QUALITY ASSURANCE PROGRAM

The Quality Assurance Program is taken from Article IX of the Policies of Total Health Care, Inc., which have been approved and adopted by the Plan's Board of Directors.

Section 9.1. Preface. The Quality Assurance Program has been formulated to objectively and systematically monitor and evaluate the quality and appropriateness of all Health Maintenance Services, pursue opportunities to improve patient care and resolve identified problems.

Section 9.2. Definition. The term "Quality Assurance" refers to the identification, assessment, correction and monitoring of important aspects of patient care designed to enhance the quality of Health Maintenance Services consistent with achievable goals and within available resources.

Section 9.3. Purpose. The Quality Assurance Program is established in consonance with the philosophy, mission and goals of the Corporation. It is the intent of the Corporation to provide care to all Enrollees regardless of age, sex, race, national origin, handicap or financial capabilities.

Section 9.4. Goals.

A. To assure that health care rendered to Enrollees is of the appropriate level of continuity and high quality.

B. To assure that treatment is consistent with the clinical impression or working diagnosis.

C. To assure that appropriate diagnostic procedures and/or consultations are obtained relative to an Enrollee's condition.

D. To assure that facility resources are used in the most efficient and effective manner possible.

E. To assure adequate accessibility and availability of Health Maintenance Services for all Enrollees, including emergency services.

F. To assure complete and accurate medical record documentation.

G. To assure compliance with the Michigan statutory and legislative requirements for health maintenance organizations.

H. To assure that the performance of the Affiliated Health Professionals is consistent with accepted medical standards of health care.

I. To assure that the overall health needs of Enrollees are met, including Enrollee satisfaction.

Section 9.5. Basic Program Components. There are four (4) basis program components of the Corporation's Quality Assurance Program: (1) Problem Identification, (2) Assessment of Health Maintenance Services, (3) Correction of Identified Problems, and (4) Follow up Monitoring.

A. Problem Identification. Identification of known or suspected problems in the health care delivery system is the foundation of the Quality Assurance Program. Problems or topics for study may be identified through, but not limited to, any of the following means:

1. Compliance with rules and regulations governing health maintenance organizations.

2. Compliance with policies and/or procedures established by the Corporation including adherence to Bylaws.

3. Known or suspected problem areas as determined by a medical audit or health care evaluation.

4. Referral from Medical Director or Executive Director of known or suspected problem areas.

5. Referral from health care center staff of known or suspected problem areas.

6. Enrollee complaints or grievances.

B. Assessment of Health Maintenance Services. Assessment of the Health Maintenance Services rendered is the next important step in a successful Quality Assurance Program. Assessment methods are varied, but may include the following:

1. Formal medical audit, complete with medically- established criteria.

2. Written health care evaluation.

3. Review of data from external sources, such as HMO survey results of the Department regarding health maintenance organizations.

4. Review of data from internal sources such as financial data, computerized patient demographic data or other similar data.

5. Enrollee surveys or questionnaires.

6. Review of utilization review data relative to length of stay and/or use of resources and services.

C. Correction of Problems. Once problem areas have been studied and results assessed, appropriate action(s) shall be taken to resolve the problem. Corrective actions may include, but are not limited to, the following:

1. Revision of policy or procedure consistent with problem resolution.

2. Continuing medical education of medical staff within his/her specialty to enhance quality of health care.

3. Education of office staff regarding policies or procedures to streamline or improve delivery of services.

Such actions may be taken by the Medical Director, for clinical problems, or by the Executive Director, for administrative problems. Written documentation shall be maintained and available for review.

Section 9.5 Follow-up Monitoring. The final but certainly the most critical aspect of a sound Quality Assurance Program is follow-up monitoring. Once corrective action has been taken to resolve a problem, follow-up monitoring shall be performed to ensure that the corrective action taken did indeed resolve the problem. The time frame and characteristics of such monitoring shall depend upon the nature and extent of the problem. However, at a minimum, one (1) follow-up study shall be performed relative to each study that required corrective action. Time frames for study shall be determined at the time that corrective actions are determined. The Quality Assurance Consultant shall be responsible for coordinating and documenting all follow-up monitoring.

Section 9.6. Reporting Relationships. The Quality Assurance Program shall be comprehensive, coordinated and integrated in nature. The Executive Director, Medical Director, Quality Assurance Committee and the Board of Directors shall each review and participate in the Quality Assurance Program. Assessment results, when applicable, shall be reported to Affiliated Providers as well as to Subscribers.

A. Role of Executive Director. The Executive Director shall insure that adequate and necessary staffing is provided to carry out the activities described in the Plan. He/she shall remain apprised of any findings relative to the management and operation of the Corporation. This includes frequent communication with the Medical Director and Board of Directors concerning the administration of policies and procedures designed to enhance or improve the quality of the Health Maintenance Services.

B. Role of Medical Director. The Medical Director shall be responsible for the development, implementation, coordination and clinical management of the Quality

Assurance Program. His/her duties shall include, but shall not be limited to, the following:

1. Guide and direct the Corporation on issues related to the delivery of Health Maintenance Services.

2. Provide clinical input necessary in the decision- making process of the Corporation.

3. Serve as the primary professional link between the principal office of the Corporation and Affiliated Providers.

4. Establish and maintain effective and cooperative relationships with the general medical community in Southeastern Michigan, including relationships with medical societies, hospital medical staffs and medical education programs, and community physicians.

5. Provide clinical input in establishing criteria and standards used in performing medical audits and health care evaluations.

6. Serve as medical liaison to the Quality Assurance Consultant to assist in evaluating Health Maintenance Services rendered, and also serve as the primary medical coordinator of the Corporation's Quality Assurance Program.
The Medical Director shall also be responsible for reporting findings of Quality Assurance Program activities to the Board of Directors, Administration, Affiliated Providers, Enrollees and Executive Director.

C. Role of Quality Assurance Committee. The Quality Assurance Committee shall be the functional component of the Quality Assurance Program, and shall be comprised of the following members:

1. Three (3) primary care physicians, one of whom shall be the Medical Director.

2. One (1)-specialty physician who shall vary as committee needs dictate.

3. Quality Assurance Consultant who shall serve as program coordinator and Co-Chairperson with the Medical Director.

4. Director of Utilization Review/Hospitalization.

5. Public Health Nurse.

6. Site representatives as needed.

7. Additional professional staff and/or physicians as needed.

Meetings of the Quality Assurance Committee shall be held at least monthly. All activities shall be recorded in the minutes of the meeting, including a synopsis of the discussion of agenda items, as well as the conclusions and actions taken, including any follow-up monitoring. Minutes and all relevant attachments shall be maintained for at least three (3) years, with regular distribution of agenda, minutes and attachments to all committee participants. These minutes shall be held as confidential, and shall be maintained for the purposes of examination or review by appropriate local, state and/or federal reviewing agencies. The results of Quality Assurance Committee activities shall be reported at least annually to the Executive Director and Board of Directors.

D. Board of Directors. The Board of Directors shall be responsible for the overall adoption and implementation of written policies and procedures governing the operation of Total Health Care, Inc., including its Quality Assurance Program. Assessment results and corrective actions taken shall be documented and reported to the Board on a regular basis. The Board shall also annually review the Quality Assurance Program to ensure compliance with written rules and regulations, which shall be evidenced by the dated signature of the Chairperson of the Corporation.

Section 9.7. Integration/Structure. There are three (3) major elements in the structure of the Quality Assurance Program:

(1) Utilization Review Management, (2) Medical Care Evaluations, and (3) Health Care Evaluation/Special Studies.

A. Utilization Review Management. The goals of the Utilization Review Management are:

1. To assure effective and efficient utilization of hospital and ambulatory facilities and services.

2. To assist in the promotion of the appropriate level of continuity and of quality Health Maintenance Services through analysis, review, and evaluation of professionally-recognized standards of medical care.

3. To assure that all services provided are medically necessary.

4. To assure that services are provided in the most economical setting without risk or injury to patients.

Inpatient Assessment. The data processing system maintained by the Corporation shall provide daily information on all hospitalized Enrollees, including diagnosis (es), procedure(s), demographic data and length of stay data. This information shall be re-viewed by the Utilization Review staff daily to determine the appropriateness of hospitalization and to establish parameters of length of stay for efficient and effective utilization of hospital services.

Standards with respect to such assessments shall be based upon estimated length of stay norms as established by the Commission on Professional and Hospital Activities (CPHA), adjusted for age and applicable operative status. In addition, where applicable, Diagnostic Related Groupings (DRG) data may also be utilized in determining appropriate estimated lengths of stay. Review of all elective and emergency admissions shall be performed on a regular basis, as well as timely and adequate arrangements for discharge planning and any follow-up visits. Over-utilization as well as under-utilization of Health Maintenance Services shall be periodically assessed.

Referrals. Inpatient admissions that do not meet established criteria, norms, or standards shall automatically be referred to the Medical Director for review and determination of authorization of stay. The attending physician shall also be consulted to further discuss patient care and to resolve any identified problems. Trends or identified patterns of inappropriate utilization of resources or services shall be routinely forwarded to the Quality Assurance Committee for review, discussion and corrective action, if necessary.

Utilization/Financial Data Analysis. It is necessary to review utilization data as it relates to the financial management of the Corporation. In this regard, the Corporation is committed to its involvement in ensuring that utilization of services is provided in the most economical setting; yet is medically necessary and attainable. Review of ancillary services (laboratory, radiology, pharmacy, dietary, etc.) shall also be performed to evaluate the cost/benefit ratio of services. In addition, alternate health care settings, i.e., nursing home care, or home health care, shall also be considered in assessing utilization of services and financial data.

B. Medical Care Evaluation. Medical Care Evaluations shall be performed at least quarterly in accordance with Michigan requirements governing health maintenance organizations. The goals of performing Medical Care Evaluations are:

1. To assure the accuracy, completeness and quality of medical record documentation.

2. To evaluate continuity and coordination of Enrollee care.

3. To objectively assess the quality of medical care provided.

Selection of Study Topics. Data retrieval may be performed by utilizing the clinical indexing system for either diagnostic or surgical categories. In addition, topics for study may also be determined by frequency of occurrence, previously identified problem areas, or topics that address new problems that have the potential to improve the quality of Enrollee care. Other examples may include:

a. Drug usage.

b. Appropriateness of external referrals.

c. Filing delays.

d. Turn-around times in completing ancillary services as well as completing pertinent medical record forms and reports by medical personnel.

e. Follow-up of abnormal reports.

f. Identification of high-risk conditions.

g. Immunizations.

h. Quality of medical record content.

Pre-established, written criteria used in the review process shall be determined by reference to professionally recognized standards of medical care. Criteria shall be developed by the Quality Assurance Consultant in consultation with the Medical Director and/or Quality Assurance Committee. Any variations shall be reviewed by the Committee for corrective action, and a timetable established for follow-up review and reporting. Study results shall be forwarded to the Executive Director and Board of Directors as indicated.

C. Health Care Evaluations. At least one (1) health care evaluation shall be ongoing at any given time, and at least one (1) study shall be completed each year. The goals of Health Care Evaluations are:

1. To promote effective and efficient use of avail-able health facilities, services and personnel consistent with Enrollee needs and professionally- recognized standards of care, including nursing care.

2. To identify and analyze patterns of patient care and recommend appropriate changes for maintaining consistently high quality patient care as well as effective and efficient use of services. Pre- established written criteria shall be used to measure patient care services. These criteria shall be approved by members of the Quality Assurance Committee for use. Examples of topics for study may include:

a. No-shows for appointments.

b. Waiting times for Enrollees.

c. Appropriateness of medical care for most frequent diagnosis.

d. Age/sex-specific referrals and diagnostic testing.

Mechanisms shall be in place to assure that data collected for any type of study is based either upon the total Enrollee population, when feasible, or on a statistically significant and valid sampling method. The exact number of records to be reviewed in each study shall be determined at the time of criteria establishment, and shall represent a statistically significant sample adequate to perform the study.

In addition, there shall be written documentation of ongoing collection and review of utilization and other study data, as evidenced by periodic on-site health care center visits. A written report shall be maintained of each visit, outlining the purpose of the visit and the outcome of the review. Results shall be forwarded to the respective health center managers and medical directors as indicated, with summary results forwarded to the Board of Directors, Executive Director, and Medical Director of the Corporation.

Section 9.8. Credentials. All Affiliated Health Professionals shall be subject to a credential review process. Included in this review shall be evaluation of the physician's Curriculum Vitae, copies of current licenses and other pertinent documents. Results of all Quality Assurance activities relative to a physician's individual clinical performance shall be permanently maintained in his/her file, and shall be utilized when determining continuation of clinical privileges and affiliation with the Corporation.

Section 9.9. Annual Review. The Quality Assurance Program shall be reviewed and, if necessary, revised on an annual basis. There shall be evidence of such review as evidenced by the signature and date by the Executive Director, Medical Director and Board of Directors (Chairperson).