Quality Improvement Program

2016 Annual Report

February 2017
TABLE OF CONTENTS

I. GHC-SCW QUALITY IMPROVEMENT PROGRAM p 3-12
   ° Purpose
   ° Goals
   ° Quality Improvement System
   ° Structure of the Program
   ° Annual Work Plan

II. 2016 ANNUAL SUMMARY p 12-20
    A. Introduction
    B. Overview of 2016
       ° Operational Recognition and Achievements
       ° HEDIS and CAHPS Performance
       ° Health Management
       ° Safety of Clinical Care
       ° Quality of Service
       ° Quality of Clinical Care
       ° Financial Health
       ° NCQA Accreditation & Compliance
       ° Employee Engagement
    C. Challenges
    D. Reflections on Overall Effectiveness

III. EVALUATION OF WORKPLAN PROJECTS p 20-46

QUALITY OF SERVICE
   ° Outreach Process Improvements
   ° Promoting Health Equity and Health Literacy
   ° Improvement of Consumer Satisfaction

QUALITY OF CLINICAL CARE
   ° Diabetes Care and Outcomes
   ° Dashboards: Provider, Urgent Care and Nursing
   ° Asthma /COPD Measures and Committee Projects
   ° Advance Care Planning
III. EVALUATION OF WORKPLAN PROJECTS (continued)

SAFETY OF CLINICAL CARE

- Cardiovascular Medication Management
- Chronic Pain and Safety of Clinical Care

BEHAVIORAL HEALTH CARE

- Antidepressant Medication Management
- Follow-up after Hospitalization for Mental Illness
- Follow-up for Children prescribed ADHD Medication
- Initiation and Engagement of AOD Treatment

IV. QUALITY IMPROVEMENT WORK PLANS  p 47- 58

- 2016
- 2017

V. APPENDICES

1. Overall Organizational Chart
2. Quality Improvement Structure
3. Clinical and Service Quality Committee
4. Peer Review Committee
5. Clinical Content Committee
6. Employee Health and Patient Safety
I. GHC-SCW QUALITY IMPROVEMENT PROGRAM DESCRIPTION

PURPOSE: a customized program in pursuit of the aim to continuously improve the quality and safety of medical and behavioral health care and the quality of services provided to GHC-SCW members.

GOALS:

° To support and achieve company mission, vision, common values & goals
° 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 description that follows is written in three sections:

- **QI SYSTEM:** summarizes system concepts and how they relate to the overall program.

- **STRUCTURE OF THE PROGRAM:** summarizes the governance and content.

- **ANNUAL WORK PLAN:** summarizes how the annual work plan is 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 performance and customer service.

A. Customer Voice
An important cornerstone of our quality improvement system is vigilant attention to the voice of the customer. Frequent customer feedback is valued and essential. Activities and strategies planned throughout the various departments of the organization consider consumer comments when actively working toward meeting member expectations. The goal is to ultimately achieve better customer service.

B. Employee Engagement
Employees represent a vital reservoir of information in which to learn from as individuals across the organization have special insight into various business needs or problems. Supervisors and employees must engage to exchange and express their concerns or ideas. Employees who contribute to the understanding of problems in their work areas become empowered to make adjustments to improve work processes. Multiple incremental improvements can lead to a higher level of overall performance. Employees treated with respect for their concerns or ideas will give their all to deliver "superb care and impeccable service", a hallmark of GHC-SCW.

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. Processes or systems are evaluated to assess if we are using the best methods and available tools. Prior to implementing improvements, the current system is carefully evaluated in quantitative terms and subsequently monitored quantitatively after changes are introduced.

D. Plan-Do-Check-Act (PDCA)
A PDCA cycle involves using a series of formal steps to solve problems or make improvements. The process encompasses an analysis of the current situation, root causes of problems, planning potential solutions, initiating pilot systems, checking results, implementing the system at full scale, monitoring results, and then repeating the steps if necessary. Use of this step wise process provides a better understanding of barriers to improvement in order to implement solutions.

E. Leadership
Leadership is, of course, crucial to any management system. Senior leaders need to provide direction for the organization. Management leaders need to set the example for all other employees. It is through leaderships commitment to open communication and by defining our companies strategic goals and priorities that the entire workforce comes together to create a positive workplace environment and position the health plan to meet the challenges ahead.
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
"Group Health Cooperative of South Central Wisconsin will be a leader among health plans in providing high quality medical care, impeccable service, competitive benefit levels and premium rates. GHC-SCW will maintain consistent membership growth and sound financial health each year."

H. Common Values
What drives the success of GHC-SCW is our unwavering belief in five Common Values which shape the way we perform each day in order to deliver the best possible member experience. We exist to serve our members.

*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

I. Core Competencies
- We are a partnership of medical and insurance services to provide population based quality care for the benefit of our members.
- We provide member-centered primary care services through our staff-model clinics.
- We listen and respond to the needs of our stakeholders and build strong relationships.

J. GHC-SCW Brand Promise “Better Together”

Meaningful relationships are a big reason why GHC-SCW is such a great organization. Our understanding of the power of relationship is clear when you consider our brand motto: Better Together. This is more than a catch phrase---it is a basic fundamental principle which makes GHC-SCW a great place to deliver and to receive care. Strong relationships aid in the delivery of health care and establish a sense of belonging, compassion and understanding. This trademark of GHC-SCW, the "Better Together" promise continues to guide our mission to develop relationships which are welcoming and central to the care and service we provide.


**Oversight and Accountability:**

The Board of Directors entrusts the overall monitoring of the QI Program to the Chief Executive Officer who assigns various components of the QI Program to the Chief Medical Officer and the Associate Medical Director of CM & Informatics as responsible senior leaders. The day-to-day operation of the Quality Program is delegated to the Manager of Quality. 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.

*Appendix 1* outlines the overall organizational structure of GHC-SCW.

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 designs and implements the behavioral healthcare aspects of the QI Program. The Medical Director for Behavioral Health serves ad hoc to the CSQC.

*Appendix 2* outlines the current structure of the QI Program.

**Scope:**

The scope of the QI Program is comprehensive. It potentially involves evaluating how well the health plan manages quality throughout every part of its delivery system -- physicians, hospitals, affiliated providers and administrative services. The process for monitoring, evaluating and improving quality is designed to incorporate two key components:

- The use of data to assist with the delivery of, ongoing monitoring and evaluation of important aspects of care and service, and continuous improvement of systems and processes.
- Involvement of medical and behavioral health professionals in the analysis to identify opportunities

These professionals include medical directors, physicians & nursing staff, quality staff, operational managers and others working together to emphasize lean principles and utilize sophisticated quality management tools and approaches.

**Behavioral Health QI Program:**

The Behavioral Health Quality Improvement program is overseen by the Clinical and Service Quality Committee and is coordinated by the Director of BH & Medical Specialty Services (LCSW) and through the work of the Committee on Continuity and Coordination of Behavioral Healthcare and Medical Care. This committee members include the Behavioral Health Medical Director (psychiatrist), GHC-SCW’s Director of BH & Medical Specialty Services (LCSW), the Program Manager of UW Behavioral Health & Recovery (the delegated substance abuse provider), staff model mental health therapist, a mental health RN, a primary care practitioner, one social worker from Care Management (UM), Pharmacist, a mental health therapist (LCSW) from a UW Department of Family Medicine PC Clinic, a clinical information analyst, the accreditation coordinator and an administrative assistant. The committee reviews all 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 and practitioners related to members diagnosed with substance use disorders
Outreach to members and practitioners with Attention Deficit and Hyperactivity Disorder
Information to post-partum members about post-partum depression
Analysis of members with co-existing medical and behavioral conditions
Analysis of all HEDIS results related to behavioral health issues
Standardization of symptom measurement for adult depression (PHQ-9) and anxiety (GAD-7) across primary care and mental health with common access to data in EMR.
Training in motivational interviewing and integration of PCBH

Health of our Community

As a non-profit, consumer sponsored HMO, GHC-SCW is committed to achieving public health goals. In 2010, the Department of Health and Human Services launched Healthy People 2020, which has four overarching goals:
- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all and,
- Promote quality of life, healthy development, and healthy behaviors across all life stages

GHC-SCW is advancing healthcare locally to help achieve these goals and in 2016 instituted a Population Health department with an ambitious MPH degree employee as the Population Health Manager. She is developing initiatives in preventive health activities and health equity programs and leading our effort for clinical Patient Centered Medical Home recognition in 2017.

GHC-SCW also cooperates with local public health and Medicaid programs to coordinate prenatal care for high-risk pregnancies and to provide outreach programs for childhood immunizations and health checks. GHC-SCW has been an active participant in the Dane County Immunization Coalition, a community-based collaborative working to insure that all citizens of Dane County are appropriately immunized against vaccine preventable diseases.

Employee Health and Patient Safety:

GHC-SCW is committed to the safety of clinical care. The primary responsibility of the Employee Health and Patient Safety Committee is to monitor patient safety and medical errors in the clinical environment, as well as, during transitions in care. The committee meets up to six times per year to address employee health and/or other organizational patient safety initiatives and as needed to review member complaints related to clinical safety.

Discussions include development and distribution of information to members and providers, clinical safety training opportunities, employee health for patient safety (i.e. TB testing and vaccinations), Patient Safety Net (PSN) occurrence reporting, review of member complaints related to clinic safety, monitoring for potential medical errors in the pharmacy system, and developing and helping to implement organizational safety-related quality improvement initiatives that may focus on members, practitioners and/or care team staff.
Committee Structure:

The Quality Improvement structure, including the four current committees, is depicted in Appendix 2. Leadership of these various committees has been delegated by the CEO or CMO. These standing committees are the central part of the QI program and are designed to address a wide range of improvement opportunities for GHC-SCW. They function to continuously screen and review information about quality issues and help to identify projects for the annual Work Plan. The individual committees are briefly summarized below with additional detail provided in the associated appendixes.

Clinical and Service Quality Committee; Appendix 3

The assignments and agenda of this committee are directed by the Accreditation Coordinator (Chair) in collaboration with the CMO and/or Clinical Quality Liaison MD or the Quality Manager. The committee oversees quality issues related to service, clinical and behavioral health and patient safety and may allocate resources necessary for the forming and functioning of various teams. The committee aids in the implementation of team recommendations, makes policy recommendations to other GHC-SCW leaders and/or managers, reviews and approves the annual work plan and QI program description and evaluation, monitors clinical practice guideline updates and reviews the reports of regular monitoring activities, improvement efforts and surveys.

Peer Review Committee; Appendix 4

This committee and its Chair is responsible for reviewing any specific clinical and behavioral health cases, which have been referred as possible instances affecting quality of care. Members, practitioners, staff or other individuals who identify quality of care concerns can forward cases to this committee.

Clinical Content Committee; Appendix 5

Committee members of the CCC serve as content experts for clinical policy review and informatics issues that relate to the activities of the Quality and Clinical Information Services Departments. This committee and it's Chair, the Associate Medical Director of Informatics and Care Management, also reviews clinical practice guidelines developed in collaboration with the University of Wisconsin Center for Clinical Knowledge against clinical evidence and approves updated guidelines at least every 2 years or more frequently if national guidelines change within the two year period.

Employee Health and Patient Safety Committee; Appendix 6

The Chief Nursing and Clinical Operations Officer chairs this committee which monitors patient safety and medical errors in the clinical environment and during transitions in care. The group may also help to develop and coordinate policies, procedures and organizational patient safety initiatives.

Credentialing:

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

- physicians and psychiatrists (MD or DO) or masters / doctorate psychologists (PhD or PsyD)
- licensed 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. It includes a comprehensive review of the work plan objectives, organizational initiatives and an overall evaluation of the impact of the QI program including progress toward influencing safe clinical practices throughout the delivery system as well as evaluating practitioner availability and complaints and appeals annually. The aforementioned evaluations are reviewed by the Clinical and Service Quality Committee to determine whether areas identified need further improvement or have been appropriately addressed.

Committee Meeting Documentation:
GHC-SCW generates agendas and detailed minutes for all the quality committee and subcommittee meetings.

Quality Improvement Program Resources:
The QI Program has support from GHC-SCW’s Chief Executive Officer. The Chief Medical Officer and the Associate Medical Director of Informatics and Care Management play key roles in the QI program. A Quality Manager, Accreditation Coordinator, Quality Analyst and Outreach and Patient Experience Coordinator make up the quality team and have a range of expertise. The Population Health Manager is also intricately involved in quality improvement efforts. The program is further supported by sophisticated information systems, electronic medical records and software tools available for quantitative and qualitative data analysis to aid in improvement initiatives.

Objectives for Serving a Culturally and Linguistically Diverse Membership:
GHC-SCW is dedicated to providing 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 eliminates health disparities whenever possible. Our objectives are:

- To identify and conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks
- To identify and reduce health care disparities
- To provide services in a culturally competent manner, regardless of gender, sexual orientation or gender identity

Some examples of work towards these objectives:

- GHC-SCW helped 120 refugees in 2016 to connect them to needed care in our community through our Refugee Assistance Program within our Community Care Department
The Health Equity Committee continues to unite staff across the organization to promote policies, initiatives, and resources for the populations we serve. GHC-SCW staff participated in a series of trainings throughout the year led by the local YWCA to learn more about creating equitable organizations.

Continued involvement in and endorsement of a variety of diverse community based programs such as partnership with the Literacy Network, the Centro Hispano Wellness Program & the Latino Health Fair.

**Objectives for serving members with complex health needs:**

Our Complex Case Management program provides proactive, medically appropriate, cost effective, coordinated care to members with complex medical / behavioral health conditions or for whom a critical event has precipitated a need for rehabilitation or additional health care support.

GHC-SCW members inquiring about or accessing care services are evaluated to determine their need. If a member does not qualify for Complex Case Management, s/he has the opportunity for continuum of care for medically necessary services through Utilization Management.

Several key objectives defined for the Complex Case Management Program are:

- To provide early intervention to prevent recurrent crisis or unnecessary hospitalizations
- To support and reinforce physician recommended treatments and therapies.
- To assist members in navigating the delivery system & to better understand their individual benefits
- To serve as a liaison to community resources regarding options and services not covered by the benefit plan
- To support members individualized learning needs related to managing their health
- To partner with providers and the community in assisting the member to achieve the highest potential for maximum independence

Some achievements in department operations in 2016 were:

- Use of the CAVE tool "Red Alert System" to identify members on an increased trend for complexity of care
- Managing members with High Risk Pregnancies resulted in a positive outcome and substantial cost savings of NICU dollars.
- Utilization Management staff improved approval/denial lag times to within 5-10 days
- Review of internal data related to medical costs determined focus areas of high priority for Complex Case Management services in 2017 and resulted in tightening our criteria to hit the highest need members whenever possible; these criteria include:
  - Diabetes diagnosis with a cardiovascular diagnosis or event
  - Substance Abuse Disorder
  - Less than 18 years old with a psych admission
  - Chronic comorbidity (two chronic diseases or conditions) with a psych admission
  - High-risk pregnancy
Collaborative Activities:

GHC-SCW’s suppliers and partners play various roles in the production and delivery of key products and support services. EPIC, which provides the EMR and MyChart infrastructure, is a key collaborator and supplier. EPIC Link and Care Everywhere 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 collaborates with MetaStar, a QI organization that consults with hospitals, clinics, nursing homes, health plans, physicians, and nurses to empower them to make lasting improvements and address the need for system-wide innovation and consistent evidence-based approaches across settings of care. MetaStar supports our efforts to improve outcomes among diabetes patients with access to community-based diabetes self-management classes.

Meriter Hospital and UW Health have a long history of collaborating to provide excellent care in our community. In 2016, GHC-SCW and UnityPoint Health – Meriter signed a contract to transition all member maternity and newborn services to Meriter Hospital effective in 2018. With this change, our members will have the option of Certified Nurse Midwives for their prenatal and birth experience and newborns needing more specialized care will access UW Health neonatologists and pediatric subspecialists. GHC-SCW members highly value the relationship with UW for specialty care.

GHC-SCW & Edgewood College are collaborative partners giving several next generation nursing students learning opportunities through clinical rotation within out-patient settings at GHC owned clinics. Students are able to link their nursing theory to real time experiences in a variety of situations including care team meetings, prenatal & pediatric visits and Case Management.

Other standing collaborations include committees such as the University of Wisconsin liaison Meeting, University of Wisconsin Endocrinology Meetings (Diabetes Care), University of Wisconsin Center for Clinical Knowledge and HealthCare partners to review and develop clinical practice guidelines, EPIC Care User Group meetings, Department of Family Medicine (DFM) liaison meetings & Dental Health Associates (DHA) liaison meetings.

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 rates, NCQA standards requirements, observed problems, member complaints and/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, teams are working on and contributing to a "living work plan", in which objectives and activities may be accomplished at variable rates as items change subsequent to business planning and budget constraints. Projects with designated team leaders or subcommittee members report periodically to QM leadership and the CSQC as appropriate.

Six major categories have been identified as work plan focus areas:
i. **Quality of Clinical Care**
Aim to improve clinical processes and outcomes provided to GHC-SCW members including care in the staff model and other contracted clinics as well as health promotion and disease management activities.

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

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

iv. **Safety of Clinical Care**
Aim at maximizing safe clinical practices for GHC-SCW members served by contracted organizational providers and practitioners. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

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

vi. **Financial Health**
Aim at optimizing value in health care delivery.

**II. 2016 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 superb quality care, more affordable care and coverage, and a member experience with the health care system that is patient centered yet efficient.

Over the last few years, the organization has experienced transformative change. Within this report we reflect on the change, challenges, and many successes of 2016.

The year began with the appointment of Dr. Mark Huth to be CEO. In recognition of his leadership achievement and commitment to the organization during an interim period, the Board President announced the decision to make Dr. Huth our next official CEO in late January 2016. He later followed with instating a Chief Financial Officer to lead our Finance team. Mid-year, Dr. Rob Matthew, resigned from the duties of Chief Medical Officer. A new leader was soon appointed to assume the responsibility. Dr. Christian Kastman was named Chief Medical Officer and continues to oversee quality and population health initiatives for the organization.

Dr. Jason Hampton began oversight of our Care Management department providing medical review of orders and judgments of Prior Authorizations for inpatient and outpatient. Protocols and guidelines may be established based on best available evidence within the Technology Assessment and Member Appeals
Committees under his supervision. He was also appointed to Chair the Clinical Content Committee and oversee medical informatics initiatives as an Associate Medical Director.

GHC-SCW continues planning to build our cooperative for the future. A systemic review of operations led to the creation of a Strategic Plan that has strengthened the organization by building on our unique qualities and values and positioning the company for a changing healthcare landscape. The Strategic Planning process is a collaborative effort involving our Board of Directors, the Senior Leadership team and many members of our management as they have established goals for the next 3-5 years.

The corporate goals, which serve as a foundation of the Strategic Plan, are as follows:

**Financial Performance**: GHC-SCW will report solid financial performance each year, incorporating a healthy revenue strategy and a dedication to increased efficiency and appropriate management of costs.

**Growth**: GHC-SCW will continue to provide competitive premiums, along with exceptional patient care and service excellence, all of which will drive continued growth in our market.

**Transformation**: Our continued innovation will drive transformation of our organization in response to an ever-changing healthcare market, bringing new opportunities for engagement, communication and partnership with our members.

**Quality**: GHC-SCW will continue its leadership position for clinical quality and patient experience in alignment with our dedication to achieving the Triple-Aim

**Culture & Community**: GHC-SCW will continue to be the healthcare employer of choice and will work to further strengthen and expand our community programs and involvement.

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 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 of 2016

**Operational Recognition and Achievements**

- GHC-SCW was surveyed by NCQA in 2016 for both its Marketplace and Commercial HMO product lines undergoing both an off-site and onsite process. The survey resulted in achieving 49.71 out of 50 points for the accreditation standards.
- GHC-SCW retained an “Excellent” NCQA Accreditation status and earned a 4.5 out of 5 star rating after adjustment of the accreditation score with our HEDIS rates and CAHPS performance for the commercial product line. The Cooperative enjoys a rich history of accomplishments in quality improvement and takes pride in maintaining this status since 1995, marking our 21st consecutive year.
- GHC-SCW was 1 of 8 private health insurance plans in WI rated a 4.5 by NCQA. This achievement reflects the strong commitment GHC-SCW has to continuous high quality health care. In 2016, NCQA rated more than 1000 health plans nationally; only 13 of the over 1000 commercial plans received a rating of 5.0.
- GHC-SCW celebrated its 40th Anniversary serving the health care needs of the people of south central WI by establishing the Look Back, Give Back Campaign to recognize Community Champions with service awards.
According to the Alliance of Community Health Plans (ACHP) benchmarking report, GHC-SCW achieved or maintained above the 90th percentile in:

- 10 of the 18 Clinical Treatment scores
- 9 of the 16 Access and Prevention scores
- 3 of the 10 Service scores

GHC-SCW ranked #1 out of 18 in Wisconsin in eight areas, namely Effectiveness of Care and Treatment, Diabetes, Respiratory, Mental Health, Prevention, Child and Maternal Health and Getting Care. Nationally, GHC-SCW ranked #1 out of 402 in Respiratory and Child and Maternal Health, however in Consumer Experience and Provider Satisfaction performance lagged nationally and at the state level. Consumer Experience and Provider Satisfaction remain important focus areas for improvement.

The table below, a reproduction of the ACHP HealthPlan Performance Gauge 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 results.

<table>
<thead>
<tr>
<th>HEDIS 2016</th>
<th>National Percentile</th>
<th>National Rank (Out of ?)</th>
<th>ACHP Rank (Out of ?)</th>
<th>State Rank (Out of ?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>97</td>
<td>12</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Treatment</td>
<td>98</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>91</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cardiac</td>
<td>92</td>
<td>34</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Respiratory Health</td>
<td>100</td>
<td>(404)</td>
<td>(34)</td>
<td>(18)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>98</td>
<td>(402)</td>
<td>(34)</td>
<td>(18)</td>
</tr>
<tr>
<td>Prevention</td>
<td>98</td>
<td>(396)</td>
<td>(34)</td>
<td>(18)</td>
</tr>
<tr>
<td>Child &amp; Maternal Health</td>
<td>100</td>
<td>(404)</td>
<td>(24)</td>
<td>(18)</td>
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</table>

<table>
<thead>
<tr>
<th>CAHPS 2016</th>
<th>National Percentile</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>76</td>
<td>98</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Provider Satisfaction</td>
<td>76</td>
<td>98</td>
<td>(34)</td>
<td>(18)</td>
</tr>
<tr>
<td>Getting Care</td>
<td>89</td>
<td>40</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Plan Satisfaction</td>
<td>94</td>
<td>40</td>
<td>34</td>
<td>(18)</td>
</tr>
</tbody>
</table>

* "(Out of ?)" 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
- Highly weighted (e.g. triple weighted outcomes measures) or lowest performing

Measures related to diabetes care continue to be areas of improvement focusing on Comprehensive Diabetes Care, specifically HbA1C control < 8.0.
Health Management

- A Diabetes registry within the EMR and action plans focus on consistent identification of diabetics and their needed care.
- Bulk Communication and Ordering tools were specifically designed to assist teams in very rapid and precise ordering and communication of clinical items to close care gaps.
- ePharmix pilot project offers communication between patients and Care Teams using text messages. Messages ask patients questions about their symptoms related to a specific condition. The pilot focuses on congestive heart failure in GHC's staff model patients.
- The Senior Leadership Team and Clinical Leadership Committee gave approval to pursue Patient Centered Medical Home Recognition through NCQA for GHC's staff model clinics. PCMH Recognition is awarded to clinical practice sites embedding Team Based Care, Population Health Management, Care Coordination and Transitions, and Performance Measurement and Quality Improvement.

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.
- Providing follow-up with members through Complex Case Management to ensure that care is received in a timely manner.
- Identifying opportunities to improve continuity and coordination of care of medical care and between medical and behavioral health care.

Occurrence Reporting System: UHC Patient Safety Database

The Employee Health and Patient Safety Committee are responsible to prevent harm where possible and prepare staff for situations that may arise. This is accomplished through reviewing incidents filed to the UHC Database on a monthly basis. GHC-SCW's occurrences of harm in our clinics and organization remained low in 2016 and risks are also low. Employees are encouraged to file reports of concern for building or parking safety, medication management, ordering processes, workflows, "near misses or almost events" through the Occurrence Reporting link on the GHC intranet. Based on the UHC reports, patient safety projects may be initiated.

Zika, Lyme and West Nile Virus and Patient Safety:
GHC-SCW prepared resource materials for staff to print and share with members on its Intranet Clinical Resources page with links to the CDC website, general patient information, testing and pregnancy guidelines and repellant information.

Chronic Pain Management

GHC-SCW continues to impact the abuse or overuse of opioid medications and help members to identify alternative pain control options. In 2016, a Chronic Opioid Registry became available in the EMR with metrics being tracked on Primary Care Provider and Nursing Dashboards. More detail surrounding this ongoing initiative is included in Section III of the Evaluation.
Implementation of e-Prescribing Platform 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.

Employee Influenza Vaccinations

Group Health Cooperative is a community leader in our efforts to prevent disease through a strong vaccination program. Along with many other Wisconsin providers, we have dramatically reduced the occurrence of health care associated infections through these efforts. To ensure that we are doing all we can to help our patients and each other live well, 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 all their members to implement an evidence-based vaccination initiative for all personnel. GHC joins other Dane County and Wisconsin medical clinics, hospitals, home health agencies, nursing homes, and pharmacies in their mandatory influenza vaccination policies.

Safety Initiatives within Pharmacy

° The pharmacy department reviews medication occurrences on a monthly basis to look for trends and opportunities to improve work flows. Medication occurrences are reported to the Employee Health and Patient Safety Committee (EHPS) biannually. Medication occurrences remain very low due to internal training and education of pharmacy staff.

° Clinical Pharmacists within GHC-SCW staff model clinics provide drug utilization review on members and provide counseling to patients to ensure the members’ medication is appropriate, effective for the medical condition, safe given comorbidities and other medications and to educate the member on how to take the medication as prescribed.

° Clinical Pharmacists continue the management of hypertension and hyperlipidemia medications by pro-actively reviewing medications before they are due for renewal to ensure the members’ medication is appropriate and testing has been ordered before the renewal is completed. The pharmacists working at this level may provide drug selection and dose adjustments along with patient education.

Quality of Service

° Achieved performance at or above the 90th percentile in the following 2016 CAHPS measures:
  • Customer Service Composite
  • Getting Care Quickly Composite

° Home Sleep Tests become available to members to aid in the diagnosis of Obstructive Sleep Apnea (OSA). This process was designed to increase member satisfaction and likelihood of test completion.

° The Lactation Committee continues to support Breastfeeding across the membership. GHC staff attended training to increase skills specific to breastfeeding to teach back to female members.
The GHC-SCW operated pharmacies at Sauk, Capitol and Hatchery began stocking several OTC items including acetaminophen, docusate and high potency probiotics; pharmacists are able to independently order and dispense upon patient or PCP request.

GHC-SCW updated processes to improve care coordination with our specialist partners. Members no longer need to get copies of their digital images to share with a practitioner at SSM clinics. Additionally, UnityPoint Health-Meriter removed the consent requirement for access to their CareEverywhere records eliminating the need to obtain authorization from GHC member patients.

GHC-SCW partnered with the University of Wisconsin Center for Tobacco Research and Intervention on a large grant-funded effort to improve smoking-cessation efforts.

**Quality of Clinical Care**

- Discharge Coordination-When patients discharge from hospitals, they are often confused and unclear about next steps, medication changes, and self-care needs. This can result in readmissions and exposure to further medical complications. To reduce readmissions and to improve our coordination of care, RN's outreached members coordinating care and reviewing care needs in an attempt to reduce readmission rates.

- Best Practice Alerts flag members with a 10-year cardiac risk of more than 7.5% and needing medication

- GHC-SCW removed injectable narcotics from all of our clinics at the end of April 2016 following a review of chronic pain management evidence-based literature and local practice guidelines.

- Population Health strategies are taking root to encompass Registry-based preventative care gap closure, Registry-based chronic disease care, RN Case Coordination and Complex Case Management.

**Financial Health**

Beginning in 2015, GHC-SCW, started an important cultural and financial turnaround. Throughout 2016, Dr. Huth has worked with the Chief Financial Officer and the finance team to create a 2017 business plan. The plan describes specific tactics, measurable objectives and outcomes target dates. The finance team also produced sales volume and pricing assumptions and finalized medical cost utilization and increase assumptions for primary care, specialist care, ancillary, outpatient and inpatient care. The 2017 operating and capital budgets were finalized for presentation to the Board in mid-December 2016. Significant effort also went into developing the 2017-2019 Capital Asset Plan. Two new software applications, *Adaptive Insights* for budgeting and *Acumatica* for accounting were introduced. The new software will prove it's worth to substantially improve GHC-SCWs budgeting, financial planning, and financial modeling capabilities.
At this time, GHC-SCW continues to track its financial performance. While 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, we continue to work to ensure a future that provides high quality care for our members regardless of the provider location. A number of very specific medical cost related initiatives were identified and began to be implemented as of late July 2016. Higher than budgeted medical costs, particularly for specialist, outpatient, and inpatient utilization, is the major challenge that adversely impacts financial performance. These costs fortunately have been offset by lower than budgeted administrative cost savings and higher than budgeted investment income which in total has been able to bring GHC-SCW to within its budget projections. Continued vigilance and hard work is necessary for GHC-SCW to continue on the path to meets its financial objectives.

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 in more than 40 areas in order 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 health care. The accumulation of the NCQA accreditation score and the HEDIS® and CAHPS® measures add up to determine 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 registered trademark of the 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.

On May 31st, 2016, GHC-SCW's Accreditation Coordinator submitted documentation to NCQA to begin the renewal process for national accreditation. 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. Despite high staff turnover in the past 2 years, GHC-SCW experienced a great result maintaining its 4.5 rating and "Excellent" status for the commercial HMO. Kudos went out to all staff that had a role in the accreditation process across the organization. The NCQA reviewers completed the onsite file review in less than one day and attributed this to our amazing staff and the concise presentation of materials.

2016 was also the first year GHC-SCW's Marketplace HMO product line was accredited via the survey process. As a Qualified Health Plan issuer, "Accredited" status allowed the organization to continue participation on the federal exchange under the Affordable Care Act and the Center for Medicaid and Medicare Service requirements.

Employee Engagement

The Quality team welcomed two new staff members in 2016. A vacancy was filled for an Outreach and Patient Experience Coordinator and a new Quality Analyst was hired to replace a staff member who was promoted to be the organizations new Population Health Manager. The Quality Manager focused attention on shaping the future direction and work of the department. Job duties of staff were evaluated to effectively manage the workload and continue needed efforts. Employees are encouraged to improve their skills through professional development within their roles.
Quality staff also participates on various committees which focus on the objectives of the work plan, accreditation requirements or other initiatives. Routine team meetings involve project updates and occasional educational webinars. 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.

In spring 2016, company employees attended the All Staff Meeting to celebrate GHC-SCW and learn about improving patient experience. In the fall, the Quality team gathered for a celebration of our accreditation achievements, social pursuit and mandatory camaraderie.

**C. Challenges**

- Change within CMO Leadership & within role of Medical Director for Care Management
- Budget constraints and business financial objectives.
- Mounting regulatory requirements
- Changing health care financing and care delivery landscape of the local healthcare market by outside of Wisconsin health plan owners
- Self-funding by the State of WI
- Outreach and engagement across our network providers
- Contracting
- Improving the patient experience
- HEDIS requirements
- Uncertainty of the impact of legislation changes with the Affordable Care Act
- Evaluating new opportunities to generate more fee-for-service revenue

**D. Reflections on Overall Effectiveness of Program**

Annually, the overall effectiveness of GHC-SCW’s 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 also ensure adequacy of resources.

Dr. Christian Kastman and his team of dedicated staff have brought forward ideas to shape the objectives of a new department and the direction of the QI program. Leadership endorsed seeking PCMH recognition for all 6 of our internal primary care clinics in 2017. PCMH recognition will also enable GHC to avoid potential financial penalties under new Medicare legislation.

GHC-SCW continues unwavering 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 this summary and evaluation herein demonstrates that GHC-SCW remains committed to our focus on the Triple Aim.
GHC continues to make progress toward influencing network-wide safe clinical practices. Outreaching members following hospital discharge to coordinate and review care in an effort to avoid miscommunication or delays that can lead to poor outcomes or contribute to readmission rates is one effort toward this aim. Competent opioid prescribing and chronic pain management processes in collaborations with our external partners (e.g. EPIC, UW Health, Access Community Health) is another of these achievements.

The detail of the 2016 and 2017 Work Plans are included in Section IV & take into account overall strategic planning as well as valued input from various committees, partners and collaborations.

### III. EVALUATION OF 2016 WORK PLAN PROJECTS

#### QUALITY OF SERVICE

### Outreach Process Improvements

**Aims**
- To review current outreach reporting, processes and marketing communications
- To expand outreach for non-staff model members

**Background**

An Outreach and Patient Experience Coordinator was hired in February 2016 that began improvements to GHC-SCW's outreach processes, materials and methodologies. Proactive outreach to patients provides comprehensive patient care and encourages adherence to evidence based practice standards.

**Goals**
- Streamline the current outreach process
- Increase outreach to non-staff model members

**Interventions**
- Reviewed reports for inclusion and exclusion criteria
- Worked with Business Intelligence to import non-staff model claims data
- Utilized messaging within GHCMyChart to decrease the amount of mailings when appropriate
- Reviewed outreach communication materials with Marketing and Health Literacy workgroup to update and improve the content
- Use of Reporting Workbench reports within EMR has shifted patient outreach to the clinical teams for diabetic patients who are overdue for an A1c or whose A1c is not at goal.
- Incorporated bulk ordering and bulk messaging to support outreach efforts

**Barriers**
- Lack of transition between former and current Outreach specialists
- Time needed for Business Intelligence team to modify reporting
Conclusions

The use of provider dashboards, reporting work bench and population health tools have improved outreach processes to staff model clinic members by care teams. Additional EPIC tools such as Cogito scheduled to be implemented in the 2017 upgrade will improve the organizations central data repository for clinical, financial and business data to further facilitate organizational processes.

Promoting Health Equity and Health Literacy

Aims

- To understand baseline demographic and health outcome data to examine where potential inequities exist
- To pursue innovative ways to promote health literacy, develop a culturally competent workforce and nurture an inclusive work environment
- To provide a safe and open space where issues related to equity, inclusivity and cultural diversity can be discussed and addressed

Background

GHC-SCW’s Health Equity Committee was revitalized in 2015. Trainings took place throughout 2016, led by the local YWCA, which offered HEC members insight into creating equitable organizations. Committee efforts have led to the development of an organizational three-year strategic plan, a vision for future priorities and projects for 2017-2019.

Goals

- To conduct needs assessments of the populations that GHC-SCW serves & reduce health outcome disparities
- To promote health literacy and cultural competency among the GHC-SCW workforce

Interventions

- Health Literacy Workgroup reviews key organizational documents and signage to ensure that they are written at an appropriate reading level and in applicable languages
- Staff use the Nutrition Activity Screening (NAS) tool to assess for food insecurity among pediatric patients and their families and connect them with community resources
- Development of a Health Equity Index Report to catalogue GHC-specific data to assess and understand member and patient demographics and the impact on health outcomes
- Several HEC members led an assessment of care pathways for patients and members that identify as transgender.
- Health Equity Lens Checklist is developed with important reminders on how to be culturally competent/sensitive as a quick resource for our frontline staff

Barriers

Disparities that exist in our community include economic hardship, differences in educational attainment, health behaviors, stereotypes, and racism that are often unintentional and pervasive. As a cooperative that values high quality patient-centered care, we are responsive and strategic in challenging these inequities.
Conclusion

The Health Equity Committee had many successes throughout 2016 reflected in the high-level support it gained from Senior Leadership. Plans for 2017 include:

° Purchase YWCA Sustainer Equity and Inclusion Package that will aid GHC-SCW in embedding equity and inclusion into our organization at all levels.
° Implement new organizational structure to support health equity work in the form of Change Teams and smaller Work Groups

Improvement of Consumer Satisfaction

Aims

° To create and sustain a culture of exceptional service for our patients and members
° To improve employee engagement and build staff skills to embody patient-centered customer service through trust, respect and compassion

Background

GHC-SCW has in recent years struggled to achieve optimal patient and member experience scores based on both health plan survey and patient survey data. A Patient Experience workgroup was convened that identified activities targeting our clinic and administration sites. These activities included:

a) Reviewing compliments and complaints to reinforce Service Standards
b) Applying existing knowledge and common values to address service issues
c) Monitoring existing clinic-based patient experience metrics to understand where targeted improvement efforts exist and/or can be focused.

Goals

° To improve Consumer Satisfaction rating, as measured by the Consumer Assessment of Healthcare and Provider Survey (CAHPS) to within the 66th-90th percentile = 4 stars

Analysis

2016 CAHPS survey; GHC-SCW performed well in the following:

° Rating of All Health Care – between the 75th and 90th National Percentiles
° Rating of Health Plan – between the 75th and 90th National Percentiles
° Plan Information on Costs – between the 75th and 90th National Percentiles
° How Well Doctors Communicate – between the 75th and 90th Percentiles
° Customer Service – 95th National Percentile
° Getting Care Quickly – 95th National Percentile

GHC-SCW has typically viewed improvement opportunities as items that score below the 50th National Percentile. Compared to other regional and national private health plans, GHC-SCW lags behind in the following measures:

° Rating of Specialist Seen Most Often – between the 10th and 25th National Percentiles
° Health Promotion and Education – between the 25th and 50th National Percentiles
° Getting Needed Care – between the 33rd and 50th National Percentiles
Barriers to better scores on the aforementioned measures may include:

- Health Promotion and Education may be influenced by the limited time in clinic appointments to address all health concerns and still promote ways to prevent illness.
- Members may experience a cumbersome referral process to specialists housed outside of GHC-SCW owned and operated clinics.
- GHC’s internal specialty services such as optometry, radiology and lab services at different clinic locations may create difficulties for members to receive convenient care, treatment or tests.
- Impacting consumer experience at the delivery system level for our members seen at the external clinic sites in Sauk and Columbia counties remain an organizational challenge.
- 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.

Conclusion

Through efforts across GHC focusing on Patient Experience, the Consumer Satisfaction rating for the commercial HMO increased to 3.5 in the 2016-17 ratings from 3.0 in 2015-16. The Patient Experience workgroup continues to plan and implement targeted efforts to positively impact CAHPS measures such as Rating of Specialist, Getting Needed Care and Health Promotion and Education at the health plan level.

**QUALITY OF CLINICAL CARE**

**Diabetes Care and Outcomes**

**Aims**

- To achieve better outcomes for patients and members with diabetes
- To develop bulk messaging and bulk ordering features in the EMR

**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 things such as a PCP-visit, A1C lab test, or blood pressure check. Work continues amongst Clinical Care Teams and the Diabetes Improvement Team to close gaps in care.

**Goals**

- Improve annual A1c testing among 18-75 year olds to 95%
- Improve A1c control < 8.0% to 60%
- Increase percentage of staff model (SM) members with diabetes (18-75 yrs.) who have an A1c goal documented on their "Problem List" in the EMR.
- Increase statin use among SM members with diabetes (40-75 yrs.) to 75%
- Improve the Well Controlled Composite measure to 40%
  a) SM members with diabetes 18-39 must have A1c <8.0 and BP < 140/90
  b) SM members 40-75 must have A1c < 8.0 and blood pressure < 140/90 and have filled a statin prescription within the last 100 days.
Analysis

Compliance rates for diabetes care over the past three years are provided in the following table.

<table>
<thead>
<tr>
<th>HEDIS Rates by Measurement Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure control (&lt;140/90 mm Hg) 18-75 yrs.</td>
<td>74.45%</td>
<td>77.55%</td>
<td>80.66%</td>
</tr>
<tr>
<td>Eye Exam (retinal) performed - 18-75 yrs.</td>
<td>75.18%</td>
<td>67.9%</td>
<td>64.60%</td>
</tr>
<tr>
<td>HbA1c (&gt;9.0%) 18-75 yrs. (lower rate is better)</td>
<td>23.54%</td>
<td>29.2%</td>
<td>25.91%</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>
</tr>
<tr>
<td>HbA1c good control (&lt;7.0%)</td>
<td>35.64%</td>
<td>29.5%</td>
<td>28.96%</td>
</tr>
<tr>
<td>Hemoglobin A1c (HbA1c) testing - 18-75 yrs.</td>
<td>92.15%</td>
<td>90.5%</td>
<td>91.42%</td>
</tr>
<tr>
<td>Medical attention for nephropathy - 18-75 yrs.</td>
<td>91.24%</td>
<td>88.5%</td>
<td>90.90%</td>
</tr>
</tbody>
</table>

GHC-SCW experienced some depressed CDC compliance rates in measurement year 2015. Blood pressure control was the one CDC measure that GHC-SCW performed above the 95 percentile (79.99) as 80.66% of Commercial HMO members with diabetes between 18-75 had a blood pressure of <140/90. GHC met its goal to improve blood pressure control to 80% by end of 2016.

GHC missed its goal to achieve 60% compliance in the A1c less than 8 measure by only 0.33% in 2016.

Lower than desired performance in some CDC ratings results reaffirmed GHC-SCW’s long-term commitment for improving diabetes outcomes, especially as the prevalence of members diagnosed with diabetes is anticipated to increase.

GHC-SCW achieved a 4 star rating on the following measures:

- Diabetic Eye Exams
- HbA1c < 8.0
- Medical Attention for Diabetic Nephropathy

Interventions

- Developed bulk messaging and bulk ordering features in the EMR for clinic staff to support outreach efforts to close gaps in care
- Developed risk scores in EMR for stratification of targeted outreach
- Completed Reporting Workbench (RWB) trainings w Care Teams
- Revamped RN Smart-Set in EMR to add clarity
- Nursing Dashboard went Live displaying at a glance diabetes metrics by practitioner
- GHC-SCW and UW Health collaborating on Maintenance of Certification diabetes project
- Solidified MetaStar opportunities focusing on referrals to community based self-management programs
Barriers

- Ongoing education of clinic staff to implement the tools in diabetes registry
- Operational and cultural shift for clinic staff to proactively outreach and close gaps in care for their own population of patients.
- Lack of integration with members seen at external provider locations presents an ongoing challenge to directly impact the quality of clinical care. Overcoming this barrier will require building relationships and working collaboratively with improvement staff at those sites and systems to share best practices and resources.
- The need for value-based contracting that could effect change and improve diabetes outcomes and rates to ensure all health plan members are receiving the highest quality of care.

Conclusions

Through GHC-SCW’s concerted efforts and the ongoing work of the Diabetes Improvement Team, our clinics continue to utilize an actionable EMR based registry. The Quality department is working closely with GHC-SCW’s Certified Diabetes Educators to refine the diabetes disease management program and improve self-management skills essential to improving outcomes.

Dashboards: Primary Care, Urgent Care and Nursing

Aims

- Clinical staff can compare performance to colleagues, as well as, state and national benchmarks
- Transparency of data helps to drive improvement efforts by:
  - a) Helping identify areas of opportunity
  - b) Generating conversation and creating engagement

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.

Interventions

As of 2016, GHC-SCW has built several dashboards that are available to clinic staff via the EMR. Additional disease and wellness registries are in various stages of being built. Metrics were selected by the Dashboard Workgroup in tandem with key stakeholders and committees. Measures selected provide information about the effectiveness of GHC-SCW’s improvement efforts and to align with the organization’s goals.

Several new automated Preventative Health metrics appear on the Primary Care and Nursing Dashboards. These metrics are: Flu Shot for Adults (18 years+); BMI for Adults (18-64 year olds); Cervical Cancer Screening for Females (21-64 year olds); Chlamydia Screening (18-24 year olds); and Gonorrhea Screening for Females (16-24 year olds). Additionally, we are working to create communication templates that can be used with the Bulk Communication functionality to help close any gaps in care by sending reminders to patients via their MyChart account, standard mail or phone.
Analysis

Although having the dashboards within the EMR should be convenient for clinic staff and increases the likelihood that they will take action, limitations still exist.

° Disparate data sources require manual manipulation to display practitioner information in a graphical format
° Additional EMR based registries are necessary to automatically track and trend data
° 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.
° Not all of measures lend themselves to immediate action

Conclusions

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 Preventative-care based metrics and reports for Care Team use.

Asthma /COPD Measures and Committee Projects

Aims

° Utilize the Asthma Risk Score Report to identify high-risk uncontrolled patients for outreach
° Develop Asthma /COPD Reporting Workbench tools

Background

GHC-SCW has a long term commitment to improving the health and disease 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.
° Piloting of Asthma Risk Report enabling Care Teams to proactively address patients' needs
° Pilot testing of a respiratory management device to track frequency of medication use related to asthma and COPD

Goals

° To develop unique approaches and strategies to improve health outcomes and costs associated with asthma and COPD
° To achieve HEDIS compliance rates above the 75th national percentile
**Analysis**

<table>
<thead>
<tr>
<th>HEDIS Results by Measurement Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Medication Ratio (AMR) total</td>
<td>83.66</td>
<td>83.87</td>
<td>83.71</td>
</tr>
<tr>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)</td>
<td>60.38</td>
<td>48.78</td>
<td>47.25</td>
</tr>
</tbody>
</table>

- AMR: achieved a rating score of 5.0 (90th 83.7)
- SPR: achieved a rating score of 4.0 (75th 45.83 - 90th 51.72)
- 2016 results for both measures met or exceeded the organizational goals

**Interventions**

In 2016, GHC-SCW's Asthma Committee continued to meet and evaluated the success of the Asthma Risk Report project. Project Care Teams were selected to use the reports to identify, rank and outreach to members who had one or more of the following:

- An inpatient visit in last 12 months
- ER visit for asthma in last 12 months
- Rescue medication in last 12 months greater than or equal to 4 fills
- Urgent Care for asthma in last 12 months
- Oral steroid count in last 12 months

A Clinical Pharmacist and RN both received color-coded Asthma Risk Reports on a monthly basis for 6 months. RNs focused outreach to members with an Asthma Medication Ratio (AMR) ≥ 0.50. Clinical Pharmacists focused on members with AMR < 0.50.

**Challenges**

- Asthma Risk Report is in a paper format
- Only includes members with GHC coverage (excludes fee-for-service, etc.)
- Clinical staff time needed to conduct outreach can reach up to 45 minutes
- Typically only connect with patients/family on 1st attempt 50% of the time

**Conclusions & Future Considerations**

The Asthma Risk pilot project with the Oak Care team at Hatchery Hill ended in June 2016 and preliminary data was shared with Clinical Leadership. The data appears to show some promise for applying a scoring algorithm to better prevent further exacerbations for high-risk members on a provider’s panel with asthma. A discussion of lessons learned and recommendations for how to bring the project to full scale were considered. A post pilot staff survey indicated Care Teams increased their engagement with high risk members. Future plans include:

- Adjusting the report to a rolling 6 months instead of monthly
- Development of an Asthma Registry in the EMR & Tracking Patient Outreach in RWB
- Utilization of Population Health tools within the EMR to Bulk message could potentially place orders for and communicate with multiple patients at one time
Advance Care Planning

Aims

- Offer a facilitated advance care planning referral to all patients 60 and above at the time of their physical examinations

Background: GHC-SCW remains active in the Honoring Choices program offered through the Wisconsin Medical Society. GHC 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%.

Goals

- Train additional staff as warranted, based on demand, to be facilitators
- Continue to build advocacy and education around advance care planning
- Greater than 50% of patients 60 and over will have an advance directive on file

Interventions

- Best Practice Alert (BPA) launched in February 2016 to remind providers to ask individuals if they would be interested in participating in a facilitated conversation.
- Two additional staff were trained as facilitators in April 2016

Analysis

We continue to monitor completion rates of all patients 60 and above with a PCP in the staff model system. As of the end of Dec 2016, 17.5% (1260/7205) had an advance directive on file in the medical record. In 2016, the organization also began offering conversations for those with a terminal diagnosis as part of the hospice benefit for State of Wisconsin Group Health Insurance members. Two facilitators from the Care Management department trained in 2016 to work with members who are high risk for hospitalization and prime opportunities for ACP outreach.

Barriers

- Many members find it challenging to return for the facilitated conversation with a chosen agent or prefer to take documents home with them thus affecting completion rates and return.
- Although GHC-SCW is currently targeting patients 60 and older as the most critical, there exists the need to expand these types of facilitated conversations to the entire member population 18 and over.
- A standardized process for suggesting a facilitated conversation does not exist. Further training for clinical staff may help providers offer the service more frequently.

Conclusions

GHC-SCW participates in community outreach in collaboration with other local health plans and providers and recognizes the importance of the ACP initiative and will continue efforts to reach its goal. A dedicated spot in the electronic medical record to store documentation will allow for better tracking and reporting. This tab in the documentation will be part of our EPIC upgrade in 2017.
Cardiovascular Medication Management

\textit{Aims}

\begin{itemize}
  \item To improve primary care practitioner-pharmacist collaboration
  \item To reduce electronic prescription renewal requests
  \item To improve GHC-SCW member blood pressure control and statin utilization.
\end{itemize}

\textit{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.

Beginning in late September 2015, a Collaborative Practice Agreement allowed the pharmacist to work with the PCP and patient to provide recommendations, education, medications, dose adjustments and appropriate monitoring more independently. The percentage of HTN patients managed by a clinical pharmacist in 2015 was 7.6\% (640/8446). The CPA process was originally designed for \textit{opting in} by provider.

\textit{Goals}

\begin{itemize}
  \item To transition a large portion of hypertension management from PCP’s to pharmacist
  \item To transition the initiation and monitoring of statin medications from PCP’s to pharmacists.
  \item Greater than 10\% of patients with uncomplicated hypertension will have a pharmacist manage their medication
\end{itemize}

\textit{Interventions}

\begin{itemize}
  \item Developed a new Collaborative Practice Agreement based on an \textit{opt-out} rather than an \textit{opt-in} model. Patients that meet the criteria designated in the protocol will automatically be eligible for Clinical Pharmacy intervention.
  \item Expanded the patient population on which the clinical pharmacists will intervene under the new CPA; CP’s assume a more proactive role in hypertension and lipid management for patients with diabetes or chronic kidney disease (stage 1-4, without proteinuria).
  \item 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.
\end{itemize}
Analysis

**Trends in statin utilization rates:**

While the number of members using a statin stayed relatively stable from the previous year, GHC has seen the cost per day of therapy drop by roughly 80% from 2015 to 2016 as a result of clinical pharmacist management.

<table>
<thead>
<tr>
<th>% members on a statin/1,000 insured members</th>
<th>Dec 2015</th>
<th>Dec 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.92 %</td>
<td>2.83 %</td>
</tr>
</tbody>
</table>

**Trends in blood pressure control rates for patients with a Staff Model Clinic PCP**

While the number of members with a controlled blood pressure has remained consistent, the percentage of Staff Model HTN patients managed by a clinical pharmacist has grown by 9.5% since 2015. In May of 2016 this percentage was 11.8% (735/6242) and by the end of the calendar year had reached 17.1% (1041/6092). GHC-SCW’s change to make the CPA an *opt-out* rather than an *opt-in* model has contributed to this growth and improvement.

<table>
<thead>
<tr>
<th>% of HTN patients with BP &lt;140/90</th>
<th>Blood Pressure Recorded Btw 5/16/2015 &amp; 5/15/2016</th>
<th>Blood Pressure Recorded Btw 1/9/16 &amp; 1/8/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4333/6188 = 70.0%</td>
<td>4465/6556 = 68.1%</td>
</tr>
</tbody>
</table>

**Barriers**

- Motivating patients with outdated/uncontrolled BP/lipids or overdue labs to engage in care
- Educating patients on the role of the Clinical Pharmacist in order 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 that began in the fall of 2015 however, did not dramatically influence the 2016 HEDIS rate for the CBP measure which fell slightly from 75.91% to 72.99% landing GHC between the 75th and 90th national percentiles.

Focused efforts to expand the capacity of Clinical Pharmacists by revising the Clinical Practice Agreement to an be opt out CPA and enlarging the patient pool to include diabetics and chronic kidney disease patients in the fall of 2016 is anticipated to positively impact this measure in the 2017 HEDIS results for CBP. The measure is triple weighed and therefore a focus of our improvement opportunity.
Chronic Pain and Safety of Clinical Care

**Aims**

- Address the epidemic of prescription opioid abuse and overdose deaths
- Reduce prescribing of opioids by providing additional pain management strategies
- Establish a standardized process for chronic pain management with a developed protocol and guidelines to address safe prescribing, abuse and misuse of medications and potentially avoid overdose
- Track outcome metrics to monitor the program

**Background**

GHC-SCW’s Chronic Pain Management protocol and guidelines underwent system-wide implementation in 2015 and progress is ongoing. By end of 2015, E-Prescribing of controlled substances began to all pharmacies with an operable interface and followed with Utilization Reports/Panel Metrics going live for each provider on the Ambulatory Care Quality Dashboard. Identifying members who receive opioid prescriptions based on claims/orders continues to be a key element for safely managing individual patients.

Since implementation, opioid prescribing has decreased by over 17% as measured by our average daily morphine dose equivalent (DME) of opiates for non-malignant chronic pain. GHC-SCW providers have been actively recommending members utilize alternative services to support their treatment plan for managing chronic pain such as OT/PT, Behavioral Health and/or Clinical Pharmacist consultations, or approaches such as massage therapy, acupuncture or other modalities.

**Measures and Goals**

<table>
<thead>
<tr>
<th>MEASURES</th>
<th>2016 GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain Diagnosis in “Problem List” in EMR</td>
<td>≥ 90% of patients with diagnosis listed in EMR</td>
</tr>
<tr>
<td>Chronic Pain Visits (encounters) in a 12 month period</td>
<td>&gt;75% of all Chronic pain patients identified on registry to have completed visits by end of year 2016</td>
</tr>
<tr>
<td>Patient utilization of services recommended to support their treatment plan for managing chronic pain as recommended by PCP (integrative or multimodal approaches to pain management)</td>
<td>Obtain the % of total Chronic Pain Patients identified on registry utilizing additional recommended services</td>
</tr>
<tr>
<td>PHQ-9 assessment due to concurrent diagnosis of depression</td>
<td>≥ 90 PHQ-9 completed on Chronic Pain patient population</td>
</tr>
<tr>
<td>Monitor Urine Drug Screens performed of patients who have Chronic Pain Dx</td>
<td>Obtain 90% Urine Drug Screens performed of patients who have Chronic Pain Dx (compare to % in 2015)</td>
</tr>
<tr>
<td>Track Average Daily Morphine Dose Equivalents (DME) of Opiates to assess network wide patient utilization</td>
<td>&gt;5 % decrease overall average daily morphine equivalent to GHC clinics overall</td>
</tr>
<tr>
<td>Trend Daily Average Consumption (DACON) of Immediate &amp; Extended Release Opiates to assess network wide patient utilization</td>
<td>Show a trend of decreased prescribing throughout GHC network</td>
</tr>
</tbody>
</table>
Interventions

- In 2016, an electronic medical record based Chronic Pain Registry and My Panel Metrics Opioid Use Dashboard went live giving care teams access to real time information. This provides the ability to perform actions within the chart directly from the registry. The updated registry includes all members who had 4 opioid fills in any of the last 6 months.

- Dashboard metrics included urine drug testing, pain visits, diagnosis on the problem list and depression screening. Support staff and providers are able to determine which patients are not in compliance with via use of the metric tables within EHR.

- Information on decision support and screening tools is available in the Chronic Pain section of Clinical Resources page on the GHC intranet. Utilization of these tools enables providers to have more knowledge about their patient’s safety and risk when prescribing opioids.

- Nursing staff review & reference the Prescription Drug Monitoring Program (PDMP) in their documentation. The State of Wisconsin is legislating use of the PDMP for all controlled substance prescriptions by April 1, 2017. PDMP workflows are being established to make sure to effectively meet this new requirement.

- GHC-SCW offered additional member support through 6 week group meetings to present “Coping Skills for Chronic Pain” with self-care tips, cognitive-behavioral strategies and mindfulness techniques. Members are able to work on personal goals and coordinate a care plan.

- Developed the Migraine Care Pathway and new SmartSet Order Panel within EHR to provide best evidence based migraine treatment within primary and urgent care setting.

- GHC-SCW removed injectable narcotics from all of our primary care staff model clinics at the end of April 2016 following a review of chronic pain management evidence-based literature and local practice guidelines.

- GHC-SCW drafted and informed all GHC-SCW Staff Model Providers and Staff regarding our Marijuana position statement.

Interventions planned for 2017:
- Establishment of Dane County Chronic Pain Collaboration meetings
- Present SBIRT Model (Screening, Brief Intervention, Referral to Treatment) to Staff Model practitioners and nursing staff in May /Jun
- Present Safe and Competent Opioid Prescribing education/training on universal prescribing with case study evaluations and 3 hour precursor online session in October
- Set a maximum DME prescribing goal for our providers by October

Analysis

The following table and graphics outlines our progress toward our goals related to Chronic Pain.
### Total Chronic Opioid Therapy Patients As of End of Year 2016 = 1082 distinct patients

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>GOAL</th>
<th>Trended ANALYSIS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain Diagnosis in “Problem List” in EMR</td>
<td>≥ 90% of patients with diagnosis listed in EMR</td>
<td>2015 = 47%  2016 = 82%</td>
<td>° Standardized protocols have improved processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° Continued consistency needed to meet our goal</td>
</tr>
<tr>
<td>Chronic Pain Visits (encounters) in a 12 month period</td>
<td>&gt;75% of all Chronic pain patients identified on registry to have completed visits by end of year 2016</td>
<td>2015 = 1.6%  2016 = 70%</td>
<td>° 2015 measure may be invalid due to lack of consistency by providers to for indication of visit in EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° % increase indicates higher # of Chronic Pain visits and standardization improvement by providers/staff</td>
</tr>
<tr>
<td>Patient utilization of services recommended to support their treatment plan for managing chronic pain as recommended by PCP (integrative or multimodal approaches to chronic pain management)</td>
<td>Obtain the % of total Chronic Pain Patients identified on registry utilizing additional recommended services</td>
<td>2016 = 32%</td>
<td>° Continue to offer multimodal approaches to our members and should see this use continue to improve in 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° Calculation mid 2016 calculated within EHR as</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° Offer Primary Care Behavioral Health and Clinical Pharmacist to assist members/providers that include opioid tapering assistance and lifestyle management improvement</td>
</tr>
<tr>
<td>PHQ-9 assessment due to concurrent diagnosis of depression</td>
<td>≥ 90 PHQ-9 completed on Chronic Pain patient population</td>
<td>2015 = 31%  2016 = 57%</td>
<td>° Improvement by 26% in the number of PHQ-9 assessments for the Chronic Pain population indicating greater awareness to treat depression issues</td>
</tr>
<tr>
<td>Monitor Urine Drug Screens performed of patients who have Chronic Pain Dx</td>
<td>Obtain 90% Urine Drug Screens performed of patients who have Chronic Pain Dx (compare to % in 2015)</td>
<td>2015 = 31%  2016 = 45 %</td>
<td>° Providers given increased information and education related to Urine Drug Screening interpretation of results in 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° Increase by 14% in number of Urine Drug Screens performed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° E-prescribing has brought new challenges to obtaining random urine drug screens. Continue to strive for efficient and standardized workflows with this measure</td>
</tr>
<tr>
<td>Track Average Daily Morphine Dose Equivalents (DME) of Opiates to assess patient utilization</td>
<td>Decrease prescribing by &gt;5 %</td>
<td>2014 = 111 mg  2015 = 99 mg  2016 = 91 mg</td>
<td>° The average DME ▼ 17% since Q4 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° Average DME ▼ 8% Q4 2015 to Q4 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>° DACON data representing our Health Plan membership shows decreased prescribing overall thru Q4 2016.</td>
</tr>
</tbody>
</table>
Trended DACON data depicts the progress made in reducing Extended Release (ER) and Immediate Release (IR) opiate prescribing for non-malignant chronic pain.
Improvements noted overall from 2015 to 2016, however Non-Staff model prescribers have shown more significant movement due to larger initial problems.
Barriers and Challenges that impact improving the safety of clinical care for patients on opioid therapy:

- Staff support for dealing with difficult conversations
- 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 chronic disease initiatives
- Patient dissatisfaction deters providers from approaching their patients
- Cycle time for visits is difficult to manage
- Variability in engagement by care teams
- Abrupt and continual changes in Wisconsin legislation have delayed GHC-SCW to publish Opioid Management Practice Guideline

Conclusions

The Chronic Pain initiative has met with both successes and challenges. We have 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 have made steady progress in our goals:

- Reducing the prescribing of Extended Release (ER) and Immediate Release (IR) opiates for non-malignant chronic pain
- Adding a chronic pain diagnosis to the patient problem list,
- Increasing the number of Chronic Pain visits and the ability to track these more effectively
- Increasing awareness/need to treat concurrent depression issues
- Providing a variety of approaches to manage chronic pain, and
- Increasing the volume of Urine Drug Screens performed

We continue to track and trend data, inform providers and staff regarding evidence based protocols, and improve our measurement and goals related to this important public safety issue. Optimization of our EHR related to panel metrics and an actionable opioid registry in 2016 improved practitioner and staff utilization of these tools. The addition of Care Conferences to monthly team meetings provides the opportunity for interdisciplinary discussion and developing strategies for our most complex Chronic Pain/Opioid Therapy patients.

In 2017, we plan to establish a maximum threshold and timeline to decrease the opioids prescribed by our highest utilizers whilst continuing to offer methods aimed at maintaining or improving function in an effort to decrease the likelihood of drug seeking in the streets for heroin. Responsible prescribing, tapered and treatment will improve safety, save lives and reduce supply to the general population.
GHC-SCW’s projects related to BH HEDIS measures or other BH quality improvement initiatives are addressed by the Continuity and Coordination of Medical and Behavioral Health Care Committee team. Here are the details of our 2016 HEDIS results and BH quality improvement efforts.

**Antidepressant Medication Management**

_Aim_

- Facilitate proper diagnosis and treatment of patients with depression by PCPs and adequate treatment periods with antidepressant medications. NCQA has established the adherence to antidepressant medication in the treatment of depression as a HEDIS measure.

_Background_

- Major depression is one of the most common mental illnesses, affecting more than 16 million Americans each year.
- Depression causes people to lose pleasure from daily life, can complicate other medical conditions, and can even be serious enough to lead to suicide.
- Depression can occur to anyone, at any age, and to people of any race or ethnic group. Depression is never a "normal" part of life, no matter what your age, gender or health situation.
- While the majority of individuals with depression have a full remission of the disorder with effective treatment, only about a third (35.3%) of those suffering from severe depression seek treatment from a mental health professional.
- Depression is very treatable, with the overwhelming majority of those who seek treatment showing improvement. The most commonly used treatments are antidepressant medication, psychotherapy or a combination of the two. The choice of treatment depends on the pattern, severity, persistence of depressive symptoms and the history of the illness.


**Measures/Goals**

GHC-SCW’s goal for depression care adherence is the 95th percentile.

The table below defines the measure and the 2016 Rate for the National- All LOBs 95th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of members on anti-depressants who continue on the medications for at least 12 of the first 16 weeks.</td>
<td>≥ 77.22%</td>
</tr>
<tr>
<td>Percent of members on anti-depressants who continue on the medications for at least 26 of 33 weeks, completing a period of continuation phase treatment adequate for defining a recovery according to AHCPR guidelines.</td>
<td>≥ 61.62%</td>
</tr>
</tbody>
</table>
Interventions and Outreach in 2016

- Increase the provision of Primary Care Behavioral Health (PCBH) consultant services in the four largest primary care clinics:
  - Hatchery Hill Clinic: added 0.5 day to a total of 3.5 days
  - Capitol Clinic: remained at 5 days; added a post masters Clinical SW intern to the team
  - East Clinic: maintained 3.0 days clinic days; added .5 days of clinical admin time
  - Sauk Trails added 0.25 day to a total of 3.5 days

- Expanded pre-visit review of appointments in primary care by PCBH to ensure greater use of PHQ-9 for depression screening, particularly for members with a history of depression or chronic condition like diabetes, cardiovascular disease, chronic pain. Allows for improved screening and diagnosis, symptom tracking, and the assessment of treatment efficacy. These efforts resulted in a 10% increase for members with a depression diagnosis completing a PHQ-9 from 2015 to 2016 (43.8% vs 54.2%).

- Expanded utilization of secure electronic patient messaging that includes PHQ-9 instrument and messages to patients regarding the importance of continuing medications so that depression improves and does not recur.

- Improved education of members regarding the importance of staying on antidepressant medicines, the typically short-term nature of the most common side effects, and the typical 3-6 week delay in symptom improvement following the initiation of antidepressant therapy.

Analysis

HEDIS results are trended for the last three measurement years. The percent of members who remained on their treatment for three months improved to 75.4% in 2016. The percent of members who remained on their treatments for 6 months also improved to 61.3%.

![Antidepressant Medication Management Chart](chart.png)
Conclusions
The rate of adherence to antidepressant medication in the treatment of depression among GHC-SCW members improved in 2016 from the previous year, in both the acute and continuation phases of treatment. As a result of these efforts and steady improvements, GHC-SCW nearly achieved its ambitious goal of the national 95th percentile on the continuation measure, missing the goal by just .3% (61.3% vs 61.6%). The gap between GHC-SCW’s results and the national 95th percentile on the acute phase of treatment is larger (1.8%) though still relatively modest. The interventions and improvement strategies implemented over the last several years appear to be resulting in significant improvements in the rate of adherence to antidepressant medication in the treatment of depression.

Barriers
° Some members are unaware of the importance of staying on antidepressant medicines, the typically short-term nature of the most common side effects, and the typical 3-6 week delay in symptom improvement following the initiation of antidepressant therapy
° Some members are ambivalent about treatment and/or not well engaged in treatment plan.
° Primary care providers, who prescribe the majority of antidepressants, often do not have adequate time to engage, motivate, and follow-up with members with depression.

Proposed Interventions
° Continue to support and maximize the utilization of Primary Care Behavioral Health Services (PCBH).
° Continue to improve and expand the use of pre-visit reviews of appointments in primary care by PCBH to ensure greater use of PHQ-9 for depression screening, particularly for members with a history of depression or chronic condition like diabetes, cardiovascular disease, and chronic pain.
° Increase the utilization of various reports in the electronic medical record that track symptoms of depression over time and that allow for improved outreach and population health intervention strategies.
° Improved utilization of secure electronic patient messaging that includes PHQ-9 instrument and messages to patients regarding the importance of continuing medications so that depression improves and does not recur.
° Continued education of members regarding the importance of staying on antidepressant medicines, the typically short-term nature of the most common side effects, and the typical 3-6 week delay in symptom improvement following the initiation of antidepressant therapy.
Follow-Up after Hospitalization for Mental Illness

**Aim**
- To ensure that members hospitalized for a mental illness have a visit in the outpatient setting within 7 and within 30 days after discharge.

**Background**
Members admitted to the hospital because of mental illness are at high risk for recurrence of admission. These patients usually experience the most severe symptoms and mental health problems, and they need close monitoring and follow-up. NCQA has identified this issue as an important measure of behavioral health service quality. The established HEDIS measure examines two rates: the number of discharges of members 6 years of age and older who were hospitalized for treatment of mental health disorders and who had a follow up visit with a mental health practitioner within 7 days and 30 days of discharge.

GHC-SCW has established protocols for ensuring that patients are offered appointments with a GHC-SCW 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. GHC-SCW utilizes a team-based effort that involves clinical and administrative staff from GHC-SCW and well as staff from in-plan, inpatient psychiatric providers to ensure timely follow up care.

**Measures/Goals**
GHC-SCW has adopted the measures and associated goals based on the HEDIS national 95th percentile. The table below defines the measure and the 2016 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 appointment within 7 days after discharge</td>
<td>≥ 71.66 %</td>
</tr>
<tr>
<td>Percent of members with a hospital admission seen for an ambulatory appointment within 30 days after discharge</td>
<td>≥ 84.95 %</td>
</tr>
</tbody>
</table>

**Interventions and Outreach in 2016**
- Continued use by the GHC-SCW MH Department of a 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 GHC-SCW MH Dept. prior to patient discharge to facilitate follow-up appointments within seven days of discharge.
- A register of admissions and follow up appointments is maintained and reviewed by MH Department administrative staff to ensure all members are scheduled. If scheduled appts are missed, GHC-SCW provides outreach to the member to reschedule the missed appointment as quickly as possible.
- Improved utilization of GHC-SCW MH Clinical Triage staff to meet with members discharged from inpatient psychiatry stay that do not have existing outpatient provider.
- Continuation of the incentive system to encourage scheduling access for discharged patients by adding patient time to GHC-SCW MH providers’ administrative time or lunch hour.
- Continued emphasis of 7-day standard of care expectation in renewed external behavioral health provider contracts.
- Utilization of Primary Care Behavioral Health Consultants for members whose PCP is in a clinic with PCBH services, when the member is not yet connected to specialty behavioral health services.

**Analysis**

Data is trended for the last three reporting years for the percent of members with an outpatient mental health visit within 7 days after discharge. The percentage improved to 85.6% which continues to exceed the goal of the national 95th percentile (71.7%). The percentage of discharges with a MH visit within 30 days of discharge also improved to 92.0% and exceeded the goal (85.0).

Although GHC-SCW exceeded our goals in each of these measures, limitations still exist. Some members no-show for scheduled follow-up appointments or decline follow-up appointments due to co-pay, co-insurance, or deductible obligations.

**Conclusions**

As measured by the percentage of members who are receiving follow-up care within 7 days of discharge, GHC-SCW’s efforts to ensure service coordination and transition between inpatient psychiatry and lower levels of care continue to be very successful. GHC-SCW’s trended results on these HEDIS measures demonstrate steady compliance and continued excellence.

**Planned Interventions**

GHC-SCW will continue current workflows and strategies that ensure members are seen within 7 days of discharge.
Follow-Up Care for Children (Age 6-12) Prescribed ADHD Medication

Aim

This measure reports the percentage of children newly prescribed Attention Deficit and Hyperactivity Disorder (ADHD) medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. The Continuation measure reports 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.

Background

Attention deficit/hyperactivity disorder (ADHD) is the most commonly treated childhood neurobehavioral disorder. ADHD is found in 3 to 6 percent of school-age children; and at least 10 percent of behavioral problems seen in general pediatric settings are due to the disorder. Children with ADHD may experience difficulties in school, troublesome relationships with family members and peers, and behavioral problems. Follow-up care and surveillance is a key aspect of ADHD treatment.

° Given the high prevalence of ADHD among school-age children, primary care clinicians should have a strategy for diagnosis and long-term management of this condition.
° Nationally, only 1 in 4 patients have a follow-up visit with their primary care physician within the 30 days following the first ADHD prescription. Nationally for patients receiving a prescription from a psychiatrist, only 29 percent reported a follow-up visit with the psychiatrist within 30 days.
° More than 4 million children ages 4 to 17 have been diagnosed with ADHD; more than half diagnosed are receiving medication treatment for the disorder.
° 70 to 90 percent of children respond to ADHD drug treatment without major side effects.
° Among children with ADHD, those on medication have shown to have less frequent and less costly emergency department visits.
° Estimates of the total annual economic cost for treating children with ADHD in the U.S. ranges from $2 billion to $11 billion

Measures/Goals

GHC-SCW has established meeting or exceeding the national 95th percentile as its goal. The table below defines the measure and the 2016 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>≥ 53.33%</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>≥ 62.16%</td>
</tr>
</tbody>
</table>
Interventions and Outreach in 2016

° Ongoing education with prescribers regarding the standard for follow up appointments.
° Because members sometimes decline follow-up appointments when the child is responding well to treatment, preferring instead to communicate by phone or MyChart™ and thereby avoiding copay, deductible, or co-insurance fees, GHC-SCW and other health plans have requested that NCQA consider allowing standardized phone or secure electronic messaging as follow up for this measure.

Analysis

The compliance rate for Care for Children Prescribed ADHD Medication Initiation Phase declined versus 2015 at 55.0% however, still exceeded the goal of the national 95th percentile (53.3). The ADHD Continuation and Maintenance Phase rate increased by 5.7% to 71.1% exceeding goal by nearly 9 percentage points (62.2%). GHC-SCW’s efforts to outreach to members and to staff facilitating Mental Health and Primary Care scheduling to ensure timely follow-up care appears to be working well. GHC-SCW continues to perform well on this measure however the following limitations still exist:

• Some providers unaware of ADHD follow-up standard of care
• Some reception staff, nurses and members are not aware of standard of care and appointments are scheduled outside of timelines
• Members sometimes decline follow-up appointments when the child is responding well to treatment, preferring instead to communicate by phone or GHCMyChartSTM, thereby avoiding copay, deductible, or co-insurance fee.
• Some members included in the measure have a history of stable, problem-free stimulant use but take a medication “holiday” in the summer. When they restart the medication a follow-up visit within 30 days is not viewed as medically necessary by the member or the provider.

Proposed Interventions

° On-going education with GHC-SCW practitioners, nursing and receptionist staff as well as in-plan contract providers regarding the standards of care for follow-up visits and monitoring for children prescribed ADHD Medication
° Continue to support request that NCQA consider allowing phone or secure electronic messaging as follow up for this measure
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Aim

- Measures assess the degree to which members identified with alcohol and other drug (AOD) abuse and dependence initiate treatment after diagnosis and engage in continued treatment after initiation.

Background

More than 9 percent of Americans age 12 and over are dependent on or abuse alcohol or illicit drugs. Alcohol and other drugs combined with tobacco, account for 1 in 4 deaths. Research supports the need for AOD users to engage in ongoing treatment to prevent relapse. Individuals who complete treatment or receive more days of treatment typically show more improvement than those who leave care prematurely. The acute stage of treatment is associated with lasting improvements only with continued rehabilitative treatment.

- 77 percent of adults with substance dependence or abuse are employed full or part time.
- Fewer than 1 in 4 patients who need treatment for alcohol and/or drug abuse get it.
- Alcoholism is one of the most common psychiatric disorders, with a prevalence of 8 to 14 percent.
- Alcohol use accounts for 85,000 deaths annually (nearly 1 in 25) and is one of the most common preventable causes of death in United States.
- Brief intervention of four or fewer sessions by a health professional helps socially stable problem drinkers to reduce or stop drinking, motivate alcohol-dependent patients to enter long-term alcohol treatment, and helps some alcohol dependent patients to abstain completely.
- Studies have shown that from $4 to $7 are saved for every dollar spent on treatment.
- Frequency and intensity of engagement is important in treatment outcomes and reducing drug-related illnesses. Addiction intervention reduces utilization of health care services and criminal activity.
- The annual cost of illicit drug abuse is $181 billion. When combined with alcohol and tobacco, costs exceed $500 billion including health care, criminal justice, and lost productivity.
- It costs approximately $3,600 per month to leave a drug abuser untreated in the community, and incarceration costs approximately $3,300 per month.

Measures/Goals

GHC-SCW has established the goal of meeting or exceeding HEDIS 90th percentile. The table below defines the measure and the 2016 Rate for the National- All LOBs 90th percentile.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of members initiating treatment within 14 days.</td>
<td>≥ 40.44%</td>
</tr>
<tr>
<td>Percentage of members engaging in treatment with two additional alcohol and other drug dependence (AOD) services within 30 days after initiation</td>
<td>≥ 18.76%</td>
</tr>
</tbody>
</table>
Interventions and Outreach in 2016

- Increased the provision of integrated Primary Care Behavioral Health (PCBH) consultant services in the four largest primary care clinics:
  - Hatchery Hill Clinic: added 0.5 day to a total of 3.5 days
  - Capitol Clinic: remained at 5 days; added a post masters Clinical SW intern to the team
  - East Clinic: maintained 3.0 days clinic days; added .5 days of clinical admin time
  - Sauk Trails added 0.25 day to a total of 3.5 days

- Provided periodic reminders and training opportunities 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.

- Created a “Best Practice Alert” in the electronic medical record that shows a pop-up informational box whenever a provider uses an alcohol or other drug use disorder diagnosis. The box states that the HEDIS standard of care is for the patient to initiate treatment within 14 days of the diagnosis, and asks to the provider to refer the patient to treatment.

- Initiated planning activities for a broad community-wide training for primary care and other providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT) to be offered in 2017 in partnership with the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) and the UW School of Medicine and Public Health.

Analysis

GHC-SCW’s rate for AOD Initiation Phase declined slightly from 2015 by 4.5 percentage points and is 6.4 percentage points below the national 90th percentile (40.4%). This marks the third year in a row of decreasing rates of initiation, after 4 years of increases. The AOD Engagement Phase declined 8.8 percentage points from 2015 and is 10.6 percentage points below the national 90th percentile (18.8%).

The fact that the national 90th percentile of compliance rates for these two measures are also experiencing yearly declines is demonstrative of how challenging these measures are across the nation.

The exact cause of the continued drop in these measures is not clearly known and improvement continues to be challenging. The rather sharp decline in the engagement phase (from 17% to 8.2%) is particularly
concerning. This suggests that of the 34.0% of members who have a follow-up appointment with a provider for the AODA diagnosis within 14 days of the initial use of the diagnosis (initial phase), very few are completing two additional AODA services within 30 days after initiation.

Conclusions
Despite the availability of efficacious treatments, less than 35% of GHC-SCW members with a substance use disorder diagnosis initiate assessment or treatment within the HEDIS time frames. The percent of members complaint with the standard of care continues to decline. The current improvement strategies have not been effective in improving timely participation in treatment.

Barriers
- Lack of member motivation to address issue
- Cultural norms that support use/abuse of alcohol
- Stigma associated with specialty care or group therapy approaches
- Access to specialty care can be limited
- Member concern with diagnostic labeling
- Member concern re: 12 step model of treatment
- Over use of dx in primary care in the absence of a full AODA diagnostic assessment, and paucity of SBIRT or other primary care-based interventions.
- Frequent intensive visit schedules often required in specialty settings are off-putting to members
- Statistics support evidence that alcohol consumption in Wisconsin is a serious health concern as few states consume more alcohol than Wisconsin per capita.

Opportunities
- Increase screening for substance use disorders in primary care
- Increase PCP use of the appropriate use of diagnostic codes for primary care appointments to reduce stigma and encourage follow-up with specialty care.
- Increase PCP knowledge regarding substance use disorders and available resources, as well as the standard of care regarding follow-up after diagnosis.
- Development and provision of brief interventions in primary care via PCPs, Primary Care Behavioral Health, and other for AOD use/risk reduction, specifically provision of Screening, Brief Intervention and Referral to Treatment (SBIRT) services
- Increase use of Motivational Interviewing in primary and specialty care
- Behavioral health consultants working alongside PCPs providing curbside and in-exam room consults on common behavioral health concerns like substance abuse improves treatment outcomes, provider productivity, medical adherence and patient satisfaction

Planned Interventions
- In partnership with the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) and the UW School of Medicine and Public Health, co-sponsor a community-wide training for primary care and other providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT) in 2017, and pilot SBIRT services in GHC-SCW primary care clinics.
- Provide additional training in Motivational Interviewing strategies to practitioners in primary care, mental health, and health education to enhance patient engagement and adherence.
- Provide integrated Primary Care Behavioral Health services that offer screening, brief intervention, referral for substance use disorders in at least four primary care clinics.
- Review lag times and access with in-plan substance use disorder providers and determine way to decrease barriers and lag times to care.
IV: QUALITY IMPROVEMENT WORKPLANS
Detail of the 2016 work plan and the organizations 2017 QI plan is presented as follows:
<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>Quality of Service</td>
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<tr>
<td>Conduct on-going assessment of patient experience and member satisfaction and develop strategies for improvement.</td>
<td>1) Improve patient experience based on 2015 &amp; 2016 Press-Ganey survey comments and results 2) Look to improve member satisfaction for CAHPS measures based on 2015 &amp; 2016 CAHPS results</td>
<td>1) QM department will help support training of clinic staff members to utilize Press-Ganey results to identify areas of actionable improvement. 2) Review CAHPS results and develop strategies for improvement for measures ranking below the 50th percentile 3) Develop patient experience agency-wide work sessions incorporating Press Ganey toolkit best practices 4) Utilize complaints and compliments to develop member-initiated improvements</td>
<td>1) Q1 through Q4 2) Q1 through Q4 3) Q1 through Q4 4) Q1 through Q4</td>
<td>Blackmon Kastman Huth Kleinmaus</td>
</tr>
<tr>
<td>Streamline the current Outreach process and increase Outreach to non-staff model members by partnering with community resources.</td>
<td>1) Review all current Outreach reporting and review 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) Incorporate bulk ordering and bulk messaging into Outreach efforts 4) Utilize MyChart and Epic tools where applicable to decrease amount of mailings.</td>
<td>1) Q1 through Q4 2) Q1 through Q4 3) Q1 through Q4 4) Q1 through Q4</td>
<td>Blackmon Kastman Huth Kleinmaus</td>
</tr>
<tr>
<td>Improve the health of the populations that GHC-SCW serves by reducing health outcome disparities by means of conducting needs assessments and 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) Health Equity Committee will research existing GHC-SCW data and compare to local, state and national demographic and health outcome disparity data to develop a Health Equity Index Report. 2) The Health Literacy Committee will continue to meet on an on-going basis to review and modify internal documents created by various GHC departments to ensure information accessed and available to GHC-SCW members and patients is written at an easy-to-understand reading level and is made available in appropriate languages to meet the needs of our diverse population. 3) GHC-SCW will invest in and create additional, on-going cultural competency and service excellence trainings to ensure that the organization promotes and practices as a welcoming and inclusive environment.</td>
<td>1) Q1-Q2 2) Q1 through Q4 and ongoing 3) Q2 and ongoing</td>
<td>Kleinmaus Hernandez Community Care Mgr Smith</td>
</tr>
<tr>
<td>GOALS</td>
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| Improve scores on reported measures related to hypertension and diabetes outcomes | 1) Look to 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; reach 77% to 80%  
2) Improve BP control < 140/90 to 75% | 1) a. Implement a pilot project in clinics for both pre-diabetes and hypertension management and evaluate impact  
b. Implement Epic’s Healthy Planet tools, Reporting Workbench and registries, to enable clinic staff to identify and provide outreach to members with diabetes.  
c. Continue to monitor workflow for newly diagnosed diabetics and diabetes care gaps in pre-visit prep  
2) Continue to monitor and provide on-going support to the Pharmacy department for the approved, pro-active, protocolized HTN medication renewal process. | 1) end of Q4 | Kastman  
Blackmon  
Twining  
Kleinmaus  
Rx/Guetzlaff |
| 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 | 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) Update workflows to incorporate ETF advance care planning protocol | 1) Q1 through Q4 | Blackmon  
Kastman |
| Create and disseminate Provider Dashboards on a quarterly basis with data on quality, cost and patient experience. | 1) Continue workgroup to establish 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  
3) In collaboration with IT, create a mechanism for provider feedback for dashboard updates and patient list requests | 1) Q2 through Q4 | Kastman  
Blackmon  
Kleinmaus  
BIEng |
| 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 pilot and evaluate future expansion of the Asthma Risk Score project to all clinics, care teams, and providers | 1) end of Q4 | Kastman  
Blackmon  
Ballweg  
Kleinmaus  
Lo |
## 2016 Quality Improvement Work Plan
### Focused by the Triple Aim

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
<th>Proposed Activities</th>
<th>Timeframe for Completion</th>
<th>Staff Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the health of populations</td>
<td>Improve behavioral health outcomes for our members</td>
<td>Improve the health of populations</td>
<td>Improve the patient experience of care</td>
<td></td>
</tr>
<tr>
<td>Safety of Clinical Care</td>
<td>Continue to monitor patient safety and look for opportunities for improvement</td>
<td>1) Continue initiative to improve safety of care for patients with chronic pain</td>
<td>1) Q1 through Q4</td>
<td>Kastman, Blackmon, Hynek</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Look to further resource Clinical Pharmacists for drug utilization reviews on members with complex prescription drug therapy</td>
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<td></td>
<td>1) Improve documentation of risk assessment, care plans, problem list, medication agreements, and patient education materials.</td>
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<td>2) Expand Chronic Pain program to a pain program and in collaboration with EA and BI incorporate a reporting workbench with the EHR.</td>
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<td>3) Continue to promote and resource Clinical Pharmacists across clinics</td>
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<td>4) Incorporate e-prescribing for narcotics for providers.</td>
<td>2) Q1 through Q4</td>
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<td>5) Utilize trends from new online safety portal for process improvement opportunities.</td>
<td>3) Q1 through Q4</td>
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<tr>
<td></td>
<td>Behavioral Health Care</td>
<td>Improve behavioral health outcomes for our members</td>
<td></td>
<td>Van Den Brandt, Hernandez</td>
</tr>
<tr>
<td></td>
<td>I. HEDIS BH Measures:</td>
<td>I. a. Continue efforts to maintain high percentile ranks for measures 1-4 thru directed member outreach, use of PCBH services in Primary Care, education of providers.</td>
<td>I. a. Q1 through Q4</td>
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<tr>
<td></td>
<td>1. ADHD</td>
<td>b. Related to measures 5-6</td>
<td>b. Report to providers quarterly</td>
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<tr>
<td></td>
<td>2. F/U After Hospitalizations for MH</td>
<td>*Provide education to prescribers of antipsychotic medications re the risk of metabolic disorders and the need for screening</td>
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<td>3. Engagement/Initiation of SUD to 4. AMM</td>
<td>*Monitor members with Schizophrenia or bipolar disorder who are prescribed antipsychotic medication to ensure they have had a glucose test within the past year</td>
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<td>5. Improve diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication;</td>
<td>*Monitor members with diabetes who are prescribed antipsychotic medication to ensure they have had a glucose and lipids test within the past 12 months</td>
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<td>6. Improve monitoring for people with Schizophrenia and Diabetes.</td>
<td>*Notify providers of members in need of screening.</td>
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<td></td>
<td>II. Clinical Quality of Adult ADHD</td>
<td>I. ii. Refine new adult ADHD dx assessment protocol</td>
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<td>Continue implementation and spread of the evidence-based dx assessment for adult ADHD in both primary care and mental health settings.</td>
<td>b. Educate prescribers in PC and MH on the use of the protocol</td>
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<td></td>
<td>Iii. Primary Care and Behavioral Health Integration</td>
<td>c. Provide education to non-prescribing MH providers on the use of ADHD dx assessment instruments.</td>
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<td>ii. Continue successful efforts to integrate BH and Primary Care and satisfaction for program</td>
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</table>
## Financial Health

**GOALS**
Implement the concepts of Choosing Wisely and shared decision making to reduce costs associated with duplicate or unnecessary testing or procedures.

**OBJECTIVES**
1. Identify savings due to analysis of duplicate and/or unnecessary testing or procedures.
2. Implement a shared decision making framework.

**PROPOSED ACTIVITIES**
1. Review data from analytical tools to determine where opportunities for education and cost savings exist.
2. Review and select a vendor to provide shared decision making tools for providers use. Education and roll-out planned and completed.

**PROPOSED TIMEFRAME FOR COMPLETION**
1) end of Q4
2) end of Q4

**STAFF RESPONSIBLE**
Kastman Blackmon

**GOALS**
Increase utilization of analytical tools to identify high cost members and target strategies for cost containment to improve member population health.

**OBJECTIVES**
1. Develop strategy and implement 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.
3. Care Management department to utilize McKesson software tools for high risk / high cost patient identification and cost containment strategies.

**PROPOSED ACTIVITIES**
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.
3. Expand use of McKesson tool as a means to identify current and future high cost patients for planning and intervention purposes.

**PROPOSED TIMEFRAME FOR COMPLETION**
1) end of Q2
2) Q2 through Q4
3) end of Q4

**STAFF RESPONSIBLE**
Kleinmaus Kastman Blackmon CM/Behl
<table>
<thead>
<tr>
<th>GOALS</th>
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<tbody>
<tr>
<td>Improve the health of populations</td>
<td>Ensure the NCQA accreditation process continues to be successful and efficient. Complete May 31st submission deadline and July 18-19, 2016 on-site audit.</td>
<td>1a) Complete outstanding documentation and committee reports and review for compliance 1b) Update finalized documentation to ISS survey tool 2) Align membership of CSQC to add core members to expand organizational knowledge of NCQA 3) Debrief after 2016 survey outcome and develop a project management plan/tool for the 2019 survey 4) Continue activities as outlined on the CSQC calendar and establish processes for new requirements in the 2016 S &amp; G’s</td>
<td>1a &amp; b) Through Q1-Q2 2-4) Q3-Q4</td>
<td>Accreditation Team</td>
</tr>
<tr>
<td>Lower per capita costs</td>
<td>Ensure the HEDIS reporting process continues to be successful and efficient.</td>
<td>1) By the end of the 2016 reporting period (2015 measurement year), all necessary documentation will be submitted accurately. 2) By the end of 2015, results will be submitted to FEHB and create a plan for the Plan Performance Assessment Initiative (to occur in 2016). 3) By the end of Q1, the HEDIS Roadmap will be submitted and validated 1-2) In collaboration with the BI Reporting and Compliance Teams, the QM department will meet on a bi-monthly basis to establish roles and responsibilities and ensure tasks are fulfilled and data is submitted in a timely manner. 3) In collaboration with the BI Reporting Team, the QM department will work closely with Advent Auditor to ensure HEDIS Roadmap data is captured and submitted accurately. 4) Identify HEDIS reviewers to ensure maximum return on HEDIS audit.</td>
<td>1) Q1-Q3 2) Q1-Q4 3) Q2</td>
<td>Kastman Blackmon Kleinmaus BV Eng Compliance Team</td>
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<tr>
<td>GOALS</td>
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<td>Quality Reporting</td>
<td>Plan and implement strategies for quality reporting purposes with WCHQ and WHIO.</td>
<td>1) By the end of 2016, ensure a plan is in place to submit data to WCHQ on behalf of GHC-SCW. 2) GHC will continue to submit data to WHIO.</td>
<td>1) In collaboration with the BI Reporting and Information Technology departments, the QM department will meet to identify measures and mechanisms necessary to report results to WCHQ.</td>
<td>1) Q1 through Q4 2) Q1 through Q4</td>
</tr>
<tr>
<td>Employee Engagement</td>
<td>To provide a work atmosphere that is professional, engaging, challenging yet open, and that encourages personal and professional growth.</td>
<td>1) Open door policy; listen to all ideas openly 2) Advocate and provide feedback on projects when appropriate 3) Provide opportunities for learning and encourage internal and external professional growth 4) Provide opportunities to engage in team building</td>
<td>1) QM staff will provide ongoing updates of work at departmental meetings. 2) QM staff will have had the opportunity to attend at least one online or in-person continuing education training. 3) QM staff will provide feedback to their peers at least 1 departmental meeting and/or performance review. 4) QM staff will have engaged in team building activities.</td>
<td>Q1 through Q4</td>
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| 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) HTN: Improve BP control < 140/90 to 75% | 1) a. Implement a pilot project in clinics for both pre-diabetes and hypertension management and evaluate impact  
b. 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.  
c. Continue to monitor workflow for newly diagnosed diabetics and 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 | end of Q4 | Kastman  
Madsen  
Twining  
Ibrahim  
Kleinmaus  
Rx/Guetzlaff |
| 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 | 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. | 1) Q1 through Q4 | Madsen  
Kastman |
| Create and disseminate Provider Dashboards on a quarterly basis with data on quality, cost and patient experience. | 1) Continue workgroup to establish 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  
3) In collaboration with IT, create a mechanism for provider feedback for dashboard updates and patient list requests | 1) Q2 through Q4 | Kastman  
Madsen  
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) Create a training video for staff to utilize the Asthma risk report | 1) end of Q1  
2) end of Q4 | Kastman  
Madsen  
Ballweg  
Kleinmaus  
Ibrahim  
Lo |
### 2017 Quality Improvement Work Plan

**Focused by the Triple Aim**

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<td>Improve the health of populations</td>
<td>1) Conduct on-going assessment of patient experience and member satisfaction and develop strategies for improvement. 2) Improve member satisfaction for CAHPS measure results below the 50th percentile based on 2016 &amp; 2017 surveys.</td>
<td>1) QM department will help support training of clinic staff members to utilize Press-Ganey results to identify areas of actionable improvement. 2) Review CAHPS results and develop strategies for improvement for measures below the 50th percentile. 3) Develop a mechanism to share compliments on the GHC public facing website. Review a process for sharing complaints. 4) Utilize complaints and compliments to develop member initiated improvements. 5) Include complaint cards at each clinic site as an additional means to garner feedback. Set up a process for.</td>
<td>1) Q1 through Q4 2) Q1 through Q4 3) Q1 through Q4 4) Q1 through Q4 5) Q1</td>
<td>Madson Kastman Sandene Patient Experience Committee</td>
</tr>
<tr>
<td>Improve the health experience of care</td>
<td>1) Evaluate Outreach process improvements and increase Outreach to 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 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) Review Population Health Strategies as they incorporate Bulk Messaging and rethink outreach for staff model and non-staff model when tools are live. 4) Incorporate a newsletter for disease management programs - Diabetes and Asthma.</td>
<td>1) Q1 through Q4 2) Q1 through Q4 3) Q1 through Q4 4) Q1 through Q4</td>
<td>Madson Kastman Sandene Health Ed</td>
</tr>
<tr>
<td>Improve the health of the populations that GHC-SCW serves by reducing health outcome disparities</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) Health Equity Committee will research existing GHC-SCW data and compare to local, state and national demographic and health outcome disparity data to develop a Health Equity Index Report. 2) Work with the Population Health Department and Marketing to create healthy literate mailings and MyChart message templates for registry activity and QM Outreach mailings. 3) GHC-SCW will invest in and create additional, on-going cultural competency and service excellence trainings to ensure that the organization promotes and practices as a</td>
<td>1) Q1-Q2 2) Q1 through Q4 and ongoing 3) Q2 and ongoing</td>
<td>Kleinmaus Francis Smith</td>
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</table>
| Safety of Clinical Care | Continue to monitor patient safety and look for opportunities for improvement | 1a) Continue initiative to improve safety of care for patients with chronic pain  
1b) Addiction Medicine in Primary Care Pilot—medication assisted treatment for patients with opioid use disorder  
2) Further resource Clinical Pharmacists for drug utilization reviews on members with complex prescription drug therapy  
3) Utilize trends from online safety portal for process improvement opportunities.  
4) Improve HEDIS measure MMA “Medication Management for People with Asthma” to 75th percentile (reduce the risk of asthma exacerbations for population at risk) 2016 rate GHC = 45.72 (25th 42.40)  
5) Improve anticoagulation management w initiation of education materials from the health plan to reduce risk and prevent adverse events associated w blood thinning medications | 1a). In collaboration with EA and BI monitor the use of the registry/reporting workbench within the EHR.  
1b) Prescribing pilot for up to 30 patients in 2017 (stable GHC patients with ongoing AODA psychosocial tx) limited to PCPs with waivers and resources  
2). Continue to promote and resource Clinical Pharmacists across clinics  
3) Safety Committee monitors portal to identify clinical opportunities  
4) In collaboration with BI, create a report to monitor consistent use of members who remained on an asthma controller. Share results with Asthma committee and clinical pharmacy department.  
5) In collaboration with BI and Clinical Pharmacy, create a report to identify members newly started on anticoagulation medication. Develop and/or purchase patient-friendly education material to disseminate about medication safety. | 1) Q1 through Q4  
2) Q1 through Q4  
3) Q1 through Q4  
4) Q1 through Q4  
5) Q1 through Q4 | Kastman  
Madson  
Ibrahim  
Hynek  
Safety Committee  
Clinical Pharmacy |
## 2017 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>
| **Behavioral Health Care** | Improve behavioral health outcomes for our members | I. **HEDIS BH Measures:** 1. ADHD 2. F/U After Hospitalizations for MH 3. Engagement/Initiation of SUD tx 4. AMM  
**New 2017 HEDIS Measures**  
• FUM: Follow-Up After Emergency Department Visit for Mental Illness  
• FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence  
II. **Clinical Quality of Adult ADHD**  
Continue spread of the evidence-based dx assessment for adult ADHD in both primary care and mental health settings.  
III. **Continue PC and BH Integration**  
IV. **Prescriber Education**  
- Improve diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed an antipsychotic medication; | I. **- Continue directed member outreach, use of PCBH services, provider education to maintain percentile goals for measures 1-4**  
- Collect data for new 2017 FUM & FUA measures  
- Report quarterly performance to providers  
II. **- Educate non-prescribing MH providers on the use of ADHD diagnosis assessment instruments.**  
III. **Continue successful BH and Primary Care program**  
IV. **- Educate prescribers of antipsychotic medications re the risk of metabolic disorders and the need for screening**  
- Educate prescribers to monitor members with schizophrenia or bipolar disorder prescribed antipsychotics to obtain a glucose test within the past year  
- Educate prescribers to monitor diabetic members prescribed antipsychotics to obtain a glucose and lipid test within the past year | I. **Q1 - Q4**  
II. **Q1 - Q4**  
III. **Q1 - Q4**  
IV. **Q1 - Q4** | Van Den Brandt  
Austin |
| **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)** Implement 10 shared decision making tools for ETF patients.  
**3)** Evaluate the feasibility of providing these to all populations | **1)** end of Q4  
**2)** end of January | 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 strategy and implement 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.  
**3)** Care Management department to utilize McKesson software tools for high risk / high cost patient identification and cost containment strategies. | **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.  
**3)** Expand use of McKesson tool as a means to identify current and future high cost patients for planning and intervention purposes. | **1)** end of Q2  
**2)** Q1 through Q4  
**3)** end of Q4 | Kleinmaus  
Madson  
CM/Behl |
## 2017 Quality Improvement Work Plan

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<tbody>
<tr>
<td><strong>Improve the health of populations</strong></td>
<td>Ensure the NCQA accreditation process continues to be successful and efficient.</td>
<td>1) maintain the activities of the Clinical and Service Quality Committee and its agenda calendar throughout the year to stay on track with NCQA related processes.</td>
<td>1) Q1-Q4</td>
<td>Ametani Madson Kastman Org Accreditation Staff</td>
</tr>
<tr>
<td></td>
<td>Ensure the HEDIS reporting process continues to be successful and efficient.</td>
<td>1) By the end of the 2016 reporting period all necessary documentation will be submitted accurately. 2) By the end of Q1, the HEDIS Roadmap will be submitted and validated. 3) Ensure GHC can comply w reporting for the Medicaid population (two new P4P measures for measurement year 2017) related to PHQ-9 for depression</td>
<td>1) Q1-Q3 2) Q1 3) Q1-Q4</td>
<td>Kastman Madson Ibrahim BI Eng</td>
</tr>
<tr>
<td></td>
<td>Maintain compliance with gathering and reporting of data for required surveys.</td>
<td>1) Complete CAHPS survey process 2) Complete PQRS survey process 3) Complete QHP survey process 4) Continue CG-CAHPS survey process</td>
<td>1) Q2 2) Q1 3) Q2 4) Q1-Q4</td>
<td>Kastman Madson Patient Exp Workgroup Sandene Compliance</td>
</tr>
<tr>
<td></td>
<td>To provide a work atmosphere that is professional, engaging, challenging yet fun and enjoyable that encourages personal and professional growth.</td>
<td>1) Open door policy; listen to all ideas openly 2) Advocate and provide feedback on projects when appropriate 3) Provide opportunities for learning and encourage internal and external professional growth 4) Provide opportunities to engage in team building</td>
<td>1) QM staff will provide ongoing updates of work at departmental meetings. 2) QM staff will have had the opportunity to attend at least one online or in-person continuing education training. 3) QM staff will provide feedback to their peers at least 1 departmental meeting and/or performance review. 4) QM staff will have engaged in team building activities.</td>
<td>Q1 through Q4</td>
</tr>
</tbody>
</table>

**Compliance**

- Ensure the NCQA accreditation process continues to be successful and efficient.
  - 1) Finalize all necessary policy revisions before the start of the look back period in May 2017.
  - 2) Establish a project management plan and team member involvement for the 2017-2019 Accreditation Cycle.
  - 3) Review all disease management documentation from 2016 submission with Quality Manager and key personnel.

- Ensure the HEDIS reporting process continues to be successful and efficient.
  - 1) In collaboration with organizational staff, QM will meet bi-monthly to establish roles and responsibilities and ensure tasks are fulfilled and data is submitted in a timely manner.
  - 2) Identify HEDIS reviewers to ensure maximum return on HEDIS audit and MRR is completed.
  - 3) In collaboration with the BI Reporting Team, QM staff will work closely with Advent Auditor to ensure HEDIS Roadmap data is captured and submitted accurately.
  - 4) In collaboration with the BI Reporting Team, QM staff will work closely to establish viable reporting for new PHQ 9 P4P.

- Maintain compliance with gathering and reporting of data for required surveys.
  - 1) Utilize DataStat for CAHPS and QHP survey processes. Submit results accordingly.
  - 2) Negotiate with Press Ganey for PQRS survey if it does not remain free for 2017.
  - 3) Utilize DataStat for QHP survey process. Submit results accordingly.
  - 4) Ongoing CG-CAHPS education of clinic managers and site chiefs.

- Employee Engagement
  - 1) QM staff will provide ongoing updates of work at departmental meetings.
  - 2) QM staff will have had the opportunity to attend at least one online or in-person continuing education training.
  - 3) QM staff will provide feedback to their peers at least 1 departmental meeting and/or performance review.
  - 4) QM staff will have engaged in team building activities.
STATEMENT OF PURPOSE

This committee is responsible for the oversight of the quality improvement activities of Group Health Cooperative of South Central Wisconsin. It fosters continuous improvement of the service and clinical care provided to all membership. Specific activities of the committee are as follows:

- Develops 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 progress and provide the direction and feedback necessary for success particularly when activities require cross-functional effort and significant resources.
- Allocate the resources necessary for the forming and functioning of project teams and for the implementation of recommendations.
- Make policy updates and recommendations to senior management as warranted by the current standards and guidelines.
- Develops the Annual Report Summary and Evaluation.
- Ensures practitioner participation in the QI program (Committees, teams, task forces) through planning, design, implementation and review.
- Identifies/institutes needed actions and follow-up as appropriate
- Review reports of regular monitoring activities and surveys.
- Oversee the review and updates to medical criteria
- Participate in the review of clinical practice guideline updates in conjunction with the Clinical Content Committee and its recommendations.

ROSTER
1. Chair: Accreditation Coordinator
2. Chief Medical Officer
3. Manager of Quality
4. Quality Analyst
5. Care Management Manager
6. Director of BH & Medical Specialty Services
7. Medical Director for Behavioral Health (Ad hoc)
8. Manager of Pharmacy Services (Ad hoc)
9. Chief Nursing Officer (Ad hoc)
10. Accreditation Consultant MD (Ad hoc)
11. Member Services Manager (Ad hoc)
12. Community Care Manager (Ad hoc)
13. Marketing Manager (Ad hoc)
14. Medical Staff Administrator (Ad hoc)
15. Population Health Manager (Ad hoc)
MEETING FORMAT AND FREQUENCY

The Chief Medical Officer and/or Quality Manager make appointments to the committee roster. 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 Health Services Committee of the Board of Directors of GHC-SCW and, ultimately, the full Board of Directors of GHC-SCW.
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.
Appendix 5

CLINICAL CONTENT COMMITTEE

STATEMENT OF PURPOSE

The purpose of the Clinical Content Committee is to serve as content experts and decision makers for clinical issues related to electronic medical record tools, clinical forms/handouts, medical/nursing policies and procedures, and department activities of Quality Management and Clinical Information Services (CIS).

The responsibilities of the Clinical Content Committee are outlined as follows:
1. Update clinical content in Epic Care.

2. Evaluate, recommend and approve clinical practice guidelines and implement associated medical record tools

3. Evaluate and recommend nursing and medical policies.

4. Evaluate and advise the CIS department on electronic medical record related issues.

ROSTER

• Chair; Associate Medical Director-Informatics & Care Management
• Medical Chief of Staff
• Enterprise Applications Analysts (3)
• Practitioners – Primary and Urgent Care (3)
• Registered Nurses (4)
• LPN or CMA (1)
• Revenue Cycle Manager (1)
• Registered Pharmacist (1)
• Quality 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.
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 safety at Group Health Cooperative of South Central Wisconsin.
2. Identify opportunities to reduce medical errors, support interventions, and monitor progress in these activities.
3. Define measures of patient safety and perform periodic measurement.
4. Review member complaints related to clinic safety.
5. Develop and distribute information to members 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.

ROSTER

- Chair; Chief Nursing and Clinical Operations Officer
- Pharmacy Services Manager
- Enterprise Applications Analyst
- Administrative Pharmacist
- Clinic Manager
- Registered Nurse
- Physician
- Quality Manager (ad hoc)

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.