2023

GHC-SCW POPULATION HEALTH MANAGEMENT

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN | 1265 J. Q. Hammons Dr. Madison WI

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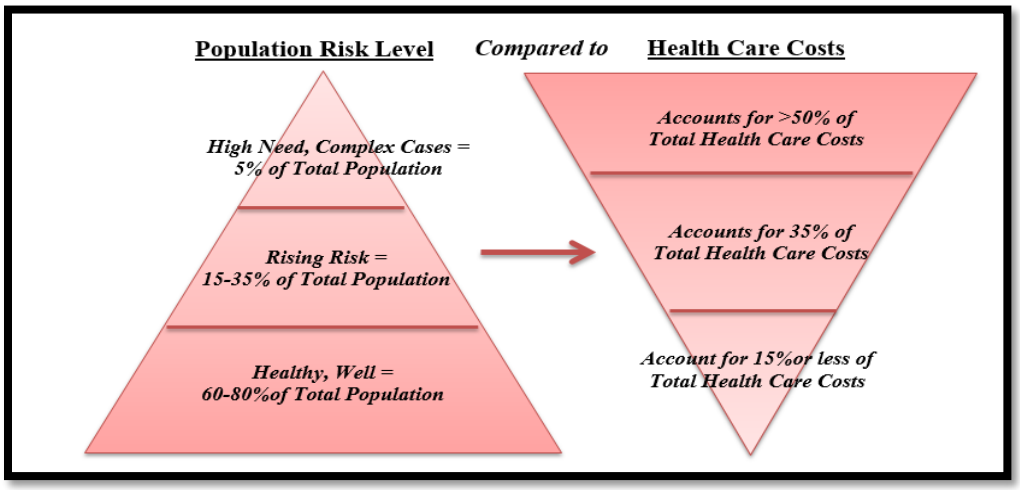
Group Health Cooperative of South Central Wisconsin

Population Health Management (PHM)

GHC-SCW's Population Health Management program was formed in 2016 to further develop our approach to delivering high quality, proactive medically managed care. The program aims to improve the health and well-being of populations while also ameliorating unjust health disparities where possible. Tailoring proactive and preventive health outreach strategies for all patients and members and improving care coordination for members with high cost and complex conditions is our goal. To do this, Quality and Population Health Department staff work in tandem with other departments and our clinics within the organization to support ongoing initiatives. This document provides an overview of our strategies and methods used toward achieving our organizational goals.

I. Strategy

Efforts to improve and manage the health of populations requires a combination of system- and patient-level approaches. GHC-SCW is dedicated to increasing the quality and value of its members' healthcare by improving preventative care, chronic disease outcomes, as well as improving care coordination for patients and members with the most complex needs. Left untreated or poorly managed, chronic conditions inevitably lead to avoidable, adverse health outcomes which are much costlier. In fact, national healthcare costs continue to increase for mental health and chronic disease at an unsustainable rate.



GHC-SCW recognizes the importance of leveraging primary care clinics to promote and educate members about routine care and healthy lifestyle behaviors which are key to reducing the incidence, burden and costs associated with chronic conditions. We also recognize that diverse and underserved populations with chronic conditions experience the most striking health disparities.

Strategic Areas, Metrics, Target Populations, Goals, and associated Programs or Services

GHC-SCW aims to coordinate and build efforts to address these strategic areas:

- Keeping members healthy through wellness and prevention
- Managing at-risk (emergent) and high-risk populations
- Focusing on patient safety initiatives
- Providing high-value care coordination and managing outcomes across settings
- Managing chronic disease and multiple co-morbidities

GHC-SCW's metrics and goals are reviewed annually by key internal workgroups or organizational stakeholders including the Director of Quality and Population Health, our Chief Medical Officer, and Associate Medical Director of Informatics and Population Health.

Programs are a collection of select services and activities to manage member health.

Services are singular activities or interventions in which individuals can participate to help reach a specified health goal.

Appendix 1 outlines our metrics, target population, goals, programs and/or services applicable under each of the key strategic areas for our Commercial and Exchange HMO. These product lines run administratively the same with respect to our PHM strategies.

Appendix 2 outlines the same information for our Medicaid HMO population. GHC-SCW has quality provisions that must be followed per our Medicaid contract with the Wisconsin Department of Health Services. The Medicaid HMO, also known as BadgerCare Plus, may involve pay for performance measures and has stipulations on marketing or outreach that may impact our strategies with respect to this population.

Program or service *Outreach* as noted in either Appendixes can be any one or a combination of direct types of member contact: US Postal (USPS) Mail, Secure Messaging (MyChart) or telephonic.

II. Integrating with Community Resources

GHC-SCW is committed to helping members and their practitioners prevent and manage chronic illness by providing tools and access to community resources. Offering resources is especially important given that behavioral and social factors contribute to more than 60% of health outcomes.

Prediabetes

GHC-SCW recommends that members who are at-risk for developing diabetes (based on clinical screening criteria) are referred to an evidence-based Diabetes Prevention Program that promotes healthy eating and encourages physical activity to prevent the onset of type 2 diabetes.

GHC-SCW has a collaborative agreement with the YMCA of Metropolitan Milwaukee to refer our members. To qualify for the YMCA's Diabetes Prevention Program, participants must be at least 18 years old, overweight (BMI > 25) and at high risk for developing type 2 diabetes indicated by a confirmatory blood value, prediabetes determined by clinical diagnosis of gestational diabetes during previous pregnancy, or a qualifying risk score.

The YMCA's Diabetes Prevention Program is a 12-month lifestyle modification program, which is a part of a national effort, by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). The goal of the program is to prevent the onset of type 2 diabetes by reducing body weight by 7% and participating in 150 minutes of physical activity per week. Additional information about this program can be found at www.ghcscw.com.

Diabetes

GHC-SCW recommends that members who have diabetes participate in programs available in the community such as the self-management support program, *"Healthy Living with Diabetes."* This is a high-level, evidence-based program administered and supported by the Wisconsin Institute for Healthy Aging (WIHA). This program information can also be found at www.ghcscw.com.

GHC-SCW is currently running a Virtual Diabetes Support Group (VDSG) that focuses on providing education from a variety of healthcare professionals sharing tips and aiding group conversation about living with diabetes. Current participants also receive twenty pounds of food at no cost to support a healthy lifestyle. Continuation of the VDSG is based on member feedback and available resources.

Other Chronic Conditions or Needs Associated with Social Determinants of Health

WIHA also has the evidence-based workshop "*Living Well with Chronic Conditions"* for people with one or more chronic conditions. Developed at Stanford University, the workshop meets for two ½ hours a week for six weeks. Classes are highly participative, where mutual support and success builds participants' confidence in their ability to manage their health condition to maintain active and fulfilling lives. It is facilitated by two trained leaders in a classroom style, but most of the learning comes from sharing and helping others with similar challenges. Members can use the WIHA link available at www.ghcscw.com to locate a workshop near or in the county they live in across most of Wisconsin.

GHC-SCW's Care Management Department maintains a list of community resources that Case Managers and clinic staff may utilize to help connect members to services within the local area that enable them to live better with their condition or provide socioeconomic support if needed. Additional information about our Care Management program can be found on the Care Management page at www.ghcscw.com.

In addition to the list of community resources maintained by GHC-SCW, web access to databases such as *Aunt Bertha* and *United Way of Dane County 2-1-1* have been made accessible to GHC-SCW staff in the *Clinical Resources Dashboard* within Epic. The health plan also has Community Service Coordinators to help connect staff model members to local resources such as housing, food banks, public benefits, transportation, etc.

In 2021, GHC-SCW began a Phase 1 implementation of Social Determinants of Health (SDoH) functionality in our electronic medical record. Adult (18+) and Pediatric (< 1-17) supplemental questionnaires include screening questions endorsed by the Dane County Health Council and new sexual health questions that follow the Centers for Disease Control and Prevention's *5P's* approach to taking a sexual history. Patients automatically receive these questionnaires prior to a Preventive Health Exam imbedded in their pre-visit MyChart message. Information provided flows into the record to populate the fields/functions in Epic. Phase II of this implementation will focus on SDoH data collection for our Medicaid population with the aim to satisfy pending State of Wisconsin requirements for BadgerCare Plus participation.

III. Data and Information Sharing with Practitioners

GHC-SCW uses EMR software (Epic®) with reporting tools for the sharing of data and information between PCPs, Urgent Care, nursing staff, behavioral health, and clinical pharmacy specialists, as well as interoperability with other local health care system providers, particularly hospital systems. This technology is fundamental to the cooperative's foundational patient centered medical home concepts within GHC-SCW owned and operated primary care clinics. Panel management tools are also enabled which allow staff to quickly order routine lab tests and send reminders about important health services.

With Epic's "*Healthy Planet*" functionality and tools such as condition-specific registries and metric-based dashboards, clinic staff can compare their performance to the organization or colleagues and various benchmarks. Dashboard metrics are selected by key internal workgroups or stakeholders including the Chief Medical Officer. Most Epic® registries and components of dashboards update weekly, practitioner level metrics update, at a minimum, on a quarterly basis. To the extent possible, metrics are built to align with HEDIS®, MIPS, and/or other quality specifications, some of which are associated with the State of Wisconsin Medicaid program. Transparency of performance data has helped to drive improvement by identifying areas of opportunity, generating conversation among care teams, and fuels provider engagement toward achieving better health outcomes for members.

IV. Coordination of Member Programs

GHC-SCW has worked to improve coordination between programs and services with the use of the "WeCare" encounter in the electronic medical record. This encounter type is used by PCPs, clinic-based RN Team Coordinators, and health plan-based case managers to longitudinally document patient outreach and care coordination for at risk- and high-risk members. With this encounter type, all partners in the member's care team have access to reviewing notes related to hospital discharge follow-up, expiring orders, care gap reminders, and care conference summaries thus limiting the potential of providing duplicative services.

GHC-SCW does not delegate population health management to any outside entities and internally coordinates the programs and services offered together with network providers/hospital systems to improve member care.

V. Eligibility and Informing Members

The cooperative maintains a dedicated page on www.ghcscw.com related to Health Management. The page provides detail about how to use available programs and services, or how to opt out. The organization informs members about information available on our website through the "*HouseCall*" member newsletter.

GHC-SCW members are informed of applicable programs and services through a variety of direct types of member contact including USPS mail, secure MyChart messages or telephonic outreach . Staff model members receive communications based on their documented preference in their medical chart. If no preference is indicated, communications default to first send via MyChart if an account is active or via USPS mail if not yet activated. Members who believe they received a notice or care gap reminder in error or would like to be removed from mailing lists are directed to contact their care team or the Quality Management Department to be excluded from future contact. In some cases, a patient will meet inclusion

criteria for a registry, but the care team may determine they should not be included and would go through a documented process to remove them to be re-evaluated later should their coverage remain active.

Members must meet specific criteria (see section IX) to qualify for Complex Case Management services. Case Management staff are responsible for reviewing various reports and data to determine which members meet current criteria. After thorough chart review, case managers conduct outreach via telephone to members providing information about their service and offering the opportunity to enroll or opt-out. A dedicated information page related to Complex Case Management is available on our website at www.ghcscw.com.

Insurance related outreach materials sent *only* to Medicaid HMO members must be reviewed and approved by the State of Wisconsin Department of Health Services who impose significant restrictions on the type of materials and methods of distribution to any Medicaid participant.

VI. Population Identification

Data Integration

GHC-SCW relies on robust, reliable data to drive a culture of continuous improvement and leverages data every day across all business functions. The capacity for combining data from multiple sources and across clinical care sites, as well as insurance domains, helps to create links between systems to coordinate care. Health plan operations are supported by sophisticated information systems, electronic medical records and business software tools that help with the execution of the right care at the right time by using information from sources such as:

- ***Medical and behavioral claims or encounters***
- ***Pharmacy claims***
- ***Laboratory results***
- ***Electronic health records,*** integrated between practices/providers through *Care Everywhere*, *Care Link* and *Share Everywhere* functionality within Epic
- ***Health services programs within the organization,*** *Utilization Management, Care Management, GHCNurseConnect or Wellness*
- ***Data warehouses or other advanced data sources***
  Examples include various chronic disease or population-based registries as well as sharing data with the Wisconsin Immunization Registry (WIR), a database developed to record and track immunization dates of Wisconsin children and adults.

Population Assessment

GHC-SCW uses the various sources listed above to identify the characteristics and needs of our member population and subpopulations. This includes population management tools designed to help healthcare organizations analyze medical and pharmaceutical claims data. Information related to medical costs is evaluated along with other member data that may identify demographics, age groups, genders, ethnic or racial characteristics, or other social determinants of health that may point to at risk populations or sectors with specific needs. Social determinants are known to be factors that contribute to overall health, such as, socioeconomic circumstances, physical environment, health behaviors or barriers to accessing care.

As a public health partner in the Healthy Dane Collaborative, our cooperative uses the local Community Health Needs Assessment (CHNA) as a source of reliable, current population data about our Dane County community to understand issues pertinent to the residents we serve. Not-for-profit hospitals are required to complete a CHNA every 3 years to identify & prioritize the health issues of greatest concern in our surrounding community. GHC-SCW participates within the Healthy Dane Collaborative on this public health initiative and the findings for the 2022-2024 CHNA assessment have been released. The CHNA survey revealed mental health treatment as the most critical need followed by substance abuse, healthy pregnancy, suicide, and diabetes.

GHC-SCW uses all relevant data (both health plan level and clinic level) from our electronic medical record system to prioritize programs or interventions best suited to the unique characteristics of our membership. GHC-SCW's population is evaluated by looking at:

- All ages including children and adolescents within the Commercial and Exchange HMO product lines, and the Medicaid HMO
- Two relevant subpopulations within the total membership that share common characteristics
- Chronic conditions, severe injuries, or disabilities
- Severe and persistent mental illness (SPMI)
- Utilization and/or cost information to determine areas of most critical impact
- Social determinants of health (unhealthy behaviors, food, financial or housing insecurity)
- Racial and ethnic diversity and any associated needs or disparities
- Limited English language proficiency and associated needs or disparities

Children and adolescents may require special adaptation when they face medical or behavioral challenges because they are still growing physically, mentally, and emotionally. Individuals with disabilities and individuals with SPMI may require acute care coordination and involve intense resource use.

Through our annual population assessment, the organization strives to define areas of highest priority for our members to target impactable patients or groups for engagement strategies based on identifiers. This aids in developing our population health programs or services such as helping to define our criteria and eligibility for Complex Case Management, effective outreach methods, or other needs.

Activities and Resources

GHC-SCW considers its annual population assessment results, reviews its PHM strategy and the associated activities and processes, and integrates appropriate community resources in its programs where necessary to meet member needs. Internal stakeholders or committee groups may make recommendations for updates to PHM activities or resources if indicated by the analysis and take into consideration changes to program or service offerings, qualifying criteria or staffing ratios for complex case management, clinical training requisites, or other external resource needs.

GHC-SCW implemented a first phase of Social Determinants of Health (SDoH) functionality in our electronic medical record and is working on future development that will increase our ability to report on SDoH and supports a more robust community resources referral guide for utilization by the staff of GHC-SCW. Our Community Health department social workers support patients, other GHC-SCW employees, or outside providers by provision of information and connection to community resources with the goal to improve the overall patient experience and quality of care.

Some examples of the type of resources that staff may offer include:

- Connecting members to transportation
- Connecting at-risk members with shelter or food security programs
- Connecting patients/members to pharmaceutical or financial assistance programs

Health Equity & Disparities Reduction

The World Health Organization defines *health equity* as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically," and GHC-SCW believes that building a health system that is centered on belonging and community is a part of the greater creation of a healthy population.

GHC-SCW's *Chief Equity and Engagement Officer* (CEEO) serves as our guiding leader who promotes health equity efforts. The CEEO is working toward improving belonging within the organization and addressing social determinants of health that present as barriers to health outcomes and strategic goals.

Equity focused committees/workgroups review initiatives for both insurance and care delivery functions of the organization. Senior leaders, managers and clinical staff across the organization aim to identify any unfair or remediable differences in health that impacts the member population. Plans for action may require an update to the organization's strategic goals or population health related activities or resources to help address a disparity once identified. Continuing to offer and improve employee training on diversity, equity & inclusion, and cultural competency is also a priority. The most recent addition to training is the "Affirming Differently Abled Members" module in our health equity course catalog.

GHC-SCW's organizational strategic plan for 2023 has five pillars and the *Impact* pillar is focused on advancing health and well-being by nurturing connections with our member-owners and the communities we serve. Our CEEO is the executive sponsor of this pillars initiatives and has defined a goal to establish a minimum of three new community partnerships per year through 2025 that enhance our giving philosophy and cultivate health equity across our community.

Segmentation

Segmentation is a function of dividing the population into meaningful categories while risk stratification focuses on using the potential of risk or risk status to target rising risk individuals for intervention. These processes represent the entire continuum of care in the population and different interventions may be based on the data source, severity of illness, completion and/or the results of tests or examinations or other inclusion factors.

GHC-SCW utilizes various reports or registries to identify members that are potential candidates for targeted preventive outreach, or either case management or chronic disease intervention based on health plan or clinic level data. Epic® registries (diabetes, chronic opioid use, cigarette use and asthma) reflect a patient (staff model) perspective. Preventive and other disease management registries (i.e., hypertension) include all actively enrolled members who have a GHC-SCW HMO plan.

GHC-SCW's preventive registries are the heart of our population health management program .They are built from specific member level information that follows inclusion rule methodology (see GHC-SCW Healthy Planet Tools) based on active GHC-SCW coverage or another active payer, their legal sex, and their current age. These preventive Epic® registries provide the basis for creating more granular and specific Reporting Workbench Reports then used to conduct bulk outreach communication and bulk lab ordering. While other registries GHC-SCW uses technically do not stratify the entire population, they are

utilized for targeted interventions or potential outreach opportunities based on a medical or behavioral health diagnosis, prescribed medications, a noted health behavior, or an aspect of utilization that could indicate a rising risk. Our segmentation analysis is customized to our local HMO population, informed by clinician expertise, and prioritizes the most critical population health needs. GHC-SCW routinely brings together experts across the organization to explore if racial bias may exist in our methodology to mitigate its influence.

Subset of Population	*HMO Product Line*	*Targeted Intervention for which eligible*
Pregnant Females	Medicaid	OB Medical Home Program (Prenatal & Postpartum)
Medically Complex Members (See criteria in Section IX)	Commercial, Exchange and Medicaid	Complex Case Management
Behavioral Health and/or SUD (See criteria in Section IX)	Commercial, Exchange and Medicaid	Complex Case Management or Care Coordination
Diabetes Registry Epic	Commercial, Exchange and Medicaid	Disease Management
Hypertension Registry QMI0010050	Commercial, Exchange and Medicaid	Disease Management
Asthma Registry Epic	Commercial, Exchange and Medicaid	Disease Management
Cigarette Use Registry Epic	Commercial, Exchange and Medicaid	Smoking Cessation
Opioid Use Registry Epic	Commercial, Exchange and Medicaid	Chronic Opioid Treatment
Asthma related UC, ER or Hospitalization "Asthma Risk score > 3 "	Commercial, Exchange and Medicaid	High Risk Asthma Care Coordination
Adult Female ≥ 18 years	Commercial, Exchange and Medicaid	Preventative Outreach; immunizations, screenings, over-due tests, or labs etc.
Pediatric Female	Commercial, Exchange and Medicaid	Preventative Outreach; immunizations, well child visits, over-due tests, or labs
Adult Male ≥ 18 years	Commercial, Exchange and Medicaid	Preventative Outreach; immunizations, screenings, over-due tests, or labs etc.
Pediatric Male	Commercial, Exchange and Medicaid	Preventative Outreach; immunizations, well child visits, over-due tests, or labs

GHC-SCW also segments our entire HMO membership in our annual Population Assessment exercise (see section VI above) which evaluates for disparities by race and/or ethnicity or needs linked to social determinants of health . This assessment accounts for member age, sex, employer, ethnicity, language, product line, race, and risk panel (staff model vs non-staff model) in our methodology. In addition, we rank the top clinical episodes by cost and/or frequency to give the organization a broad understanding of conditions that are most prevalent or of prospective focus for complex case management. The Case Management program is inclusive of all HMO members that meet our specified criteria should they choose to opt in. Case Managers also utilize a host of other specific reports to help identify patients or members who may benefit from care coordination.

Where applicable, GHC-SCW utilizes tools developed by Change Healthcare™ to align patients with appropriate interventions & maximize allocation of plan resources effectively to achieve the greatest health impact. Change Healthcare's Risk Manager™ and its' associated data warehouse offers clinical intelligence to help improve care and compliance. The tools' algorithms identify patients who have chronic and acute conditions or should be targeted for improvement on quality measures as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®).

VII. Delivery System Supports

Practitioner or Provider Supports

GHC-SCW's practitioners have access to evidence-based guidelines at the point of care that can help them make clinically sound decisions with their patients. GHC-SCW utilizes *UpToDate®,* a clinical decision support resource associated with improved outcomes. Embedded links within our Epic EMR give clinicians easy access. In addition, GHC-SCW purchased *Lippincott® Solutions,* a suite of clinical decision support tools and CE courses that provides evidence-based practice resources to strengthen our staff's quality of clinical care. Whether the goal is treatment recommendations, getting information on a lab result, or providing patient education, integration brings the answers clinicians need into the workflow at the point of care. Decision support tools decrease care variation and boost both practitioner and patient satisfaction.

GHC-SCW has a *Clinical Content Committee* for the evaluation of the relevance, currency and accuracy of clinically shared information or policy and maintains a *Clinical Resources Dashboard* within Epic. Evidence-based and/or HEDIS® guidelines serve as the framework for our PHM strategies and cover at least the following three spheres of health care: 1) chronic or acute medical conditions, 2) behavioral health and 3) preventive health.

Additionally, the cooperative utilizes an annual training curriculum that expands on diversity, equity and inclusion principles and offers tools for daily practice that supports all staff practitioners in the delivery of culturally and equitably responsible care

Data Sharing

Transmission of member data to the provider or practitioner that assists in delivering services, programs, or care to the member is the definition of data sharing. Being an integrated delivery and insurance system affords GHC-SCW the benefits of data sharing from both insurance operations and clinical care as we have access to Epic® medical records as well as claims information. Epic® Care Link and Care Everywhere functionality allows data sharing with other regional health system partners.

GHC-SCW strives to provide practitioners with timely and actionable data to support better care and counseling of a patient or member. Epic® reports provide knowledge of triggering events such as urgent care or ER visits and hospital admissions that can facilitate practitioner development of an appropriate plan of care.

Staff who work at a GHC-SCW clinic utilize dashboards and can create "WeCare" encounters that allow care teams to review information prior to and/or during a scheduled patient appointment that help coordinate care. Several dashboards are available to clinic staff via the EMR in addition to chronic disease or other types of registries (i.e., diabetes, cigarette use, opioid use, asthma).

In addition to the data available at GHC-SCW clinic locations, the health plan continues to develop and make available timely and actionable registries/reports that can help proactively provide the right patient care and services at the right time. For example, our Quality staff shares care gap reports on Medicaid HMO members with external providers at contracted UW Department of Family Medicine and Access Community Health Care clinics.

Shared Decision Making Aids

Shared Decision Making (SDM) aids are particularly useful for diagnoses that have more than one treatment option as they can be used to improve patient knowledge of their condition, explain the treatment options and the potential outcome probabilities. Decision aids also facilitate dialogue to engage the member and improve agreement between patient preference and subsequent treatment decisions.

GHC-SCW uses and makes evidence-based decision aids available from *Healthwise*®, a licensed online resource whose SDMs meet International Patient Decision Aids Standards (IPDAS). Members may be provided aids as print material directly from their practitioner /care team at the visit or by mail from the health plan or may access *Healthwise*®, by logging in to their GHCMyChart℠ account.

GHC-SCW practitioners have access to SDM content within Epic®. Some examples of decision support aids used by GHC-SCW providers geared toward high cost and high preference conditions include several orthopedic procedures and PSA screening for prostate cancer. Ten different consult orders will prompt a Best Practice Alert in the EMR for the provider to offer an SDM aid to the patient. These include:

- PSA screening
- Uterine fibroids
- Total knee
- Total hip
- Back surgery
- ACL
- Achilles
- Meniscus tear
- Shoulder
- Carpal tunnel

Prompts currently appear only on patients with insurance coverage under the State of Wisconsin Group Health Insurance Program, however, decision aids are available and can be offered to any member prior to the specialist/surgical referral or testing.

Practice Transformation Support

GHC-SCW's *Provider Engagement Specialist* supports professional and personal development and assists with the management of onboarding for new providers. The onboarding process serves as the foundation for integrating new employees into our brand. Thereafter, GHC-SCW supports its practitioners in meeting their population health management goals through frequent technology related upgrades to the electronic medical record and investing in clinical decision support tools and CE courses that provide evidence-based practice resources to strengthen our staff's quality of clinical care. GHC-SCW also has a *Telehealth Program Manager* who supports process improvements that keep practitioners up to date with industry trends.

Staff model Primary Care, Urgent Care and Dermatology providers interested in collaborating on *Maintenance of Certification* credit projects have the support of the Senior Medical Director and the Quality Management Department if needed. The cooperative also supports employees financially in pursuing and accessing learning opportunities such as webinars or conferences or other continuing education.in addition to sharing best practices across the organization.

All six GHC-SCW staff model primary care clinics were recognized by NCQA as Level 3 Patient Centered Medical Home (PCMH) practices under the 2014 standards. In 2020, GHC-SCW made a strategic business decision to not pursue maintenance of our PCMH recognition, however, our six staff model clinics still function like patient centered medical homes with some level of reporting still operational. Our staff model practitioners continue to build on these foundational principles in their practices.

VIII. Wellness and Prevention

At GHC-SCW, we have always been committed to whole person care for our members. This means health and wellness. GHC-SCW's *ManageWell* member wellness program is part of a comprehensive PHM strategy and focuses on promoting health with the primary aim of lowering the total cost of health care by slowing the increase of risk. Most GHC-SCW members including subscribing members and their spouses/significant others who are eighteen and older are eligible to participate in the wellness program.

GHC-SCW Medicaid HMO enrolled members and members with Medicare as their primary coverage and GHC-SCW as their secondary coverage are also eligible to participate in the program however some incentive restrictions may apply. The *ManageWell* platform is highly customizable and creates personalized experiences for participants that choose to opt-in by registering. The program incentivizes members by earning points to be well through completion of various activities.

Platform activities include the following and may require a purchase and/or proof of participation*:

- Health Risk Assessment
- Preventive health (e.g., Flu shot, annual physical with primary care provider)
- Setting SMART health goals
- Utilizing other healthcare services (e.g., Health Education, Complementary Medicine, and Diabetes Nurse Educator visits)
- External weight management or health coaching programs *
- Community Supported Agriculture share *
- Wearables* that link to ManageWell to track steps, exercise, and sleep (e.g., Fitbit, Apple Watch, smartphone)
- Additional trackers (e.g., Nutrition and water)
- Educational programs*

The *ManageWell* program is administered quarterly with points resetting at the beginning of each quarter. Incentive payouts are determined based on the tier each participant meets and are then distributed after claims for the prior quarter have been processed.

GHC-SCW also provides wellness and prevention services to purchasers that request these services, such as, biometric screening. Our Wellness department office staff work directly with the workforce of requesting employer groups to obtain biometrics, review results and/or provide wellness services as dictated per their wellness service agreements.

In addition, GHC-SCW makes self-management tools available within GHCMyChart [SM] or our website through *Healthwise* that provides interactive resources to our members on such topics as a healthy weight (BMI), tobacco cessation, encouraging physical activity and healthy eating, managing stress, or avoiding risky alcohol consumption, and identifying depressive symptoms

IX. Complex Case Management

GHC-SCW's Complex Case Management (CCM) program is a short-term service with a goal of graduating the member from the program within a year or shortly thereafter. Our CCM program provides proactive, medically appropriate, cost effective, coordinated care to members with complex medical and/or behavioral health conditions. Members inquiring about or accessing care services are evaluated to determine their need. If a member does not qualify for Complex Case Management based on our current criteria, he/she has the opportunity for care coordination services through primary care in collaboration with GHC-SCW Utilization Management (UM).

GHC-SCW's CCM program is led by a Medical Director and the Care Management Department Manager. The program is currently staffed by a Case Manager Team Lead (RN) who handles all medically complex cases and a licensed Social Worker who handles behavioral health and/or substance use disorder needs. The organization requires and assists our case managers to obtain professional certification through the Commission for Case Manager Certification; CCMC.

Case managers contact the member and/or caregiver telephonically or through a virtual visit. The case manager may provide or offer services to the member directly or may arrange for services to be provided by other entities including, but not limited to:

- Care coordination, including arranging appointments, acting as a liaison between specialists and their PCP, and creating referrals to community resources.
- Medication reconciliation, including medication education with the member and referral to GHC-SCW Clinical Pharmacy Program as needed.
- Case management plan development with member identified performance goals in which the member strives for self-management and improved adherence to a mutually agreed upon plan of care between member and their provider.

In accordance with NCQA standards, GHC-SCW considers complex case management to be an opt-out program: *all eligible members have the right to participate or to decline to participate*.

Access to Case Management

GHC-SCW has multiple avenues for members to be considered for case management services including, but not limited to, the following:

- Medical management referrals that come from other organizational programs such as our health line, GHC NurseConnect, or utilization management activities
- Discharge planners from hospitals who identify members with complex conditions requiring immediate case management or with special needs
- Member or caregiver referrals
- Practitioner referrals (i.e., internal practitioners, mental health practitioners, and external specialists)
- New members identified during transitions of care as a means of providing ongoing care (medical and/or behavioral health) without interruption
- Various Business Intelligence or Epic reports (i.e., MUM0002010 hospital census, MED0008020 recent ER activity from claims, facility readmissions, specific condition reports, newly insured members, etc.)
- Risk stratification tools focus on using the potential of risk or risk status to target rising risk individuals for intervention (i.e., inpatient and ER episodes)

Information regarding the referral process and participation in GHC-SCWs Complex Case Management program is communicated to both members and practitioners in a variety of ways:

- Website https://www.ghcscw.com/health-insurance/complex-case-management
- Internally to staff on the Intranet
- Member, practitioner, and staff electronic communications and/or postal mailings
- Provider Newsletter "Practitioner Update"
- Member Newsletter "HouseCall"
  Information provided to providers during new provider orientation

Case Management is available to members who meet criteria and support is available for up to a year. The Care Management Department Manager and Case Management Team Lead may also identify cases that do not meet the current criteria per his/her discretion. Potential case management members must live in the state of Wisconsin and have GHC-SCW insurance as their primary payor. Members who have Medicare A & B as primary insurance do not qualify for GHC-SCW Case Management.

To be a candidate for ***Medical Complex Case Managemen****t*, members must:

- Be at least age 18 or older and have primary, current coverage through GHC-SCW insurance (Commercial or Exchange HMO, PPO, POS, and Medicaid HMO members) **AND**
- Have five or more chronic health conditions requiring specialist involvement **OR**
- Currently hospitalized and have a LACE score of > 10 (LACE assesses four variables to predict the risk of death or nonelective 30-day readmission after hospital discharge among both medical and surgical patients: (L) length of stay, (A) acuity of the admission, (C) comorbidity of the patient and (E) emergency department use in the duration of 6 months before admission **OR**
- Case manager individual discretion

To be a candidate for ***Behavioral Health and/or SUD Case Management***, members must:

- Have primary, current coverage through GHC-SCW insurance (Commercial or Exchange HMO, PPO, POS, and Medicaid HMO members) **AND**
- Have a diagnosis of substance abuse disorder (opioid or non-opioid) **OR**
- Have a sentinel dx of asthma, COPD, cancer, cardiac dysfunction, or diabetes **AND** have been hospitalized for an in-patient psychiatric stay within the past 2 months **OR**
- Less than 18 years old **AND** have been hospitalized for an in-patient psychiatric stay within the past 2 months **OR**
- Case Manager individual discretion

GHC-SCW's Care Management Department also offers ***Care Coordination*** for members with immediate needs who could benefit from brief intervention and coordination of care and services. These interactions are designed to be resolved within two months or less. Care Coordination is available *only* for members living with substance use disorders (SUD), behavioral health challenges, and/or a dual diagnosis. The goal of care coordination is to quickly connect members to appropriate providers and community resources. To be eligible for Care Coordination members *must* have GHC as their primary insurer. Members who do not have GHC insurance can still receive assistance through our Community Health department. At the discretion of the case manager, members who are being care coordinated may also be offered case management.

Case Management Systems and Case Management Processes are documented in policy CM.MED.039.

Experience with Case Management

GHC-SCW obtains feedback with the CCM program by evaluating experience surveys specific to case management and/or care coordination from members whose cases have closed. Member feedback helps us to determine the participants overall satisfaction with the program, including whether they achieved their goals, and their personal experience with our staff. The survey information is used to evaluate the program and work towards continuous improvement. The survey is offered to all members who have opted-in to the program and who have at least completed the initial assessment. The survey is also sent to all members who have opted-in to the care coordination program and have completed at least two phone calls with a case manager.

The Clinical and Service Quality Committee (CSQC) reviews the CCM survey results annually to evaluate program performance against stated goals. The Care Management Manager conducts a causal analysis if goals are not achieved and directs improvement initiatives as applicable.

X. PHM Impact

GHC-SCW evaluates the effectiveness of its population health management strategies by conducting a comprehensive analysis of performance against determined goals annually. Measures may focus on one segment of a population or include the entire population identified as eligible for interventions and annually include:

- One (1) clinical outcome or process measure by product line
- One (1) utilization or cost measure by product line
- Member experience with CCM (see Section IX) plus at least one other program or service offered that is relevant to members of each or one or more product line.

The measures reported shall be vetted by the organization's Director of Quality and Population Health and/or other members of the CSQC. For each measure, the impact report shall clearly define:

- why the measure is relevant
- the specifications/methodology for the data collected
- compare results with an established threshold, goal, or benchmark.

Each analysis shall trend prior performance, if applicable, and include a qualitative analysis if stated goals are not achieved. The CSQC may set new goals, recommend interventions, or develop an improvement process to increase performance, as it relates to any aspect of member experience reported or a metric under evaluation within each impact report.

XI. Acknowledgment *for significant contributions to the content of this document:*

i. Mary Ametani.....Accreditation Coordinator
ii. Lisa Behl, RN, BSN, CCM.....Care Management Manager
iii. Erica Jenson, CCM..…… Case Manager Team Leader
iv. Maggie Steiner, MHA, CPHQ.....Director of Quality and Population Health

The organizations 2023 Strategic Plan goal is for all **Triple Weighted** Metrics to achieve at or greater than the 75th percentile.

KEEPING MEMBERS HEALTHY Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric **Triple Weighted**	**Target Population**	**MY2021 Rate**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Flu Vaccination	Adult 18-64	76.76	NA	≥ 75 %	Outreach Flu Clinics
Cervical Cancer Screening (CCS)	Female 21-64	80.78 **C** 66.42 **E**	90th-95th	90th 80.37 95th 82.40	Outreach
Breast Cancer Screening (BCS)	Female 52-74	70.11 **C** 59.82 **E**	33rd-50th	75th 74.48 90th 77.73	Outreach
Colorectal Cancer Screening (COL)	Members 45+	74.94 **C** 66.67 **E**	90th-95th	90th 72.46 95th 76.16	Outreach
Prenatal (PPC)	Female Prenatal visit in first trimester	96.35 **C** 94.12 **E**	95th	95th 95.65	Outreach
Postpartum (PPC)	Female Postpartum visit on or between 7 and 84 days of delivery	95.38 **C** 94.12 **E**	95th	95th 94.62	Outreach
Combo 1 (IMA)	Adolescents who turn 13 during the MY	82.48 **C**	50th	90th 91.14	Outreach
Combo 2 (IMA)	Adolescents who turn 13 during the MY	54.01 **C**	95th	Achieve ≥ 75th	Outreach
Combo 10 (CIS)	Child turning 2 during the MY	73.72 **C**	90th-95th	Achieve ≥ 75th	Outreach
Well Child 3-11 (WCV)	Child Age 3-11	71.65 **C** 64.41 **E**	50th-66th	75th 75.16 90th 83.16	Outreach

The organizations 2023 Strategic Plan goal is for all **Triple Weighted** Metrics to achieve at or greater than the 75th percentile.

MANAGING AT RISK AND HIGH RISK MEMBERS Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric **Triple Weighted**	**Target Population**	**MY2021 Rate Or current value**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Diabetes A1c < 8.0 (HBD)	Diabetes Registry	62.29 **C** 53.28 **E**	66th-75th	Achieve ≥ 75th	Outreach Diabetes Educators Disease Mgmt.
Diabetes Blood Pressure Control (BPD)	Diabetes Registry	71.29 C	75th-90th	Achieve ≥ 75th	Outreach Diabetes Educators Disease Mgmt.
Controlling High Blood Pressure (CBP)	Hypertension Registry	78.10 **C** 74.11 **E**	95th	Achieve ≥ 75th	Outreach Disease Mgmt. Clinical Pharmacists
Asthma Control Testing Rate	Asthma Registry (Staff Model patients)	As of Dashboard Q2 2022 1995 / 5082 39 %	NA	Improve ACT MyPanel Metric among GHC practitioners to ≥ 50%	Outreach Clinical Pharmacy Asthma Educator Disease Mgmt.
Cigarette Use	Registry (Staff Model patients)	As of Aug 2022 2267 / 73923 3.07 %	NA	Decrease current smokers by ≥ 1 %	Smoking Cessation Referral Outreach

PATIENT SAFTEY Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric	**Target Population**	**MY2021 Or current value**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Opioids at High Dosage (HDO)	Opioid Use Registry	3.53 **C**	50th-66th	50th 4.12 66th 3.10	Chronic Opioid Treatment Program
Opioids MP-MP&MP (UOP)	Opioid Use Registry	0.95 **C**	33rd-50th	50th 0.75 75th 0.45	Chronic Opioid Treatment Program
Risk of Continued Opioid Use > =31 Days Total (COU)	Opioid Use Registry	1.39 **C**	75th-90th	90th 1.05	Chronic Opioid Treatment Program

OUTCOMES ACROSS SETTINGS Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric	**Target Population**	**MY2021 Rate**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service#**
Plan All Cause Readmissions **(PCR)**	HMO members who had an inpatient hospital stay ≥ 3 days	0.5013 **C**	66th-75th	90th 0.4475	Care Coordination Outreach Complex Case Management

MANAGING MULTIPLE CHRONIC CONDITIONS Commercial & Exchange				
Metric	**Targeted Population**	**Measurement**	**Percentile and/or Goal**	**Program or Service**
Percentage members indicating program helped them	HMO members opting in and enrolled in CCM	Closing Survey	80 %	Complex Case Management

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*MY2023 baselines for HEDIS Pay-for-Performance measures*** are set using MY2023 HEDIS statewide standardized averages and national HEDIS percentiles as published in 2024 NCQA's Quality Compass (MY2023 HEDIS data). An HMO will earn the highest level of performance if the HMO's rate is at or above the national 75th percentile.

KEEPING MEMBERS HEALTHY Medicaid HMO (BadgerCare Plus) Percentiles are National All LOB					
Metric **Triple Weighted**	**Target Population**	**MY2021 Rate**	**Current Percentile**	**Percentile and/or Goal ***	**Program or Service**
Prenatal (PPC) ***	Female Prenatal visit in the first trimester	93.27	95th 93.27	75th	Outreach
Postpartum (PPC) ***	Female Postpartum visit on or between 7 & 84 days of delivery	83.65	75th 81.27 90th 84.18	75th	Outreach
Combo 3 (CIS) ***	Child Age 2	56.36	10th 53.77 25th 58.39	75th	Outreach
Combo 2 (IMA) ***	Adolescent Age 13	46.40	75th 41.12 90th 48.42	Achieve ≥ 75th	Outreach
Combo 10 (CIS)	Child Age 2	43.64	75th 42.09 90th 49.88	Achieve ≥ 75th	Outreach
Well Child (WCV) Total ***	Infants & Children	48.93	33rd 45.73 50th 48.94	75th	Outreach
Well Child (WCV) 15-30 months	Child 15-30 months	58.14	10th 54.43 25th 60.53	75th	Outreach
Well Child (WCV) First 15 Months	Infant 12-15 months	42.42	10th 40.74 25th 49.82	75th	Outreach
Cervical Cancer Screening (CCS)	Female 21-64	67.40	90th 66.88 95th 69.85	75th	Outreach
Breast Cancer Screening (BCS)	Eligible Females	53.35	50th 50.95 67th 53.96	75th	Outreach

The organizations 2023 Strategic Plan goal is for all **Triple Weighted** Metrics to achieve at or greater than the 75th percentile.

* MY2023 baselines for HEDIS Pay-for-Performance measures*** are set using MY2023 HEDIS statewide standardized averages and national HEDIS percentiles as published in 2024 NCQA's Quality Compass (MY2023 HEDIS data). An HMO will earn the highest level of performance if the HMO's rate is at or above the national 75th percentile.

MANAGING AT RISK AND HIGH RISK MEMBERS Medicaid HMO (BadgerCare Plus) Percentiles are National LOB					
Metric **Triple Weighted**	**Target Population**	**MY2021 or Current Value**	**Current Percentile**	**Percentile and/or Goal ***	**Program or Service**
Diabetes A1c < 8.0 (HBD) * **	Diabetes Registry	51.19	50th 50.12 67th 52.80	Achieve ≥ 75th	Outreach Diabetes Educators Complex Case Mgmt. Disease Mgmt.
Diabetes BP < 140/90 (BPD)	Diabetes Registry	70.83	75th 67.40 90th 72.75	Achieve ≥ 75th	Outreach Diabetes Educators Complex Case Mgmt. Disease Mgmt.
Controlling High Blood Pressure (CBP) * **	Hypertension Registry	52.50	33rd 56.20 50th 59.85	Achieve ≥ 75th	Outreach Disease Mgmt. Clinical Pharmacy
Diabetes Poor A1c Control (CDC)	Diabetes Registry	38.69	50th 39.90 67th 36.98	75th	Outreach Diabetes Educators Complex Case Mgmt. Disease Mgmt.
Asthma Med Ratio (AMR) * **	Asthma Registry Age 19-50	65.71	50th 64.30 67th 68.21	75th	Outreach Clinical Pharmacy Health Ed/ Asthma Educator Disease Mgmt.
Cigarette Use	Registry (Staff Model patients)	As of Aug 2022 643 / 8021 8.02 %	NA	Decrease current smokers by ≥ 2 %	Smoking Cessation Referral Outreach

* MY2023 baselines for HEDIS Pay-for-Performance measures*** are set using MY2023 HEDIS statewide standardized averages and national HEDIS percentiles as published in 2024 NCQA's Quality Compass (MY2023 HEDIS data). An HMO will earn the highest level of performance if the HMO's rate is at or above the national 75th percentile.

PATIENT SAFTEY Medicaid HMO (BadgerCare Plus) Percentiles are National All LOB					
Metric	**Target Population**	**MY2021 Rate or Current Value**	**Current Percentile**	**Percentile and/or Goal ***	**Program or Service**
Opioids at High Dosage (HDO)	Opioid Use Registry	36.08	< 5th 20.72	75th	Chronic Opioid Treatment Program
Opioids MP-MP&MP (UOP)	Opioid Use Registry	3.01	10th 4.37 25th 2.69	75th	Chronic Opioid Treatment Program
Risk of Continued Opioid Use ≥ 31 Days Total (COU)	Opioid Use Registry	4.72	10th 6.12 25th 4.58	75th	Chronic Opioid Treatment Program
Lead Screening (LSC) ***	Child Age 2	66.36	50th 63.96 67th 70.07	75th	Outreach

* MY2023 baselines for HEDIS Pay-for-Performance measures*** are set using MY2023 HEDIS statewide standardized averages and national HEDIS percentiles as published in 2024 NCQA's Quality Compass (MY2023 HEDIS data). An HMO will earn the highest level of performance if the HMO's rate is at or above the national 75th percentile.

OUTCOMES ACROSS SETTINGS Medicaid HMO (BadgerCare Plus) Percentiles are National All LOB # PPR = % reduction in Actual to Benchmark Ratio (ABR) in the Measurement Year (MY) compared to the baseline					
Metric	**Target Population**	**MY2021 Rate or Current Value**	**Current Percentile**	**Percentile and/or Goal ***	**Program or Service**
Follow Up Within 30 Days After Hospitalization for Mental Illness (FUH) Total ***	BadgerCare Plus member age 6 years and older who had an inpatient stay for a diagnosis of mental illness or intentional self-harm	72.5	75th 67.10 90th 74.05	75th	Outreach
Plan All Cause Readmissions	BadgerCare Plus members who had an inpatient hospital stay ≥ 3 days	MY2021 0.8231	90th 0.8511 95th 0.8047	75th	Care Coordination Outreach Complex Case Management
Potentially Preventable Readmissions#	BadgerCare Plus members with readmissions	MY2021 ABR=0.9125	NA	Tier 1 with baseline ABR <= 0.95	Care Coordination Outreach Complex Case Management

The goal of the WI state PPR# Initiative is to reduce readmissions for Wisconsin Medicaid members served by HMOs to improve patient outcomes and reduce costs through discharge planning and coordination of care across sites of service.

MANAGING MULTIPLE CHRONIC CONDITIONS Medicaid HMO (BadgerCare Plus)				
Metric	**Targeted Population**	**Measurement**	**Percentile and/or Goal**	**Program or Service**
Percentage members indicating program helped them	BadgerCare Plus members opting in and enrolled in CCM	Closing Survey	80%	Complex Case Management