



**HEALTH ALLIANCE MEDICAL PLANS  
2011 QUALITY IMPROVEMENT PROGRAM**

**DEFINITION OF QUALITY:**

- **Clinical quality** is defined as minimum variation from evidence-based practice or expert consensus.
- **Service quality** is defined as meeting or exceeding the valid service requirements of our customers.

**PURPOSE**

Quality Improvement (QI) at Health Alliance is an integrative process of continuous assessment and monitoring that strives to improve care and service provided to Health Alliance members. Activities are monitored according to a variety of quality indicators as outlined in the annual QI Plan. These indicators assess the healthcare programs delivered within the Health Alliance system. Based on quality indicator measurements and continuous evaluation of the program components, opportunities for improvement are identified. These opportunities enhance the quality of care and service provided to our members by improving efficiency, increasing the span of healthy life and reducing disparities in the healthcare provided.

**GOALS**

The goals of the Health Alliance QI program include:

- A. Establish standards of clinical care and service for members and measure performance outcomes
- B. Identify opportunities to enhance clinical care and service for members
- C. Respond with appropriate interventions to prioritized opportunities to improve clinical care and service
- D. Measure the effectiveness of interventions and implement actions as needed to improve

**OBJECTIVES**

The objectives of the Health Alliance QI program include:

- A. Utilize a population-based approach to measuring and addressing continuous quality improvement for clinical care and service for members
- B. Develop, refine, and maintain data systems capable of providing systematic, reliable, and meaningful data for use in the QI program
- C. Facilitate a partnership between practitioners, providers, members, and Health Alliance for the purpose of maintaining and improving plan-wide services
- D. Annually measure access, availability, and trends in member satisfaction for improving service
- E. Develop and maintain approaches to providing high-quality clinical care, including disease management, practice guidelines, utilization criteria and guidelines, complex case management, peer review, medical technology review, pharmaceutical management procedures, medical record criteria, and processes to enhance communication and continuity of care between practitioners and providers
- F. Involvement of designated behavioral health care practitioners to address behavioral health issues, including continuity and coordination of care, preventive health, clinical practice guidelines, appropriate triage and referral, customer service, clinical care including pharmaceutical management and all aspects of the QI program.
- G. Develop and maintain a utilization management (UM) program that incorporates nationally recognized criteria, use of appropriate clinical professionals, risk management, member and practitioner appeal rights, and appropriate handling of denials of service
- H. Develop and maintain a pharmaceutical management program that includes the development of policies and procedures, processes for restrictions and preferences, patient safety, review and update of procedures, participation of pharmacists and physicians, notification to practitioners, and prior authorization processes including denials and appeals.

- I. Develop and maintain a credentialing and recredentialing program for individual practitioners and provider organizations that adheres to federal and state regulations, as well as standards for accreditation
- J. Provide access to information about patient safety to members and practitioners through our Website and publications while encouraging accountability for patient safety with contracted providers through our Never Events and Quality of Care processes.
- K. Assess cultural and linguistic needs of member population at least annually and report findings to the Members Rights and Responsibilities/Quality Improvement Committee. Annual assessment includes evaluation of census data, CAHPS survey demographic data, Language Line translation requests for oral translation services with documentation available upon request, complaint data, CACTUS credentialing system data for provider language spoken, CCMS case management cultural need responses, language spoken by Health Alliance service region (from Claritas for PCensus\*) and data provided by Health Alliance's four major provider systems. \*2009 Nielsen Claritas Demographic Update provides the most current and accurate demographic estimates available by combining high quality data input sources from local governments, consumer databases and postal delivery counts together with data from the U.S. Census Survey.
- L. Provide members with information regarding rights and responsibilities, health plan policies and procedures, benefit and coverage information, and ensure appropriate oversight of procedures that protects the privacy and confidentiality of member information and records.
- M. Develop and promote preventive health standards and programs to encourage members and practitioners to utilize appropriate guidelines and early detection services for prevention of illness
- N. Provide an appeals process designed to protect the rights of the member, physician and hospital as fully as possible. Ensure that any member, provider or practitioner who is affected by an adverse determination is given the opportunity to appeal through a verbal or written request for medical and administrative review.
- O. Establish standards and processes for maintenance and oversight of delegated activities
- P. Establish an annual QI Plan that describes specific activities undertaken each year to address the components of the QI program
- Q. Annually review the QI program activities for determining effectiveness and focus for the coming year

## **PROGRAM SCOPE**

The scope of the Health Alliance QI program is designed to fulfill the goals and objectives of the program, while efficiently utilizing resources to promote and enhance integration of quality activities internally (within Health Alliance) and externally with practitioners, providers, members, employers, state and federal agencies, and appropriate parties. The scope of the QI program includes, but is not limited to:

- A. Clinical Care
  - 1. preventive health activities
  - 2. clinical quality improvement activities
  - 3. clinical management criteria and guidelines
  - 4. disease management
  - 5. credentialing and recredentialing
  - 6. utilization management
  - 7. complex case management
- B. Service
  - 1. member complaints and appeals
  - 2. trends in member dissatisfaction/satisfaction
  - 3. appointment and after hours access monitoring
  - 4. practitioner availability monitoring
  - 5. telephone access
  - 6. written and verbal communications with members
- C. Behavioral Health Services
  - 1. preventive health
  - 2. mental health and substance abuse quality improvement activities
  - 3. behavioral management criteria and guidelines
  - 4. telephone and appointment access monitoring
  - 5. credentialing and recredentialing
  - 6. utilization management
- D. Patient Safety

1. continuity and coordination of care between practitioners and providers
2. tracking and trending of adverse events
3. evaluation of clinical care against aspects of evidence based guidelines that improve safe practices
4. implementation of health management systems that support timely delivery of care
5. Annual review of CMS Hospital Compare data

The process of integrating the quality improvement initiatives with various Health Alliance departments and committees is accomplished, in part, through appointment of representatives to the committees listed in the structure of the quality improvement program with a diversity of knowledge and skills. These individuals support the development and continuous evaluation of the QI Program, through the plan, do, check and act cycle. It is the primary responsibility of the QI Department to diffuse QI initiatives throughout the organization. The following are examples of areas where other departments interact with Quality Management.

- Utilization Management: handling of appeals, linking case management with disease management, integration of complex case management with data from quality management.
- Pharmacy management: handling appeals, patient safety, and physician education about clinical guideline recommendations regarding first line medication prescribing
- Credentialing: Reviewing member ambulatory review scores, satisfaction surveys and act on reports of negative provider quality from the Peer Review Committee.
- Member Services: promoting preventive health, timely handling of complaints and appeals, member satisfaction, privacy and confidentiality, understanding member materials and communication with members and prospective members.
- Marketing: Health fair coordination and education for quality improvement programs.
- Information Systems: HEDIS, quality report cards, confidentiality, process improvement.
- Claims: HEDIS, member satisfaction for claims processing.

## **STRUCTURE OF PROGRAM**

The Quality Improvement Program provides a comprehensive structure to identify, evaluate and improve clinical care and service provided to members individually and collectively. The Health Alliance Board, through its Quality Committee, oversees the structure with day-to-day accountability designated to the Chief Medical Officer and Quality Improvement Committee (QIC). Subcommittees of the QIC provide a focus on initiatives involving quality improvement such as utilization management, members' rights and responsibilities, credentialing and pharmacy. In addition to committees, multiple departments and individual staff members have key roles and responsibilities in the QI program.

Key committees for quality improvement activities are outlined on the following pages, including detailed descriptions of roles, membership and responsibilities.

## KEY PERSONNEL

1. **The Chief Medical Officer (CMO)** chairs the Medical Director Committee, and participates on the Quality Improvement Committee, Pharmacy and Therapeutics Committee and Members' Rights and Responsibilities Committees. The CMO provides daily leadership for quality management initiatives, including but not limited to disease management, appeals, clinical guidelines, prevention, appointment access, credentialing, confidentiality and HEDIS. Designated Senior and Regional Medical Directors are responsible for other functional areas, i.e. credentialing, pharmacy, utilization management, behavioral health care, regional sites and report to the CMO.
2. **Senior and Regional Medical Directors** support quality improvement and act as leaders for committees and oversee ongoing activities in the following areas: pharmacy and therapeutics, case and disease management, peer review, needs assessment, medical policies, transplants, prior authorization, technology review, concurrent review, credentialing, and quality activities throughout Illinois and Iowa. . The Senior Medical Director chairs the Medical Policy Committee. Regional Medical Directors assign tasks and implement interventions at the participating practitioner level to Health Alliance Medical Directors. Health Alliance Medical Directors are participating providers who have accountability for dissemination of health plan policies and procedures to their regions
3. **The Quality and Medical Management Director** provides oversight for the quality and medical management department. Responsible for identifying, implementing monitoring and evaluating quality and medical management activities to improve care and service provided to all Health Alliance members. Responsible for overseeing the areas of credentialing and re-credentialing for all providers (individual and facilities); health promotion/disease prevention activities that enhance Joint Venture and Community partnerships; member relations appeal and grievance monitoring to meet regulatory agency requirements; clinical guidelines for acute, chronic, preventative and behavioral health services; population-based disease management programs with the goal of improving health outcomes; case management to ensure engagement and improvement in quality of life; utilization management to focus on reducing medical spend while maintaining or improving quality; and ensuring appropriate document and reporting systems are utilized to maximum efficiency.
4. **The Quality Improvement Manager**, responsible for day-to-day management population based disease management, behavioral health access, patient safety, and wellness programs.
5. **The Quality Improvement Coordinators**, through accountability for assigned quality initiatives, facilitates solutions to improve care and service, HEDIS data collection, completes tasks that support activities defined in the QI work plan and prepares routine reports to the Quality Improvement Committee (QIC).
6. **The Health Management Services Coordinators**, through accountability for assigned health promotion/prevention initiatives, HEDIS data collection, facilitates tasks as defined in the QI work plan and prepares routine reports to the Quality Management Director and QIC.
7. **The Member Relations and Utilization Management Manager** oversees the appeals process, DOI complaints, and preauthorization process for Intake Coordinators and UM Nurse Coordinators. Ensures compliance with all regulatory requirements for appeals and utilization management processes.
8. **Member Relations Coordinators**, works directly with various internal and external Health Alliance customers on appeal issues and resolution to ensure timelines are met and that each appeal has all required documentation prior to a final decision. Member relations coordinators are trained to assess coverage decisions based on policy language as part of the appeal process for administrative issues.
9. **HEDIS/NCQA Reporting Manager** oversees HEDIS data retrieval and analysis, works with clinical reporting tools, provides reports for quality and medical management interventions that ensure NCQA and regulatory compliance.
10. **Data Analysts** provides statistical comparisons and analysis for quality improvement studies and supplies data for multiple initiatives, including access, various components of member satisfaction, clinical guideline surveys, and inter-rater reliability analysis.
11. **Case Management Manager for Inpatient and PHC Program**, oversees the case management programs for the continuum of care promoting improved quality of life for members. Promotes right care, right time, right place with members in complex case management and care coordination.
12. **The Communications Specialist** is dedicated to quality management to provide consultation for material presentation and coordinate material distribution, as needed.
13. **The Credentialing Manager and Coordinators** credential and re-credential all practitioners and providers, as well as manage the delegated credentialing program.

14. **Behavioral Health Resources** are coordinated by collaborating with the lead staff from our largest behavioral health providers; the Chairman of the Quality Committee is a Behavioral Healthcare Practitioner/Certified Addictionist; QIC has a practicing psychologist as a voting member; and a practicing psychiatrist was added as a Health Alliance Associate Medical Director in October 2008.

The organization chart for the Quality and Medical Management department depicts the reporting structure for some of the key personnel integral to the quality improvement program.

## RESOURCES

The Quality Management Department has a number of technical resources available to support the initiatives and programs offered to members and providers including, but not limited to:

1. Care Enhance Resource Management Software (CRMS™) systems from McKesson Health Solutions for HEDIS:
  - ChartReview Manager (CRM) supports the process of medical record review that is required for HEDIS® hybrid reporting methodology.
  - Health Plan Reporter (HPR) enables reporting on HEDIS domains of care, including Effectiveness of Care measures, Access/Availability of care measures, Use of Services measures and others. This program can identify compliant and noncompliant members based on HEDIS criteria and is used to provide feedback to providers.
2. CareEnhance Clinical Management Software (CCMS) is a McKesson system that provides full medical management services including utilization management, case management, disease management, management of members at risk (complex case management) and documentation of appeals. The system allows evaluation of care management by tracking and measuring goals, interventions and outcomes.
3. In 2010 Health Alliance purchased a suite of quality tools from McKesson Health Solutions to support our expanding quality initiatives:
  - CareEnhance® Episode Profiler – a physician profiling tool that helps realize cost and quality improvements by providing data on how physicians manage conditions.
  - CareEnhance® Quality Profiler – provides data to help monitor, evaluate and manage the quality of care to promote better outcomes.
  - CareEnhance® Patterns Profiler – this tool uses data to help identify overutilization, clinically inappropriate care and unusual services
4. CareEnhance® Financial Profiler – provides reports that monitor cost and utilization performance
5. InterQual is embedded in CCMS and is an industry-leading evidence-based tool for determining the appropriateness of health care interventions and levels of care across the continuum. This program supports preauthorization, concurrent review and retrospective analysis of clinical appropriateness.
6. MC400 – Managed Care 400 claims processing system from OAO Healthcare Solutions retains member eligibility information, applies provider contract and payment terms and adjudicates claims based on specific rules established for employer benefit packages.
7. MedImpact – pharmacy benefit manager offers customized products and uses an evidence-based approach to manage costs.
8. Visual CACTUS - houses all data for credentialed providers and drives the recredentialing process.
9. Ambulatory Review Database – an Access based system developed by Health Alliance staff that enables tracking, documentation and reporting of ambulatory review criteria and results.
10. WorldDoc - available to all Health Alliance members and providers free of charge via the Health Alliance website. WorldDoc offers around-the-clock access to information that can make challenging health decisions a little easier. Tools and information on health risks, illnesses, treatment options and medications are included.
11. MEDai, Inc./Risk Navigator predictive modeling software - predicts future expenditures by analyzing patterns of service utilization and diagnosis codes to identify Medicare Advantage members at high risk for clinical events in the near future.
12. SPSS- Allows users to sample, manipulate, and analyze data including statistical testing, correlations, and regression analysis
13. SQL Query Analyzer- Allows users to query data from the data warehouse for reporting or producing mailing lists.
14. Crystal Reports- Allows users to query data from the data warehouse for reporting or producing mailing lists
15. MCNet.- pulls member information for the customer service representative from the member number entered into the Cisco Systems IVR by the caller or when accessed manually by the representative. MCNet combines access to a call

tracking process from another system by Onyx called Customer Center with data housed in the MC400. Calabrio's Work Force Management and Quality Management software are used for staff scheduling, call recording, and call monitoring. They are fully integrated with the phones by Cisco Systems.

16. Cisco Systems - phone system that provides reporting on telephone utilization.

17. Complaints are tracked in Onyx's Customer Center which feeds into our data warehouse. Reports are run using Crystal Enterprises.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

## 1. QUALITY COMMITTEE

- a. Role:** The Quality Committee reviews and makes recommendations to the Board of Directors regarding matters relating to the quality of care and service provided to Health Alliance members. Through the annual population assessment, the Quality Committee monitors health plan-wide goals for health service quality and participates in the implementation of the health plan's strategic plan for quality management, including credentialing, wellness, population based disease management, quality improvement and patient safety. The Board has delegated to the Quality Committee, which has delegated to Quality Improvement Committee (QIC), direction, implementation, oversight and coordination for all QI activities. The QIC acts on behalf of the Health Alliance Medical Plans Board to review and approve policies, procedures, interventions and effectiveness of QI initiatives throughout Health Alliance Medical Plans.
- b. Chairperson:** Chief Medical Officer, The Foundation/Adult Medicine/Certified Addictionist
- c. Membership:**  
*VOTING:*  
Outside Health Alliance Medical Plans Director  
Family Medicine Physician, Carle Physician Group  
Chief Executive Officer, Carle Physician Group  
Health Alliance Medical Plans Chief Executive Officer  
Health Alliance Midwest Medical Plans Enrollee Board Member  
*NONVOTING (Health Alliance Staff)*  
Chief Medical Officer and/or Designee  
Senior Medical Director  
Vice President of Corporate Communications  
Vice President of Sales and Marketing  
Vice President of Employee Relations  
Director, Quality and Medical Management
- d. Responsibilities:**
- Annually review and approve the Quality Improvement Program, Quality Improvement Plan, and Quality Improvement Evaluation.
  - Provide oversight for the Health Alliance quality improvement program structure.
  - Recommend policies and programs to further the health plan's activities in disease management, wellness and health evaluation.
  - Review and Approve minutes of the Quality Improvement Committee.
- e. Meets:** Quarterly
- f. Minutes:**
- Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.

## 2. QUALITY IMPROVEMENT COMMITTEE (QIC)

- a. **Role:** Primary responsibility is to provide direction, implementation, oversight and coordination of quality improvement initiatives throughout Health Alliance.
- b. **Chairperson:** Chief Medical Officer or Designee, Health Alliance
- c. **Membership:**
  - Senior Medical Director, Health Alliance
  - Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
  - Medical Director/Southern Region, Health Alliance; Participating Practitioner, Pediatrics
  - Regional Medical Director, Health Alliance; Participating Practitioner, Psychiatry
  - Vice President of Quality and Senior Medical Director, Carle
  - Director of Quality Management Services, Carle
  - Director, Individual and Medicare Services or Designee, Health Alliance
  - Director, Quality and Medical Management, Health Alliance
  - Director, Communications, Health Alliance
  - Quality Improvement Manager, Health Alliance
- d. **Reporting:** Reports to the Health Alliance Medical Plans Board through the Quality Committee.
- e. **Responsibilities:**
  - Identify and initiate quality improvement activities as they relate to the enrolled Health Alliance population.
  - Continuously monitor data from quality improvement activities as outlined in the annual work plan and recommend appropriate action.
  - Evaluate and allocate resources for quality improvement activities.
  - Evaluate the quality improvement structure and complete a formal QI Plan and QI Evaluation on an annual basis.
  - Monitor sub-committee and task group activities through review of meeting minutes and reports.
  - Delegate any of the above activities to sub-committees with appropriate oversight.
  - Adopt, develop, and implement overall preventive health and clinical guidelines.
  - Oversee all quality improvement initiatives as described in the annual plan.
  - Review new NCQA standards and make recommendations to operationalize, as needed.
- f. **Meets:** Monthly
- g. **Minutes:**
  - Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.

### 3. CREDENTIALING COMMITTEE

- a. **Role:** Primary responsibility is to review all credentialing and recredentialing files and determine approval or denial of individual practitioners and facilities at the time of initial credentialing and recredentialing.
- b. **Chairperson:** Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
- c. **Membership:**
  - Senior Medical Director, Health Alliance
  - Regional Medical Director/Springfield Region, Health Alliance; Participating Practitioner Internal Medicine
  - Medical Director/Local Service Area, Health Alliance; Participating Practitioner, Psychiatry
  - Regional Medical Director/Peoria Region/Participating Practitioner, Adult Medicine-Urgent Care
  - *Non-Voting:* Credentialing Manager or Designee
- d. **Reporting:** Reports to the Quality Improvement Committee for informational purposes.
- e. **Responsibilities:**
  - Review all materials relevant to an applicant regarding credentialing and recredentialing issues as identified in the Health Alliance credentialing policies and procedures.
  - Share identified issues with the Peer Review Committee during the credentialing and recredentialing process.
  - Determine approval or denial status as a Health Alliance participating practitioner or facility.
  - Review and revise all policies and procedures related to credentialing and recredentialing activities at a minimum annually.
- f. **Meets:** Bimonthly
- g. **Minutes:**
  - Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.

4. **PEER REVIEW COMMITTEE**

- a. **Role:** Identifies opportunities to improve the quality of health care delivered to members of Health Alliance by providing a professional review of potential quality of care events across the health care continuum. These events may concern the professional competence or professional conduct of a physician or the quality of care or services provided by a contracted facility or business. A professional review must include a reasonable effort to obtain the facts of the matter. Actions recommended by the Peer Review Committee must be based on the reasonable belief that the action will further the quality of health care.
- b. **Chairperson:** Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
- c. **Membership:**
  - Senior Medical Director, Health Alliance, Family Medicine
  - Participating Practitioner, Adult and Pediatric Medicine, Allergy and Immunology, Internal Medicine, Springfield, IL
  - Participating Practitioner, Pulmonology, Bloomington, IL
  - Participating Practitioner, Surgery, Ames, Iowa
  - OB/Gyn Peer Consultant, Urbana, IL
  - Health Alliance Legal Counsel
  - Quality Improvement Coordinator
  - Ad-Hoc Members, as needed
- d. **Reporting:** Reports to Credentialing and Medical Director Committee, as needed.
- e. **Responsibilities:**
  - Oversee the policy and procedure for Provider Peer Review Procedures.
  - Trend and track quality of care issues for improvement opportunities.
  - Review information from individual cases
  - Recommend action on individual cases according to the procedures in the Provider Peer Review policy. Refer providers with substantial quality issues to the Credentialing Committee for action.
- f. **Meets:** Quarterly or as needed.
- g. **Minutes:**
  - Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.

5. **MEDICAL DIRECTORS' COMMITTEE (MDC)**

a. **Role:** Primarily responsible for oversight and review of medical management activities and strategic planning for initiatives that will enhance the provision of care.

b. **Chairperson:** Chief Medical Officer, Health Alliance

c. **Membership:**

*VOTING*

- Senior Medical Directors, Health Alliance
- Regional Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Family Medicine
- Associate Medical Director/Southern Region, Health Alliance; Participating Practitioner, Pediatrics
- Associate Medical Director/Southern Region, Health Alliance; Participating Practitioner, Family Medicine
- Associate Medical Director/Peoria Region, Health Alliance; Participating Practitioner, Emergency Medicine
- Associate Medical Director/Springfield Region, Health Alliance; Participating Practitioner, Pediatrics and Adult Medicine
- Associate Medical Director/Springfield Region, Health Alliance; Participating Practitioner, Internal and Geriatric Medicine
- Associate Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Allergist
- Associate Medical Director/East Central Illinois Region, Health Alliance; Participating Practitioner, Psychiatry
- Director of Quality and Medical Management, Health Alliance
- Manager, Member Relations and Utilization Management, Health Alliance
- Manager, Quality Improvement, Health Alliance
- Manager, Case Management for Inpatient and PHC Programs, Health Alliance

*NONVOTING*

- Pharmacist, Health Alliance
- Quality Improvement Coordinator, Member Relations, Health Alliance
- Project Managers, Medical Management, Health Alliance
- Senior UM Nurse Coordinator, Health Alliance
- Senior Intake Coordinator Health Alliance
- Senior PHC Program Nurse Coordinator, Health Alliance
- Director of Communications or Designee, Health Alliance
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d. **Reporting:** Reports to the Quality Improvement Committee for informational purposes only.

e. **Responsibilities:**

- Oversee medical policies and share changes with the Operations Steering Committee.
- Review reports from the Peer Review Committee, as needed.
- Identify, evaluate and recommend actions for utilization issues.
- Oversee the review of information involving new technologies and/or treatments.
- Reviews appeal decisions from External Review Organizations (EROs) to determine if changes in current criteria are indicated.
- Reviews utilization reports to assist joint venture partners in identifying opportunities to improve service and quality of care as related to cost.
- Review the annual utilization management plan, program and evaluation for input and recommendations to the Chief Medical Officer.

- Performs annual potential over/underutilization analysis
- Reviews trends based on claims to identify risk areas by joint venture partner
- Issues reports to assist joint venture partners in health system performance
- Reviews and approves department policies presented for new or changed UM activities or processes
- Discusses UM issues that are appropriate for the Leadership level of review

**e. Meets:** Bimonthly.

**f. Minutes:**

- Generated for each meeting and approved by the committee.
- Reflect the activity, discussion, analysis and recommendations of the committee as well as follow-up and resolution of prior recommendations.
- Shared with the Quality Improvement Committee.

**6. MEDICAL POLICY COMMITTEE (MPC)**

- a. Role:** Primary responsibility to review and provide practitioner input on new and updated criteria, medical policies, and policies and procedures.
- b. Chairperson:** Senior Medical Director
- c. Membership:**
  - Chief Medical Officer, Health Alliance and/or Senior Medical Director, Health Alliance
  - Minimum of five Health Alliance participating practitioners representing primary and specialty care services.
- d. Reporting:** Provides feedback to the Medical Directors' Committee, as needed.
- e. Responsibilities:**
  - Review case requests for new technology based on literature with recommendations based on area of expertise
  - Review and updates to policy and procedures with recommendations based on area of expertise
- f. Meets:** Monthly
- g. Minutes:**
  - Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
  - Reviewed by Corporate Medical Directors' Committee monthly and shared with the Quality Improvement Committee.

## 7. PHARMACY AND THERAPEUTICS COMMITTEE

a. **Role:** Provides guidance for pharmacy utilization for Health Alliance providers.

b. **Chairperson:** Chief Medical Officer or Designee, Health Alliance

c. **Membership:**

### *VOTING*

- Chief Medical Officer, Health Alliance
- Medical Director/Springfield, IL, Health Alliance, Participating Practitioner, Internal Medicine
- Medical Director/East Central Illinois Region, Health Alliance, Allergy
- Participating Practitioner, Geriatrics, Urbana, IL
- Participating Practitioner, Family Medicine, Springfield, IL
- Participating Practitioner, Nephrology, Springfield, IL
- Participating Practitioner, Psychiatry, Champaign, IL
- Participating Practitioner, Adult Medicine, Ames, IA
- Participating Practitioner, Pediatrics, Urbana, IL
- Participating Practitioner, Family Medicine, Mahomet, IL
- Participating Practitioner, Internal Medicine, Taylorville, IL
- Participating Practitioner, Internal Medicine, Carlinville, IL
- Participating Geriatric Pharmacy Manager, Monticello, IL
- Participating Director of Pharmacy, Health Alliance

### *NONVOTING*

- Pharmacist (Retail), Urbana, IL
- Pharmacist, Health Alliance
- Pharmacist, Health Alliance
- Pharmacist, Health Alliance
- Pharmacist, Health Alliance
- Pharmacist, Health Alliance
- Pharmacist, Health Alliance
- Pharmacy Manager, Health Alliance
- Pharmacy Rebate Contract Analyst, Health Alliance
- Pharmacy Medicare Specialist
- Clinical Peers (consulted as needed, determination based on agenda)

d. **Reporting:** Reports to Medical Directors Committee for informational purposes only.

e. **Responsibilities:**

- Annually review the pharmacy program.
- Maintain and establish a formulary.
- Reviews and updates pharmaceutical management policies and procedures annually based on new technologies.
- Approves or disapproves medications including biotechnology and medications. Medication on the formulary may be removed or have its status changed.
- May, from time to time, determine that a prior approval guideline should be developed and implemented.
- May establish guidelines for criteria based medications.
- Establish and implement a Drug Utilization Evaluation (DUE) program.
- Designate a Task Force or Subcommittee to study particular prior approval guideline.
- Ensure an appeal process for pharmacy issues is maintained.

**f. Meets:** Bimonthly

**g. Minutes:**

- Generated for each meeting and approved by the Chairman.
- Reflects the activity, discussion, analysis, and recommendations of the committee as well as follow-up and resolution of prior recommendations.
- Distributed to all Health Alliance providers and the Medical Director Committee.
- Distribute a summary of minutes to all Health Alliance Practitioners

## 8. **BEHAVIORAL HEALTH Care Advisory Group**

- a. **Role:** Identifies opportunities to improve the quality of behavioral health care delivered to members of Health Alliance throughout all service areas.
- b. **Chairperson:** Quality Improvement Manager, Health Alliance
- c. **Membership:**
  - Medical, Psychiatric and Psychological Team
    - Child Psychiatrists
    - Adult Psychiatrist
    - Family and Child Psychologist
    - Family Medicine Physicians
    - Pediatrician(s)
    - Patient Care Manager, Outpatient Behavioral Health
    - Behavioral Health Triage Therapist
    - Ad hoc members (Carle Clinic Behavioral Health Nursing Manager)
  - Alcohol and Other Drugs Misuse Team
    - Carle Representative from addiction recovery program
    - Family Medicine Physicians
    - Ad hoc members, as needed
  - *Ad-Hoc Members, as needed*
- f. **Reporting:** Reports to the Quality Improvement Committee.
- g. **Responsibilities:**
  - Advise Health Alliance on issues related to improving continuity and coordination of care between medical care and behavioral health care
  - Review HEDIS results for measures related to behavioral health care and advise Health Alliance on improvement opportunities and action plans
  - Addresses any identified patient safety improvement opportunities around behavioral health.
  - Identify and recommend actions to improve access to behavioral health services
- h. **Meets:** At least quarterly e-meetings are held with the teams or members of the teams. Annually, the team meets face-to-face to review the Continuity and Coordination of Care survey results.
- i. **Minutes:**
  - Email content reflects discussion shared among the team as coordinated by the QI Manager.
  - Agendas and minutes, if applicable, are created and shared among the teams.
  - Topics discussed at the Quality Improvement Committee are recorded in the QIC minutes and reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.

**9. MEMBERS' RIGHTS AND RESPONSIBILITIES COMMITTEE (MRRC)**

**a. Role:**

To assist in maximizing the value of our members' health care by monitoring available reports and information and making recommendations for improvement to the Quality Improvement Committee. Information reviewed includes but is not limited to: complaints and appeals data, policies and procedures, member communications, prospective member communications, member satisfaction survey results (CAHPS and new member surveys), provider satisfaction survey results, employer satisfaction survey results, disenrollment survey results, cultural and linguistic service needs, service-related HEDIS measures, and service-related Key Performance Indicators.

**b. Chairperson:** Vice President of Corporate Communications, Health Alliance

**c. Membership:**

- Chief Medical Officer, or designated Medical Director, Health Alliance
- Director, Quality & Medical Management, Health Alliance
- Director, Customer Service, Health Alliance
- Director, Medicare & Individual Plans, Health Alliance
- Director, Contracting and Provider Services, Health Alliance
- Director, Communications, Health Alliance
- Manager, Regulatory Compliance, Health Alliance
- Manager, Member Relations, Health Alliance
- Quality Improvement Coordinator, Health Alliance
- Operations Management Representative, Health Alliance
- Retention Manager, Health Alliance
- Pharmacy Manager, Health Alliance
- Senior QM Data Analyst

**d. Reporting:** Reports to the Quality Improvement Committee.

**e. Responsibilities:**

- Facilitate mutually respectful relationships with members and providers through an established statement of members' rights and responsibilities.
- Review member complaints and appeals data (at least biannually) to identify trends, provide recommendations for improvement as needed. Monitor development, implementation and tracking of applicable policies and procedures.
- Ensure member and prospective member communications clearly outline benefits and contain information needed to understand benefit coverage and how to obtain care via review of survey results.
- Ensure cultural and linguistic needs of members are assessed and addressed annually
- Review findings of member and practitioner satisfaction surveys (at least annually) to identify trends and opportunities for improvement.
- Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.
- Monitor service-related HEDIS measures and service-related organizational Key Performance Indicators to identify opportunities for improvement. Support development and implementation of action plans and monitor progress and subsequent data to determine effectiveness.

**f. Meets:** Every other Month starting June 2003 (quarterly prior to this time).

**g. Minutes:**

- Generated for each meeting and approved by the committee

- Reflect the activity, discussion, analysis and recommendations of the committee
- Shared with the Quality Improvement Committee and the Quality Committee (via QIC minutes), subcommittee of the Health Alliance Board.

## 10. CONSUMER ADVISORY COMMITTEE

- a. **Role:** Identifies and reviews consumer concerns and makes advisory recommendations to Health Alliance. In addition, Health Alliance makes requests of the committee to provide feedback to proposed changes in plan policies and procedures, programs, materials and processes, which will affect enrollees.
- b. **Chairperson:** Elected by the committee.
- c. **Membership:**  
Eight enrollees selected as required by law. An enrollee may not serve on the committee if during the two years preceding service the enrollee: (1) has been an employee, officer, or director of the plan, an affiliate of the plan or a provider or affiliate of a provider that furnishes health care services to the plan or affiliate of the plan; or (2) is a relative of a person specified in item (1).

Four enrollees will serve a two-year term and four enrollees a one year term. After the term expires, Health Alliance will re-appoint or appoint an enrollee to serve on the committee for a two-year term.

*Resources to the Committee:*

Director of Compliance, Health Alliance  
Marketing Communications Specialist, Health Alliance  
Chief Medical Officer or Designee, Health Alliance

- d. **Reporting:** Reports to the Members' Rights and Responsibilities Committee.
- e. **Responsibilities:**
  - Identify and review consumer concerns and make advisory recommendations.
  - Provide feedback to proposed changes in plan policies and procedures which will affect enrollees.
  - Identify and recommend improvement of Health Alliance membership and educational materials.
  - Provide input and recommendations for coverage issues.
- f. **Meets:** Quarterly
- g. **Minutes:**
  - Generated for each meeting and reviewed/approved by the committee.
  - Reflects the activity, discussion, and decision of the committee, as well as follow-up and resolution of prior recommendations.
  - Reported to the Members' Rights and Responsibilities Committee.

## 11. COMPLIANCE COMMITTEE

- a. **Role:** Provide direction and support in the ongoing oversight of the Compliance Program. The Compliance Committee acts on behalf of the Health Alliance Board of Directors to review and approve policies, procedures and activities of the Compliance Program.
- b. **Chairperson:** Director of Compliance, Compliance Officer, Health Alliance
- c. **Membership**
- Chief Medical Officer, Health Alliance
  - Chief Financial Officer, Health Alliance
  - Vice President, Corporate Affairs and General Counsel, Health Alliance
  - Vice President, Corporate Communications, Health Alliance
  - Vice President, Sales and Account Management, Health Alliance
  - Vice President, Employee Relations, Health Alliance
  - Chief Information Officer, Health Alliance and Carle Clinic
  - Director, Quality & Medical Management, Health Alliance
  - Director, Medicare and Individual Services, Health Alliance
  - Director, Internal Audit, Health Alliance
  - *Non-Voting:* Compliance Program Manager/Privacy Officer, Health Alliance
- d. **Reporting:** Reports to the Audit Committee of the Health Alliance Board of Directors through minutes of the Compliance Committee meetings and updates from the Compliance Officer or designee.
- e. **Responsibilities:**
- Assess the organization's regulatory environment, the legal requirements with which it must comply and specific risk areas.
  - Ensure up-to-date compliance policies and procedures are in place.
  - Approve standards of conduct and policies and procedures that promote allegiance to the Compliance Program.
  - Recommend and monitor, in conjunction with internal departments, the development of systems and controls to carry out policies and procedures as part of its daily operations.
  - Develop strategies to promote compliance with the program and detection of any potential violations through a hotline and other fraud reporting mechanisms.
  - Oversee and evaluate responses to compliance complaints and problems.
  - Assist with the creation of effective corrective action and preventive plans and ensure that they are implemented and monitored.
  - Ensure that training and education are appropriately completed.
  - Ensure a system for employees and contractors to ask compliance questions and report potential instances of fraud, waste or abuse confidentially or anonymously without fear of retaliation is in place.
  - Provide oversight and guidance for confidentiality and privacy issues within the organization including but not limited to:
    - Confidentiality, privacy and security policies for the organization. Policies with material changes, as determined by the Compliance Officer or designee, will be forwarded to the committee for review and approval.
    - Mechanisms to ensure application of confidentiality and privacy policies
    - Opportunities for reducing collection of unnecessary member data or using blinded and/or aggregate data
    - Levels of user access to data across the delivery system, including practitioners and their staff as well as Health Alliance staff, i.e. claims, utilization management and customer service departments
    - Mechanisms for adhering to specific requests to limit access to data

- Provision of an appeals process to address member concerns regarding confidentiality of data
- Support the Compliance Officer's need for sufficient staff and resources to carry out his or her duties

The committee may also address other functions, as the compliance concept becomes a part of the overall operating structure and daily routine.

- f. Meets:** The committee shall meet on a quarterly basis and may hold special meetings as may be called by the Chairperson.

A majority of the Committee shall constitute a quorum and the majority of a quorum is necessary for committee action.

**g. Minutes:**

- Generated for each meeting and approved by the committee
- Reflect the activity, discussion, analysis and recommendations of the committee, as well as follow-up and resolution of prior recommendations.

## 12. MEDICARE WORKGROUP

- a. **Role:** Identifies and reviews quality activities to ensure compliance with CMS and NCQA requirements for the HMO and PPO products and Medicare Deeming.
- b. **Chairperson:** QI Coordinator/Medicare
- c. **Membership**
  - Director, Medicare and Individual Services
  - Manager, Medicare and Individual Services
  - Director, Quality & Medical Management
  - Director, Medicare Advantage Revenue Management
  - Communications Manager
  - Medical Management Manager of Personal Health Coordination
  - Medical Management Senior Coordinator Personal Health Coordination
  - Medical Management Project Managers
  - Clinical Pharmacist
  - Pharmacy Medicare Specialist
  - QI Senior Data Analyst
  - QI Coordinator/Accreditation
  - Compliance Program Manager
  - Compliance Auditor
  - Provider Network Manager
  - Provider Network Manager
  - Member Relations Manager
- d. **Reporting:** Reports to the Quality Improvement Committee.
- e. **Responsibilities:**
  - Review annual population assessment to identify opportunities for new programs and make recommendations to the QIC.
  - Review customer satisfaction, i.e. CAHPS, complaints and appeals, and make recommendations to MRRC and/or act upon recommendations of the MRRC for Medicare beneficiaries.
  - Review Medicare HEDIS results annually and make recommendations to the QIC.
  - Oversee the HRA process and response rate.
  - Review HOS survey results to identify opportunities for quality programs/
  - Review Part C and Part D Report Cards (Star Ratings)
  - Identify an annual QI project.
  - Keep up-to-date on new Medicare/NCQA regulatory requirements specific to quality.
- f. **Meets:** Monthly
- g. **Minutes:**
  - Generated for each meeting and reviewed/approved by the committee.
  - Reflects the activity, discussion, and decision of the committee, as well as, follow-up and resolution of prior recommendations.

**13. NEVER EVENTS AND PATIENT SAFETY COMMITTEE**

- a. Role:** Reviews potential never events identified through the peer review process as defined by the National Quality Forum and delineated in provider contracts. Makes decisions about nonpayment of claims when applicable and oversees notification and resolution. Provide recommendations for patient safety interventions to QIC.
- b. Chairperson:** Chief Medical Officer, Health Alliance or Designee
- c. Membership:**
  - Chief Medical Officer, Health Alliance
  - VP of Corporate Affairs and General Counsel
  - Medical Director Chair for the Peer Review Committee, Health Alliance
  - Regional medical director as assigned
  - Director for Quality and Medical Management
  - Director of Client and Provider Services
  - Director of Claims
  - Corporate Relations Manager
  - Client and Provider Services managers
  - Quality Improvement Manager
  - Quality Improvement Coordinator
  - Ad-Hoc Members, as needed
- d. Reporting:** Reports to Credentialing Committee and Peer Review, as needed; and the Quality Improvement Committee.
- e. Responsibilities:**
  - Oversee the policy and procedure for Never Events Process.
  - Trend and track never events for annual reporting to QIC.
  - Reviews information from individual cases.
  - Recommends action on individual cases according to the procedures in the Never Events Process Policy and Procedure.
- f. Meets:** Monthly or as needed.
- g. Minutes:**
  - Generated for each meeting and approved by the committee.
  - Reflect the activity, discussion, analysis and recommendations of the committee, as well as, follow-up and resolution of prior recommendations.

The Quality Improvement Committee (QIC) approved the first QI Program on May 24, 1994. The QIC reviews and revises the QI Program document at least annually. After review and approval by the QIC, the program is submitted to the Health Alliance Medical Plans Board for final approval. As of August 2001, the Health Alliance Board designated this function to the newly formed Quality Committee. Approval dates are reflected in the following chart.

<b>QI Program</b>	<b>QIC Review/Approval</b>	<b>Board Review/Approval</b>
2011	November 19, 2010	December 6, 2010
2010	November 20, 2009	November 30, 2009
2009	November 6, 2008	November 17, 2008
2008	November 21, 2007	February 25, 2008/May 19, 2008
2007	November 15, 2006	November 20, 2006
2006	October 19, 2005	November 7, 2005
2005	November 17, 2004	November 22, 2004
2004	December 17, 2003	February 23, 2004
2003	February 19, 2003	February 24, 2003
2002	January 16, 2002	February 25, 2002
2001 (revised)	May 16, 2001	August 27, 2001
2001	November 15, 2000	February 26, 2001
2000	January 19, 2000 November 17, 1999	February 28, 2000
1999 (revised)	May 21, 1999	August 23, 1999
1999	December 16, 1998	February 22, 1999
1998	December 17, 1997	March 26, 1998
1997	December 18, 1996	February 13, 1997
1996	November 15, 1995	January 11, 1996
1995 (revised)	April 19, 1995	April 27, 1995
1995	January 18, 1995	January 26, 1995
1994	May 24, 1994	September 8, 1994

### **DELEGATION**

If quality improvement, utilization management, or credentialing activities are delegated to another organization or provider group, strict procedures for assessing and monitoring the delegation relationship are followed, including:

- Pre-delegation site visit to determine scope and current capabilities
- Formal, written contract and description of roles and responsibilities for both parties
- Specified regular reporting by delegate to Health Alliance
- Annual oversight audit with appropriate follow-up for deficiencies
- Review and approval of delegates' pertinent program descriptions, policies and procedures

At present, Health Alliance does not delegate any other functions except Credentialing.

### **CONFIDENTIALITY AND CONFLICT OF INTEREST**

QI information is considered confidential and handled in accordance with Health Alliance confidentiality policies and procedures. Health Alliance employees and committee members sign a confidentiality and conflict of interest statement, as applicable, on an annual basis.

The organizational chart for the Quality and Medical Management Department that follows demonstrates the reporting relationships for quality improvement staff.