2017 Blue Cross Blue Shield of Michigan
Commercial PPO/Marketplace Quality Improvement Program Description

March 31, 2017
Blue Cross Blue Shield of Michigan (Blue Cross) is committed to conducting business with integrity and in accordance with all applicable federal, state, and local laws and any accompanying regulations thereto. Corporate compliance policies have been established which demonstrate the Blue Cross commitment to identifying and preventing misconduct and treating our customers, as well as all of our constituents, with fairness and integrity. Ethical business practices are essential to gaining and keeping stakeholder’s trust as Blue Cross strives to make the corporate vision and mission a reality. All employees are required to review and attest to a conflict of interest policy. Human Resources maintains the statement, signed annually by all employees.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAFP</td>
<td>American Academy of Family Practice</td>
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<tr>
<td>AAP</td>
<td>American Academy of Pediatrics</td>
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<tr>
<td>AB</td>
<td>Abandonment Rates</td>
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<tr>
<td>ABA</td>
<td>Applied Behavioral Analysis</td>
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<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
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<tr>
<td>ACP</td>
<td>Advanced Care Planning</td>
</tr>
<tr>
<td>ACP</td>
<td>American College of Physicians</td>
</tr>
<tr>
<td>ADT</td>
<td>Admission, Discharge, Transfer (and ED visits)</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<tr>
<td>AIM</td>
<td>American Imaging Management</td>
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<tr>
<td>AOA</td>
<td>American Osteopathic Association</td>
</tr>
<tr>
<td>ASA</td>
<td>Average Speed of Answer</td>
</tr>
<tr>
<td>ASCO</td>
<td>American Society of Clinical Oncology</td>
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<tr>
<td>ASPIRE</td>
<td>Anesthesiology Performance and Improvement Reporting Exchange</td>
</tr>
<tr>
<td>BCBSA</td>
<td>Blue Cross Blue Shield Association</td>
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<tr>
<td>BLUE CROSS</td>
<td>Blue Cross Blue Shield of Michigan</td>
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<tr>
<td>BCN</td>
<td>Blue Care Network</td>
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<tr>
<td>BDC</td>
<td>Blue Distinction Centers for Specialty Care®</td>
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<tr>
<td>BDC+</td>
<td>Blue Distinction Centers Plus</td>
</tr>
<tr>
<td>BMC2</td>
<td>Blue Cross Blue Shield of Michigan Cardiovascular Consortium</td>
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<tr>
<td>CA</td>
<td>Care Advance</td>
</tr>
<tr>
<td>CAHPS®</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
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<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
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<tr>
<td>CER</td>
<td>Comparative Effectiveness Research</td>
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<td>CIT</td>
<td>Clinical Innovator Technology</td>
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<td>CIU</td>
<td>Continuous Improvement Unit</td>
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<tr>
<td>CLQI</td>
<td>Clinical Quality Improvement Initiative</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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</table>
COPD  Chronic Obstructive Pulmonary Disease
CQI  Collaborative Quality Initiative
CSR  Customer Service Representative
EBC  Evidence-Based Care
EBCT  Evidence-Based Care Tracking
EMR/DMR  Electronic Medical Record/Disease Management Registry
ESI  Express Scripts, Inc.
FTE  Full-Time Equivalent (employee)
FUH  Follow-up after Hospitalization
GTRQC  Genetic Testing Resource and Quality Consortium
HCDC  Health Care Delivery Committee
HCV  Health Care Value
HEDIS®  Healthcare Effectiveness Data and Information Set
HIE  Health Information Exchange
HMO  Health Maintenance Organization
HMS  Hospital Medicine Safety
HOTP  Human Organ Transplant Program
HRM  High Risk Medications
ICP  Intra-cranial Pressure
IMPACT  Integrated Michigan Patient-centered Alliance on Care Transitions
INR  International Normalization Ratio
INS  Infusion Nurses Society
IVR  Interactive Voice Response
JSM  Joint Statistical Meeting
JUMP  Joint Uniform Medical Policy
MAQI2  Michigan Anticoagulation Quality Improvement Initiative
MARCQI  Michigan Arthroplasty Registry Collaborative for Quality Improvement
MBSC  Michigan Bariatric Surgery Consortium
MEC  Member Experience Committee
MEDIC  Michigan Emergency Department Improvement Collaborative
MHA  Michigan Health and Hospital Association
MiBOQI  Michigan Breast Oncology Quality Initiative
MiHIN  Michigan Health Information Network
MiPCT  Michigan Primary Care Transformation Project
MOQC  Michigan Oncology Quality Consortium
MQIC  Michigan Quality Improvement Consortium
MSQC  Michigan Surgical Quality Collaborative
MSTCVS  Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative
MTQIP  Michigan Trauma Quality Improvement Project
MUSIC  Michigan Oncology Quality Consortium
NCQA  National Committee for Quality Assurance
NDC  National Drug Code
NRT  Nicotine Replacement Therapy
OC  President’s Operating Committee
OOP  Out-of-Pocket Maximum
OSC  Organized System of Care
P4P  Pay for Performance
PCI  Percutaneous Coronary Intervention
PCMH  Patient-Centered Medical Home
PCMH-N  Patient-Centered Medical Home Neighbor
PDCM  Provider Delivered Care Management
PCORI  Patient-Centered Outcomes Research Institute
PCP  Primary Care Physician
PGIP  Physician Group Incentive Program
PHI  Protected Health Information
PMPM  Per Member Per Month
PO  Physician Organization
PPO  Preferred Provider Organization
PSO  Patient Safety Organizations
QI  Quality Improvement
QIC  Quality Improvement Committee
QHP  Qualified Health Plan
QOPI®  Quality Oncology Practice Initiative
QRS  Quality Rating System
STS  Society of Thoracic Surgeons
SVP  Senior Vice President
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
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<tr>
<td>TSF</td>
<td>Telephone Servicing Factor</td>
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<tr>
<td>UM</td>
<td>Utilization Management</td>
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<tr>
<td>UMC</td>
<td>Utilization Management Committee</td>
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<tr>
<td>VIC</td>
<td>Vascular Interventions Collaborative</td>
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<tr>
<td>VMCOE</td>
<td>Vendor Management Center of Excellence</td>
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<tr>
<td>VOC</td>
<td>Voice of the Customer</td>
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<tr>
<td>VP</td>
<td>Vice President</td>
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<tr>
<td>VTE</td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td>WATCH</td>
<td>Warfarin Alternative Treatment CoHort</td>
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<tr>
<td>WCM</td>
<td>Wellness and Care Management</td>
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1.0 INTRODUCTION

Headquartered in Detroit, Blue Cross Blue Shield of Michigan (Blue Cross) is the state’s largest Preferred Provider Organization (PPO) health plan, serving approximately 2.2 million members in the state of Michigan.

This program description document applies to PPO Commercial and Marketplace products. Marketplace indicates the Quality Rating System (QRS) and Exclusive Provider Organization (EPO) population unless specified otherwise. Federal Employee Program (FEP) PPO products are included with Commercial PPO.

Blue Care Network (BCN), the Blue Cross HMO health care product, has been accredited with the National Committee for Quality Assurance (NCQA) for 15 years. In 2012, Blue Cross began expanding its accreditation effort to include the commercial PPO product in the state of Michigan. In 2013, the Blue Cross Commercial PPO received NCQA accreditation with a rating of Commendable. Blue Cross retained the Commendable rating from 2014 to 2016, our most recent survey date.

1.1 Background

The Blue Cross Commercial PPO product is transforming health care through a series of initiatives promoting personal and population health, improving quality and lowering costs. Our goal is to combine innovative plan designs, dedicated health support and enhanced care delivery to provide members with the highest quality health care experience.

1.1.1 Hospitals

Since 1997, Blue Cross has partnered with hospitals across the state of Michigan in a joint effort to improve health care quality and patient safety surrounding many common and costly areas of surgical and medical care. The Blue Cross / BCN-sponsored Hospital Collaborative Quality Initiatives (CQIs) enable hospitals and clinicians across the state work together in a trusted, non-competitive environment collecting patient risk factors and clinical process and outcomes data. Over 80 hospitals across Michigan participate in at least one CQI – 94 percent of eligible hospitals participate in the five most established CQIs.

Collectively, CQIs analyze the care given to over 500,000 surgical and medical patients across Michigan annually. Hospital CQIs collect data on all Michigan patients undergoing surgical procedures or medical treatments – not just Blue Cross members. Hospitals and physicians collect and analyze data to find links between process and outcomes of care. These collaboratives foster the development of best practices that reduce errors, prevent complications and improve outcomes. These outcomes demonstrate that collaborative efforts improve patient safety and clinical quality by preventing complications and reducing morbidity and mortality.

The nationally recognized Blue Cross CQI program has received multiple awards from organizations as diverse as the Blue Cross Blue Shield Association and the National Business Coalition on Health. Findings generated by the CQIs have been profiled in peer-reviewed literature more than 150 times over the last five years. Blue Cross and our hospital CQI partners are routinely asked to present locally and nationally on our statewide success in quality improvement and CQI best practices.
1.1.2 Ambulatory Care

Since 2005, Blue Cross has engaged providers in the ambulatory community through the Physician Group Incentive Program (PGIP). Physicians across the state collaborate on initiatives designed to improve and transform the health care system. Each initiative offers incentives based on clearly defined performance improvement and program participation metrics.

Currently, over 40 physician organizations (POs) participate in PGIP, representing nearly 20,000 primary and specialty care physicians from the Blue Cross network. Physician organizations serve as the effector arm of PGIP by providing the structure and technical expertise to support the development of shared information systems and shared processes of care amongst Michigan physicians.

PGIP provides physician organizations and their physician members with a variety of claims-driven reports including evidence-based care reports that are aligned with Healthcare Effectiveness Data and Information Set (HEDIS®) measures focused on preventive care services and chronic care management. Physicians engaged in PGIP care for approximately 87 percent of the commercial PPO population for Blue Cross in Michigan.

Working with the Michigan provider community, Blue Cross oversees the largest health plan sponsored Patient-Centered Medical Home (PCMH) program in the United States. As of July 2016, Blue Cross PCMH-designated practices included:

- 1,638 designated practices
- 4,534 designated primary care physicians
- 1.25 million attributed Blue Cross members

In PCMH practices, a care team led by a primary care physician focuses on each patient’s health needs and goals to coordinate care across all health settings. Blue Cross designed the PCMH program in partnership with the Michigan physician community as a way to strengthen the primary care system, better manage member care and help patients play an active role in promoting their own good health. Blue Cross continues to expand PCMH designations in Michigan—currently, there are Blue Cross PCMH-designated primary care physicians in 80 of Michigan’s 83 counties—or 96 percent of Michigan counties.

Since 2012, Blue Cross has expanded its provider partnerships by embracing the Patient-Centered Medical Home Neighbor (PCMH-N) concept, which further solidifies the collaborations between PCPs and specialists and rewards specialists for transforming care delivery processes.

Beginning January 1, 2017, select PCMH-designated practices will participate in the Comprehensive Primary Care Plus (CPC+) initiative. CPC+ is a regional, multi-payer, five-year CMS-supported initiative that is intended to strengthen primary care through efforts to transform payment reform and the care delivery system. Michigan is one of fourteen participating regions in this program. Some PCMH-designated practices will also participate in the State Innovation Model (SIM), administered by the Michigan Department of Health and Human Services using a grant from the United States Department of Health and Human Services. These efforts build upon our PCMH model and synergize existing efforts to deliver coordinated care to all patients, including those with chronic conditions.
Finally, Blue Cross is taking these efforts to the next level with Organized Systems of Care (OSC). Organized Systems of Care build on the foundation laid by the PCMH program by linking primary care physicians, specialists, health care facilities and hospitals, to fully integrate and coordinate care through the entire health care system. These strategies are integrated into a comprehensive population-based approach to ensure all Blue Cross PPO members receive patient-centered care that provides needed prevention services, chronic care management and integration of behavioral and medical care. Blue Cross launched Personal Choice PPO in Fall 2016. This new product is based on the OSC program.

The PGIP field team supports the statewide collaborative relationships with the over 40 physician organizations and 39 OSCs to ensure program integrity through the following activities:

- Providing educational support to POs and their physicians on all PGIP initiatives, administrative requirements and enhancements and associated data distributed
- Developing strategies to improve PO performance in PGIP initiatives to ensure program value and improved clinical outcomes
- Engaging in frequent, proactive communication with the PO community regarding program changes, updates and enhancements

In addition to PGIP collaboration and field team support, Blue Cross provides ongoing practitioner education and involvement by addressing gaps in care for clinical measures using PO reports; offering practitioner educational programs; publishing newsletters; distributing and promoting clinical practice guidelines and continuing patient-centered medical home physician designation through the PGIP program.

### 1.2 Quality Improvement Program

Blue Cross created the **Commercial PPO/Marketplace Quality Improvement (QI) Program** to systematically and comprehensively assess, monitor, measure, evaluate and implement strategies to improve the quality of care delivered to Blue Cross members. Developed in accordance with our corporate vision and mission, the quality improvement program outlines the structure, processes and methods Blue Cross uses to determine activities and influence outcomes related to the improvement of the care and treatment of members.

The President’s Operating Committee (OC) and Health Care Delivery Committees (HCDC) oversee the quality improvement program. The Quality Improvement Committee (QIC), which reports to OC and HCDC, was developed in accordance with accreditation, contractual, federal and state regulatory, local and organizational requirements and guidelines.

Blue Cross collects annual information on member access to care, availability of services, clinical quality and satisfaction, provider performance and compliance and health outcomes through HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Blue Cross member satisfaction surveys. Assessment of provider and service accessibility, clinical quality, utilization/medical management programs, quality improvement projects, member satisfaction, delegation, continuity and coordination of care, objectives to serve members with complex health needs, addressing members with culturally and linguistically diverse needs and patient safety are also monitored and evaluated within the scope of the Quality Improvement Program. Using a data-driven strategy to
direct the Quality Improvement Program, Blue Cross uses this information to understand our population and to identify opportunities to improve member health and satisfaction.

1.2.1 Staffing
The following resources support the Blue Cross Quality Improvement Program:

- Designated Associate Medical Director who chairs the Quality Improvement Committee
- Director and four health care analysts (two analysts are Registered Nurses)

Involvement of Designated Physician in QI Program

An Associate Medical Director is dedicated to the QI Program — responsibilities are as follows:

- Chair the QIC, assisting with preparation of Quality Improvement program documents and review of clinical guidelines for QI programs
- Participate in behavioral health QIC and associated activities
- Assist with QI activities related to HEDIS and continuity and coordination of care improvements
- Provide delegation oversight
- Oversee program related to improvement of health disparities
- Ensure alignment of utilization management and case management with NCQA standards and assist with internal process improvement

The QI program is further supported by the Health Care Value (HCV) team with IT and HCV data analytics as explained further in the following section.

Data Sources and Analytical Resources

The HCV Data Analytics department leads data acquisition and analysis for the QI program at Blue Cross PPO. Analytic outcomes include identifying eligible population for accreditation, developing dashboards for reporting HEDIS metrics to providers, ascertaining racial/ethnic disparities in quality metrics and understanding variation in quality across the Blue Cross statewide network. HCV Data Analytics analyzes data to understand what is driving gaps in care and identify areas for provider improvements in order to improve overall quality of care. HCV Data Analytics also performs the following:

- Conducts analytics to create HEDIS quality metrics for our physician organization partners in addition to public reporting
- Provides analytic support to IT groups responsible for data submission to the HEDIS analytic vendor and analytics to support audit and medical chart review process

Following are a few more examples of data analytic outcomes of the HCV Data Analytics team in support of Blue Cross quality improvement:

- Map vision and lab claims for inclusion in the data mart to enhance relevant metrics
• Enhanced PGIP Clinical Quality Initiative report to include HEDIS accreditation measures
• Created process to identify members that need to receive letters informing them that their provider has left the network
• Identified the cultural ethnicity/diversity of our population and assist with planning of outreach programs
• Develop platforms to incorporate supplemental data for HEDIS and physician reports
• Responsible for Informatics functions related to data acquisition from physician practices
• Create customer-specific performance reports on HEDIS metrics to help employer groups make data-driven decisions regarding health promotion focused programs for employees
2.0 ORGANIZATIONAL STRUCTURE

The Blue Cross board of Directors, program committees, operational departments and employees all work together to promote quality throughout the Blue Cross organization, as described on the following pages. Blue Cross committees provide oversight and implementation of all quality improvement activities (access and availability, clinical quality, member satisfaction, qualified providers and compliance).

2.1 Board of Directors and Health Care Delivery Committee

The Board of Directors, who is responsible for overall governance of Blue Cross, has designated the Health Care Delivery Committee (HCDC), a Board subcommittee, to perform board-level oversight of the Quality Improvement Program. The HCDC, which includes individuals representing the provider and member community, reviews and approves the QI Program Description, Work Plan and Evaluation annually.
2.2 President’s Operating Committee

The President’s Operating Committee (OC) is the Blue Cross executive team that conducts quality oversight for the Quality Improvement Program. The OC facilitates alignment of the Blue Cross-strategic plan with the quality mission of the organization. The Blue Cross CEO chairs this committee.

<table>
<thead>
<tr>
<th>President’s Operating Committee</th>
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<tr>
<td>President and Chief Executive Officer (CEO)</td>
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<tr>
<td>Senior VP and Chief Information Officer (CIO)</td>
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<td>Senior VP, Health Care Value and Chief Medical Officer (CMO)</td>
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<td>Senior VP – Corporate Secretary and Services</td>
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<td>Senior VP – General Auditor and Corporate Compliance</td>
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<td>Senior VP – Health Care Value</td>
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<td>Executive VP, Chief Financial Officer (CFO) and President – Emerging Markets</td>
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<td>Executive VP – Group Business and Corporate Marketing</td>
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<td>Executive VP – Health Care Value</td>
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<td>Executive VP – Operations and Business Performance</td>
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<td>Executive VP – Strategy, Government and Public Affairs</td>
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<td>VP – Corporate Strategy</td>
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<td>VP – General Counsel</td>
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2.3 QI Program Committees

The Quality Improvement, Utilization Management, and Member Experience committees report directly to the President’s Operating Committee (OC), which has the authority to assess overall performance, address potential barriers and prioritize company resources to continuously improve the quality of care, clinical outcomes and member experience with Blue Cross. Activities planned for the year are described in the Quality Improvement Work Plan which addresses the quality of clinical care and service, safety of care, yearly objectives, expected timeframe needed to accomplish these activities, monitoring and annual evaluation. The Quality Improvement, Utilization Management and Member Experience committees meet quarterly, at a minimum.

There are also three enterprise-wide quality improvement subcommittees, performing functions for both Blue Cross and BCN. For the Blue Cross commercial PPO Michigan membership, these sub-committees report either to the QIC or UM Committee.

1. Credentialing Committee – reports to the QIC.

The Credentialing Committee is an enterprise committee representing Blue Cross Blue Shield of Michigan and Blue Care Network, with oversight responsibility for credentialing and re-credentialing activities for practitioners and organizational providers. The Credentialing Committee meets monthly.
2. **Pharmacy and Therapeutics (P&T) Committee** – reports to the UM Committee.

The Pharmacy and Therapeutics Committee evaluates the clinical use of drugs, determines the appropriate formulary placement of drugs, ensures that the formulary is appropriately revised to adapt to both the number and types of drugs on the market, and advises in the development of policies for managing drug use, drug administration, and the formulary system. Decisions are based on available scientific evidence and may be based on economic considerations that achieve appropriate, safe and cost effective drug therapy. Therapeutic advantages in terms of safety and efficacy are considered when selecting formulary drugs and when reviewing placement of formulary drugs into formulary tiers.

The committee is comprised of 15 members, who represent various clinical specialties. Nine of the 15 members are external (not employed by Blue Cross or BCN) and include six practicing physicians, two practicing pharmacists and one consumer advocate. The remaining six members include two Blue Cross and BCN pharmacy directors, two BCN physicians and two Blue Cross physicians. The Committee also relies on invited guests within or outside Blue Cross/BCN, including contracted providers or health care professionals who can contribute specialized or unique knowledge or skills. The P&T Committee meets quarterly.


The Joint Uniform Medical Policy Committee, an official corporate committee of Blue Care Network and Blue Cross Blue Shield of Michigan, evaluate new technologies, devices and health care services, as well as new uses of existing technologies, devices and health care services. Evaluations may result in the development or revision of medical policy statements that describe the technologies, devices and health care services as investigational or non-investigational. A behavioral health care professional participates in the decision making process on the committee for behavioral medicine topics. The JUMP Committee meets a minimum of four times a year.
2.3.1 Quality Improvement Committee

The Quality Improvement Committee (QIC) provides direction, input and oversight to QI activities that are developed and implemented within the QI program. The QIC meets quarterly.

<table>
<thead>
<tr>
<th>QUALITY IMPROVEMENT COMMITTEE</th>
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</table>
| **Co-Chairs** | **Amy McKenzie, MD, FAAFP** – Associate Medical Director, Health Care Value, Quality Management  
**Vicki Boyle, RN** – Director of Quality Management and Accreditation, Health Care Value |

| Committee Members | **Associate Medical Director** – Health Care Value, Disease Management  
**Associate Medical Director** – Health Care Value, Case Management  
**Director** – Pharmacy Services  
**Director** – Blue Care Network (BCN) Quality Management  
**Director** – Market Research  
**Director** – Medical Affairs  
**Director** – Program and Quality Support  
**Manager** – Executive Services  
**Manager** – FEP Care Coordination and Managed Care  
**Manager** – Health care Value IT  
**Manager** – Medical Informatics  
**Manager** – PPO and Care Management  
**Manager** – PPO Network Administration  
**Manager** – Value Partnerships  
**Business Unit Compliance Liaison** – Service Operations  
**ECV Business Consultant** – Value Partnerships |

QIC Committee Responsibilities

- Provide clinical quality oversight including review and annual approval of the QI Program Description, QI Program Evaluation and QI Work Plan
- Facilitate integration of quality initiatives and operations across the enterprise
- Evaluate the Quality Improvement Program and its activities on a regular basis and identify needed actions
- Recommend, review and approve policies relevant to quality improvement at least annually
- Provide annual updates to the Health Care Delivery Committee (HCDC) and President’s Operating Committee (OC)
- Ensure practitioner participation in QI program
- Identify QI program enhancements based on analysis and significance to the organization and provide follow up as appropriate
- Provide oversight of activities shared with BCN
- Approve clinical guidelines annually
2.3.2 Utilization Management Committee (UM)

The Utilization Management Committee provides oversight for the Utilization Management program. The UMC meets quarterly.

<table>
<thead>
<tr>
<th>UTILIZATION MANAGEMENT COMMITTEE</th>
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| Co-Chairs | Carla Laethem, RN, MPA – Vice President, Utilization Management  
Duane DiFranco, MD – Senior Medical Director |
| Committee Members |  
Associate Medical Directors (2) – PPO & Care Management  
Medical Director – Clinical Management  
Medical Director – New Directions Behavioral Health  
Director II – Provider Servicing  
Director – Claims Payment & Data Analytics  
Director – Clinical Review  
Director – Chronic Condition Management Program Delivery  
Director – Federal Employee Program  
Director – Quality Management & Accreditation  
Manager – Executive Services  
Manager – Pharmacy Services - Clinical |

**UM Committee Responsibilities**

- Approve and review the UM program description at least annually to include program structure, scope, processes and information sources used to make UM determinations
- Designate a senior physician who is actively involved in implementation, supervision, oversight and evaluation of the UM program as a member of this committee
- Designate a behavioral health practitioner who is actively involved in implementing behavioral health care aspects of the UM program as a member of this committee
- Designate representatives from the Pharmacy & Therapeutics, Joint Uniform Medical Policy (JUMP), and Criteria Review committees who are actively involved in developing criteria used to make utilization decisions
- Review and provide feedback on criteria used to make utilization decisions and procedures used to apply the criteria
- Measure and report a plan to evaluate and make improvements to the UM program annually:  
  - Member and practitioner access to staff seeking information about the UM process and the authorization of care  
  - Member and provider experience with the UM program  
  - Type and volume of requests for services, denials and appeals  
  - Consistency in application of criteria to deny services  
  - Timeliness of denials and appeals
- Provide Quality Improvement Committee (QIC) updates quarterly and to the President’s Operating Committee (OC) on request
2.3.3 Member Experience Committee

The primary purpose of the Member Experience Committee (MEC) is to provide oversight for all member and prospective member interactions including communications, satisfaction, grievance, and protected health information to improve quality and consistency in services for members across channels, functions and member touch points. The MEC meets quarterly.

<table>
<thead>
<tr>
<th>MEMBER EXPERIENCE COMMITTEE</th>
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<tbody>
<tr>
<td><strong>Co-Chairs</strong></td>
</tr>
<tr>
<td>Amy Frenzel, VP – Service Operations</td>
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<td>Kathryn Levine, VP – Corporate Marketing and Customer Experience</td>
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<td><strong>Committee Members</strong></td>
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<tr>
<td>Director – Customer Experience</td>
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<tr>
<td>Director – Pharmacy Services</td>
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<td>Director – Digital Experience</td>
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<td>Director – Executive Services</td>
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<td>Director – Federal Employee Program</td>
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<tr>
<td>Director – Wellness &amp; Care Management</td>
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<td>Director – Provider Outreach</td>
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<tr>
<td>Manager – Ancillary Program Management</td>
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<td>Manager – Executive Services</td>
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<tr>
<td>Manager – Federal Employee Program</td>
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<tr>
<td>Senior Health Care Analyst – Ancillary Program Management</td>
</tr>
<tr>
<td>VP – Wellness &amp; Care Management</td>
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</tbody>
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**Member Experience Committee Responsibilities**

- Review a variety of available information related to member experience and make recommendations to improve the experience
- Review results from member surveys, including but not limited to CAHPS and Behavioral Health Services, to determine if activities designed to improve the experience are effective or need to be further modified based on survey outcomes
- Promote cultural diversity initiatives
- Provide oversight and evaluation of materials for all stakeholder communications across channels
- Provide oversight of website and print materials for member health (pre-enrollment and enrollment)
- Recommend and create content for member and provider communication
- Facilitate external and internal member communication channels across the enterprise
- Review member complaints and appeals and make recommendations
- Review and approve all policies relevant to this committee at least annually
- Provide Quality Improvement Committee (QIC) updates quarterly and to the President’s Operating Committee (OC) on request
- Analyze member complaints and appeals data for both medical and behavioral services and identify opportunities for improvement in the following areas: quality of care, access, attitude and service, billing and financial issues, and quality of practitioner office site
- Scope includes the commercial PPO, Marketplace, and Federal Employee Program product lines
3.0 PROGRAM ACTIVITIES

Quality Improvement Program activities are designed to (1) continuously monitor and evaluate the quality of care and services provided to Blue Cross members and (2) develop strategies to improve member outcomes, safety and overall satisfaction. Blue Cross uses the QI work plan to track and monitor QI Program goals and activities.

The QI Program is designed to achieve the following goals for all members:

- Ensure quality of care and services that meet the state, federal and accreditation requirements using established, best practice goals and benchmarks to drive continuous performance improvement
- Measure, analyze, evaluate and improve the administrative service of the plan
- Measure, analyze, evaluate and improve health care services delivered by contracted practitioners
- Promote medical, behavioral health and preventive care delivered by contracted practitioners that meet or exceed accepted standards of quality
- Achieve outcome goals related to health care access and availability, quality, cost and satisfaction
- Empower members to make healthy lifestyle choices through health promotion activities, support for self-management of chronic and/or complex conditions and coordination with community resources
- Promote safe and effective clinical practice through established standards and best practice guidelines
- Educate members about patient safety through member newsletters/communications, health promotion activities and community outreach efforts

Current Blue Cross programs include the following areas of quality improvement:

- Value Partnerships programs
- Patient safety management
- Behavioral health
- Shared Enterprise Services for credentialing/re-credentialing, including access and availability of services and continuity and coordination of care
- Member satisfaction
- Cultural and linguistic needs of members
- Medical management programs, including utilization management, case management and disease management to address members with complex health needs
- Quality of clinical care, including clinical quality initiatives and clinical practice guidelines
- Delegation oversight
• programs for safety and medication adherence

### 3.1 Value Partnerships Program

Value Partnerships is a collection of clinically oriented initiatives and Blue Cross-sponsored partnerships that have significantly improved the quality of patient care throughout the state of Michigan. Through these initiatives, Blue Cross partners with physician organizations, physicians, behavioral specialists, and hospitals to create an innovative and quality-based approach to reward the transformation of health care. These initiatives focus on:

- Enhancing clinical quality
- Decreasing complications
- Managing costs
- Eliminating errors
- Improving efficiency
- Improving health outcomes
- Enhancing continuity and coordination of care

The goals of the Value Partnerships programs are aligned with the Institute for Health care Improvement’s Quadruple Aim goals, which include:

- Improving the patient experience of care
- Improving the health of the population
- Reducing the per capita cost of health care
- Creating joy in practice

Value Partnerships initiatives support the organization’s move from a fee-for-service to a fee-for-value approach to reimbursement. Detailed information about each initiative can be found at [www.valuepartnerships.com](http://www.valuepartnerships.com).
3.1.1 Physician Group Incentive Program

Founded in 2005, the Physician Group Incentive Program (PGIP) includes over 20 initiatives aimed at capability building, improving quality of care delivery and appropriate utilization of services. PGIP includes the Patient-Centered Medical Home (PCMH) program, which helps facilitate the transformation of health care delivery in physician practices and the PCMH designation program, which recognizes those practices that have implemented a significant number of PCMH capabilities and have delivered high quality and cost effective care.

3.1.1.1 Patient-Centered Medical Home

In partnership with PGIP physicians and physician organizations, Blue Cross developed the Patient-Centered Medical Home (PCMH) program in 2008. This program is based on the Joint Principles of the Patient-Centered Medical Home issued in March 2007 by the American Academy of Family Practice (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and the American Osteopathic Association (AOA).

Blue Cross’s PCMH program supports physicians in implementing patient-centered information systems and care processes. Some elements of the PCMH model that specifically address patient safety include:

- Electronic patient registries incorporating evidence-based guidelines and information from other care settings – giving providers a comprehensive view of the care patients have received and ensuring treatment is appropriate and safe
- Written and jointly developed goal planning and patient education and self-management support that uses the teach-back method to ensure patient comprehension
- Provisions for 24/7 telephone availability of clinical decision-makers with access to patient’s medical record or patient registry information
- Tracking system with safeguards in place to ensure patients receive needed tests, timely and accurate results and follow-up care
- Electronic prescription systems that ensure accurate information is transmitted to the pharmacy and alerts providers to any prescribing errors, patient allergies and potential adverse outcomes or drug interactions
- Timely response to urgent patient needs and proper patient guidance about emergency situations and seeking care
- Care coordination and care transition protocols that ensure (1) patient care is efficiently coordinated across all settings and (2) patients receive timely, appropriate care. An example of care coordination is Blue Cross’ Health Information Exchange (HIE) initiative which reports admissions, discharges and transfers notifications to the Michigan Health Information Network (MiHIN), a statewide health information exchange,

NOTE: Although there are two PCMH capabilities related to HIE, the HIE Initiative is not part of the PCMH program. It is a part of the PGIP and the Hospital P4P program.
Specialist referral processes that provide the specialist with detailed information regarding the patient’s needs and past medical history to avoid exposing patients to duplicative or unnecessary testing or treatment and include a feedback loop to the primary care provider.

**PCMH Program: Cost Avoidance**

Cost avoidance figures for the first six years of the PCMH program overall, using data from the time period of July 2008 - June 2014, is an estimated $427 million.

**2017 program goal**

Increase penetration of Patient-Centered Medical Home-designated providers throughout the state of Michigan in 2017. Success in this goal means increasing the number of designated physicians by a minimum of 2-3%.

**3.1.1.2 Patient-Centered Medical Home—Neighborhood**

Patient-Centered Medical Home (PCMH) primary care practices are the foundation of many PGIP programs. PCMH practices must be supported by high-performing specialty practices – known as PCMH-Neighbors (PCMH-N) – that are aligned with the principles and processes of PCMH. The PCMH-N concept was initially defined in a position paper published by the American College of Physicians (ACP) in 2010. Similar to PCMH, the Blue Cross PCMH-N program was developed in partnership with Michigan’s provider community.

While specialists have always been welcome to implement PCMH capabilities, they are now fully integrated into the PCMH model through the Patient Centered Medical Home Neighbor (PCMH-N) concept. All PGIP specialists – more than 13,500 physicians, fully licensed psychologists and chiropractors – can implement PCMH-N capabilities. Specialist practices that serve as high-performing PCMH-Neighbors:

- Provide appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practice
- Assure that appropriate patient information is provided promptly to the PCMH
- Establish shared responsibility for relevant types of clinical interactions
- Support patient-centered high-quality care and enhanced access
- Recognize the PCMH practice as the source of the patient’s primary care
- Understand that the PCMH practice has overall responsibility for coordination and integration of care provided to the patient

The Blue Cross Patient-Centered Medical Home/Patient-Centered Medical Home-Neighbor Interpretive Guidelines describe the various capabilities that practices can implement to become fully functioning, high performing PCMH-Neighbors. The specialist-specific guidelines were developed in collaboration with the practitioner community. Specialists who are recognized by their physician organizations as embracing PCMH-N principles and who are associated with high-quality, cost-effective care at the population level can be reimbursed in accordance with
BCBSM’s Value-Based Reimbursement (VBR) Fee Schedule. In 2017, all physician specialty types, as well as fully licensed psychologists and chiropractors, are eligible to be considered for VBR.

**2017 program goals**

- Encourage physician organizations to develop plans for working in close partnership with practices to implement PCMH-N capabilities
- Explore ways to incorporate *PCMH-N Interpretive Guidelines* into the VBR methodology
- Focus on collaborating with the Collaborative Quality Initiatives to develop aligned metrics
- Develop a measure that addresses engagement with physician organizations
- Explore PCMH-N designation

### 3.1.1.3 Organized Systems of Care

Organized Systems of Care (OSC) is a Blue Cross term used to describe a community of caregivers with a shared commitment to quality and cost-effective health care delivery for the primary care-attributed population of patients. By joining primary care physicians, specialists and hospitals into coordinated care delivery systems, OSCs are designed to address problems inherent in the delivery of fragmented and costly health care services that fail to meet the needs of the patient population.

Organized Systems of Care are defined by PCP-attributed member populations and have a shared commitment to proactive population and individual care management across care settings and over time. OSCs are expected to have the ability to conduct ongoing quality and efficiency measurement and to use data from all key providers in their performance measurement efforts.

OSC build upon the success of the PGIP and PCMH-N programs by acting as a catalyst for establishment of systems of care that coordinate delivery of health care services with clinical integration across the continuum and are accountable for the management of a defined patient population. Over time, the OSC will become the central hub of patient-specific and population information. Care management efforts and population level analyses generated from this information will be more robust than information derived solely from claims data from payers and will enable the OSC to manage their population of patients.

To support PGIP physician organizations in the transition to OSCs, Blue Cross invites PGIP-participating organized systems of care to collaborate on the following three initiatives to support incremental implementation of OSC-related capabilities. All opportunities are optional for PGIP-participating OSCs.

1. **OSC Integrated Patient Registry Initiative** builds on the capabilities in the PCMH Registry Initiatives and enables OSC providers to perform OSC-wide management of the attributed patient population and reduce disparities in the provision of health care services.

2. **OSC Integrated Performance Measurement Initiative** builds on the capabilities in the PCMH Performance Reporting Initiative and enables OSCs to generate OSC-wide performance reporting for all patients. Initially, performance reports will be for internal use, but in the longer-term, OSCs will collaborate to define a common set of measures that can be used to provide external entities with information for payment and public reporting.
3. **OSC Processes of Care Initiative** builds on the foundational capabilities in the PCMH Initiatives, catalyzing the OSC to ensure that care partners communicate, coordinate, and collaborate to achieve clinical integration at the OSC level. This initiative is designed to ensure that the relevant PCMH domains of function are in place across all care partners with appropriate linkages at the OSC level.

**2017 program goal**

Increase number of OSC capability phases implemented by at least 5%
3.1.2 Hospital Pay-for-Performance (P4P) Program

The Blue Cross Hospital Pay-for-Performance (P4P) programs provide incentives to acute care providers who improve health care quality, cost efficiency and population health.

The program for large and medium-sized hospitals encompasses the following program components:

- A mandatory prequalifying condition that ensures hospitals take basic steps to demonstrate a commitment to building a culture of patient safety
- Participation in the Blue Cross hospital Collaborative Quality Initiatives and the Great Lakes Partnership for Patients Hospital Improvement Innovation Network initiatives sponsored by the Michigan Health and Hospital Association’s (MHA) Keystone Center for Patient Safety (see section 3.1.5.3 for program details)
- Service-line efficiency within the Michigan Value Collaborative
- Health Information Exchange requirements to help physicians better manage patient care across the entire continuum
- All-cause readmissions performance and readmissions-related initiatives

The program for small and rural hospitals, including critical access hospitals, is structured to positively challenge rural hospitals to deliver the most value to the unique communities they serve. The program includes the following components:

- Participation in quality improvement initiatives under the Hospital Improvement Innovation Network sponsored by the Michigan Health and Hospital Association’s (MHA) Keystone Center for Patient Safety
- Performance and improvement on selected Centers for Medicare and Medicaid Services (CMS) quality Indicators
- Population health webinar attendance and population insights evaluation by designated Population Health Champions
- High-level health information exchange efforts to align with large and medium-sized hospitals programs
- Community service plans that address unique health needs of rural communities

2017 program goals

- Continue to require 100% of hospitals to fully comply with the program’s patient-safety prequalifying condition, including:
  - Conducting regular patient safety walk-rounds with hospital leadership
  - Assess and improve patient safety performance by fully meeting one of the following options:
    - Complete and submit the National Quality Forum Safe Practices section of the Leapfrog Hospital Survey at least once every 18 months
    - Complete the Joint Commission Periodic Performance Review of National Patient Safety Goals at least once every 18 months
    - Review Compliance with the Agency for Health care Research Patient Safety Indicators at least once every 18 months
- Participate in a federally-qualified patient safety organization
  o Ensure results of the patient safety assessment and improvement activities are shared with the hospital’s governing body and incorporated into a board-approved, multi-disciplinary patient safety plan that is regularly reviewed and updated
- Increase the number of hospitals demonstrating favorable year-over-year improvements in their own hospital-specific 30-day all-cause readmission rate from the previous program year (n= ~40% of participants). Hospitals are assessed using the CMS/Yale Hospital Wide 30-day unplanned readmission rate (HWR: NQF 1789) for their BCBSM commercially insured PPO population.
- Observe year-over-year improvements in hospital-selected Michigan Value Collaboration service lines, including:
  o Acute Myocardial Infarction
  o Colectomy (non-cancer)
  o Congestive Heart Failure
  o Coronary Artery Bypass Graft
  o Joint Replacement (hip and knee episodes combined)
  o Pneumonia
  o Spine Surgery
- Engage all P4P-participating acute care providers in more robust Health Information Exchange use cases, including:
  o Implementation of the Common Key Service
  o Developing querying abilities via the statewide notification service
  o Submitting lab values into the state’s disease surveillance system for communicable diseases
3.1.3 Hospital Value-Based Contracting

In 2013, Blue Cross began a value-based contracting (VBK) initiative designed to transition providers away from traditional fee-for-service toward a value-based system that rewards collaboration and improvements in population health.

Initially, BCBSM’s VBK efforts were intended to serve as a glide path for acute care providers to build the necessary infrastructure and partnerships with partnering physician organization partners needed to be successful in this new reimbursement environment. Since the program’s inception, sixty-nine Michigan hospitals, representing nearly 85 percent of the total Blue Cross commercial hospital payout, have signed a Value Based Contract. Although fifteen contracts have expired, the remaining fifty-four contracts represent over 70 percent of the total Blue Cross commercial hospital payout.

In the program’s first three years, VBK-participating hospitals have generated over $130 million in savings, over half of which was shared with participating providers. Additionally, VBK participating sites experienced both a lower point-in-time per-member-per-month (PMPM) and year-over-year trend for the patient population they serve with their partnering physician organization partners.

2017 program goals

- **Continue to experience both lower point-in-time and year-over-year PMPM trends for VBK-participating hospitals as compared to their non-participating peers.** BCBSM’s actuarial department evaluates VBK provider performance annually.
- **Develop a second iteration of VBK contracts that potentially address provider feedback from first iteration of contracts including:**
  - Outlier methodology
  - Provider attribution
  - Quality metrics
  - Target price benchmarking
3.1.4 Collaborative Quality Initiatives

Collaborative Quality Initiatives (CQIs) support Blue Cross efforts to work collaboratively with physicians, hospital partners and community leaders to develop programs and initiatives that save lives and reduce health care costs. CQIs are developed and administered by Michigan physician and hospital partners, with funding and support from Blue Cross and Blue Care Network (BCN). CQIs seek to address some of the most common, complex and costly areas of surgical and medical care.

CQIs support continuous quality improvement and development of best practices for areas of care that are highly technical, rapidly evolving and associated with scientific uncertainty. Given that valid, evidence-based, nationally accepted performance measures are only established for a narrow scope of health care, Blue Cross leverages collaborative, inter-institutional, clinical data registries to analyze links between processes and outcomes of care to generate new knowledge, define best practices and guide quality improvement interventions across Michigan.

The CQI Program supports:

1. Data Collection – Timely feedback of robust, trusted, consortium-owned performance data to hospitals and providers
2. Collaborative Learning – Collaborative, data-driven learning fostered in a non-competitive environment (meetings are held in person, typically on a quarterly basis)
3. Improvement Implementation – Systematic development, implementation, and testing of hospital-specific and Michigan-wide quality improvement interventions

The goal is to empower providers to self-assess and optimize their processes of care by identifying opportunities to bring care into closer alignment with best practices, which leads to improved quality and lower costs for selected, high cost, high frequency and highly complex procedures. The CQI model has proven remarkably effective in raising the bar on clinical quality across a broad range of clinical conditions throughout Michigan.

CQI Coordinating Centers

Each CQI is led by a Blue Cross-commissioned, provider-led Coordinating Center, that is independent of BCBSM. Dedicated Coordinating Centers are responsible for ensuring the validity of the CQI program data and for managing quality improvement activities focused on improving outcomes, increasing efficiencies and reducing patient care costs. Coordinating Centers guide the development of quality improvement plans and generate new knowledge about best practices. The CQIs focus on areas where:

1. Identifiable and clear variations in practices of care exist throughout the health care continuum
2. An opportunity to positively influence outcomes is evident
3. Knowledge about optimal practices are not widely implemented or scientific uncertainty exists

The Coordinating Center is staffed by individuals whose primary function is the activities of the consortium—with the exception of the project leader (a practicing physician/surgeon, usually between a 0.25 to 0.40 FTE). Typically staffed by quality improvement, nursing and epidemiological personnel from a hospital (usually an academic center), the Coordinating Center’s role is to engage the provider community in all aspects of the consortium.
In most cases, participants submit disease or procedure-specific data to a centralized data registry. The Coordinating Center conducts risk-adjusted analyses to identify best practices and opportunities for improvement. Reports are then shared with participating hospitals where systematic implementation of the recommendations result in improved outcomes, increased efficiencies and cost avoidance associated with reduction in adverse outcomes.

Quality improvement interventions include:
- Selected processes that have been proven by registry-based analyses to be effective and appropriate for the vast majority of patients
- Aspects of clinical care that are generally known to be evidence-based, with significant variability across providers, and known to yield improved outcomes.

As of 2017, Blue Cross is providing funding and active leadership for 18 CQIs addressing one or more of the following clinical conditions:

<table>
<thead>
<tr>
<th>Hospital CQIs</th>
<th>Ambulatory CQIs</th>
<th>Hybrid CQI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology (ASPIRE)</td>
<td>Urology (MUSIC)</td>
<td>Integrated Michigan Patient-Centered Alliance on Care Transitions (IMPACT)</td>
</tr>
<tr>
<td>Cardiovascular(BMC2)</td>
<td>Lean transformation (Lean)</td>
<td></td>
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<tr>
<td>Anticoagulation (MAQI2)</td>
<td>Pharmacy (MPTCQ)</td>
<td></td>
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<tr>
<td>Bariatric surgery (MBSC)</td>
<td>Oncology (practice and treatment) (MOQC)</td>
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<tr>
<td>Cardiac surgery (MSTCVS)</td>
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<tr>
<td>Emergency department care (MEDIC)</td>
<td></td>
<td></td>
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<tr>
<td>General surgery (MSQC)</td>
<td></td>
<td></td>
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<tr>
<td>Hospital efficiency (MVC)</td>
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<td>Hospitalist care (HMS)</td>
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<td>Radiation oncology (MROQC)</td>
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<tr>
<td>Spine surgery (MSSIC)</td>
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<tr>
<td>Total knee and hip replacement (MARCQI)</td>
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<tr>
<td>Trauma (MTQIP)</td>
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Cost Avoidance for CQI program from 2008-2014

<table>
<thead>
<tr>
<th></th>
<th>Bariatric Surgery</th>
<th>General Surgery</th>
<th>Cardiac Surgery</th>
<th>Angioplasty &amp; Vascular Intervention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSM, BCN, MA</td>
<td>17,223,416</td>
<td>203,699,323</td>
<td>19,985,514</td>
<td>86,771,387</td>
<td>327,679,640</td>
</tr>
<tr>
<td>Total Statewide</td>
<td>36,283,277</td>
<td>341,969,362</td>
<td>174,864,374</td>
<td>479,720,423</td>
<td>1,035,837,437</td>
</tr>
</tbody>
</table>

**2017 program goals**

- Continue to develop additional best practices for CQI programs to demonstrate improved patient outcomes and share lessons learned locally, nationally, and internationally
- Evaluate CQI program performance to identify opportunities for strengthening, revamping or retiring
3.1.5 Patient Safety Management
Blue Cross monitors and improves patient safety through activities focused on identifying and reporting safety concern; reducing medical errors; and collaboration with delivery systems, hospitals and physicians/clinicians to develop innovative plans to improve patient safety and clinical outcomes.

Patient safety efforts are designed to work in collaboration with other Michigan managed care plans, hospitals, purchasers and practitioners to identify safety concerns, develop action plans with measureable outcomes and implement plans with the goal of improved patient safety and fewer medical errors. Patient safety standards are developed and communicated in key areas that have been documented as potential patient safety concerns, such as reduction of medical errors and improving patient outcomes, computer physician order entry system, intensive care unit physician staffing and an evidence-based hospital referral standard.

3.1.5.1 Blue Distinction Centers for Specialty Care® (BDC)
Established in 2006, Blue Distinction Centers for Specialty Care® (BDC) are national networks of designated centers used by participating Blue Cross plans across the country.

BDC has demonstrated expertise in delivering quality health care in specific high-cost, high-variability services. The evaluation processes for these centers are based on a “total value” designation, which incorporates quality and patient safety measures, cost, and network access. The designation is based on objective, evidence-based selection criteria established in collaboration with expert physicians and medical organizations. These medical professionals evaluate best practices, guidelines and standards that help support the coordination and delivery of services to targeted populations with specific diagnostic and therapeutic needs. Facilities designated as BDCs have collectively demonstrated better outcomes and fewer complications for patients seeking the specialized care the center provides.

BDCs identify facilities that demonstrate proven expertise in delivering safe, effective and cost-efficient care for select specialty care procedures. These areas currently include bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacements, spine surgery, transplants and maternity care. The program was developed in 2006 to eliminate gaps in provider quality and to guide members to higher value facilities.

The Blue Distinction Program has grown to include a new designation—Blue Distinction Centers+—which evaluates hospitals on cost-efficiency measures in addition to more robust quality measures focused on patient safety and outcomes. This value-based designation is critical because the areas of specialty care covered by the program represent more than 30 percent of inpatient hospital expenditures.

2017 program goals
1. Provide continued communications support of the new maternity care designation program as well as this year’s re-designation of facilities with cardiac care, knee/hip replacement, and spine surgery BDC designations.
2. Measurement: meet all Association tactical deadlines. Communications will be done through BCBSM news releases and articles in our various BCBSM provider e-newsletters.
3.1.5.2 Blue Distinction Total Care SM (BDTC)

In 2015, the Blue Cross Blue Shield Association launched a newly created program for all Blues plans with value based programs call Blue Distinction Total Care, expanding the Blue Distinction program into the area of primary care. This new designation identifies high-performing Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) that meet nationally consistent criteria for quality, efficiency and patient outcomes. BDTC programs incorporate patient-centered and data-driven practices to better coordinate care and improve quality and safety as well as affordability of care. Providers in BDTC programs are paid with value-based reimbursement rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes. Participation in the BDTC program is a Blue Cross Blue Shield Association mandate.

To be considered for BDTC designation, a provider must be part of a value-based program with a local Blue Cross and/or Blue Shield Plan that meets all six of the nationally consistent required selection criteria, carefully selected based on their part in driving higher quality and more affordable care:

1. Program focuses on managing care for a population of BCBS members.
2. Program attributes BCBS members to the provider responsible for managing care.
3. Program provider contracts contain value-based incentives associated with both cost and quality outcomes.
4. Providers, in collaboration with BCBS Plans, are responsible for utilizing additional data and analytics to support activities including at least three of the following five practices to improve quality and affordability.
   a. Practice Referral Pattern Management – assessing provider referral patterns to enhance quality and affordability
   b. Labs and Imaging Practice Management – assessing lab and imaging patterns to enhance quality and affordability
   c. Readmissions Practice Management – assessing patterns for quality and affordability that reduce avoidable readmissions
   d. Medication Practice Management – assessing patterns for quality and affordability that enhance medication management
   e. Emergency Room Practice Management – assessing patterns for quality and affordability that reduce ambulatory sensitive ER visits
5. Program is available to BCBS members through a PPO-based product.
6. Program is available to BCBS members covered by administrative services only (ASO) and fully insured products.

2017 program goals

- Report attribution and work with our internal teams to develop key performance indicators that include cost, quality and utilization of BDTC participating programs
- Improve understanding of BDTC program nationally and leverage these designations for customer solutions
3.1.5.3 MHA Keystone Center for Patient Safety & Quality

Blue Cross provides considerable funding to the Michigan Health and Hospital Association (MHA) to support the MHA Keystone Center, a collaborative effort among Michigan hospitals – along with state and national patient safety experts – to improve patient safety and reduce health care-acquired infections.

Over the past several years, the MHA Keystone Center has focused on initiatives related to care transitions, catheter-associated urinary tract infections (CAUTI), emergency rooms, intensive care units, obstetrics, sepsis, surgery and pain management. The center was also a co-leader in three national projects aimed at eliminating specific hospital-associated infections and serves as a Partnership for Patients Hospital Engagement Network.

In 2016, the Keystone Center partnered with both the Illinois Health & Hospital Association (IHA) and the Wisconsin Hospital Association (WHA) to form the Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN). The focus of the HIIN is to implement person and family engagement practices, enhance antimicrobial stewardship, build cultures of high reliability and address the following types of inpatient harm:

- Adverse drug events
- Central line-associated blood stream infections
- Catheter-associated urinary tract infections
- Clostridium difficile bacterial infection, including antibiotic stewardship
- Injury from falls and immobility
- Pressure ulcers
- Sepsis and septic shock
- Surgical site infections
- Venous thromboembolism
- Ventilator-associated events
- Readmissions

2017 program goals

The primary goal of the Blue Cross funding for the MHA Keystone Center is to remove participation barriers for hospitals. In addition, the 2017 Blue Cross Hospital Pay-for-Performance Program rewards hospitals for the following HIIN-related activities:

- Submission of outcome data
  - Goal: At least 90% of outcome data submitted across 12-month period
- Improvement on pain management for sepsis and CAUTI measures
  - Goal: Improvement on adverse events related to catheter-induced urinary tract infections, sepsis and inpatients receiving opioids
- Launch of Patient and Family Advisory Councils
  - Goal: Fully include patient advisors
- Assessment of current practices for antimicrobial stewardship (AMS)
  - Goal: Complete AMS gap analysis
3.1.5.4 Health Information Exchange (HIE)

The Health Information Exchange (HIE) component is designed to ensure caregivers have the data they need to effectively manage the care of their patient population. The HIE component is focused on improving the quality of data transmitted through the Michigan Health Information Network (MiHIN) statewide service, expanding the types of data available through the service, and developing capabilities that will help facilitate statewide data exchange going forward.

Since the HIE component was introduced in 2014, hospitals have significantly improved the availability and quality of admission, discharge, transfer and medication data available to caregivers across the state. In addition, HIE and the MiHIN service support PGIP physician organizations by providing practitioners with a single access point to obtain daily admit-discharge-transfer (ADT) and Emergency Department (ED) information for all of their patients, regardless of whether they have an affiliation with the hospital. The service uses existing health information exchange infrastructure to receive hospital ADT and ED visit data, identify which physician has a care relationship with each patient and transmit a notification to the relevant physician organization.

Expanding on the hospital ADT data available to POs, BCBSM introduced a Skilled Nursing Facility (SNF) Pay-for-Performance program into the HIE continuum beginning in January 2016. The SNF P4P program provides freestanding and hospital-based SNFs the opportunity to earn an incentive for meeting HIE expectations, including submission and receipt of all-payer admission, discharge, transfer notifications through the MiHIN statewide service.

Overall participation in the statewide service provides foundational support to the PCMH model of care and is designed to improve care by ensuring practitioners receive timely notification when one of their patients has an ADT or ED event. This is expected to result in a better care transition, an improved health outcome and reduced likelihood of an unplanned readmission. Blue Cross Blue Shield of Michigan (BCBSM) also participates with MiHIN as a health plan qualified organization, which allows it to transmit and receive data for its members. In addition, BCBSM’s Chief Medical Officer serves as a member of the MiHIN board.

3.1.5.4.1 Peer Group 1-4 Hospitals Engagement in HIE Initiative

Since the HIE Initiative was introduced in 2014, 100 hospitals have started participating in MiHIN’s statewide notification service. Hospitals have significantly improved the availability and quality of admission, discharge, transfer and medication data available to caregivers across the state. Participating hospitals are currently sending notifications for approximately 91 percent of all admissions statewide. These efforts will continue to be recognized through 2018, with hospitals earning a portion of their BCBSM P4P HIE points through continued data quality conformance standards for the ADT and Medication Reconciliation use cases. The remaining points will be earned by participating in at least one new HIE use case through the MiHIN statewide service each year. The use case options through 2018 include the common key service, exchange statewide lab results and find patient record.
3.1.5.4.2 Peer Group 5 Hospitals Engagement in HIE Initiative

BCBSM designates small, rural acute care facilities that provide access to care in areas where no other care is available as peer group 5 facilities. Additionally, many of these hospitals are also classified as Critical Access Hospitals (CAH) by Medicare. The BCBSM PG5 Hospital P4P program provides these hospitals with an opportunity to demonstrate value to their communities and customers by meeting expectations for access, effectiveness and quality of care.

One component of the BCBSM PG5 P4P is called Health of the Community. Beginning in the 2016-2017 program year, hospitals have the option of participating in the MiHIN statewide service by implementing the Admission-Discharge-Transfer use case. While this is an optional portion of the Health of the Community component in 2016, it is BCBSM’s intention to make it a mandatory component in upcoming program years.

3.1.5.4.3 Skilled Nursing Facility Engagement in HIE Initiative

BCBSM introduced a Skilled Nursing Facility (SNF) Pay-for-Performance program into the HIE continuum beginning in January 2016. The SNF P4P program provides freestanding and hospital-based SNFs the opportunity to earn an additional 1 percent of their commercial BCBSM payment for meeting HIE expectations, including submission and receipt of all-payer admission, discharge, transfer notifications through the MiHIN statewide service.

3.1.5.4.3 Physician Organizations (PO) Engagement in HIE Initiative

Since 2014, thirty physician organizations have started participating in MiHIN’s statewide notification service through implementation of the Admission-Discharge-Transfer (ADT) and Exchange Medication Reconciliation use cases. Participation in both use cases offers providers a single access point to obtain daily ADT and medication information for all their patients, regardless of hospital affiliation. Participating POs currently receive daily ADT and ED visit notifications for more than 7 million Michigan patients.

In 2017, HIE efforts will continue to focus on connecting new physician organizations to the statewide service, improving data quality, and helping recipients appropriately incorporate ADT messages and medication information into processes of care. The HIE Initiative will also promote key foundational use cases such as the Active Care Relationship Service (ACRS) and the statewide Health Directory. These foundational use cases are designed to improve Michigan’s shared services data sharing infrastructure and increase coordination and collaboration across multiple settings to support population health management and payment reform.

2017 HIE program goal

Increase PO participation in statewide foundational data sharing use cases by at least 5 physician organizations

3.1.5.5 Value Partnerships Pharmacy Workgroup

Formed in 2013 with a focus on partnering with and providing value to our members and providers, Value Partnerships, HCV Data Analytics and Pharmacy Services formed a workgroup to collaborate internally and externally to generate ideas, prioritize efforts, determine and implement success measures, and evaluate efforts. The collaboration is designed to further strengthen Blue Cross’ quality efforts as we strive to improve
upon those. Pharmacy-related topics are identified and presented to pharmacy representatives at provider organizations related to medication safety, quality and cost-effectiveness. In addition, the workgroup facilitates the use of clinical data by physician organizations to address gaps in clinical care and improve prescribing.

2017 program goals

In 2017, the workgroup will identify further opportunities to work with pharmacists in physician organizations. Topics addressed through the workgroup will include, but not be limited to opioids, medication adherence, antibiotics, medication reconciliation and pharmacy costs. Goals for the Value Partnerships Pharmacy Workgroup include holding at least 8 meetings with PGIP physician organization; sustaining physician organization interest and engagement on pharmacy issue; conducting at least one survey; and implementing at least one change as a result of the survey.

3.1.6 Program Optimization

The objective of Program Optimization is to establish performance recognition incentives and consequences designed to ensure that all PGIP physician organizations and OSCs are fully engaged in PGIP programs and are striving to deliver optimal care to their attributed patient populations.

Blue Cross will implement Program Optimization in two phases:

- **Phase 1** — High performing and improving physician organizations and OSCs may receive bonus payments. Low performing physician organizations and OSCs that are not making progress will be placed on either an Action Plan or Probation, depending on their score.
- **Phase 2** — Beginning in 2017, low performing physician organizations will have their PGIP reward payments reduced. (The exception to this policy is if a physician organization was on probation during 2015-2016 and continues to be on probation, the penalty will be applied in January 2017.)

The goal of Program Optimization is to catalyze physician organizations and OSCs to deliver optimal patient-centered care, and in particular, to ensure focus on clinical quality, adoption of the PCMH, PCMH-N and OSC models and leadership and engagement in population management and PGIP programs. All existing physician organizations and OSCs will participate in Program Optimization. New physician organizations and OSCs are not yet eligible (considered new to PGIP if at least 51% of their physician members were not participants in PGIP during the most recent twelve-month period).

Each physician organization and OSC will receive a scorecard annually, showing their overall Performance and Improvement scores and ratings, as well as their scores on each of the individual measures. The scorecard will include comparative information on the ratings and financial impact of all other POs or OSCs.

2017 program goals

Deliver scorecards to 45 physician organizations and 39 organized systems of care by year-end 2017
3.2 Behavioral Health

In 2015, New Directions assumed behavioral health management of Blue Cross members nationwide. New Directions is a managed behavioral health organization accredited by the National Committee for Quality Assurance. With more than 20 years’ experience in utilization and case management services, in addition to extensive experience working with Blue plans nationwide, New Directions’ services include preauthorization and case management for members who receive behavioral health through Blue Cross.

The Blue Cross Behavioral Health Quality Improvement Committee reports to the QIC with a goal of creating and maintaining a comprehensive and integrated approach to behavioral and medical management. New Directions is responsible for oversight of the Blue Cross behavioral health program and participates in the BH QIC. BH QIC membership includes New Directions BH medical director, medical directors from Blue Cross and BCN and other internal Blue Cross clinical and non-clinical staff, including representation from the following teams: Behavioral Health, Value Partnerships, Epidemiology and Biostatistics and Quality Management and Accreditation. The group meets minimally quarterly to review initiatives, clinical guidelines and policies and to assess metrics for the behavioral health program.

From 2012 to December 2015, PGIP showed an increase from 444 to 997 combined behavioral health specialists. This represents an increase in total behavioral health practitioner engagement with POs by 124.5 percent over year 2012. Fully licensed psychologist engagement increased by 98.5 percent between 2012 and 2015. Psychiatric engagement increased by 167.3 percent between 2012 and 2015.

Behavioral Health vendor oversight is provided by the Quality Management and Accreditation Team, including a quality improvement Associate Medical Director and the center of excellence at Blue Cross responsible for overseeing vendors (VMCOE).

2017 program goals

- Continue work with PGIP and the behavioral health workgroup to promote dialogue between physician organizations, their primary care physicians and the behavioral health specialists who provide services to attributed members. This work could include a specific incentive or could enhance the integration of behavioral health into existing programs.
- Work to include behavioral health conditions as part of the required contents of patient registries for PCMH with a proposed measure being the proportion of medical charts with contact from behavioral health specialists
- Streamline authorizations by implementing online authorization application called WebPass, offered by new vendor, New Directions
3.3  **Shared Enterprise Services**

Blue Cross Blue Shield of Michigan maintains an annual agreement with its sister organization Blue Care Network (BCN). Through a Shared Enterprise Agreement, BCN—an NCQA-accredited HMO—performs certain functions for Blue Cross Commercial PPO, including:

- Handling credentialing for the entire organization
- Investigating complaints regarding quality of care issues
- Obtaining and reporting provider access and availability
- Collecting and reporting information on continuity and coordination of care

The components of the Shared Enterprise Agreement are overseen by Blue Cross during meetings attended by representatives from both organizations.

3.3.1  **PPO Network Management and Health Services Contracting**

Through its quality and legal oversight process, Blue Cross ensures that PPO providers are credentialed before they are contracted and re-credentialed every three years. All credentialing and re-credentialing functions are carried out by BCN on behalf of Blue Cross and provider contracts are compliant with accreditation and regulatory requirements. The oversight groups ensure that contracted Michigan providers adhere to contract requirements and provider manual guidelines and policies, which include compliance with quality improvement activities, access to medical records and protection of member information confidentiality. Contracts with PPO practitioners include affirmative statements indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

**2017 program goals**

In 2017, Blue Cross will focus on the following goals with respect to qualified providers:

- Develop and promote educational opportunities for in-network healthcare providers using Blue Cross-sponsored collaborative initiatives outlined in this document
- Oversee process for credentialing and re-credentialing PPO providers including follow up on provider complaints or quality issues brought to the attention of Blue Cross through the clinical complaint process via Executive Services. These are then referred to BCN for further investigation.
- Review physician practices to identify and assist providers with aberrant utilization
- Monitor PPO provider utilization to ensure requirements for utilization management programs are met

3.3.2  **Access and Availability**

The overall goal of the Quality Improvement Program is to improve the quality of healthcare services Blue Cross members receive and to improve the health status of the entire Blue Cross population.

**2017 program goals**

In 2017, Blue Cross will focus on the following access/availability goals:

- Identify and resolve issues related to member access to and availability of healthcare services
Monitor, evaluate and support PPO providers to ensure standards for access and availability are being met for primary, specialty and behavioral health care practitioners.

Ensure a consistently high level of care is delivered to all members regardless of age, gender, care delivery site, healthcare status, ethnicity or religious beliefs through monitoring of member needs and availability of practitioners within the PPO network, adjusting available network practitioners if necessary.

Access and availability of practitioners will be measured routinely through processes established by PPO Network Management and the Blue Cross quality improvement team. Member feedback from CAHPS, member complaints and survey results will be analyzed. Areas of focus will include but not be limited to the following:

- Access to services 24 hours a day, 7 days a week
- Appointment availability
- Quality of care
- Urgent care appointments

Blue Cross conducts quarterly meetings with BCN to review reports on access and quality and an annual summary is presented to the QIC for review, analysis and recommendations. The appropriate committee(s) will communicate issues that arise throughout the year to the QIC.

### 3.3.3 Continuity and Coordination of Care

Blue Cross is committed to improving the quality of care delivered to members. Coordinated care is a critical element in achieving this goal. Coordination involves communication amongst multiple providers each providing individual expertise, knowledge and skills working toward the goal of reducing inefficiencies and responding to patients’ unique care needs.

#### 2017 program goals

In 2017, Blue Cross will focus on the following Coordination of Care goals:

- Collect and analyze data to identify opportunities for improvement in coordination of medical care
- Collect and analyze data to identify opportunities for improvement in coordination between medical and behavioral care
- Select three opportunities for improvement in coordination of medical care to take action upon and measure effectiveness of the interventions implemented.
- Select two opportunities for improvement in coordination between behavioral and medical care to take action upon and measure effectiveness of interventions implemented.
3.4 Member Satisfaction

Corporate Marketing and Customer Experience serves as the market and customer insight engine to the organization. These groups provide strategic direction and thought leadership to drive sales, improve the customer experience and build retention and loyalty. We are building a customer-centric organization and transforming digital and offline customer touchpoints to ensure increasingly easy, useful, and enjoyable experiences. By leveraging the insights gained from CAHPS and other research, as well as the Voice of the Customer efforts, this department identifies opportunities and aligns company resources to drive improvements in selected areas. Member experience annual documentation includes analysis of complaints and appeals, CAHPS and other data, and identifying opportunities for improvement of member satisfaction with Blue Cross services, behavioral health care and services, and Marketplace network transparency and experience.

The Customer Experience Department creates ongoing programs to educate employees on member “pain points” identified through research and analysis. This department also develops opportunities and tools to help employees improve the member experience. Blue Cross believes employees who are knowledgeable about member issues and concerns can make positive improvements in the member experience.

The 2017 annual corporate goals include a customer experience component that applies to all employees. This component focuses employees and resources on key improvement initiatives designed to address significant issues affecting the customer experience.

2017 program goals

Blue Cross will focus on the following member satisfaction goals in 2017:

- Assess member satisfaction with Blue Cross care and services through CAHPS and other member surveys along with other sources of member feedback
- Support continuous improvement of services and satisfaction for members and providers
- Improve member accessibility to Blue Cross through self-servicing digital channels with which members are already familiar and comfortable
- Develop and promote opportunities, as well as provide education for employees to learn about member “pain points” and how to address them
- Systematically evaluate member complaints and appeals as a source of data on member satisfaction, identify root cause, implement process improvements and assess impact of process improvements to ensure member issues are addressed
- Address plan understanding by identifying improvement initiatives through our voice of the customer and survey data and ensure member touchpoints are clear and simple®
3.4.1 Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
Blue Cross surveys its members using the CAHPS survey instrument conducted annually by an NCQA-certified vendor. The QIC and Member Experience Committees evaluate survey results, combining them with other member feedback surveys to determine areas in which BSCSM can improve service to members. CAHPS survey results are reported to NCQA and other governmental and regulatory agencies as required.

3.4.2 Voice of the Customer (VOC)
The Blue Cross/BCN Voice of the Customer (VOC) program is designed to gather and track member feedback from multiple channels and touchpoints across the enterprise. The VOC team uses an analytics dashboard that provides a central repository for employees to access and analyze qualitative and quantitative feedback on the member experience. Data feeding the analytics dashboard refreshes on a daily basis allowing the organization to monitor changes in customer satisfaction identify issues when they occur, track progress of overall member experience improvement initiatives and share insights with key leadership and stakeholders company-wide.

3.4.3 Digital Experience (DX)
The Blue Cross/BCN Digital Experience (DX) team supports the organization by delivering experiences that help prospective members, current members and group customers at their moments of need. The DX team currently manages:

- **BCBSM.com** – Destination for prospective members to evaluate plan options and for existing members to learn more about their health care journey
- **Member Portal** – Secured and personalized experience that helps members manage their coverage and explore care options
- **Member Mobile Application** – Smartphone application that puts members’ plan information at their fingertips – available anytime, anywhere
- **Agent Portal** – Hub for BCBSM agents to guide their portfolios from quote to enrollment
- **Group Portal** – One-stop shop for group customers to access and manage their coverage details
- **Provider Portal** – Wealth of resources for the Blue Cross network of doctors and hospitals, assisting with provision of member quality care

As part of their human-centered design practice, the DX team actively engages users in the testing of new features and content. They gather feedback from their own initiatives and combine it with those from partnering business units to ensure that every person coming to our site or app has an exceptional health care experience.

3.4.4 Member Complaints
Blue Cross uses member complaint data to improve services and increase overall member satisfaction. All member complaints regarding medical, contractual or administrative concerns are received, categorized, reviewed and analyzed. Complaint resolution is accomplished through a cooperative effort between Blue Cross and BCN. Blue Cross clinical complaints are forwarded to BCN Quality Improvement using a mutually agreed-upon process for investigation, resolution, tracking and trending. These service trends are taken into account in the provider re-credentialing process.

Blue Cross Executive Services maintains a consistent process in compliance with federal and state regulations for handling member pre-service appeals, post-service appeals, coverage appeals and managing the federal external review process.
3.4.5  Network Transparency and Experience
Blue Cross provides members with appropriate information to assist them in determining the best plan option for their health care needs. In addition, we monitor the member experience with Marketplace plans to identify opportunities for improving the member experience and the plan offerings. Monitoring includes but is not limited to:

- Using clear and simple language to explain the criteria that Blue Cross uses when selecting practitioners to participate in the Marketplace plan options
- Identifying the types of practitioners and hospitals included and their geographic distribution
- Providing details on the quality and member experience measures utilized to select practitioners and hospitals for participation
- Conducting an annual analysis of Marketplace/EPO member complaints, appeals and requests for out-of-network requests to identify opportunities and prioritize actions to improve satisfaction and performance.
3.5 Cultural and Linguistic Diversity

In 2017, Blue Cross will narrow its focus and address disparities using our Value Partnerships patient-centered medical home program. The PCMH program supports provider collection of race, ethnicity and language (REL) data in addition to supporting language translation services and bilingual materials. Core PCMH capabilities that support addressing health disparities within our population include open access same day appointments and extended hours; quality reporting and test tracking; care coordination and case management.

The Blue Cross PCMH program was featured in the April 2015 JAMA publication. The longitudinal study of 2218 primary care practices examined breast, cervical and colorectal cancer screening rates on the practices’ plan patients. Results indicated that the implementation of PCMH was associated with higher screening rates and reductions in socioeconomic disparities that were otherwise seen for preventive cancer screenings.

PCMH capabilities that relate to addressing health/health care disparities include the following:

<table>
<thead>
<tr>
<th>Guideline number</th>
<th>PCP and Specialist Guideline</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.20</td>
<td>Registry contains advanced patient information that will allow the practice to identify and address disparities in care</td>
<td>Primary/preferred language, race, ethnicity, measures of social support (e.g., disability, family network), disability status, health literacy limitations, type of payer (e.g., uninsured, Medicaid), relevant behavioral health information</td>
</tr>
<tr>
<td>2.21</td>
<td>Registry contains advanced patient demographics</td>
<td>Gender identity, sexual orientation, sexual identity</td>
</tr>
</tbody>
</table>
| 5.9              | Practice unit has telephonic or other access to interpreter(s) for all languages common to practice’s established patients | Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population  
Language services may consist of 3rd-party interpretation services or multi-lingual staff  
Asking a friend or family member to interpret does not meet the intent of the capability |
| 5.10             | Patient education materials and patient forms are available in languages common to practice’s established patients | Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population  
Patient education materials and forms are clear and simple and written at an appropriate reading grade level |

Annually, Blue Cross analyzes marketplace and PPO populations to assess disparities across race/ethnicity as well as socioeconomic status for various clinical data measures based upon geocoded data utilizing membership zip
code as well as other proprietary logic. While activities to address disparities have been occurring across the company, in 2016, an Enterprise workgroup was formed with the following purpose:

- Create a shared understanding and vision for addressing health disparities
- Collect data
- Define an enterprise health disparities focus

The newly formed Health Disparities Action Team comprised of employees from Diversity and Inclusion, Health Care Value, Social Mission, Pharmacy Services, Sales and Marketing, Medicare and Human Performance meets every other month and has worked to catalog all of the existing activities and initiatives across the organization and define measures that are critical to success across products and stakeholders.

2017 program goals

- Maintain PCMH capabilities to encourage provider collection of REL data
- Define specific measures of focus
- Define strategic programs to impact health disparities
3.6 Medical Management Programs
Blue Cross medical management programs include Utilization Management, Disease Management and Case Management.

3.6.1 Utilization Management (UM)
The Blue Cross UM Program is a comprehensive program that includes medical care and behavioral health utilization activities across the care continuum. In order to provide quality care to our membership the UM Program structure is unique and focused on member specific needs. The UM Program relies upon a multidisciplinary approach to ensure efficient delivery of health care services in the best setting suited to meet the medical and psychosocial needs of the members.

UM program scope of activities includes but is not limited to the following components:

- Medical policy development
- Benefits administration and interpretation, including new technology assessment and determinations regarding experimental and investigational procedures
- Clinical review of medical procedures or treatment before it is performed
- Clinical review of inpatient and select outpatient services and procedures
- Admission and concurrent review
- Clinical review of behavioral health services
- Potential quality of care problem identification
- Complaint management
- Member/Provider appeal process
• Analysis of utilization data for trends in over and underutilization
• Interrater reliability assessment of clinical decisions
• Facility, Physician and member UM satisfaction assessment
• Compliance and performance improvement
• Delegated medical management oversight activities

A summary of the Disease Management and Case Management programs is provided on the next pages. For a detailed description of each, UM program, goals and measureable objectives, see the 2016 Utilization Management Program Evaluation.

3.6.2 Case Management

Case Management targets members with high-cost complex chronic and acute conditions, as well as those who are at high risk for incurring high-costs in the future. This population represents the greatest opportunity to positively affect member utilization, health status, quality of care, and/or benefit cost. To effectively manage these members, case management provides contract benefit management along with offering the flexibility of occasionally providing cost effective services outside of the member’s benefit plan (extra-contractual or non-contractual services).

Blue Cross Case Management is a member-centric program, available to all members, that provides support and coordination of health care services. The goal of the case management program is to develop cost-effective and efficient ways of coordinating health care services that improve the member’s quality of life. This is achieved through collaboration with the member, family, and the treating physician and members of the health care team to arrange appropriate services and care settings, assist in the evaluation of services, encourage communication among health care providers, and provide education for complicated health care needs. This collaborative process includes assessment, planning, implementation, monitoring, and evaluation of options and services to promote quality outcomes.

2017 Case Management goals:

• Ensure member has an attributed primary care physician
• Ensure member has scheduled and attends follow-up appointment with primary care physician within 7 days of discharge
• Increase member’s medication adherence (MMS)
• Increase member’s functional status (SF-8)
• Close member’s gaps in care

3.6.3 Disease Management

The Blue Cross Disease Management program is an integrated, member-centered program with a comprehensive continuum of care management interventions designed to help members manage their conditions/diseases. This
program offers support and assistance to relatively healthy, chronically ill and acutely ill members to maintain, restore or improve health. The program also does “reach and engage” activities for members to ensure interventions are delivered at the most effective point in time, optimizing member health.

Disease Management is available nationwide to all Blue Cross members who are eligible for Blue Cross Health and Wellness®. Member participation is voluntary and members may opt out of the program at any time. The program is tailored to meet the member’s individual needs based on his or her diagnosis and risk factors. Members and their caregivers will receive personalized educational and self-care materials and assistance in the management of their chronic conditions based on current evidence-based practice and standards of care.

The Disease Management program is based on the principles of self-management. Self-management programs emphasize the patients’ central role in managing their illness. It has been estimated that 95 to 99 percent of chronic illness care is given by the person who has the illness. However, without sustained support, many adults will not succeed in managing their conditions well, which can result in poor health outcomes, including expensive hospitalizations and avoidable complications. Therefore, it is crucial to support the patient in the role as self-manager.

Disease Management addresses a broad segment of the Blue Cross member population with targeted chronic conditions. The program identifies members for whom health education and self-care management interventions can have a positive impact on the quality, clinical outcomes and cost effectiveness of care. This is achieved through the proactive identification of our member population with select chronic conditions and the provision of interventions that address demonstrated needs. These interventions are available to members with specific chronic conditions that are generally healthy and may have gaps in the management of their chronic conditions, which require more intensive support in order to achieve compliance with evidence-based clinical practice guidelines for their diseases.

**2017 Disease Management goals:**

- Increase member compliance with closing gaps in care
- Increase members with an attributed primary care physician
- Increase member motivation of medication adherence or stay in high quadrant
- Increase member knowledge of medication adherence or stay in high quadrant
3.7 Clinical Quality Improvement

All Blue Cross efforts include continuous quality improvement in the interest of improving member and provider services and quality. Our clinical quality improvement efforts focus on improving clinical quality and outcomes as measured by HEDIS. PGIP’s Clinical Quality Initiative is our provider strategy to provide data and incentives focused on process of care improvements. All of our clinical work is guided by the clinical practice guidelines we have adopted — developed by the Michigan Quality Improvement Consortium (MQIC) and the preventive guidelines established by the United States Preventive Services Task Force (USPSTF).

In 2017, Blue Cross focused on the following clinical quality goals:

- Collecting required HEDIS measures and identifying additional opportunities to engage members and physicians to close gaps in care. The target outcome measurement included the 2016 CLQI score remaining constant at 73.6% for the year.
- Engaging provider community through PGIP meetings, webinars, and other forums. The target process measurements included the CLQI team successfully executing 75% of our 35 provider outreach onsite meetings. Additionally, the measurement required the team to respond to 70% of our priority issues within seven business days.
- Provider satisfaction after onsite meetings was used as a balancing measure, whereby a year-end survey was sent to targeted physician organizations. The survey was scored based on satisfaction and engagement with the CLQI team on a 1-5 rating scale, with 1 as a low rating and 5 as a high rating. The target outcome was to receive a score of 3.5 on a 5-point scale.

3.7.1 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool Blue Cross uses to measure performance as it relates to important dimensions of care and service. Because so many health plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an equivalent basis. Blue Cross uses HEDIS results to analyze where improvement efforts should be focused.

Blue Cross complies with all the HEDIS reporting requirements established by NCQA, the Office of Financial and Insurance Regulations, Centers for Medicare and Medicaid Services and Michigan Department of Community Health. Activities focused on improving rates for select HEDIS measures are integrated with the Disease Management Program, Complex Case Management Program and Physician Group Incentive Program. Blue Cross implements interventions based on the reporting year results. The impact of the interventions is monitored in the subsequent year. HEDIS activities and results are audited by an NCQA-certified auditor and submitted for public reporting annually.

After scores are reported, a series of HEDIS quality improvement activities are implemented in order to address those areas in which opportunities are identified.

HEDIS 2016 included the following product lines: Commercial PPO, QHP PPO (on-market), and QHP EPO (on-market).
3.7.2 Clinical Quality Initiative

At Blue Cross, PGIP administers the Clinical Quality Initiative, a reward-based program incorporating HEDIS measures aimed to driving improvement among PGIP participating physician organizations (PO). This initiative strives to promote clinical quality improvement by driving best practice behaviors among PGIP physicians. Value based reimbursement is provided at the population level for POs who are able to achieve high performance and improve over time.

In 2017, BCBSM will be working intensely with approximately ten high impact PGIP physician organizations to improve quality scores through the Clinical Quality Initiative. These high impact physician organizations were identified by reviewing the total BCBSM membership attributed to each physician organization and their quality score from 2015. Physician organizations with the greatest opportunity to improve quality will participate in discussions with the BCBSM PGIP Clinical Quality team at regular intervals throughout 2017. Regular meetings are designed to discuss quality, process improvement opportunities, best practices, and to provide analytic support as needed. Activities are expected to start in summer 2017 when 2016 year-end data has been released, and continue throughout the performance year.

The overall objective of the Clinical Quality Initiative is to improve the performance of these high-impact PGIP physician organizations by providing key ad-hoc data analysis, guidance and coaching and regular feedback about initiative performance.

To achieve rewards physician organizations must be able to complete the following activities:

- Identify opportunities for improvement by analyzing Blue Cross data provided at the PO and practice level
- Encourage or lead rapid quality improvement interventions at partnering practices
- Promote best practices among member physicians
- Support innovation and constructive change in processes for the delivery of care
- Develop and implement strategies for population health management

Blue Cross internal subject matter experts, in collaboration with physician organization leadership, annually review measures of care to determine which measures should continue as part of the initiative and which should be retired. Measures selected for the Clinical Quality Initiative include childhood and adolescent prevention, adult prevention, antibiotic use, heart disease, diabetes, medication management and appropriate use of services measures. Blue Cross provides commensurate reporting to PGIP participating physician organizations that includes population performance, practice performance, relative performance to other PGIP PO, and performance against applicable benchmarks.

2017 program goals

The BCBSM team has developed two goals. The first is to achieve a 2% increase in average composite quality score (includes both performance on Medicare Advantage and Commercial PPO quality measures) for high impact POs, and second to achieve a 5% increase in treatment gaps closed from 2016 to 2017 for commercial PPO quality measures.
3.7.3 Clinical Practice Guidelines

Blue Cross adopts and disseminates clinical practice guidelines relevant to its members for the provisions of preventive and non-preventive acute and chronic medical services and for preventive and non-preventive behavioral health services. These clinical practice guidelines are reviewed and approved by the QIC every year to ensure the guidelines are evidence-based and are known to be effective at improving health outcomes for members. These guidelines are the evidence-based foundation for the performance reports Blue Cross provides to physician organizations at least quarterly.

Michigan Quality Improvement Consortium

Blue Cross has adopted the clinical practice guidelines developed by the Michigan Quality Improvement Consortium (MQIC). Founded in the fall of 1999, MQIC consists of physicians and other personnel from 13 Michigan-based health plans, along with the Michigan Association of Health Plans, Michigan Department of Health and Human Services, Michigan Osteopathic Association, MPRO, and Michigan State Medical Society, as well as the University of Michigan Health System. The Blue Cross Blue Shield of Michigan’s Chief Medical Officer has been the Co-chair of MQIC since its inception.

The purpose of MQIC is to achieve significant, measurable improvements in health care through the development and implementation of common evidence-based clinical practice guidelines. The guideline topics are selected by the MQIC Medical Directors’ Committee and are based on a number of factors including scientific-based evidence, data demonstrating relevancy to the health plans’ population, potential use of subject matter by the primary care practitioner, HEDIS measures and internal and external requests for guideline development. MQIC designs concise guidelines focused on key clinical management components demonstrated to improve outcomes, with the goal of standardizing these processes for Michigan physicians and other health care providers.

When developing new or updating current guidelines, current research is reviewed and feedback is requested from several professional organizations. Recommendations with [A] (randomized controlled trials) and [B] (controlled trials, no randomization) levels of evidence are given priority status. Preventive care guidelines are based on the United States Preventive Services Task Force A and B recommendations.

MQIC clinical practice guidelines are reviewed and updated every two years. In addition, guidelines may be re-evaluated and updated at any time before the established two-year review cycle as new scientific evidence is released. Current versions of all MQIC guidelines are available on the mqic.org website, and the MQIC application for mobile devices. The MQIC website link is also available on the Blue Cross.com public website and in the site’s provider portal. Any interested party may also ask to receive a copy of the guidelines by U.S. mail.

2017 program goals

MQIC will review and update a total of 17 guidelines in 2017.
3.8 Delegation Oversight

Procurement, the Vendor Management Center of Excellence (VMCOE) and Business Area Contract Administrators (BACA) are responsible for monitoring selected delegated activities to ensure that sub-contracted functions are performed in accordance with contract stipulations and accreditation standards. Monitoring includes the periodic review of relevant program documents in relation to sub-contracted functions and the subcontractor’s performance. Documents for review include but are not limited to the Quality Improvement Program and the Utilization Management Program if applicable.

The delegated activity objectives are:

- Perform a pre-delegation evaluation of newly delegated entities’ capacity to meet NCQA requirements within 12 months prior to implementation
- Complete an annual assessment of current delegated activities to ensure ongoing compliance
- Monitor oversight of delegated activities through semiannual regular reports as defined in the contract
- Annually review and approve the delegate’s Quality Improvement or Utilization Program based on delegated functions
- Audit complex case management and utilization management files against the NCQA standards for each year the delegation is in effect (if applicable)
- Identify and follow up on opportunities for improvement
- Ensure delegated entities meet or exceed established performance and operational measures
- Ensure delegated entities meet or exceed accreditation standards
- Establish corrective action plans if performance measures are not met
4.0 QUALITY IMPROVEMENT WORK PLAN

The QI Work Plan specifies quality improvement activities Blue Cross will undertake in the upcoming year. The plan includes goals and objectives based on the strengths and weaknesses identified in the previous year’s evaluation and issues identified in the analysis of HEDIS and CAHPS scores and member complaints. The work plan is a mechanism for tracking quality improvement activities and is updated as needed to assess the progress of initiatives.

The QI Work Plan includes but is not limited to the following objectives for improving and monitoring ongoing progress throughout the year:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members’ experience
- Program scope
- Yearly goals
- Yearly planned activities to achieve goals
- Timeframe within which each activity is to be achieved
- Blue Cross staff member responsible for each activity
- Previously identified issues with monitoring progress of resolution
- Evaluation of the QI program
- HEDIS and CAHPS submission and performance improvement
5.0 QUALITY IMPROVEMENT PROGRAM EVALUATION

Blue Cross completes an evaluation of the QI Program annually. The written evaluation is an assessment of the effectiveness of the individual components as well as overall effectiveness of the program. The evaluation outlines accomplishments, documents limitations or barriers to meeting objectives and makes assessments and recommendations for the upcoming year. The evaluation addresses the structure and functioning of the overall quality improvement program, the processes in place and the outcomes or results of QI activities.

Quality improvement program evaluation criteria may include but not be limited to the following:

- Evaluation of the effectiveness of activities performed with an emphasis on the identification of improvement in the quality and safety of clinical care and quality of services delivered
- Determination of whether quality improvement information was communicated accurately and to the appropriate person, committees, providers and/or other groups
- Determination of whether identified system-wide issues were adequately addressed and resolved in a timely manner with execution of appropriate follow-up actions
- Assessment, trending and documentation of measurable improvement in the quality of clinical care and quality of service
- Analysis of the results of quality improvement activities including barrier analysis
- Adequacy of resources for the quality improvement program
- Assessment of practitioner participation and leadership in QI program
- Recommendation of changes needed to improve the effectiveness of the quality improvement program
- Analysis of the progress made on influencing safe clinical practices

Measurement (data collection) is the basis for determination of the existing level of performance and the outcomes from those processes. Quantitative measures will be established to evaluate the most critical elements of care and services provided. Selected indicators include:

- Structure measures – used to assess the availability of organized resources
- Process measures – focus on using the expected steps in the course of treatment
- Outcome measures – assess the extent to which care provided resulted in either the desired or unintended affect

Data assessment will determine the current performance level and whether or not performance needs improvement. The assessment process includes trending performance over time and comparison to established benchmarks. Action taken is directed at improving outcomes as well as processes. Blue Cross conducts quality improvement projects to systematically evaluate the quality of clinical care and service delivered to members with the goal of achieving demonstrated improvement in care and services.
## 6.0 FEDERAL EMPLOYEE PROGRAM

The Federal Employee Program (FEP) Quality improvement Program is consistent with the Commercial PPO/Marketplace program with following exceptions:

<table>
<thead>
<tr>
<th>2017 Commercial PPO/Marketplace Quality Improvement Description</th>
<th>FEP Exception</th>
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<tr>
<td><strong>Page 11</strong></td>
<td>The FEP Director’s Office (not the Member Experience Committee) assumes responsibility for providing oversight of the website and print materials for member health (pre-enrollment and enrollment).</td>
</tr>
<tr>
<td><strong>Page 32</strong></td>
<td>The website used by FEP members is <a href="http://fepblue.org">fepblue.org</a>. Web content and member digital experience are managed and monitored by the Director’s Office, not Blue Cross Blue Shield of Michigan.</td>
</tr>
<tr>
<td><strong>Page 32</strong></td>
<td>Administrative member complaints for FEP are handled by FEP. FEP administrative member complaint statistics are provided to Executive Services quarterly for inclusion in the corporate report. FEP Clinical member complaints are handled by BCN and follow the corporate process.</td>
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Required Approvals

Approval Signature(s):

Amy McKenzie, MD, FAAFP
Date Signed  March 31, 2017

Associate Medical Director
Co-Chair, Quality Improvement Committee
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<th>Rev #</th>
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