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I. VISION 2017

MercyCare Health Plans (MCHP) is a wholly owned subsidiary of Mercy Health System Corporation. The following is the vision 2017 statement of the Mercy Health System:

Quality – Excellence in Patient Care
- Demonstrate excellence in patient care using evidence based medicine, best practices and industry benchmarks to ensure continuous improvement
- Promote a culture of patient safety
- Foster an effective Corporate Compliance program
- Provide information systems and technology to support excellence in health care

Service – Exceptional Patient and Customer Satisfaction
- Provide exceptional patient services using customer satisfaction best practices and benchmarks to ensure patient-focused care
- Continually improve integrated programs and services based on patient need
- Provide educational programs and health initiatives to improve community health
- Improve community good with special concern for those most in need

Partnering – Best Place to work
- Cultivate high partner engagement and satisfaction by being a best place to work
- Recruit and retain board-certified physicians and other qualified partners
- Promote a safe and healthy work environment
- Encourage a culture of learning and continuous improvement

Cost – Long-Term Financial Success
- Continue growth initiatives and integration strategies
- Emphasize cost containment through efficient operations
- Promote accountable care strategies to meet the changing needs of patients and purchasers of healthcare services
- Enhance access to capital and achieve long-term financial success
MercyCare Health Plans
2016
Quality Improvement Program Description
for MercyCare HMO

MercyCare Health Plans seeks to apply the four principles of quality, service, partnering and cost to its business practice and internal culture in the following ways:

**Quality**

The Quality Program at MercyCare Health Plans is not limited to a distinct department but is an integral part of the work ethic of all partners at MercyCare Health Plans. We consistently apply the principles of continuous quality improvement (Plan, Do, Check, Act) to improve the quality of our services and communications. Annually, we participate in HEDIS® and CAHPS reporting and follow-up with initiatives designed to improve the care our members receive.

**Service**

The Quality Improvement Committee approved The Service Quality Commitment on September 12, 2001.

*Service Quality is the way of doing business within MercyCare. Every MercyCare partner is committed to the following:*

- Recognize that every partner within the company shares the responsibility for quality and quality improvement;
- Create an environment whereby both internal and external customer expectations are met or exceeded;
- To make incremental continuous improvements in every aspect of our work; and
- To respond to every customer complaint with effective corrective action and by annual review of patient perceived satisfaction ratings of CAHPS® data.

**Partnering**

We seek to achieve quality partnerships with physicians and other practitioners, providers, employees, vendors, drug companies and employers to achieve better health for our members.

**Cost**

We are extremely conscious of the need to maintain the affordability of health care for our members. We promote accountable and evidenced-based care practices with our network providers.
II. PURPOSE

This document describes the scope, structure and function of MercyCare Health Plans Quality Improvement Program for MercyCare Health Plans. The purpose of the Quality Improvement Program is to provide the operational structure and processes necessary to achieve the quality goals and objectives approved by MCHP’s Board of Directors.

III. AUTHORITY AND RESPONSIBILITY

The MercyCare Board of Directors holds the ultimate authority and accountability for the quality of care and service delivered to MCHP members and is the highest level of oversight for the Quality Management Program. The Board of Directors delegates responsibility for quality management oversight to MCHP Vice President and the Medical Director.

The Vice President is the de facto Chief Operating Officer of the health plan. The Vice President chairs the Quality Improvement Committee, which is the key quality committee of MercyCare Health Plans. The Quality Improvement Committee actively monitors quality program goals, activities and results.

The Medical Director of MercyCare Health Plans is responsible for development, implementation, direction and evaluation of quality improvement activities. The Medical Director is the manager of the Quality Health Management Department, which is responsible for the quality management, utilization review, case management and health management of the health plan membership. The Medical Director is responsible for ensuring compliance with accrediting standards and meeting contractual obligations for National Committee on Quality Assurance (NCQA) and Wisconsin Medicaid Program Quality Improvement Projects.

The Behavioral Health Medical Director reports to the Medical Director and sits on the Quality & Utilization Management Committee, Credentials, Peer Review, Pharmacy and Therapeutics Committee and chairs the Behavioral Health Quality Improvement Committee. The Behavioral Health Medical Director is responsible for clinical support and guidance regarding behavioral health care to the Quality Health Management Department staff and committees and conducts utilization management reviews for prior authorization, concurrent review and retrospective case reviews. The Behavioral Health Medical Director is the liaison for the behavioral health practitioner community and develops implements, directs and evaluates all behavioral health quality programs and activities.
IV. SCOPE

The scope of the Quality Improvement Program encompasses the assessment, monitoring and improvement of all aspects of care and service received by members, including the following:

- Care delivered in inpatient and outpatient settings at all acuity levels;
- Primary and specialty care, including care delivered by behavioral health practitioners, ancillary providers and other contracted practitioners; and
- Services delivered by other health plan vendors.

V. PROGRAM OBJECTIVES

The following are key objectives of the Quality Improvement Program:

- To conduct routine monitoring of members’ access to and availability of practitioner services.
- To identify several areas of clinical relevance to MCHP member population (for preventive and acute/chronic care), establish evidence-based practice guidelines, disseminate the guidelines and assess the degree to which members receive care consistent with those guidelines.
- To assess practitioner and member satisfaction with MCHP utilization & pharmacy management services including prior authorization, concurrent review and case management services.
- To identify chronic diseases that impact MCHP member population. To implement disease management programs and to monitor and improve the receipt of recommended services by these populations.
- To identify member with multiple medical conditions that could benefit from the assistance of a complex case manager and assigning them to complex case management.
- To design and maintain the quality structure and processes that support continuous quality improvement including identification of quality improvement opportunities, measurement, trending, analysis, intervention and re-measurement.
- To initiate quality improvement activities in clinical and service quality, which meet or exceed NCQA, ACA, State of Wisconsin quality standards.
- Tracking and trending of practice patterns to identify over and under utilization.
- Establish credentialing and related quality standards and ensure that all network practitioners and providers meet those qualifications.
- Serve members with complex health issues, either through Health Plan complex case management, through provider multispecialty clinic, or case management.
Monitor network organizations’ progress on safety & service goals and inform members of where such information is published and educate members regarding these measures.

- Ensure confidentiality of patient information and medical records.
- Ensure providers treat all members in a culturally sensitive manner and communicate in a language appropriate to the member. Educate MercyCare personnel to do so as well.

VI. ORGANIZATIONAL STRUCTURE

A. Committees

An organizational chart depicting the QI Committee structure is available in Appendix A.

MercyCare Health Plans physician committee participation information sheets can be found in Appendix B.

**Quality Improvement Committee (Quarterly)** is responsible for oversight of the quality management program, including care and service issues. Receives, reviews, and approves committee meeting minutes of all committees listed in appendix A. Reviews and approves quality monitors and performance on QI goals, identifies and approves major quality improvement initiatives for the organization and provides resources to support the improvement activities. The Committee monitors the care and service provided by contracted practitioners, providers and health plan staff and approves annual quality management work plans, evaluations and performance goals for quality indicators. This committee is responsible for problem identification and resolution strategies as revealed by quality monitoring activities and uses the following data sources to evaluate care and service: clinical measurement studies, member and practitioner satisfaction surveys, ambulatory medical record review, risk management reviews, utilization management reviews and complaint and grievance tracking and trending.

**Directors’ meeting (Weekly)** The Vice Presidents, Directors and Managers that comprise the QIC meet weekly to discuss health plan business. In the interim between QIC meetings, this meeting serves as the forum for the quality program of the health plan as the committee memberships are identical.

**QI Staff meeting (weekly)** meets with the medical director to discuss ongoing activities, current results and barriers and revised interventions. This committee tries to address all projects and activities with a “plan-do-check-act” process.

**Quality & Utilization Management Committee (Quarterly)** provides clinical expertise to the Quality Management Program and approves clinical care guidelines and health management programs. The Committee provides medical feedback on health management programs, improvement interventions and technology assessment.
activities. Profiles and evaluates patterns of use for inpatient and outpatient services, including pharmacy services.

**Behavioral Health Quality Improvement Committee (quarterly)** provides clinical expertise to the Quality Management Program in behavioral health. The Committee provides medical feedback on health management programs, improvement interventions and technology assessment activities. Profiles and evaluates patterns of use for inpatient and outpatient services, including pharmacy services. Is responsible for overseeing quality improvement activities in Behavioral Health.

**Credentialing Committee (Quarterly)** is responsible for the development and implementation of the credentialing policies and procedures and has the authority to approve or deny applicants and re-applicants. The Committee reviews performance and monitoring indicators at the time of re-credentialing.

**Peer Review Committee (As needed)** reviews cases of sub-standard care and sentinel events that need to be addressed and monitors corrective action plans. The Medical Director, if during the course of business or medical management activities an instance of possible sub-standard care or a patient safety issue is identified, refers cases to the committee for review and determination. The physicians on our Credentialing Committee also serve as our Peer Review Committee.

**Pharmacy & Therapeutics Committee (Quarterly)** constructs and maintains the plan’s formulary. Works with the plan’s pharmacy benefits manager (PBM) to maintain the pharmacy policies and procedures. Evaluates drugs for inclusion in the formulary and reviews medical literature in support of the efficacy and appropriate use of drugs.

**Appeals Committee (Weekly)** conducts the internal review of member appeals.

**Grievances Committee (Weekly)** gives members a fair grievance hearing when they have adverse decisions made by the Medical Director that have been upheld by the Appeals Committee.

**Benefit Interpretations Committee (As needed)** reviews and updates benefits stated in the plan policy and related documents including certificate, schedule of benefits, drug riders and member handbooks. This committee also provides interpretation of policy language.

**Privacy and Confidentiality Committee (As requested by the plan’s Chief Privacy Officer)** reviews and develops policies to document the privacy practices in place at the health plan, relative to the use, disclosure and storage of personally identifiable information. Responsible for implementation of HIPAA Privacy rule, education of staff on privacy policies, responds to reports of breaches in
confidentiality (complaints) and audits practices relative to the privacy policies. This committee is comprised of the privacy officer, Behavioral Health Medical Director and a staff member from each of the functional business areas.

Behavioral health committee (monthly) Key staff from our principle outpatient BH clinic and inpatient unit meet with our health plan staff to discuss concerns and improve the quality of care coordination for our members.

Disease Management Advisory Committees (Semi-Annually) review and discuss individual Disease Management Programs, these being our Diabetes, and Asthma programs. Each committee contains at least one physician advisor in addition to the Medical Director. Program content is discussed and feedback given to the Case Manager responsible for that program. Policies and procedures are presented, discussed and approved. Results are discussed and analyzed with an emphasis on barrier analysis and outcomes.

Complex Case Management Advisory Committee (Annually) reviews and discusses the Complex Case Management program and results. Program content is discussed and feedback given to the Case Manager responsible for that program. Policies and procedures are presented, discussed and approved. Results are discussed and analyzed with an emphasis on barrier analysis and outcomes.

B. Program Staff

A departmental organizational chart is provided as Appendix C.

All members of the Quality Health Management Department are included in the quality process to the greatest extent possible. Each staff member is accountable for the quality projects related to their area of responsibility.

Pharmacy Director (Registered Pharmacist) and Managed Care Pharmacist (2 FTEs)

- Pharmacy Director is a Registered Pharmacist and reports to the VP not the medical director.
- Responsible for overall formulary management, while promoting high quality medication prescribing practices on the part of our providers.
- Conducts and evaluates drug utilization review studies, troubleshooting claims processing issues and participates on therapeutic committees.
- Participated in evaluation of complex care management cases.
- Authors a variety of physician and patient-oriented materials and provides written drug information responses as required.
Business Analyst (1 FTE)
- Reports to the Director of IS & Compliance.
- Supports the Quality Health Management Department through data base development and reporting.
- Supports all quality activities through database management, data reporting, data analysis and presentations.
- Provides necessary computer analysis and report writing for HEDIS® data collection.
- Manages HEDIS® data collection; devise project timeline, coordinate data collection teams, analyze data and submit results to NCQA.
- Coordinates HEDIS® audit and prepares Baseline Assessment Tool.
- Supports web-based software used in health & wellness activities.

UR/CM Manager (1 FTE)
- CCM certified RN responsible for management of case management and utilization review personnel and process.
- Responsible for oversight of QI initiatives associated with programs under Case Managers, including:
  - Asthma disease management program and asthma HEDIS indicators.
  - Diabetes disease management program and diabetes HEDIS indicators.
  - Depression disease management program and depression HEDIS.
  - “Healthy Heart” program for cardiovascular risk factors of hypertension and hypercholesterolemia and related HEDIS indicators.
  - Complex case management program and related NCQA standards.

QI Specialists (2 FTE)
- Documents data obtained during all quality improvement activities consistent with company policies and procedures.
- Identifies member and provider barriers to health care access/services and recommends interventions for quality improvement.
- Analyzes several data sources, including HEDIS®, of assigned projects.
- Communicates significant issues or developments identified during quality improvement activities and provides recommended process improvements to management, providers and outside vendors.
- Prepares reports of quality improvement activities.

QI Data Analyst and Access programmer
- Supports access programming for both UM and QI while we await installation of EPIC tapestry in several years.
- Access programs this position is responsible for include UM letter writing software, UM reporting software, Complex and Disease management software, QI project databases and pharmacy prior authorization databases.
Assists in formulating requests for the business analyst as well as MHS epic programming reports.

**UR Team Lead (1 FTE)**
- Develops UR policies and procedures manages relationships between the UR department and both internal and external customers.
- Serves as a resource to the UR nurses for management of individual cases, facilitation of decision-making and communication content.
- Conduct concurrent and retrospective reviews for all MercyCare inpatient members and identify possible quality of care issues including coordination of care problems between medical and behavioral health providers.
- Review of outpatient service requests for benefit determination and provider appropriateness.
- Reviews UR nurses for accuracy and inter-rater reliability.

**Utilization Review Nurses (3 FTE)**
- Conduct concurrent and retrospective reviews for all MercyCare inpatient members and identify possible quality of care issues, including coordination of care problems between medical and behavioral health providers.
- Review of outpatient service requests for benefit determination and provider appropriateness.

**Case Management Coordinators (2 FTE)**
- Responsible for disease management of MercyCare Health Plans member populations.
- All case management activities are conducted or supervised by a Certified Case Manager (CCM).
- Responsible for coordinating and monitoring quality initiatives and reviews including but not limited to, focus studies, clinical guidelines and preventive health guidelines.
- Attends and contributes as required to health plan committees such as Quality Improvement Taskforce, specialized Disease Management Task Force committees and others as designated by the Medical Director.
- Hold quarterly meetings that include physician advisors other than our medical directors to provide clinical input into our disease management programs.
- Conduct periodic PHQ2 or PHQ9 and annual SF-12 surveys to document degree of program effectiveness.
Complex Case Management Coordinator (1 FTE)

- All case management activities are conducted or supervised by a Certified Case Manager (CCM).
- Enrolls and engages members into our complex case management program, when indicated, and has primary responsibility for appropriate evaluation, intervention, facilitation and follow up.
- Conduct periodic PHQ9 and SF-12 surveys to document degree of program effectiveness.
- Hold quarterly meeting that include physician advisors other than our medical directors to provide clinical input into our disease management programs.

Credentials Specialist (1 FTE)

- Integrated into the MHS credentialing department
- Obtains primary source verification necessary for credentialing.
- Coordinates all credentialing activities including implementation and maintenance of the credentialing database, provider files and provider directory.
- Coordinates the maintenance of department policies & procedures including review of their compliance with MCHP and NCQA Standards.
- Assists with the preparation of key documents that are required for NCQA accreditation including the internal work plan document.
- Collects quality information from a variety of sources for presentation to the Credential Committee for re-credentialing instances.

Quality Health Management Specialist Team Lead (1 FTE)

- This position serves as a resource to the other Quality Health Specialists (QHS).
- Monitors overall workflow for the QHS.
- Trains new staff.
- Serves as a resource to other departments.
- Initially reviews claims pended due to lack of authorization, customer service and provider inquiries

Quality Health Management Specialists (3 FTE)

- This staff provides the clerical and data entry support for utilization review, health management and quality improvement activities and service quality projects.
VII. QUALITY MANAGEMENT METHODS AND MONITORS

A. Methods

MHP’s quality management and improvement methods include a four-stage process for identifying and improving the quality of clinical care and service rendered by the plan and plan practitioners:

- Identification of monitors of important aspects of care and service (Plan)
- Implementation of interventions addressing the identified opportunities for improvement (Do)
- Identification of opportunities for improvement as a result of monitoring clinical care and service (Check)
- Re-measurement to determine if the interventions were effective in improving clinical care and service (Act).

B. Monitors

The categories of monitors for care and services are listed below:

1. **HEDIS®**: The health plan participates in HEDIS® reporting yearly.

2. **Clinical and Preventive Guidelines**:  
   - Cholesterol Management  
   - Hypertension  
   - Major Depression  
   - Post Partum Depression Screening Position Statement  
   - Diabetes Mellitus Care  
   - Asthma  
   - Tobacco Dependence  
   - Adult & Pediatric Preventive Health  
   - Attention Deficit/Hyperactivity Disorder

*Our preventive health guidelines are age-specific, describe the prevention or early detection interventions, are based upon scientific authority, or are developed with practitioners who have appropriate knowledge. Appropriate practitioners and new practitioners are notified when new or revised guidelines are adopted.

3. **Continuity and Coordination of Care Monitors**:  
   The small size of our health plan and our non-gatekeeping model allows the Medical Director to meet daily to conduct a full concurrent review with the Utilization Reviewers for evaluation of referral requests, prior authorizations, inpatient admissions and complex cases. Cases requiring complex case management or disease management, sentinel quality events and other possible quality problems are identified at this time.
Any coordination and continuity of care needs between specialists or medical and behavioral health specialists are identified and discussed for resolution. On a weekly basis, Complex Case Managers present difficult cases as do Disease Managers to the Medical Director and Behavioral Health Medical Director. At the same meeting particularly complex cases from UR are discussed for potential Case Management interventions.

4. **Member Satisfaction:**
   CAHPS® – data is obtained yearly by our vendor and is analyzed by the Quality Improvement and Quality Utilization Management Committees. Opportunities for improvements are pursued in accordance with our quality improvement process. Satisfaction of members participating in our disease management programs is surveyed and reviewed annually.

5. **Practitioner Satisfaction with UM Services:**
   Practitioners are surveyed annually to measure their satisfaction with the UM process. This data is reviewed, analyzed and opportunities for improvement identified by the QUM committee.

6. **Monitoring of Access and Availability:**
   MCHP ensures that the overall network availability of primary care and behavioral health care practitioners is sufficient based on total membership. MCHP's standards take into account the number and geographic distribution of primary care and specialty practitioners. Annually, an overall network composition summary is prepared using specialized software, GeoAccess®, that includes identification for special cultural needs, preferences or secondary languages requests that determine network adequacy.

VIII. **HEALTH MANAGEMENT PROGRAMS**

In addition to the quality improvement process described above, MCHP also employs several programs to manage the health status of enrollees with specific high-risk conditions or diseases. All our programs identify members through capture and review of laboratory values or ICD9 codes received on claims or pharmacy data. All are op-out programs based on intervention thresholds except for our depression program, which must be opt-in to be compliant with Wisconsin law. The following disease management programs are operational during this program year:

**Asthma Health Management Program:** This program includes members with a diagnosis of Asthma and under poor control as identified by pharmacy or medical encounter claims. The goal of the program is to increase the delivery of optimal treatment to members by network practitioners as defined by the NHLBI Asthma
Guideline. This includes promotion of increased use of inhaled corticosteroids in members with persistent asthma and the use of a written Asthma Action Plan & Peak Flow Meter. Case management is focused on those members who are stratified as having suboptimal control due to having had emergency room visits, inpatient hospitalizations, over utilization of “rescue” medications and under-utilization of preferred treatment.

**Diabetes Health Management Program**: This program is for all MCHP members who have been diagnosed with Type I or Type II diabetes. The goal of the program is to increase HgbA1c awareness, decrease HgbA1c levels, increase the frequency of foot exams and retinal eye exams, monitor for nephropathy, improve blood pressure control, improve LDL-C screening and LDL-C below 100. Educational activities include targeted mailings for members and practitioners. Patients who have had HgbA1c $\geq 8.5$ are placed in case management. These members are in our program until both HgbA1c and LDL are at goal. Education and interventions to these members are provided telephonically, in addition to the targeted mailings received by members with diabetes.

**Complex Case Management Program**: Identification of patients needing more intensive case management interventions to improve their health and avoid catastrophic events and costs. Members’ physical and mental health status are assessed with SF-12 and PHQ-9 testing when entered and re-assessed for objective improvement when graduated.

IX. **BEHAVIORAL HEALTH SERVICES**

- MCHP promotes standards of care for the primary care of several behavioral health conditions and monitors coordination of care between medical and behavioral health care.
- Inpatient psychiatric discharge summaries sent to the Primary Care Physicians. MCHP monitors the percentage of mental health discharge summaries, which are received by Primary Care Physicians. Results are shared with Inpatient Mangers. Barriers are discussed and addressed.
- Appropriate screening, diagnosis, treatment and referral of depression in the primary care setting. A guideline has been developed and distributed and compliance with guideline standards is monitored through HEDIS® measures and drug utilization reports. The PHQ-9 is promoted as a screening tool for primary care physicians and for obstetricians during the pre-partum and post-partum periods.
- Concurrent Medical Problems are reviewed by the Utilization Review Nurse on all psychiatric admissions. Attending physicians are notified if a referral for medical consultation seems warranted after discussion with the Medical Director. We follow a similar procedure with medical admissions with attention to the need for behavioral health follow up when transitioning to new care settings.
A preventive guideline has been developed on identifying and treating postpartum depression in all outpatient settings.

An ADHD guideline has been developed for primary care practitioners and will again be promoted with our physicians.

A joined depression-diabetes project, which ensures that diabetic case management members are screened for depression annually.

X. PATIENT SAFETY MONITORS AND ACTIVITIES

- Patient education regarding published safety and quality reporting. In the state of Wisconsin, the hospital association collects and publishes self-reported quality and safety data at [www.wicheckpoint.org](http://www.wicheckpoint.org). All of our network hospitals participate in this collaborative project. Our website directs members interested to wicheckpoint.org and elsewhere and link this site to our website. Similar education regarding Wisconsin Collaborative for HealthCare Quality..
- Educate members on their right and responsibilities, importance of knowing how to communicate with their physicians and availability of additional quality and safety resources.
- Clinical site reviews of new sites for safety issues and follow up site reviews in response to member complaints.
- Monitoring polypharmacy. Continue to prior authorize or have quantity limits on certain medications to insure safe prescribing practices.
- Surveying the continuity and coordination of care between PCPs, specialists and behavioral health practitioners and encouraging better communications.
- Determining if members diagnosed with asthma, diabetes, hypertension, ADHD, and depression are received appropriate care through HEDIS reporting and case management programs for asthma and diabetes.
- Monitoring complaint and member’s satisfaction data to determine if any adverse trends in patient safety exist.

XI. CONFIDENTIALITY AND CONFLICT OF INTEREST

Member and practitioner information is confidential and MercyCare Health Plans is compliant with the HIPAA privacy rule standards and State of Wisconsin rules. Some of the physical safeguards employed to ensure confidentiality include: Locked cabinets for member and practitioner files, controlled access to the building, secured access to computer drives and systems where information is stored. Some of the privacy practices in place include: Deployment of a “minimum necessary” standard; whereby employees have access to only that personally identifiable information, which is required to perform their job functions; yearly education of all staff in privacy policies and procedures; signing of a confidentiality agreement; implementation of appropriate authorization to release member information per HIPAA and State or Wisconsin statutes; provision of Notice of Privacy Practices to both members and practitioners; de-identification, when necessary, of information disclosed outside the health plan. The QIC is responsible, via the Privacy and
Confidentiality Committee: To develop and implement MercyCare Health Plans privacy policies and procedures.

To avoid conflicts of interest, no person may participate in the review, evaluation or disposition of any quality utilization management case in which she/he has been professionally or personally involved.

XII. ANNUAL CYCLES OF THE QUALITY PROGRAM DESCRIPTION, PROGRAM EVALUATION AND WORK PLAN

The Medical Director presents the annual Quality Improvement Evaluation, the next year’s Quality Program Description and Work Plan to the Board of Directors for review and approval during the 4th quarter of the calendar year after HEDIS® and Quality Compass® results are available. Physician input is obtained through the QUM Committee and individual program advisory committees.

XIII. APPROVALS:

_________________________________________  _________________
Dave Syverson  
Board of Directors, Chair  

_________________________________________  _________________
E. Patrick Cranley  
Vice President  

_________________________________________  _________________
Philip S. Bedrossian, MD  
MercyCare Medical Director