GHC-SCW QUALITY IMPROVEMENT PROGRAM ANNUAL REPORT
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I. GHC-SCW QUALITY IMPROVEMENT PROGRAM

**AIM:** continuously improve the quality and safety of medical and behavioral health care and the level of service provided to GHC-SCW members.

**GOALS:**

- To support and achieve company mission, vision, common values & member value proposition
- To identify clinical, service, safety and behavioral health issues of impact to plan membership & seek opportunities to improve
- To develop objectives & activities to address those opportunities.

The program is described in three sections:
- **QI SYSTEM:** summarizes concepts and how they relate to the overall program.
- **STRUCTURE:** summarizes the governance and content.
- **ANNUAL WORK PLAN:** summarizes how work plans are developed

**QUALITY IMPROVEMENT SYSTEM**

Quality Improvement engages both the organization’s employees and customers. The system relies on careful data analysis and structured tools to inform and give substantive evidence to guide improvement efforts. GHC-SCW leadership reinforces the importance of continuous improvement through innovation and emphasizes strategic goals to achieve higher levels of clinical outcomes and customer service.

**A. Customer Voice**

An important element of our quality improvement system is vigilant attention to the voice of the customer. Customer opinion is essential to continue to improve and provide high-quality service, therefore, we need to know when or how we fall short, as well as, any compliments about what we are doing well directly from the members we serve. GHC-SCW primarily utilizes Press Ganey services to gather information we value about our members clinic experiences and health plan level consumer feedback through the annual CAHPS® survey. Patient and member perspectives exert a powerful influence on consumer choice when they are making decisions about healthcare.

**B. Employee Engagement**

Employee engagement has been identified as a key driver of performance and is especially relevant in health care today, where the definition of excellence has expanded beyond clinical outcomes. Todays’ employee must focus on safety and quality, as well as the patient perception of the care experience.

GHC-SCW is striving to improve communication and collaboration within its’ workforce to optimize all aspects of the care experience. “Cooperative Experience” training has helped us raise our service levels across the organization and strengthen the cultural environment. Transformation happens when employee engagement aligns with our mission to be a personalized, patient-centered, quality driven and community involved organization where service is both celebrated and supported.
C. Data Analysis

Data analysis allows for an accurate assessment of past and current performance and provides an objective look at opportunities for continuous improvement. Our Business Intelligence team are dedicated to helping the organization achieve its’ goals by analyzing production data from new angles and different viewpoints. Raw data is transformed into actionable, understandable and informative reports. Sources include all Epic production systems such as EpicCare, Cadence, Resolute, and Tapestry among others, as well as, pharmacy data supplied by our pharmacy information clearinghouse. A data warehouse is also available that allows users guided Self-Service.

D. Enterprise Project Management Office

In 2018, GHC-SCW established an Enterprise Project Management Office (EPMO) as a central hub for intake of large projects that affect multiple areas of the organization. Time, cost, scope and quality of deliverables are the four main constraints of large-scale projects. GHC-SCW has acquired a software system called Planview to track and report on these objectives. To qualify for EPMO project manager resources, a project must have a finite start and completion date and require a minimum of 60 hours of work. Once a project is submitted, the EPMO team will initiate a scoring and prioritization process that ties to our strategic plan and goals. Vetting, approving and budgeting are important components before work begins. Senior leadership make the final decisions on which strategic projects have the largest impact and go through to completion.

E. Leadership

GHC-SCW’s Board of Directors, President and CEO and other Senior Leaders provide direction for the organization by defining our companies’ strategic goals and priorities. Leadership influences the ability to deliver on our member promise, “Better Together” by active and continuous support of the purpose, people and processes required to be a top-rated health insurance plan. Long-term success requires the convergence of system leadership, clinical caregivers and health plan employees around the strategic plan to continue our course toward future sustainability in the health insurance and care delivery marketplace.

F. Mission Statement

"The mission of Group Health Cooperative of South Central Wisconsin is to provide accessible, comprehensive, high quality health care and outstanding service in an efficient and personalized manner."

G. Vision Statement

“Our local, member owned cooperative will be South Central Wisconsin’s most trusted resource for lifelong health. We will deliver an innovative blend of high-quality primary care, specialty care and insurance. Our respected team will improve the health of diverse communities with services that are personalized, equitable, accessible and affordable.”

H. Common Values

We are innovative ~ we create a culture of openness, honesty and the freedom to generate and express new ideas which provide solutions and enhance services to members
We are quality-driven ~ we foster personalized excellence in primary care for members
We are patient-centered ~ we foster personalized excellence in primary care for members
We are community involved ~ we work to cultivate partnerships with our community by performing good deeds, and contributing to and aiding community organizations
**We are not-for-profit cooperative** ~ we empower our members to set service standards and to have “a voice” in their health care while recognizing the unique nature and opportunities of our non-profit, cooperative governance structure

**We believe:**
~Healthcare is a human right.
~In treating all people with dignity and respect.
~There is strength in diversity.
~Equity celebrates our humanity.
~We are better together.

I. GHC-SCW Value Proposition

Our cooperative offers unrivaled integration of health care with insurance and is motivated to continuously enhance the health of our member owners within the communities of south-central Wisconsin. Safe, high-quality, personalized care and service is guided by empathic, passionate professionals encompassing our value proposition of “Better Together for Lifelong Health”.

**STRUCTURE OF THE QUALITY IMPROVEMENT PROGRAM**

Oversight and Accountability:

The Board of Directors entrusts the overall monitoring of the QI Program to the President and Chief Executive Officer who assigns various components of the QI Program to the Chief Medical Officer and the Associate Medical Director of Care Management & Informatics as responsible senior leaders. The day-to-day operation of the Quality Program is delegated to the Manager of Quality and Population Health. The Medical Director for Behavioral Health and the Director of Behavioral Health and Medical Specialty Services are also involved in QI efforts associated with the operations of the Mental Health department. GHC-SCW has established the Clinical and Service Quality Committee (CSQC) as the oversight body responsible for quality improvement planning, chartering quality improvement project teams, allocating resources, monitoring the progress of QM efforts, recommending policy decisions to leaders and evaluating the results of QI activities. The Manager of Quality reports the activities of the Clinical and Service Quality Committee to the executive leadership team. The Director of BH & Medical Specialty Services participates in the Clinical and Service Quality Committee and plans and implements the behavioral healthcare aspects of the QI Program. The Medical Director for Behavioral Health serves ad hoc to the CSQC. Appendix 1 diagrams the organizations structure.

Scope:

Our QI Program is comprehensive and involves evaluating how well the health plan manages quality throughout every part of its delivery system -- physicians, hospitals, affiliated providers and administrative services. Involved professionals include medical directors, clinical staff, operational managers and others working together to emphasize LEAN principles and utilize quality management tools and approaches. The process for evaluating and improving quality is designed to incorporate two key components:

i. The use of data to assist with the delivery, ongoing monitoring and evaluation of important aspects of care and service, and continuous improvement of systems and processes.

ii. Involvement of both medical and behavioral health professionals in the analysis.
Behavioral Health QI Program:

The Behavioral Health (BH) Quality Improvement program is coordinated by the Director of Behavioral Health & Medical Specialty Services (LCSW) through the work of the Committee on Continuity and Coordination of Behavioral & Medical Healthcare and in conjunction with the Clinical and Service Quality Committee. Behavioral Health committee members include the Medical Director (psychiatrist), Director of BH & Medical Specialty Services (LCSW), the Program Manager of UW Behavioral Health & Recovery (our main substance abuse provider), a staff model mental health therapist, a mental health RN, a primary care practitioner, one social worker from Care Management (UM), a Pharmacist, a mental health therapist (LCSW) from a UW Department of Family Medicine clinic, a clinical information analyst, the Accreditation Coordinator and administrative support staff. The committee reviews BH HEDIS® measures and behavioral health reports, conducts quantitative and qualitative analyses, and develops action plans to address barriers. Examples of behavioral health QI activities are:

- Outreach to members on anti-depressant medications
- Follow-up of members hospitalized due to mental illness to ensure outpatient care
- Outreach to members/practitioners related to members diagnosed with substance use disorders
- Outreach to members/practitioners related to Attention Deficit Hyperactivity Disorder
- Information to new mothers about post-partum depression
- Evaluation of members with co-existing medical and behavioral conditions
- Analysis of HEDIS® results related to behavioral health
- Standardization of symptom measurement for depression (PHQ-9) and anxiety (GAD-7) across primary care and mental health with common access to data in EMR.
- Motivational interviewing and Screening, Brief Intervention, and Referral to Treatment (SBIRT) training
- Conducting member experience surveys across all levels and settings of BH care

Health of our Community

As a non-profit, consumer sponsored HMO, GHC-SCW is committed to achieving public health goals. The Wisconsin Department of Health Services (DHS) Healthy Wisconsin initiative is the state’s strategic plan to improve issues affecting the health of Wisconsin families. The five priority areas for improving health by 2020 encompass Alcohol, Nutrition and Physical activity, Opioids, Suicide, and Tobacco.

DHS has enlisted the help of organizations across the state working closely on these issues and invited GHC-SCW, as one of three insurers, to present to the Governor’s Task Force on Opioid Abuse. Our Chief Medical Officer presented information about the multi-year effort and successes at our health plan to address opioid safety. Other GHC-SCW initiatives to help achieve a Healthy Wisconsin comprise the work of our outreach staff who are engaging current smokers with cessation efforts in collaboration with the UW Center for Tobacco Research and Intervention. Another example, an approach that aligns with the Safe Communities’ Zero Suicide Collaborative to reduce suicide rates in Dane County, consists of screening all patients 18 years and older for depression at target clinical visits as recommended by the US Preventative Services Task Force.

In addition, GHC-SCW is a participant of the Healthy Dane collaborative comprised of four hospitals and Public Health of Madison and Dane County to assess community health needs. The cooperative has also been an active participant for several years in the federal program, Vaccines for Children, and locally with the Dane County Immunization Coalition, to insure all citizens of Dane County are appropriately immunized against vaccine preventable diseases.
Employee Health and Patient Safety

GHC-SCW patient care is better and safer through our patient-centered care models. An internal committee focuses on clinical safety training, employee health requirements (i.e. TB testing and flu vaccinations), monitoring occurrence reporting and/or member complaints related to safety in the clinical environment, in the pharmacy system or during transitions in care.

Committee Structure

Our quality program structure, including the main committees, is outlined in Appendix 2. Leadership of these various committees has been delegated by GHC-SCW’s President and CEO or the Chief Medical Officer. These standing committees are the central part of the QI program and are designed to continuously screen and review information about quality and address a wide range of improvement opportunities. The programs committees are summarized in the following appendixes:

- Appendix 3: Clinical and Service Quality Committee
- Appendix 4: Peer Review Committee
- Appendix 5: Clinical Content Committee
- Appendix 6: Employee Health and Patient Safety Committee

A new Quality Committee (Appendix 7) launched in October of 2018 to provide high-level oversight of GHC-SCW owned clinic improvement projects. Future project proposals will be reviewed by this group for feasibility, scalability, timing and status monitoring. The Pharmaceutical and Technology Assessment Committee is integral to organizational UM processes including delegation oversight. Other committees vital to our process improvement are:

- Cooperative Experience
- Hypertension
- Asthma
- Diabetes Improvement
- Health Equity
- Immunizations
- Hospital Readmissions
- Pain Committee
- Continuity and Coordination of Medical and Behavioral Healthcare
**Credentialing**

GHC-SCW credentials all medical doctors, DOs, oral surgeons, DPMs, DCs, NPs, PAs, ODs, physical therapists, speech language therapists, optometrists, podiatrists, & chiropractors who are under contract to provide services to GHC-SCW. Behavioral health practitioners requiring credentialing are defined as:

- Physicians and psychiatrists (MD or DO) or doctorate psychologists (PhD or PsyD)
- Advanced Practice Nurse Prescribers (APNP)
- Masters or doctorate level Licensed Clinical Social Workers (LCSW)
- Licensed Marriage & Family Therapists (LFMT) Licensed Professional Counselors (LPC) or licensed Clinical Substance Abuse Counselors (CSAC) certified to practice independently.

The Peer Review Committee makes recommendation for approval to the Chief Medical Officer.

**Evaluation of the QI Program**

GHC-SCW is uniquely positioned to achieve our quality vision thanks to the excellence of our practitioners and providers, our ability to efficiently and effectively organize care around patient populations, and the use of technology to support personalized care. Our QI program summary and evaluation is compiled annually and includes a comprehensive overview of work plan objectives, organizational initiatives and impact of the QI program including progress toward influencing safe clinical practices throughout the delivery system. Work plan evaluations are primarily reviewed by the Clinical and Service Quality Committee to determine areas that need further improvement or have been appropriately addressed.

**Committee Meeting Documentation**

GHC-SCW generates agendas and minutes for all committees and any related subcommittee meetings.

**Quality Program Resources**

The QI Program has support from GHC-SCW’s President and Chief Executive Officer. The Chief Medical Officer and the Associate Medical Director of Care Management and Informatics play key roles in the QI program. A Quality and Population Health Manager, Accreditation Coordinator, Quality Analyst, Wellness Department and Population Health outreach coordination staff make up a diversified team and have a range of expertise. The program is further supported by sophisticated information systems, electronic medical records and software tools available for quantitative data assessment to aid in improvement initiatives.

**Objectives for serving a culturally and linguistically diverse membership**

GHC-SCW is dedicated to delivering culturally and linguistically appropriate care for our members. The goal is to ensure staff and practitioners have the skills and tools needed to provide culturally competent communication and health care that recognizes and tries to eliminate health disparities whenever possible. Our objectives are:

- To identify and conduct targeted interventions that focus on risks associated with race, ethnicity, or other social determinants of health
- To reduce disparities and provide services regardless of sexual orientation or gender identity
Some examples towards these objectives are:

- Member of the Dane County Health Council, a leadership group dedicated to eliminating gaps and barriers to optimal health and improving health outcomes for all
- Proud sponsor for Centro Hispano of Dane County to help strengthen Latino families
- Sponsorship for the Hmong Language and Cultural Enrichment Program
- Partner with Foundation for Madison’s Public Schools “Adopt a School” Literacy Program
- Support of African American Breastfeeding Alliance of Dane County
- YWCA Equity and Inclusion Trainings (1) Understanding Social Identities, Privilege, and Oppression and (2) Racial Justice Series

**Collaborative Activities**

EPIC®, which provides our EMR and MyChart infrastructure, is a key collaborator and supplier. Epic Link, Care Everywhere and Share Everywhere functionality provides secure EMR access to providers and permits physicians to collaborate across practice sites and between legal entities (e.g. facilities and medical groups) to share patient histories related to their health care.

GHC-SCW is collaborating with the UW Center for Tobacco Research and Intervention on a grant project to increase tobacco cessation among our patients.

Edgewood College partners with GHC-SCW in educational learning opportunities as nursing students link their nursing theory to real time experiences in a variety of situations through clinical rotation in a primary care setting. Other standing collaborations include Healthy Dane public health partners, the Dane County Health Council, UW Endocrinology for diabetes care, UW Center for Clinical Knowledge, EPIC® User Groups, UW Department of Family Medicine & Dental Health Associates.

**ANNUAL QUALITY WORK PLAN**

The Clinical and Service Quality Committee, CSQC, is responsible for reviewing and approving the annual QI Work Plan. Multiple sources are used to identify potential improvement projects based on continuous analysis of information which comes to staff and standing committees through member experience surveys, HEDIS® or CAHPS® data, NCQA reports, observed needs or problems, member complaints or the evaluation of errors or events. The final decision on the priority of projects in the annual work plan is made by QM leadership and takes into consideration the organizations strategic plan. In this manner, staff are working on and contributing to a "living work plan", in which objectives and activities may be adjusted as needs change based on measurement of effectiveness, business planning or budget constraints. Designated team leaders or subcommittee members report periodically to QM leadership and the CSQC as appropriate. Six categories of focus have been prioritized:
i. **Quality of Clinical Care**: Aim to improve clinical processes and outcomes as well as health promotion and disease management across staff model and non-staff model delivery systems

ii. **Behavioral Health Care Quality**: Aim to improve on processes and outcomes of behavioral health care provided across staff model and non-staff model delivery systems

iii. **Quality of Service**: Aim to improve on clinical and health plan processes to positively impact member and employer group satisfaction and overall organizational service quality

iv. **Safety of Clinical Care**: Aim to maximize safe clinical practices by reducing risks

v. **NCQA Accreditation & Compliance**: Aim to meet the expectations of our members, employer purchasers and those that regulate the industry

vi. **Financial Health**: Aim to maintain a sustainable organization and optimize value in care delivery

**II. 2018 ANNUAL SUMMARY**

**A. Introduction**

At Group Health Cooperative of South Central Wisconsin, we are working diligently to live up to our member’s expectations. We know that to best serve our members, we need to deliver quality care, affordable coverage, and a member experience that is patient centered. Within this report, we reflect on some of the highlights and accomplishments of 2018.

On January 26, Dr. Mark Huth signed the Joint Operating Agreement (JOA) between GHC-SCW and the University of Wisconsin Hospital and Clinics and Unity Point-Meriter. This historic agreement makes it much easier administratively for our members to choose either UW, an academic facility, or Meriter hospital, for their care. The JOA also incorporates risk sharing as a value-based payment structure that is helping to shape the future of our payment arrangements with our long-term partners.

As the calendar year turned over, the Patient Experience Committee made the decision to change their name to the “Cooperative Experience” committee with the goal to stay member focused. A new series of learning and development classes were rolled out for all employees facilitated by trainers from across organizational departments to Anticipate, Communicate and Sustain.

GHC-SCW continues to build our cooperative for the future using our strategic plan for the next 5 years. Seven **Driving Strategies** serve as the roadmap for what we have planned to accomplish.

1. Deepen key partnerships to further enhance our quality, access, member satisfaction and affordability.
2. Innovate to be the leader in the delivery of care in a primary setting.
3. Enhance access and equity for our services.
4. Partner with employers to develop comprehensive solutions that reduce their total cost of care.
5. Foster an environment that supports, challenges and empowers our team.
6. Diversify and solidify our sources of positive revenue, improve efficiency and strengthen our capital base.
7. Continue to build awareness and preference for our integrated cooperative model.
Our strategic plan will be brought to fruition through active planning and internal discussion about our direction, as well as, through teamwork behind these initiatives. As a non-profit medical delivery system and health plan, GHC-SCW is committed to the Institute for Health Care Improvement’s Triple Aim: improving health, enhancing the patient experience and making health care more affordable. The QI work plan strives to frame projects around the Triple Aim by applying efforts toward opportunities to improve clinical quality and the patient experience and implementing concepts and strategies to lower costs for our members and the organization.

B. Overview

Operational Recognition and Achievements

- GHC-SCW retained “Excellent” NCQA Accreditation status for the commercial product line. Our cooperative enjoys a rich history of accomplishments in quality improvement and takes pride in maintaining this status since 1995, marking our 23rd consecutive year.

- GHC-SCW's Marketplace HMO product line remains "Accredited" through July 2019; this allows the organization to continue participation on the federal exchange under the Affordable Care Act and the Center for Medicaid and Medicare Service requirements as a Qualified Health Plan issuer.

- GHC-SCW is 1 of 2 commercial health insurance plans in the US rated 5 out of 5 in NCQAs Private Health Insurance Plan Ratings for 2018-19. NCQA rated more than 1000 plans nationally including commercial, Medicare and Medicaid. This achievement reflects the persistent commitment GHC-SCW has toward continuous high-quality health care.

- GHC-SCW is the top-rated HMO in Wisconsin in NCQAs Private Health Insurance Plan Ratings for 2018-19.

- GHC-SCW’s six staff model clinics are Level III Patient Centered Medical Homes recognized by NCQA through 2020. The NCQA Patient-Centered Medical Home standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement.

- GHC-SCW was presented with two Exceptional Community Leadership Awards at the 100 Black Men of Madison Annual Ceremony

- GHC-SCW introduced Wisconsin’s first money back experience guarantee in 2018. Every healthcare organization in our market promises great care and service however our cooperative is the only health plan in our area who offers this new innovative approach.

HEDIS® & CAHPS® Performance: Measurement Year 2017

Per reporting by the Alliance of Community Health Plans (ACHP), the health plan achieved or maintained above the 90th percentile in:

- 12 of the 21 Clinical Treatment scores
- 8 of the 11 Access and Prevention scores
- 2 of the 7 Service scores
GHC-SCW ranked # 1 out of the 17 plans in Wisconsin in Effectiveness of Care, Respiratory Health, Prevention, Child and Maternal Health and Plan Satisfaction. GHC-SCW ranked # 4 in the Nation and in the top 1% in our Total HEDIS® and CAHPS® Scores out of 382 Commercial plans. Consumer Experience, Provider Satisfaction and Getting Care remain important focus areas for needed improvement in the years ahead.

The table below, a reproduction of the ACHP Dashboard Ratings Report, displays these rankings for GHC-SCW’s Commercial HMO. Analyses in the table do not include NCQA accreditation scores which account for 10% of the plans final rating result.

<table>
<thead>
<tr>
<th>HEDIS 2018-19</th>
<th>National Percentile</th>
<th>Rating</th>
<th>National Rank (Out of *)</th>
<th>ACHP Rank (Out of)</th>
<th>State Rank (Out of)</th>
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</thead>
<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>98</td>
<td>4.3</td>
<td>10 (381)</td>
<td>6 (42)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>-Treatment</td>
<td>96</td>
<td>4.07</td>
<td>16 (379)</td>
<td>8 (42)</td>
<td>3 (17)</td>
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<tr>
<td>-Diabetes</td>
<td>91</td>
<td>4.22</td>
<td>16 (379)</td>
<td>6 (42)</td>
<td>6 (17)</td>
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<tr>
<td>-Cardiac</td>
<td>99</td>
<td>4.8</td>
<td>2 (379)</td>
<td>2 (42)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>-Respiratory Health</td>
<td>100</td>
<td>4.6</td>
<td>2 (376)</td>
<td>1 (42)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>-Mental Health</td>
<td>94</td>
<td>4</td>
<td>22 (373)</td>
<td>7 (41)</td>
<td>2 (17)</td>
</tr>
<tr>
<td>-Prevention</td>
<td>99</td>
<td>4.73</td>
<td>5 (381)</td>
<td>3 (42)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>-Child &amp; Maternal Health</td>
<td>100</td>
<td>5</td>
<td>1 (372)</td>
<td>1 (41)</td>
<td>1 (17)</td>
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<table>
<thead>
<tr>
<th>CAHPS 2018-19</th>
<th>National Percentile</th>
<th>Rating</th>
<th>National Rank (Out of *)</th>
<th>ACHP Rank (Out of)</th>
<th>State Rank (Out of)</th>
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</thead>
<tbody>
<tr>
<td>Consumer Experience</td>
<td>82</td>
<td>3.71</td>
<td>68 (378)</td>
<td>13 (42)</td>
<td>3 (17)</td>
</tr>
<tr>
<td>-Provider Satisfaction</td>
<td>82</td>
<td>3.75</td>
<td>67 (375)</td>
<td>14 (42)</td>
<td>5 (17)</td>
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<tr>
<td>-Getting Care</td>
<td>60</td>
<td>3</td>
<td>148 (368)</td>
<td>18 (42)</td>
<td>8 (17)</td>
</tr>
<tr>
<td>-Plan Satisfaction</td>
<td>100</td>
<td>5</td>
<td>1 (378)</td>
<td>1 (42)</td>
<td>1 (17)</td>
</tr>
</tbody>
</table>

* scores change because some plans did not report a sufficient number of measures in the category

HEDIS® and CAHPS® priorities are selected based on the following criteria:

- Measures with small denominators where small changes in compliance can result in large changes in performance
- Triple weighted outcomes measures or lowest performing
- New measures that impact scoring for the commercial product line

Measures related to re-admissions (PCR) and glucose control for diabetics (CDC) continue to be areas of focus. ADD and APM were also identified as additional measures that need attention.

**Health Management**

- In 2018, a hotline opened allowing primary care doctors and other providers in the state to consult with addiction experts. The hotline, funded by a grant from the WI Department of Health Services (DHS), offers daily on-call help to providers who seek support and direction for their patients’ substance abuse problems.
- GHC-SCW’s partnership with the UW Center for Tobacco Research and Intervention grant enabled the hire of two Outreach Specialists who pro-actively engage cigarette smoking
members in setting a quit date, connect them to resources, and enable their success. The program is ongoing in all staff model clinic sites and continues in various stages of progress.

- GHC-SCW continues to recommend the YMCA Diabetes Prevention Program (DPP) for members age 40 to 70 at risk. A Result BPA appears in In-baskets if the patient’s A1c or Fasting Glucose indicates prediabetes. The certified YMCA program includes small group activities that encourage healthier eating and increased physical activity.

- SmartTools available in EMR help with patient outreach related to screening and prevention. Electronic bulk communication and ordering tools assist clinical care teams in communication of prevention or care gap notifications and in placing orders for overdue tests or needed labs.

Safety of Clinical Care

GHC-SCW is improving patient safety by:
- Reviewing and responding to quality of care complaints and patient safety concerns in accordance with established policies and procedures
- Identifying opportunities to improve continuity and coordination of care of medical care and between medical and behavioral health care

Lab Improvements

GHC-SCW’s Laboratory Department went through a successful upgrade to its software systems in 2018. The new SOFT AR software enhances the detail and the accuracy of tests being collected and performed. The upgrade went smoothly with minimal disruption to care. This is one example of the good work we are doing to move our workflows and systems to a more robust clinical format to improve care and have clearer communication for accuracy.

Occurrence Reporting Database

GHC-SCW’s occurrences of harm in our clinics remain low and risks are also low. Employees are encouraged to file reports of concern for safety, medication management, ordering processes, workflows, "near misses or almost events" through the Occurrence Reporting link on the organizations’ intranet. Based on the filed reports, patient safety projects may be initiated.

Opioid Safety Program

GHC-SCW continues to impact the abuse or overuse of opioid medications and help members to identify alternative pain control options. Our aim is to manage to safe levels and offer additional multidisciplinary therapies with a focus on function not complete elimination of pain. Patients who previously received higher doses of opioids are navigating the mindful road in close collaboration with their primary care providers to taper down to safer levels. Through perseverance with difficult conversations and engaged supportive care, GHC-SCW has continued to decrease the highest risk, highest-dose members to safer levels and reduce the amount of medication prescribed overall with steady declines in our average Daily Morphine Equivalents. A Peer Review Subcommittee meets monthly to investigate safety concerns identified with internal prescribers. Recommendations are issued, as needed, based on clinical best practice and organizational opioid policy.
e-Prescribing for Scheduled Medications

GHC-SCW has engaged in the use of electronic (paperless) transmission of prescriptions for controlled substances since December of 2015. The use of this sophisticated technology allows for safer and more secure provider specific prescribing minimizing the risk of prescription forgery and lost or stolen paper prescriptions. The State of Wisconsin implemented a process for all prescribers of Schedule II-V medications to have the state’s Prescription Drug Monitoring Program (PDMP) database checked prior to prescribing scheduled medications. Programs such as the PDMP have been set up for accountability from a governmental standpoint. GHC-SCW has integrated our EMR with the PDMP allowing clinical staff to more efficiently access the database for patient information.

Employee Influenza Vaccinations

Group Health Cooperative is a community leader in our efforts to prevent disease through a strong vaccination program which also ties into antibiotic stewardship. Along with many other Wisconsin providers, we have dramatically reduced health care associated infections through these efforts. All personnel are required to receive an annual influenza vaccination as a condition of employment per policy HR. EH.014. The Wisconsin Healthcare Influenza Prevention Coalition encourages implementing an evidence-based vaccination initiative for all personnel. GHC-SCW joins other Dane County and Wisconsin clinics, hospitals, home health agencies, nursing homes, and pharmacies in their mandatory influenza vaccination policies.

Safety Initiatives within Pharmacy

Medication errors remain very low due to the training and education of pharmacy staff. The Clinical Pharmacy Team helps patients with medication reconciliation, transition of care and optimization of pharmaceutical treatments, working closely with both the care teams and patients directly. The impressive work of our Clinical Pharmacists to improve hypertension treatment performance and statin adherence with patients at risk for stroke and heart disease attracted national attention as a Best Practice presentation at the first NCQA Health Care Quality Congress in Dallas in October of 2018.

Quality of Service

- Achieved performance at or above the 90th percentile in the following 2018 CAHPS® measures:
  - Rating of All Health Care
  - Rating of Health Plan
  - Customer Service Composite

- Launched the GHC Experience Guarantee SM, a promise that every patient and member have the best experience. The Guarantee ensures every experience at a GHC-SCW owned and operated clinic that fails to meet expectations in any way, will be refunded of some or all out-of-pocket costs associated with the visit, a developmental first in Wisconsin healthcare.

- After-Visit Summaries (AVS) now contain contact information to direct members to a Patient Financial Coordinator (PFC) if needing to request an estimate for services rendered. The AVS will also print in Spanish for patients who have identified Spanish as their preferred language.

- New ADA compliant Check in Kiosks improve service that have CHIP card readers for payment and ask to obtain Emergency Contact information.
- MyChart: Members can now pay either a premium or medical bill using a credit card, debit card or their bank account and view benefit accumulations i.e. deductibles or MOOP.

- Food insecurity and housing questions were added to the Pregnancy Questionnaire completed by RN’s following a positive pregnancy test to help address these social determinants of health.

- GHC-SCW has trained 26 clinical care team staff as Outpatient Breastfeeding Champions in our Lactation Program. Newborn Feeding Assessments for infants up to 30 days old give added information about feeding options and access to formula or adequate amounts of breastmilk in supplement to Care Team staff weight checks.

- PHQ-9 screening tools translated into several additional languages (i.e. Hmong, Arabic etc.) were made available as clinical resources for primary care and mental health staff.

### Quality of Clinical Care

- GHC-SCW is participating in a pilot with YouScript® for genetic testing on how individuals metabolize pharmaceutical medications involving our clinical pharmacist team. The service is designed to help with medication choices that are more effective or offer less adverse reactions for patients.

- Osteopathic Manipulation Treatments become available at East and Capitol Clinics for treating acute to chronic musculoskeletal based pain.

- Introduced an innovative pilot Physical Therapy approach with Kiio Inc. to engage select members with mild back pain using curated PT regimens on smartphones to help patients progress through a series of steps to regain a healthy back.

- Nursing staff have been working to promote safe transitions for our members from the hospital to home with a goal of reducing our readmission rates by providing a phone call to the member within 48 to 72 hours of discharge for the most at-risk types of admissions. Every time we help a member succeed at managing their health, without entering the hospital, we support the overall health of our cooperative and our community.

- Strategies designed around registry-based preventative care gap closure, registry-based chronic disease care, care coordination and Complex Case Management encompass the four Population Health management focus areas defined by NCQA.

### Financial Health

For the last several years, our Board and executive leadership have focused on financial sustainability that has helped add to the cooperatives’ financial reserves. These reserves, in turn, assist in emergencies such as the unforeseen event that shut down operation of our Sauk Trails Clinic in 2018. As the recovery process evolved, temporary facilities were necessary to accommodate displaced staff and help centralize access to some services over this extended period. Managing costs associated with outside laboratory processing fees has been difficult following the forced closure of the Sauk Trails Central Lab facilities. Increases in high cost claims and stock market volatility in 2018 have also been impactful to operating margins.
Plans to incorporate disaster mitigation at the Sauk Trails location will provide a safe and accessible building when it reopens sometime in 2019. GHC-SCW’s financial health, along with FEMA assistance, are allowing us to recover from this incident without a major impact to long-term viability. Strategies for management of expenses remain key to help rebuild from incurred losses.

Our medical group remains central to our ability to provide quality care and service at a lower cost within our owned and operated clinic system. Capital investments in our facilities designed to expand and improve workspace for our clinical staff and to enhance sites for members were fully completed at our East clinic site. Progress at the De Forest site is delayed while we focus on Sauk Trails re-opening and examining options for a new Central Lab build-out. Given the ongoing marketplace changes and the increasing expectation from employers for health insurance premium relief, the new year will remain challenging. The 2019 operating and capital budgets were approved by the Board in December.

**NCQA Accreditation & Compliance**

The National Committee for Quality Assurance is a private, not-for-profit organization dedicated to improving health care quality. Accredited health plans today face a rigorous set of standards and must report on their performance to earn NCQA’s seal, a widely recognized symbol of quality. The Accreditation process evaluates how well a health plan manages quality throughout every part of its delivery system to continuously improve. The accumulation of the NCQA accreditation score and the HEDIS and CAHPS scores add up to determine the overall rating of the plan. HEDIS® is a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare the performance of managed health care plans and is a registered trademark of NCQA. CAHPS® is a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care and is a registered trademark of the Agency for Healthcare Research and Quality. These measures and standards serve as tools to identify opportunities for improvement for the following years.

GHC-SCW remains NCQA accredited and is preparing for our 2019 submission deadline. NCQA recertifies organizations every 3 years via an off-site review of documentation, as well as by visiting on location, to review random examples of the plans case management, utilization management and appeal files and credentialing documentation.

**Employee Engagement and Recognition**

At GHC-SCWs Winter Gathering several individuals were recognized for the amazing support they give to our members and to each other as a team. Nominations from peers are solicited for the Helen Parrish Award. Winners in 2018 were Oliver E., Nettie B., Alicia H. and East Clinical Pharmacists Dan P., Jill P. and Tera K. PCMH Certificates were also handed out to clinic leaders.

In spring, company employees attended the All Staff Meeting. Dr. Huth, had informative news about improving patient satisfaction scores, NCQA quality scores and a positive financial outlook. Presentations about being “Thoughtfully Fit” from Darcy Luoma and how to escape adulthood and stave off “Adultitis” from Jason Kotecki inspired with humorous tips for dealing with stress.

A new Quality and Population Health Manager, Margaret S, joined GHC-SCW in the summer of 2018. She brings new enthusiasm to the role and the organization looks to her to lead these respective areas with fresh insight. Throughout the year, Primary Care Conferences provide a venue to obtain information related to health plan operations or changes in our clinics and patient care environments. Quality staff also participate on various committees which focus on the objectives of the work plan, accreditation requirements or other initiatives.
C. Challenges in 2018

On the evening of August 20th, GHC-SCW was impacted by torrential rainfall over the course of hours that flooded and forced the closure of our west Madison Sauk Trails Clinic. Services affected included Primary Care, Mental Health, Complementary Medicine, Chiropractic, Pharmacy, Central Lab and Call Center. The lower level of the building, home to our Central Lab, was a complete loss. Patients and staff were trapped inside the building during the storm requiring evacuations. Remediation teams were needed to assess damage. Relocations were assigned for all staff from Sauk Trails Clinic and Primary Care schedules had to be built at new locations. This was a very difficult, emotional and challenging situation that highlighted the resilience of our leadership team and the support of staff to continue to serve our members in the face of adversity. Other challenges throughout the year included:

- Managerial changes in Quality, Population Health, Contracting, Sales, Revenue Cycle, Chief Human Resources Officer, Health Information and Privacy
- Construction projects at East and De Forest Clinics
- Replacement of equipment and supplies lost in the flood
- Generating new sales and securing renewals of employer groups
- EMR and other IT infrastructure upgrades
- Budget constraints and business financial objectives
- Outreach and engagement across our network
- Improving the consumer experience
- HEDIS, Meaningful Use and MIPS reporting
- Variable subsidies associated with the Affordable Care Act
- Preparation for NCQA accreditation renewal

D. Reflections on Overall Effectiveness

Annually, the overall effectiveness of the QI program is assessed. The intent of the process is to determine whether areas identified as needing improvement have been appropriately addressed, established indicators adequately assess the performance of the organization’s quality of care and service, and objectives are being accomplished. This includes review of committee structure and leadership involvement to ensure adequacy of resources. Workplan development considers overall strategic planning, as well as, input from various committees, partners or collaborations. Detail of the organizations yearly Work Plans are provided in Section IV.

Throughout most of 2018, the organization has been working diligently on an Epic® systems upgrade that will be continuing into the new year. Infrastructure upgrades are costly and time-consuming, however, assure our health plan and clinic practices are up-to-date with system improvements that impact the effectiveness of health plan operations and the safety of clinical care network-wide. Other impactful initiatives have included competent opioid prescribing and developing tapering plans in collaboration with our community partners, compliance with WI state prescription drug monitoring requirements and outreaching members following hospital discharge to coordinate and review care. Annual assessment of our member population including social determinants of health and development of a population health management strategy with defined goals is helping the organization to focus on member needs in four priority areas:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses
GHC-SCW remains resolute in our vision of affordable, high quality, patient-centered care with achievements in most of the clinical, behavioral health, safety and service goals outlined in our work plan. Review of the activities in Section II and the project evaluations in Section III serve to demonstrate that the organization remains committed to attain the goals of the Triple Aim. GHC-SCW also feels strongly that attaining work-life balance, often referred to as the Quadruple Aim, is fundamental for cooperative employees for we know even within the best-performing health care organizations, staff burnout has a direct negative effect on the experience of care for the patient. From our commitment to a non-profit, member-owned cooperative care model to the investments made in the benefits and the well-being of our employees, GHC-SCW believes in a culture of exceptional care and quality.

III. EVALUATION OF 2018 WORK PLAN PROJECTS

QUALITY OF SERVICE

Outreach Processes

Background

Improvements to outreach processes, materials and methodologies began in early 2016. Healthy Planet tools including registries, Reporting Workbench reports and My Panel metrics are currently in use and are a part of our Population Health management strategy.

Goals

- Review outreach reporting processes for improvement opportunities
- Shift patient outreach to clinical care teams using reports within the EMR
- Expand outreach to non-staff model members

Interventions

- Hired new Quality and Pop Health Manager and administrative personnel
- Reviewed reports for inclusion and exclusion criteria
- Utilized messaging within MyChart to decrease mailings when appropriate
- Incorporated tools for bulk ordering and messaging to support outreach by the care teams

Barriers

- Transition and learning curve between former and current staff
- Continuing to reinforce bulk ordering and messaging tools with care teams
- Implementing Caboodle to more effectively outreach to non-staff model HMO members

Conclusions

The use of provider dashboards, reporting workbench and population health tools have improved outreach processes to staff model clinic members by care teams for preventive services. Processes to implement Caboodle are still under construction and full functionality is being considered a long-term IT project.
Promoting Health Equity and Health Literacy

Background

GHC-SCW’s Health Equity Committee (HEC) was revitalized in 2015 and led to the development of an organizational strategic plan known as the “Roadmap for Health Equity 2017-2019”. An 11-member Inclusion Change Team was formed in April 2018 that consists of dedicated employees from a variety of roles, leadership levels, and backgrounds. Together they serve as a multiracial, intercultural leadership council committed to driving the health equity agenda forward. As a cooperative that values high quality patient-centered care, we are challenging our staff to be responsive to inequities, income and educational attainment differences, health or other personal behaviors, stereotypes, and racism. We are working to overcome these barriers.

Goals

• Improve the health of populations that GHC-SCW serves by reducing health outcome disparities
• Pursue innovative ways to promote health literacy, develop a culturally competent workforce and nurture an inclusive work environment
• Provide a safe and open space where issues related to equity, inclusivity and cultural diversity can be discussed and addressed

Interventions

• Provided Sexual Orientation and Gender Identity (SOGI) Training for clinical staff
• Implemented SOGI Smart Form in EMR to aid organizational staff in capturing sensitive, critical information about members who are in various stages of gender transition
• Partnered with the YWCA Madison to help us reach our diversity, equity and inclusion goals
• Professional development training in Health Equity, Diversity and Inclusion for all employees
• Four “We Believe” statements that speak to the heart of our mission and values became permanent installations in our buildings. The statements are displayed in the six most frequently spoken languages of our membership: English, Spanish, Hmong, Mandarin Chinese, Tibetan and Arabic

Conclusion

The GHC-SCW Health Equity Committee felt it was important to show our community and our members what we stand for and what should be expected. The “We Believe” statements are the result of the committee’s important work and have become a foundational element to our Common Values. Members of our Health Equity Committee made a video explaining what these statements mean to them. The video is available HERE. Future objectives are to pursue Health Equity Index recognition from the Human Rights Campaign and to strengthen community partnerships through increased presence in underserved communities.
Improvement of Consumer Experience

Background

GHC-SCW has in past years struggled to achieve optimal patient and member experience scores based on both health plan survey and patient survey data. A workgroup was convened that identified activities targeting both our clinic and administration sites. In 2018, the workgroup chose to change their name from Patient Experience to the “Cooperative Experience” Committee.

Goal

Improve the overall Consumer Experience rating = 4 stars as measured by the Consumer Assessment of Healthcare and Provider Survey (CAHPS) to within the 66th-90th percentile.

GHC-SCW performed well in the following measures from the 2018 CAHPS survey:

- Rating of All Health Care – between the 90th and 95th National Percentiles
- Rating of Health Plan – between the 90th and 95th National Percentiles
- Customer Service – between the 90th and 95th National Percentiles
- Shared Decision Making – between the 75th and 90th National Percentiles
- Rating of Personal Doctor – between the 75th and 90th National Percentiles
- How Well Doctors Communicate – between the 66th and 75th Percentiles

Measures with scores below the 66th National Percentile included the following:

- Rating of Specialist Seen Most Often – between the 50th-66th National Percentiles
- Getting Needed Care – between the 50th and 66th National Percentiles
- Getting Care Quickly – between the 50th and 66th National Percentiles
- Plan Information on Costs – between the 50th and 66th National Percentiles
- Coordination of Care – between the 50th and 66th National Percentiles
- Health Promotion and Education – between the 10th and 25th National Percentiles

Barriers:

- Health Promotion and Education: limited time within an appointment to address all health concerns and continue to promote ways to prevent illness
- Rating of Specialist: impacting experience with specialists housed outside of GHC-SCW clinics.
- Getting Needed Care: Services such as optometry, radiology and lab facilities at different clinic locations can create difficulties receiving convenient needed care, treatment or tests
- Getting Care Quickly: ability to impact experience at the delivery level with external providers
- The lag time of reported CAHPS results (a half year after the measurement period) presents a barrier to immediately address issues and measure the effectiveness of interventions

Interventions:

- Cooperative Experience trainings developed through research by Press Ganey were rolled out and made mandatory for all staff, both clinical and non-clinical. These trainings provide the language and tools that promote a culture of service excellence
- Monthly Cooperative Experience exercises with staff help brainstorm situations in how to lead conversations with language that conveys confidence and trust
- Improved reports and the data sharing process to better reflect the progress being made
Conclusion
Work facilitated by the Cooperative Experience Committee has been an integral piece of the improvement in the health plans ratings score over the last three years. The overall Consumer Experience rating for the commercial HMO increased from 3.0 to 3.5 in the 2016-17 ratings and remained at 3.5 throughout 2017-18. Currently, the 2018-19 Consumer Experience rating for the commercial HMO is 3.5 and although we did not yet achieve goal, overall trends have risen, and we remain committed to impact consumer experience.

QUALITY OF CLINICAL CARE

Hypertension and Diabetes Outcomes

Background
GHC-SCW created an automated registry within the EMR system used in staff model clinics in the summer of 2015. This registry enabled clinics to retrieve specific reports to identify which of their patients may be overdue for a primary care visit, A1c lab test, or blood pressure check. Work continues amongst care teams and our Hypertension and Diabetes Improvement Committees to close gaps in care. The Quality department continues to work closely with clinical staff to refine strategies for improving HEDIS measures.

Goal for Diabetes CDC Rates
- Improve annual A1c testing among the 18-75 age group to 95%
- Improve A1c control < 8.0% to reach 67-70%
- Maintain BP control <140/90 at 80% or greater

<table>
<thead>
<tr>
<th>HEDIS Rates by Measurement Year (MY)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP control (&lt; 140/90 mm Hg) 18-75 yrs.</td>
<td>74.45</td>
<td>77.55</td>
<td>80.66</td>
<td>81.57</td>
<td>82.85</td>
</tr>
<tr>
<td>HbA1c control (&lt;8.0%) (first year indicator)</td>
<td>59.31</td>
<td>54.9</td>
<td>59.67</td>
<td>61.13</td>
<td>56.02</td>
</tr>
<tr>
<td>Hemoglobin A1c testing - 18-75 yrs.</td>
<td>92.15</td>
<td>90.5</td>
<td>91.42</td>
<td>91.97</td>
<td>92.34</td>
</tr>
</tbody>
</table>

Goal for Hypertension CBP Rate
- Improve BP Control <140/90 to 75% or greater

<table>
<thead>
<tr>
<th>HEDIS Rates by Measurement Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBP Total</td>
<td>72.26</td>
<td>75.91</td>
<td>72.99</td>
<td>75.18</td>
<td>78.83</td>
</tr>
</tbody>
</table>
Interventions

- Clinical Pharmacy staff continue work on HTN medication review prior to renewals of prescriptions
- Registered Dietician staff work with newly diagnosed Diabetic patients to improve their nutrition
- Hypertension Committee and Diabetes Committee continue to meet monthly to impact change in needed areas and brainstorm ways to increase compliance rates
- GHC-SCW is partnering with the YMCA's Diabetes Prevention Programming which started this year with zero cost sharing to members who are identified with prediabetes. The committee is currently discussing the potential of creating our own prevention program
- Planning for a BP cuff pilot at two of our staff model clinics and working on collaborating with various UW specialty clinics to improve coordination of care with members who present to their specialty appointments with elevated blood pressure

Barriers
Lack of integration with members at external provider locations presents an ongoing challenge to directly impact their quality of clinical care. Overcoming this barrier will require working collaboratively with staff at those sites and systems to share best practices and resources.

Conclusions

1) Diabetes

- Met one of the three diabetes goals; CDC BP rate 80% or greater at 82.85%
- Work is still needed towards achieving our A1c testing goal; the most recent three-year trend has been climbing and we are now within 2.7% of goal.
- Glucose Control rate improvements have been lagging over the trended 5-year period. A concerted effort to target A1c control will be piloted in 2019.

2) Hypertension

- Met the CBP rate goal of 75% or greater at 78.83%
- Steady and sustained effort on improving this measure has been occurring since 2013.

Dashboards

Background

Historically, a paper format dashboard was disseminated to all primary care providers at staff model clinics. GHC-SCW invested in more data tools and EMR upgrades that provided the opportunity to improve and develop additional dashboards. A Dashboard Workgroup was convened in 2015 to explore hosting dashboards within the EMR. As of 2016, GHC-SCW has built several dashboards that are available to clinic staff via the EMR. Metrics were selected by the Dashboard Workgroup in tandem with key stakeholders and committees. Measures provide information about the effectiveness of improvement efforts and align with the organization’s Population Health strategy and goals.

Interventions

- Automated Preventive Health metrics appear on Primary Care and Nursing Dashboards
- Letter templates used for bulk communications send reminders to patients to close care gaps through a variety of methods including MyChart
Auto-tabulating of metrics are occurring where currently feasible; more registries are necessary to automatically trend data with additional disease and wellness registries in various build stages. Clinical staff can compare performance to colleagues, as well as, national benchmarks.

Conclusions

Dashboards are used to monitor trends on an organizational and provider-level to assist in determining when further outreach intervention is appropriate. Although dashboards within the EMR are convenient for clinic staff and increase the likelihood that action will be taken, some limitations still exist.

- Manual process to create and display practitioner level data in a graphical format
- Display of data and information does not necessarily mean that staff will initiate or are equipped to improve metrics. Clinical care teams have been asked to focus on one or two metrics that need improvement, however, not all of measures lend themselves to immediate action.

Dashboards in our EMR have improved the timeliness and transparency of clinical quality, cost and patient experience data. Data at the fingertips of the clinicians and care team staff involved helps the organization to work collectively to address issues, generate conversation and participate in quality improvement. We continue to evaluate and prioritize additional metrics and reports for care team use. Members of the Cooperative Experience Committee are also looking into opportunities to meet with each clinic's leadership team to identify specific improvements based on patient experience reports.

Asthma Measures and Committee Projects

Background

GHC-SCW has a long-term commitment to improving the health and outcomes for members with asthma and COPD. Improvement activities endorsed by GHC-SCW’s Asthma Committee have included:

- Member outreach from a dedicated Asthma Educator to help close gaps in care and improve compliance with HEDIS measures.
- Asthma Risk Report enabling care teams to proactively address patients with increased risk

Goals

- Develop unique approaches to improve health outcomes and costs associated with asthma/COPD
- To achieve HEDIS compliance rates above the 75th national percentile
- Utilize the Asthma Risk Score Report to identify high-risk uncontrolled patients for outreach
- Develop Asthma/COPD Registry and Reporting Workbench tools

Analysis

<table>
<thead>
<tr>
<th>HEDIS Results by Measurement Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Medication Ratio (AMR) total</td>
<td>83.66</td>
<td>83.87</td>
<td>83.71</td>
<td>84.73</td>
<td>86.61</td>
</tr>
</tbody>
</table>

- AMR achieved greater than the 90th percentile (85.23) and has been steadily increasing since measurement year 2013 surpassing the original goal
Interventions

- Quarterly Asthma Risk Report is triaged by Asthma Educator, Clinical Pharmacists and RNs
- Asthma Committee reviewed exhaled nitric oxide level (FeNO) data to make recommendations regarding future purchase of additional analyzers to determine lung inflammation

Barriers

- Lack of an electronic Asthma Registry in the EMR to help better manage and improve outreach

Conclusions

The Asthma Committee continues to meet and evaluate HEDIS® results and associated projects. Work is in the early stages to develop an Asthma Registry in the EMR. Tools already available within the EMR for bulk communications or orders have helped to improve outreach to multiple patients at one time.

Advance Care Planning

Background

GHC-SCW remains active in the Honoring Choices program offered through the Wisconsin Medical Society. GHC-SCW is one of 29 organizations across the state offering facilitated advance care planning conversations to patients as part of the program. The completion rate of patients 60 and over with an advance care plan on file in 2014 was 12.6%. A Best Practice Alert (BPA) reminds providers to ask individuals if they would be interested in participating in a facilitated conversation. We continue to have staff trained as facilitators as needed. Currently, there are 10 trained facilitators. A process change was implemented in May 2018 that allows patients and members to receive the documents to complete even if they're not interested in facilitated conversation. The documents are part of the patient education materials on hand in GHC-SCW clinic rooms.

Goals

- Offer a facilitated advance care planning referral to all patients 60 and above
- Train staff to be facilitators based on demand
- Continue to build advocacy and education around advance care planning
- Strive to have more patients 65 and over with an advance directive on file

Analysis

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Power of Attorney (POA) for Healthcare</th>
<th>Living Will Code Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec 2018</td>
<td>Dec 2018</td>
</tr>
<tr>
<td>18 to 59 years</td>
<td>1.4 %</td>
<td>0.4 %</td>
</tr>
<tr>
<td>60-64 years</td>
<td>7.8 %</td>
<td>2.4 %</td>
</tr>
<tr>
<td>≥ 65 years</td>
<td>28.3 %</td>
<td>9.3 %</td>
</tr>
</tbody>
</table>

The data above is restricted to members who receive care at GHC-SCW staff model clinics. The percentages in the ≥ 65 cohort for POA shows a 1.2% increase (27.1%; Dec 2017) despite no specific interventions directed toward this initiative.
Barriers

Although GHC-SCW is currently targeting patients 60 and older, there exists the need to expand these types of conversations within primary care. Many members find it challenging to return for a facilitated conversation with a chosen agent or prefer to take documents home with them thus affecting completion rates and return. Members who receive care at other network clinics may also have this information on file but were not captured in the above percentages.

Conclusions

GHC-SCW remains diligent in recognizing the importance of advance care planning conversations despite the recognized barriers and will continue to monitor completion rates of all patients 60 and above in the staff model system.

SAFETY OF CLINICAL CARE

Clinical Pharmacists and Medication Management

Background

Blood pressure management and statin utilization are two areas of preventive cardiology that are heavily guideline-based and represent opportunities for collaborative, team-based care. These two conditions also account for a sizeable portion of the insured population with chronic disease. In streamlining the workflows in this area of care, the pharmacist is integrated more completely as a liaison between the patient and their care provider to improve quality of care and simultaneously decrease workload of practitioners.

In 2016, staff developed a Collaborative Practice Agreement (CPA) based on an opt-out model with designated criteria that defined eligibility for Clinical Pharmacy intervention. The percentage of patients managed by a clinical pharmacist has grown since inception and the health plan has seen the cost per day of statin therapy drop in response to clinical pharmacist management.

Goals

- Improve primary care practitioner-pharmacist collaboration and reduce electronic prescription renewal requests
- Improve GHC-SCW member blood pressure control and statin utilization for patients with uncomplicated hypertension
### Diabetic Statin and BP Rates

<table>
<thead>
<tr>
<th>Measure CDC &amp; SPD (Weight)</th>
<th>2017 Rate (Score)</th>
<th>2018 Rate</th>
<th>2018 Percentile Ranking</th>
<th>2018 Score</th>
<th>2018 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP Control ≤ 140/90 (3)</td>
<td>81.57 (5)</td>
<td>82.85 (5)</td>
<td>79.08 95th</td>
<td>–</td>
<td>↑</td>
</tr>
<tr>
<td>Statin Therapy (1)</td>
<td>69.97 (5)</td>
<td>69.44 (5)</td>
<td>67.79-69.48 90th-95th</td>
<td>–</td>
<td>↓</td>
</tr>
<tr>
<td>Statin Adherence (1)</td>
<td>75.67 (5)</td>
<td>78.46 (5)</td>
<td>78.27 95th</td>
<td>–</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Cardiovascular Statin and BP Rates

<table>
<thead>
<tr>
<th>Measure (Weight)</th>
<th>2017 Rate (Score)</th>
<th>2018 Rate</th>
<th>2018 Percentile Ranking</th>
<th>2018 Score</th>
<th>2018 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statin Therapy SPC (1)</td>
<td>88.59 (5)</td>
<td>86.27 (4)</td>
<td>84.28-86.67 75th-90th</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Statin Adherence (1)</td>
<td>64.58 (3)</td>
<td>85.71 (5)</td>
<td>83.39 95th</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Controlling BP (3)</td>
<td>75.18 (5)</td>
<td>81.27 (5)</td>
<td>78.83 95th</td>
<td>–</td>
<td>↑</td>
</tr>
</tbody>
</table>

### Interventions
- Pharmacist identifies patients with blood pressure above goal or who may benefit from initiation or monitoring of a statin drug utilizing the hypertension and cardiovascular disease registries.
- Pharmacist and Practitioner execute the CPA

### Barriers
- Motivating patients with outdated/uncontrolled BP/lipids or overdue labs to engage in care
- Educating patients on the role of the Clinical Pharmacist to gain their trust.
Conclusions

GHC-SCW practitioners in collaboration with Clinical Pharmacists are striving to improve member blood pressure control and statin utilization. The efforts to expand the capacity of Clinical Pharmacists to include diabetics and chronic kidney disease patients has positively impacted the CBP & SPC measures in our most recent HEDIS® results with a 21% up-tick in our compliance for Statin Adherence in the cardiovascular patient. These measures were a focus of improvement and has proven the effectiveness of this project to have staff model patients with uncomplicated hypertension have a pharmacist manage their medication.

Medication Assisted Treatment in Primary Care

Background:

Opioid use disorder (OUD) is a growing epidemic with overdose deaths widespread across the nation. Evidence supports a combination of counseling and medication as the best treatment for OUD, however, medication assisted treatment (MAT) can be difficult to access for many patients. GHC-SCW’s MAT program started with a single waivered physician in 2017. The goal of the program was to provide evidence-based treatment for OUD in the context of a primary care relationship. The program serves two populations 1) Stable patients (i.e., long term recovery) on opioid agonist therapy from the consulting addiction psychiatrist, 2) Patients with current OUD who required initiation of buprenorphine/naloxone, to facilitate recovery.

In 2018, two additional methadone clinics have opened in Madison, WI, doubling capacity and giving the city four of the state-licensed centers, a sign that the state is more fully embracing medication-assisted treatment to curb opioid abuse. Additional Primary Care practitioners in GHC-SCW owned clinics have since obtained the prescriber waivers and training required.

Overall Assessment of MAT Program at GHC-SCW Clinics

Over the course of 2018, the number of providers with waivers in our staff model clinics has increased from 2 to 7 (250 %); four (4) MDs, two (2) Physician Assistants and one (1) Nurse Practitioner. Of these providers, one has chosen not to prescribe (aside from refills) and one is not accepting new patients while two have ability to prescribe buprenorphine for prenatal patients.

Outpatient substance use and addiction services are provided primarily by our partner, UW Behavioral Health and Recovery, which is one of the most common sources of referral. Other sources include:

- Primary Care Practitioner
- GHC-SCW Primary Care Behavioral Health Consultants
- Care Management staff
- Madison Comprehensive Treatment Center (methadone clinic)
- Patient Self-Referral
The practitioner who initiated the MAT program at GHC-SCW has since increased her waiver to 100 patients per year. She is actively prescribing to thirty-eight (38) patients with twelve (12) patients receiving prescriptions this year no longer under care. The primary reasons patients terminated medication assisted treatment under this physician's care included 1) change of insurance 2) lost to follow-up/quit coming to appointments or 3) transfer to another prescriber within GHC-SCW.

Conclusions

GHC-SCW has been successful with our Medication Assisted Treatment Program within our staff model clinics. The program has grown substantially since starting with a single waivered physician in 2017. We are proud to report zero (0) total deaths and zero (0) overdose deaths to date within the program. In 2018, ER visits for overdoses with members under treatment were low (3) and three (3) additional patients have been prescribed naltrexone extended release (vivitrol) for management of alcohol use disorder without opioid use disorder.

Opioid Safety Program

Aim

For all existing patients on non-cancer opioid treatment, reduce members to less than 90 Daily Morphine Equivalents (DME) or from increasing past a DME of 90.

Background

The Opioid Safety Program underwent system-wide implementation at GHC-SCW in 2015. Since then, providers have been actively recommending members utilize alternative services to support their treatment plan for pain management, as well as, working to design tapering regimens or offering Medication Assisted Treatment within Primary Care for opioid use disorder. Our average DME continues to trend downward and since 2016, has reduced from 129 to 65. Equally important, the number of members under 200 DME has increased to 96 % as our practitioners deal with challenging conversations while continuing to offer supportive care.

Analysis

Two HEDIS® metrics related to opioids have been reported representing measurement year 2017.

<table>
<thead>
<tr>
<th>HEDIS METRICS</th>
<th>GHC-SCW 2018 Rate per 1000 members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Opioids at High Dosage (UOD)</td>
<td>66.46</td>
</tr>
<tr>
<td></td>
<td>63/948</td>
</tr>
<tr>
<td>Use of Opioids from Multiple Providers (UOP; Multiple Prescribers &amp; Multiple Pharmacies)</td>
<td>26.20</td>
</tr>
<tr>
<td></td>
<td>29/1107</td>
</tr>
</tbody>
</table>

GHC-SCW trends Daily Average Consumption (DACON) of Extended Release (ER) and Immediate Release (IR) Opiates to assess network wide patient utilization. The three-year trended data shown below is for all associated prescribers’ and demonstrates our evolution in helping to reduce consumption.
Interventions

- Offering access to Primary Care Behavioral Health consultants and Clinical Pharmacists to assist with pain management coping strategies or tapering regimens
- Offering Medication Assisted Treatment in Primary Care
- Assessing patients at highest risk of overdose. Providers and nursing staff determine those patients who have greater need to taper, find alternative approaches to pain management, and co-prescribe naloxone.
- Epic tools were designed to help identify those patients for whom controlled substances should not be prescribed or prescribed with caution; FYI’s that will trigger an associated Best Practice Alert related to opioid medication orders.

Challenges that impact improving the safety of clinical care for patients on opioid therapy:

- Support for dealing with difficult conversations & variability in engagement
- Literacy level of this subset of patients / alternative approaches or materials
- Reluctance to participate in multimodal approaches due to copayment fees
- Competing demands of other initiatives
- Cycle time for visits is difficult to manage
- Compliance with Wisconsin legislation

Conclusions

GHC-SCW has seen a decrease in the distinct patient opioid prescribed counts and overall a reduction in prescribing for both the Staff Model and Non-Staff Model insured populations. We continue to track and trend data, inform providers and staff regarding evidence-based protocols, and improve our processes related to this important public safety issue. Optimization of our EHR related to metrics and an actionable opioid registry have improved practitioner and staff utilization of these tools. Team meetings provide the opportunity for interdisciplinary discussion and developing strategies to handle complex patients. The health plan also reported HEDIS measures related to opioids in 2018. Responsible prescribing, tapering and treatment will improve safety & save lives. GHC-SCW’s Pain Committee will be helping to determine the next level of clinical workflow standardization with respect to acute pain versus chronic pain, guidelines for prescribing other sedatives in conjunction with opiates and interpretation of and guidelines for urine drug screening.
BEHAVIORAL HEALTH CARE

GHC-SCW’s projects related to behavioral health (BH) HEDIS measures or other BH quality improvement initiatives are addressed by the Continuity and Coordination of Medical and Behavioral Health Care Committee team. The following are the details of our 2018 HEDIS results and improvement efforts.

Antidepressant Medication Management (AMM)

Aim
Facilitate proper diagnosis and treatment of patients with depression by prescribing primary care or specialty mental health providers and ensure adequate periods of treatment with antidepressant medications.

Background
Depression can occur to anyone, at any age, and is never a normal part of life, no matter the situation. Depression complicates other medical conditions and can increase risk for suicide. While most individuals with depression have a full remission with effective treatment, only about a third of those suffering from severe depression seek treatment from a mental health professional. Depression is very treatable, with the overwhelming majority who seek treatment showing improvement. The most commonly used treatments are antidepressant medication and/or psychotherapy. The choice of treatment depends on the pattern and history of the illness, as well as, the severity and persistence of symptoms.

Measures/Goals

GHC-SCW’s goal for depression care adherence is the national 95th percentile. The table below defines the measure and the 2018 Rate for the National- All LOBs 95th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute: Percent of members on anti-depressants who continue the medications for at least 12 of the first 16 weeks.</td>
<td>≥ 77.52</td>
</tr>
<tr>
<td>Continuation: Percent of members on anti-depressants who continue the medications for at least 26 of 33 weeks, completing a period of continuation phase treatment adequate for defining a recovery per AHCPR guidelines.</td>
<td>≥ 62.77</td>
</tr>
</tbody>
</table>
Analysis

GHC-SCW’s HEDIS results for these measures are trended for the last three measurement years. The 75.3% of members who continued their treatment for three months (acute phase) was only 2.2 % below the 95th percentile goal of 77.5%. The percent of members who remained on their treatments for 6-months (continuation phase) improved to 63.3 % which exceeds the 95th percentile (62.8%).

![Antidepressant Medication Management](image)

Barrier associated with the Acute Phase

Primary care providers, who prescribe most antidepressants, often do not have adequate time to follow-up with members with depression to reiterate the importance of staying on antidepressant medicines following the initiation of antidepressant therapy.

Interventions in 2018

- Support and maximize the utilization of Primary Care Behavioral Health (PCBH) team members by primary care providers to address psychoeducation, motivational enhancement, and follow-up.
- Continue to improve and expand the use of pre-visit huddles and review of appointments in primary care by PCBH to ensure greater use of PHQ-9 for depression screening and symptom monitoring, particularly for members with a history of depression or chronic conditions such as diabetes, cardiovascular disease, and persistent pain.
- Improve utilization of secure patient messaging to administer the PHQ-9 instrument and message to patients regarding the importance of continuing medication.
- Continue to educate members regarding the typically short-term nature of most side effects and the expected delay in symptom improvement following initiation.
Conclusions

The trended rate of adherence to antidepressant medication in the treatment of depression shows consistent high performance. The intervention strategies utilized over the past few years have proven effective to maintain or improve the rate of member adherence to antidepressant medication in the treatment of depression overall.

Follow-Up after Hospitalization for Mental Illness (FUH)

Aim
To ensure members hospitalized for a mental illness have a prompt follow-up visit with an outpatient behavioral health provider. Follow-up utilizes two measures: the percent of members seen within 7 days of discharge and the percent of members seen within 30 days after discharge.

Background
Members admitted to the hospital because of mental illness are at high risk for recurrence of admission. Patients requiring inpatient level of care often experience the most severe mental health symptoms and functional impairments, and they benefit from close monitoring and follow-up. NCQA has identified this issue as an important measure of behavioral health service quality. The established HEDIS measure examines the number of discharges of members 6 years of age and older who were hospitalized for treatment of mental health disorders and evaluates both the 7-day and 30-day rates.

GHC-SCW has established protocols for ensuring that patients are offered appointments with a staff model or contract mental health provider within 7 days of discharge to ensure continuity of care, appropriate care coordination, and the adequacy of the treatment plan. Our organization utilizes a team-based effort that involves clinical and administrative staff from GHC-SCW as well as staff from network inpatient psychiatric providers to ensure timely follow up care.

Measures/Goals
GHC-SCW has adopted goals based on the HEDIS national 95th percentile. The table below defines the measure and the 2018 Rate for the National- All LOBs 95th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of members with a hospital admission seen for an ambulatory</td>
<td>≥ 65.42 %</td>
</tr>
<tr>
<td>appointment within 7 days after discharge</td>
<td></td>
</tr>
<tr>
<td>Percent of members with a hospital admission seen for an ambulatory</td>
<td>≥ 83.22 %</td>
</tr>
<tr>
<td>appointment within 30 days after discharge</td>
<td></td>
</tr>
</tbody>
</table>

Analysis

In 2018, due to significant changes to the measure regarding discharge criteria and the addition of telehealth, results for this measure cannot be trended to previous year’s results. Although GHC-SCW exceeded our goals in each of these measures, limitations still exist when members’ no-show for scheduled follow-up appointments or decline due to co-pay, co-insurance, or deductible obligations.
Interventions in 2018

- The presence and utilization of Primary Care Behavioral Health Consultants for members whose PCP is in a clinic with PCBH services continues to provide an excellent point of entry and follow up to mental health services.
- Continue GHC-SCW Mental Health (MH) daily census of behavioral health admissions (including patients admitted for overdose or suicide attempts).
- UW Hospital, Unity Point Meriter Hospital, and Roger’s Memorial Hospitals continue to contact our MH department prior to patient discharge to facilitate follow-up within seven days of discharge.
- A register of admissions and follow-up appointments is maintained and reviewed by MH administrative staff to ensure all members are scheduled. If appointments are missed, GHC-SCW contacts the member to reschedule the missed appointment as quickly as possible.
- Improved utilization of clinical triage staff to meet with members discharged from an inpatient psychiatry stay that do not have an existing outpatient provider.
- Continued emphasis of standard of care in renewed external behavioral health provider contracts.

Conclusions

Results on these HEDIS measures demonstrate high performance. Plans to continue current workflows and strategies ensure that this important service coordination and transition between inpatient psychiatry and lower levels of care continue to occur.
Follow-Up Care for Children (Age 6-12) Prescribed ADHD Medication (ADD)

_Aim_

These two measures report 1) the percentage of children newly prescribed medication for the treatment of Attention Deficit and Hyperactivity Disorder (ADHD) that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase; and 2) the percentage of children with a prescription for ADHD medication, who remained on the medication for at least 210 days and had at least two follow-up visits in the nine months after the end of the Initiation Phase (the Continuation Phase).

_Badground_

Attention deficit/hyperactivity disorder is the most commonly treated childhood neurobehavioral disorder. Children with ADHD may experience difficulties in school, troublesome relationships with family members and peers, and other behavioral problems. Follow-up care and surveillance is a key aspect of ADHD treatment. Primary care clinicians need a strategy for diagnosis and long-term management of this condition given the high prevalence among school-age children.

_Measures/Goals_

GHC-SCW has established meeting or exceeding the national 95th percentile as its goal. The table below defines the measure and the 2018 Rate for the National- All LOBs 95th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation Phase:</strong> The percentage of children 6 to 12 years of age with a prescription for ADHD medication who had one follow-up visit with a practitioner during the 30-day Initiation Phase.</td>
<td>≥ 55.60%</td>
</tr>
<tr>
<td><strong>Continuation and Maintenance Phase:</strong> The percentage of children 6 to 12 years of age with a prescription for ADHD medication, who remained on the medication for at least 210 days and had at least two follow-up visits in the nine months after the end of the Initiation Phase.</td>
<td>≥ 62.14%</td>
</tr>
</tbody>
</table>
Analysis

In 2018, telehealth was added to the measure. Trending between 2018 and prior years is cautioned.

The compliance rates for Care for Children Prescribed ADHD Medication Initiation Phase & Continuation and Maintenance Phase decreased versus 2017 quite dramatically. We believe this decline was due to the loss of dedicated personnel monitoring compliance with these timeframes. Other limitations include:

- Members sometimes decline follow-up visits to provide behavioral change or school feedback to the prescriber preferring to communicate by phone or MyChart secure messaging. The member can typically provide adequate follow-up to the provider through these means, while avoiding bringing the child back into clinic and incurring co-pays or other fees.

- Furthermore, some members included in the measure have a history of stable, problem-free stimulant use during school and take a medication “holiday” in the summer. When restarting the medication, a follow-up visit within 30 days may be required by the HEDIS metric, but it is not viewed as medically necessary by the member or the provider.

Interventions in 2018

- In September 2018, GHC-SCW’s Enterprise Applications Team implemented recommended changes to Smart Texts and Smart Phrases in the electronic medical record to allow better tracking of compliance and facilitate staff intervention.
- GHC-SCW’s Quality Management staff began reviewing reports twice per month to identify children in this metric. Staff messages are sent to the appropriate Care Team or other staff who assist families in scheduling (or rescheduling) appointments
- Updated Patient After Visit Summaries for ADHD visits to encourage follow-up visits within 30 days, 3 months, and 6 months.
Mental Health Call Center, Reception and Psychiatry staff were reminded to emphasize to families with children treated with stimulant medication the importance of being seen clinically within the 30-day standard.

Conclusions

The rise in alternative means for sharing ADHD behavioral change or school feedback results with prescribing providers continues to serve as an obstacle to the completion of face-to-face appointments following the initiation of stimulant treatment. GHC-SCW has re-energized our efforts related to this measure to improve rates and is interested to leverage new technologies to bring timely care to patients with the adoption of telehealth as an evidence supported option.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Aim
This measure assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care:

Initiation of AOD Treatment: Adolescents and adults who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Engagement of AOD Treatment: Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Background

Alcohol consumption is a social activity in Wisconsin which affects the health of families. Research provides strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can potentially save millions of dollars on health care related costs. Individuals who initiate and complete more days of treatment typically show more improvement than those who leave treatment prematurely and fall victim to relapse. The acute stage of treatment is associated with lasting improvements only with continued rehabilitation.

Measures/Goals

GHC-SCW has established the goal of meeting or exceeding HEDIS 90th percentile. The table below defines the measure and the 2018 Rate for the National- All LOBs 90th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation Percentage of members initiating treatment within 14 days of diagnosis.</td>
<td>≥ 42.0 %</td>
</tr>
<tr>
<td>Engagement Percentage of members engaging in treatment with two additional alcohol and other drug dependence (AOD) services within 30 days after initiation.</td>
<td>≥ 18.88 %</td>
</tr>
</tbody>
</table>
Analysis
Due to significant changes made to these measures by NCQA, the 2018 results for these measures cannot be exactly trended with previous year's results. Therefore, the historical trends with the data presented here should be interpreted with caution. GHC-SCW’s 2018 IET rates did improve yet did not reach the goal of the 90th percentile.

<table>
<thead>
<tr>
<th>Analysis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to significant changes made to these measures by NCQA, the 2018 results for these measures cannot be exactly trended with previous year's results. Therefore, the historical trends with the data presented here should be interpreted with caution. GHC-SCW’s 2018 IET rates did improve yet did not reach the goal of the 90th percentile.</td>
<td></td>
</tr>
</tbody>
</table>

### Barriers
- Cultural norms that support use/abuse of alcohol
- Limited access to or stigma associated with specialty care or group therapy approaches
- Members’ lack of motivation to address the issue
- Members’ apprehension regarding preconceived notions of treatment models
- Over-use of SUD diagnosis in primary care in the absence of a full AODA diagnostic assessment
- Intensive visit schedules often required in specialty SUD settings are unmanageable for members

### Interventions in 2018
- Periodic reminders to providers via email, primary care newsletter, and practitioner meetings regarding screening for substance use disorders, appropriate use of diagnostic codes for ambulatory appointments, and standard of care regarding follow-up.
- “Best Practice Alert” in the electronic medical record reminds practitioners of the HEDIS standard of care to initiate treatment within 14 days of the diagnosis, and asks the provider to refer the patient to treatment if certain diagnosis codes are used.
- Continued support for Screening, Brief Intervention, and Referral to Treatment (SBIRT) and access to Primary Care Behavioral Health consultant services in four GHC-SCW clinics
- Increased the number of waivered practitioners who can provide medication assisted treatment (MAT) in primary care for the treatment of opiate use disorder or prescribe naltrexone extended release (vivitrol) for management of alcohol use disorder without opioid use disorder.
Conclusions

Despite the availability of efficacious treatments, compliance with the standard of care remains torpid both within GHC-SCW and nationally. Opportunities within GHC-SCW exist to:

- Leverage new technologies to bring timely care to patients with the adoption of telehealth as an evidence supported option for behavioral health diagnosis and treatment
- Increase knowledge regarding substance use disorders and available resources, as well as the standard of care regarding follow-up after diagnosis
- Increase SBIRT services in primary care via providers, Primary Care Behavioral Health, and others for AOD risk reduction

Follow-up after Emergency Department Visits for Alcohol or Other Drug Dependence (FUA)

Aim

Review plan data related to the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage for follow-up within 7 days of the ED visit.
- The percentage for follow-up within 30 days of the ED visit.

Background

Individuals with AOD who are discharged to the community from the ED are particularly vulnerable to losing contact. Use of the ED signals crisis and may also indicate lack of access to routine outpatient care. Individuals with behavioral health problems who do not receive follow-up care after substance abuse ED visits are much more likely to readmit to the ED. Health plans have a responsibility to connect patients to care. Discharge from the ED is an important transition because it is an opportunity to secure appropriate follow up treatment in the outpatient setting.

Analysis

Following 2017, the first reporting year, GHC-SCW set an improvement goal of 10% for both the 7-day (28.8%) and 30-day measure (40.6%). In 2018, GHC-SCW did not see improvement in our rates from the previous year or meet our goals. In reviewing the national percentiles, we concluded our 10% rate increase goal may have been overly optimistic given that our 2018 rates were already trending above the 90th and 95th percentiles respectively.
The barriers to improvement here tend to resemble those identified in the measure reviewed previously, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). While timely follow-up is relatively good on a percentile basis (at or above the 90th percentile), the actual percentage of members being seen is still quite low. Opportunities for improvement include:

- Development of enhanced reporting capabilities for timely identification of members seen in the ED for AOD dependence
- Increase the capacity for identifying needs for follow-up within Care Management
- Development of telemedicine protocols for follow-up after ED visits.

**Conclusions**

GHC-SCW’s current practices to secure appropriate follow-up treatment in the outpatient setting for members seen in the ED for AOD issues have been relatively effective however, implementation of the opportunities listed will likely improve the number of members who receive timely follow-up care after an ED visit for alcohol or other types of drug dependence.

**Follow-up after Emergency Department Visits for Mental Illness (FUM)**

**Aim**

Review plan data related to the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage for follow-up within 7 days of the ED visit.
- The percentage for follow-up within 30 days of the ED visit.
Background

Individuals with mental illness who are discharged to the community from the ED are particularly vulnerable to losing contact. Use of the ED signals crisis and may also indicate lack of access to routine outpatient care. Individuals with behavioral health problems who do not receive follow-up care after psychiatric visits are much more likely to readmit to the ED. Health plans have a responsibility to connect patients to care. Discharge from the ED is an important transition because it is an opportunity to secure appropriate follow up treatment in the outpatient setting.

Analysis

Following 2017, the first reporting year, GHC-SCW set an improvement goal of 5% for a follow-up visit within 7 days (62.7%) and what proved to be an overly optimistic increase of 10% for a follow-up visit within 30 days (84.1%) as the 2018 Nat’l 95th percentile reported was 79.5%. While both 2018 rates did not reflect our goals for improvement, the 18.5% decline in the 7-day rate was a concern as it fell below the 50th percentile.

| Follow-up after ED Visit for Mental Illness within 7 and/or 30 days of discharge |
|---------------------------------|--------|--------|--------|--------|--------|
| w/in 7 days of discharge        | 49     | 39.2%  | 44.4%  | 63     | 64.7%  |
| w/in 30 days of discharge       | 74.1%  | 60.4%  | 79.5%  |

Barriers potentially include:

- Time constraints with notification of ED visit, communication/coordination of care, scheduling
- Availability of Mental Health provider appointments in the specified time frame
- Member concerns regarding stigma or about missing work/school
- Member concerns about co-pays, deductibles and co-insurance
- Transportation issues or cultural and linguistic barriers

GHC-SCW has opportunities for improvement to:

- Develop enhanced reporting capabilities for timely identification of members seen in ED for mental health disorders and follow-up capacity within Care Management or other GHC-SCW departments, as well as with outpatient network providers
Increase availability of Primary Care Behavioral Health Services that allow access to effective follow-up care without requirement of immediate appointment with a specialist, likely reducing members concerns about privacy and stigma, as well as transportation or other access issues

- Continue efforts at improving the cultural competence and linguistic and cultural diversity of the provider network
- Explore the adoption of telehealth to bring more timely care to patients

**Conclusions**

Over calendar year 2018, GHC-SCW’s efforts to secure appropriate follow up treatment in the outpatient setting for individuals with mental illness has shown improvement based on our monthly compliance rates reported by our Business Intelligence team. GHC-SCW anticipates our official 2019 rates for FUM to be positively impacted. Timely follow-up care for mental health disorders following an ED visit continues to be a focus of the organization.

**IV: QUALITY IMPROVEMENT WORKPLANS**

- **2018**
- **2019**
<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>PROPOSED ACTIVITIES</th>
<th>PROPOSED TIMEFRAME FOR COMPLETION</th>
<th>STAFF RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Service</strong></td>
<td>Conduct on-going assessment of patient experience and member satisfaction and develop strategies for improvement.</td>
<td>1) Increase readability of monthly patient satisfaction reporting. 2) Improve patient experience based on 2018 Press Ganey survey comments and results. 3) Improve member satisfaction for CAHPS measure results below the 50th percentile based on 2017 surveys</td>
<td>1) Work with Press Ganey to modify reporting metrics in an effort to improve the clarity of the monthly reports . 2) QM department and Patient Experience Committee will help support training of all GHC-SCW staff members via Press-Ganey coursework. Set a Year 1 and Year 2 goal for improvement for each metric. 3) Review CAHPS results and develop strategies for improvement for measures below the 50th percentile 4) Review a process for sharing complaints. Consider an electronic mechanism. 5) Utilize complaints and compliments to develop member initiated improvements 6) Utilize comment cards for review and share results to the patient experience committee</td>
<td>1) January 2018 2) 2018 - 2019 3) Ongoing 4) Q1 through Q4 5) Q1 through Q4 6) Begin process Q1</td>
</tr>
<tr>
<td></td>
<td>Evaluate Outreach process improvements and increase Outreach to non-staff model members</td>
<td>1) Review all current Outreach reporting for opportunities to incorporate non-staff model members. 2) Partner with outlying community resources to educate non-staff model members of opportunities within their community.</td>
<td>1) Review all reports for inclusion/exclusion criteria. 2) Work with BI to import non-staff model claims data into Epic Healthy Planet tools 3) Establish written Population Health Strategy 4) Increase frequency of Diabetes and/or other chronic disease newsletters to quarterly. 5) Incorporate Bulk Messaging and outreach for non-staff model members when Caboodle tools and processes are working and are live.</td>
<td>Q1 through Q4 2) Q1 through Q4 3) By July 2018 4) Q1 through Q4 5) Long term</td>
</tr>
<tr>
<td></td>
<td>Improve the health of the populations that GHC-SCW serves by reducing health outcome disparities Promoting health literacy and cultural competency values and training among GHC-SCW workforce.</td>
<td>1) Understand baseline demographic and health outcome data to examine where potential inequities exist. Staff and Committee members will examine and compare internal data to local, state and National public health statistics and other available evidence. 2) Pursue innovative ways to promote organizational health literacy, develop a culturally competent workforce, and nurture an inclusive work environment. 3) Provide a safe and open space where issues related to equity, inclusivity and cultural diversity can be discussed and addressed.</td>
<td>1) Translate selected member materials into Mandarin as it has been identified as the 3rd most common spoken language regionally. 2) Work with the Population Health Department and Marketing to create health literate mailings and MyChart message templates for registry activity and QM Outreach mailings. 3) Continue to follow the 3 yr strategic plan “Roadmap for Health Equity: 2017-2019” to ensure that the organization promotes and practices as a welcoming and inclusive environment. a) Gender / Sexual Identity field added to the EHR and training provided to staff members. b) YWCA health equity trainings provided org-wide in 2018.</td>
<td>1) Q1-Q2 2) ongoing 3) ongoing a) Q1 b) Q1-Q4</td>
</tr>
</tbody>
</table>
### 2018 Quality Improvement Work Plan

**Focused by the Triple Aim**

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>PROPOSED ACTIVITIES</th>
<th>PROPOSED TIMEFRAME FOR COMPLETION</th>
<th>STAFF RESPONSIBLE</th>
</tr>
</thead>
</table>
| Improve the health of populations | Improve scores on reported measures related to hypertension and diabetes outcomes | 1) Improve HEDIS measures for members with diabetes:  
- HbA1c testing among 18-75 year olds; reach 95%  
- HbA1c control < 8.0 %; reach 67% - 70%  
- BP Control <140/90; maintain 80 % or greater  
2) Expand hypertension efforts to entire patient population (beyond patients with diabetes).  
1a. Implement a project in clinics and for health plan members for coverage of pre-diabetes classes and evaluate impact.  
1b. Monitor the implementation of Epic’s Healthy Planet tools, Reporting Workbench and registries, to enable clinic staff to identify and provide outreach to members with diabetes. Continue to provide support to internal staff.  
1c. Continue to monitor workflow for newly diagnosed patients with diabetes/diabetes care gaps in pre-visit prep  
2) Continue to monitor and provide on-going support to the Pharmacy department for the approved, protocolized HTN medication renewal process. Assess impact of new, expanded pharmacy roll.  
3) Review the impact of statin management via pharmacy protocol  
4) Review other opportunities for pharmacy medication protocols  
5) In collaboration with BI and Pop Health, review Epic registry outreach opportunities  
6) Implement Hypertension Committee pilot to improve hypertension control in staff model patients and review results for potential organization wide improvement. | 1a) Referral process for pre-diabetes to begin Q1  
1b-c) ongoing  
2) ongoing  
3) Q1 and Q2  
4) Q2  
5) ongoing  
6) Q1 2018 | Kastman  
Madson  
Twining  
Ibrahim  
Kleinmaus  
Rx/Guetzlafl |
| Improve the patient experience of care | Continue to grow the organization’s commitment to build system change, advocacy and education around advanced care planning. | 1) Train additional staff, as warranted based on demand, to be facilitators dedicated to implementing advance care planning  
2) Offer a facilitated advance care planning referral to all patients 60 and above at the time of their physical exams  
3) Work with SLT to identify strategic goal for advance care planning.  
4) Strive to achieve 30 % or greater of patients 65 and above with an ACP on file | 1) Continue to outreach clinic staff regarding the Honoring Choices initiative and have additional staff trained as facilitators as warranted by demand  
2) Monitor advance care planning referrals to all patients 60 and above at the time of their physical exams  
3) Review the feasibility of the kiosk message for advance care planning. | Madson  
Kastman  
ACP Facilitator Team |
<table>
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<tr>
<th>GOALS</th>
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</thead>
</table>
| Quality of Clinical Care | Create and disseminate Provider Dashboards on a quarterly basis with data on quality, cost and patient experience. | 1) Continue workgroup to maintain Nursing Dashboard and Urgent Care Dashboard  
2) Incorporate auto-tabulating metrics where possible. | 1) Meet regularly with Epic Applications and Business Intelligence Teams to discuss current state of the Provider Dashboard, barriers and opportunities and future additions of other population health tools to populate a Dashboard within the EMR  
2) Meet regularly with Nursing leadership and Urgent Care leadership to create meaningful metrics for two new clinical dashboards | 1) Q2 through Q4  
2) Ongoing | Kastman  
Madson  
Kleinmaus  
Ibrahim  
Bi/Eng |
| Look to develop unique approaches and strategies to improve member health outcomes and costs associated with asthma. | 1) Utilize the Asthma Risk Score reports to identify high-risk, uncontrolled asthma patients for outreach in GHC-SCW clinics.  
2) In collaboration with BI and EA, develop Asthma reporting workbench report. | 1) Asthma Committee continues bi-monthly meetings to evaluate expansion of the Asthma Risk Score project to all clinics, care teams, and providers  
2) In collaboration with the Population Health department, develop an Epic asthma registry and reporting workbench to facilitate bulk ordering and messaging.  
3) ACT project in which pharmacy staff do asthma control testing when members pick up medication. Review medication ratio and alert providers. | 1) Ongoing  
2) end of Q4  
3) Ongoing monitoring | Kastman  
Madson  
Ballweg  
Kleinmaus  
Ibrahim  
Lo |
## 2018 Quality Improvement Work Plan
**Focused by the Triple Aim**

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<tr>
<th>GOALS</th>
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<tbody>
<tr>
<td>Improve the health of populations</td>
<td>Continue to monitor patient safety and look for opportunities for improvement</td>
<td>1) Continue initiative to improve safety of clinical care for patients with non-cancer chronic pain taking opioids 2) Monitor number and impact of practitioners that provide Medication Assisted Treatment within Primary Care 3) Continue to promote and resource Clinical Pharmacists across clinics 4) Safety Committee monitors portal to identify clinical opportunities</td>
<td>1) Q1 through Q4 2) Q1 through Q4 3) Q1 through Q4 4) Q1 through Q4</td>
<td>Kastman  Madson  Ibrahim  Hynek  Safety Committee  Clinical Pharmacy</td>
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<tr>
<td>Lower per capita costs</td>
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<tr>
<td>Improve the patient experience of care</td>
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<tr>
<td>Safety of Clinical Care</td>
<td>1) For all existing patients on non-cancer Chronic Opioid treatment, reduce all members to less than 90 Daily Morphine Equivalents by October 2018. 2) For all existing patients on non-cancer Chronic Opioid treatment, reduce all members to less than 90 Daily Morphine Equivalents by October 1st, 2018. 3) Effective immediately, prevent any non-cancer patients from increasing past a Daily Morphine Equivalent of more than 90. 4) Decrease or eliminate the co-administration of opioids and benzodiazepines/sleep aids. 5) Medication Assisted Treatment within Primary Care 6) Resource Clinical Pharmacists for drug utilization reviews on members with complex prescription drug therapy 7) Utilize trends from online safety portal for process improvement opportunities.</td>
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### GOALS
- **Safety of Clinical Care**

### OBJECTIVES
- Continue to monitor patient safety and look for opportunities for improvement.

### PROPOSED ACTIVITIES
- 1) Continue initiative to improve safety of clinical care for patients with non-cancer chronic pain taking opioids.
- 2) Monitor number and impact of practitioners that provide Medication Assisted Treatment within Primary Care.
- 3) Continue to promote and resource Clinical Pharmacists across clinics.
- 4) Safety Committee monitors portal to identify clinical opportunities.

### PROPOSED TIMEFRAME FOR COMPLETION
- Q1 through Q4
- Q1 through Q4
- Q1 through Q4
- Q1 through Q4

### STAFF RESPONSIBLE
- Kastman
- Madson
- Ibrahim
- Hynek
- Safety Committee
- Clinical Pharmacy
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<tr>
<td>Improve behavioral health outcomes for our members</td>
<td>I. <strong>HEDIS BH Measures</strong>: maintain percentile goals for measures 1-4</td>
<td>I. Continue directed member outreach, use of PCBH services &amp; provider education</td>
<td>II. Q1 - Q4</td>
<td>Van Den Brandt</td>
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<tr>
<td></td>
<td>1. ADHD</td>
<td>Report quarterly performance to providers</td>
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<td>Austin</td>
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<td></td>
<td>2. F/U After Hospitalizations for MH</td>
<td>II. Define the health plans goals and opportunities to improve for 2018 and beyond related to these 2 measures</td>
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<td>3. Engagement/Initiation of SUD to</td>
<td>III. Evaluate member and practitioner experience with PCBH services</td>
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<td>4. AMM</td>
<td>IV. Engage and collaborate to disseminate improvements</td>
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<td>II. <strong>Monitor and trend performance on ED measures</strong></td>
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<td>• FUM: Follow-Up After Emergency Department Visit for Mental Illness</td>
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<td>• FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence</td>
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<td>III. <strong>PCBH</strong></td>
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<td>Continue PC and BH Integration</td>
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<td>IV. <strong>WCHQ BH QI Steering Team Charter</strong></td>
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<td>Have a GHC-SCW representative from within our Mental Health department participate and potentially share data with WCHQ</td>
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**2018 Quality Improvement Work Plan**
Focused by the Triple Aim

**Behavioral Health Care**

Improve the health of populations

Lower per capita costs

Improve the patient experience of care
# 2018 Quality Improvement Work Plan
## Focused by the Triple Aim

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</table>
| **Financial Health**                             | Implement the concepts of Choosing Wisely and shared decision making to reduce costs associated with duplicate or unnecessary testing or procedures | 1) Identify savings due to analysis of duplicate and/or unnecessary testing or procedures.  
2) Implement a shared decision making framework. | 1) Review data from analytical tools to determine where opportunities for education and cost savings exist.  
2) Evaluate the feasibility of providing shared decision making tools to all populations | 1) end of Q4  
2) end of Q4 | Kastman  
Madson  
Ibrahim |
| Increase utilization of analytical tools to identify high cost members and target strategies for cost containment to improve member population health | 1) Develop and implement strategy to lower per capita costs and improve population health  
2) Assess the need for tools/resources Case Managers would like to support their population health management efforts. | 1) Utilize high cost case reports to identify high cost members.  
2) Establish regular meetings with the Care Management department to improve population health through strategies to utilize analytical tools to the highest capacity. | 1) end of Q2  
2) Q1 through Q4 | Kleinmaus  
Madson  
CM/Behl |
| Utilize analytical tools to identify opportunities for employer specific health and wellness programming | 1) Identify trends in employer group pharmacy spend, hospitalizations, etc. and utilize information to offer specific programming to increase awareness and healthy behaviors. | 1) Utilize QM analytical tools to identify employer specific trends.  
2) Identify high utilizers and set up meetings to suggest programming.  
3) Monitor for trends. | 1-3) Ongoing | Sandene  
Madson  
Kastman  
Wellness Team |
### 2019 Quality Improvement Work Plan
#### Focused by the Triple Aim

<table>
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<tr>
<th>GOALS</th>
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<tr>
<td><strong>Quality of Service</strong></td>
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</table>
| Conduct on-going assessment of patient experience and member satisfaction and develop strategies for improvement. | 1) Develop project management structure for Cooperative Experience Committee to effectively impact improvements to Press Ganey and CAHPS results. | 1) Develop project management structure for Cooperative Experience Committee. | 1) Q1  
2) Ongoing | Steiner  
Sandene  
Kastman  
Cooperative Experience Committee |
| | 2) Improve cooperative experience based on 2019 Press Ganey survey comments and results. | 2) Learning and Development and Cooperative Experience Committee continue to support training of new GHC-SCW staff members using Press Ganey coursework (Anticipate, Communicate & Sustain). | 3) Ongoing  
4) End of Q2  
5) Ongoing  
6) Q2  
7) Q3-Q4 | |
| | 3) Improve member satisfaction for CAHPS measure results below the 50th percentile based on 2018 surveys. | 3) Review CAHPS results and develop strategies for improvement for measures below the 50th percentile. | 4) Review a process for sharing complaints. Consider an electronic mechanism such as CRM. | |
| | | 5) Utilize complaints and compliments to develop member initiated improvements. | 5) Review a process for sharing complaints. Consider an electronic mechanism such as CRM. | |
| | | 6) Implement Cyder at Regent Mental Health. | 6) Implement Cyder at Regent Mental Health. | |
| | | 7) Implement Provider Transparency by posting Press Ganey survey comments and results on the GHC-SCW website. | 7) Implement Provider Transparency by posting Press Ganey survey comments and results on the GHC-SCW website. | |
| | | | | |
| Conduct ongoing evaluations of current and future outreach initiatives. | 1) Evaluate all current outreach initiatives for continuation. | 1) Review all reports for inclusion/exclusion criteria. | 1) Q1-Q4  
2) Q1-Q4  
3) Q3  
4) Q1-Q4  
5) TBD  
6) Ongoing | Steiner  
Ibrahim  
Kastman  
Bi  
EA  
Health Ed |
| | 2) Review all current outreach reporting for opportunities to incorporate non-staff model members. | 2) Work with BI to import non-staff model claims data into Epic Healthy Planet tools. | | |
| | 3) Partner with outlying community resources to educate non-staff model members of opportunities within their community. | 3) Annual Review of Population Health Strategy and its Impact PHM 6 A @ CSCQ. | | |
| | | 4) Evaluate the interest in reintroducing the Diabetes and/or other chronic disease newsletters on a quarterly basis. | | |
| | | 5) Incorporate bulk messaging and outreach for non-staff model members when Caboodle tools and processes are live. | | |
| | | 6) Monitor the following outreach initiatives:  
- ADHD Initiation/Continuation Follow Up Appointments  
- Adolescent Well Child | | |
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<tr>
<td>Improve the health of populations</td>
<td>1) Understand baseline demographic and health outcome data to examine where potential inequities exist. Staff and committee members will examine and compare internal data to local, state, and national public health statistics and other available evidence. 2) Pursue innovative ways to promote organizational health literacy, develop a culturally competent workforce, and nurture an inclusive work environment. 3) Provide a safe and open space where issues related to equity, inclusivity and cultural diversity can be discussed and addressed.</td>
<td>1) Work with the Population Health Department and Marketing to create health literate mailings and MyChart message templates for registry activity and Quality outreach mailings. 2) Continue to follow the 3 year strategic plan “Roadmap for Health Equity: 2017-2019” to ensure that the organization promotes and practices a welcoming and inclusive environment. 2a) Demographic data collection improvement project 2b) MyChart improvement project.</td>
<td>1) Ongoing 2) Ongoing 2a) Q1-Q4 2b) Q1-Q4</td>
<td>Steiner Ibrahim Francis Health Equity Committee Inclusion Change Team</td>
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| Improve scores on reported measures related to diabetes outcomes | 1) Improve HEDIS measures for members with diabetes:  
- HbA1c testing among 18-75 year olds; reach 95%  
- HbA1c control < 8.0 %; reach 67% - 70%  
- BP Control <140/90; maintain 80 % or greater | 1a) Implement a project in clinics and for health plan members for coverage of pre-diabetes classes and evaluate impact.  
1b) Monitor the implementation of Epic’s Healthy Planet tools, Reporting Workbench and registries, to enable clinic staff to identify and provide outreach to members with diabetes. Continue to provide support to internal staff.  
1c) Continue to monitor workflow for newly diagnosed patients with diabetes/diabetes care gaps in pre-visit prep. | 1a) Ongoing  
1b) Ongoing  
1c) Ongoing | Kastman  
Steiner  
Twining  
Ibrahim  
Rx/Guetzlaff |
| Improve scores on reported measures related to hypertension | Expand hypertension efforts to entire patient population (beyond patients with diabetes). | 3) Continue to monitor and provide on-going support to the Pharmacy department for the approved, protocolized HTN medication renewal process. Assess impact of new, expanded pharmacy role.  
4) Review the impact of statin management via pharmacy protocol.  
5) Review other opportunities for pharmacy medication protocols.  
6) In collaboration with BI and Pop Health, review Epic registry outreach opportunities.  
7) Spread Hypertension Committee pharmacy consult pilot to additional clinic to improve hypertension control in staff model patients.  
8) Implement BP Cuff pilot.  
9) Implement pilot with UW Health Rheumatology to schedule follow up appointments for GHC-SCW members with uncontrolled hypertension. | 3) Q1-Q4  
4) Q1-Q4  
5) Ongoing  
6) Ongoing  
7) End of Q2  
8) Q1  
9) Q1 | Kastman  
Steiner  
Twining  
Ibrahim  
Rx/Guetzlaff |
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<tr>
<td><strong>Quality of Clinical Care</strong></td>
<td>Continue the organization’s commitment to build system change, advocacy and education around advanced care planning.</td>
<td>1) Continue to outreach clinic staff regarding the Honoring Choices initiative and have additional staff trained as facilitators as warranted by demand.</td>
<td>1-3 Ongoing</td>
<td>Steiner</td>
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<td></td>
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<td>2) Monitor advance care planning referrals to all patients 60 and above at the time of their physical exams.</td>
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<td>3) Review the feasibility of the kiosk message for advance care planning.</td>
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<tr>
<td>Create and disseminate Provider Dashboards on a quarterly basis with data on quality, cost, and patient experience.</td>
<td>1) Continue workgroups to maintain Nursing Dashboard and Urgent Care Dashboard.</td>
<td>1) Meet regularly with EA and BI teams to discuss current state of the Provider Dashboard, barriers and opportunities, and future additions of other population health tools to populate an EMR dashboard.</td>
<td>1) Ongoing</td>
<td>Twining Ibrahim</td>
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<td>2) Incorporate auto-tabulating metrics where possible. Movement of the quarterly manually-calculated metrics to the real-time pop health metrics of the dashboard.</td>
<td>2) Meet regularly with Nursing and Urgent Care leadership to create meaningful metrics for new clinical dashboards.</td>
<td>2) Ongoing</td>
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<tr>
<td>GOALS</td>
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| Quality of Clinical Care | Look to develop unique approaches and strategies to improve member health outcomes and costs associated with asthma. | 1) Utilize the Asthma Risk Score reports to identify high-risk, uncontrolled asthma patients for outreach in GHC-SCW clinics.  
2) In collaboration with BI and EA, develop Asthma reporting workbench report. | 1) Asthma Committee continues bi-monthly meetings.  
2) Analysis of FeNO data to make possible recommendations regarding the future of purchasing additional machines.  
3) In collaboration with the Population Health Department, develop an Epic asthma registry and reporting workbench to facilitate bulk ordering and messaging. | 1) Ongoing  
2) Q2-Q3  
3) Q2-Q3 | Ballweg  
Ibrahim  
Steiner |
| Create an evidence-based Wellness program for external employer groups, GHC employees, members and patients. | 1) Develop a Wellness Change Team, Wellness Committee, and smaller project-based workgroups to implement evidence-based wellness initiatives. | 1) Implement the Wellness Change Team, Wellness Committee, and smaller project-based workgroups.  
2) Implement the Kiiio pilot at American Family.  
3) Spread the Kiiio pilot if successful.  
4) Implement Profile as a wellness benefit for GHC employees.  
5) Spread Profile as a wellness benefit to employer groups if successful. | 1) Q1  
2) Q1  
3) TBD  
4) Q1  
5) TBD | Kastman  
Steiner  
Sandene  
Wellness |
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<tr>
<td>Continue to monitor patient safety and look for opportunities for improvement.</td>
<td>1a) For all existing patients on non-cancer Chronic Opioid Therapy treatment, reduce all members to less than 90 mg daily morphine equivalents. 1b) Prevent any non-cancer patient from increasing past a daily morphine equivalent of 90 mg. 1c) Decrease or eliminate the co-administration of opioids, benzodiazepines, and sleep aids. 2) Explore Medication Assisted Treatment within Primary Care. 3) Continue to involve PCBH in counseling in the primary care setting. 4a) Resource Clinical Pharmacists for medication review for members with complex prescription drug therapies. 4b) Continue to utilize Clinical Pharmacists as needed as a resource for providers to develop opioid tapering plans. 5) Obtain information and trending from the PDMP. 6) Develop pain management competencies to support necessary monitoring and practices for safe pain management. 7) Develop criteria for Naloxone prescribing.</td>
<td>1) Continue initiative to improve safety of clinical care for patients with non-cancer chronic pain who receive chronic opioid therapy. Publish GHC-SCW pain management guidelines. 2) Monitor number and impact of practitioners that provide Medication Assisted Treatment. 3) Monitor number of PCBH encounters and chronic pain group participants to determine involvement of PCBH with pain managed patients. Continue to promote and resource PCBH across clinics and referrals to chronic pain group. 4) Monitor clinical pharmacy encounters for pain managed patients. Continue to promote and resource Clinical Pharmacists across clinics. 5) Comparison of our prescribing data compared to PDMP portal data. Quality and Safety Committee review. 6) Monitor increased utilization of RN support for pain management appointments and increased confidence via use of a pain management survey. 7) Determine threshold for Naloxone prescribing based upon RIOSORD decision support tool. Determine opioid dosing threshold for Naloxone prescribing. Monitor naloxone prescribing based upon RIOSORD scores and daily morphine equivalent prescribed. 8) Anticipate future HEDIS metrics. Set goals for the HEDIS opioid measures.</td>
<td>1-7) Q1-Q4 8) Ongoing</td>
<td>Kastman Steiner Ibrahim Hynek Safety Committee PCBH Clinical Pharmacy Mental Health L&amp;D</td>
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### Behavioral Health Care

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</table>
| Improve behavioral health outcomes for our members. | I. HEDIS BH Measures: maintain percentile goals for measures 1-4  
   1. ADHD Continuation (ADD)  
   2. Antidepressant Med Mgmt Continuation (AMM)  
   3. F/U After Hospitalizations for MH-7 (FUH)  
   4. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)  
   5. Alcohol or Drug Treatment Engaged (IET)  
 II. Monitor, trend and improve performance on ED follow-up measures:  
   - FUM: Follow-Up After Emergency Department Visit for Mental Illness  
   - FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence  
 III. Primary Care Behavioral Health  
   - Continue PC and BH Integration  
   - Improve primary care population surveillance for depression.  
   - Improve safer suicide care in primary and behavioral health care.  
 IV. WCHQ BH QI Steering Team Charter  
   Continue to have representatives (M. Steiner, J. Austin) from GHC-SCW participate on committee. | I. Continue directed member outreach, use of PCBH services & provider education. Report quarterly performance to providers.  
   II. Define the health plan’s goals and opportunities related to these 2 measures.  
      a. Surveillance of current performance and determine/develop more efficient reporting capacity and timely notification of ED visit.  
      b. Improve understanding of expectation and communication workflows between health plan and both staff model and contracted providers regarding follow up visits.  
 III.  
      a. Evaluate member and practitioner experience with PCBH services.  
      b. Expand, enhance, and standardized screening for depression in primary care through implementation of PHQ-2/PHQ-9 screening protocol.  
      c. Pilot and evaluate use of Columbia Suicide Severity Rating Scale in primary care.  
 IV. Engage and collaborate to disseminate improvements. | I. Q1 - Q4  
   II.a Q1 - Q2  
   III.a Ongoing  
   III.b Q2 - Q3  
   III.c Q1 - Q4  
   III.d Q1 - Q4  
 IV. Q1-Q4 | Van Den Brandt  
   Austin  
   Fucci |
Appendix 3

CLINICAL & SERVICE QUALITY COMMITTEE

STATEMENT OF PURPOSE

This committee is responsible for the oversight of quality improvement activities for the health plan of Group Health Cooperative of South-Central Wisconsin. Specific activities are as follows:

- Develop the Annual Quality Work Plan with input from GHC-SCW Executive Leadership, Managers and/or Supervisors, Committees, project teams, strategic planning, or other sources.
- Oversee the establishment of NCQA standards and guidelines, improvements and timetables.
- Periodically review QI progress and provide the direction necessary for success
- Champion the forming of project implementation or recommendations.
- Make policy updates as warranted by business practice or current NCQA standards/guidelines.
- Develop the Annual QI Report including the summary and evaluation.
- Ensure practitioner participation in the planning, design, implementation of the QI program and periodic review of supporting committees or teams
- Identifies/institutes needed actions and follow-up as appropriate
- Review reports of regular monitoring activities and surveys for continuous improvement of the service and clinical care provided to all membership.
- Participate in the review of Population Health Management strategies in conjunction with other relevant committees

ROSTER

- Chair; Accreditation Coordinator
- Chief Medical Officer
- Quality & Population Health Manager
- Quality Analyst/HEDIS Coordinator
- Care Management Manager
- Director of Behavioral Health & Medical Specialty Services
- Member Services & Sales Manager
- Manager Pharmacy Services (Ad hoc)
- Nursing Representative (Ad hoc)
- Community Care Representative (Ad hoc)
- Marketing Representative (Ad hoc)
- Medical Staff Administrator (Ad hoc)

MEETING FORMAT AND FREQUENCY

The committee reviews the various clinical and quality items on the agenda, reaches conclusions and defines actions for follow-up which includes the responsible person and timeframe for completion as maintained in the meeting minutes. The committee maintains a monthly meeting calendar.
Appendix 4

PEER REVIEW COMMITTEE

STATEMENT OF PURPOSE

Peer Review is the review of clinical activities of members of the medical staff by other qualified practitioners with comparable training and experience who can render an unbiased opinion on the quality of care. The purpose of peer review is to promote continuous improvement of the quality of health care provided by the medical staff at Group Health Cooperative of South Central Wisconsin (GHC-SCW). The Peer Review Committee (PRC) investigates patient or practitioner complaints/concerns about the quality of clinical care provided by GHC-SCW practitioners and makes recommendations for corrective actions. The Committee also reviews sentinel conditions identified by Care Management staff as having quality concerns. In addition, the PRC is the committee that makes recommendations regarding credentialing and re-credentialing for all practitioners (as defined in policy MED.046) credentialed by GHC-SCW.

CONFIDENTIALITY OF INFORMATION

1. The PRC is a distinct and separate Committee within GHC-SCW’s Quality Improvement Program. All PRC activities are protected by federal and state laws and are immune to discoverability.

2. Peer Review is organized and operated to help improve the quality of health care. Accordingly, no person acting in good faith who participates in the review or evaluation of services of health care practitioners as part of the GHC-SCW Peer Review Committee is liable for any civil damages because of any act or omission by such person in the course of such review or evaluation. This civil immunity, pursuant to law, applies to acts and omissions including, but not limited to, censuring, reprimanding or taking any other disciplinary action against a health care practitioner.

3. No person who participates in the review or evaluation of the services of health care practitioners as part of the GHC-SCW Peer Review Program may disclose any information acquired in connection with such review or evaluation, nor may any record of the investigation, inquiries, proceedings and conclusions of the Peer Review Committee be released to any person under Section 804.10(4), Wis. Stats, or otherwise, except as permitted by the exceptions set forth in Section 146.38(3), Wis. Stats. Any person who testifies during, or participates in the review or evaluation may testify in any civil action as to matters within his or her knowledge, but may not testify as to information obtained through her or his participation in the review or evaluation, nor as to any conclusion of such review or evaluation, as provided in Section 146.38(2), Wis. Stats.

4. Consistent with its goals of helping to improve the quality of health care, the PRC reports its findings to the Chief Medical Officer who in turn, reports general activities of the PRC to the full Board of Directors of GHC-SCW as warranted.
ROSTER

The Chair makes appointments to the PRC. The PRC membership includes:
- Family Medicine Physicians (2-3)
- Internists (1-2)
- Pediatricians (1)
- Physician Assistant or Nurse Practitioner (1)
- Other specialists as needed for case review or credentialing decisions (e.g. Chiropractor, Psychiatrist)
- Medical Staff Administrator

MEETING FORMAT AND FREQUENCY

1. The minutes of the previous Committee meeting are reviewed. Cases are prepared outside the committee by an initial reviewer who presents the case for further review and discussion at the meeting. Corrective actions, if any, are recommended. Policies concerning confidentiality are followed.

2. Every three years, re-credentialing information is reviewed prior to re-appointment. Credentials of new staff are presented to the Committee.

3. The Committee meets quarterly.

COMMITTEE AUTHORITY

The Board of Directors is ultimately responsible for the quality of health care provided to GHC-SCW members. The Board delegates the responsibility of ensuring a high level of quality of care to the Chief Medical Officer who, in turn, charges the PRC to review all quality concerns referred to it. The PRC provides educational feedback to the involved practitioners, reports findings to the Chief Medical Officer and when appropriate, make recommendations for credentialing, re-credentialing, reduction, suspension or termination of individual practitioner privileges. The Chief Medical Officer acts in a manner providing for maximum protection for documentation from legal discovery and protection of the identity of individual practitioners.

SOURCES OF QUALITY OF CARE CONCERNS FOR COMMITTEE REVIEW

Quality of care concerns can be brought to the PRC from several sources, including but not limited to the following:
1. Practitioners
2. Chief Medical Officer
3. Members through Member Services complaints or other member generated communications.
4. Care Management Department
5. QM Department including other QA/QI committees or teams
6. Medicare / Medicaid Sanctions
7. Licensure Sanctions or Limitations
8. Requests for review by external regulatory agencies or payers
PEER REVIEW PROCESS

The PRC will carefully review the medical care in all situations in which a quality concern has been raised. The involved practitioner will be notified, in writing, of a possible quality concern and asked to present additional verbal or written information for the primary reviewer prior to the date of the PRC meeting. The PRC will take these practitioner comments into consideration when reviewing the case.

The PRC will evaluate the quality concern related to medical care and make a determination as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards. The PRC will send a written evaluation of the quality concern to the involved practitioner along with any recommendations / actions. A copy is also sent to the Chief Medical Officer.

The Committee may make a recommendation for an educational activity for the involved practitioner such as reviewing a text or an article or attendance at a CME related to the quality of concern. The PRC will obtain information to substantiate the recommendations are carried out in a timely manner.

If the PRC observes a pattern of quality concerns regarding a single practitioner, the Committee may suggest reduction, limitation, or suspension of privileges or contract termination.

After receiving the PRC’s recommendation, the Chief Medical Officer will make a decision and create an action plan. The reason for the action and a summary of the appeal rights and processes will be communicated, in writing, to the involved practitioner. The practitioner can then appeal the Chief Medical Officer’s decision according to the Appeals / Hearing Process outlined below.

APPEAL / REQUEST FOR HEARING

Practitioners have the right to request a hearing and appeal any decision of the GHC-SCW Peer Review Committee.

The practitioner must request a hearing, in writing, within 30 days from the date the provider receives the Chief Medical Officer’s final decision and action plan. The request should be sent via certified mail to the Chair of the Peer Review Committee, 1265 John Q. Hammons Drive, Madison, WI 53717.

WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within the time and in the manner specified waives his/her right to any hearing or any appellate review to which he/she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the initial review.
NOTICE OF TIME AND PLACE FOR HEARING

Upon receiving a timely and proper request for hearing, the Chief Medical Officer shall then schedule a hearing. Within fifteen (15) business days of receipt of the request for hearing, the Chief Medical Officer shall send the practitioner, via certified mail, notice of the time, place and date of the hearing. The hearing date shall be within forty-five (45) days of the date the notice of hearing was sent to the provider.

The notice of hearing must contain a concise statement of the practitioner’s alleged acts or omissions, a list of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action that is the subject of the hearing.

APPOINTMENT OF HEARING PANEL

When a hearing has been requested in the manner specified above, the Chief Medical Officer shall appoint a hearing panel composed of the Chief of Staff, who shall Chair the panel, and no less than three (3) additional members whose practice is relevant to the issue addressed. This may necessitate the use of non-employed practitioners. The hearing panel shall be composed of members of the medical staff who have not participated actively in consideration of the matter involved at any previous level. Knowledge of the reasons or subject matter forming the basis for the adverse action or recommendation, which gave rise to the request for a hearing, shall not preclude a member of the medical staff or other person from serving as a member of the hearing panel.

ATTENDANCE / REPRESENTATION

The practitioner may attend the hearing in person or may submit written materials in lieu of their presence. The practitioner may be accompanied and represented at the hearing by an attorney or by another person of his/her choice. The practitioner shall inform the Chief Medical Officer in writing of the name of that person at least ten days prior to the hearing date. GHC-SCW shall appoint an individual to represent them. Such individual may be an attorney or any other person designated by the Chief Medical Officer.

RIGHTS OF PARTIES

During the hearing, each party shall have the following rights:

a) call and examine witnesses
b) introduce exhibits
c) cross-examine any witness on any matter relevant to the issues
d) rebut any evidence
e) to have a record made of the proceedings, copies of which may be obtained by the appellant upon payment of reasonable charges for the preparation thereof

POSTPONEMENT

Requests for postponement or continuance of a hearing may be granted by the Chief Medical Officer only upon a timely showing of good cause.
HEARING PANEL REPORT

Within twenty (20) days after adjournment of the hearing, the hearing panel shall make a written report of its findings and recommendations. The report shall contain a summary of the basis of the decision. The hearing panel shall forward the report along with the record and other documentation to the Chief Medical Officer. The practitioner shall also be given a copy of the report.

NOTIFICATION OF AUTHORITIES

As required by the Health Care Quality Improvement Act of 1986, as amended and 45 Code of Federal Regulations Part 60, the Chief Medical Officer or his/her designee shall report to the State Medical Examining Board and/or the National Practitioner Data Bank (NPDB) in accordance with the respective state and federal regulations. Incidents requiring reporting include, but are not limited to: contract suspension/termination due to quality reasons; involuntary reduction of current clinical privileges; suspension of clinical privileges; termination of all clinical privileges. All submissions will be reviewed by corporate council prior to notification to authorities.
CLINICAL CONTENT COMMITTEE

STATEMENT OF PURPOSE

The purpose of the Clinical Content Committee is to serve as content experts and decision makers for clinical matters related to electronic medical record tools, clinical forms/handouts, medical/nursing policies and procedures, and/or clinical topics or activities associated with Quality, Population Health or Patient Centered Medical Home requirements. The responsibilities of the Clinical Content Committee are outlined as follows:

- Update clinical content in Epic Care.
- Evaluate, recommend or approve practice guidelines and implement associated medical record tools
- Evaluate and recommend nursing and medical policies.
- Evaluate and advise on electronic medical record related issues.

ROSTER

- Chair; Associate Medical Director-Informatics & Care Management
- Medical Chief of Staff
- Representatives from Enterprise Applications
- Representative Practitioners within GHC-SCW Primary and Urgent Care
- Representative Registered Nurses
- Representative LPNs or CMAs
- Representative from Pharmacy Administration
- Quality and Population Health Manager (ad hoc)

MEETING FORMAT AND FREQUENCY

The group discusses items brought to the agenda, concludes and defines the actions to be taken, the responsible person or team and appropriate timelines for completion. The committee meets monthly.
Appendix 6

EMPLOYEE HEALTH AND PATIENT SAFETY COMMITTEE

STATEMENT OF PURPOSE

To maximize safe clinical practice in patient settings, and during transitions in care for all members of Group Health Cooperative of South Central Wisconsin. The Committee’s main responsibilities are:

1. Develop and coordinate policies, procedures and activities related to monitoring patient and employee safety
2. Identify opportunities to reduce medical errors, support interventions, and monitor progress in these activities.
3. Define measures of patient and employee safety and perform periodic measurement.
4. Review member complaints related to clinic safety.
5. Develop and distribute information to members, employees and practitioners that improves their knowledge about clinical safety through newsletters and through medication safety activities.
6. Establish a liaison representative with community hospitals to support hospital-based patient safety activities.
7. Report patient safety initiatives to the National Committee for Quality Assurance, as applicable.

ROSTER

- Chair; Vacant
- Employee Health and Safety Specialist-PA-C
- Facilities Technician
- Facilities Supervisor
- Lab Services Manager
- Administrative Assistant
- Clinic Manager
- Registered Nurse
- Ad hoc Representation, as needed

MEETING FORMAT AND FREQUENCY

The committee discusses various items on the agenda, reaches conclusions and defines the necessary actions including the responsible person or team and appropriate deadlines. The committee meets every other month, or as needed.
QUALITY COMMITTEE

STATEMENT OF PURPOSE
To review and approve current and proposed GHC-SCW staff model clinic quality improvement (QI) projects for feasibility, scalability and timing, and monitor ongoing progress.

SCOPE
This committee reviews clinical QI projects for both the insurance and care delivery functions of Group Health Cooperative of South Central Wisconsin, makes recommendations for and approves new projects, sets initiatives that align with strategic planning, and assesses resources for starting, continuing, and discontinuing clinical QI projects. The committee reviews data to monitor success and identifies areas of opportunity. Contract negotiations and off budget proposals without the inclusion of Finance are out of scope. Projects and improvements related to clinic efficiency and Lean projects are out of scope.

ACTIVITIES
- General oversight of the individual clinical improvement subcommittees.
- Project updates of ongoing clinical QI projects.
- Prioritization of projects based on strategic planning, regulation, staffing availability, etc.
- Charter new projects and committees.
- Retire processes or committees as needed
- Maintain a listing of clinical QI projects and current project status.
- Reviews:
  - Monthly quality performance data
  - Monthly Clinical and Service Quality Committee (CSQC) minutes
  - Quarterly clinical quality dashboards
  - Yearly HEDIS metrics
  - Yearly Quality Compass and ACHP results
  - Yearly MIPS results
  - Annual QM Work Plan & QI Report
  - ETF, FEHB, and QHP requirements for potential project needs

ROSTER
- Chair, Quality & Population Health Manager
- Co-Chair, Chief Medical Officer
- Chief of Staff
- Chief Nursing Officer
- Director Behavioral Health and Medical Specialty Services
- Clinical Practice Solutions Manager
- IT Business Intelligence Manager
- Enterprise Applications Manager
- Learning & Development Manager
- Accreditation and Quality Improvement Coordinator
- Administrative Assistant
- Quality Analyst
- BI representative
- Others as appropriate
MEETING FORMAT AND FREQUENCY

The committee reviews the agenda, reaches conclusions and defines actions for follow-up which includes the responsible person and timeframe for completion as maintained in the meeting minutes. The committee meets at least quarterly or ad hoc as needed.