2024

GHC-SCW POPULATION HEALTH MANAGEMENT

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

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Group Health Cooperative of South Central Wisconsin

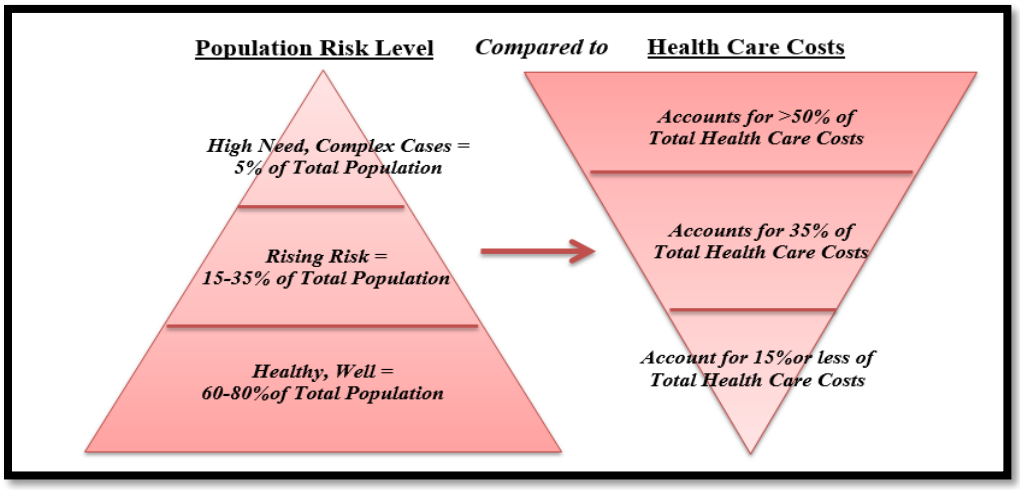
Population Health Management (PHM)

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

The Population Health Department focuses on community partnerships, community health programs, and social services to enhance the efforts around social determinants of health to deliver equitable care for all members and patients. The Quality Management Department supports NCQA Accreditation needs including HEDIS® and CAHPS®, clinical quality committees and/or projects, and prevention and/or care gap closure for disease management among other initiatives. This document provides an overview of our strategies and the methods used toward achieving our goals.

I. Strategy

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



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

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

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

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

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

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

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

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

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

Outreach as noted in Appendixes 1 and 2 can be any one or a combination of direct types of member contact about a program or service: US Postal (USPS) Mail, Secure Messaging (MyChart) or telephonic. Secure messaging (MyChart) and telephonic outreach provide interactive communication between our organization and the member/patient.

II. Activities Integrating Community Resources

GHC-SCW is committed to offering our members and their practitioners' alternative resources or programs that they can utilize to help prevent and manage chronic illnesses that are not direct member interventions. Offering alternative resources is especially important given that behavioral and social factors contribute to health outcomes.

Prediabetes

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

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

previous pregnancy, or a qualifying risk score.

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

Diabetes

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

GHC-SCW has also been facilitating a Virtual Diabetes Support Group (VDSG) that focuses on providing education from a variety of healthcare professionals sharing tips and aiding group conversation about living with diabetes. Participants also may receive twenty pounds of food at no cost to support a healthy lifestyle. Continuation of the VDSG by the health plan is based on member interest and available staffing or other resources.

Other Chronic Conditions or Needs Associated with Social Determinants of Health

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

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

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

In 2021, GHC-SCW began a first phase of social determinants of health (SDoH) functionality in our electronic medical record. Adult (18+) and Pediatric (< 1-17) supplemental questionnaires include screening questions endorsed by the Dane County Health Council and new sexual health questions that follow the Centers for Disease Control and Prevention's *5P's* approach to taking a sexual history. Patients automatically receive these questionnaires prior to a Preventive Health Exam imbedded in their pre-visit MyChart message. Information provided flows into the record to populate the fields/functions in Epic

III. Data and Information Sharing with Practitioners

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

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

IV. Coordination of Member Programs

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

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

V. Eligibility and Informing Members

The cooperative maintains a public facing website page related to health management that provides details about how to use available programs and services, or how to opt out. The organization informs about information available on our website through the member newsletter or other communications.

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

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

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

VI. Population Identification

Data Integration

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

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

In 2023, GHC-SCW launched a large scale project to transform the organizations' business intelligence and data integration structure to fully leverage Epic's Caboodle and retire our Enterprise Data Warehouse.

Population Assessment

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

GHC-SCW uses relevant data from the health plan and/or clinic level electronic medical record system to prioritize programs or interventions best suited to the unique characteristics of our membership. The member populations needs are surveyed by evaluating:

- All ages including children and adolescents within the Commercial, Exchange & Medicaid HMO and impactful social determinants of health such as transportation, food insecurity, financial hardship and/or housing insecurity
- Two relevant subpopulations that share common characteristics with the total membership
- Chronic conditions and/or disabilities
- Serious mental illness (SMI) or serious emotional disturbance (SED)
- Our populations racial and ethnic diversity and any associated disparities
- Our populations overall language profile to identify members with limited English language proficiency and any associated disparities

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

As a public health partner in the Healthy Dane Collaborative, our cooperative also participates in and uses the local Community Health Needs Assessment (CHNA) as a source of reliable, current population data about our Dane County community to understand issues pertinent to the residents we serve. The CHNA is conducted every 3 years to identify & prioritize the health issues of greatest concern in our surrounding community. The findings from the 2022-2024 assessment revealed mental health treatment as the most critical need followed by substance abuse, healthy pregnancy, suicide, and diabetes. The collaborative recognizes that the needs identified from the assessment are complex and is committed to working together in coordinated ways.

Activities and Resources

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

GHC-SCW is working on further developments that will increase our ability to report on SDoH and support a more robust community resources referral guide for utilization by the staff of GHC-SCW. Our Population Health Department's social workers support patients, other GHC-SCW employees, or outside providers by provision of information and connection to community resources with the goal to improve the overall patient experience and quality of care. Some examples of the type of resources that staff may offer include:

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

Promoting Health Equity

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

Equity focused committees/workgroups review initiatives for both insurance and care delivery functions of the organization. Senior leaders, managers and clinical staff across the organization aim to identify any unfair or remediable differences that impact the member population. Plans for action may require an update to the organization's overall strategic goals or population health activities or resources to help address a disparity once identified.

GHC-SCW's strategic plan through 2025 has five pillars. The *Impact* pillar focuses on advancing health and well-being by nurturing connections with our member-owners and the communities we serve. The organization's Executive Sponsors of this pillar have defined a goal to establish a minimum of three new community partnerships per year through calendar year 2025 that enhance our giving philosophy and cultivate health equity across our community.

Annual employee training on diversity, equity & inclusion, is also an organizational commitment associated with the Health Equity Accreditation GHC-SCW obtained from NCQA on August 3rd, 2023.

Segmentation

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

GHC-SCW utilizes various reports or registries to identify members that are potential candidates for targeted preventive outreach, or either case management or chronic disease intervention based on health plan or clinic level data. Epic® registries (currently diabetes, chronic opioid use, cigarette use and asthma) reflect a patient (staff model) perspective. An Epic® Hypertension registry is being slated for 2024 which will allow retirement of the older version of this registry (QMI0010050).

Preventive registries include all actively enrolled members who have a GHC-SCW HMO plan and are the heart of our population health management program. They are built from specific member level information that follows inclusion rule methodology (see GHC-SCW Healthy Planet Tools) based on active GHC-SCW coverage or another active payer, their legal sex, and their current age. These preventive Epic® registries provide the basis for creating more granular and specific Reporting Workbench Reports then used to conduct bulk outreach communication and bulk lab ordering. While other registries GHC-SCW uses technically do not stratify the entire population, they are utilized for targeted interventions or potential outreach opportunities based on a medical or behavioral health diagnosis, prescribed medications, a noted health behavior, or an aspect of utilization that could indicate a rising risk. Our segmentation analysis is customized to our local HMO population, informed by clinician expertise, and prioritizes the most critical population health needs. GHC-SCW routinely brings together experts across the organization to explore if racial bias may exist in our methodology to mitigate its influence.

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

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

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

VII. Delivery System Supports

Practitioner or Provider Supports

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

The *Clinical Content Committee* evaluates the relevance, currency and accuracy of shared internal policy and helps maintain a *Clinical Resources Dashboard* within Epic. Nursing staff can utilize *Lippincott® Solutions*, a suite of clinical decision support tools and CE courses that provides evidence-based resources to strengthen our staff's quality of clinical care.

Evidence-based guidelines serve as the framework for our PHM strategies and cover at least the following three spheres of health care: 1) chronic or acute medical conditions, 2) behavioral health and 3) preventive health. GHC-SCW's Quality and Population Health Steering Committee has vetted guidelines from recognized sources such as the American Diabetes Association, American Heart Association, American Psychiatric Association, US Preventive Services Task Force, the Global Initiative for Asthma and American College of Obstetrics and Gynecology encompassing each of these spheres. These recommended guidelines are resources for participating providers but not a substitute for appropriate clinical judgment.

GHC-SCW has also partnered with *Wisconsin Health Literacy* to create customized training modules as part of our health equity efforts and encourages all staff to participate. Health Literacy 101 is a prerequisite to three additional training modules. Module 102 has a clinical focus, while the remaining modules are related to health insurance literacy and geared toward staff in those roles. All employee training on diversity, equity, and inclusion, is also an organizational commitment associated with the maintenance of our Health Equity Accredited status with NCQA.

Data Sharing

GHC-SCW strives to provide practitioners with timely and actionable data to support better care and counseling of a patient or member. Transmission of member data to the provider or practitioner that assists in delivering services, programs, or care to the member is the definition of data sharing. Being an integrated delivery and insurance system affords GHC-SCW the benefit of data from both insurance operations and clinical care as we have access to Epic® medical records as well as claims information. Epic® Care Link and Care Everywhere functionality allows data sharing with other regional health system partners. Epic® reports provide knowledge of triggering events such as urgent care or ER visits and hospital admissions that can facilitate practitioner development of an appropriate plan of care.

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

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

Shared Decision Making Aids

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

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

GHC-SCW practitioners have access to SDM content within Epic® . These aids can be offered to any member prior to specialist/surgical referral or testing:

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

Practice Transformation Support

GHC-SCW's staff model primary care clinics were previously recognized by NCQA as Level III Patient Centered Medical Home (PCMH) practices, however, in 2020, the organization made a strategic business decision to let PCMH recognition lapse due to budgeted resources. Since that time, our staff model clinics continue to build on the foundational principles of a medical home with some level of sharable reporting still operational.

The organizations *Learning and Development Team Lead/ Provider Engagement Specialist* engages with all incoming staff model practitioners as practice onboarding serves as the foundation for integrating new employees into our brand. Thereafter, GHC-SCW supports its practitioners in meeting their population health management goals through frequent technology related upgrades to the electronic medical record and investing in clinical decision support tools and CE courses that provide evidence-based practice resources to strengthen our staff's quality of clinical care.

GHC-SCW launched Dragon Medical One, a cloud based speech recognition platform in 2023 that provides practitioners with a personalized experience to document patient care whenever and wherever is most convenient and, also supports process improvements that keep practitioners up to date with telehealth industry trends.

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

VIII. Wellness and Prevention

GHC-SCW's ManageWell member wellness program is part of a comprehensive PHM strategy and focuses on promoting health with the primary aim of lowering the total cost of health care by slowing the increase of risk. Most GHC-SCW members including subscribing members and their spouses/significant others who are eighteen and older are eligible to participate in the wellness program.

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

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

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

Administered quarterly, the programs points reset at the beginning of each quarter. Incentive payouts are determined based on the tier each participant meets and are then distributed after claims for the prior quarter have been processed.

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

IX. Complex Case Management

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

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

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

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

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

Access to Case Management

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

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

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

- Website
- Internally to staff on SharePoint
- Member, practitioner, and staff electronic communications and/or postal mailings
- Information provided during new practitioner orientation

Potential case management members must live in the state of Wisconsin and list GHC-SCW insurance as their primary payor and meet one or more of the following criteria:

i. Have five (5) or more health conditions which require specialty care OR
ii. Struggle with alcohol, opioid, or recreational drug use OR
iii. Are over the age of 18 with chronic health conditions and a recent psychiatric admission OR
iv. Are under the age of 18 with a recent psychiatric admission

Care Management Department staff may also utilize their discretion to offer case management.

GHC-SCW also offers care coordination for members with immediate needs who could benefit from brief intervention of two months or less. Care coordination is available only for members living with substance use disorders, behavioral health challenges, and/or a dual diagnosis. Members must also list GHC-SCW as their primary insurer. The goal of care coordination is to connect member to appropriate resources based on need.

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

Experience with Case Management

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

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

X. PHM Impact

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

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

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

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

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

The organizations 2024 goal is for all **Triple Weighted** Metrics to achieve or exceed the 75th percentile.

KEEPING MEMBERS HEALTHY Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric **Triple Weighted**	**Target Population**	**MY2022 Rate**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Adult Immunizations					
AIS-E Influenza	Age 19-65	41.44 **C**	95th	95th 38.71	Outreach/Flu Clinics
AIS-E Td/Tdap	Age 19-65	55.51 **C**	90th-95th	90th 54.72 95th 62.09	Outreach
AIS-E Zoster	Age 50-65	42.23 **C**	95th	95th 30.84	Outreach
Child/Adolescent Immunizations					
IMA Combo 1	Age 13	78.59 **C**	10th-25th	75th 88.73 90th 91.97	Outreach
IMA Combo 2	Age 13	48.91 **C** 37.50 **E**	90th-95th	75th 38.93 90th 46.23	Outreach
CIS Combo 10	Age 2	77.62 **C** 60.00 **E**	95th	75th 64.44 90th 70.58	Outreach
Cancer & Other Screenings					
Cervical (CCS)	Female Age 21-64	78.83 **C** 70.32 **E**	75th-90th	75th 77.68 90th 80.78	Outreach
Breast (BCS)	Female Age 50-74	75.68 **C** 70.27 **E**	50th-66th	75th 76.85	Outreach
Breast (BCS-E)	Female Age 50-74	75.58 **C**	50th –66th	75th 76.84	Outreach
Colorectal (COL)	Total	63.26 **C** 61.31 **E**	75th-90th	75th 62.29 90th 66.91	Outreach
Colorectal (COL)	Age 46-49	36.14 **C** 26.32 **E**	75th-90th	75th 34.72 90th 39.66	Outreach
Colorectal (COL)	Age 50-75	70.12 **C** 66.95 **E**	75th-90th	75th 67.97 90th 72.59	Outreach
Chlamydia (CLA) Total	Eligible 16-24	34.17 **C** 34.92 **E**	5th -10th	75th 51.84	Outreach
Maternal Health					
Prenatal (PPC)	Female	98.30 **C** 100.00 **E**	95th	75th 90.00 90th 93.62	Outreach
Postpartum (PPC)	Female	97.08 **C** 97.06 **E**	95th	75th 89.53 90th 93.01	Outreach
Utilization					
Well Child (WCV) Total	Age 3-21	59.06 **C** 54.55 **E**	50th-66th	75th 64.16 90th 72.13	Outreach

The organizations 2024 goal is for all **Triple Weighted** Metrics to achieve or exceed the 75th percentile.

MANAGING AT RISK AND HIGH RISK MEMBERS Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric Triple Weighted	**Target Population**	**MY2022 Rate Or current value**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Diabetes					
Diabetes A1c < 8.0 (HBD)	Diabetes Registry	64.23 **C** 53.28 **E**	66th-75th	75th 65.69 90th 69.33	Outreach Diabetes Educators/Disease Mgmt.
Diabetes BP Control (BPD)	Diabetes Registry	74.45 **C**	75th-90th	75th 71.53 90th 76.39	Outreach Diabetes Educators/Disease Mgmt.
Statin Therapy (SPD)	Diabetes Registry	63.19 **C** 69.57 **E**	25th-33rd	75th 67.73 90th 70.20	Outreach Diabetes Educators/Disease Mgmt.
Cardiovascular					
Controlling High Blood Pressure (CBP)	Hypertension Registry	74.21 **C** 73.89 **E**	90th-95th	75th 69.73 90th 74.04	Outreach Disease Mgmt. Clinical Pharmacists
Asthma					
Asthma Med Ratio (AMR)	Asthma Registry	86.46 **C** 69.57 **E**	50th-66th	75th 87.84 90th 90.62	Outreach Clinical Pharmacy Asthma Educator Disease Mgmt.

PATIENT SAFTEY Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric	**Target Population**	**Current value**	**Current Percentile**	**Percentile and/or Goals**	**Program or Service**
Chronic Opioid Treatment (COT) Current value data is staff model members all products lines					
Urine Drug Screening UDS*	Opioid Use Registry	Qtr 3 2023 79%	NA	≥ 80 %	Chronic Opioid Treatment Program
Qtrly Visit Completion COT**	Opioid Use Registry	Qtr 3 2023 76%	NA	≥ 80 %	Chronic Opioid Treatment Program

* Percent of patients who had a urine drug screening (UDS) within the last 12 months

** Percent of patients who had a visit in Primary Care for (COT) within the last 3 months

OUTCOMES ACROSS SETTINGS Commercial (C) Exchange (E) as applicable Percentiles are National All LOB					
Metric	**Target Population**	**MY2022 Rate**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service#**
Plan All Cause Readmissions **(PCR)**	HMO members who had an inpatient hospital stay ≥ 3 days	0.4479 **C**	75th-90th	90th 0.4441	Care Coordination Outreach Complex Case Management
Follow Up Within 7 Days After Hospitalization for Mental Illness (FUH) Total	Member age 6 years or older who had an inpatient stay for a diagnosis of mental illness or intentional self-harm	63.89 **C** 58.33 **E**	90th -95th	90th 61.53 95th 65.08	Outreach

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

KEEPING MEMBERS HEALTHY Medicaid HMO Percentiles are National All LOB					
Metric **Triple Weighted** **(Pay-for-Performance ***)**	**Target Population**	**MY2022 Rate**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service**
Adult Immunizations					
AIS-E Influenza	Age 19-65	19.27	75th 17.70 90th 21.05	66th	Outreach
AIS-E Td/Tdap	Age 19-65	48.89	75th 47.11 90th 56.63	66th	Outreach
AIS-E Zoster	Age 50-65	20.91	95th 17.21	66th	Outreach
Child / Adolescent Immunizations					
Combo 3 (CIS)***	Age 2	60.00	25th 58.64 33rd 60.34	75th	Outreach
Combo 10 (CIS)	Age 2	36.77	67th 35.04 75th 37.64	≥ 75th	Outreach
Combo 2 (IMA)* **	Age 13	47.44	75th 40.88 90th 48.80	≥ 75th	Outreach
Maternal Health					
Prenatal (PPC)***	Female	91.60	90th 91.60 95th 92.35	75th	Outreach
Postpartum (PPC)***	Female	76.47	33rd 75.18 50th 78.10	75th	Outreach
Cancer and Other Screenings					
Cervical (CCS)	Female 21-64	63.99	75th 61.80 90th 66.48	75th	Outreach
Breast (BCS)	Eligible Females	51.22	33rd 48.06 50th 52.20	75th	Outreach
Colorectal (COL)	Total	34.23	NA	66th	Outreach
Colorectal (COL)	Age 46-49	14.89	NA	66th	Outreach
Colorectal (COL)	Age 50-75	40.79	NA	66th	Outreach
Chlamydia (CHL)	Eligible 16-24	56.99	50th 56.04 67th 61.07	66th	Outreach
Utilization					
Well Child (WCV)***	Total	40.86	10th 38.61 25th 42.99	75th	Outreach
Well Child (WCV)	15-30 months	53.49	5th 53.49	75th	Outreach
Well Child (WCV)	First 15 Mo.	45.11	10th 44.02 25th 52.84	75th	Outreach

MANAGING AT RISK AND HIGH RISK MEMBERS **Medicaid HMO** **Percentiles are National LOB**					
Metric **Triple Weighted** **(Pay-for-Performance ***)**	**Target Population**	**MY2022 or Current Value**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service**
Diabetes					
A1c < 8.0 (HBD) ***	Diabetes Registry	48.15	25th 46.96 33rd 49.39	≥ 75th	Outreach Diabetes Educators Complex Case Mgmt.
BP < 140/90 (BPD)	Diabetes Registry	70.37	75th 70.07 90th 74.56	≥ 75th	Outreach Diabetes Educators Disease Mgmt. Complex Case Mgmt.
Poor A1c Control (HBD)	Diabetes Registry	43.89	25th 44.77 33rd 41.61	≥ 75th	Outreach Diabetes Educators Disease Mgmt. Complex Case Mgmt.
Cardiovascular					
Controlling High Blood Pressure (CBP) ***	Hypertension Registry	64.12	50th 61.31 67th 65.45	≥ 75th	Outreach Disease Mgmt. Clinical Pharmacy
Asthma					
Asthma Med Ratio (AMR) Total ***	Asthma Registry Age 19-50	68.52	50th 65.61 67th 69.41	≥ 75th	Outreach Clinical Pharmacy Asthma Educator Disease Mgmt.

PATIENT SAFTEY Medicaid HMO Percentiles are National All LOB					
Metric (Pay-for-Performance ***)	**Target Population**	**MY2022 Rate or Current Value**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service**
Chronic Opioid Treatment (COT) Current value **d**ata is staff model members all product lines					
Urine Drug Screening UDS#	Opioid Use Registry	Qtr 3 2023 79%	NA	≥ 80 %	COT Program
Qtrly Visit Completion **COT##**	Opioid Use Registry	Qtr 3 2023 76%	NA	≥ 80 %	COT Program
Lead Screening					
Lead Screening (LSC) ***	Age 9 mo-2 years	64.52	50th 62.79 67th 67.12	75th	Outreach

Percent of patients who had a urine drug screening (UDS) within the last 12 months

Percent of patients who had a visit in Primary Care for (COT) within the last 3 months

OUTCOMES ACROSS SETTINGS **Medicaid HMO** **Percentiles are National All LOB**					
Metric **Pay-for-Performance** ***	**Target Population**	**MY2022 Rate or Current Value**	**Current Percentile**	**Percentile and/or Goal**	**Program or Service**
Follow Up Within 30 Days After Hospitalization for Mental Illness (FUH) Total ***	Member age 6 years and older who had an inpatient stay for a diagnosis of mental illness or intentional self-harm	64.62	67th 63.47 75th 65.38	75th	Outreach
Plan All Cause Readmissions	Members who had an inpatient hospital stay ≥ 3 days	0.4976	95th 0.7816	75th	Care Coordination Outreach Complex Case Mgmt

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