2013 Quality Management Program Evaluation

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I. Executive Summary

Blue Cross and Blue Shield of Rhode Island is a market-leading health insurer with a seventy-five year history of improving the health of our members and all Rhode Islanders by providing access to cost-effective, high-quality healthcare. Our guiding principles are as follows:

Mission
To improve members' health and peace of mind by facilitating their access to affordable, high-quality healthcare.

Vision
To improve the quality of life of our customers and of the people of Rhode Island by improving their health.

Our Commitment to Quality
Blue Cross and Blue Shield of Rhode Island believes that a key element in achieving our mission and vision is an organization-wide commitment to quality and continuous improvement, with a culture oriented toward the ability of all contributors to affect improvement. We maintain a Quality Management Program that provides the structures, processes, resources, and expertise necessary to ensure that high-quality, cost-effective care and services are provided to our members. We annually evaluate the overall effectiveness of our Quality Management Program, tracking progress in completion of objectives, monitoring the success of activities, and implementing changes to meet the needs of our membership and operations. Our program evaluation also guides the development of the upcoming year's Quality Management Program Description and Work Plan.

Scope
Our Quality Management Program includes all Commercial, Exchange, and Medicare members and encompasses activities designed to improve processes and outcomes including preventive, acute, and chronic care interventions, care coordination, and behavioral health services. Our efforts to improve quality span the healthcare delivery system, including primary and specialty care, hospital care, nursing facility care and home care. We evaluate delivery system access and adequacy, and monitor complaints and sentinel events. We measure member and provider satisfaction with clinical and administrative services, and the results inform plan improvements. The Quality Program is guided by the principles of continuous quality improvement and aligned with our corporate mission and vision. This Program Evaluation assesses the Quality Management Program during the calendar year 2013.

Quality Program Objectives
In 2013, we selected the following Quality Management Program objectives, aligned with our corporate mission and reflective of our enterprise-wide commitment to quality improvement:

- Perform quality improvement and assurance activities in alignment with corporate goals, missions, and strategies.
- Improve the quality, safety, and coordination of care for our members across the continuum.
- Integration of medical and behavioral healthcare to improve the quality of care delivered to our members.
- Continuously promote and monitor evidence-based best clinical practices across our network of providers
- Collaborate with community partners to achieve improved care for all BCBSRI members.
- Improve the quality of member and provider engagement and satisfaction with the health plan, including access to care.
- Identify the spectrum of cultural and linguistic needs of our membership to offer a diverse array of services which provide meaningfully improved care to our members and support our providers' care to our members.
- Improve the cost, quality, and efficiency of service delivered to our members and providers.

Key Accomplishments

Clinical Accomplishments

- Established and launched a new Disease Management Program.
- Collaborated with new Pharmacy Benefit Manager (PBM) to develop patient safety initiatives
- Successfully transitioned new Behavioral Health (BH) vendor for case management and utilization management.
- Sponsored 2013 Nurse Care Manager (NCM) Best Practice Learning Collaborative, at which Nurse Care Managers from Medical Homes around the state networked and presented clinical best practices.
- Reduced readmission rates through Transition of Care program

Service/Administrative Accomplishments

- Restructured Quality committee membership and updated charters
- Contracted with new HEDIS vendor.
- Enhanced hospital contracts to include quality incentives; this now includes the entire network of Rhode Island Hospitals
- Enhanced accessibility of member benefit information on our member web portal and with clearer language in Explanation of Benefits (EOB) documents.
- Provided cultural competence education to 99.8% of employees with routine member contact, and to 99.4 % of managers.
- Improved customer satisfaction and decreased financial risk with the completion of thirty-six Continuous Improvement (CI) projects to reduce costs in claims processing and customer service.

II. Quality Management Program Evaluation

II.1 Objective 1: Perform quality improvement and assurance activities

In 2013, Blue Cross and Blue Shield of Rhode Island leadership identified a need for recommitment to nationally recognized evaluations of health plan performance in order to assist consumers and providers in making informed choices about their health plan. The opportunity to share BCBSRI's performance in clinical effectiveness, core plan operations, and levels of satisfaction is in keeping with our goals for transparency and increased consumer and provider engagement. A candid and thorough review of preparedness for accreditation revealed opportunities for increased standardization, measurement, and transparency, which could be effectively promulgated with fortified Quality Management processes.

Strengthening our Quality Management Program was reliant upon committee structure change, staff reorganization, and the support of executive leadership. Quality activities demonstrated a need for increased committee attention to member experience, utilization management activities, and network performance. New committees were created for each of these areas, and the roles, accountabilities, and membership of every committee was updated and documented in new committee charters. Our new quality committee structure is provided in Attachment B.

The reorganization of Quality Management staff is further discussed in the Conclusion, with adequacy of program resources. Reassignments resulted in more efficient alignment of staff skills and competencies with business need and quality program objectives.

II.2 Objective 2: Improve quality, safety, and coordination of care for our members

A. Clinical Improvement Activities

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

According to the Agency for Healthcare Research and Quality (AHRQ), antibiotics are frequently prescribed for adults with acute bronchitis. Clinical guidelines do not indicate this treatment unless the patient has co-morbidities or a secondary infection. Acute bronchitis is among the top ten diagnoses accounting for outpatient physician visits. The use of antibiotics in nonbacterial illness leads to antibiotic resistance, which is responsible for significantly increasing cost as antibiotic-resistant infections proliferate. Acute bronchitis also sends many patients to the Emergency Room for care, resulting in costly treatment that can often be managed on an outpatient basis. Although 90% of acute bronchitis cases are viral, 65-80% of cases are treated with antibiotics. We chose this measure given its relevance to our membership as evidenced by a 2012 HEDIS PPO result of only 15.89% Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, significantly below both the 2012 HEDIS PPO national average of 21.49% and the 2012 HEDIS PPO New England Regional average of 23.14% (see below).

HEDIS Measure	HEDIS 2012 Blue Cross Rate	HEDIS 2012 New England PPO Regional Average	HEDIS 2012 National PPO Average
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**15.89%**	**23.14%**	**21.49%**

Metrics: We utilized a single HEDIS measure: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, defined as the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Data Source and Methodology: BCBSRI claims provided source data for our measure, and the methodology used mirrored HEDIS technical specifications to eliminate members with comorbidities or those prescribed antibiotics within 30 days prior to date of current prescription. This serves to provide accurate reporting of antibiotics prescribed solely for the diagnosis of uncomplicated acute bronchitis.

Performance Goal/Benchmark: to increase the rate of eligible adult members who avoid antibiotic treatment for acute bronchitis

Results and Quantitative Analysis: BCBSRI claims showed an avoidance rate of 17.06% in 2013, a minimal improvement over 2012 performance of 15.89% avoidance.

Qualitative Analysis and Barriers: HEDIS results for this measure indicate that BCBSRI network of providers prescribe a high rate of antibiotics for members diagnosed with acute bronchitis. Barriers include member expectation that they will be prescribed an antibiotic for this condition, unaware that it is a viral infection which is resistant to antibiotics. Nationally, many providers feel pressured to provide antibiotic treatment for acute bronchitis.

Actions Taken: Formed a work group consisting of a Provider Relations Representative, a Patient-Centered Medical Home (PCMH) Practice Coach, Pharmacists, and Medical Economics Analyst to address this issue. The workgroup obtained a report utilizing HEDIS specifications to identify BCBSRI providers who frequently prescribe antibiotics for acute bronchitis. A letter was drafted for these providers regarding claims trends that may indicate frequent prescription of antibiotics for viral infections. Target mailing date is February 2014. Drafted an article regarding evidence-based practice for treating upper respiratory infections. This article is scheduled to appear in Provider Update, a communication tool for our provider network.

A Member Communication plan was created to organize a member education campaign (to include internet vehicles and mailings) regarding appropriate treatment of upper respiratory infections and use of antibiotics.

Opportunities for Improvement and Activities Planned for 2014: Opportunities for improving avoidance of antibiotic treatment in adults with acute bronchitis include improved provider and member education regarding proper treatment of acute bronchitis and antibiotic use. In 2014, the following interventions will help accomplish this:

- Letters were mailed during the week of February 10, 2014, to providers who prescribed more than 5 antibiotics for this diagnosis.
- An article about treating upper respiratory infections appeared in the January 2014 edition of Provider Update, a communication tool for our provider network.
- Member education regarding upper respiratory infection treatment and use of antibiotics is planned for release throughout 2014. An article posted on our intranet for employee members entitled, "Did You Get a Flu Shot?" discussed the importance of the flu vaccine and that upper respiratory infections rarely require antibiotics. Other member education materials will be provided through our website, on our Intranet for employee members, and through our Wellness vendor and employer groups.

Improving Coordination of Care after a Hospital Stay

In 2013 BCBSRI initiated a Quality Improvement Project with the goal to reduce avoidable readmissions by providing members with the knowledge and support to prevent illness exacerbation, maintain medication adherence, and seek care early before inpatient care is required. Two groups of members were studied: FEP members and non-FEP members. This improvement activity, entitled *Transition of Care after a Hospital Stay*, involves BCBSRI nurses who evaluate and educate recently discharged members from acute inpatient facilities with diagnoses bearing a high risk for readmission (such as congestive heart failure (CHF) and chronic obstructive pulmonary disease). The educational intervention includes topics such as self-management of illness, avoiding complications by understanding medication use, and the importance of post-discharge follow-up care.

Metrics/Frequency of Reporting: The following three indicators were monitored on a quarterly basis:

- Members discharged will schedule a follow up appointment with their PCP/Specialist within two weeks of discharge.
- The nurse will review medications with members to ensure their understanding
- Actual readmission rate for eligible members

Data Source and Methodology: Data is extracted from CCMS, our medical management software system. The results are expressed as a percentage, derived from division of a numerator by a denominator. The specifications for each indicator are as follows:

Indicator: **Numerator:** **Denominator:**	• Members discharged will schedule a follow up appointment with their PCP/Specialist within two weeks of discharge • Confirmation of follow up appointment scheduled within two weeks of hospital discharge • Number of completed assessments
Indicator: **Numerator:** **Denominator:**	• RN will review medications with members to ensure their understanding • Number of members taking medications correctly • Number of completed assessments
Indicator: **Numerator:** **Denominator:**	• Calculate actual readmission rate for eligible members • Number of readmissions within 30 days by members with specific diagnosis • Number of members discharged that have been reached with specific diagnosis

Goals/Benchmarks: The goals for the non-FEP member group were based on the results of the pilot Transition of Care program, conducted in 2011.These goals were also recommended for the FEP member group; however, the goals were ultimately increased by the FEP Quality Committee. Goals for both groups are as follows:

Indicator	Goal: FEP Members	Goal: Non-FEP Members
Members discharged from the hospital who schedule a follow up appointment with their PCP/Specialist within two weeks of discharge.	80%	60%
The nurse will review medications with members to ensure their understanding.	80%	60%
Number of readmissions within 30 days among members with specific diagnoses.	10%	15%

Results (for items in red see Qualitative Analysis and Barriers paragraph below)**:**

Indicators (FEP)	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr. CY 2013	Goal and/or Benchmark
Members will schedule follow-up with PCP within two weeks of discharge					
	10/12 *10/16	14/19	6/9	19/23	**80%**
Total	83% 63%	74%	67%	83%	
CM's will review medication needs with members discharged					
	12/12 *12/16	15/19 *14/19	7/9	23/23	**80%**
Total	100% *69%	79% *74%	69%	100%	
Calculate actual readmission rate for those members in CM					
	1/12	1/17	0/4	0/24	**10%**
Total	8%	6%	0%	0%	

Indicators (Non-FEP)	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr. CY 2013	Goal and/or Benchmark
Members will schedule follow-up with PCP within two weeks of discharge					
	371/631	480/622 *480/654	308/383	434/498	**60%**
Total	59%	77% *73%	80%	87%	
CM's will review medication needs with members discharged					
	419/631	527/622 *527/654	346/383	491/496	**60%**
Total	66%	85% *81%	90%	99%	
Calculate actual readmission rate for those members in CM					
	24/393	33/472	16/187	42/431	**15%**
Total	6%	7%	9%	10%	

Quantitative Analysis: Among FEP members, improvement was seen across all three measures in 2013. Eighty-three percent of FEP members scheduled post-discharge follow-up in the fourth quarter compared to 63% in the first quarter. One hundred percent of members indicated understanding of medications in the fourth quarter, compared with only 69% in the first quarter. Readmissions were significantly reduced from 8% to 0%.

Among non-FEP members, there was improvement in two of three measures. Eighty-seven percent of non-FEP members scheduled post-discharge follow-up in the final quarter of 2013 compared with 59% in the first quarter. Ninety-nine percent of members indicated understanding of medications in the fourth quarter, compared to 66% in the first quarter. Unfortunately, readmission rates rose to 10% in the fourth quarter, compared to 6% in the first quarter.

***Qualitative Analysis and Barriers:** A major barrier was data entry of the Transition of Care assessment in the CCMS system. Staff were closing the assessment with the wrong reason code, so members who should have been excluded were counted in the denominator. This required some retraining to ensure accurate reporting, and re-examination of the denominator. After reviewing the first three quarters' data, the denominator was adjusted for measures 1 and 2 to include only the members actually participating in program's TOC assessment, not all members who might be eligible to participate. The 4th quarter results now reflect this more accurate denominator, with denominator and percentage adjustments noted in red in the Results section.

Fourth quarter results for measures 1 and 2 reflect the addition of interventions designed to increase each measure's rate. For measure 1, when members responded "no," nurses offered to make a follow up appointment for them. For measure 2, if members answered "no" to taking correct medication, nurses provided medication education.

Opportunities for Improvement: Enhancing member education on the importance of post discharge follow up appointments and medication adherence is a recurring need, and informs ongoing discussion about how to decrease readmissions. This appears especially important for our non-FEP group, for whom readmissions increased in 2013.

This group includes our Medicare population; with more co-morbidities than the younger FEP group, factors influencing their readmission rate are likely more complex and require enhanced and additional interventions.

Actions for 2014: Have nurses conduct enhanced interventions with members, ensuring follow-up with physicians and helping members understand the need for medication adherence. Ongoing monitoring of results.

B. Case Management Program

The purpose of the Case Management program is to identify and assist members with multiple and/or complex conditions. Case Managers assist members in obtaining access to care and comprehensive services (medical, dietary, behavioral, community based), as well as coordinate a member's care with his or her identified providers. Case Managers are clinical advocates who promote member understanding and management of current health status and explain why identified treatments are vital to improving health. In summary, Case Managers act as catalysts to member navigation though our complex health care system, to improved communication and cohesion among a member's care team, and to member self-management support. This multi-faceted effort enables members to achieve their personal health goals more effectively and efficiently.

Measuring Satisfaction with and Effectiveness of Case Management
In order to best address the needs of our membership and monitor our overall effectiveness from the member's perspective, Case Management regularly surveys members who participate in Case Management.

Metrics/Frequency of Reporting: Case Management Satisfaction Surveys are sent to all members upon discharge from Case Management. Results are reported on a quarterly basis. We chose the following two survey questions as our indicators for this study:

- Overall, how satisfied are you with the Care Coordination Program?
- Please indicate how well your Care Coordinator helped you to better understand your condition and health goals?

Data Source and Methodology: The source of survey data is member self-report. For the two indicators we selected, members had the following choice of responses to respective questions:

- Overall, how satisfied are you with the Care Coordination program?
  - Answer Options:
    - ✓ Very Satisfied
    - ✓ Satisfied
    - ✓ Neither Satisfied nor Dissatisfied
    - ✓ Dissatisfied
    - ✓ Very Dissatisfied

- Please indicate how well your Care Coordinator helped you understand your health condition.
  - Answer Options:
    - ✓ More than met my needs
    - ✓ Fully met my needs
    - ✓ Mostly met my needs
    - ✓ Somewhat met my needs
    - ✓ Didn't meet my needs

Performance Goal/Benchmark: Goals for the two indicators selected are listed in chart below.

Results:

Indicator	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr. CY 2013	Goal and/or Benchmark
Overall, how satisfied are you with the Care Coordination program?					
Total	96.6% (86/89)	100% (32/32)	100% (24/24)	95% (20/21)	**95% will respond "Satisfied" or "Very Satisfied"**
Please indicate how well your Care Coordinator helped you understand your health condition.					
Total	90% (66/73)	67% (12/18)	100% (24/24)	100% (20/20)	**95% will respond "More than met my needs or Fully met my needs"**

Quantitative Analysis: Results for: "Overall, how satisfied are you with the Care Coordination program?" showed members responded that they were either "satisfied" or "very satisfied" in 100% of responses; therefore we exceeded the goal of 95% throughout the all four quarters of 2013. Results for: "Please indicate how well your Care Coordinator helped you understand your health condition" were lower than our goal rate for both the first and second quarter of 2013. For both quarter 3 and 4, members reported their care coordinator either "Exceeded my needs or Fully met my needs" in 100% of the responses received.

Qualitative Analysis and Barriers: Analysis of the survey response results indicated that although 19% of respondents from quarter 1 and 38% of respondents from quarter 2 felt we did not "exceed or fully meet" their need to further understand their medical condition, these same respondents answered question #1 on the survey as being 100% satisfied with the Care Coordination program. More importantly, all the respondents (total of 13) who did not answer that we "exceeded or fully met" their needs, responded that we "mostly met their needs" for this measure. There were no respondents in any quarter of 2013 who responded with the answers of: "somewhat" or "did not" meet their needs.

Opportunities for Improvement: Upon analyzing question #2, we felt there may be confusion due to the similarity in meaning between "fully met my needs" and "mostly met my needs." Future surveys will be edited to include scoring choices that are more distinct.

C. Population Health Program

Blue Cross and Blue Shield of Rhode Island's Population Health program aims to improve health for member populations including children, adults, and seniors. In 2013, programming was directed at prevention of communicable disease, clinical performance improvement, and disease management (although a separate Disease Management program would be created later in the year). Members were identified through a variety of data sources, and received mailing and automated telephonic reminders on various topics, including:

- Closing gaps in care by increasing adherence with obtaining recommended tests and screenings.
- Improving medication adherence
- Providing member education and support
- Collaborating with physicians

Population Health Program efforts in 2013 were challenged by reduced resources and a company re-organization. The company decided to focus on distinct deliverables for Disease Management (DM) and HEDIS Improvement. DM will offer interventions based on stratification of Commercial members with diabetes and asthma. HEDIS Improvement will analyze data to create effective programs to improve HEDIS measures for all lines of business.

The focus for Population Health programming continues to be established. Critical to improving member health are successful collaborative efforts with our internal and external partners. Member-focused areas such as CMS 5-Star, DM, HEDIS and Pharmacy will increase collaboration with physician-facing teams like contracting and provider relations. Together, we can seek improve health of our members through a variety of activities.

Child & Adolescent Immunizations

According to the Rhode Island Department of Health (HEALTH), RI's childhood immunization rates continue to be well above regional and national averages. BCBSRI supports the work of HEALTH in promoting childhood vaccination and well visits as important foundations of health and wellness.

Metrics: We planned to use the HEDIS Childhood Immunization Status measures for children and adolescents to measure impact. Blue Cross and Blue Shield of RI member participation in immunization interventions was defined by the following criteria:

- Newborn: Upon being added to a parent's plan, families with a newborn are mailed an informational letter and brochure about immunizations and well visit and primary health promotion leading up until 24 months.

- Toddler: The month a toddler member turns 24 months, parents are automatically sent an educational newsletter about childhood immunizations and health prevention information.
- Adolescent: The month a child turns 12, the household is sent an educational brochure about adolescent specific health concerns and recommended immunizations.

Participation by age group for the first quarter of 2013 was as follows:

	Newborn Members	Toddler Members	Adolescent Members
January 2013 – March 2013	698	804	207

Data Source and Methodology: HEDIS data collected annually according to HEDIS technical specifications.

Performance Goal/Benchmark: Healthy People 2020 immunization goals for children from 19 to 35 months of age include achieving coverage rates of 90% or greater for each individual vaccine series and 80% coverage rates for the combination series 4:3:1:3:3:1:4 (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 Hep B, 1 varicella, 4 PCV).

Results: Results were not available due to discontinuation of the program and rotation of HEDIS measures.

Quantitative Analysis: We had planned to monitor 2013 HEDIS results for evidence of maintained or improved rates of childhood vaccination status. However, in accordance with HEDIS policies, vaccination measures were rotated in 2012 (scores from 2012 were accepted for 2013). Our 2012 childhood vaccination rates exceeded regional averages, as shown below.

HEDIS Measure	BCBSRI HEDIS 2012 Commercial Rate	HEDIS 2012 New England HMO/POS Regional Average	HEDIS 2012 HMO/POS National Average
Childhood Immunization Combination 2	92.38%	80.95%	77.84%
Childhood Immunization Combination 3	90.48%	79.00%	75.65%
Childhood Immunization Combination 4	31.43%	34.34%	32.41%
Childhood Immunization Combination 5	78.10%	63.83%	63.62%
Childhood Immunization Combination 6	77.14%	62.01%	52.79%
Childhood Immunization Combination 7	27.62%	29.84%	28.73%
Childhood Immunization Combination 8	28.57%	27.92%	23.92%
Childhood Immunization Combination 9	68.57%	51.58%	46.24%
Childhood Immunization Combination 10	25.71%	24.34%	21.64%
Diphtheria – Pertussis Tetanus	94.29%	90.48%	86.65%
Poliovirus	100.00%	94.64%	92.41%
Measles-Mumps-Rubella	96.19%	93.64%	91.37%
Haemophilus Influenza Type B	98.10%	95.96%	94.18%
Hepatitis B	98.10%	90.44%	88.18%
Chicken Pox	97.14%	92.43%	91.33%
Pneumococcal Conjugate Vaccine	94.29%	90.83%	87.26%
Hepatitis A	33.33%	37.88%	36.23%
Rotavirus	86.67%	74.02%	75.11%
Influenza	82.86%	72.41%	61.54%

Qualitative Analysis and Barriers: With our repeated success in childhood immunization rates and the successful state-wide programs by the RI Department of Health, there was a recommendation that this program be discontinued after the first quarter of 2013. This decision may decrease our immunization rates among children and adolescents.

Opportunities for Improvement: In order to maintain higher than average ratings, it is imperative we maintain our collaborative relationship with the Rhode Island Department of Health, particularly with their "Immunize for Life" and "Vaccinate before You Graduate" programs. There is an opportunity to resume this program and potentially expand it to include programs that impact HEDIS measures for childhood well-visits, immunizations, and weight assessments and counseling for nutrition and physical activity.

Participation – Newly Identified/Welcome

Certain chronic illnesses, including diabetes, asthma, high blood pressure, high cholesterol , and COPD, are prevalent in our membership, as in many parts of the country. Initially designed as part of our Population Health Program, this initiative sought to provide members newly identified with specific conditions with educational support and resources to help manage their condition. This activity, through its identification efforts, helped provide data for diabetes and asthma disease management programs that were newly developed toward the end of 2013.

Metrics: There were no formal measures as this activity was designed to identify members by diagnosis for later intervention.

Data Source and Methodology: Members were identified as follows:
Hypertension, High Cholesterol, COPD: Active members with an ETG for high blood pressure, high cholesterol, or COPD. Asthma, Diabetes: In April and September 2013, members newly diagnosed with Asthma and Diabetes were based on the Johns Hopkins ACG predictive model of identification. However, in November 2013, ACG was replaced with HEDIS identification criteria. These criteria yielded identification of eligible members at the following volumes per diagnosis:

Newly Identified/Welcome	April 2013	September 2013	November*
Diabetes	247	347	14,474
Asthma	156	141	5,329
High Blood Pressure	491	509	
COPD	36	28	
Hyperlipidemia	622	575	

*In November 2013, revised identification criteria (based on HEDIS) and risk stratification for members with Persistent Asthma and Diabetes created a new 'registry' of members who received an initial official Disease Management (DM) welcome letter. Mailings to members with high blood pressure, COPD, and hyperlipidemia were discontinued.

Actions: Members with diabetes, asthma, COPD, high blood pressure, or hyperlipidemia received mailings with educational material specific to their newly diagnosed condition, and resources for further information and support.

Qualitative Analysis and Barriers: Attempts to measure the results of these interventions have included tracking web site "hits" on recommended pages, as well as, a satisfaction survey. Feedback from surveys was favorable, but with a very low response rate. Barriers to maintenance and development of this activity included reduced staffing in 2013 and a company re-organization. Though collaboration was strong, accountability and ownership was decreased. Recognizing this, an effort was made to create distinct deliverables for Disease Management (DM) and HEDIS Improvement rather than Population Health.

Opportunities for Improvement: In November 2013, a formal Disease Management program was created that effectively identifies and stratifies our members newly diagnosed with diabetes and asthma. Outreach includes educational material, as well as, an invitation to Health Coaching for moderate and high-risk members. Mailings regarding conditions other than asthma and diabetes have been suspended. Consideration of potential member outreach activities is recommended as an opportunity to improve population health for our members.

Participation – Diabetic Gaps in Care

The Rhode Island Department of Health estimated that as of 2010, 7.4% (62,000) of Rhode Island adults have a diagnosis of diabetes. In 2010, Blue Cross Blue Shield of Rhode Island (BCBSRI) spent over $5 million dollars on hospitalizations that identified diabetes as the primary diagnosis, and spent over $10 million treating ambulatory cases of diabetes. Given its prevalence and the expectation that diabetes diagnoses will increase nationwide as the population ages, taking steps to help our members manage their diabetes is a priority.

Metrics/Frequency of Reporting: For this activity, we planned to conduct a one-time analysis of post-intervention compliance among diabetic members with getting annual dilated eye exams, HbA1c tests, and LDL cholesterol tests.

Data Source and Methodology: Members with diabetes were identified using the Johns Hopkins Adjusted Clinical Groups® (ACG®) system. Compliance with recommended tests/exams was determined via claims reports.
Performance Goal/Benchmark: Goal for each gap in care was to see improvement over baseline measurements of compliance.

Actions Taken: In April 2013, we conducted the following outreach activities:

- Mailing to 138 diabetic members who did not have an eye exam within the last 12 months; these members received a letter and an informational brochure on the importance of dilated eye exams for people with diabetes.
- Mailing to 63 Members who did not have HbA1C and/or LDL tests within the last 12 months; these members received a letter and report indicating their last date of testing to encourage them to make an appointment with their provider.
- A letter with a list of Certified Diabetic Educators (CDOEs) was mailed to 812 unique members with one or more elevated lab value (HbA1c and/or LDL). The members' physicians were also notified of individual member lab values and sent a list of local CDOEs.

Results, Qualitative Analysis, and Barriers: Formal follow-up analysis was not conducted due to limited resources and a shift in priorities for diabetes interventions to be included in a new Disease Management Program. An analysis would have included examination of claims data to determine compliance rates at baseline and post-intervention (typically six months after intervention).

Opportunities for Improvement: Our newly created Disease Management program allows us to stratify members by disease severity and need. Targeted interventions are expected to have a successful level of engagement and help address a variety of needs in members with diabetes. Another opportunity for improvement in clinical outcomes is the continuation of a pay-for-performance model with primary care physicians, implemented in the 3rd quarter of 2013. Physicians receive incentives for closing gaps in care and improving outcomes among patients with diabetes; several measures have seen increased rates of compliance.

D. Disease Management Program

A major accomplishment in 2013 was the development of an in-house Disease Management (DM) program. Implemented December 1, 2013, the program will initially serve members with asthma and members with diabetes in our Commercial population.

Asthma and diabetes were chosen as lead disease management programs due to their prevalence in our membership. One in ten (11%) children in Rhode Island has asthma (13% of boys and 9% of girls under age 18). According to the RI Department of Health, asthma hospitalizations and emergency room visits in RI often exceed national averages and meet or exceed Healthy People 2020's upper limit targets. Asthma is consistently in the BCBSRI Top 50 Ambulatory and Inpatient Diagnoses rivaling or exceeding that of other common chronic illnesses, such as diabetes, CAD, and COPD. In 2010 the Rhode Island Department of Health estimated that 7.4% (62,000) of Rhode Island adults carried a diagnosis of diabetes.

In 2010, Blue Cross and Blue Shield of Rhode Island (BCBSRI) spent over $5 million dollars on hospitalizations that identified diabetes as the primary diagnosis, and spent over $10 million treating ambulatory cases of diabetes. Disease management programs that help patients with asthma or diabetes manage and prevent exacerbations, improve disease control, empower patients lead to better quality of life and health outcomes and decreased healthcare costs.

Metrics and Frequency of Reporting: Our disease management program was implemented December 1, 2013. In 2014 we will collect data annually on the following measures; benchmarks are yet to be determined:

Asthma:

Active Participation Rates	• Low Risk Mailing • High Risk Mailing
Health Coaching Effectiveness	• Number & Percentage Participated • Number & Percentage Engaged • Interventions Completed
HEDIS Measure	• Use of Appropriate Medications for People with Asthma • Medication Management for People with Asthma

Our current (2012) Commercial HEDIS scores in these asthma measures are as follows:

HEDIS Asthma Measures	BCBSRI HEDIS 2012 Commercial Rate
Use of Appropriate Medications for People with Asthma (Total)	90.91%
Medication Management for People with Asthma - 50% Compliance	70.00%
Medication Management for People with Asthma - 75% Compliance	46.43%

Diabetes:

Active Participation will be measured by calculating the number of members who received intervention by the number who have opted-out (mail programs) or opted-out (Health Coaching).

Health Coaching Effectiveness will be measured by the number of percentage of members who participate and engage and the number of interventions completed.

Program Effectiveness will be evaluated through the following HEDIS Comprehensive Diabetes Care measures: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

- Hemoglobin A1c (HbA1c) testing performed
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population*
- Eye exam (retinal) performed
- LDL-C screening performed
- LDL-C control (<100 mg/dL)
- Nephropathy monitoring
- BP control (<140/80 mm Hg)
- BP control (<140/90 mm Hg)

*This is an internal measure not included in HEDIS

Our current (2012) Commercial HEDIS scores in these diabetes measures are as follows:

HEDIS Diabetes Measures	BCBSRI HEDIS 2012 Commercial Rate
HbA1c Screening	92.17%
Poor HbA1c Control	24.10%
HbA1c Control < 8%	64.46%
Eye Exam	71.39%
LDL-C Screening	87.05%
LDL-C Control (<100mg)	48.49%
Nephropathy Monitoring	79.52%
Blood Pressure Controlled <140/80	48.49%
Blood Pressure Controlled <140/90	73.49%

Actions Planned: Members with asthma and members with diabetes will be stratified by risk and will receive interventions tailored to their stratification level, including mailings, telephonic outreach, Health Coaching, educational material, and access to additional resources.

E. Pharmacy Programs

Catamaran, our pharmacy benefits manager, has several clinical improvement programs that include mail notifications to members and providers. The following Catamaran clinical programs involve such mailings:

- Depression Compliance Program
- Diabetic Gaps in Care
- Rheumatoid Arthritis Gaps in Care
- Statin/Lipid Lowering Agent Compliance Program

Members in respective categories (i.e. members with diabetes, members with depression who are taking prescribed antidepressants, etc.) receive information from Catamaran at the direction of BCBSRI, reminding them to refill certain prescriptions. Providers receive notification that a member is late filling a medication or that a targeted drug is not documented in their prescription profile as a prompt for them to intervene. When appropriate, provider mailings include standard of care guidelines. These interventions help to improve outcomes for member medication adherence and chronic illness, and decrease the incidence of medication error.

Ongoing collaborative quality improvement projects with Catamaran include development of an antibiotic program reminding prescribers of the importance of withholding antibiotics unless a bacterial infection is documented with positive cultures. Another forthcoming project is the finalization of guidelines for the appropriate use and safe practice in prescribing the following medications:

- Controlled substances
- Carisoprodol (a muscle relaxant with safety risks and potential for abuse)

Below are highlights from a Pharmacy Department quality improvement activity designed to improve the percentage of diabetic members with hypertension who are using an ACE/ARB.

Pharmacy Outreach to Improve ACE/ARB Use in Diabetics

In an effort to increase the number of Medicare members with diabetes who are using an ACE/ARB medication (clinically recommended) for hypertension (and potentially impacting the related CMS Star Rating), the Pharmacy department conducted outreach to provider offices.

Metrics/Frequency of Reporting: Our indicator was the number of Medicare diabetics treated with an oral diabetic medication and either an ACE/ARB medication for hypertension. Reporting occurred once.

Data Source and Methodology: Data was collected from Acumen, our CMS vendor. Specifically, they provided both a list of providers with a high volume of diabetic members who were on an anti-hypertensive medication that was not an ACEI/ARB (clinically recommended for people with both diabetes and hypertension), as well as a list of members.

Performance Goal/Benchmark: Our goal was to increase the number of Medicare diabetics treated with an oral diabetic medication and either an ACE/ARB medication for hypertension.

Results:

Members Identified	Members For Whom Responses Were Received	Change Being Made/Considered	ACEI/ARBs Contraindicated/Not Tolerated	No Changes Being Made
105	45	11	22	4

Quantitative Analysis: 105 members were identified, tied to 52 individual providers. The provider response rate was 38.46%; providers responded regarding 45 of the original 105 members identified. Of those 45 members, 24.4% (11/45) are being switched or are under consideration for a switch to an ACE/ARB. Contraindications to ACEI/ARBs were reported in 48.8% (22/45) of members identified, and 8.8% (4/45) of members did not have their medication regimens changed.

Qualitative Analysis and Barriers: Outreach was very small for this study. While an intervention of this type has the potential to positively impact CMS Star Ratings, our understanding is limited about the actual number of members needed to accomplish this. Another barrier is that CMS Star Ratings do not allow removal of members with a contraindication/or intolerance to the suggested medication from the denominator.

Opportunities for Improvement: Inclusion of more members should this study be expanded, and validation of the actual numbers of members needed impact the Star rating.
Actions Taken: Once physicians and members were identified, Provider Representatives distributed forms to identified providers requesting information on why the members were not on an appropriate anti-hypertensive. They also provided materials educating providers on why ACEI/ARBs are preferred for diabetic members. Pharmacists performed peer-to- peer calls when necessary.

F. 2014 CMS Star Ratings

The Centers for Medicare and Medicaid Services (CMS) developed the Star Ratings program to help consumers evaluate the quality of Medicare Advantage plans. Plans receive a star rating (one to five stars, with five being the highest) on their performance in over fifty measures of preventive care and clinical outcomes, member experience with the plan, and plan operational performance. The ratings are then rolled up into an overall Star Rating for the plan. All Medicare Advantage and Prescription Drug plans are required to participate in the Star Ratings Program.

2014 Star Ratings results were released in October of 2013. BCBSRI received a 4.0 overall Star Rating for 2014 (the unrounded score was 3.83, up from 3.48 for 2013). A rating of 4 stars secures approximately $32 million in Quality Bonus Payments for the plan. This rating will be in effect until October 2014, when the 2015 Star Ratings will be released.

CMS Five-Star Initiatives

Blue Cross and Blue Shield of Rhode Island initiated several interventions in 2013 to help improve member outcomes and 2015/2016 star ratings in key clinical areas. A selection of these interventions (for which data collection and analysis continues into 2014) are discussed here.

HEDIS Gaps in Care Calls

HEDIS results inform our CMS Star Ratings, and a review of our 2013 HEDIS measures indicated an opportunity to improve on or maintain performance on indicators related to key elements of care. BCBSRI contracted with a call vendor, CareNet, to conduct two rounds of outreach calls to members found to be non-compliant with 9 screening measures that feed into Star Ratings performance.

Metrics/Frequency of Reporting: Metrics are displayed in the table under Results. Official HEDIS rates reported annually. Appointment scheduling rates reported weekly during intervention. Member compliance rates measured 6 months following intervention.

Data Source and Methodology: Sampling methodology and compliance rates are determined utilizing NCQA-developed criteria for the following HEDIS measures:

- Indicator: Breast Cancer Screening
- Indicator: Colorectal Cancer Screening
- Indicator: Cardiovascular Care - Cholesterol Screening
- Indicator: Diabetes Care – Cholesterol Screening

- Indicator: Diabetes Care – HbA1C Screening
- Indicator: Diabetes Care – Eye Exam
- Indicator: Diabetes Care - Kidney Disease Monitoring
- Indicator: Osteoporosis Management in Women who had a Fracture
- Indicator: Glaucoma Testing

Performance Goal/Benchmark: No goals/benchmarks were set for this intervention in 2013.

Results:

Indicators/Metrics & Results	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr. CY 2013	Goal and/or Benchmark
Gap closure appointment scheduled with CareNet rep/Total unique members identified			550/9323 6%	125/4770 3%	None set
Compliant members/Members whose appointments were scheduled with CareNet rep			**/550	**/125	None set
Compliant members/Members who stated that they would schedule their own appointment			**/711	**/295	None set
HEDIS measure numerator/HEDIS measure denominator (Breast Cancer Screening, Colorectal Cancer Screening, Cardiovascular Care – Cholesterol Screening, Diabetes Care – Cholesterol Screening, Glaucoma Testing, Osteoporosis Management, Diabetes Care – Eye Exam, Diabetes Care – Kidney Disease Monitoring)			Expect by 5/2014	Expect by 5/2014	

Quantitative Analysis: Out of 9,323 unique members identified for outreach in 2013 (members contacted in Q4 were a subset of the total population identified for outreach in Q3, who were not reached for intervention during the first round of calls), CareNet scheduled 675 members for appointments to close their gaps (7.2%). Carenet also identified 1,006 unique members across both quarters (10.8%) who stated that they would schedule their own appointments to close identified gaps.

In Q2 2014, additional analysis will be performed on the population of members successfully scheduled by CareNet, to determine whether those members did in fact become compliant with their identified gaps. Analysis will also be performed on members who stated that they would schedule their own appointments, to determine whether speaking with the rep may be correlated with a member coming into compliance. HEDIS 2014 results will determine whether the overall rate of members compliant with the screening measures improved from HEDIS 2013 performance.

Qualitative Analysis and Barriers: Due to data extraction imitations, member lists were generated from data through the end of CY 2012. This led to a high percentage of members contacted who had already completed the appointment in 2013 (28% of members reached in the first round, 19% of members reached in the second round). In addition, clear performance expectations for the intervention, as well as the vendor performing calls, were not set for the outreach.

Opportunities for Improvement:

- Improve analytics generating non-compliant members lists, to ensure appropriate members are receiving outreach
- Improve analytics monitoring performance of intervention, to allow for more real-time
- Set appropriate goals for the interventions, and identify performance expectations for the vendor

Actions:

- In progress: BCBSRI will be implementing a Stars analytics system from Peak Health Solutions which will allow for the generation of more real-time lists of non-compliant members, as well as real-time monitoring to determine whether impacted members have kept their appointments and closed identified gaps.

- Completed: BCBSRI has implemented a new HEDIS vendor who will run rates on a monthly basis, allowing us to monitor improvements in expected HEDIS rates attributable to outreach.
- Planned: BCBSRI will work with CareNet to develop appropriate expectations for the number of appointments to be scheduled during outreach

Diabetes Care: Blood Sugar and Cholesterol Control Calls

Guided by HEDIS results for blood glucose and cholesterol control in members with diabetes (and verified by lab data), RD Case Managers made outreach calls flagged as uncontrolled for one or both, in order to provide education and resources to assist members in lowering those values.

Metrics/Frequency of Reporting: Metrics are displayed in the table in Results. Official HEDIS rates are reported annually. Member compliance rates measured monthly (beginning Q2 2014).

Data Source and Methodology: Sampling methodology and compliance rates, as well as ultimate success metrics will be determined utilizing NCQA-developed criteria for the following HEDIS measures:

- Indicator: Diabetes Care – Cholesterol Control
- Indicator: Diabetes Care – Blood Sugar Control
- Indicator: Diabetes Care – Poor HbA1C Control

Performance Goal/Benchmark: No goals/benchmarks were set for this intervention in 2013.

Results:

Indicators/Metrics & Results	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr. CY 2013	Goal and/or Benchmark
Controlled members/Total engaged members			**/147		None set
HEDIS measure numerator/HEDIS measure denominator (Cholesterol Control, Blood Sugar Control, Poor HbA1C Control)			Expect by 5/2015		

Quantitative Analysis: Out of 305 members identified initially:

- 296 cases were opened
- 149 of those members (50.3%) were enrolled (i.e. agreed to speak with the case manager)
- 148 of the enrolled members (99.3%) participated (i.e. completed an assessment with the case manager)
- 147 of the participating members (99.3%) were engaged (i.e. met at least one assigned goal)
- A total of 246 goals were completed across all 147 engaged members

Throughout 2014, additional analyses will be performed on the population of members who worked with Case Management, to determine whether those members were able to bring their lab values under control. Analysis will also be performed on which CCMS goals were most frequently associated with members able to lower their HbA1C and/or LDL. HEDIS 2015 results will determine whether the overall rate of members controlling their lab values improved from HEDIS 2013 performance.

Qualitative Analysis and Barriers: Due to limitations in available lab data caused by issues with the lab feeds from Medicare network labs, there is a high probability that uncontrolled members were missed in the data pull. In addition, clear performance expectations for the intervention were not set. The study is also longitudinal; improvements are not expected to be reflected in HEDIS results until HEDIS 2015, and are not expected to be reflected in Stars results until the 2016 Star Ratings Period.

Opportunities for Improvement:

- Improve lab feeds from Medicare network labs, to ensure that all uncontrolled members can be identified
- Improve analytics monitoring performance of intervention, to allow for more real-time analysis of intervention performance
- Set appropriate goals for the intervention

Actions:

- In progress: BCBSRI will be implementing a Stars analytics system from Peak Health Solutions which will allow for real-time monitoring to determine whether uncontrolled members have improved their lab values. BCBSRI is also working with 4 lab vendors (ESCL, Quest, Coastal, Lifespan) to ensure that weekly data feeds are accurate, which will provide more accurate counts on uncontrolled members
- Completed: BCBSRI has implemented a new HEDIS vendor who will run rates on a monthly basis, allowing us to monitor improvements in expected HEDIS rates attributable to outreach.
- Planned: BCBSRI will work with the Case Managers performing outreach to develop appropriate expectations for performance

*The BCBSRI 2013 HEDIS results for PPO and Medicare can be found in Attachment A of this document.

G. Member Safety

The safety of our members is of the utmost importance. In 2013, Blue Cross and Blue Shield of Rhode Island addressed member safety in several ways. Highlighted here are three member safety initiatives: the Hospital Quality Program, the Transitions of Care Program, and Medication Recall Outreach. **The Hospital Quality and Transitions of Care programs are discussed elsewhere in this evaluation and are revisited below.**

Hospital Quality Program

The Hospital Quality Program incorporates quality incentive measures into hospital contracts. In 2013, contracts with quality incentives (including Lifespan's Rhode Island Hospital, The Miriam, Newport, and Bradley Hospitals; Care New England's Kent Hospital, Women & Infants, and Butler Hospitals; Charter Care's Roger Williams Medical Center and Fatima Hospital; and South County Hospital) were expanded to also include Memorial Hospital, Westerly Hospital, and Landmark Medical Center, for a total of 13 hospitals. This represents the entire Rhode Island hospital network.

The 2013 Hospital Quality Program aligned a selection of Program measures with the Centers for Medicare and Medicaid's (CMS) Value-Based Purchasing Program (VBP) for Core Clinical Process of Care measures, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures. Safe Transitions process measures for best practices in discharge planning are derived from the Rhode Island Medicare Quality Improvement Organization (QIO), Healthcentric Advisors. While most of the hospitals had already been participating in these measures, they were new Program measures for some, as recently required by the Rhode Island Office of Health Insurance Commissioner (OHIC) as a condition for contracting. A new outcomes measure was also introduced to the Program: All-Cause Readmissions within 30 Days of Discharge.

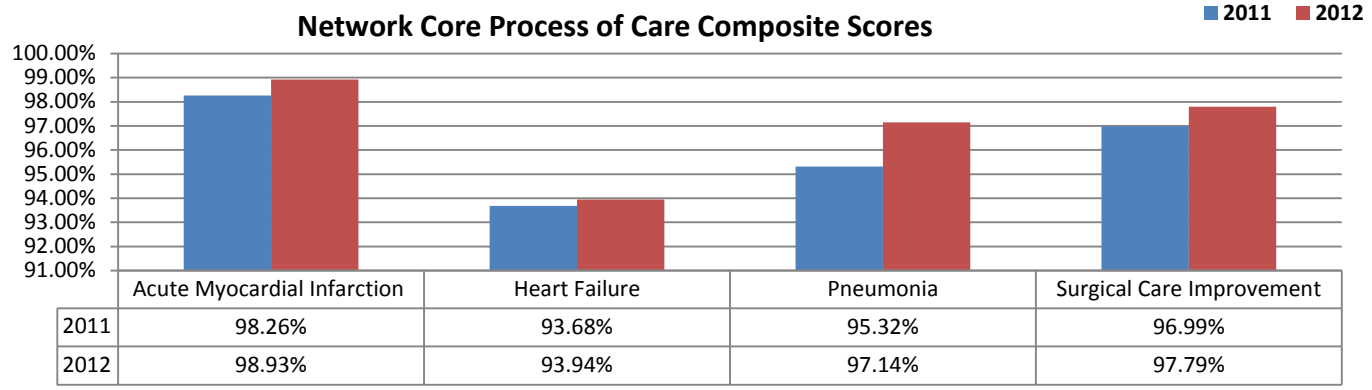
Metrics/Frequency of Reporting: In 2013, network performance on the Program measures (collected annually) was reviewed using 2011 and 2012 data. The Program's measures are as follows:

Network Core Process of Care Measures:	**HCAHPS Measures:**	**Safe Transitions Measures:**
• Acute Myocardial Infarction • Heart Failure • Pneumonia • Surgical Care Improvement	• Cleanliness • Communication about Medicines • Discharge Information • Doctor Communication • Nurse Communication • Pain Management • Quietness • Responsiveness of Hospital Staff • Overall Hospital Rating • Willingness to Recommend	• Notify PCP about admit • Provide follow-up phone number • Provide hospital clinician's contact information • Medication Reconciliation • Written discharge instructions • Summary clinical information to PCP • Schedule outpatient follow-up appt

Data Source and Methodology: Network Core Process of Care Measures are developed by the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission, a hospital quality accreditation organization. HCAHPS Measures are national standardized measures developed by CMS. Safe Transitions Measures were created by Rhode Island's quality improvement organization (QIO), Healthcentric Advisors. Rates for all measures are calculated by the division of a numerator by a denominator.

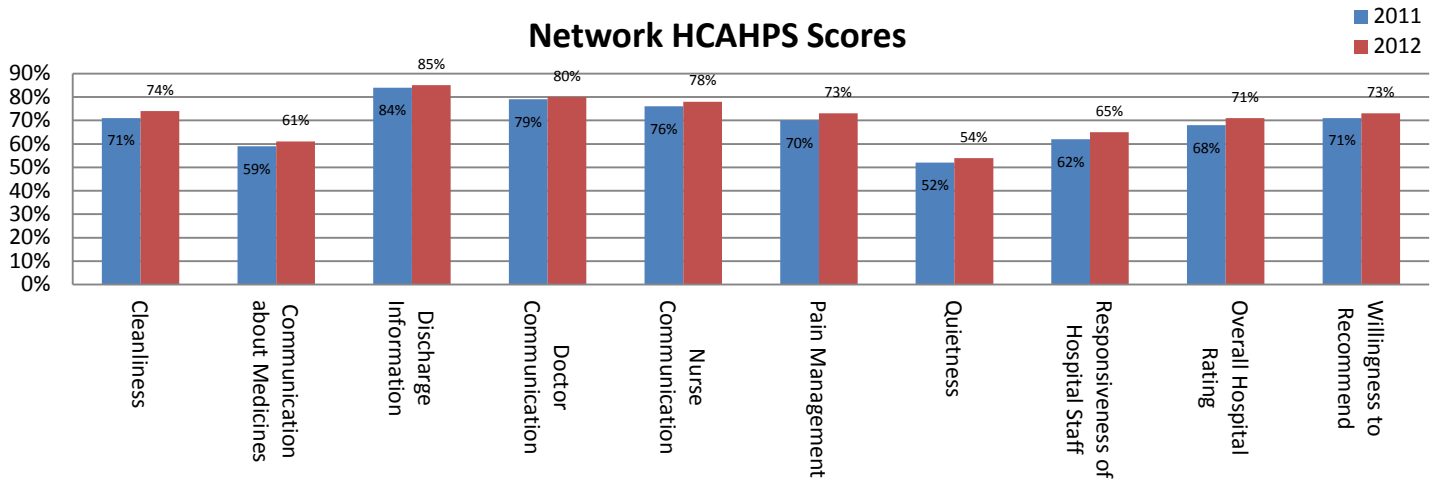
Performance Goal/Benchmark: To see improvement in each measure from year to year.

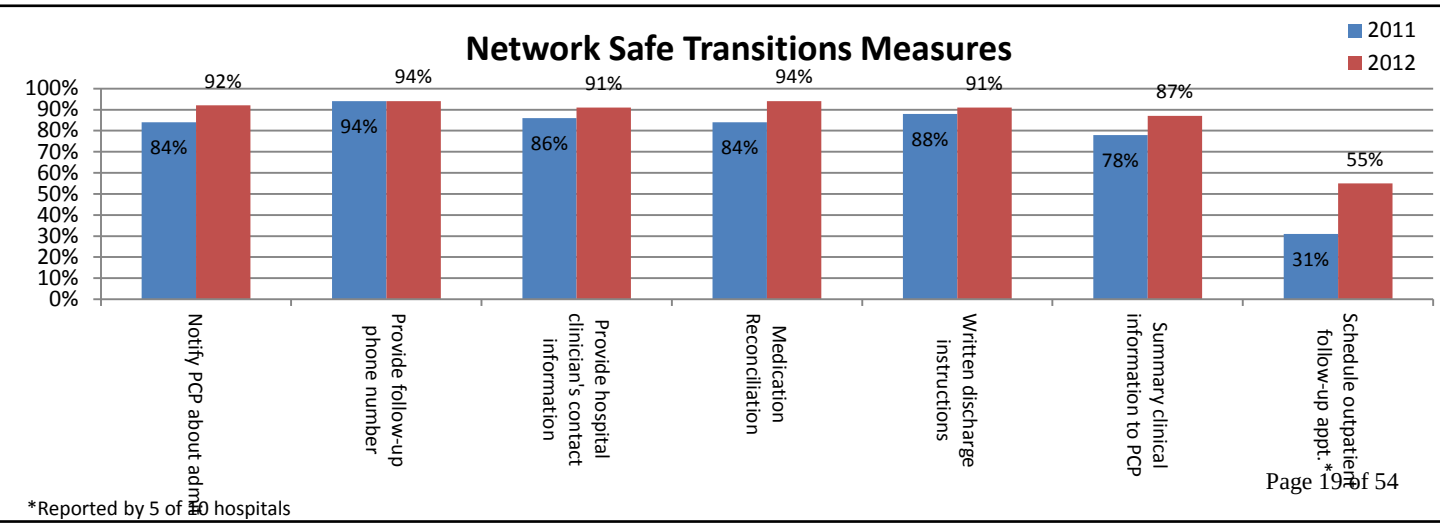
Results: Results for each of the three categories of measures are depicted respectively in the following charts:



	Acute Myocardial Infarction	Heart Failure	Pneumonia	Surgical Care Improvement
2011	98.26%	93.68%	95.32%	96.99%
2012	98.93%	93.94%	97.14%	97.79%

Note: RIH, Miriam and Newport reported invidual measure results. Therefore, composites are calculated as the average of the reported averages.





*Reported by 5 of 10 hospitals

Quantitative Analysis: All measures demonstrate improvement from 2011 to 2012.

Qualitative Analysis and Barriers: Barriers to stronger performance among Safe Transitions measures include the need for area hospitals to develop processes and data capture and reporting capabilities. There was also concern about measurement consistency across the hospital network. To address this, a stakeholders meeting was coordinated with the QIO in February 2013, resulting in some clarification of measure specifications and a revised guidance document issued by the QIO. Program barriers included a lack of outcomes measures and lack of emphasis on measures supporting CMS 5 Star for plan performance. To address outcomes, the 2013 Hospital Quality Program added an All Cause Readmission Within 30 Days of Discharge measure, for which seven hospitals have performance targets. Final results will not become available until March 2014, although preliminary performance through 3rd Quarter 2013 demonstrates that four hospitals are meeting or exceeding their targets. To address CMS 5 Star, a collaboration to share lab data involving key measures for diabetes and cholesterol management was initiated with Lifespan, the largest hospital system in the state. A pilot project was also initiated with three Lifespan hospitals to address high risk medications in the elderly.

Opportunities for Improvement: Continued collaboration with stakeholders across hospitals and state agencies for further program growth and development.

Actions for 2014: The Hospital Quality Program continues to align with CMS VBP for Clinical Process of Care and HCAHPS Measures. Safe Transitions measures will continue and with ongoing support and guidance to hospitals still in development mode. The All Cause Readmission measure is expected to expand to include 11 hospitals having performance targets. In support of CMS 5 Star, lab data share will expand to all hospitals. High Risk Medication in the Elderly focus is expected to expand to include at least an additional two hospitals. Discussions are also underway with five hospitals to address diabetics not having an ACEI or ARB medication ordered and to audit for prevalence of adequate communication of administration of flu vaccine to the next level of care provider.

Transition of Care Program

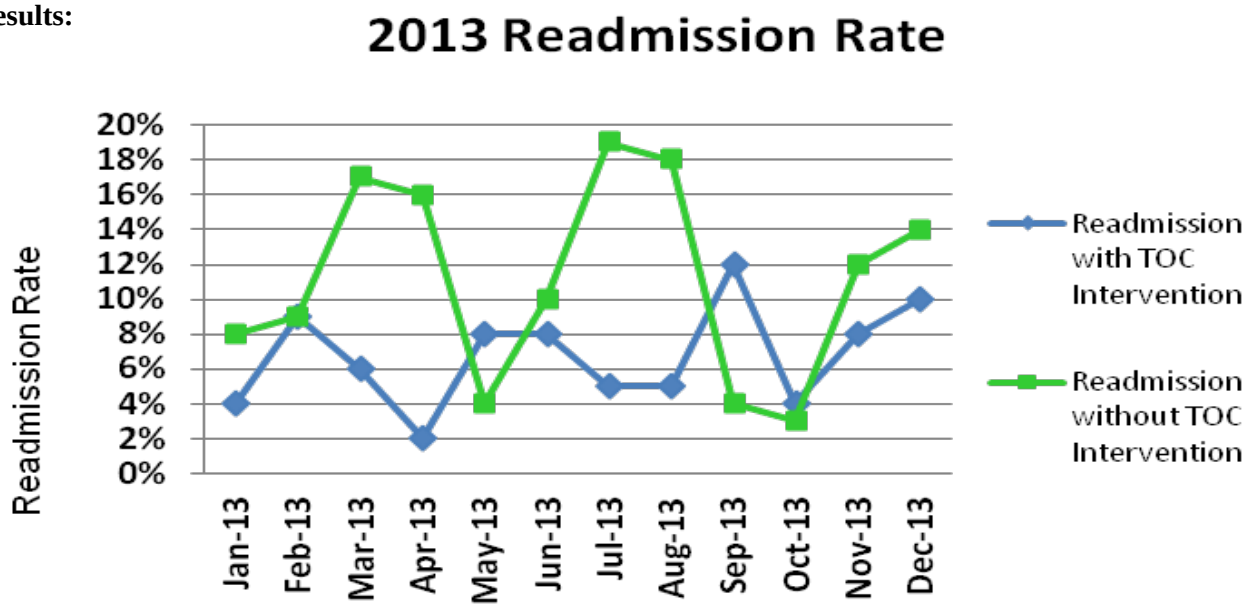
Nationwide and locally, avoidable hospital readmissions account for increasing health care costs and contribute to decreased quality of life. Gaps in the coordination of multiple health needs after a hospitalization jeopardize patient safety and contribute to this trend. In response to this problem, Blue Cross and Blue Shield of RI introduced the Transition of Care (TOC) Program in 2012. The Program works to reduce avoidable hospital readmissions by educating members regarding their health status and medications while in the hospital, in preparation for a safe transition home, where additional health services and coaching are made available when indicated. It is one of several initiatives, both internally and in the Rhode Island medical community, concurrently addressing avoidable readmissions. The Hospital Quality Program is another major BCBSRI initiative working to decrease readmissions. In the community, efforts among PCMHs, home care providers, and community agencies are also helping to address this issue. The BCBSRI Transition of Care program is intended to create a seamless experience from inpatient to outpatient care, while facilitating the transfer of information from facility to outpatient treatment.

Data Source, Methodology, Metrics, and Frequency of Reporting: We compare two sets of metrics: readmission rates to the hospital for members participating in TOC, and readmission rates to the hospital for members not participating in TOC. Data comes from our Medical Repository; it is reported and evaluated on a monthly basis. The readmission rate is calculated by the division of a numerator by a denominator, as follows:

- **Metric:** readmission rates among TOC participants
  - Numerator: the number of members participating in TOC who were readmitted to the hospital after initial admission
  - Denominator: the number of members participating in TOC with an initial hospital admission
- **Metric:** readmission rates among members not participating in TOC
  - Numerator: the number of members not participating in TOC who were readmitted to the hospital after initial admission
  - Denominator: the number of members not participating in TOC with an initial hospital admission

Performance Goal/Benchmark: Reduce the percentage of readmissions among members participating in the TOC Program.

Results:



2013 Monthly and Year-to-Date Comparisons:
Readmission Rates Among TOC vs Non-TOC Groups

Month	TOC Intervention		Without TOC Intervention	
	Discharges	Related Admits	Discharges	Related Admits
Jan-13	97	4	74	6
Feb-13	131	13	69	6
Mar-13	138	8	23	4
Apr-13	137	4	29	4
May-13	180	14	23	1
Jun-13	170	13	50	5
Jul-13	139	7	21	4
Aug-13	86	4	17	3
Sep-13	99	12	23	1
Oct-13	99	4	32	1
Nov-13	155	12	23	2
Dec-13	148	15	35	5
YTD	1579	108	409	41
YTD %	7%		10%	

Quantitative Analysis: Members participating in the Transition of Care (TOC) program experienced fewer hospital readmissions compared to members not participating in the TOC Program. TOC participants had an average annual readmission rate in 2013 of 7%, compared with an average annual readmission rate in 2013 of 10% among members not participating in the Transition of Care program.

Qualitative Analysis and Barriers: A barrier to further decreases in readmission rates is that despite early post-discharge telephonic outreach (a BCBSRI nurse called TOC participants 2 days post-discharge), some members were still being readmitted to the hospital.

Opportunities for Improvement and Actions Planned for 2014: Although BCBSRI nurses called members within 2 business days of notification of discharge, we found that many members were still being readmitted. Further review of data indicated that the readmission is most likely to occur on day 10-12 post discharge. A second call will now be included and will take place on post-discharge day #8. Another barrier was that hospital discharge planning conferences did not include the BCBSRI nurse. Moving forward, the BCBSRI onsite nurse or case manager will take a more active role in the discharge planning process. An enhanced Transition of Care (TOC) program will be implemented in the first quarter of 2014, allowing for the presence of the BCBSRI onsite nurse at daily Case Rounds to assist in facilitating a safe discharge plan. We anticipate subsequent improvements in care coordination, readmission rates, and member satisfaction.

Medication Recall Outreach

In February 2013, Village Fertility Pharmacy announced a voluntary recall of compounded medications shipped over the previous three months. The recall resulted after particulate was discovered in a small percentage of one lot of Progesterone, a medication used to support gestation. Village Fertility expanded the recall to include Leuprolide, an ovulation suppressant. A total of six forms of the two medications were recalled. Sixty BCBSRI members were affected across multiple product lines. They were notified immediately via letter and email about the recall and were provided with instructions, a hotline phone number, and postage for returning the recalled product. Prescribing providers were also notified about the recall.

On several dates in 2013 (see Results section), Catamaran (our pharmacy benefit manager), announced medication or product recalls. Members were notified immediately via letter about the recall, and were provided with instructions and a hotline phone number specific to each recall. Prescribing providers were also notified about the recalls.

Data Source and Methodology: For the Village Fertility recall, data sources were Village Fertility Pharmacy and BCBSRI claims data; methodology was extract report from software. For the Catamaran recalls, the data sources were Catamaran and BCBSRI claims data; methodology was also extract report from software.

Performance Goal/Benchmark: not applicable for any of the recalls

Results:

Table 1: Village Fertility Pharmacy Recall

Members Affected by Recall	Members Notified	Members Reporting Adverse Events
60	100% 60/60	0% 0/60

Table 2: 2013 Catamaran Recalls

Product Recalled	Date of Recall and Notification	Commercial Members Affected and Notified	Medicare Members Affected and Notified
FreeStyle InsuLinx® Blood Glucose Meter	4/18/2013	10	0
Enteric Coated Aspirin	6/24/2013	198	0
Benztropine mesylate injection	7/3/2013	0	1
NOVA Max Blood Glucose Test Strips	7/29/2013	15	25

Quantitative Analysis: For the Village Fertility Pharmacy recalls, sixty members were affected and 100 percent of those members were contacted within 24-48 hours of public reporting of the recall. Zero percent of the members reported adverse events related to the recalled medication. For the Catamaran recalls, 223 Commercial members and 26 Medicare members were affected by four separate recalls. 100 percent of those members were notified expeditiously by Catamaran. Adverse event reporting was not handled by Catamaran and thus is not available.

Qualitative Analysis and Barriers: No barriers were identified for any of the recalls.

Opportunities for Improvement and Actions Planned: Continue working closely with all network pharmacies and Catamaran, our Pharmacy Benefit Manager, to respond rapidly to medication recalls in order to ensure the safety of our members.

Member Safety Actions Planned for 2014: We will continue the growth, development, and evaluation of our Hospital Quality, Transition of Care, and Pharmacy safety programs. In addition, we will continue the following safety initiatives in 2014:

Safety Mechanism	Description	
Providing Education to Members	Our website provides members with the following safety information:	
	• Aging Well: Making Your Home Fall-Proof • Alzheimer's and Other Dementias: Making Your Home Safe • Carbon Monoxide Detectors • Disease and Injury Prevention • Health and Safety, Birth to 2 Years • Helping Your Teen Become a Safe Driver • How to Get Up Safely After a Fall • Lead Poisoning: Reducing Lead in Your Home • Organizing Your Medical Records • Prevent Errors with Medicines	• Preventing Falls in Older Adults • Preventing Falls in Older Adults Who Take High-Risk Medicines • Preventing Medicine Errors • Preventing Medicine Errors in Children • Quick Tips: Helping Your Child Stay Safe and Healthy • Safer Sex • Staying Safe When You Take Several Medicines • Staying Safe: If You Are in a Violent Relationship/After You Leave a Violent Relationship • What you Can Do to Prevent Medical Errors
Providing Education to Providers	Through our provider communication tool, *Policy Update*, we notify providers about policy changes, updates to practice guidelines, recalls and safety issues relevant to the care of our members.	
Transitions of Care	Our Transitions of Care Program helps members reduce avoidable hospital readmissions through nurse intervention and education about the member's care plan, medication safety, and health status.	
Member Complaint Review	Member complaints are reviewed routinely to identify complaints related to quality of care, accessibility, and availability.	
Pharmacy Management	BCBSRI, through our Pharmacy Benefit Manager, implements prior authorization processes and quantity limits on specific drugs to prevent over-utilization, ensure appropriateness of medications, identify poly-pharmacy issues, identify abuse of narcotics, and reduce the exposure of members to new medications with uncertain side-effects. Activities include, but are not limited to: providing timeline notification to patients and their practitioners of voluntary and mandated drug recalls and/or withdrawals.	
Clinical Practice Guidelines	Blue Cross and Blue Shield of Rhode Island has clinical practice guidelines in place to ensure the care members are receiving is in keeping with the latest standards and to assist members with making decisions related to their health. These guidelines are available to all physicians and members.	
CurrentCare	We actively encourage members to register for CurrentCare, the state's Health Information Exchange. This secure data repository allows providers, facilities, labs, and pharmacies to share accurate clinical information that improves patient safety by reducing overprescribing, duplicate treatment, and potentially contraindicated treatments. Members can opt to allow for emergency-only access by providers, or to allow for access by a fuller range of providers involved in their care on an as-needed basis.	
Electronic Medical Records	Our support of Patient Centered Medical Homes includes encouraging the use of electronic medical records. Implementation of the EMR allows practitioners to share information more efficiently and reduce handwritten medical errors.	
Network Adequacy	BCBSRI performs an analysis of the population and the provider network at least annually to determine if the network is adequate to support the healthcare needs of the members we serve. When opportunities for improvement are identified, Contracting staff work to develop contracts with needed providers.	
Credentialing	BCBSRI credentials providers and performs site visits in accordance with regulatory and accreditation requirements. Site visits ensure practices meet our standards for safety, cleanliness, documentation, access, and patient satisfaction.	

II.3 Objective 3: Integration of medical and behavioral healthcare to improve quality of care

A. Intensive Case Management

Blue Cross and Blue Shield of Rhode Island's claims data indicates that members with medical diagnoses are more apt to have underlying behavioral health symptoms which can significantly impact their outcomes and treatment adherence. In July 2013, BCBSRI partnered with Value Options (VO), a behavioral health organization who assumed behavioral health case management at that time. VO's behavioral health (BH) Intensive Case Managers (ICM) and BCBSRI's medical ICM staff work collaboratively to co-manage members with co-morbid (medical and behavioral) conditions. Members voluntarily engage in complex case management when they have experienced a critical event or diagnosis that requires the extensive use of resources and need assistance navigating the care delivery care system.

VO scores co-managed members either High Intensity, Tier 3, with medical co-management or Tier 2, Moderate Intensity who are also co-managed by the Health Plan. High Intensity members with medical co-management receive multiple contacts per week or weekly as needed in the first weeks of engagement. Acute management period may last up to 30 to 60 days to stabilize and engage member in ongoing treatment. Members are re-evaluated for transition to Tier 2 (or Moderate Intensity) for ongoing care management when acute care plan goals are met. Tier 2, Moderate Intensity members receive weekly or bi-weekly contact in the first month, and then monthly until the care plan is met. For both intensity tiers the ICM program duration is targeted for 3 months to 12 months depending on chronicity and potential risk.

Co-management interventions include assessment, development and monitoring of a care plan, education and support, and referrals to additional providers and resources as needed.

Data Source, Methodology, and Reporting Frequency: Members were initially identified via data extract from McKesson CCMS, the BCBSRI Care Management software system. In 2013, data was reported annually for the timeframe 1/1/13-12/31/13. Methodology and data sources are as follows: (1) Initial identification: Medical case management cases that were opened as a result of an inpatient medical admission and had a behavioral need at discharge, as documented in McKesson CCMS; (b) Subsequent identification: Members were then identified as having had a behavioral health intervention, by extract from McKesson CCMS. (c) Engagement rate: calculated by a numerator (unique eligible members who engaged in intensive case management, determined by an extract from CCMS of members having interventions indicating BH referral for co management) divided by a denominator (the total number of unique members eligible for medical and behavioral health intensive case management (as identified by data extract from CCMS).

Metrics and Results:

BCBSRI/VO Co-Management Results (Q1-Q2: BCBSRI BH and Medical ICM)	**1st Qtr. CY 2013 (BCBSRI)**	**2nd Qtr. CY 2013 (BCBSRI)**	**3rd Qtr. CY 2013 (VO)**	**4th Qtr. CY 2013 (VO)**	**Goals**
Unique Members with Inpatient Medical Admission who had a BH Intervention marked as "Met." "Met" is the CCMS terminology for completing an intervention.	7	10	3	4	
Unique Members who met qualifying criteria for co management, where there was collaboration between the BCBSRI medical ICM and BH ICM	2	5	0	4	
Engagement rate	8% 2/24	21% 5/24	0% 0/24	17% 4/24	**40%**

Quantitative Analysis: The initial extract identified 24 unique members eligible for intensive case management; 11 of these members were co-managed by BCBSRI's medical Intensive Case Management (ICM) and behavioral health (BH) ICM. BCBSRI attributes the small sample size and low engagement rates to the new BH ICM program that started in July 2013 following the a behavioral health vendor transition. BCBSRI anticipates broader identification and participation of members in 2014.
The co-management goal for 2013 was 40%. In all quarters the goal was not met.

- January 1, 2013-June 30, 2013, 7/24 (29%) of members had evidence of co-management.
- July 2013- December 2013, 4/24 (17%) of members had evidence of co management.
- January 1, 2013-June 30, 2013, 7/24 (29%) of members had evidence of co-management.
- July 2013- December 2013, 4/24 (17%) of members had evidence of co management.

In 2013, 13/24 (54%) of members were not co-managed due to the following reasons:

- Declined medical case management.
- Loss of contact or unable to reach by BH ICM.
- Medical case was closed as medical needs were met after referral made to BH ICM.

Qualitative Analysis and Barriers: The following barriers were identified during CY 2013:

- BCBSRI transitioned the ICM program from BCBSRI to Value Options (VO). As a result of the transition to the new delegate, several members were discharged as they no longer needed care management; new cases were identified in Q3 of 2013.
- BCBSRI medical ICMs required training on referrals to Value Options ICM and co- managed cases post transition.
- BCBSRI did not share claims data with VO in 2013.

Opportunities for Improvement:

- Expand the definition of members for co management to increase identification and enrollment of members.
- Develop specific criteria for referrals from utilization managers to BH ICM and from medical to BH ICM.
- Continue joint case rounds (BCBSRI and VO) to identify new referrals and to ensure members identified for co-management receive outreach and support.
- Enhance communication between BH and medical ICMs.
- Schedule training for VO BH Intensive Case Management and BCBSRI's medical care management team.
- Use ER hospital reports to assist in further identification of members for co-management opportunities.

Actions Planned for 2014:

- BCBSRI and VO will continue to work collaboratively to increase enrollment and engagement rates of co- managed members in 2014.
- BCBSRI utilization managers to begin training on new referral criteria in the 2nd quarter of 2014.
- Continue to collaborate with BCBSRI medical ICM for co management.
- Continue to collaborate with BCBSRI medical UM and ICM team to monitor and track referrals.
- BCBSRI will use data to inform the development of a behavioral health sub provider network who will work closely with our primary care network.
- BCBSRI will communicate the findings with the BH provider community through communication materials, its BH Advisory Committee, and provider forums. BCBSRI will work collaboratively with its behavioral health practitioners to identify and act upon opportunities for improvement.

II.4 Objective 4: Continuously promote and monitor evidence-based best clinical practice across our network of providers

A. Professional Advisory Committee

The BCBSRI Professional Advisory Committee, which is composed of six board certified network physicians (including primary care providers and specialists) review and approve updated evidence-based clinical practice guidelines for screening and treatment every two years. BCBSRI adopts recommendations of the US Preventive Services Task Force as presented on web site for the Agency for Healthcare Research & Quality (AHRQ). Approximately 19 guidelines for prevention, screening and treatment were reviewed in 2013. Once approved, the guidelines were posted on the Provider Update website, available to all network providers and facilities.

B. Nurse Care Manager Best Practice Learning Collaborative

BCBSRI held the "Nurse Care Manager (NCM) Best Practice Learning Collaborative" on 11/5/2013 at BCBSRI. Nurse Care Managers are embedded in PCMH practices where they function as care team members, providing self-management support, education, and oversight to complex and chronically ill patients.
The event provided a forum for NCMs from across the state to share best practices and outcomes on a variety of important topics including coordination, care management, overcoming barriers, and the incorporation and advancement of health information technology.

II.5 Objective 5: Collaborate with community partners to achieve improved care for all BCBSRI members

A. Practice Innovation – Patient Centered Medical Home (PCMH) Program

As of January 1, 2014 approximately 100,000 Commercial members are attributed to a Patient Centered Medical Home (PCMH) in either the BCBSRI or multi-payer Chronic Care Sustainability Initiative (CSI). This model focuses on overall population health as well as the proactive management of chronic conditions. Members benefit from a more comprehensive approach to care, which leverages a care team comprised of Physicians, Nurse Care Managers, and in some cases Pharmacists and Behavioral Health providers.

Metrics/Frequency of Reporting/Goals: Standard reporting received on a quarterly and annual basis. Practices self report information from their EHR systems and report in an excel format (at an aggregate level across their patient population). Benchmarks/Goals are derived based on national metrics as well as past performance of the reporting group (i.e. rates increased year over year as overall performance improves). CSI allows for payout either for meeting defined target OR getting more than 1/2 towards threshold IF that change is more than 2% points (i.e. they had to be 5% points below threshold in prior year.)

Data Source and Methodology: Practices self report information from their EHR systems and report in an excel format (at an aggregate level across their patient population).

Results:

Adult	2013 Target	2014 Target	Pediatric	2013 Target	2014 Target
DM - HbA1C Poor Control (>9%)	<=20%	<=20%	URI - Appropriate Treatment	90%	90%
DM - HbA1C Control (<8%)	65%	69%	Pharyngitis - Appropriate Testing	90%	90%
DM - LDL Control (<100)	50%	50%	Tobacco Use	95%	95%
DM - BP Control	70%	76%	Weight Assessment	60%	70%
Tobacco Use	95%	95%	Immunization - Childhood Status	85%	85%
Tobacco Cessation Intervention	80%	85%	Immunization - Adolescent Status	90%	90%
Adult BMI	45%	60%	Chlamydia Screening - Sexual History	50%	75%
Fall Risk	65%	70%	Chlamydia Screening -Testing	45%	65%
HTN - BP Control (<140/90)	68%	72%	BP Screening	95%	90%
Depression Screening	50%	75%	Annual Preventive visit	95%	95%

Targets increased based on previous year performance and newly established targets for CSI 1

Practice reporting below is illustrative based on the results of a midsized CSI practice quarterly reporting submission.

Indicators/Metrics & Results	1st Qtr. CY 2013	2nd Qtr. CY 2013	3rd Qtr. CY 2013	4th Qtr CY 2013	Goal and/or Benchmark
Indicator: Diabetes Mellitus – HbA1c Control Numerator: diabetic patients (Type 1 or 2) age 18-75 with controlled disease (having an A1c value less than 8.0%). Denominator: diabetic patients (Type 1 or 2) age 18-75	68%	71%	72%	76.77%	**69%**
Indicator: Diabetes Mellitus – LDL Control Numerator: diabetic patients (Type 1 or 2) age 18-75 with LDL > 100 Denominator: diabetic patients (Type 1 or 2) age 18-75	56%	57%	61%	72.65%	**50%**
Indicator: Diabetes Mellitus – BP Control Numerator: diabetic patients (Type 1 or 2) age 18-75 with controlled BP (BP < 140/90) Denominator: diabetic patients (Type 1 or 2) age 18-75	85%	84%	84%	79.94%	**76%**

Quantitative Analysis: On a quarterly basis, practices convene at the Practice Reporting workgroup to vet data submission. This process includes validating numerator and denominators to identify anomalies and any inconsistencies. Data stability is monitored based on variability over time to further validate submissions.

Qualitative Analysis and Barriers: Since the inception of the program, results have improved. At the beginning, much of this was a result of improvements in data reporting (entering information into the EHR in a consistent manner in extractable fields). As data has remained stable over time, focus is placed greater on higher performance within each metric. Barriers remain in patient behavior as well as consistency of reporting. Patient behavior and choice impacts outcomes in a number of ways:

- If member does not have test completed (regardless of what outcome would be) they are considered non compliant
- Member benefits/cost sharing impacts patient compliance

Opportunities for Improvement:
As mentioned above, the Practice Reporting workgroup serves as a best practice sharing forum to serve as an opportunity for sites to learn from others. Improvements are achieved through a number of forums including CSI subcommittees and best practice sharing. Although data reporting plays a significant role, practice redesign and use of the care model dramatically impacts practice outcomes. Examples include:

- ***Collaborative/Committee Based Interventions:***
  - **Nurse Care Manager Best Practice Learning Collaborative:** Over 90 NCMs from PCMHs around the state from both the BCBSRI and CSI-RI PCMH programs participated in our 2013 NCM Best Practice Learning Collaborative, which took place here at BCBSRI on November 5, 2013. The event provided a forum for NCMs to share best practices and outcomes with one another on a variety of important topics including coordination, care management, overcoming barriers, and the incorporation and advancement of health information technology.
  - **Nurse Care Manager Best Practice Committees:** On a monthly basis, NCMs convene to share ideas and discuss opportunities for improvement. This occurs in two settings – one facilitated by BCBSRI open to CSI and BCBSRI participants in a bi-monthly conference call as well as a monthly in person meeting specific to CSI NCMs.
  - **Practice Transformation Committee**: Monthly meeting open to PCMH practices, largely attended by CSI practices, focused on the development of PCMH principles within the practice. This committee is co-chaired by the Manager of Practice Innovation at BCBSRI.
  - **Practice Reporting Committee:** Opportunity for practices to report quality based measures to CSI and discuss barriers and lessons learned

- ***Individual Practice Based Interventions:***
  - **Onsite practice assessments and practice facilitation:** BCBSRI leads practice facilitation services in both our own program as well as the CSI program. These services are aimed to expedite practices along the transformation continuum as well as to foster sustainable change within the practice.

Actions: Practice reporting will continue through existing processes. Greater emphasis on patient engagement will continue to drive greater adherence.

B. Hospital Quality Program

The Hospital Quality Program incorporates quality incentive measures into hospital contracts. In 2013, contracts with quality incentives (including Lifespan's Rhode Island Hospital, The Miriam, Newport, and Bradley Hospitals; Care New England's Kent Hospital, Women & Infants, and Butler Hospitals; Charter Care's Roger Williams Medical Center and Fatima Hospital; and South County Hospital) were expanded to also include Memorial Hospital, Westerly Hospital, and Landmark Medical Center, for a total of 13 hospitals. This represents the entire Rhode Island hospital network.

The 2013 Hospital Quality Program aligned a selection of Program measures with the Centers for Medicare and Medicaid's (CMS) Value-Based Purchasing Program (VBP) for Core Clinical Process of Care measures, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures. Safe Transitions process measures for best practices in discharge planning are derived from the Rhode Island Medicare Quality Improvement Organization (QIO), Healthcentric Advisors. While most of the hospitals had already been participating in these measures, they were new Program measures for some, as recently required by the Rhode Island Office of Health Insurance Commissioner (OHIC) as a condition for contracting. A new outcomes measure was also introduced to the Program: All-Cause Readmissions within 30 Days of Discharge.

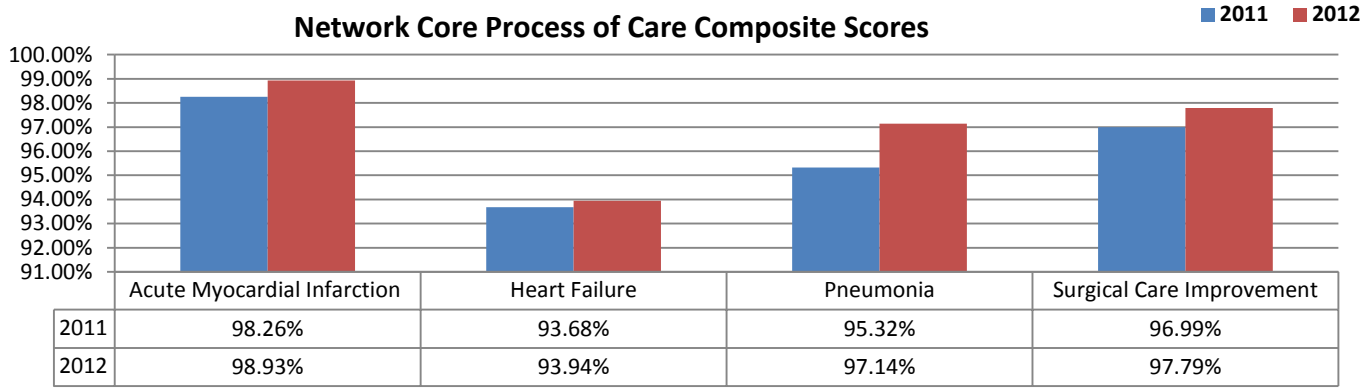
Metrics/Frequency of Reporting: In 2013, network performance on the Program measures (collected annually) was reviewed using 2011 and 2012 data. The Program's measures are as follows:

Network Core Process of Care Measures:	**HCAHPS Measures:**	**Safe Transitions Measures:**
• Acute Myocardial Infarction • Heart Failure • Pneumonia • Surgical Care Improvement	• Cleanliness • Communication about Medicines • Discharge Information • Doctor Communication • Nurse Communication • Pain Management • Quietness • Responsiveness of Hospital Staff • Overall Hospital Rating • Willingness to Recommend	• Notify PCP about admit • Provide follow-up phone number • Provide hospital clinician's contact information • Medication Reconciliation • Written discharge instructions • Summary clinical information to PCP • Schedule outpatient follow-up appt

Data Source and Methodology: Network Core Process of Care Measures are developed by the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission, a hospital quality accreditation organization. HCAHPS Measures are national standardized measures developed by CMS. Safe Transitions Measures were created by Rhode Island's quality improvement organization (QIO), Healthcentric Advisors. Rates for all measures are calculated by the division of a numerator by a denominator.

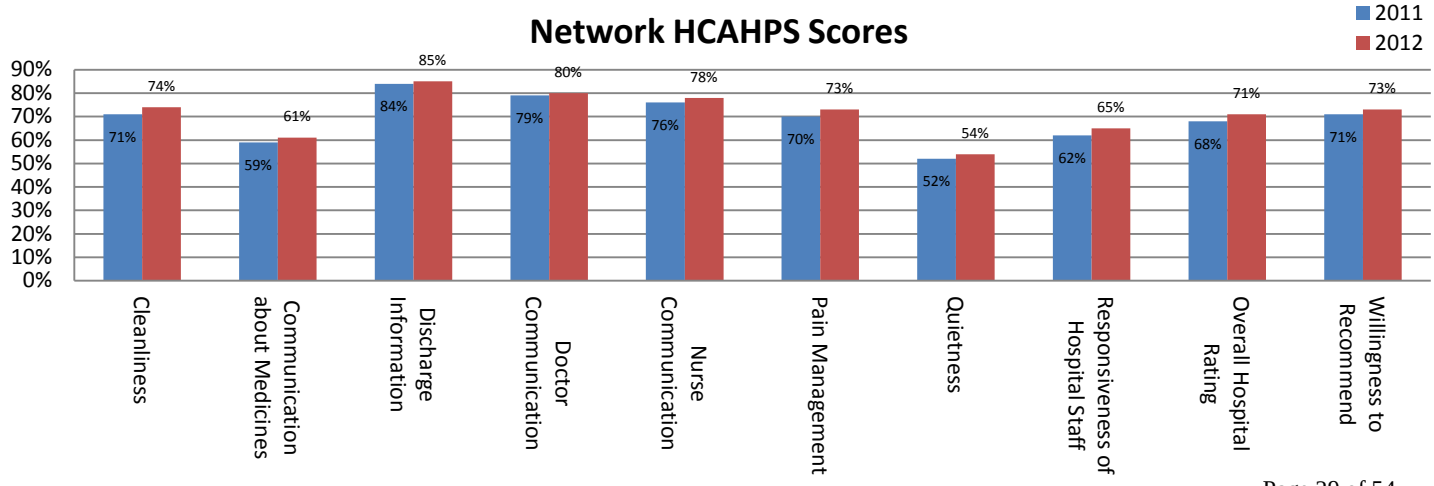
Performance Goal/Benchmark: To see improvement in each measure from year to year.

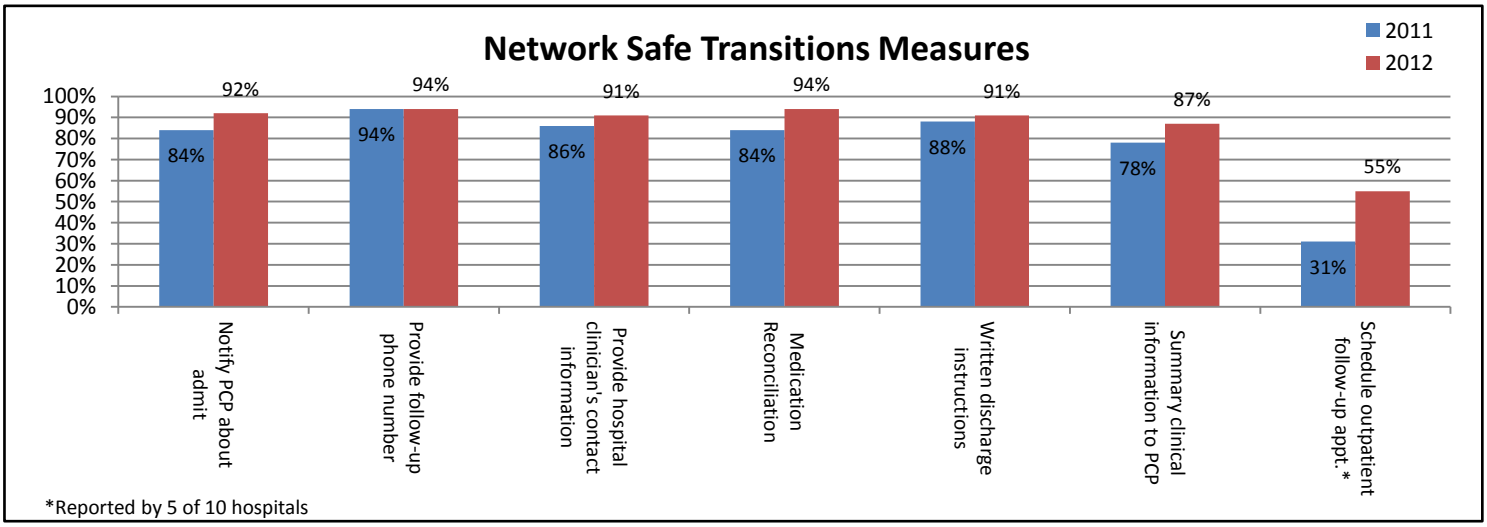
Results: Results for each of the three categories of measures are depicted respectively in the following charts:



	Acute Myocardial Infarction	Heart Failure	Pneumonia	Surgical Care Improvement
2011	98.26%	93.68%	95.32%	96.99%
2012	98.93%	93.94%	97.14%	97.79%

Note: RIH, Miriam and Newport reported invidual measure results. Therefore, composites are calculated as the average of the reported averages.





Quantitative Analysis: All measures demonstrate improvement from 2011 to 2012.

Qualitative Analysis and Barriers: Barriers to stronger performance among Safe Transitions measures include the need for area hospitals to develop processes and data capture and reporting capabilities. There was also concern about measurement consistency across the hospital network. To address this, a stakeholders meeting was coordinated with the QIO in February 2013, resulting in some clarification of measure specifications and a revised guidance document issued by the QIO. Program barriers included a lack of outcomes measures and lack of emphasis on measures supporting CMS 5 Star for plan performance. To address outcomes, the 2013 Hospital Quality Program added an All Cause Readmission Within 30 Days of Discharge measure, for which seven hospitals have performance targets. Final results will not become available until March 2014, although preliminary performance through 3rd Quarter 2013 demonstrates that four hospitals are meeting or exceeding their targets. To address CMS 5 Star, a collaboration to share lab data involving key measures for diabetes and cholesterol management was initiated with Lifespan, the largest hospital system in the state. A pilot project was also initiated with three Lifespan hospitals to address high risk medications in the elderly.

Opportunities for Improvement: Continued collaboration with stakeholders across hospitals and state agencies for further program growth and development.

Actions for 2014: The Hospital Quality Program continues to align with CMS VBP for Clinical Process of Care and HCAHPS Measures. Safe Transitions measures will continue and with ongoing support and guidance to hospitals still in development mode. The All Cause Readmission measure is expected to expand to include 11 hospitals having performance targets. In support of CMS 5 Star, lab data share will expand to all hospitals. High Risk Medication in the Elderly focus is expected to expand to include at least an additional two hospitals. Discussions are also underway with five hospitals to address diabetics not having an ACEI or ARB medication ordered and to audit for prevalence of adequate communication of administration of flu vaccine to the next level of care provider.

II.6 Objective 6: Improve the quality of member and provider engagement and satisfaction with the health plan, including access to care

A. 2013 CAHPS

Every year, Blue Cross and Blue Shield of Rhode Island conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of members who have been with BCBSRI for at least one year. The CAHPS survey is used by most health plans and helps consumers evaluate health plan quality and member satisfaction.

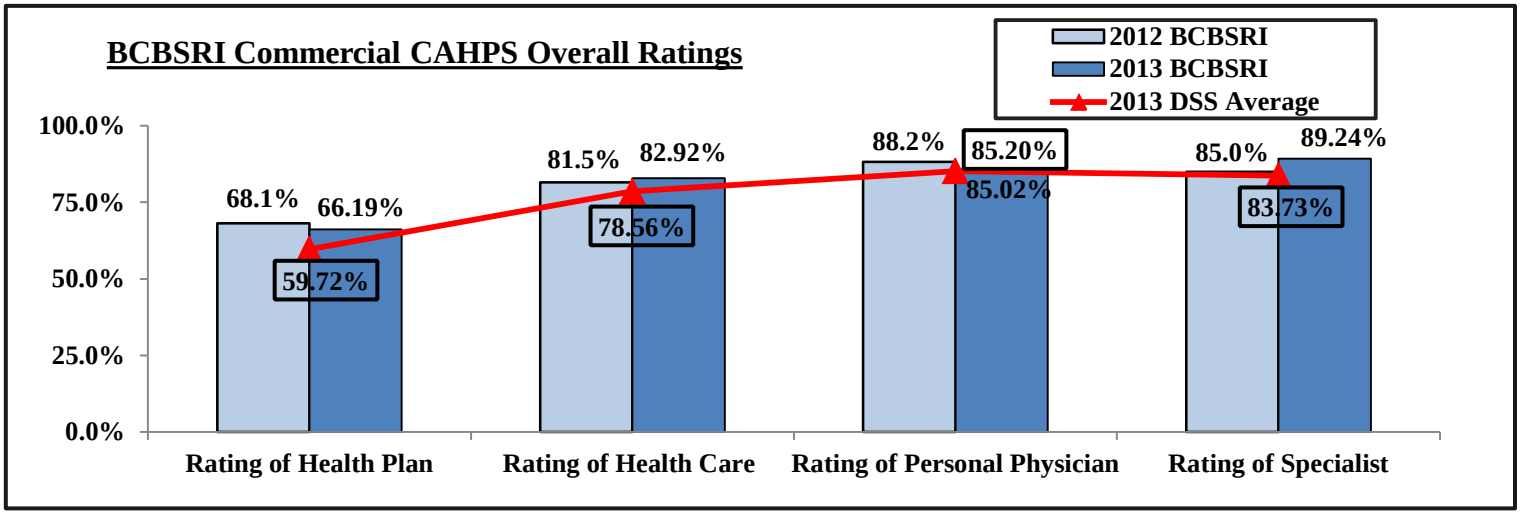
Commercial CAHPS

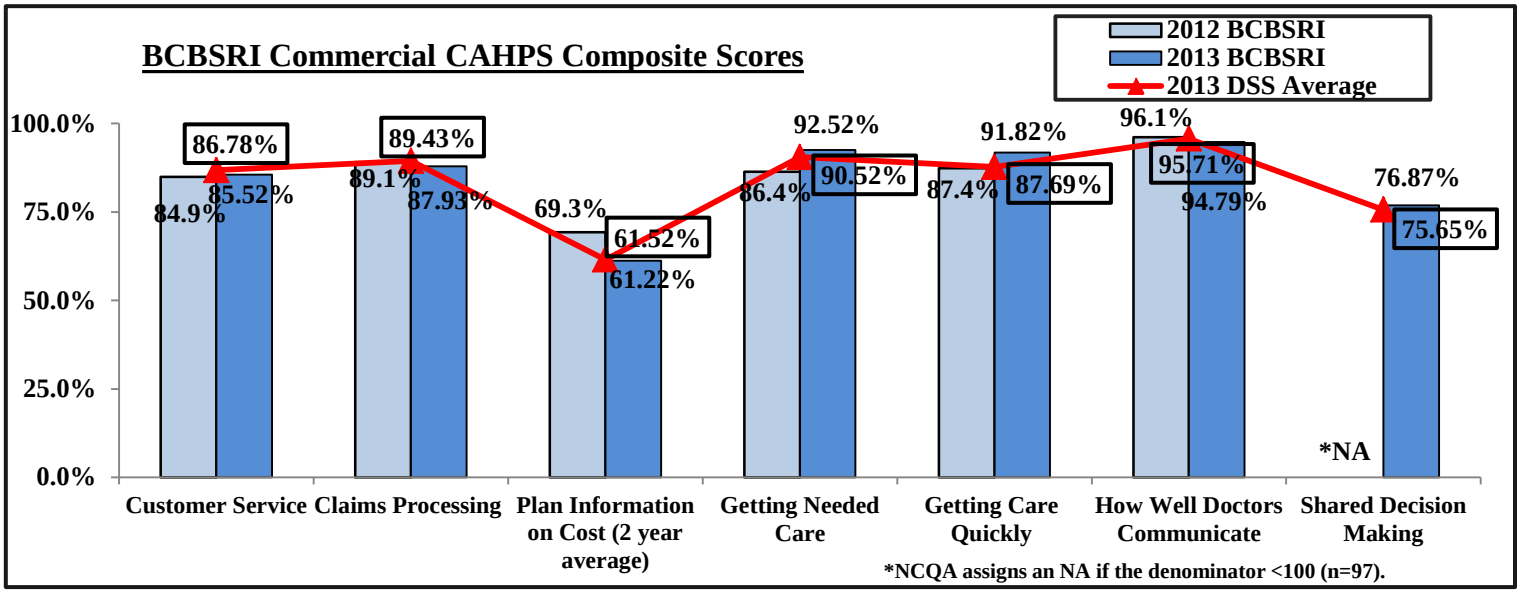
Metrics/Frequency of Reporting: Metrics are displayed in the tables in the Results section. CAHPS data is reported annually.

Data Source and Methodology: Data comes from our annual CAHPS survey. DSS, our vendor for Commercial CAHPS and Medicare CAHPS surveys, utilizes standard CAHPS specifications for sampling and survey data collection. Surveys are initially fielded by mail; subsequent telephone calls are made if we need more finished/completed surveys. In 2013 our Commercial CAHPS response rate was nearly 36%.

Performance Goal/Benchmark: Our goal is to improve upon the prior year's performance for every indicator.

Results:





Quantitative Analysis: We experienced drops in Commercial CAHPS overall rating of Health Plan in 2013 compared to 2012, but the difference is not considered statistically significant. We also are still ahead of the 2013 DSS (vendor) average and the 2012 "Quality Compass" of aggregated publicly reportable company ratings (approx. 300 companies participate). One area where our ratings declined was in Plan Information on Costs, which is consistent with results from the Member Experience study.

Qualitative Analysis and Barriers: The decrease in Plan information on costs is attributable to a higher percent of members seeking information on how the health plan works in written or online materials, and there was a significant decrease in ease of completing health plan forms (but the number of respondents for this was low).

Opportunities for Improvement: The web team is working to improve access Catamaran's formulary drug lookup tool, to facilitate member access to cost information. Benefit pages on the member portal are also changing in the next few months; letters will go out to all members letting them know about forthcoming changes. We have seen a slight increase in the 2-year average for members getting flu shots; this is a clinical CAHPS measure.

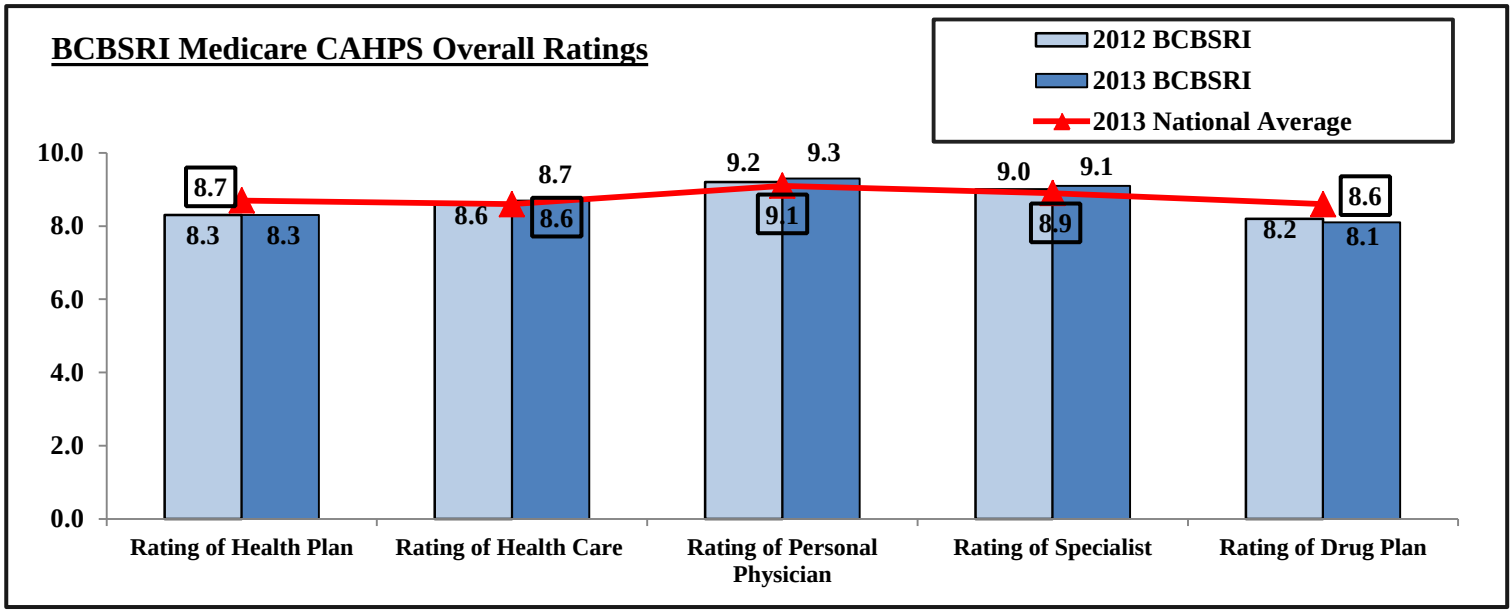
Medicare CAHPS

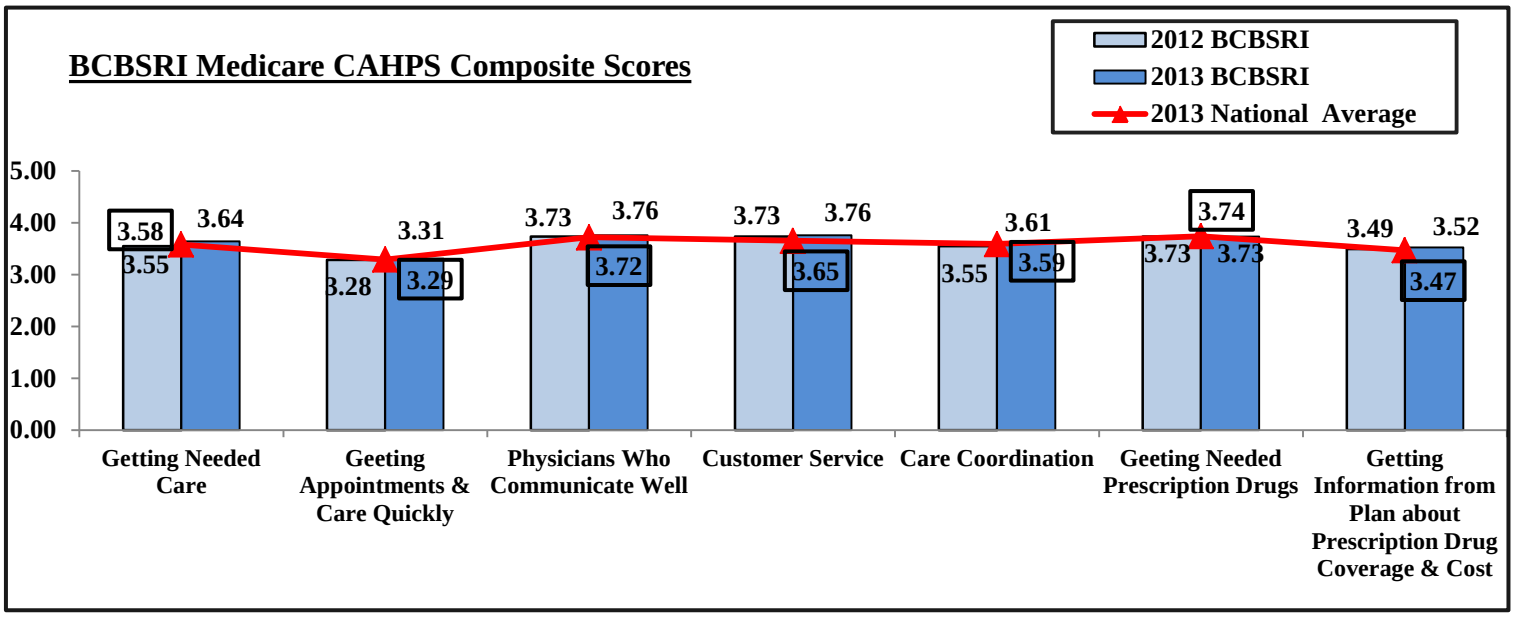
Metrics/Frequency of Reporting: Metrics are displayed in the tables in the Results section. CAHPS data is reported annually.

Data Source and Methodology: Data comes from our annual CAHPS survey. DSS, our vendor for Commercial CAHPS and Medicare CAHPS surveys, utilizes standard CAHPS specifications for sampling and survey data collection. Surveys are initially fielded by mail; subsequent telephone calls are made if we need more finished/completed surveys. In 2013 our Commercial CAHPS response rate was nearly 36%.

Performance Goal/Benchmark: Our goal is to improve upon the prior year's performance for every indicator.

Results:





CMS 5 Star Measures from 2013 CAHPS results & 2014 Star Rating:

	Measure		CAHPS	Star Rating
C24	Getting Needed Care	CAHPS	88%	4
C25	Getting Appointments and Care Quickly	CAHPS	77%	4
C26	Customer Service	CAHPS	92%	5
C27	Overall Rating of Health Care Quality	CAHPS	87%	4
C28	Overall Rating of Plan	CAHPS	83%	2
C29	Care Coordination	CAHPS	86%	4
D08	Rating of Drug Plan	CAHPS	81%	1
D09	Getting Needed Prescription Drugs	CAHPS	91%	4

Quantitative Analysis: Our Overall Rating of Health Plan is stable but below the national average. Overall Rating of Drug Plan decreased only slightly and is also below the national average. Customer Service has been identified as strength for our plan. Decreased satisfaction with the ease of getting prescription drugs is likely related to issues during BCBSRI's switch to Catamaran in early 2013; CAHPS was fielded in February, right after the switch. We are also significantly below the national average for Willingness to Recommend Drug Plan. Fewer than 50% of Medicare members said they received outreach from their doctor or health plan to remind them to get a flu shot.

Qualitative Analysis and Barriers: The change to Catamaran, a new Pharmacy Benefit Manager, during early 2013 was problematic and reflected in decreased satisfaction rates among Medicare members.

Opportunities for Improvement: We utilized a telephone outreach program (Televox) to contact Medicare members; this is an automated telephone reminder service. It does not offer live person-to-person interaction with the member, and may not be as successful in influencing members to obtain missed tests or appointments.

Actions Taken: Some interventions with Medicare members were designed to affect both CAHPS and CMS 5-Star ratings. In 2013, BCBSRI contracted with a call vendor, CareNet, to perform outreach to existing Medicare in Q1 2013. Carenet reached 14,445 members out of 31,809 identified. Of the members reached, CareNet completed 9918 successful calls. The goal of the calls was to provide member s with a positive plan interaction prior to the distribution of the 2013 CAHPS survey, in an effort to improve performance on the Overall Rating of Health and Drug Plan measures. Call agents also collected member feedback and concerns regarding the plan and forwarded some members to Customer Service and Case Management for follow-up.

Contracting and design delays prevented the calls from going live until after the CAHPS survey was already mailed, minimizing the calls' potential impact. Combined with negative member experiences related to our PBM transition to Catamaran, BCBSRI did not realize improvements in the targeted measures. Additionally, due to CMS restrictions, BCBSRI is not able to identify the specific members who receive and return the survey, eliminating our ability to effectively target interventions for maximum impact.

Actions Planned: In 2013, Carenet began calling Medicare members in mid-January, well in advance of the 2014 CAHPS survey. BCBSRI is also working on a number of strategies to improve Medicare member experience with the plan, including a dedicated Medicare Concierge line in Customer Service, improved community events, and a streamlining of member outreach due to enhanced analytic capability.

B. Member Touchpoint Measures (MTMs)

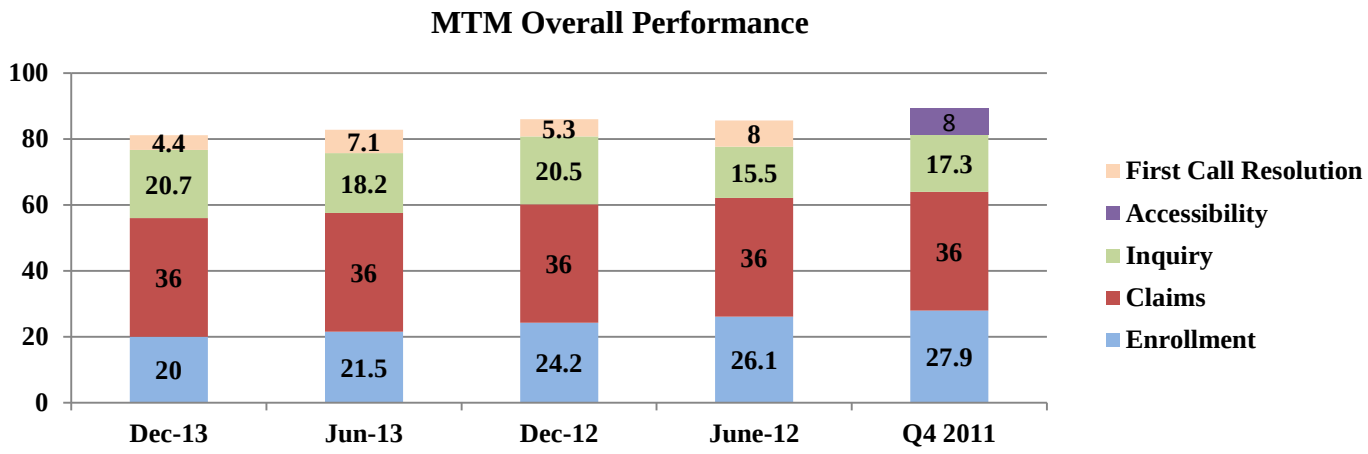
Blue Cross and Blue Shield of Rhode Island takes part in the Blue Cross Blue Shield Association's Member Touchpoint Measures (MTM) Program, which assesses operational and service performance of most branded, core health business (except Federal Employee Program and BlueCard Host claims) through the monitoring of claims processing, customer service, and enrollment processing functions. An external vendor, which is managed by BCBSA, conducts the surveys to ensure that a consistent methodology is followed.

Metrics/Frequency of Reporting: Metrics are displayed in the figures in the Results section. Metrics were previously reported quarterly to BCBSA. In January 2012, this was changed to a semiannual (every 6 months) basis.

Data Source and Methodology: member survey conducted by vendor; index scores calculated internally in accordance with the Blue Cross Association guidelines for Member TouchPoint measures.

Performance Goal/Benchmark: The performance goal for the overall index score is 86.0.

Results:



Category	Six Months Ended 12/31/2013 Total Points	Six Months Ended 6/30/2013 Total Points	Six Months Ended 12/31/2012 Total Points	Six Months Ended 6/30/2012 Total Points	Qtr 4 2011 Total Points	Performance Ranges
Enrollment						
Enrollment Timeliness %	99.73 10.0	99.89 10.0	99.16 10.0	97.77 8.6	99.82 10.0	>=99 10 points <=90 no points
Member-Level Accuracy %	94.53 0.00	98.60 9.0	98.08 7.7	99.33 10.0	98.82 9.6	>=99 10 points <=95 no points
Group-Level Accuracy %	99.17 10.0	96.00 2.5	97.60 6.5	97.99 7.5	98.33 8.3	>=99 10 points <=95 no points
Claims						
Claims Timeliness %	98.99 10.0	99.14 10.0	99.48 10.0	99.52 10.0	99.50 10.0	>=98 10 points <=95 no points
Processing Accuracy %	99.53 13.0	99.44 13.0	99.47 13.0	99.45 13.0	98.90 13.0	>=98 13 points <=95 no points
Financial Accuracy %	100.00 13.0	99.98 13.0	99.94 13.0	99.97 13.0	99.68 13.0	>=99 13 points <=96 no points
Inquiry						
Inquiry Timeliness %	96.20 10.0	96.83 10.0	96.86 10.0	96.72 10.0	97.05 10.0	>=95 10 points <=85 no points
Inquiry Accuracy %	95.70 10.7	94.14 8.2	95.57 10.5	92.45 5.5	93.57 7.3	>=99 16 points <=89 no points
Accessibility						
Blockage Rate %	N/A	N/A	N/A	N/A	0.00 4.0	<=2 4 points >=5 no points
Abandoned Rate %	N/A	N/A	N/A	N/A	1.36 4.0	<=5 4 points >=8 no points
First Call Resolution						
First Call Resolution %	66.00 4.4	72.00 7.1	68.00 5.3	74.00 8.0	N/A	>=74 8 points <=56 no points
Total Index Score	81.1	82.8	86.0	85.6	89.2	100 points

Quantitative Analysis: The overall MTM program score for the last six months of 2013 was 81.1, a decrease of 1.7 points from the previous 6 month performance of 82.8 points. All measures within the claims category achieved or exceeded goal. The First Call Resolution (FCR) measure decreased from 7.1 to 4.4 points. During the last six months, there was a decrease in performance in the enrollment accuracy metrics, specifically member-level enrollment accuracy.

Qualitative Analysis and Barriers:

- Enrollment
  - Twenty-seven of the 30 errors resulted from manual keying errors. The keying errors consisted of the following being keyed incorrectly: member names, member addresses, and member's PCP selections. Additional quality assurance would reduce the errors.
- Inquiries
  - There were 16 errors identified across all channels (e.g. BCBSRI.com, Interactive Voice Response (IVR) and Blue Exchange). The inquiry accuracy errors consisted of channels displaying and voicing incorrect benefit and claims information (e.g. deductibles, accumulators, out-of-pocket maximum, claim payment, tiered benefits). Management has addressed some of the errors identified; however, there are some known issues that cannot be corrected and/or require systematic solutions. There also were errors identified resulting from Customer Service Representatives responding incorrectly to and incorrect responses to correspondence and membership inquiries.

Opportunities for Improvement: Additional quality assurance and correction of outstanding system issues and any new issues that may be identified in a timely manner.

Actions Taken: (in 2013) and Actions Planned (for 2014): Customer Service representatives were retrained as necessary in 2013. The Channels team is currently reviewing outstanding systematic errors for correction in order to reduce the error quantity. In order to improve the First Call Resolution (FCR) score, there will be additional calls monitored and there will be a LEAN transformation process to improve the score for FCR and for quality. This will be coordinated by the Customer Service department.

C. 2013 Service Priorities

Health Plan information is easy to access and understandable for members
Annually, Blue Cross and Blue Shield of Rhode Island conducts a Member Experience Survey to gauge member satisfaction with and ability to understand information about the plan and their benefits. We use the feedback provided with this survey to improve our information and educational materials for members.

Metrics/Frequency of Reporting: Metrics are displayed in the table shown in the results section; the Member Experience Survey is conducted annually.

Data Source and Methodology: A member study file of current members with a minimum of 6 months tenure from Commercial (Group and Direct Pay) and Medicare Advantage lines is pulled and delivered to our vendor, ORC International, who uses a random sampling technique to identify the members who will receive the surveys. Separate surveys are sent to Commercial Group, Direct Pay and Medicare Advantage members. ORC sends several thousand surveys (in total) and makes follow-up phone calls only if they have not yet reached the required number of completes. Members were offered the option to complete their survey via postal mail, web and telephone. Survey response quantities and margins of error are noted below:

Member Segment	Sample Size	Error Margin**
Commercial Group	**208**	**+/- 6.7**
Direct Pay	**228**	**+/- 6.4**
Medicare Advantage	**222**	**+/- 6.5**
TOTAL	**658**	**+/- 3.7**

Performance Goal/Benchmark: there was no single goal or benchmark.

Results:

	Top Two Box Rating*		
Relevant 2013 Member Experience Study Question	**2012**	**2013**	**Change**
Overall experience with Benefit Information provided by BCBSRI	62%	59%	-3%
Benefit Information…Helped me understand what my plan covers and does not cover	56%	56%	0%
Benefit Information…Helped me understand what I would pay for specific services	55%	54%	-1%
Benefit Information…Was displayed in an easy to follow format	55%	54%	-1%
Benefit Information…Was explained using simple words and examples	57%	59%	+2%
Benefit Information…Helped me understand where I could find benefit information on BCBSRI.com	55%	56%	+1%
Overall experience with Explanation of Benefits statement	67%	69%	+2%
BCBSRI.com…Was easy to navigate	N/A	58%	**
BCBSRI.com…Gave me access to what I needed without further assistance	N/A	53%	**
BCBSRI.com…Gave me access to online tools to help me manage my health care (i.e. "Find a Doctor")	N/A	65%	**
BCBSRI.com…Gave me access to personalized healthcare information, including detailed claims, benefits and coverage information in the password-protected member section of BCBSRI.com	N/A	69%	**

*Top-Two Box rating indicates percentage of members selecting "Fully Met My Needs" or "Exceeded My Needs"
** The BCBSRI.com portion of the Member Experience study changed focus in 2012, so comparisons cannot be made to 2012 ratings for these.

Quantitative Analysis: Ratings of members' access to and understanding of health plan information were fairly flat from 2012 to 2013, as evidenced by the table in the Results section, with some areas experiencing minimal improvements and others experiencing minimal declines. All movements were within the margins of error sufficiently enough to suggest that no statistically significant shifts occurred. Measurement was taken via the annual Member Experience survey, which was fielded in June and July of 2013 – and whose results were corroborated by the 2013 CAHPS studies for Commercial and Medicare members.

Qualitative Analysis and Barriers: Regarding barriers, there is no single owner of all member communications. Individual business area owners have the responsibility for producing and maintaining the content that pertains to their specific business area. This limits our ability to create cohesive messages across member communication vehicles. The Member Experience study is an annual survey, so changes that take effect just after the study (or close to when the study is fielded) may not register with members in time for the study to capture good feedback. This creates a lag in reporting information, since the data on a particular change may not be reported until the following year's study – by which time, other changes may have occurred.

Opportunities for Improvement and Actions Taken: The Explanation of Benefits document (EOB) was identified as an area where improvements could be made. The EOB page orientation was changed from landscape to portrait to save on paper, and we consolidated multiple claims onto a single EOB to save on postage. The new EOB goes out every three weeks (instead of once per claim) and consolidates all claims detail from that period into a single envelope. The changes were made too close to the annual Member Experience research to be able to capture the full impact of the new EOB in the annual study. The post-authentication member portal on BCBSRI.com was modified in Fall 2013 to provide members with more information at-a-glance. Two examples of member-friendly changes include:

- Added the top 10 most commonly used benefits to the portal home page, so members can easily see their cost-sharing and benefits structure for those benefits (such as primary care visits).
- Displayed the most recent claims on the portal home page, allowing members to quickly view their recently processed claims.

Actions Planned for 2014: The Client Operations team has assigned an internal resource to manage review and editing of all system-generated mailing. The Retail Strategy area will modify channel-based delivery of information (i.e. web, mobile, interactive voice response system) and implement user-friendly improvements to post-authentication data through these channels.
The Member Experience survey will occur twice in 2014, and three times per year thereafter. The member study file will now include members with 3 month tenure rather than 6 months. The CX team will offer a Customer Experience course, open to all employees and offering training on the use of a customer-focused approach in all day-to-day activities, regardless of the number of degrees of separation between the employee and the customer.

2013 Service Priority: Improve Claims Processing

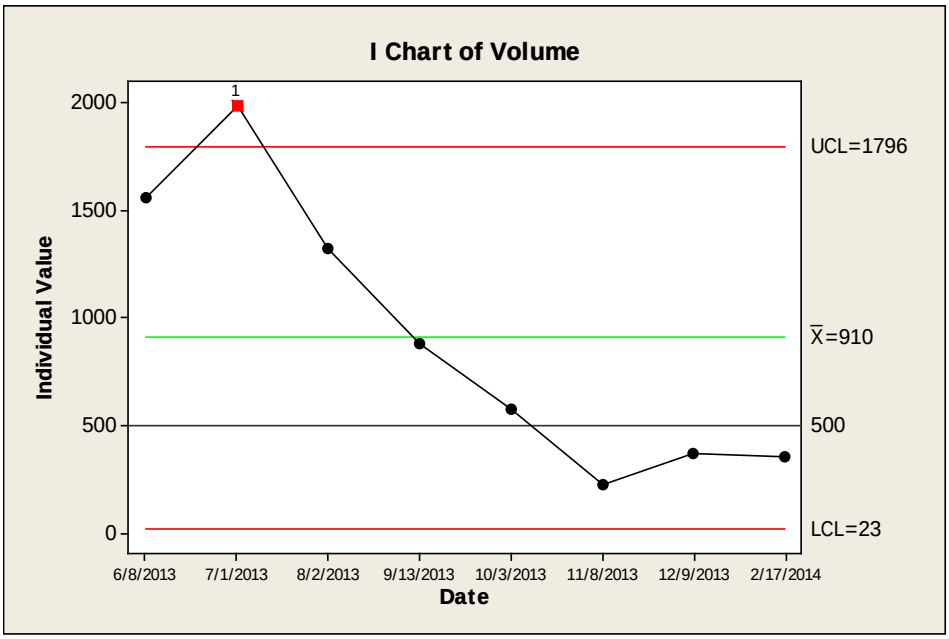
Claims Processing Improvements: Our membership relies on BCBSRI to process claims in a timely manner to ensure providers are reimbursed sufficiently to maintain their businesses and that the members themselves maintain adequate cash flow for themselves and their families. Since converting to a new claims processing system, we experienced claims backlogs resulting in a large spike in claims over 30 days in age and claims suspended for "pricing." We conducted an improvement activity to clear this delay and ensure we can continue providing service that meets our members' and providers' needs and expectations.

Metrics/Frequency of Reporting: Metrics included claims over 30 days and claims suspended for "Pricing." Claims backlogs are monitored on a daily, weekly, and monthly basis by product (i.e. Medicare, FEP, and Commercial. Etc) basis

Data Source and Methodology: Data is extracted from the FACETS claims processing system on a weekly basis. A cross-functional group representing claims, pricing, configuration management, customer service, and provider database departments meets weekly and prioritizes claims based on age and dollar amounts, root cause, and expected fixes.

Performance Goal/Benchmark: Process 99% of clean claims within 30 days of receipt.

Results:



Quantitative Analysis: In early 2013, the pricing queue had over 2,000 claims older than 30 days, with charges of more than $5 million awaiting processing and suspended with a status of "Awaiting Pricing." Through the efforts of a cross-functional team, that queue has been reduced to just under 400 claims and the rate of additions to the queue have dropped from over 1,000 per week to an average of 55 per week. Although some claims were missing for pricing being loaded into the system, a majority of these claims were pended due to system configuration issues.

Qualitative Analysis and Barriers: Claims that suspend for "Pricing" can have multiple reasons for suspending, some of which are unrelated to pricing. Analysis of the root cause for suspended claims yields seven major reasons for suspension: lack of pricing in the system, FACETS processing logic and hierarchy (claims are pushed top pricing before benefit is determined), Medicare Compliance (need for in-house expertise on Medicare reimbursement), Provider configuration (inappropriately billed claims stop rather than suspending), Provider linkages (lack of visibility about how many providers are tied inaccurately to fee schedules), lack of clear business rules (for Medicare as primary and Commercial as secondary), and differences from the Legacy claims processing system compared to the new processing system. Of these only the first root cause, lack of pricing in the system, is a legitimate reason for a claim to suspend for "pricing." All other suspends result in claims that need to be researched to determine why the claim suspended and how to get it paid. The complexity of the process makes it difficult for any one individual to determine root cause and the fix needed to successfully pay to claim in a timely manner. As a result, the work queue becomes backlogged and delays occur in claims processing.

Opportunities for Improvement: The 7 areas listed above are the opportunities to improve this process and initiatives are underway to address the root causes. Other opportunities for improvement include:

- Develop governance structure, consisting of cross-functional group of senior staff, to help regulate the creation or sales of services that are operationally difficult to execute.
- Developing contracting "Guardrails" that dictate what contracting managers can write into provider contracts and subscriber agreements. Guardrails would help ensure that additions can be accommodated by the new claims processing system without manual work-arounds.
- Improving communication between the pricing team, contract negotiators, and the configuration team and customer service is dysfunctional and results in breakdowns in the claims process and disconnects when discussing issues with our members.
- Resolve customer service training gaps regarding the new claims processing system. The pricing and configuration group can share more of their knowledge to the front lines to reduce their workload and service members in a more timely manner.

Actions for 2014:

- Continue the work of the cross functional team in identifying root causes of items in pricing suspended queue, and facilitating resolution.
- Continue weekly meeting to discuss upcoming contract negotiations, product management ideas, medical policy and payment controls challenges with configuration, sales, contracting and customer service.
- Develop contract guardrails for Ancillary, professional and facilities.
- Form a governance structure to address exceptions to contracting guardrails.
- Develop training for customer service as needed for root causes of pended claims

2013 Service Priority: Improve Customer Service Efficiency

The Continuous Improvement (CI) team was tasked with improving the efficiency of call center staffing models and schedules while fully meeting the needs of our members, providers, and associates. The CI Team considered the following experiences of the member calling BCBSRI, before being connected with an agent:

- Does BCBSRI have enough staff to handle the call volume traffic?
- How long is the customer waiting to get through?
- Who will the customer connect to?
- Will the agent be fully skilled, partially skilled or not skilled at all to answer the customer's questions and/or concerns?

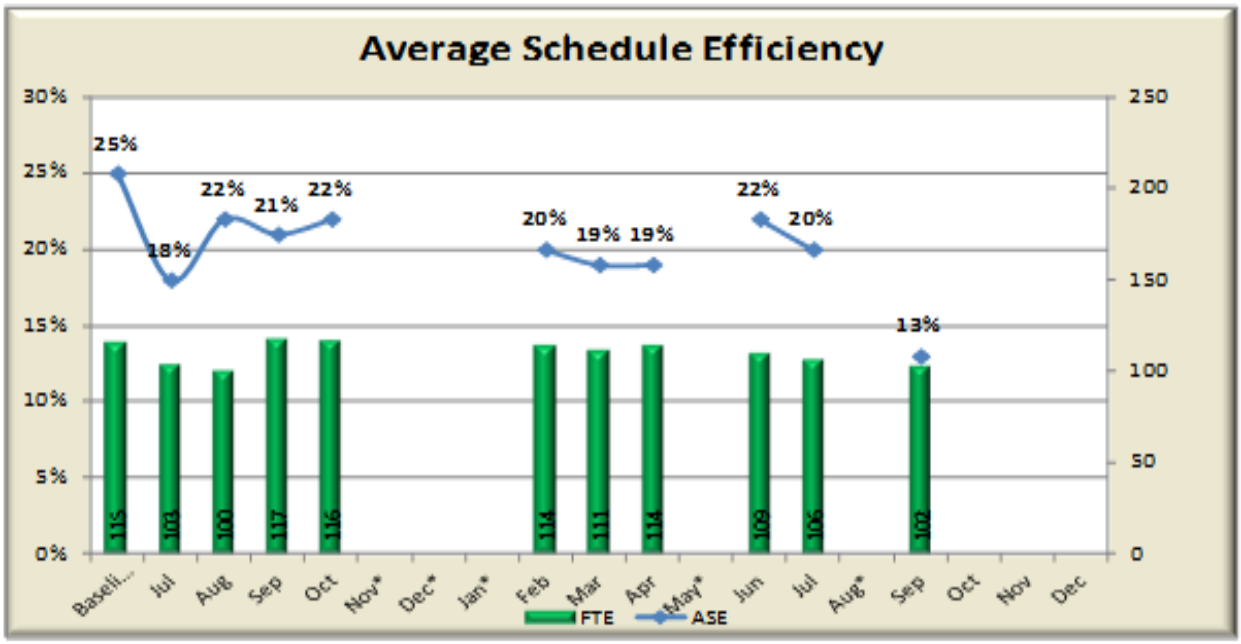
Metrics/Frequency of Reporting: The following indicators of agent availability are measured on a daily basis:

- Average Schedule Efficiency (ASE) % = Average of the full days ISE%
- Interval Schedule Efficiency (ISE) % = (Actual Scheduled / Required Staff)

Data Source and Methodology: Data was provided by the Call Center Management system and the methodology followed was a classic Lean Six Sigma DMAIC (define, measure, analyze, improve, control) process.

Performance Goal/Benchmark: Decrease ASE from 25% to 15% by December 31, 2013.

Results:



		8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	13:00	13:30	14:00	14:30	15:00	15:30	16:00	16:30	17:00	17:30	18:00	18:30	19:00	19:30	Average Schedule Efficiency
Current	Base Required	22	44	60	72	77	81	84	80	72	66	66	69	74	76	75	73	67	35	24	19	14	11	10	7	
	Shrink	0.23	0.23	0.23	0.23	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.28	0.28	0.32	0.32	0.32	0.23	0.23	0.23	0.23	
	Actual Required	27	54	74	89	102	107	111	106	95	87	87	91	98	100	99	94	86	46	32	25	17	14	12	9	
	Scheduled	48	64	82	92	102	102	104	113	113	113	113	113	114	114	116	116	116	70	55	37	27	14	14	12	
	+/- Variance	21	10	8	3	0	-5	-7	7	18	26	26	22	16	14	17	22	30	24	23	12	10	0	2	3	
Interval Schedule Efficiency		77%	18%	11%	4%	0%	-5%	-6%	7%	19%	30%	30%	24%	17%	14%	17%	24%	35%	52%	74%	48%	57%	3%	14%	39%	25%

		8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	13:00	13:30	14:00	14:30	15:00	15:30	16:00	16:30	17:00	17:30	18:00	18:30	19:00	19:30	Average Schedule Efficiency
Optimized	Base Required	22	44	60	72	77	81	84	80	72	66	66	69	74	76	75	73	67	35	24	19	14	11	10	7	
	Shrink	0.23	0.23	0.23	0.23	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.28	0.28	0.32	0.32	0.32	0.23	0.23	0.23	0.23	
	Actual Required	27	54	74	89	102	107	111	106	95	87	87	91	98	100	99	94	86	46	32	25	17	14	12	9	
	Scheduled	36	67	82	95	95	111	114	119	119	119	109	107	107	95	95	94	98	43	35	30	19	12	11	8	
	+/- Variance	9	13	8	6	-7	4	3	13	24	32	22	16	9	-5	-4	0	12	-3	3	5	2	-2	-1	-1	
Interval Schedule Efficiency		33%	24%	11%	7%	-7%	4%	3%	13%	25%	37%	25%	18%	10%	-5%	-4%	0%	14%	-7%	11%	20%	10%	-11%	-11%	-7%	9%

- **Successfully decreased ASE**
- **Total Project Savings = $347,900**
- **FTE Savings = 5.5 FTE or $214,500**
- **30hr Part Time Savings = $133,400**
- **Diversity in staffing profiles**
- **Flexibility to associates as well as open opportunities for the business**

Quantitative Analysis: The improvement project decreased ASE, providing increased efficiency for Customer Service while limiting overstaffing. We also realized a $347,900 cost savings.

Qualitative Analysis and Barriers: ASE was decreased and subsequently effectiveness was increased by examining standard staffing patterns and creating more flexible staffing profiles. This not only yielded some cost savings, but offered increased flexibility to associates while improving member service.

Opportunities for Improvement: Thus far, only 30-hr schedules for Customer Service representatives have been implemented. Expanding schedule options to include 20-hr schedules will further expand the benefits projected for ASE. Human Resources will need to review its package of company-provided benefits to staff who work 20 hrs/wk.

Actions Taken: The CI Team took the following steps: (1) Reviewed Agent Occupancy Percentage as reported through Avaya, our telephone system. (2) Conducted an updated review of staffing levels based on required FTE and Staffed FTE. (3) Utilized a bottom-up approach in analyzing agent efficiency. (4) Reviewed baseline metrics of Average Schedule Efficiency (ASE) performance. (5) Developed understanding of the effect of ASE on agent effectiveness. (6) Identified triggers for impacting ASE. The team discovered that staffing schedules were contributing to increased ASE; this led to diversification of the staffing profile as follows:

- Part Time – 5 days per week, 4hr days (0.62 FTE)
- 30 Hrs – 5 days per week, 6hr days (0.81 FTE)
- Full Time – 5 days per week, 8.5hr days (1 FTE)

This increased efficiency in gap coverage and limited overstaffing, while ultimately decreasing ASE.

Actions Planned for 2014:

- Create Work @ Home Programs; offer open 30 hr/PT shifts to interested candidates, starting with Provider Service representatives
- Offer 30 hr/PT schedules to the floor through a bidding process (scorecard ranking, seniority)
- Allow natural attrition to create schedule openings which will be filled in with proposed schedules
- Through the New Hire process, identify openings with 30 hr/PT needs
- Optimize all current staff schedules to meet business goals

D. Practitioner Availability Analysis

In order to ensure needed practitioners are available to all plan members, BCBSRI annually evaluates its practitioner network to ensure compliance with its availability performance standards. BCBSRI evaluates practitioner availability for Commercial and MedAdvantage networks separately. This analysis includes an evaluation of practitioner availability for all primary care practitioners, high volume specialists and behavioral health (BH) specialists against our established availability standards, and indicates any need to adjust the number and types of contracted practitioners by specialty and location to meet the needs of plan members.

Metrics/Frequency of Reporting: Practitioner availability is evaluated annually. Indicators include member-to-practitioner ratios and geographic availability (the number of practitioners within a geographic area) for primary care, high volume specialty, and behavioral health practitioners.

Data Source and Methodology: Claims data is entered into Optum GeoAccess software to produce practitioner availability data, which is compared against company standards.

Performance Goals/Benchmarks: Performance goals for primary care, high volume specialist, and behavioral health provider availability are as follows:

Table 1: PCP Availability Standards
Our standard is that at a minimum, 95% of our membership has access to primary care services within the parameters listed below:

Primary Care Practitioner Specialty	Member to Practitioner Ratio Standard	Geographic Availability Standard
Family Practice	1 PCP for every 1000 members	2 PCPs Within 15 miles
Internal Medicine	1 PCP for every 1000 members	2 PCPs Within 15 miles
Pediatrics	1 PCP for every 1000 members	2 PCPs Within 15 miles

Table 2: High Volume Specialist Availability Standards
Our standard is that at a minimum, 95% of our membership has access to specialty care services within the parameters listed below.

High Volume Specialty Care Practitioner	Practitioner to Member Ratio Standard	Geographic Availability Standard
All high volume specialty care practitioners	1 Specialist for Every 2000 Members	2 Specialists Within 30 Miles

Table 3: Behavioral Health Practitioner Availability Standards
Our standard is that at a minimum, 95% of our membership has access to specialty care services within the parameters listed below.

Behavioral Health Practitioner Category	Practitioner to Member Ratio Standard	Geographic Availability Standard
All behavioral health practitioners	1 Behavioral Health Practitioner for Every 2000 Members	2 Behavioral Health Practitioners Within 15 Miles

Results:

PCP Availability Performance

Commercial PCP Specialty	Commercial Members Residing in BCBSRI's Service Area	PCP Locations	Current Practitioner to Member Ratio	Percent of Members Meeting Geographic Standard
Family Practice	295,508	439	1.5 1000	**99%**
Internal Medicine		916	3.1 1000	
Pediatrics		348	1.3 1000	
MedAdvantage PCP Specialty	**Commercial Members Residing in BCBSRI's Service Area**	**PCP Locations**	**Current Practitioner to Member Ratio**	**Percent of Members Meeting Geographic Standard**
Family Practice	44,365	436	9.8: 1000	**100%**
Internal Medicine		916	20.6: 1000	
Pediatrics		347	7.8: 1000	

Commercial High Volume Specialist Availability Performance

Commercial Specialist	Commercial Members Residing in BCBSRI's Service Area	Specialist Locations	Current Practitioner to Member Ratio	Percent of Members Meeting Geographic Standard
Cardiology	295,508	698	4.72: 2000	99.8%
Gastroenterology		183	1.24: 2000	99.8%
General Surgery		246	1.66: 2000	100%
Hematology/Oncology		208	1.4: 2000	99.5%
Neurology		159	1.1: 2000	99.7%
OB/GYN		559	3.8: 2000	99.9%
Ophthalmology		264	1.79: 2000	100%
Orthopedic Surgery		329	2.23: 2000	99.7%
Podiatry		227	1.5: 2000	99.9%
Radiology		1449	9.8: 2000	100%
Urology		167	1.3: 2000	99.8%

MedAdvantage High Volume Specialist Availability Performance

MedAdvantage Specialist	MedAdvantage Members Residing in BCBSRI's Service Area	Specialist Locations	Current Practitioner to Member Ratio	Percent of Members Meeting Geographic Standard
Cardiology	44,365	697	15.7: 2000	100%
Gastroenterology		181	4.1: 2000	100%
General Surgery		242	5.5: 2000	100%
Hematology/Oncology		208	9.38: 2000	100%
Neurology		158	3.6: 2000	100%
OB/GYN		555	12.5: 2000	100%
Ophthalmology		260	11.7: 2000	100%
Orthopedic Surgery		308	13.9: 2000	100%
Podiatry		219	4.9: 2000	100%
Radiology		1314	29.6: 2000	100%
Urology		162	3.7: 2000	100%

Commercial Behavioral Health Practitioner Availability Performance

Commercial Behavioral Health Practitioner Category	Commercial Members Residing in BCBSRI's Service Area	Behavioral Health Provider Locations	Current Practitioner to Member Ratio
Psychiatry	295,508	632	4.2 : 2000
Psychology		792	5.4 : 2000
Social Worker		1565	10.6: 2000
Marriage and Family Therapist		135	0.91 : 2000
Mental Health Counselor		704	4.8 : 2000
Clinical Nurse Specialist		213	1.4 : 2000

MedAdvantage BHP Availability Performance

MedAdvantage Behavioral Health Practitioner Category	MedAdvantage Members Residing in BCBSRI's Service Area	Behavioral Health Provider Locations	Current Practitioner to Member Ratio
Psychiatry	44,365	608	27.4 : 2000
Psychology		768	34.6 : 2000
Social Worker		1526	68.8 : 2000
Marriage and Family Therapist		1	N/A: service not offered for product
Mental Health Counselor		1	N/A: service not offered for product
Clinical Nurse Specialist		209	9.4 : 2000

Behavioral Health Practitioner Geographic Availability Performance

Behavioral Health Practitioner Category	Commercial Network Availability	MedAdvantage Network Availability
Psychiatry	98.1%	99.8%
Psychology	99.1%	100%
Social Worker	100%	99.9%
Mental Health Counselor	98.8%	n/a
Marriage and Family Therapy	96.6%	n/a
Clinical Nurse Specialist	98.8%	100%

Quantitative Analysis: Both Blue Cross and Blue Shield of Rhode Island's Commercial and MedAdvantage Networks exceed the 95% threshold for geographic access standards for all three primary care practitioner types; ninety-nine percent of Commercial members and one hundred percent of MedAdvantage members have 2 primary care practitioners available within 15 miles of their zip code. In both the Commercial and MedAdvantage Networks, the practitioner-to-member ratio standard of 1:1000 is exceeded for every type of primary care practitioner.

- Our Commercial and MedAdvantage Networks exceed the 95% threshold for geographic access standards for all high volume specialty care practitioner types; more than ninety-nine percent of Commercial members and one hundred percent of MedAdvantage members have 2 specialists (in every category) available within 30 miles of their zip code. In both the Commercial and MedAdvantage Networks, the practitioner-to-member ratio standard of 1:2000 is exceeded for every high volume specialty care practitioner type.
- Our Commercial and MedAdvantage Networks also exceed the 95% threshold for geographic access standards for all behavioral health practitioner types; more than ninety-nine percent of Commercial and MedAdvantage members have 2 BHPs (in every category) available within 15 miles of their zip code. In both the Commercial and MedAdvantage Networks, the practitioner-to-member ratio standard of 1:2000 is exceeded for every high volume specialty care practitioner type.

Qualitative Analysis and Barriers: The geographic and volume availability performance thresholds for primary care, high volume specialists, and behavioral health practitioners were exceeded for both the Commercial and MedAdvantage networks. BCBSRI's network distribution is assisted by its small territory (Rhode Island and contiguous Massachusetts and Connecticut counties), and by the distribution of urban areas likely to have specialty locations, which leaves very few members without access to a primary care practitioner, specialist, or behavioral health practitioner.

Opportunities for Improvement: While our geographic and volume performance for all practitioner types remains above goal, BCBSRI recognizes additional methods for assessing primary care practitioner availability, including assessment of practitioner cultural and linguistic features, as well as assessment of PCPs accepting new patients. In early 2014, BCBSRI collected preliminary data on practitioner race and language, which is discussed in a separate report. We look forward to developing that assessment in the coming year, so as to better serve our membership.

In 2013, Blue Cross and Blue Shield of Rhode Island expanded its assessment of practitioner availability by collecting data on Primary Care Practitioners (PCPs) accepting new patients. Although we did not set a threshold, we anticipate that we will do so in 2014. This aspect of practitioner availability provides an enhanced understanding of true availability and will help guide future network improvements. Our evaluation yielded the following data:

Commercial PCP Specialty	**Commercial Members Residing in BCBSRI's Service Area**	**PCPs Accepting New Patients**
Family Practice	295,508	90.9%
Internal Medicine		85%
Pediatrics		98.9%
MedAdvantage PCP Specialty	**Medicare Members Residing in BCBSRI's Service Area**	**Current Practitioner to Member Ratio**
Family Practice	44,365	90.8%
Internal Medicine		84.9%
Pediatrics		98.9%

II.7 Objective 7 - Identify the spectrum of cultural and linguistic needs of our membership to offer a diverse array of services.

Blue Cross and Blue Shield of RI's Office of Diversity & Inclusion (D&I) strives to improve the quality of healthcare offered to our increasingly diverse member population. Our cross-functional initiatives in 2013 included the following:

A. Employee Initiatives

- Ninety-eight point eight (98.8%) of employees who have regular interactions with members about their health or health care completed cultural competence training.
- Ninety-nine point four (99.4%) of all managers attended a full-day learning session entitled "Leading Inclusion."
- Human Resources co-facilitated "LGBTQ Culture & Issues" as a result of specific feedback received in the Diversity and Inclusion assessment
- A Diversity Council was established consisting of a cross-section of employees nominated by their managers.
- Human Resource Diversity Data has been created and is monitored on a quarterly basis.
- "Diversity & Inclusion @ BCBSRI" page launched on Inside Blue, the company's intranet. These pages provide associates with diversity related information, such as a Diversity Dictionary, links to D&I resources and a guide to observing religious holidays at work.

Supplier diversity:

In 2013, D&I created a supplier diversity business plan with a goal of increasing spending with MWBEs (Minority and Women-owned Business Enterprises) as a percentage of total administrative spend (target: 6.0%). Experts consulted on the development of this business plan. As of October 31, 2013, we achieved 3.4% MWBE spend.

B. Provider Initiatives

In 2013, we offered our PCMH (patient centered medical home) providers the opportunity to use Quality Interactions®, a web-based, case-based program created by and for doctors and other providers to increase cultural competence in patient interactions. Blue Cross and Blue Shield of RI covered the cost of software licenses so that Quality Interactions was free to PCMH providers; completing this module also provided continuing medical education (CME) credits to physicians and contact hours to nurses.

Community Relations

- Developed relationships with organizations that serve culturally specific communities
- Supported/attended various community events including Feria de la Familia, Cambodian New Year, Colombian Independence Day, Feria Latina de Rhode Island, RI GLBT Health Fair, RI Pride, and the Emancipation Day celebration.
- Developed advertisements and communications aimed at specific communities. This included advertisements published in The Providence American (local African-American publication), Get, and Options (local LGBT publications), and on the cover of the Hispanic Yellow Pages.
- Completed a guide to navigating the RI healthcare system; this guide will be distributed to our members in 2014.

Next Steps for 2014:

- Identify our ideal culture and analyze changes needed to achieve that culture
- Continue work with the Diversity Council
- Develop transition guidelines
- Create and roll out structured mentoring program
- Provide professional development opportunities specific to women and people of color
- Develop framework for Associate & Business Resource Groups (ABRGs; affinity groups)
- Provide D&I education for all individual contributors
- Support the Multicultural Marketing Strategy

II.8 Objective 8: Improve the cost, quality, and efficiency of service delivered to our members and providers.

A. Transition of Care Program

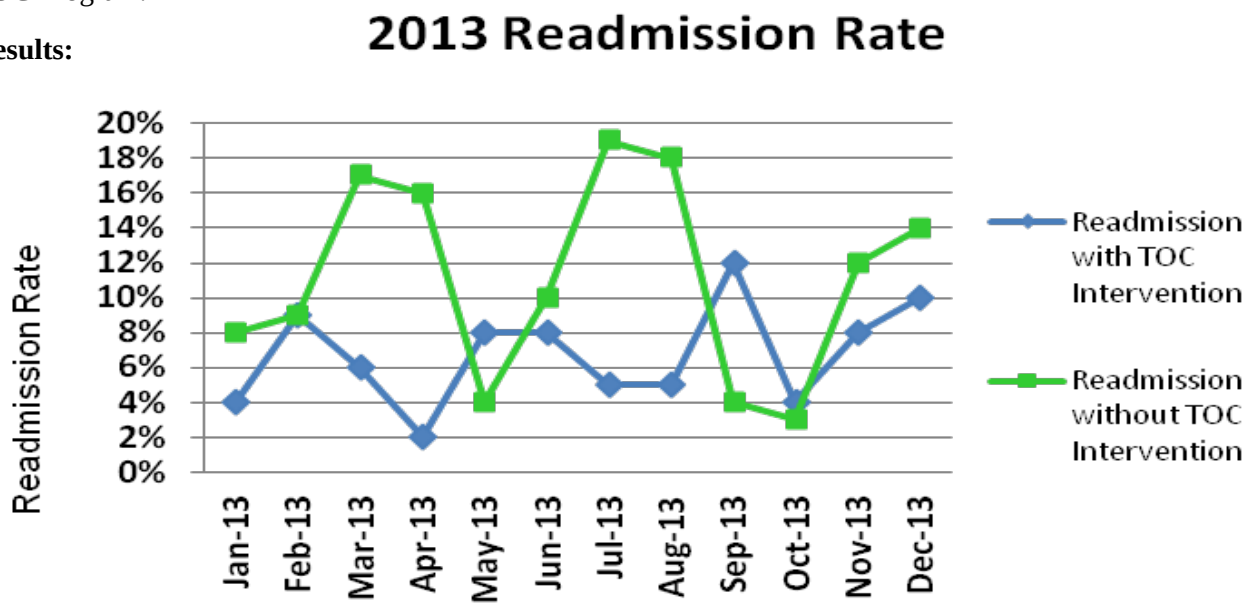
Nationwide and locally, avoidable hospital readmissions account for increasing health care costs and contribute to decreased quality of life. Gaps in the coordination of multiple health needs after a hospitalization jeopardize patient safety and contribute to this trend. In response to this problem, Blue Cross and Blue Shield of RI introduced the Transition of Care (TOC) Program in 2012. The Program works to reduce avoidable hospital readmissions by educating members regarding their health status and medications while in the hospital, in preparation for a safe transition home, where additional health services and coaching are made available when indicated. It is one of several initiatives, both internally and in the Rhode Island medical community, concurrently addressing avoidable readmissions. The Hospital Quality Program is another major BCBSRI initiative working to decrease readmissions. In the community, efforts among PCMHs, home care providers, and community agencies are also helping to address this issue. The BCBSRI Transition of Care program is intended to create a seamless experience from inpatient to outpatient care, while facilitating the transfer of information from facility to outpatient treatment.

Data Source, Methodology, Metrics, and Frequency of Reporting: We compare two sets of metrics: readmission rates to the hospital for members participating in TOC, and readmission rates to the hospital for members not participating in TOC. Data comes from our Medical Repository; it is reported and evaluated on a monthly basis. The readmission rate is calculated by the division of a numerator by a denominator, as follows:

- **Metric:** readmission rates among TOC participants
  - Numerator: the number of members participating in TOC who were readmitted to the hospital after initial admission
  - Denominator: the number of members participating in TOC with an initial hospital admission
- **Metric:** readmission rates among members not participating in TOC
  - Numerator: the number of members not participating in TOC who were readmitted to the hospital after initial admission
  - Denominator: the number of members not participating in TOC with an initial hospital admission

Performance Goal/Benchmark: Reduce the percentage of readmissions among members participating in the TOC Program.

Results:



2013 Monthly and Year-to-Date Comparisons:
Readmission Rates Among TOC vs. Non-TOC Groups

Month	TOC Intervention		Without TOC Intervention	
	Discharges	Related Admits	Discharges	Related Admits
Jan-13	97	4	74	6
Feb-13	131	13	69	6
Mar-13	138	8	23	4
Apr-13	137	4	29	4
May-13	180	14	23	1
Jun-13	170	13	50	5
Jul-13	139	7	21	4
Aug-13	86	4	17	3
Sep-13	99	12	23	1
Oct-13	99	4	32	1
Nov-13	155	12	23	2
Dec-13	148	15	35	5
YTD	1579	108	409	41
YTD %	7%		10%	

Quantitative Analysis: Members participating in the Transition of Care (TOC) program experienced fewer hospital readmissions compared to members not participating in the TOC Program. TOC participants had an average annual readmission rate in 2013 of 7%, compared with an average annual readmission rate in 2013 of 10% among members not participating in the Transition of Care program.

Qualitative Analysis and Barriers: A barrier to further decreases in readmission rates is that despite early post-discharge telephonic outreach (a BCBSRI nurse called TOC participants 2 days post-discharge), some members were still being readmitted to the hospital.

Opportunities for Improvement and Actions Planned for 2014: Although BCBSRI nurses called members within 2 business days of notification of discharge, we found that many members were still being readmitted. Further review of data indicated that the readmission is most likely to occur on day 10-12 post discharge. A second call will now be included and will take place on post-discharge day #8. Another barrier was that hospital discharge planning conferences did not include the BCBSRI nurse. Moving forward, the BCBSRI onsite nurse or case manager will take a more active role in the discharge planning process. An enhanced Transition of Care (TOC) program will be implemented in the first quarter of 2014, allowing for the presence of the BCBSRI onsite nurse at daily Case Rounds to assist in facilitating a safe discharge plan. We anticipate subsequent improvements in care coordination, readmission rates, and member satisfaction.

III. Conclusion

In 2013, Blue Cross and Blue Shield of Rhode Island's Quality Management Program accomplished several quality improvement objectives, restructured its quality committees to optimally support clinical and service quality management, and initiated and maintained programs oriented toward improved outcomes for members and providers. We continued to lead, both locally and nationally, in healthcare delivery and innovation as evidenced by expansion of PCMH practices, quality and utilization based contracting, proactive relationships with providers, and increased focus on member needs and experience.

We look forward in 2014 to continuing our focus on member and provider quality improvement and healthcare delivery innovation, as well as expanding the scope of our Quality Program. We anticipate multidisciplinary program growth in 2014, including first-year outcomes from our Disease Management program, the opportunity to demonstrate the effectiveness of member safety programs, and formal processes for assessing and providing for the cultural, ethnic, racial, and linguistic needs of members.

Successes

Clinical outcomes, quality based contracting, healthcare delivery and innovation, and member experience initiatives were among our strongest quality management efforts in 2013:

- Project: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis has helped decrease unnecessary prescribing and antibiotic use
- 2013 CAHPS results that exceeded national DSS averages and indicate sustained member satisfaction
- CMS 5-Star Program's 4.0 Star Rating resulted in $32 million in Quality Bonus Payment for the plan
- Our Patient Centered Medical Homes (PCMH) collaboration has saved $2 million net and resulted in improved coordination of care, better care transitions, and NCQA PCMH accreditation of local practices.
- The Transition of Care Program along with other statewide initiatives has helped to reduce avoidable hospital readmissions and increased coordination of care in at-risk patients.

Opportunities for Improvement
In 2014 we look forward to continuing our existing programs and to fostering the growth of new clinical and service initiatives. We plan to conduct formal evaluation of new projects and will re-measure the progress of existing programs. Among our opportunities in 2014 are the following:

- Develop programs and interventions for the following top clinical priorities:
  - Use of Imaging Studies for Low back Pain
  - Postpartum Care
  - Follow up after hospitalization for Mental Illness at 7 and 30 days post-discharge
- Continue the development of our Disease Management program, and evaluate first-year outcomes
- The opportunity to demonstrate the effectiveness of member safety programs through formal data collection, evaluation, and intervention where needed
- Institution of formal processes for assessing and providing for the cultural, ethnic, racial, and linguistic needs of members.

Resource Assessment
The Quality Program is supported by our Quality Department, divided into Quality Management, Accreditation, Hospital Quality, and Utilization Management Vendor Monitoring areas. We enjoy collaborative relationships with key departments including the CMS Five Star program, Medical Economics (for HEDIS), Health Analytics (for CAHPS), Provider Relations, Contracting, Customer Service, Case Management, Disease Management, Compliance, and the Grievance and Appeals Unit.

The Quality Department was restructured in 2013 to better align staff skill and experience with business need. Some new positions were added, including a Senior Administrative Coordinator who supports key committee meetings and quality activities. In its current format, the Quality Program's staff resources adequately support its scope and objectives.

Committee Structure
In 2013, Blue Cross and Blue Shield of Rhode Island reorganized its quality committee structure in order to provide specificity and governance to the Quality Management Program, achieve QM Program goals and objectives, and implement the QM Work Plan. The new committee structure reflects our interdisciplinary commitment to quality and focus on the input of our members and providers. Our updated committee structure is as follows:

- Executive Quality Council
- Accreditation Steering Committee
- Pharmacy and Therapeutics Committee
  - Sub-committee: Specialty Pharmacy & Therapeutics Committee
- Professional Advisory Committee
  - Sub-committee: Provider Credentialing Committee
- Clinical Quality Oversight Committee
- Utilization Management Committee
  - Sub-committee: Medical Policy/Payment Committee
- Network Quality Committee
- Behavioral health Committee
- Customer Experience Committee

Unless otherwise noted in a committee description, membership terms for committees are one year. Committee members may be reappointed. To promote consistency, no more than 50% of physician, behavioral health specialists, and pharmacist members are replaced at one time (as applicable for committee composition).

Minutes are taken at all meetings and include the names of attendees, absent/excused members, date and time of meeting, agenda items, discussion, major decisions, recommendations, action items, barriers to improvement, responsible party for follow-up, and follow-up reporting date. Committee members are responsible for reviewing the minutes and reports for comments, recommendations, and to assure their accuracy. Whenever possible, personally identifiable member and provider information are de-identified. Attachment B depicts our quality committee structure.

Practitioner Participation:

The Physician Advisory Committee (PAC) serves an important role in advising and guiding aspects of the Quality Program. The Committee is chaired by Dr. Brian Wolf, Senior Medical Director and a surgical oncologist. Seven additional board-certified physician members represent the following specialties: family medicine (1), pediatrics (1), internal medicine (1), general surgery (1), emergency medicine (1), psychiatry (1), and obstetrics/gynecology (1). In addition to its physician members, the Committee includes a group practice manager, the Director of Quality Management, a nurse Quality staff member, and the Managing Director of Behavioral Health and Quality. Ad hoc members from Disease Management, Quality, Analytics, and other departments attend PAC meetings as needed to present reports or participate in pertinent discussion.
The purpose of the PAC is to oversee the design and execution of clinical and preventive health monitoring and evaluation activities/studies and medical care standards (including preventive healthcare guidelines); review appropriate policies & procedures; review care that is of potentially substandard quality or presents patterns of inappropriate utilization; review disciplinary or sanction information from licensure authorities and when necessary approve corrective action plans for individual providers. The Committee may also initiate provider disciplinary actions up to and including termination.

Responsibilities include, but are not limited to:

- Review and approve clinical and preventive health practice guidelines or standards of care
- Review, recommend and, when appropriate, assist in the design of clinical and preventive health studies
- Recommend to the EQC the priorities for monitoring and evaluation of clinical activities and of administrative functions that support clinical care
- Act on the decisions of the EQC on prioritization and the scope of the clinical monitoring and evaluation activities
- Oversee the review of cases that are referred through the QM Department indicative of potential medical and behavioral health quality of care concerns
- Formulate corrective action plans for individual providers, as necessary;
- Make determinations regarding termination, or limitation of clinical privileges of individual providers
- Recommend system/process improvements for the EQC
- Review reports of disciplinary actions by licensure authorities

Physician Leadership:

Dr. Tracey Cohen, Medical Director, Clinical Affairs and Quality, is the physician responsible for our Quality Program. She chairs the Clinical Quality Oversight Committee, collaborates with Quality staff and leadership on quality of care complaint management, and co-chairs the Accreditation Steering Committee with the Director of Quality. Dr. Peter Hollmann, Associate Chief Medical Officer, chairs the Network Quality Committee, and the Pharmacy and Therapeutics Committee. Dr. Brian Wolf, Senior Medical Director, chairs the Professional Advisory Committee (PAC) and the Utilization Management Committee.

Executive Leadership Team (ELT):

Our Executive Leadership Team (ELT) recognizes and supports the integral role of Quality Management in achieving our mission. Dr. Augustine Manocchia, Vice President and Chief Medical Officer, is a member of ELT and chairs our Executive Quality Council (EQC). Accreditation and quality updates are provided weekly at ELT meetings, and ELT members have provided clear avenues for addressing and escalating quality issues requiring attention across all business activities.

IV. Quality Improvement Activities for 2014

Quality Program Structure

- Continuously evaluate performance of re-structuring based on measures including but not limited to: reporting meeting new data and measurement expectations, HEDIS and CAHPS results, accreditation status and audits

Quality of Clinical Care

- Continue collaboration with new behavioral health vendor to ensure integrated care and access to full spectrum of behavioral health services
- Improve collection and analysis of HEDIS data with new vendor
- Assess first-year outcomes of new Disease Management Program and develop subsequent interventions and offerings as needed

Quality of Service

- Ongoing leadership in development and expansion of PCMH model
- Improve communications to members and providers via enterprise wide oversight and coordination of all forms of communication and web site enhancements as overseen by the Customer Experience Committee and ELT
- Enhanced coordination and management of CAHPS
- Implement formal processes for the evaluation of the cultural, ethnic, racial, and linguistic needs of members, and develop solutions for provision of those needs

Member Safety

- Evaluate effectiveness of existing member safety mechanisms
- Implement new member safety programs
- Continue work with PBM on medication safety initiatives to include development of new opiate management processes

Provider Quality Incentives

- Continue quality-based P4P programs offered to all PCPs as well as those embedded within PCMH programs.

Transitions of Care

- Increased resources as UM nurses begin engaging members while they are inpatients at local hospitals.

Attachment A: HEDIS Reports

BCBSRI PPO 2013 HEDIS Results

Clinical Measures	HEDIS 2012 Blue Cross Rate	HEDIS 2013 Blue Cross Rate	2013 Nat'l NCQA Percentile- All LOB
Use of Spirometry in the Assessment & Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	61.25%	56.74%	90th
*Colorectal Cancer Screening	72.51%	72.51%	90th
*Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents:			
• Counseling for Nutrition Total	79.71%	79.71%	90th
• Counseling for Physical Activity Total	74.82%	74.82%	90th
Breast Cancer Screening	74.06%	73.64%	75th
Cervical Cancer Screening	79.57%	78.46%	75th
Chlamydia Screening in Women	48.72%	52.26%	75th
*Comprehensive Diabetes Care: Eye Exam	61.80%	61.80%	75th
Controlling High Blood Pressure	61.58%	68.11%	75th
*Childhood Immunization Combination 2	83.45%	83.45%	75th
Appropriate Testing for Pharyngitis	87.05%	90.52%	75th
Flu Shots for Adults Ages 50-64	58.17%	62.16%	75th
Timeliness of Prenatal Care	94.58%	95.92%	75th
Persistence of Beta Blocker Treatment After a Heart Attack	78.90%	86.96%	75th
Use of Appropriate Medications for People with Asthma	92.40%	91.96%	50th
*Comprehensive Diabetes Care: HbA1c Screening	90.75%	90.75%	50th
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication Initiation Phase	46.46%	40.92%	50th
Follow-up After Hospitalization for Mental Illness: 7 Days	69.98%	57.35%	50th
Timeliness of Postpartum Care	87.08%	84.69%	50th
*Comprehensive Diabetes Care: Poor HbA1c Control	28.95%	28.95%	50th
*Comprehensive Diabetes Care: LDL Screening	86.37%	86.37%	50th
Follow-Up Care for Children Prescribed (ADHD) Medication: Continuation & Maintenance Phase	54.92%	41.15%	50th
Appropriate Treatment for Upper Respiratory Infection	83.54%	84.91%	50th
*Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	87.32%	87.32%	50th
Antidepressant Medication Management Effective Continuation Phase Treatment Rate	50.06%	56.75%	50th
*Comprehensive Diabetes Care: Nephropathy	81.51%	81.51%	25th
*Comprehensive Diabetes Care: Nephropathy	81.51%	81.51%	25th
Use of Imaging Studies for Low Back Pain	72.19%	73.53%	25th
Antidepressant Medication Management Effective Acute Phase Treatment Rate	63.78%	68.79%	25th
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	15.89%	17.06%	10th

*All hybrid measures except controlling hypertension were rotated out of review for 2013 (same result reflected)

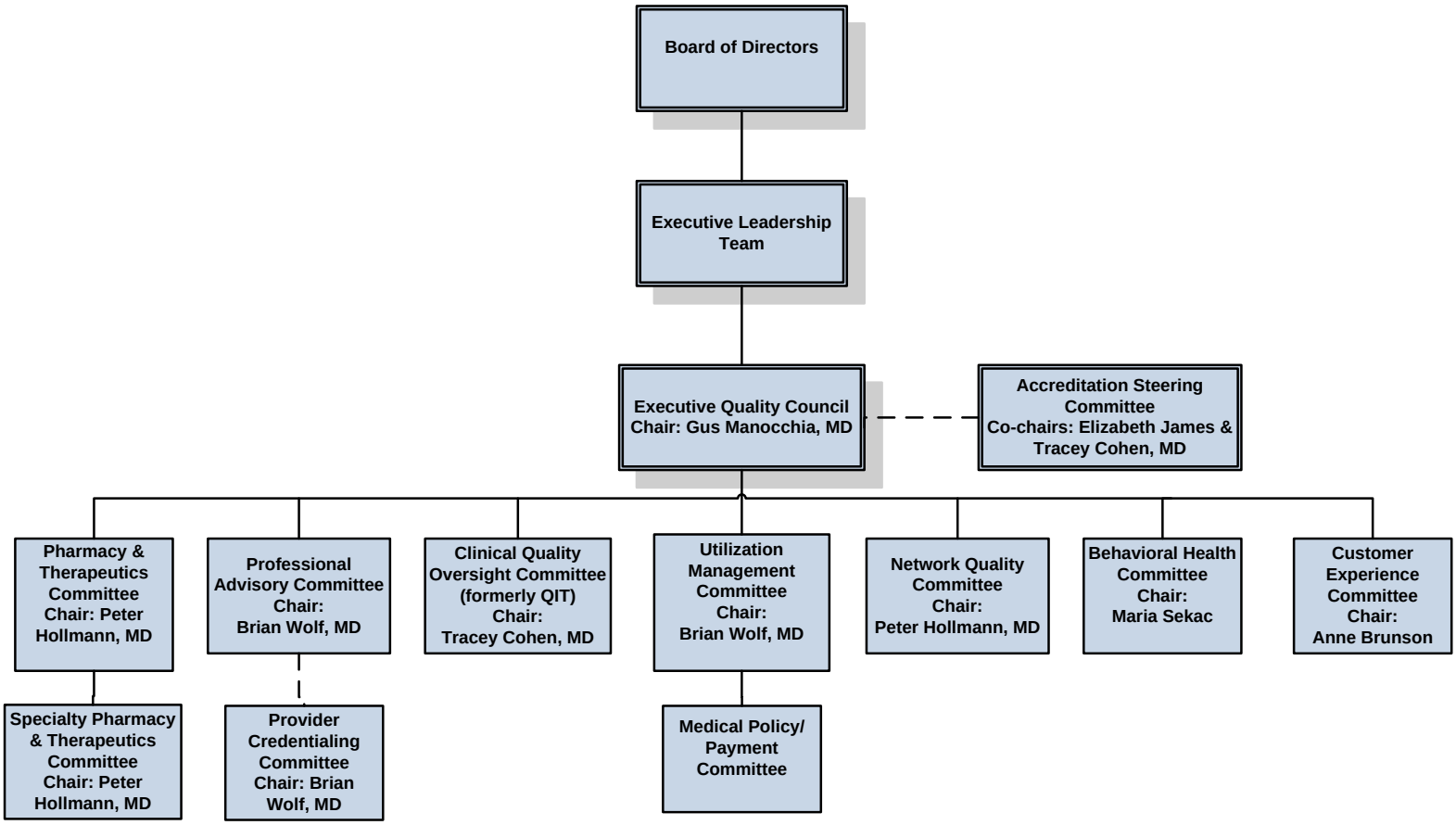
Medicare 2013 HEDIS Results

****5 Star Measures**

Clinical Measures	HEDIS 2012 Medicare Rate	HEDIS 2013 Medicare Rate	2013 Nat'l Percentile-All LOB	2014 Star Rating
Colorectal Cancer Screening	76.01%	80.00%	90th	5
Glaucoma Screening in Older Adults	80.18%	79.78%	90th	5
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	81.68%	89.40%	90th	5
Breast Cancer Screening	79.17%	79.16%	75th	4
Controlling High Blood Pressure	69.27%	74.29%	75th	4
Cholesterol Management for Patients with Cardiovascular Conditions:				
• LDL-C Screening	92.82%	91.80%	50th	5
• LDL-C Control (<100mg)	67.82%	67.76%	75th	
Comprehensive Diabetes Care:				
• HbA1c Screening	93.67%	93.61%	50th	
• Poor HbA1c Control	15.33%	15.97%	75th	
• HbA1c Control (<8.0%)	72.75%	72.73%	75th	5
• Eye Exam	76.64%	75.18%	75th	5
• LDL-C Screening	90.02%	89.93%	50th	4
• LDL-C Control (<100mg)	62.77%	59.21%	75th	5
• Nephropathy Monitoring	89.29%	87.47%	25th	4
• Blood Pressure Controlled <140/80	55.72%	57.25%	75th	
• Blood Pressure Controlled <140/90	77.62%	79.12%	90th	
Adult BMI Assessment	70.90%	81.32%	50th	4
Osteoporosis Management in Women Who Had a Fracture	16.08%	15.80%	25th	2
Use of Spirometry Testing in the Assessment & Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	51.39%	50.50%	90th	
Pharmacotherapy Management of COPD Exacerbation (New Measure):				
• Systemic Corticosteroids	81.00%	78.17%	90th	
• Bronchodilator	87.46%	84.07%	75th	
Follow-Up after Hospitalization for Mental Illness:				
• 7 Days	41.18%	73.85%	75th	
• 30 Days	65.44%	47.69%	50th	
Antidepressant Medication Management:				
• Effective Acute Phase Treatment Rate	67.72%	70.47%	25th	
• Effective Continuation Phase Treatment Rate	58.86%	66.32%	75th	
Persistence of Beta Blocker Treatment After a Heart Attack	80.00%	87.26%	25th	
Annual Monitoring for Patients on Persistent Medications:				
• ACE Inhibitors or ARBS	92.03%	92.23%	25th	
• Digoxin	94.19%	93.55%	25th	
• Diuretics	92.63%	92.60%	25th	
• Anticonvulsants	75.27%	66.86%	50th	
Total	92.08%	92.05%	50th	
Use of High Risk Medications in the Elderly:				
• One Prescription	13.16%	12.04%	NA	
• At Least Two Prescriptions	1.57%	1.16%	NA	
Potentially Harmful Drug – Disease Interactions in the Elderly:				
• Falls & Tricyclic Antidepressants or Antipsychotics	13.06%	15.06%	25th	
• Dementia & Tricyclic Antidepressants or Anticholinergic Agents	19.10%	16.20%	90th	
• Chronic Renal Failure & Nonaspirin NSAIDs or COX-2 Selective NSAIDs	4.48%	6.67%	50th	
Total	16.74%	15.50%	75th	

Attachment B: Quality Committee Structure

Blue Cross Blue Shield of Rhode Island
Quality Committee Structure



Attachment C: Committee Action Item List

EXAMPLE

BCBSRI: (Name of Committee) Action Items

Meeting Date	Item/Topic	Action	Assigned To	Due Date	Status	Date Completed