

**2011 QUALITY IMPROVEMENT PROGRAM DESCRIPTION
MEDICAL ASSOCIATES HEALTH PLAN
DUBUQUE, IA
AND
MEDICAL ASSOCIATES CLINIC HEALTH PLAN OF WISCONSIN**

AUTHORITY

Medical Associates Health Plan, Inc. and Medical Associates Clinic Health Plan of Wisconsin, (collectively doing business as Medical Associates Health Plans and hereafter referred to as MAHP) have entered into contractual relationships or services agreements to make provision for medical and hospital services to enrollees. Medical Associates Health Plan, Inc. is licensed to do business as a health maintenance organization in the states of Iowa and Illinois and Medical Associates Clinic Health Plan of Wisconsin, is licensed to do business as a health maintenance organization in the state of Wisconsin.

Medical Associates Clinic (sole shareholder of Medical Associates Health Plan, Inc. and sole Service Agreement participant with Medical Associates Clinic Health Plan of Wisconsin, and hereafter referred to as Clinic) has agreed to establish standards and procedures to assure the quality of health care rendered to MAHP enrollees as well as quality MAHP services to enrollees, employers, physicians and other health care practitioners, at the request of the Board of Directors of Medical Associates Health Plan, Inc. and Medical Associates Clinic Health Plan of Wisconsin. The Quality Improvement Committee (QIC), under the direction of the Clinic Board of Directors, is responsible for carrying out these requirements. The members of the Committee are responsible to the Clinic Board of Directors. Members are appointed on a rotating basis so that a portion of the membership remains each year to assure the continuity of the quality improvement process.

PURPOSE

The purpose of the MAHP's QIC is to optimize the delivery of safe quality patient/enrollee care and MAHP services within available resources. The program is designed to provide a continual monitoring of the quality improvement process and services provided by the Clinic/MAHP, satellites, participating health care practitioners, participating hospitals, skilled nursing facilities, home health care agencies, and rehabilitation centers which directly contribute to the preservation and improvement of the quality of patient care. The program provides for the objective assessment of important aspects of patient care, safety and MAHP service, the correction of identified problems, and the continual monitoring to assure the success of the Continuous Quality Improvement (CQI) process. The following are items specifically monitored:

1. Optimum achievable patient outcomes
2. Patient and family understanding and satisfaction
3. Patient Safety
4. Cost effectiveness
5. Reasonable documentation
6. Over- and/or under-utilization of services
7. MAHP Claims processing and payment, membership services, case management, hospital utilization review, marketing, contracting & finance
8. Provider credentialing/recredentialing
9. Trends of clinical and service monitors
10. Incidence of acceptable/unacceptable complications

Serving a culturally and linguistically diverse membership is not a current challenge for MAHP. According to the Consumer Assessments of Healthcare Providers and Systems (CAHPS) survey results from 2007 thru 2010, only 1% of those surveyed indicated that they were of Hispanic or Latino origin while 99% of the respondents indicated that they were Caucasian. In order to assist members who do not speak English MAHP can make available a resource listing of names of individuals who speak various foreign languages. Interpret-Talk is a language line that the health plan can also utilize if the need arises.

Comment and direction will be provided as determined pertinent through those QIC activities described elsewhere in the Program Description.

GOVERNING BODY

By MAHP Board of Directors' resolution the duties of the Quality Improvement Program of MAHP are assigned to the Clinic. The governing body of the Clinic is the Board of Directors. This Board assumes ultimate responsibility for establishing, maintaining, and supporting the Quality Improvement Program of MAHP.

SCOPE

The QIC has the authority to establish continuous monitoring activities for all quality improvement activities including quality of care, quality of service and patient safety issues at the Clinic, its satellite locations, all MAHP participating practitioner offices, and recommend correction of identified problems. Monitoring will also include MAHP issues such as quality consistency and accordance to UM decisions, Credentialing, Contracting and other functions of the MAHP delivery system, including but not limited to: ambulatory care, inpatient, extended care, and mental health. (Ref: Health Care Service Policies and Procedures # 76 & # 77) See "Duties of the QIC" listed on pages 3 – 5. Upon request, MAHP makes available to its members and practitioners information about the QI program. (Program Description, Work plan, audit results, and progress of goals).

MEMBERSHIP

Membership of the QIC is designed to be broadly representative of the specialty (including Behavioral Health Practitioner, who is directly involved in the aspect of behavioral health care) and primary care departments of the Clinic, MAHP, satellites and participating MAHP physicians, and will total 9 physicians, including the Chairperson. There will also be physician representation of the MAHP Network, Family Care Network and MAHP of Wisconsin. Other physician & non-physician personnel are invited to participate when agenda items concerning specific areas of study involving their functions are discussed.

The Chief Medical Officer of the Clinic and Health Plan is appointed by the Clinic Board and serves as the Chairperson of the committee. The Clinic Board appoints members for three-year terms with one-third of the membership rotating each year. Members may be reappointed for consecutive terms. Members will be expected to attend 75% of the meetings. Excused absences (defined as a member giving advance notice of his/her inability to attend a scheduled meeting) will count as "present" when computing the 75% attendance minimum. Members not meeting this minimum attendance requirement may be subject to replacement as determined by the Chairperson.

Staff representatives from the MAHP include the Chief Medical Officer, MAHP Executive Director, Director of Operations, Director of Health Care Services, Health Care Services/Quality Improvement

Manager (HCS/QI), Quality Improvement Coordinator and Quality Improvement Nurse Auditor. Representatives from the Clinic include the Manager of Health Information Services, Director of Primary and/or Specialty Care, Clinic Quality Report Coordinator and the Risk Manager. The QIC meets at least nine times annually or more frequently if necessary, on the third Tuesday of the month. The committee has a blended format of clinic and health plan business. Health Plan business is covered in the months of January, March, May, July, September and November. Clinic business is covered in the months of February, April, June, August, October and December. Only Physician members may vote on matters concerning medical judgment.

The Chairperson is also responsible for coordinating all QIC activities, including developing, implementing, educating practitioners, and monitoring the outcome of all QIC actions. All QIC activities will be communicated by the Chairperson or his designee to the Clinic Board of Directors.

The Chief Medical Officer is responsible for auditing quality and utilization of services and in general, assuring that efficiently and appropriately rendered services are available to all MAHP enrollees. The Chief Medical Officer will manage and direct such named activities of the MAHP and be responsible as described in the Job Description of Chief Medical Officer. The QIC will serve as the forum for discussing, planning, educating providers/members of quality and utilization issues, and monitoring such activities as auditing credentialing/recredentialing, patient complaints, and member/practitioner satisfaction surveys. Other MAHP staff responsible to the QIC for MAHP-related Quality Improvement activities, functioning under the direction of the Chief Medical Officer include: Director of Health Care Services, Manager Health Care Services/Quality Improvement and staff, the Director of Operations, the Director of Finance and staff, the Marketing Manager and staff, the Credentialing Coordinator, the Manager of Claims, the Manager and staff of the Patient Services Department, the Member Services staff and the Information Systems staff.

DUTIES OF THE QIC

- Identify and appraise all present activities of the Clinic, its satellites and all MAHP participating practitioner offices concerned with quality of care & service, under the direction of the Clinic Board of Directors.
- Establish audits on all aspects of the MAHP's health care delivery system, including but not limited to ambulatory care, inpatient and long term care, and mental health.
- Promote the development of practitioner clinical practice guidelines, including but not limited to Preventive Health Services, referencing clinically valid criteria, to communicate established guidelines to all MAHP participating practitioners and members, and to monitor compliance to established guidelines.
- Receive and evaluate reports for patient safety concerns conducted by such committees as Safety/Infection Control, Utilization Management, Pharmacy & Therapeutics, Credentialing (Site Visits), and provide recommendations to Clinic Board of Directors as indicated.
- Receive and evaluate reports of all quality improvement activities being conducted by such committees as Safety/Infection Control, Utilization Management, Pharmacy and Therapeutics, Credentialing (Site Visits) and provide recommendations to the Clinic Board of Directors as indicated.
- Report at least quarterly to the Clinic Board of Directors the progress on all quality improvement activities. The Chief Medical Officer reports the Quality Improvement activities to the governing Board of the MAHP at least quarterly.

- Identify problems and set priority for their investigation, including causes, extent, responsibility, previous remedial action, corrective action plan, and continued monitoring.
- Identify clinical indicators based upon demographic and epidemiological characteristics of MAHP membership, and focus future quality improvement monitoring and health promotion measures based upon these indicators.
- Monitor the quality of services provided by MAHP services such as Claims Processing, Member Services, Case Management, Utilization Review & Marketing.
- Provide an educational process for practitioners and/or staff resulting from the findings of the QIC.
- Review of patient complaints, appeals and grievances. MAHP Departments will follow policy and procedure in processing these complaints, appeals and/or grievances. Any identified patterns of concern, and provide recommendations to QIC and the Clinic Board of Directors as indicated.
- Conduct periodic assessment of patient, employer, and provider satisfaction through random surveying, identify problems to be addressed, and provide recommendations to the Clinic Board of Directors as indicated. Areas to be assessed include access to care, availability of services, claims payment, case management, hospital and other utilization review, provider network, etc.
- Informational to QIC, the practice performance and review of the credentials of all participating practitioners once every three years.
- Informational to QIC, the credentials of all health delivery organizations once every three years.
- Respond to the recommendations made by all external review organizations, including the Iowa Foundation for Medical Care, Illinois Department of Public Health, and the Accreditation Agency.
- Appraise annually, the Quality Improvement Program. The reappraisal conducted by the QIC and Clinic Board of Directors should identify components of the program that need to be instituted for the upcoming year, altered or deleted. Resultant recommendations, when instituted, should assure that the program is continuous, comprehensive, and effective in improving patient care/practitioner performance and MAHP/Clinic services, and conducted with cost-efficiency.

QUALITY IMPROVEMENT MINUTES

The Quality Improvement minutes will reflect all committee decisions, discussions and actions. Minutes will be produced and distributed prior to the appropriate meeting (Health Plans or Clinic agenda). Minutes are signed and dated by the person recording them. The chairman of the committee will sign and date the minutes after approval by the Quality Improvement Committee.

PATIENT SAFETY

Patient Safety will be monitored through the following data collection measures and/or interventions:

- MAHP will collaborate with Mercy (Primary Hospital utilized), annually assessing maintenance of Magnet status and will provide requested reports regarding patient safety and quality. This Magnet certification is reserved for those hospitals that meet the highest standards of quality for their nursing services and is indicative of clinical excellence for the organization as a whole. In the event Mercy does not maintain their Magnet status, other patient safety items will be monitored.
- Site visit results from initial credentialing of practitioners and organizations are reviewed to monitor and enforce patient safety. Any issues identified will be discussed at the Credentialing meeting where an action plan will be prepared; the safety concern will be presented with the action plan to the Board of Directors for approval.
- Potential Quality Issues are tracked and trended to identify any safety issues that may influence or impact patient safety. If an issue is identified, it is presented to the QIC for review and potential action plan.

- Discharge Summaries from hospital admissions being adequate to meet the needs of the primary care providers. Adequate Discharge Summaries will increase continuity and coordination of care; increase patient safety and quality of care when transferred from hospital to another care facility or to outpatient physician.
- MAHP will inform practitioners and members of patient safety and quality care through identification of practitioners participating in the ADA/NCQA Diabetic Recognition Program and the AHA/NCQA Heart Stroke Recognition Program through newsletters and the provider directory.

BEHAVIORAL HEALTH CARE

MAHP has established policies and procedures to ensure access to medical care for members needing behavioral health care and to establish standards for access. A Behavioral Health Practitioner is a member of the QIC. QIC focuses on improving Behavioral Health care through monitoring of HEDIS measures, auditing of member access and exchange of information to ensure continuity and coordination of care between referring and treating practitioners.

COLLABORATIVE PROJECTS

MAHP is determining ways to expand upon the collaborative activities between a members' primary care practitioner and MAHP's Disease Management and Complex Case Management programs. The goal is to increase the exchange of information between the health plan and the primary care practitioner and to enhance the continuity and coordination of care for the member.

MAHP currently collaborates with MAC on several projects. One is the Wellness Committee, which involves numerous department employees in creating and educating employees on health and fitness. Another program is the Diabetes program. MAHP has a disease management and complex case management programs that interface with the Clinic. Education programs are presented to members with the assistance of the Disease Management and Complex Case Management staff, Diabetic Educators, Dietician, etc. Thirdly, MAC and Mercy developed a Disease Management Program on Congestive Heart Failure.

RECORDKEEPING

The confidential nature of QI materials will be respected. Minutes, reports, and communications of the QIC will be recorded and filed; such files will be available to the QIC, as well as External Review Organizations and Accrediting Agencies, or other required entities as business demands.

QUALITY ASSURANCE PROCESS

The Quality Assurance Process consists of problem identification, problem prioritizing, problem solution, problem follow-up, and continued problem monitoring.

A. Problem Identification

A number of systems exist in the Clinic/MAHP, which function as sources for problem identification data for the QIC. These sources include, but are not limited to QIC members, subcommittee findings, MAHP practitioners, supervisors' meetings, administrative staff, patient, employer and practitioner satisfaction studies, demographic and epidemiological characteristics, data collection, member complaints trending reports, risk management, UR case manager findings, and UR statistics.

B. Problem Prioritization

It is the responsibility of the QIC to review all of the data and document any significant problems requiring attention. Quality indicators that are objective, measurable, and important to the MAHP's quality of care and/or service are selected. The QIC prioritizes problems to assure the most important problems are dealt with on a timely basis. The QIC approves the quality indicators selected, study design, QI data collection tool and the performance goal or benchmark for every Continuous Quality Improvement (CQI) activity.

C. Problem Solution

The QIC may recommend solutions to the problems and develop corrective action plans upon approval of the Clinic Board of Directors. These action plans include acceptable benchmarks, goals to be achieved, and time frames for continual monitoring.

D. Problem Follow-Up

The QIC will have the responsibility to make certain that solutions are generated for problems that are identified and that the problems are resolved.

E. Problem Monitoring

The QIC has the responsibility to monitor advancement towards established goals.

SUB-COMMITTEE ACTIVITY REPORTING

It is the responsibility of the QIC to objectively assess the activities of the following sub-committees as it relates to the entire Continuous Quality Assurance Process of the Clinic/MAHP and make recommendations to the Clinic Board of Directors.

The following sub-committees are responsible for reporting activities and recommendations to the QIC:

1. Utilization Management Committee

Chaired by: Chief Medical Officer of Medical Associates Clinic and Health Plan who is appointed by the clinic board.

Members: MAHP practitioners selected by the Chief Medical Officer. Membership including the Chief Medical Officer and at least six other practitioners representing various specialties, appointed and re-appointed by the CMO based upon plan need for areas of focus, provider specialty, willingness to serve and understanding of managed care principles. Must be Health Plan Provider. MAHP staff includes the Director of Health Care Services and the Manager of Health Care Services/Quality Improvement.

Purpose: This Committee, which originated in July of 1989, meets every other month for the purposes of providing a monitoring system to assure that services are delivered to MAHP enrollees at the appropriate level of care and is cost efficient; continually reassessing and improving the quality of care and resource allocation within the organization; utilizing studies of patterns of utilization for improved patient care and practitioner continuing education; and evaluating advancing medical technologies to determine future MAHP coverage.

Pharmacy and Therapeutics Committee reports to the Utilization Management Committee and is chaired by a Medical Associates Clinic physician selected by Chief Medical Officer. MAHP staff

includes Director of Health Care Services, Manager of Health Care Services/Quality Improvement and Designated Case Managers. Members include MAHP practitioners and retail pharmacists selected by the Chief Medical Officer. Membership includes 8 practitioners, retail network pharmacists and Chief Medical Officer. The committee meets at least quarterly to develop, monitor and maintain a prescription drug formulary addressing the health care needs of plan members in a cost effective manner while ensuring quality of care. The Pharmacy and Therapeutics Committee is responsible for monitoring quality and utilization issues related to the formulary developed.

3. *Safety Committee*

Chaired by: An HR Generalist, approved by the Chief Executive Officer of the Clinic.

Members: Director of Clinical Services and other Clinic staff selected by the Chairperson.

Purpose: This Committee, which originated in February 1987, meets quarterly for the purposes of addressing environmental safety issues of Clinic employees and patients, not limited to work-related injuries, OSHA requirements, disaster drills/reporting.

4. *Infection Control Committee*

Chaired by: An Infectious Disease Specialist, selected by the Chief Executive Officer of the Clinic.

Members: Representatives from several Clinical departments selected by the Chairperson.

Purpose: This Committee, which originated in July of 1989, meets quarterly for the purpose of addressing OSHA mandated requirements for infection control, such as the Bloodborne Pathogen Standard. The committee addresses the prevention and control of infectious disease in the work environment.

5. *Credentialing Committee* **The Credentialing Committee reports directly to the Clinic BOD with activities and recommendations. Credentialing/Recredentialing updates are brought to QIC as informational only.**

Chaired by: Chief Medical Officer of Medical Associates Clinic and Health Plan, who is appointed by the clinic board.

Members: Active membership consists of the Chief Medical Officer of Medical Associates Clinic, P.C. and Medical Associates Health Plans, four other participating physicians of different specialties, a participating mid-level practitioner, MAC Risk Manager and representatives from MAHP that include: the Chief Medical Officer, the Director of Operations, the Provider Relations Coordinator, Credentialing Coordinator and the Quality Improvement Coordinator.

In addition, a board-certified practitioner of a same or similar specialty as the Practitioner under review will peer review the credentialing/recredentialing file of each Practitioner. Their comments are made available to Committee members and considered when making decisions regarding recommendation for appointment and reappointment. Peer reviewers will be available at the Committee's discretion. Only physicians and the mid-level practitioner will be allowed to vote on

issues of a medical or credentialing/recredentialing nature.

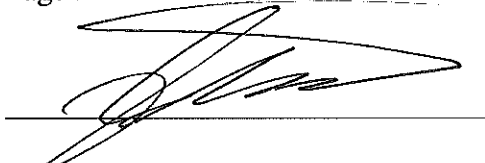
The Chief Medical Officer serves as the Chairperson and is directly responsible for the credentialing program. As specified in established credentialing policies and procedures, he/she is assisted by members of the committee in carrying out the program's agenda and in decision-making. The Medical Associates Clinic, P.C. shareholders appoints the four physicians of different specialties to serve staggered terms of no more than three years. The Medical Associates Clinic, P.C. Board of Directors appoints a mid-level practitioner to serve staggered terms of no more than three years. Members may be reappointed for consecutive terms.

Purpose: This Committee, which originated in September of 1996, meets at least every other month for the purpose of assuring and maintaining a MAHP network of appropriately credentialed and recredentialled practitioners and Health Delivery Organizations. Initial credentialing and triennial recredentialing is accomplished through a peer review process of established standards that reviews education and training; board certification, licensure; malpractice coverage and claims history; physical and mental health status; limitation, sanctions or disciplinary actions taken by various medical organizations; as well as quality of care practitioner performance.

Prior to going thru the initial credentialing process practitioners are reviewed by the Medical Associates Health Plan Management Committee. This committee is chaired by the Executive Director of MAHP and consists of the administrative directors of MAHP and the Chief Medical Officer. The committee is responsible for reviewing, approving or denying requests from practitioners who would like to become MAHP providers.

EVALUATION OF THE QUALITY IMPROVEMENT PROGRAM

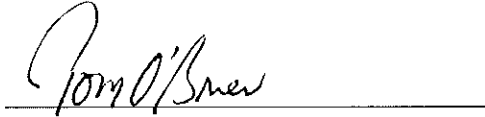
- A. The QIC will annually reassess, amend, and approve the Quality Improvement Program Description and Work Plan.
- B. Participating practitioners and staff will be requested to provide annual comments and suggestions relative to the Quality Improvement program in the first quarter of every year. These suggestions will be taken into consideration by the QIC in its annual assessment of the program.
- C. The QIC will review a summary of the quality improvement activities that include quality and safety of clinical care and services for the year. The summary will list the problem areas identified, the assessment techniques used, the results or impact on patient care and clinical performance, and time frames for continued monitoring. This problem list including action plans can be amended as needed throughout the year.
- D. Trending of measures to assess the performance in quality and safety of clinical care and quality of service will be completed through analysis of this information, any deficiencies, inadequacies or trends in the quality and safety of care provided will be identified and addressed, including barrier analysis.
- E. Changes in policies, authority, and communication techniques will be made as deemed appropriate.
- F. Evaluation of the overall effectiveness, including progression towards influencing network-wide safe clinical practices.
- G. Results of this evaluation, as well as the plan of action for the upcoming year developed by the Committee Chairman, will be summarized and reported to the MAHP and Clinic Board of Directors.



John Tallent
Chief Executive Officer
Medical Associates Clinic & Health Plans

3/22/11

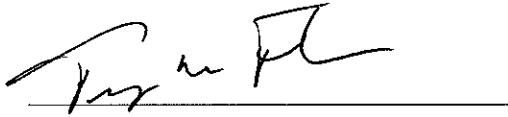
Date



Tom O'Brien
Executive Director
Medical Associates Clinic and Health Plan

3/22/11

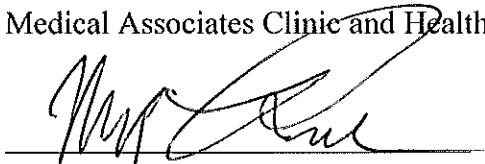
Date



Terry M. Flander, DO, MPH, MHA
Chief Medical Officer
Medical Associates Clinic and Health Plan

3/22/11

Date



Mark P. Runde, MD
President
Medical Associates Clinic

3/22/11

Date

Approved:..... February 1989
 Revised: August 1989
 Approved: May 2, 1990
 Reviewed and Approved with no Revisions:..... November 1990
 Reviewed and Approved with no Revisions:.....February 11, 1992
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