

**MercyCare Insurance Company**  
**2009**  
**Quality Improvement Program Description**  
**for MercyCare HMO**

I. MISSION

MercyCare Insurance Company (MCIC) is a wholly owned subsidiary of Mercy Health System Corporation. The Mercy Health System has had a Culture of Excellence Program for over ten years. The following are the mission and vision-2012 statements of the Mercy Health System.

*MISSION*

*The mission of Mercy Health System is to provide exceptional healthcare services resulting in healing in the broadest sense.*

*VISION*

*Quality – Excellence in Patient Care*

- *Demonstrate excellence in patient care using best practice 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 through measured customer satisfaction*
- *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 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*
- *Foster a learning organization*

*Cost – Long – Term Financial Success*

- *Continue growth initiatives and integration strategies*
- *Emphasize cost containment through efficient operations*
- *Enhance access to capital*
- *Achieve long-term financial success*

MercyCare Insurance Company 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 Insurance Company is not limited to a distinct department but is an integral part of the work ethic of all partners at MercyCare

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Insurance Company. 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. The cost consequences to our members of our actions is always a consideration in our decision making process.

II. PURPOSE

This document describes the scope, structure, and function of MercyCare Insurance Company Quality Improvement Program for MercyCare Insurance Company. The purpose of the Quality Improvement Program is to provide the operational structure and processes necessary to achieve the goals and objectives approved by MCIC'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 MCIC members, and is the highest level of oversight for the Quality Management Program. The Board of Directors delegates

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responsibility for quality management oversight to MCIC Vice President and Medical Director.

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

The Medical Director of MercyCare Insurance Company 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, health management, and credentialing activities of the health plan including ensuring compliance with accrediting standards and meeting contractual obligations for National Committee on Quality Assurance (NCQA) and Wisconsin Quality Improvement Medicaid Program 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 and Behavioral Health Advisory 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 MCIC 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.

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- To assess practitioner and member satisfaction with MCIC utilization & pharmacy management services including prior authorization, concurrent review, and case management services.
- To identify chronic diseases that impact MCIC member population. To implement disease management programs and to monitor and improve the receipt of recommended services by these populations.
- 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, GM, and the 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.
- Address patient safety issues through identification and review of sentinel events and sub-standard care and require corrective action from providers involved.
- Monitor network organizations' progress on safety goals and inform members of where such information is published and educate members regarding these measures.
- Ensure confidentiality of patient information and medical records.

#### VI. ORGANIZATIONAL STRUCTURE

##### A. Committees:

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

MercyCare Insurance Company 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. The Committee uses the following data sources to evaluate care and service: clinical measurement studies, member and practitioner satisfaction surveys, ambulatory medical record

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review, hospital safety data, utilization management reviews, and complaint and grievance tracking and trending.

**Quality & Utilization Management Committee (quarterly)** provides clinical expertise to the Quality Management Program and approves clinical care guidelines, 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.

**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, monitoring indicators at the time of re-credentialing.

**Peer Review Committee (at least annually and more frequently if requested by the Medical Director)** 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 (monthly)** reviews and updates of 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 (at least annually and if 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.

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**Behavioral Health Quality Improvement Committee (monthly)** reviews behavioral health policies and practices with the goal of providing quality behavioral healthcare to our members. The committee monitors progress of quality projects. Maintains and updates the behavioral health work plan. Responsible for analyzing behavioral health data, identifying opportunities for improvement, analyzing barriers to care, implementing interventions, and measuring the effectiveness for the interventions.

**Behavioral Health Advisory Committee (annually)** brings our behavioral health specialists together with a panel of primary care physicians to improve the quality of care our members receive. At this committee, we obtain behavioral health colleagues input, opinions, ideas and suggestions regarding our quality improvement projects. The committee helps to determine our quality improvement priorities and interventions related to behavioral health.

**Quality Improvement Taskforce Committee (as needed)** is internal committee consisting of many members of the staff that provides input on clinical quality projects and policies and procedures as requested by our Medical Director.

**Women and Childhood Health Initiatives Taskforce Committee (quarterly)** addresses projects involving women and children's preventative care.

**Disease Management Advisory Committees (quarterly)** review and discuss individual Disease Management Programs, these being our Diabetes, Asthma, Depression, and Healthy Heart [cardiovascular risk factors] 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.

**B. Program Staff**

A departmental organizational chart is provided as Attachment 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.

**Pharmacist (1 FTE):**

- 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.
- Authors a variety of physician and patient-oriented materials and provide written drug information responses as required.

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**Business Analyst (1 FTE):**

- Reports to the Director of IS & Operations
- 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 prepare Baseline Assessment Tool (BAT).
- Supports web based software used in health & wellness activities. (Ex HRA)

**UR/CM Team Leader (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

**Quality and Health Initiatives Team Leader (1 FTE- currently an open position)**

- Assists the Medical Director with the development of quality improvement activities, supports program design, implementation and execution.
- Supports committee analysis of quality improvement initiatives.
- Responsible for the design of clinical and service quality improvement studies. Ensures that studies conform to regulatory body specifications. Devises strategies for data collection and analysis.
- Supports service quality studies as needed.
- This position is responsible for organizing and supervising activities that focus on the health and wellness of MercyCare Insurance Company (MCIC) including HRA screening fairs.
- This position is responsible for providing leadership in quality improvement activities of MCIC related to health maintenance, health screening, and periodical physical exams and other areas except those QI initiatives that are not associated with an active Disease Management Program including:
  - Women’s and children’s health initiatives
  - Colorectal screening.

**QI Specialist (2 FTE)**

- Documents data obtained during all quality improvement activities, consistent with company policies and procedures.
- Identifies member and providers’ barriers to health care access/services and recommends interventions for quality improvement.

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- 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.

#### **Senior UR Review Coordinator (2 FTE)**

- Assists CM/UR Team Leader in developing policies and procedures and in management or relationships with external customers.
- Serves as a resource to less senior 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
- Enrolls and engages members into our complex case management program when indicated and has primary responsibility for appropriate intervention, facilitation and follow up.

#### **Utilization Review Nurses (2 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 Coordinator(s) (3 FTE including one Case Manager with a Behavioral Health background):**

- Responsible for disease management of MercyCare Insurance Company member populations
- 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.
- 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 intervention, facilitation and follow up.

#### **Credentials Specialist (1 FTE):**

- Obtains primary source verification necessary for credentialing.
- Coordinates all credentialing activities including implementation and maintenance of the credentialing database, provider files, and provider directory.

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- Coordinates the maintenance of department policies & procedures including review of their compliance with MCIC 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.

#### Provider Relations Representative – (1 FTE):

- Reports to Director of Sales, Marketing, and Contracting
- Representative visit practitioner offices for dispensing pertinent MCIC administrative and clinical information regarding updates and changes.
- Responsible for monitoring of practitioner appointment access and availability in accordance with MCIC policies and NCQA standards.
- Conducts provider site visits.
- Participate in practitioner appeals and policy needs, as well as field any peripheral practitioner/clinic manager concerns or complaints.
- Work with customer service in helping to resolve member complaints regarding MCIC participating practitioners.
- Participate in quality improvement task forces and committees.
- Participate in some chart reviews related to medical and behavioral health quality improvement activities.

#### Quality Health Management Specialists (4 FTE)

- This staff provides the clerical and data entry support for utilization review, health management and quality improvement activities and service quality projects.

#### Statistical Consultant (PRN):

- Dr John Hanson MD, previous Medical Director of Group Health Cooperative in Madison WI is consulted when needed for 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, and (**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

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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
  - Major Depression
  - Post Partum Depression Screening
  - Essential Diabetes Mellitus Care
  - Asthma
  - Tobacco Dependence
  - Adult & Pediatric Preventive Health
  - Management of Alcohol Withdrawal
  - Screening for Alcohol Dependence.

\*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. New/updated preventive health guidelines are distributed to appropriate practitioners.

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. Case 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.
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 Quality Improvement and QUM
6. **Monitoring of access and availability:**

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MCIC ensures that the overall network availability of primary care and behavioral health care practitioners is sufficient based on total membership. MCIC'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.

7. **Medical Record Documentation:**

MCIC reviews and promotes medical record documentation standards including communication, documentation and continuity of treatment and coordination of care. A medical record improvement project is conducted annually

VIII. HEALTH MANAGEMENT PROGRAMS

In addition to the quality improvement process described above, MCIC 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 opt-out programs based on intervention thresholds except for our depression program which must be opt-in due 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 sub optimal control due to having had emergency room visits, inpatient hospitalizations, over-utilization of “rescue” medications, and under-utilization of preferred treatment.
- Diabetic Health Management Program. This program is for all MCIC members who have been diagnosed with Type I or Type II diabetes. The goal of the program is to increase HgbA<sub>1c</sub> awareness, decrease HgbA<sub>1c</sub> levels and increase the frequency of foot exams and retinal eye exams. Educational activities include targeted mailings for members and

practitioners. Patients who have had HgbA<sub>1c</sub> > or = to 8.5 are placed in case management. These members are in our program until both HgbA<sub>1c</sub> 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.

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- Health Heart Management Program, Last year we created a cardiovascular risk management program that addresses members with poorly controlled hypertension and/or hyperlipidemia. We are currently initiating a full disease management program on these newly identified populations.
- Depression Case Management Program- This program is for all adult members 18 years and older identified with major depressive disorder resulting in a hospitalization or identified from “new starts” pharmacy data. Proactive coordination of care, including screening, patient self-management, clinician education, treatment guidelines, treatment coordination and clinician availability are core elements for the Depression Disease Case Management Program.
- Complex Case Management Program- We have developed this program in early 2008 and will continue to increase the 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

- MCIC 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. MCIC monitors the percentage of mental health discharge summaries, which are received by Primary Care Physicians. Results are shared with Inpatient Managers. 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.
- Substance Abuse Detoxification Project. We review the care of patients admitted for detoxification to medical facilities to ensure appropriate AODA assessment and detoxification schedules, and coordination of care with behavioral health practitioners.
- 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.

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

**X. PATIENT SAFETY MONITORS AND ACTIVITIES**

- We will expand 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 [checkpoint.org](http://checkpoint.org) and elsewhere and link this site to our website.
- We will encourage all of our hospitals to participate in leapfrog and other national and regional quality initiatives.
- Monitoring sentinel/adverse events occurring in inpatient settings.
- Medical record audits for and follow-up of substandard documentation practices.
- Clinical site reviews of new sites for safety issues and follow up site reviews in response to any member complaints.
- Monitoring polypharmacy.
- We will encourage physicians to report any instances of generic medications failing to perform as expected to the FDA MedWatch program.
- Surveying the continuity and coordination of care between PCPs, specialists and behavioral health practitioners and encouraging better communications.
- Determining if members diagnosed with asthma and diabetes, hypertension, ADHD, hypercholesterolemia and depression are received appropriate care according to medical care guidelines and promoting care in keeping with the latest standards.
- 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 Insurance Company is compliant with the HIPAA privacy rule standards and State of WI. 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 Insurance Company privacy policies and procedures.

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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 Description and work plan to the Board of Directors for review and approval during the 4<sup>th</sup> quarter of the calendar year after HEDIS® and Quality Compass® results are available. These documents are also reviewed and approved by the Quality Utilization Management Committee and the Quality Improvement Committee.

**XIII. APPROVALS:**

	Date
Stephen VanGalder Board of Directors, Chair	
	Date
Joseph D. Nemeth Vice President & COO	
	Date
Philip S. Bedrossian, MD MercyCare Medical Director	