QUALITY IMPROVEMENT PROGRAM

QI PROGRAM PURPOSE

The Physicians Plus Quality Improvement Program is member-centric. It is designed to deliver safe and effective medical and behavioral healthcare, at the right time in the right place, with efficiency and equitability. The QI Program is rooted in our mission statement: “Collaborate with clients to maximize the value of healthcare solutions”, and is our guiding principle in serving over 64,000 covered lives.

The Quality Improvement Program’s consistent application of QI methods, tools, and interventions continuously improve the level of care and services provided. The QI Program will act on opportunities to improve the coordination of medical and behavioral healthcare to reduce potential safety risks and increase member satisfiers, as well as address members’ cultural and linguistic needs to reduce health disparity. The QI Program promotes a robust and collaborative work effort with network providers and practitioners to provide effective and valuable healthcare for our membership. The QI Program is assessed continually, and reported on annually within the QI Work Plan Evaluation. It includes a comprehensive review of all QI activities and an evaluation of its impact on the membership we serve.

QI PROGRAM SCOPE AND OBJECTIVES

The Quality Improvement Program intends to identify, evaluate, and ultimately improve the quality of medical and behavioral healthcare and services across all settings throughout our network. Areas of focus will include:

- Quality of Clinical Care
- Continuity and Coordination of Medical Care
- Safety of Clinical Care and Services
- Clinical Practice Guidelines
- Preventative Health Guidelines
- Utilization Management
- Complex Care Management
- Disease Management
- Quality of Services for Members
- Members’ Access to Care and Services
- Quality of Behavioral Health Clinical Care
- Quality of Behavioral Health Services
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- Continuity and Coordination Between Medical Care and Behavioral Healthcare
- Practitioner Experience
- Member Experience

The attached 2017 QI Plan includes the targeted QI initiatives, measureable objectives, completion timeframes, and responsible department tied to each area of focus.

QI OBJECTIVES

The quality program is aligned with the corporate mission, vision, values and critical success factors. Annually, specific goals are set based on Physicians Plus Business Plan, HEDIS-CAHPS results, and performance on the previous year’s goals. While the initiatives and targets may vary from year-to-year, the objectives remain consistent.

The following seven objectives are the driving themes for annual quality program operations as they relate to quality of care, quality of service and member (patient) safety.

**Objective 1:** To ensure Physicians Plus members have access to a network of available providers who meet, or exceed, defined standards of education and experience. Physicians Plus monitors and measures this objective through its annual access and availability survey process and its credentialing process. This objective is met when performance meets or exceeds Physicians Plus’ established goals. If goals are not met, Physicians Plus takes action to address identified opportunities for improvement.

**Objective 2:** To ensure a consistent, positive experience for our membership in their interactions with the functions, systems and processes of Physicians Plus. Physicians Plus conducts member surveys and service quality audits to monitor and measure member satisfaction, complaints and grievances, e-mail response time and phone communications, the accuracy of online benefit information, web-site usability, and member understanding of health plan information. This objective is met when performance meets or exceeds Physicians Plus’ established goals. If goals are not met, Physicians Plus takes action to address identified opportunities for improvement.

**Objective 3:** To identify and improve health care, health status and health functions which are important to the members of Physicians Plus, and to ensure the highest levels of patient safety. This objective is met through Physicians Plus’ disease management, disease-specific case management, complex case management, pharmacy management, medical management, patient safety and health promotion and wellness programs.
Objective 4: To ensure that services are delivered in an efficient and value-added means to our members, providers, partners and stakeholders. This objective is met through medical management activities, along with clinical and service quality monitors and interventions.

Objective 5: To identify opportunities and improve services important to providers. This objective is met through Physicians Plus’ annual provider survey, along with feedback received through the call center and by provider network management liaisons.

Objective 6: To collaborate with partners and stakeholders to measurably improve the performance of the provider network and the health care services provided to members. This objective is met through interventions aimed at improving Physicians Plus’ annual HEDIS rates, through Clinical Quality Incentive Programs (CQIP) with key provider networks.

Objective 7: To measurably improve the overall business functioning of the corporation in terms of value delivered to the customer, stakeholder and supplier. The goal is improved performance in the following areas:

- Business Results
- Leadership
- Strategic Planning
- Customer and Market Focus
- Information and Analysis
- Human Resource and Development
- Process Management

This objective is met through Physicians Plus’ annual strategic and business planning process, which includes development of a comprehensive business plan, reporting of dashboard results, and an employee incentive program. This objective is also met through the annual evaluation of Physicians Plus’ Quality Management and Utilization Management programs.

CLINICAL QUALITY MONITORS AND ACTIVITIES include targeted measures on:

- Behavioral health services
- Patient safety
- Health promotion and disease prevention
- Acute and chronic care, including adherence to clinical practice guidelines
Quality Improvement Section

- Continuity and coordination of care
- Under- and over-utilization of services
- Complaint and grievance data
- Return on Investment (ROI) analysis
- Satisfaction with disease management and complex case management programs
- Access and availability to health plan services and medical and behavioral health care services

PATIENT SAFETY MONITORS AND ACTIVITIES identify potential clinical care issues via:

- Concurrent review conducted by Physicians Plus’ registered nurses and through ongoing communications with discharge planners at network hospitals.
- Reviewing and responding to quality of care complaints and patient safety concerns in accordance with Physicians Plus’ established processes. Physicians Plus monitors for adverse events. Established processes allow for identification, investigation and evaluation as to the severity of the event. Issues determined to be severe in nature are immediately reviewed by the Medical Director, and forwarded to the Peer Review Committee when deemed necessary.
- Providing follow-up with members through complex case management and disease management programs to ensure that care is received in a timely manner.
- Addressing opportunities for improvement in continuity and coordination of medical care and between medical and behavioral health care.
- Monitoring new clinical sites for safety issues through facility review audits.
- Monitoring dosage and duration of prescribing habits for selected high-risk conditions via pharmacist reviews of members in case management.
- Collaborating with our Pharmacy Benefit Manager (PBM) to monitor member prescriptions for possible contraindications.
- Supporting Meriter Hospital’s patient safety activities via the annual Clinical Quality Incentive Program.
Behavioral Health Services Monitors and Activities direct collaboration between Physicians Plus and network practitioners to ensure the on-going coordination of medical and behavioral healthcare and services.

- A practicing psychiatrist and the UW Behavioral Health Program Director, MSSW, act as the designated practitioners responsible for advising and supporting the behavioral health aspects of the Quality Improvement and Utilization Management Programs for Physicians Plus.
- Physicians Plus delegates behavioral health utilization management for commercial members to UW Behavioral Health (UWBH). UWBH, a network provider partner, identifies and monitors treatment of behavioral health issues. Outreach to members and providers is regularly conducted.
- Journey Mental Health is Physicians’ Plus behavioral health provider for BadgerCare members.
- Under- and over-utilization of behavioral health services is monitored annually. Rates of key services are analyzed for appropriate use of services. Deviation from normal use rates is analyzed and may be the basis for a future continuous quality improvement projects.
- Physicians Plus completes an annual survey of BH practitioners, primary care providers, and members who have received behavioral health resources. Survey results are reviewed and analyzed, and action plans are created to correct any concerns or deficiencies.
- Access and availability of behavioral health care practitioners is monitored on an annual basis through member satisfaction and appointment availability surveys, and through network composition analysis.
- Member complaints related to access and availability are monitored on a quarterly basis. Any network deficits are addressed through corrective action plans with targeted efforts made to expand behavioral health access and availability throughout the network.

Physicians’ Plus works collaboratively with UW BH to improve continuity and coordination of care between medical practitioners and providers and BH practitioners and providers. Physicians Plus will send outreach letters to members of new start antidepressant medications and also will assess the number of children who had two or more antipsychotic prescriptions and whether they have received a blood glucose or A1c test and a LDL or cholesterol test. Behavioral health clinical practice guidelines are approved, implemented and distributed to all participating practitioners.
Performance against at least two important aspects of care is monitored annually.

Physicians Plus complex case managers and disease management nurses perform the PHQ-9 an initial assessment of behavioral health status, including cognitive functions and coordinate appropriate care. WellPlus program includes wellness tools and resources for member wellness from prevention to chronic condition management. Members will be sent a letter encouraging them to participate in an online wellness workshop titled Depression.

**SERVICE QUALITY MONITORS AND ACTIVITIES** ensure Physicians Plus’ members receive superior service, every time. Service quality monitors and activities include:

- Assessing member feedback via member complaint and grievance (appeals) data as part of the annual member satisfaction analysis.
- Assessing member satisfaction via annual CAHPS survey results as part of the annual member satisfaction analysis.
- Auditing the quality (consistency, courtesy, accuracy and thoroughness) of information that member service staff provide to members via e-mail and telephone. In addition, e-mail turnaround response time is audited against a one-business-day standard.
- Auditing the quality and accuracy of pharmacy benefit information provided via the Formulary, RxEOB, ePocrates and Web content. In addition, audits are conducted on Pharmacy Assistant phone calls.
- Auditing the quality and accuracy of benefit information provided to members via Physicians Plus’ MyChart member portal.
- Conducting usability testing of the online Physician and Provider Directory.
- Assessing new member understanding of health plan procedures via calls received by member service and an annual analysis conducted by the Director of Member Services.
- Auditing operations outputs including, but not limited to, claims, billing and enrollment, referral authorizations, benefits configuration, contracts configuration and provider setup.
- Implementing an internal audit function to systematically oversee high-risk business processes and evaluate those processes to identify opportunities for improvement. Recommendations are presented to the Finance Department, ELT and the BOD’s Finance and Audit Committee.
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REPORTING QUALITY & SATISFACTION RESULTS

Quality & Satisfaction results measures and reports quality results on an annual basis using the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by more than 90 percent of America’s health plans to measure performance on important aspects of care and service. In addition, Physicians Plus assesses member satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey is a comprehensive survey that asks members to evaluate the care that they receive and the relationship that they have with their physician. Physicians Plus’ HEDIS and CAHPS results total 50% of our NCQA accreditation scoring.

HEALTH IMPROVEMENT PROGRAMS

Physicians Plus offers several proactive programs aimed at managing the health status of members who are at-risk for, or who have been diagnosed with, specific chronic conditions or diseases. The following disease management programs are offered to members who meet eligibility criteria:

- Diabetes Management Program
- Heart and Vascular Disease Program

Members of these programs are screened for alcohol and tobacco use, and for depression. Self-management education is a key component of these programs and program materials are made available to program members via the mail (upon request), as e-mail attachments and via the Physicians Plus website.

Program interventions include:
- Self-management education
- Care reminders
- Case management
- Medication management
- Provider profiling
- Incentives
- Remote disease monitoring
- System-wide improvement efforts within provider network and community

In addition to these chronic condition management programs, Physicians Plus offers its members 24/7 access to My Healthy Choices, an on-line personal health management suite of services available to members ages
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18 and older. This innovative offering includes a comprehensive health risk assessment, individualized action plan for health status improvement, and lifestyle and condition management programs.

CLINICAL PRACTICE GUIDELINES

Evidence-based clinical practice guidelines are developed and implemented in collaboration with Physicians Plus’ provider network, and include the input of clinical professionals in the community with expertise in the defined area.

• Guidelines are reviewed, and revised as needed, at least every two years.
• Physicians Plus’ Quality & Utilization Management (QUM) Committee is responsible for reviewing and approving new and revised guidelines.
• New guideline alerts are included in the provider newsletter. Provider Network Management Liaisons provide clinic managers with summary documentation of new programs and relevant guidelines.
• Physicians Plus bases clinical decision making on evidence-based clinical practice guidelines that determine the right care in the right place at the right time.

QI PROGRAM AUTHORITY AND RESPONSIBILITY

Organizational Overview

Physicians Plus is a provider-owned, for profit, regional managed health care organization based in Madison, Wisconsin. Physicians Plus is a Chapter 611 Stock Insurance Corporation, licensed and regulated by the Wisconsin Office of the Commissioner of Insurance (OCI). Physicians Plus is owned by UnityPoint Health, a multi-state health system based in Des Moines, IA. Physicians Plus operates as a Primary Care Provider (PCP) model HMO, requiring members in its HMO and POS plans to choose a PCP to coordinate their care. Physicians Plus contracts with approximately 4,900 providers and 28 hospitals in 21 counties in the State of Wisconsin, primarily located in south-central Wisconsin. The practitioner panel includes the full spectrum of office practices including large multi-specialty groups, as well as large independent and rural practitioners.
OVERSIGHT AND ACCOUNTABILITY

Board of Directors (BOD)
The Physicians Plus’ Board of Directors (BOD) holds the ultimate authority and accountability for the quality of care and services delivered to members, and provides the highest level of oversight for the quality improvement program. To this end, the BOD annually reviews and approves the Quality Improvement Program Description, QI Work Plan, and QI Program Evaluation. The BOD then delegates responsibility for Quality Improvement oversight and adoption of quality improvement processes to the Chief Operating Officer (COO) and Medical Director.

Chief Operating Officer (COO)
The COO is accountable to the BOD for the quality of medical and behavioral healthcare and services delivered to Physicians Plus’ members, and for the strategic quality planning and provision of needed resources for quality management processes and activities.

Medical Director
As the designated physician, the Medical Director provides leadership in the development, implementation and evaluation of QI programs and processes. He too, is a designate of the BOD in assuring quality medical and behavioral healthcare to the membership. The Medical Director serves as the Chair for the QI lead committee, Quality and Utilization Management Committee (QUM). He is responsible for overseeing the activities of QUM and other sub-committees within the quality structure:
- Credentialing Committee
- Peer Review Committee
- Pharmacy & Therapeutics (P&T) Committee
- Grievance Committee
- Medical Policy Committee
- Service Quality Committee

Executive Leadership Team (MELT)
The MELT membership includes the COO, Medical Director, and all executive leaders within Physicians Plus. The MELT shapes the organization’s strategic direction and priorities, helps facilitate the development and execution of QI projects and initiatives that support that strategic direction, and provides additional oversight for QI work activities. Physicians Plus believes every employee is responsible to team accountability and action in carrying out quality efforts on behalf of our membership. The MELT is instrumental in the promotion and application of quality improvement principles, and incentivizes employees’ quality
work activities throughout the organization.

**Vice President of Managed Care & Finance**

The VP of Finance and Managed Care communicates the strategic and collaborative plans for quality improvement to the Quality Team. The VP then oversees the day-to-day operations that support all QI activities to ensure successful and timely implementation of the QI Work Plan.

**Quality Excellence Department**

Physicians Plus recognizes the importance of ongoing quality improvement initiatives, it established the Quality Excellence Department in 2016. The Quality Excellence Department assists in establishing, communicating, implementing, and achieving targeted quality initiatives to continually improve care for all members. It also provides company-wide leadership in maintaining NCQA accreditation. NCQA is the nationally recognized quality assessment tool bound to clinical performance (HEDIS) and consumer experience (CAHPS). Physicians Plus commits to attaining excellence in its accreditation status for national recognition within a competitive market. The Quality Excellence Department offers education and support around analysis, reporting, and accountability within all implemented standards of NCQA. The Quality Excellence Department answers directly to the VP of Finance and Managed Care.

**Structure of Quality Committees**

Quality Improvement activities are managed through the oversight and input of eight (8) standing committees:

1. **Quality and Utilization Management Committee (QUM):** The QUM is the official quality committee of the Board of Directors of Physicians Plus. The purpose of QUM is outlined in the Corporation Bylaws Article 2, Section 2.19:
   - (QUM will) advise the Board on activities of Physicians Plus that are designed to monitor and improve the quality of care and efficiency of the delivery system.
   - Review and report to the Board of Directors of Physician Plus on quality and utilization management activities, including, but not limited to, quality assurance assessment plans, key policy decisions for quality, and key performance indicators and criteria.
   - Perform related duties as may be conferred or authorized by the Board of Directors, provided that such duties are delegable duties of the Board of Directors. The QUM Committee shall also include no less than two members who are on the Board of Directors.

More specifically, QUM will continually offer the BOD recommendations on strategy and policy regarding medical management, clinical quality.
improvement and provider relations; recommend approval for evidence-based guidelines and clinical policies; provide direction for clinical quality and utilization management projects, programs and monitoring activities; offer targeted analysis, evaluation, and needed action on QI and UM programs and processes; facilitates practitioner participation in the QI activities through attendance and discussion on relevant QI committees and sub-committees; serves as a sounding board and catalyst for quality innovation, research and system improvements.

QUM also approves new delegation agreements and provides oversight of existing delegation agreements; reviews Credentialing Committee recommendations; and annually approves the QI Program Description, QI Work Plan and QI Annual Evaluation, presenting them then to the BOD for ratification.

The Board of Directors appointed physician, the Medical Director, serves as the chairperson of QUM. The Chair creates the agenda, facilitates the meeting, ensures meeting discussion and decisions are recorded, and then those minutes are committee-approved, and attends other quality sub-committees. Membership of QUM also includes Physicians Plus administrative staff including the Manager of Quality Excellence, the Manager of Care Management, the Clinical Engagement Program Manager, the Manager of Contracting, the HEDIS & CAHPS Administrator, two BOD representatives, a designated behavioral health practitioner(s), practicing Psychiatrist, and representation of network providers. The QUM Committee must meet at least eight times per year. Meetings are scheduled to meet every month; however, a meeting may be cancelled if there are no agenda items. Additional meetings may be scheduled as needed. Agendas and meeting materials, along with minutes of the previous meeting are distributed in advance of each meeting. QUM also receives and approves meeting minutes and reports from the P&T, Credentialing, Grievance, Medical Policy and Service Quality Committees.

2. Credentialing Committee:

- The Credentialing Committee ensures a consistent, non-discriminatory process for the initial credentialing and re-credentialing of practitioners.
- It provides ongoing monitoring, reduction and/or suspension of privileges, and disciplinary actions and termination when indicated.
- The Credentialing Committee is also responsible for the approval and oversight of credentialing delegates, the appeal process, and the reporting to authorities as needed.

Specifically, the Credentialing Committee reviews and approves credentialing and panel participation criteria, and policies and procedures; approves delegation of credentialing activities and
oversees development and execution of delegation agreements; reviews credentialing and re-credentialing files, ongoing monitoring information, makes decisions as to panel participation, and then sends decisions to QUM for confirmation; and oversees facility-related credentialing activities, such as facility reviews and facility/organizational assessments, as needed.

The Credentialing Committee reports to the QUM Committee. A practicing practitioner serves as Chair of the Credentialing Committee. Membership includes Physicians Plus Credentialing and Provider Network Management staff (non-voting) the Medical Director, Vice President of Managed Care and Contracting, no less than one board of director representatives, designated Behavioral Health, Chiropractic, and Dental Consultants serve as consultants to the Committee practitioner(s), practicing PCPs, participating specialists and Ad hoc specialist consultants. The chairperson’s role is to create the agenda, facilitate the meeting, approve minutes. The Credentialing Committee is required to meet at least 8 times per year. Meetings are scheduled monthly; however, if there are no agenda items a meeting may be cancelled. Agendas are distributed in advance of each meeting. Minutes are distributed and reviewed at the meeting and are approved by the Medical Director.

3. Peer Review Committee:
- The Peer Review Committee is responsible for, but not limited to, reviewing potential quality of care issues identified through member complaints, credentialing/re-credentialing on-going monitoring activities, quality assurance reviews, utilization management, or by network management activities.

- The Medical Director reviews any Quality of Care issues as received through the complaint process.

The Peer Review Committee reports to the Board of Directors. A board-appointed practicing physician serves as Chair. Membership includes Physicians Plus Provider Relations Supervisor, Manager of Contracting, Medical Director, Vice President of Finance and Managed Care, and no less than one board of director representative. A designated behavioral health representative, chiropractic representative, and dental representative serve as consultants to the committee. Practitioner(s), practicing PCPs, participating specialists, and ad hoc specialist consultants chosen by the medical director, complete the make-up of this committee. The Peer Review Committee meets as needed. Issue summaries are distributed prior to the meeting. Peer Review Committee minutes are approved by the Medical Director.
4. Pharmacy & Therapeutics Committee (P&T)

- P&T provides oversight, coordination and direction for all aspects of the Physicians Plus Pharmacy Management Program.
- P&T encourages quality improvement and therapeutically appropriate, cost effective, formulary utilization.
- P&T develops and performs an annual review of the Physicians Plus Drug Formulary and pharmacy management policies and procedures. Specifically, P&T develops the criteria used to adopt pharmaceutical management procedures using evidence from appropriate external organizations. P&T annually and after updates, communicates to members and prescribing practitioners, a list of pharmaceuticals including restrictions and preferences; information on how to use the pharmaceutical management procedures; an explanation of limits and quotas; information practitioners must provide when making a request for an exception; and the process for generic substitutions, therapeutic interchange and step therapy protocols.
- P&T reviews new medications by evaluating efficacy, comparative trials against existing agents, safety, drug interactions, adverse effects, pharmacokinetics, and cost-effectiveness. P&T conducts and recommends drug prior authorization criteria to promote clinically appropriate and cost effective use, and considers drug plan benefit designs during drug reviews. P&T monitors drug utilization and prescribing patterns, new clinical developments, drug safety bulletins and new drug technologies. P&T also provides advice in Drug Utilization Review, assessment of physician prescribing patterns or clinical step development functions, and oversees formulary and pharmaceutical management communications to providers.
- The P&T Committee reports to QUM. A practicing practitioner serves as chair of the P&T Committee. Membership includes the acting chairperson, a practicing practitioner, practicing family medicine practitioner, practicing internal medicine practitioner, practicing specialist, a pharmacy representative of one or more participating provider physician organizations, Meriter Hospital Pharmacy Representative, Physicians Plus Medical Director or VP of Health Services, Director of Pharmacy Services, and Ad Hoc Specialists (non-voting). P&T meets quarterly. Agendas and review materials are distributed via a portal in advance. Minutes are included in the packet and reviewed at the meetings.

5. Grievance

- The Grievance Committee provides oversight, coordination, and direction for Physicians Plus appeals and complaints.
- The Grievance Committee oversees appropriate resolution of appeals and complaints.
The Grievance Committee is responsible for objectively and impartially reviewing any submitted member dissatisfaction. Committee reviews are made in the context of the existing Medical Certificate of Coverage, Summary of Benefits, Medical Policies, Administrative Procedures, and applicable regulations and laws. The Committee ensures timely decisions and communication with enrollees and/or their representatives, and operates in compliance with statutory regulations and standards (§ 632.83, Ins. 18), and NCQA standards. The Grievance Committee has the responsibility, when appropriate, to make formal recommendations to Physicians Plus on suggested changes to benefits, the Medical Certificate of Coverage, Summary of Benefits, Medical Policies and Administrative Procedures. The Committee also has the responsibility to make recommendations to the QUM Committee regarding quality improvements for Physicians Plus. In addition, the Grievance Committee reports to department directors/managers regarding specific department and/or employee concerns, and the need for additional training to ensure quality standards are maintained. Membership includes Physicians Plus Director of Member Services, Clinical Engagement Program Manager, VP of Operations, Medical Director, VP of Finance and Managed Care, Appeals Administrator, Compliance Officer, practicing physicians within the community, and ad hoc attendance of BadgerCare Director, Counsel of Boardman Law Firm, practicing specialists related to the grievance in question. The Grievance Committee meets every 3 weeks throughout the year, and as needed for expedited grievances.

6. Medical Policy Committees (MPC)

- The Medical Policy Committee (MPC) provides oversight, coordination, and direction for all aspects of the Physicians Plus medical policies
- MPC advises the development, maintenance, updating, and approval of all Physicians Plus medical guidelines and criteria
- MPC conducts and reviews research related to new technologies and new applications for existing technologies.
- MPC monitors indications for coverage and advises on benefits for new medical and behavioral healthcare technologies

The MPC acts to improve the quality of medical and behavioral healthcare with the cost-effective utilization of therapeutically appropriate new technologies through on-going monitoring of clinical trials and potential consequences, government requirements and regulations, medical literature, and the current opinion of specialists and professionals. MPC considers safety, efficacy, complications, cost, and appropriate use when developing policies and reviewing new technologies and new uses for existing technologies. Policies are reviewed by the Benefits and Policy (B&P) Committee for consideration as a benefit under each line of
business. MPC decisions regarding technologies and policies are presented to the Quality & Utilization Management (QUM) Committee for final approval. Membership includes Physicians Plus administrative staff, VP of Health Services, Manager of Care Management, designated primary care practitioners and practicing specialists, Behavioral Health Practitioner (ad hoc), and other practicing clinicians as designated. The Medical Policy Committee meets monthly, as needed, throughout the year.

7. **Service Quality Committee (SQC):** The Service Quality Committee helps facilitate service quality initiatives through dissemination of surveys, analyses of results, and provision of quality improvement recommendations based on:
   - Annual CAHPS satisfaction survey (as part of the annual Member Satisfaction analysis)
   - Member complaints and grievances (appeals) (as part of the annual Member Satisfaction analysis)
   - Member Services email and phone audits
   - Member Services email turnaround response time
   - Pharmacy benefit information audits
   - Pharmacy Assistant phone audits
   - Online benefit information audits
   - Online Physician and Provider Directory usability audits
   - New member understanding of health plan procedures analysis

The Service Quality Committee reports to the Quality & Utilization Management (QUM) Committee. Membership includes Physicians Plus administrative staff, Manager of Quality Excellence, HEDIS & CAHPS Administrator, Director of Claims, Director of Member and Provider Services, Compliance and Privacy Officer, Manager of Provider Relations, Provider Network Management Liaison, and Pharmacy Operations Supervisor. The Service Quality Committee meets at quarterly throughout the year.

8. **Behavioral Health Committee (BHC):** The BHC will be inaugurated in January 2017, and will focus quality efforts within the coordination of medical and behavioral healthcare services. The BHC will be chaired by a psychiatrist or psychologist, and is a sub-committee of QUM.

Membership of BHC will include licensed behavioral healthcare professionals from the network.

This committee will review all HEDIS measures and behavioral health reports to better identify barriers. Action plans will be implemented to drive effective coordination of medical and behavioral healthcare. The 2017 targeted behavioral health QI activities include:
   - Outreach to members on anti-depressants
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- Follow-up with hospitalized SPMI members to ensure outpatient care
- ADHD
- Communication between BH and medical practitioners
- AODA

SERVING A CULTURALLY AND LINGUISTICALLY DIVERSE MEMBERSHIP

It is our goal to eliminate health disparities with our dedicated provision of culturally and linguistically appropriate care for our membership. Physicians Plus proactively identifies the needs of members with cultural and linguistic preferences, and uses culturally competent communications, tools, materials, and services to meet the needs of a diverse membership. Physicians Plus provides all employees with access to over-the-phone language interpretation resources via subscription to Language Line Services. Language Line Services allows staff to immediately access a pool of interpreters fluent in over 170 languages. Language Line Services operates 24 hours a day, allowing Physicians Plus staff to access an interpreter in real time whenever the need arises.

If a member with limited English proficiency comes to Physicians Plus in person, staff can accommodate the member by phone-conferencing with an interpreter in a private meeting room. When a member contacts Physicians Plus and requests translator services, Physicians Plus will contact the contracted language interpreter service. This allows the member to effectively communicate about his benefits and policy coverage. Translator/interpreter services are provided at no cost to the member. A variety of Physicians Plus print and website communications materials are available in English and Spanish. Physicians Plus' Spanish site is available at [http://www.pplusic.com/home/espanol](http://www.pplusic.com/home/espanol). In addition, Physicians Plus will prepare a specific piece(s) of information in the language requested at no cost to the employer group, provider, or broker/agent. Physicians Plus annually analyzes the cultural, ethnic, racial and linguistic needs of its membership by conducting a quantitative and qualitative assessment of needs in Dane County. If any language population (Spanish, Hmong etc.) increases to 10% or greater (5% or 1000 county residents for Dane County), Physicians Plus provides vital written documents in the identified language. As appropriate, Physicians Plus uses data to improve network access and availability to better meet the cultural needs of underserved groups.
CONFIDENTIALITY AND CONFLICT OF INTEREST

The security of Protected Health Information (PHI) is mandated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes a set of federal regulations regarding privacy, confidentiality and security of member information. Any organization with patient/member information must prevent improper access to electronically stored records or the interception of electronic transmissions containing confidential information.

HIPAA and Wisconsin law direct how PHI can be used and disclosed, and provide enhanced privacy rights to Physicians Plus members. Physicians Plus also has policies and procedures that ensure compliance with HIPAA and Wisconsin’s privacy requirements. Every employee, committee member, intern, or other associate is committed to safeguard the privacy of PHI in accordance with these regulations. Information security is vitally important not only to managing our business but also to our members, owners and business partners. Physicians Plus has
To further its security program, Physicians Plus HIPAA Privacy and Security policies ensure encryption when sending PHI or any other proprietary data outside the organization through the Internet. Physicians Plus has also placed role based restrictions on our data systems that contain PHI. Employees are only given access to member information as needed to perform specific job duties. To ensure member and provider confidentiality, medical records and information are kept in a locked environment away from public access. Access to personal member or provider information and QI monitoring results are provided on a need-to-know basis only, unless otherwise required by law. Members routinely execute a release of information form at the time of enrollment, allowing Physicians Plus to provide data to outside parties under specific circumstances. Only de-identified member data are provided outside Physicians Plus. Physicians Plus’ Compliance and Privacy Officer is responsible for the development and implementation of corporate confidentiality policies and procedures. All employees, committee members, and consultants must sign a confidentiality statement at the time of employment or committee appointment. No person may participate in the review, evaluation or disposition of any quality or UM case in which (s)he has been professionally or personally involved or where his or her judgment might otherwise be compromised. Physicians Plus will not allow a physician to review a case in which (s)he has provided care, in which (s)he may have a financial interest, or in which (s)he was involved in making the initial coverage determination. Physicians Plus employees and
Board members are required to adhere to Physicians Plus’ Conflict of Interest policies and procedures, and sign a Conflict of Interest form on an annual basis. Physicians Plus requires that all employees who make UM decisions annually sign an affirmation statement, as published in member and practitioner/provider materials. It affirms:

- UM decision making is based on coverage, and appropriateness of care and service.
- The organization does not reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
CASE MANAGEMENT

Case management is a systematic, problem-solving process designed to provide cost-effective care and access to resources to improve or maintain the quality and continuity of services for members. Case Managers (Licensed Practical Nurses, Registered Nurses and Social Workers) assist in activities to provide a comprehensive, coordinated continuum of care for members.

The purpose of complex case management is to provide personalized services to members with multiple or complex conditions to obtain coordinated access to care and services. Eligible members are identified through the following methods:

- routine utilization management functions
- hospital data
- claims or encounter data
- the health information line
- pharmacy data
- hospital discharge planners
- other internal departments
- providers and members

Case Managers monitor and facilitate the member's care by communicating with the member, member's family and significant others and providers to develop an individualized case management plan including long and short-term goals. Physicians Plus’ clinical management software system assists with recording and tracking compliance to the case management plan and access to necessary services.

The disease management programs including case management for diabetes and heart and vascular disease, are designed to assist at-risk members in achieving their optimal level of health by encouraging self-management skills, facilitating access to available services, and strengthening the patient-provider relationship. The following components are defined and documented for each chronic illness program:
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- Evidence-based care guidelines
- Clinical care management and outreach
- Collaborative practice models
- Informed decision making
- Outcomes measurement

If there is a potential need or benefit for Case Management, please contact a Physicians Plus Case Manager at (608) 282-8900 or 1-800-545-5015 for assistance in coordinating care or services for your Physicians Plus patient.
ACCESS TO CARE

An important consideration of members when they are assessing the quality of care they receive, concerns their ability to receive appropriate care when they feel that it is required. The Board of Directors has adopted standards for access to routine, preventive, urgent, and emergency care. Member’s actual experience in receiving access within these time frames is monitored by member surveys, member complaints, office site visits and annual access/availability analysis.
CREDENTIALING AND RE-CREDENTIALING OF PRACTITIONERS

Physicians Plus has established a systematic credentialing process for reviewing practitioners who wish to become participants in the network. The credentialing process includes verifying education and training, as well as investigating the history and background of applicants to ensure that they meet the required criteria for participation in the network. Only practitioners who have fulfilled the requirements for credentialing or re-credentialing are permitted to see Physicians Plus members and bill for services.

Credentialing, re-credentialing, ongoing monitoring of sanctions and complaints, and facility reviews are integral to the Physicians Plus program in regard to the monitoring of care received by our members.

Purpose

Credentialing is intended to provide a systematic approach to the selection, evaluation, discipline, or termination of Physicians Plus participating practitioners. Credentialing investigates the historical record of a practitioner to ascertain that he/she has the background required, but also has an acceptable record on issues of standard of care, ethics, character, and judgment.

Practitioners are considered for selection based on member need, reputation in the community, and employer or member request. The final practitioner acceptance is contingent upon his/her successful completion of the credentialing review process.

As applicants for credentialing or re-credentialing with Physicians Plus, with the exception of information determined by Physicians Plus to be protected by peer review laws, practitioners have the following rights: 1) the right to review the information received from third parties in connection with the practitioner’s credentialing or re-credentialing application; 2) to correct any erroneous information submitted by another source; and 3) to receive the status of the practitioner’s credentialing or re-credentialing application, upon request.
FACILITY REVIEW POLICY

Purpose
Physicians Plus periodically evaluates the facilities of participating providers.

Policy Statement
The term "facility" is described as a participating site, clinic or solo practice. Because most patient care is provided in practitioner offices rather than institutions such as hospitals, a facility review measuring the quality of the facility in which care is provided is an important element to ensuring quality of patient care, compliance with Physicians Plus standards, and proactively identifying areas of needed improvement.

A facility review is performed at Primary Care Physician and behavioral health clinics if the clinic is new to the Physicians Plus network, or if an already-contracted clinic moves to a new location. A facility review is also performed at any type of clinic (primary care physician, behavioral health, specialty medical) if Physicians Plus receives complaints regarding a clinic’s physical accessibility, physical appearance, adequacy of waiting room space, and/or adequacy of examining room space. Additionally, behavioral health clinics that are not certified by the State of Wisconsin under DHS 35 are subject to a facility review every three years.

Each facility must provide an environment that is sanitary and functionally safe for patients and personnel. A facility review includes the following categories.

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting/Exam Room Space
- Policies and Procedures
- Fire/Safety
- Infection Control Policies - medical clinics only
- Control of Medications
- Continuity of Care - behavioral health clinics only
- Availability of Appointments - newly contracted clinics only
- Medical Records

If deficiencies or other problems are identified, a Physicians Plus reviewer will return to the facility for re-evaluation and action.