



QUALITY IMPROVEMENT PROGRAM

Introduction

Molina Healthcare of Michigan serves Michigan members in counties throughout Michigan. Molina Healthcare of Michigan, also referred to as Molina Healthcare, MH Michigan and “health plan” in this document) has served Medicaid patients since 2000. For all plan members, Molina Healthcare emphasizes personalized care that places the physician in the pivotal role of managing healthcare. Molina Healthcare is responsible for managing the provision of accessible, appropriate, cost-effective, high quality health care services for its members throughout the continuum of care. The health plan assists members as they move through the managed care system, reducing barriers to care, and supporting members in reaching optimal health. Molina Healthcare credentials and contracts with individual practitioners, provider organizations, facilities and institutions to deliver health care and service to members. Molina Healthcare delegates the authority to perform specified plan functions and services, while maintaining oversight responsibility for delegated and non-delegated activities.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and improvement of the health of its members. The QIP assists Molina Healthcare to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan’s customers and the standards established by the medical community, regulatory and accrediting bodies.

The following QI Program Description includes discussion of program philosophy, scope, structure, and methodology.

1. Program Philosophy

Molina Healthcare of Michigan maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry “best practice” or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the organization, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.
- Internal and external feedback about Molina Healthcare’s programs and processes is integrated into the improvement efforts.



2. **Quality Improvement Program Goals**

Molina Healthcare of Michigan has defined the following goals for the QI Program:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members. Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare of Michigan (also referred to as MHM) structure, process, and outcomes.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals and to ensure participation of community providers in the MH Michigan network.
- Facilitate organizational efforts *which* achieved and maintain regulatory compliance and NCQA Accreditation-Excellent in 2005

3. **Quality Improvement Program Objectives**

3.1 QIP objectives direct personnel, activities, and resources to achieve Program goals. Written objectives address:

- Activities planned,
- Methodologies,
- Persons responsible, and
- Time frames for meeting each objective

3.2 Objectives are developed and established annually with consideration given to:

- Important aspects of care and service provided by Molina Healthcare.
- Objectives identified from ongoing and annual evaluation.
- Changes in policies, procedures, benefits or product offerings.
- Changes in member demographics and epidemiological characteristics.
- Recommendations made by NCQA, Michigan Department of Community Health (MDCH), practitioners, practitioner groups, and members.
- Contractually mandated improvement activities that address state-wide QI goals
- National, state, and local public health goals.
- Identified "Best Practices".
- Delegated activities and delegates' performance.
- Member and provider satisfaction data.
- Network changes.
- Ability to achieve meaningful improvement with available resources.



- 3.2 QIP objectives are reviewed and revised annually or more frequently as needed. Specific activities are identified to support the achievement of the objectives. These activities are tracked and are recorded in an annual QI Work Plan. **(APPENDIX A)**

4. *Scope of Program Activities*

The Molina Healthcare QI Program encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. The scope of service includes but is not limited to, those provided in institutional settings, ambulatory care, home care and mental health. Contracted provider groups, primary care and specialty practitioners and ancillary providers may render these services.

4.1 Important Aspects of Care

To provide for overall quality functioning as a managed care plan, Molina Healthcare continuously monitors important aspects of care. These aspects or activities of care/service include, but are not limited to:

- Access and Availability
- Continuity and Coordination of Care
- Health Management Systems
- Under and Over Utilization
- Behavioral Health Care
- Chronic and Acute Care
- Member Safety and Error Avoidance
- High-Risk/High-Volume/Problem-Prone Care
- Preventive Care and Services
- Member and Practitioner Satisfaction/Dissatisfaction
- Guideline Management; Clinical Practice and Preventive Guidelines
- Health Plan Service Standards
- Quality of Care Complaint Review and Clinical Case Review
- Pharmacy Services

4.2 Data Sources and Staff Resources

Quality Improvement is a data driven process. Molina Healthcare utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter and Claims data
- Pharmacy Benefit Manager data
- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaint data obtained through call tracking,



Utilization Management (UM), Provider Services and other sources

- Provider and member satisfaction survey results
- Appeal information
- Statistical, epidemiological and demographic member information
- Authorization and denial reporting
- Enrollment; regional, disenrollment
- HEDIS
- Behavioral Health data
- Geo-Access provider availability data and analysis
- Feedback other than complaints regarding services and programs from members and providers.
- CAHPS

QI Staff and Analytical Resources include, but are not limited to:

- Chief Medical Officer (1.0 FTE)
- QI Director (1.0 FTE)
- Health Analyst (3.0 FTE)

Additional QI Expertise resources are in the following functional areas:

- UM
- Case Management
- Pharmacy
- Member Services
- Provider Services
- Government Contracts/Compliance
- Finance
- Credentialing

5.0 Quality Improvement Strategy

5.1 Quality Improvement Activities

To meet the purpose, goals and scope of this program, QI activities as reflected in the QI Work Plan will be focused in the following areas.

1. Improvement of the health status of the health plan membership through:
 - Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members. These programs will include preventive health, health education, disease management (health management), and care guidelines.
 - Monitoring the outcomes of care against national and available regional practice standards.
 - Utilization of multi-disciplinary and multi-dimensional teams to address process improvements that can enhance care and service, including primary, specialty and behavioral health practitioners.



- Oversight of delegated processes to ensure delegated organizations MHM standard
2. Identification of appropriate safety and error avoidance initiatives for MHM members in collaboration with the primary care provider through:
- Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
 - Education of members regarding their role in receiving safe, error free health care services through the member newsletter and the Molina web site.
 - Education of providers regarding improved safety processes in their practice through the provider newsletter, member profiles and the Molina web site.
 - Dissemination of information regarding important safety activities and Health Delivery Organization (HDO) audit findings for safety concerns to members and providers.
 - Evaluation for safe clinic environments during office site reviews.
 - Education to members regarding safe practices at home through health education and incentive programs.
 - Intervention for identified safety issues as identified through case management, care management and the grievance and clinical case review process.
 - Collection of data regarding hospital activities relating to member safety.
 - Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
3. Evaluation of the continuity and coordination of care through annual analysis of data to include:
- Transition of Care processes and the effectiveness of inter-provider communications and documentation.
 - Medical record audits.
 - Tracking quality of care issues, including adverse events.
 - Focused health management programs.
 - Member and practitioner satisfaction surveys and complaint and appeal review.
 - Identification of chronically ill or complex new patients through assessment processes.
 - Oversight of delegated activities.



4. Monitoring over-utilization and under-utilization through:
 - Tracking quality of care issues, including adverse outcomes and sentinel events.
 - Member complaint and appeal review.
 - Utilization review and case management reports.
 - Practitioner medical, pharmacy and utilization profiles.
 - Performance measures relative to implementation of preventive and clinical practice guidelines
 - Oversight of delegated group member satisfaction and utilization.

5. Evaluation of access and availability of care and service through:
 - Measurement and evaluation of geographic access to primary care physicians, key specialists, hospitals and other health care services.
 - Evaluation of appointment access and availability of after-hours care and after hour information offered by practices.
 - Evaluation of MHM Member Services telephone access.
 - Evaluation of all satisfaction measures for availability and access to care.
 - Oversight of delegated activities.

6. Management of Molina Healthcare's interface with practitioners, providers, members and state agencies to implement programs, including:
 - Inclusion of contracted practitioners and providers in the planning and implementation of clinical programs.
 - Review, approval, and dissemination of preventive health and clinical practice guidelines and measurement of adherence with current recommendations.
 - Review of clinical performance measures including HEDIS results to identify actions for improvement.
 - Identification of legislative and benefit changes that enhance health promotion.
 - Annual review of practitioner surveys and proposed activities for improvement.

7. Management of health care practitioner and provider credentialing/recredentialing to include:
 - Review of credentialing/recredentialing policies and procedures.
 - Peer review of credentialing/recredentialing decisions.
 - Peer review of investigated quality of care issues and proposed corrective action plans.



- Oversight of delegated credentialing activities.
8. Ensure that medical records comply with standards of structural integrity and contain evidence of appropriate medical practices for quality care by:
- Review of medical record audit results and corrective actions.
 - Practitioner education and corrective action where indicated.
9. Oversight of member satisfaction measurement and improvement activities:
- Review of all sources of member satisfaction information including, but not limited to, CAHPS Surveys, disenrollment information, complaints and appeals and identify opportunities for improvement.
 - Design and evaluate initiatives to improve satisfaction.
10. Evaluation of the effectiveness of QI activities in producing measurable improvements in the care and service provided to members through:
- Organization of multi-disciplinary teams, including clinical experts, to analyze service and process improvement opportunities, determine actions for improvement, and evaluate results.
 - Track the progress of quality activities through appropriate quality committee minutes and review/update the QI work plan quarterly.
 - Revise interventions as required based on analysis.

5.2 Quality Improvement Methodology

A cyclic, continuous, systematic process is used to improve performance and communicate clinical and service quality issues. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost, and outcomes related to their areas of responsibility. The model includes the following steps:

- Establish standards and benchmarks
- Collect data
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Establish clear improvement objectives
- Design and implement interventions
- Measure effectiveness



6.0 Organizational Structure Supporting Quality Improvement: Accountability Roles and Responsibilities:

6.1 The Board of Directors

Molina Healthcare of Michigan's Board has ultimate authority and responsibility for the quality of care and service delivered by MHM. The Board is responsible for the direction and oversight of the QI Program and delegates authority to the Quality Improvement Committee (QIC) under the leadership of the Chief Medical Officer. The President/CEO also serves as a member of the Molina Healthcare of Michigan Board of Directors.

6.2 The Quality Improvement Committee (QIC)

The QIC is responsible for the implementation and ongoing monitoring of the Quality Improvement program. Through the Quality Improvement Sub-committees, the QIC recommends policy decisions, analyzes and evaluates the progress, results and outcomes of all quality improvement activities, institutes needed actions and ensures follow-up.

The QIC sets the strategic direction for all quality activities at Molina Healthcare. The QIC receives reports from all QI sub-committees, advises and directs the committees on the focus and implementation of the QI program and work plan. The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The QIC is chaired by the Chief Medical Officer, and is composed of management of key health plan functions and network practitioners. The QIC confirms and reports to the Board that plan activities comply with all state, federal, regulatory and NCQA standards. The QIC reports to the Board any variance from quality performance goals and the plan to correct the variance. The QIC submits to the Board approved, signed, minutes reflecting committee decisions and actions of each meeting. In addition it presents an annual QI program, work plan and prior year evaluation, as well as quarterly summaries of important activities to the Board.

6.3 Quality Leadership

1. **The Chief Medical Officer and Director of QI are responsible to plan, design, implement and coordinate QI activities. Their combined responsibilities include but are not limited to:**

- **Reporting to the Board at the quarterly meetings.**
- **Demonstration and promotion of the QI Program through communication, practice, and resource allocation.**
- **Achievement of organizational goals.**



- **Direct involvement in QI activities to include:**
 - Analysis of UM and QI data
 - Serve as chair of QI committees
 - Ensure effectiveness of quality activities and allocate resources
 - Ensure practitioner participation
2. The Chief Medical Officer is the designated physician who has substantial involvement in the QI Program. This individual is responsible for:
- Supervision of all of Healthcare Services including operational oversight responsibility for the Quality Improvement, Utilization Management, Credentialing, and Pharmacy departments. Additionally the Chief Medical Officer will evaluate the link between Behavioral Health and MHM on a regular basis.
 - Chairing the Quality Improvement Committee (QIC), and co-chairing the Pharmacy and Therapeutics Committee (P&TC), the Peer Review/Credentialing Committee (PRC), and the Utilization Management Committee (UMC).
 - Oversight of development, dissemination, implementation and evaluation of clinical practice guidelines, preventive health guidelines and benefit interpretation guidelines.
 - Communication of information and decisions to network practitioners and providers, and follow-up on corrective action plans implemented for issues regarding quality of care, patient safety, or service.
 - Directs the provision of medical management for health care services, including behavioral health services, in conjunction with the Medical Director, the Clinical Behavioral Health Director and the Pharmacy Director.
3. The Director, QI under the direction of the Chief Medical Officer, leads the QI function and has the following responsibilities:
- Promote and maintain quality as a priority and guiding principle throughout the organization.
 - With the Chief Medical Officer, implements the MHM Safety Strategy.
 - Make available administrative support for planning, oversight, and allocation of resources to establish and maintain an organization-wide system of QI.
 - Serve as a resource for planning, implementation, and evaluation of the QI Program.
 - Provide operational oversight of the QI Program and annual work plan, Health Education, HEDIS, Health Management, Delegation Oversight,



and other clinical measurement processes.

- Coordinate health service activities to provide for measurement and analysis, obtaining needed expertise as needed.
- Coordinate the organization's ongoing NCQA Accreditation activities.

6.4 Standing Quality Improvement Sub-Committees

The QIC delegates QI functions to specific sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHM Quality Sub-committees meet at a minimum quarterly and all keep contemporaneous minutes using a standard format.

The activities of all quality committees are treated in a confidential manner, as outlined in their policies. (Please refer to attached 2007 Committee Purpose and Meeting Dates, **APPENDIX B** for a full description of sub-committee membership and responsibilities)

- The Quality Improvement Committee (QIC). Information from the QIC is reported to the Board of Directors on a quarterly basis or more often as appropriate.
- The Peer Review/Credentialing Committee (PRC). The PRC reports to the QIC.
- The Member and Provider Satisfaction Committee. Reports to the QIC.
- The Pharmacy and Therapeutics Committee (P&TC). The P&TC reports to the QIC.
- The Utilization Management Committee (UMC). The UMC reports to the QIC.
- The Compliance Committee (CC). The CC reports to the QIC.
- The Policy and Procedure Committee reports to the QIC

6.5 QI Department Roles and Responsibility

The QI Department is comprised of appropriately credentialed registered nurses, health professionals, and ancillary personnel who are responsible for coordination of the QIP and planned QI activities. These include, but are not limited to:

- Coordination of a health plan wide annual evaluation and planning cycle, resulting in an annual QI work plan that outlines organizational QI objectives with action plans, goals, responsibilities, timeframes and reporting requirements.
- Coordination of clinical and service quality measurement and quarterly reporting to the QIC.



- Management of QI projects, studies and interventions, preparation and submission of QI documents and reports, and recommendations to appropriate quality sub-committees.
- Identification of opportunities for improvement through monitoring and analysis of clinical and satisfaction data.
- Ensuring compliance with MHM and regulatory standards for timely response or resolution of complaints and appeals, in conjunction with UM and Member Services staff.
- Monitoring QI preparations for compliance with regulatory requirements and for future accreditation. Coordinates the preparation of the formal study documentation, including Quality Improvement Activities (QIAs) and Performance Improvement Projects (PIPs).
- Development, adoption, and implementation of relevant health education programs.
- Implementation of the clinical quality of care case review process.
- Membership on appropriate Quality Sub-committees.
- Maintenance of accountability and oversight of delegated administrative functions to include credentialing, utilization management, and claims to contracted provider groups.
- Development, maintenance and implementation of QI policies and procedures.
- Maintenance of necessary QI resources including, but not limited to written materials, software, specialty consultation, analyst and statistical support.
- Identification and interventions for disparities for racially and ethnically diverse populations

6.6 Other Departmental Roles and Responsibilities for QI

All departments have a key role in quality improvement. Departments participate in interdepartmental activities but also focus on intradepartmental opportunities to improve effectiveness or efficiency. All departments participate in one or more of the Quality Improvement Committees.

The UM staff is responsible for:

- Development and maintenance of the UM Program, policies and procedures, annual UM work plan and program evaluation in compliance with NCQA, MHM and other regulatory and accrediting standards.
- Monitoring over and under-utilization, coordination and continuity of care, including access to a nurse advice line.
- Documentation of all potential quality of care, risk management, and



member safety issues identified during UM review. The Chief Medical Officer determines the severity of each case and determines if peer review is required.

- Oversight of the coordination of care with healthcare delivery organizations (i.e., facilities) and contracted entities, and with groups delegated for UM functions.
- Implementation of a case management program in collaboration with health management and prevention programs.

The Provider Services staff is responsible for:

- Monitoring practitioner, provider and health delivery organization access and availability, including behavioral health, and implementing improvement plans.
- Review of practitioner satisfaction surveys, practitioner complaints and other forms of practitioner feedback and implementation of improvement plans.
- Dissemination of provider education materials as identified including statements of members' rights and responsibilities.
- Administration of the provider inquiry process for payment issues related to post-service claims and/or authorization denials.
- Monitoring the trends of member concerns, complaints, appeals and disenrollment related to dissatisfaction with provider and provider inaccessibility and identifying opportunities for improvement, in conjunction with Member Services staff and QI.

The Member Services staff is responsible for:

- Administration of the members' rights and responsibilities.
- Monitoring member access to Molina Healthcare and compliance with contractual and regulatory standards for timely response or resolution of all issues, in conjunction with Provider Services.
- Monitoring trends of member complaints, appeals and disenrollment and identification of opportunities for improvement.
- Review of member satisfaction surveys and other forms of member feedback, identification of opportunities for improvement, and implementation of improvement activities.
- Reporting all potential quality of care and risk management issues that are reported by members following policy and procedure.
- Administration of the member complaint and appeal policy, ensuring timelines met per policy.



Compliance Manager is responsible for:

- Coordination of compliance audits.
- Oversight of compliance with all applicable statutory, regulatory and contractual requirements.
- Review of draft and final regulations and statutes.
- Education and training for Molina Healthcare staff regarding contract provisions and new law/regulation.
- Liaison with the state of Michigan.
- Coordination of contract renewal activities.
- Implementation and monitoring of the Compliance Plan.
- Maintenance of approved policies and procedures, ensuring annual review and approval.
- Preparation and review of member communications and submission to the state for approval as required, including member handbook and mailings.
- Management and review of confidentiality issues and provision of training as needed.
- Coordinate organizational compliance for HIPAA (Health Insurance Portability and Accountability Act).

The Credentialing staff is responsible for:

- Implementation of a credentialing and recredentialing program that includes completion of office site visits to ensure a safe environment for members and appropriate practices, development and maintenance of provider profiles including available data from health plan functions and staffing the PRC.
- Implementation of the medical record-keeping audit program.
- Delegation Oversight

The Pharmacy staff is responsible for:

- Identification of key processes to evaluate pharmacy safety and effectiveness.
- Maintenance of notification system for drug alerts.
- Development and maintenance of operational policy and procedures for effective formulary management, authorizations processes and safe practices.



- Oversight of Pharmacy Benefit Manager to ensure practices meets MHM's standards.

6.7 Role of Participating Providers

Participating practitioners serve on all clinical committees including, QIC, UMC, P&TC and PRC. Through this committee activity, participating providers may:

- Review and provide feedback on proposed practice guidelines, preventive health standards, clinical protocols, health management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures.
- Review proposed QI study designs.
- Participate in the development of action plans and interventions to improve levels of care and service.

In cases where specific specialty feedback or assistance is needed, community specialists are used to review cases and to provide feedback on proposed interventions or programs. As needed, focus groups of practitioners may be used for assisting with the design or evaluation of specific programs.

6.8 Confidentiality

Molina Healthcare of Michigan is authorized by specific regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations, including Title 42 Code of Federal Regulations, Molina Corporate Employee Handbook, Section B, Security and Confidentiality. Use of Protected Health Information (PHI) is outlined in a privacy notice distributed to all members.

All Molina Healthcare personnel sign a Confidentiality Agreement and a Code of Conduct and Employee Handbook Acknowledgment form. Signed documents are on file in the Human Resources Department. In addition, non-Molina Healthcare members of QI committees sign a confidentiality statement when attending committee meetings and are protected from being required, with some exceptions, to testify in civil actions related to specific committee activities and actions.

As an approved Coordinated QI Program by MDCH, information and documents created specifically for, and collected and maintained by an approved program receive protections from public disclosure. Molina Healthcare's QI documents are maintained in compliance with all legal requirements and include, but are not limited to, internal reviews, including patient care review studies, QI studies and reports, minutes of QI committees and administrative (i.e., non-clinical) processes having a direct impact on the provision of care or service. The findings of all Molina Healthcare QI committees are part of the QI Program. Such findings will



not be released to any outside agency without the express permission of the originating agency and assurance that confidentiality will be maintained.

The Board assigns the responsibility of managing and reviewing confidentiality issues to the Government Contracts and Compliance Department. A Compliance Committee has been formed as directed by the Compliance Plan. This committee addresses issues of confidentiality.

6.9 **Conflict of Interest**

No reviewing physician may perform a review on one of his/her patients, the patients of his/her partners, or cases in which the reviewing physician has a proprietary financial interest in the site providing care.

7. ***Delegation Activities***

Molina Healthcare of Michigan may delegate Credentialing, UM, and Claim activities to provider groups that meet delegation requirements. Prior to delegation, Molina Healthcare conducts on-site delegation pre-assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of monthly reports and annual on-site assessments.

The QIC monitors ongoing delegate compliance with regulatory and accrediting requirements. The committee requires corrective action of delegates when necessary. MHM's Director, QI is responsible for the delegation oversight process, which includes coordinating and conducting annual on-site assessments, monitoring credentialing reports, overseeing the corrective action process, and providing staff support.

MHM currently delegates the following:

- Credentialing
- Quality Improvement for Behavioral Health
- Utilization Management for Behavioral Health

8. ***Program Evaluation and Revision***

The Quality Improvement Program Description and Work Plan govern the program structure and activities for a period of one calendar year. At least annually, the QI Department will facilitate a formal evaluation of the QI Program. Evaluation of all quality activities will include a description of limitations and barriers to improvements.

The annual QI evaluation identifies the outcomes and includes the following areas:

- Evaluates the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service.
- Where available, includes a trended indicator report and brief analysis of changes in trends and improvement actions taken as a result of the trends.
- Identifies opportunities to strengthen member safety activities.
- Evaluates resources, training, scope, and content of the program and practitioner participation.



- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year.
- Evaluates the overall effectiveness of the QI Program.

9. Governing Body Review and Approval

Molina Healthcare of Michigan's QI Program is accountable to and reports activities to the Board of Directors through the Quarterly and Annual Reports. The Quality Improvement Program Evaluation, the QIP and the Work Plan are submitted to the Board of Directors for review and approval.



10. Glossary

BH:	Behavioral Health
CAHPS:	Consumer Assessment of Health Plans
ED:	Emergency Department
HCA:	Health Care Authority
HDO:	Health Delivery Organization
HEDIS:	Health plan Employer Data and Information Set
MDCH:	Michigan Department of Community Health
NCQA:	National Committee for Quality Assurance
PRC:	Peer Review Committee
P&T:	Pharmacy and Therapeutics
PHI:	Protected Health Information
PCP:	Primary Care Provider
QIC	Quality Improvement Committee
QIP:	Quality Improvement Program
UM:	Utilization Management
UMC:	Utilization Management Committee