problem identification and resolution, process redesign, and continuous improvement.
• Serves as accreditation resource and provide consultative services on accreditation to all departments.
• Leads staff in identifying, prioritizing, and developing action plans to respond to identified needs. Leads and/or participates in performance improvement initiatives.
• Reviews and interprets data and analytics to develop actionable information that facilitates improvement and uses these data to facilitate change, to develop goals, and determine progress toward relevant evidence-based benchmarks.
• Provides technical assistance in quality assessment, monitoring, and improvement and facilitates quality improvement activities across all departments.

Quality Improvement staff work collaboratively with Care Management and Utilization Management staff, and work closely with Community Clinics Quality Improvement staff, with the University of Utah Medical Group, and other providers, to operationalize the Triple Aim® and ensure that all aspects of care and service are evidence-based, appropriately assessed, improved, and monitored and evaluated over time.

The Care Management Teams implement member-directed interventions, advise the Quality Improvement Team of quality of care concerns, member safety and members who may be at risk as a result of a lack of caregiver support or threats of violence, participate in internal and external quality improvement projects, and recommend member and provider outreach activities.

The Utilization Management Team monitors the appropriateness of medical and behavioral health care and advises the Quality Improvement Team of concerns related to over- or under-utilization of medical or behavioral health care that may impact the quality and or safety of care provided.

This collaborative structure provides a framework for measuring and improving complex care management, disease management, and population health:

Population health outcome measures for FY 2018 include:

**Asthma**

- Asthma medication ratio (amr) (preferred and used for PIP)
## Quality Improvement Program Description and Work Plan FY 2018

<table>
<thead>
<tr>
<th>Condition</th>
<th>Measures</th>
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</thead>
<tbody>
<tr>
<td><strong>Heart Failure</strong></td>
<td>• Medication Management for People with Asthma (mma)</td>
</tr>
<tr>
<td></td>
<td>• Pre- and post-ACT score</td>
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<tr>
<td></td>
<td>• ED/inpatient admissions</td>
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<tr>
<td><strong>Diabetes</strong></td>
<td>• Pharmacotherapy Management of COPD Exacerbation (pce)</td>
</tr>
<tr>
<td></td>
<td>• Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)</td>
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<tr>
<td></td>
<td>• Pharmacy data</td>
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<tr>
<td></td>
<td>• ED/inpatient admissions</td>
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<tr>
<td></td>
<td>• Readmissions (related)</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>• Comprehensive diabetes care (cdc) – multiple components – we should select only 2 or 3</td>
</tr>
<tr>
<td></td>
<td>• Pharmacy data</td>
</tr>
<tr>
<td></td>
<td>• ED/inpatient admissions</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>• Antidepressant Medication Management (amm)</td>
</tr>
<tr>
<td></td>
<td>• Follow-Up Care for Children Prescribed ADHD Medication (add)</td>
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<tr>
<td></td>
<td>• Follow-Up After Hospitalization for Mental Illness (fuh)</td>
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<td></td>
<td>• Follow-Up After Emergency Department Visits for Mental Illness (fum)</td>
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<tr>
<td></td>
<td>• Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence (fua)</td>
</tr>
<tr>
<td></td>
<td>• Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)</td>
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<tr>
<td></td>
<td>• Pharmacy data on opioid use</td>
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</tbody>
</table>

Measuring and improving the experience of care, based on the IOM aims:

- Safe
- Effective
- Timely
- Patient-centered
- Equitable
- Efficient
Measuring and improving the cost of care through functions designed to detect inappropriate or inadequately managed care or services, and identifying those leading to best outcomes.

Together the components of the Triple Aim® provide a framework for measuring value.

C. Committee Structure and Function
Commities are structured according to contractual and/or regulatory requirements and business needs and may include oversight, decision making, or advisory bodies. Committee composition and functions are driven by the committee’s purpose. Committees central to Health Plans operations, and quality of care and service, are detailed in Appendix B.

D. Performance Improvement Teams
Cross functional teams support ongoing quality improvement initiatives and address quality improvement and member safety concerns. Teams may include staff from any or all health plans departments depending on the initiative or concern, and providers as appropriate. Teams accomplish their work using the Nolan model and rapid cycle improvement. The Quality Improvement Manager reports progress and results of quality improvement initiatives to the Quality Improvement Council quarterly.

III. Program Description

A. Purpose and Scope
The purpose of the Quality Improvement Program is to assess and improve the quality, availability, and appropriateness of medical and behavioral health care, member safety, and service to our members. We do this by:

7 http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx
• assessing care and service delivery and care coordination for all members, including those with complex health needs;
• identifying opportunities for improvement, including identifying and reducing barriers to service for those with complex conditions;
• implementing quality improvement initiatives, across the continuum, that will have the greatest impact on members’ physical and mental health, address the needs of a diverse membership including members with complex health issues; and
• measuring the effectiveness of our interventions and using those results to plan future quality improvement initiatives.

The Quality Improvement Program and all associated activities apply to all lines of business.

B. **Areas of Special Interest Within the Scope**

**Patient Safety**

A key purpose of the Quality Improvement Program is to ensure member safety. To ensure member safety, we focus on:

• Promoting safe care environments
  i. Member outreach on when, where and how to get care
  ii. Choosing quality (credentialed) clinicians and facilities
  iii. Medication management
  iv. Antibiotic stewardship
• Reducing readmissions
• Adopting evidence-based medical policies
• Adopting clinical practice guidelines for medical and behavioral health conditions
• Adopting preventive health guidelines
• Maintaining or improving well/preventive care for all age groups and the perinatal population
• Creating member communications that meet health literacy guidelines
• Analyzing and addressing complaints related to quality of care and patient safety

**Behavioral Health**

We view behavioral health to be equally as important as physical health. To ensure that, we:

• Manage anxiety and depression for children and adults and anxiety and depression with suicidal ideation for adolescents under the direction of our behavioral health practitioner and according to evidence-based clinical practice guidelines
• Screen, coordinate and direct members to resources
• Assess members’ experience with our behavioral health programs and initiate improvement activities as indicated
• Actively collaborate and partner with behavioral health providers
• Promote communication between medical and behavioral health providers
• Identify and act on improvement opportunities

**Serving a Diverse Membership**

We believe in patient-centered care and seek to treat all members equally based on identified needs and according to their wishes. Enrollment and Health Risk Assessment (HRA) data provide us with member characteristics including race, ethnicity, cultural background, residence, language preference, physical and mental health preferences or limitations, barriers to care (e.g., transportation, financial), and other needs, preferences, or limitations. To meet the needs of a diverse membership we:

• Provide member materials, including outreach materials, in both English and Spanish and have access to additional translation services through the our translation service
• Identify gender and languages spoken by providers in the provider directory
• Continually assess and improve our network to ensure that all populations, including rural, can be adequately served
• Partner with providers and community agencies to address the needs of the underserved
• Utilize University of Utah resources and those of community partners that are available to us
• Employ Spanish-speaking care management and customer service staff

**Serving Members with Complex Conditions**

The overall goal of complex care management is to help members regain optimum health and/or improved functional capacity, in the right setting and in a cost effective manner. It involves comprehensive assessment of the member’ condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow up. UUHP offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other UUHP programs. All members have the right to participate or to decline to participate.

Members with complex conditions are identified through health risk assessments, care and utilization management triggers, claims history, risk and cost profiles, emergency room and inpatient admissions, pharmacy and analytic data, and by referral. Populations identified as having complex conditions include, but are not limited to, the physically and/or developmentally disabled of all ages, members with chronic conditions or serious injuries, members, especially children, with special healthcare needs, those with serious persistent mental illness, and women with high risk pregnancy. We ensure this population experiences care in accordance with the IOM aims by:

• Communicating our referral process and Complex Care Management Program to both members and providers through multiple means
• Timely conduct of initial assessments
• Thorough and accurate documentation of assessed needs
• Establishment of an individualized care plan, identification of barriers, referral to appropriate resources
• Development of a self-management plan
• Timely follow up and assessment of progress

B. Strategic Aims
These aims broadly represent what we intend to accomplish through activities related to care, service, and administrative functions. These activities are outlined in the Quality Improvement Work Plan (Appendix A) which is developed annually by the Quality Improvement Council. The Work Plan is also evaluated annually to assess the effectiveness of our interventions and to prioritize our work for the coming fiscal year. Briefly, the aims include:

1. Administration and Leadership
Under the direction of the Governing Body and, with its support, University of Utah Health Plans’ leadership is responsible to adopt and support an Accountable Care Organization (ACO) business model. To meet this obligation requires a shift from episodic care with fee for service payment, to population management with payment methodologies aligned to achieve value-based payment. The overall outcome is intended to be improved population health, improved experience of care (quality and satisfaction), and reduced costs for all lines of business.

2. Quality Assessment and Performance Improvement
University of Utah Health Plans employs a systematic quality assessment and performance improvement process based on the Nolan model, Plan-Do-Study-Act, and the Interdependent Project/Program Model. The process applies to all aspects of the health plans including clinical, administrative, and financial functions. More detail can be found in the Quality Improvement Work Plan.

3. Enrollee rights and Responsibilities
University of Utah Health Plans established functions, operating under established policies and procedures, which are designed to provide safe, effective, efficient, timely, equitable and patient-centered services to our members. Those functions include member and community education and outreach, an efficient enrollment process, accurate and timely claims processing, avenues to communicate appeals and grievances, and mechanisms to assist members to make informed decisions about their care.

4. Access and Availability
University of Utah Health Plans ensures that all services are available, accessible, and provided to members in a culturally and linguistically appropriate manner. We utilize primary language information in the claims system to provide member materials for all languages making up 3% or more of the enrolled population and provide translation services for all situations. We continually strive to increase access to and availability of services to all members through scheduling, technology, expanded service hours and expanded services within those hours.
5. Coordination and Continuity of Care
University of Utah Health Plans is committed to providing coordinated care across the continuum. Strengthening the care management team with physician leaders, using technology to expand the care managers’ reach, engaging members in self-management of chronic illnesses, and improving the potential and quality of life for tech dependent children are key strategies to achieve coordinated care across the continuum. The outcomes will include increased member satisfaction, higher quality care, improved member physical and behavioral health, increased access to care, and lower overall cost.

6. Utilization Management
In order to provide evidence-based, efficient, and equitable medical and behavioral health care and services to our members. University of Utah Health Plans is committed to a utilization management program based on nationally recognized criteria that are accurately and appropriately applied in all cases.

7. Provider Participation
University of Utah Health Plans engages medical and behavioral health care providers through newsletters, updates and performance feedback. Providers are active participants on all Health Plans committees; participate in process improvement initiatives; advise care managers; and lead population-based care management teams. Implementing a provider portal adds another level of engagement. Increasing performance feedback on all quality measures will provide additional opportunities for engagement and collaboration.

8. Information Systems
Information systems support the University of Utah Health Plans overall improvement strategy by facilitating the collection, aggregation, analysis, tracking, and reporting of utilization, cost, quality, and service data. Information systems includes claims, registries, databases, electronic medical records, and analytical programs. A key component is the Provider Database which serves as a resource for claims processing, customer service, and provider directories. Increasing the accuracy of the Provider Database will result in more accurate provider directories, better customer service to members and providers, a decreased number of misdirected payments, and increased efficiency during the credentialing process.

9. Resource Allocation
University of Utah Health Plans’ administrative team is aware and fully supportive of quality improvement initiatives as evidenced by encouraging innovative ideas and solutions, use of technology, and use of resources that will better serve members, providers, staff, and the University community.

10. Program Documentation and Evaluation
University of Utah Health Plans is contractually obligated to maintain a Quality Improvement Program. The Quality Improvement program is organized through the Quality Improvement Program Description, Quality Improvement Work Plan, and
Quality Improvement Program Evaluation.

C. Implementation Strategy
Quality improvement activities are designed using the Model for Improvement developed by Langley, et. al.\(^8\), (Appendix C, Figure 1), and the Interdependent Project/Program Model\(^9\) (Appendix C, Figure 2). For studies reviewed by the External Quality Review Organization we use the Centers for Medicare & Medicaid Services protocol\(^10\).

D. Measurement
UUHP measures performance against internal and external benchmarks and thresholds when available and where applicable. Whenever possible, measures and associated benchmarks are based on national measurement standards, i.e., HEDIS, CAHPS, measures endorsed by the National Quality Forum, the Centers for Medicare & Medicaid Services, and local measures established by the Division of Medicaid and Health Financing or the respective partnerships in which we participate. Baselines are established and improvement monitored over time. Interventions are assessed to determine whether process changes have led to improvement or have corrected identified issues.

E. Data Collection and Analysis
Data are collected to quantify clinical, service, and financial performance against targeted benchmarks and thresholds. Data sources include, but are not limited to, medical records, claims data, customer satisfaction surveys, utilization management activities, complaints and appeals data, pharmacy utilization data, CAHPS surveys, and care management assessments.

Data are analyzed to identify trends, variances, improvements, and improvement opportunities. Results are reported to the Quality Improvement Council quarterly. Contractually required reports are submitted as required.

F. Outreach and Education
   1. Providers
      Outreach and education regarding quality improvement initiatives is accomplished internally through existing committee structure, monthly staff meetings, and ongoing written and electronic communications. Provider Relations and Quality Improvement staff collaborate to educate providers and provider organizations

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9 http://nationalqualitycenter.org/index.cfm/5852/13487
regarding quality improvement initiatives through provider meetings, on-site quality improvement technical assistance visits, provider newsletters, and our website.

2. Members

Member outreach and education is accomplished collaboratively by health plan departments including Enrollment, Marketing, Quality Improvement, and Care Management. All new enrollees also receive the Member Handbook and a new enrollee education call to ensure they understand the benefits and services available to them. 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 Care Management, and receive written self-care education. All members receive the member newsletter, which is aimed at providing members with evidence-based health care information.

Outreach is culturally and linguistically appropriate. We continuously update members’ primary language information in our system, which allows us to customize education by language preference. Outreach materials are provided in both English and Spanish, and translation services are available to any member needing additional assistance. Staff complete Culturally and Linguistically Appropriate Services (CLAS) training annually and prepare and evaluate materials with cultural and language preferences in mind.

Quality Improvement staff reach out to members in order to provide important health information and to promote services to which they are entitled. General health and member safety information is disseminated primarily through member newsletters and on our website. We promote services directly to members through reminder letters and calls. Examples include:

- Reminders to parents about well child and CHEC exams and immunizations for children and adolescents.
- Women’s health services reminders: Breast and cervical cancer screening, chlamydia screening.
- Monthly health information linked to national health observances and seasonal health topics.
- Preventive health and wellness program offerings.

G. Provider Participation

1. Credentialing, Recredentialing, and Provider Profiling:

The University of Utah Health Plans Credentialing Program ensures that providers approved to participate in the Plan network have met professional and clinical standards that reflect their ability to render quality medical care.

Provider profiling consists of the identification of outliers in billing practices or clinical performance. The primary purpose is to identify nonstandard behavior that may include fraud and abuse, safety, and quality of care issues. If identified, health plans management and the Provider Contracting Committee institute corrective
actions plans. If the issue is related to clinical care, safety, competence, or conduct, the Credentialing Committee may also take action up to and including termination of the provider’s participation or application for network participation.

Data used for profiling include
- Billing data obtained from claim detail reports, the pended claim process, the claim editing system that detects improper coding, and provider profile reports that identify variances in billing patterns as compared to their peer group;
- Clinical performance data obtained from medical record review including HEDIS and CHEC and Abortion, Hysterectomy, and Sterilization audits;
- Utilization management data reflecting aberrancies detected through pended claims, medical necessity, benefit determination, and benefit exception reviews;
- Customer service data including complaints related to access and availability, quality of care, or behavior issues.

2. Performance Feedback
Performance feedback is provided through special mailings, provider newsletters, or meetings with provider organizations. 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 patient data is communicated directly to providers and/or the provider organization. Specific feedback may include, but is not limited to:
- List of members who require specific care or services;
- Discussions regarding the findings from medical record review, health management program audits, complaints, appeals, referral patterns, utilization, suspected fraud or abuse, access and/or availability, and compliance with contractual requirements, policies, or procedures.
- Recognition for performance or contributions.

3. Service to Health Plans
Participating providers serve on Health Plans committees whose role is to:
- Review and provide feedback on preventive health standards, clinical protocols for medical and behavioral health, health management programs, quality outcomes and HEDIS results, new technology and other clinical issues as needed;
- Review proposed quality improvement interventions and study design;
- Participate in the development of interventions to improve care, service, or safety.

Providers may also be asked to:
- Support the Quality Improvement Program by serving as a physician champion;
• Provide consultation as a subject matter expert for improvement initiatives;
• Provide independent peer review for utilization review and appeals.

H. Community Collaborations
We actively participate in the Division of Medicaid and Health Financing activities, and collaborate with several groups in the Utah Department of Health. We participate with, and our work is supported by:
• Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ)
• Health Plan Partnership (HPP)
• HealthInsight (Utah’s QIN-QIO)
• University of Utah School of Medicine, and the Colleges of Nursing, Pharmacy, and Health
• University Neuropsychiatric Institute (UNI), Valley Behavioral Health, Optum, and community based behavioral health organizations
• Other organizations and initiatives as appropriate

Community initiatives such as Green and Healthy Homes, Living Well with Chronic Disease, and Million Hearts are important components of our efforts to provide safe, high quality, cost effective medical and behavioral health care for individuals and populations.

E. Confidentiality
All content produced by Health Plans, written or electronic, that impacts business operations, members, or providers is confidential. Access is limited to the Quality Improvement Council, health plan personnel with a need to know, regulators, accreditors, and contracted entities for the sole purpose of quality review and delegation audits. Content is privileged and prepared in a manner to maintain confidentiality, meet HIPAA requirements, and are stored securely. Privileged and confidential information may not be disclosed outside of the committees or review entities.
University of Utah Health Plans (UUHP) Organizational Chart

Chief Medical Officer
Dr. Russell Vinik

UHSC Chief Compliance Officer
Brian Watts

CEO Health Plans
Chad Westover

Governing Board UUHIP
Lorrin Betz, MD, PhD
Interim Sr. VP Health Sciences, CEO UoU Health and Executive Dean SOM

Appendix A Figure 1

Quality Improvement Program Description FY 2018
University of Utah Health Plans (UUHP) Organizational Chart
Clinical Operations

Chief Medical Officer
Dr. Russell Vinik

Psychiatry Medical Director
Dr. Susie Wiett

CEO Health Plans
Chad Westover

Chief Operating Officer
David Call

Clinical Operations Director
Josette Dorius

Medical Review
Medical Director
Dean Smart, MD

Care Management Manager
Lisa Armour-Roth

Utilization Management Manager
Travis Ault

Quality Improvement Manager
Linda Johnson

Project Manager

Nurse Educator

UM Supervisor

QI Specialists

Accreditation Specialist

Complex Care/Disease Management Coordinators

Complex Care/Disease Management Supervisor

UM Coordinators

UM Nurses

Care Transitions Team

Population Health Team

Behavioral Health Team

Appendix A Figure 2
## Committees

<table>
<thead>
<tr>
<th>Committee</th>
<th>Purpose</th>
<th>Function</th>
<th>Composition</th>
<th>Meeting Frequency</th>
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</thead>
</table>
| University of Utah Health Insurance Plans Board of Directors | The Board provides strategy, operational input and direction to the management team of the Health Plans Department to ensure plan members are receiving high value care and quality outcomes at a cost and through a benefits delivery system that is sustainable to plan members and to the University of Utah Health Care system. | • General oversight of strategy and operations  
• Review and approve financials  
• Review and approve the strategic direction and associated initiatives | CEO, University Health Care  
CEO, University Hospitals and Clinics  
Vice President & CFO, Kaiser Permanente  
Regional VP, Great Lakes Region Aetna Medicaid  
Business & Intellectual Property Attorney, Ray, Quinney, & Nebeker  
Chief Strategy Officer, University of Utah  
Managing Director, Cynosure Group | Quarterly |
| Quality Improvement Council | The Quality Improvement Council develops, implements, and oversees the Quality Improvement Program. | • Recommends policy decisions  
• Analyzes and evaluates results of QI activities  
• Ensures practitioner participation in the QI program  
• Prioritizes quality improvement activities  
• Identifies needed actions  
• Ensures follow up  
• Evaluates overall program effectiveness | Russell Vinik, MD, Chief Medical Officer - Chair  
Quality Improvement Manager - Co-chair  
Clinical Operations Director  
Pharmacy Director  
Care Management Manager  
Accreditation Specialist  
Jennifer Leiser, MD, Family Medicine  
Julie Day, MD, Internal Medicine  
Chuck Norlin, MD, Pediatrics  
Rachel Wier, MD, Psychiatry  
Bob Pendleton, MD, U of U Chief Medical Quality Officer  
Community Clinics Quality Manager | Monthly |
## Appendix B

### Quality Improvement Program Description FY 2018

<table>
<thead>
<tr>
<th>Committee</th>
<th>Purpose</th>
<th>Function</th>
<th>Composition</th>
<th>Meeting Frequency</th>
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</thead>
</table>
| **Operations Committee**   | The Operations Committee serves as the body that strategically reviews health plan processes and operations. | • 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. | Director of Quality & Patient Safety, Utah Dept. of Health  
Association of Utah Community Health Centers (FQHCs)  
Utah QIN-QIO  
Utah Hospital Association  
Utah Association of Healthcare Quality  
Health Plans COO – Chair  
Product Director  
Provider Contracting Director  
Systems Director  
Clinical Operations Director  
Operations Director  
Finance Director  
Actuarial Director  
Other operations and clinical personnel as appropriate | Monthly |
| **Provider Contracting Committee** | The Provider Contracting Committee oversees all provider related functions and activities for the health plan. | • Assesses the need for new providers.  
• Reviews and discusses credentialing/re-credentialing issues.  
• Addresses contract claims- | Provider Contracting Director – Chair  
Medical Informatics Director  
General Medical Director  
Care Management Director  
Executive Director of Health Plans | Monthly |
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<tbody>
<tr>
<td>Credentialing Committee</td>
<td>The Credentialing Committee reasonably ensures that medical professionals applying to be a UUHP network provider are qualified to provide health care services to UUHP members.</td>
<td>- Establishes credentialing standards; approves the UUHP Credentialing Policies &amp; Procedures; reviews and revises the UUHP Credentialing Policies &amp; Procedures as needed, but at least annually to maintain compliance with the credentialing standards of any UUHP guidelines.</td>
<td>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</td>
<td>Monthly</td>
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*Appendix B*

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<td>The Credentialing Committee</td>
<td>The Credentialing Committee is composed of a multi-specialty physicians, legal, and health plan administrative personnel. The 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.</td>
<td>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. • 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.</td>
<td>University of Utah - OB/GYN Private Practice - Pediatrics University of Utah Risk Management University of Utah General Council UUHP Contracting Director UUHP Provider Relations Representatives Other specialists and subspecialists for review and consultation as needed</td>
<td>Monthly</td>
</tr>
<tr>
<td>ED Collaboration Committee</td>
<td>The ED Collaboration Committee seeks to reduce non-emergent and non-urgent ED visits by innovatively addressing access and availability issues.</td>
<td>• Develop methods to identify actionable causes of excess ED use • Implement programs and policy initiatives based on best practices • Develop innovative systems of care to engage patients • Track outcomes to determine the impact of the program</td>
<td>UUHP Clinical Operations Director UUHP Care Management Manager UUHP QI Specialist Community Clinics Nursing Director Salt Lake, Davis, Weber, Summit, and Utah County hospital care managers UNI Crisis Team</td>
<td>Monthly</td>
</tr>
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| Pharmacy & Therapeutics Committee | University of Utah Health Plan is fiscally responsible for the pharmacy costs of our insured members. Pharmacy costs are the fastest growing component of health care costs, partially due to the rapid rise of specialty drugs and biologics for chronic conditions. The P&T committee will be inclusive of many disciplines and has the potential to positively impact the lives of many health plans members. | • Review and recommend changes to the current formulary to address the needs of our members, paying attention to efficacy, cost and quality of life.  
• Support an effective prior authorization process to meet the strategic mission of the health plan.  
• Review new drugs to determine clinical efficacy, prior authorization and care management interventions as needed.  
• Address population health considerations in relation to disease management and overall adherence of our patients.  
• Monitor trends and costs of pharmaceutical agents to determine effectiveness and opportunities for continuous improvement. | Voting Members  
Adam Cohen, M.D., Hematology/Oncology  
Carrie McAdam Marx, PhD, RPh  
James Ashworth, M.D.  
Child/Adolescent Psychiatry  
Jeremy Biggs, MD, Occupational Medicine  
John Houchins, M.D., Family Medicine  
John Rose, M.D., Neurology  
Julie Day, M.D., Family Medicine  
Karen Gunning, PharmD  
Kathryn Peterson, M.D., Gastroenterology  
Laura Britton, PharmD, Facilitator  
Margaret Solomon, M.D., Internal Medicine/Pediatrics  
Russell Vinik, M.D., Hospitalist, Chair  
Sankar Swaminathan, M.D., Infectious Disease  
Sandra Snider, RN, QI  
Stacy Johnson, M.D., Internal Medicine | Quarterly |
## Medical Policy Committee

### Purpose
The committee exists to guide utilization management decisions and to support the benefits as outlined in the Summary Plan Documents (SPD).

### Function
- Evaluate the medical necessity and evidence-based practice of new or existing services
- Develops policy based on the evidence and clinical observations
- Review Medical Policies annually (at minimum) to determine continued applicability and appropriateness and to determine whether there is a need for revision.

### Composition
- **Non-voting Members**
  - Lexy Hayes, CPhT
  - Mindy Peterson
  - Robert Nohavec, RN

- **Chief Medical Officer; Chair**
- **Program Director; Co-Chair**
- **Clinical Operations Director**
- **Operations Director**
- **Provider Network Director**
- **Pharmacy Director**
- **Care Management Manager**
- **UM Review Nurse**
- **Accreditation Specialist**
- **Medical Director**
- **Care Manager**

### Meeting Frequency
Monthly
Systematic Improvement Process

Integration of Program and Project Cycles

- **Program Cycle**
  - Step I: Develop and plan a quality management program.
  - Step II: Facilitate implementation of the quality program.
  - Step III: Evaluate the quality management program.
  - Step IV: Plan and test changes
  - Step V: Evaluate results with key stakeholders
  - Step VI: Systematize changes

- **Project Cycle**
  - Step 1: Review, collect, and analyze project data.
  - Step 2: Develop a project team
  - Step 3: Investigate the process
  - Step 4: Plan and test changes