2026

GHC-SCW Population Health Management

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN| Madison, WI

2026 Population Health Program Strategy

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2026 Population Health Management (PHM) Program Strategy

Introduction

GHC-SCW's Population Health Program aims to improve the health and well-being of our members and reduce health disparities where possible. We do this by tailoring outreach strategies to meet the needs of our members and providing care coordination that supports members who are experiencing complex health conditions. These strategies require a coordinated effort between our Quality Management and Population Health staff and our clinics, by collaborating on initiatives that support these efforts.

The Population Health Department focuses on creating and maintaining community partnerships, community programs and social work services that address social determinants of health (SDoH) that may impact the delivery of equitable care to all GHC-SCW members and patients.

The Quality Management Department supports NCQA Accreditation needs, including HEDIS® and CAHPS®, clinical quality committees and projects, and works on closing prevention and disease management care gaps. This report provides an overview of the strategies and methods used toward achieving our Population Health Management goals.

1. Strategy

Improving and managing the health of our members requires a combination of system level strategies and personalized care. Our focus is on enhancing the quality and value of health care by prioritizing preventive services, improving chronic conditions and strengthening care coordination, particularly for members and patients with complex health needs.

When left unmanaged, chronic conditions may result in avoidable and costly health outcomes. National trends show unsustainable growth in healthcare spending, especially in areas related to behavioral health and chronic disease. We are also focused on addressing health disparities among our membership. Through targeted outreach and equitable care initiatives, GHC-SCW aims to close the gaps in health outcomes and ensure all members receive high quality, coordinated care.

Strategic Areas, Metrics, Target Populations, Goal and Associated Programs or Services

- Keeping members healthy through wellness and prevention

- Managing at-risk (emerging risk) and high-risk populations
- Focusing on patient safety initiatives
- Providing high value care coordination and managing outcomes across settings
- Managing chronic diseases and co-morbidities

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

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

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

***Appendix 1*:** outlines the metrics, target population, goals, programs and/or services applicable under each key strategic area for our **Commercial HMO** and **Exchange HMO** populations.

***Appendix 2**:* outlines our metrics, target population, goals, programs and/or services applicable under each of the key strategic areas for our **Medicaid HMO** population.

Outreach is done by direct member contact about a program or service available to a member. This is done through US Postal Service (USPS), Secure MyChart messaging, text message or by telephone. Interactive communication is often done through secure messaging between our organization and members.

2. Chronic Condition Resources and Programs

GHC-SCW is committed to supporting both members and their healthcare practitioners by offering alternative resources or programs designed to help prevent and manage chronic illnesses. These resources, which complement direct clinical care, are especially valuable because behavioral and social factors – such as lifestyle, environment, and mental health – play a significant role in overall health outcomes.

Prediabetes

Members who are at risk of developing diabetes (based on screening criteria), may be referred to an evidence-based Diabetes Prevention Program (DPP), which

promotes healthy eating and encourages physical activity to prevent the onset of Type 2 Diabetes.

This program features a collaborative agreement with the YMCA of Metropolitan Milwaukee and allows GHC-SCW to refer qualified Commercial and Medicaid HMO members, ages 35-70 with a BMI greater than or equal to 25, and do not have a current diagnosis of diabetes. Members are required to be screened for prediabetes prior to being offered the program. If a member's results indicate they are prediabetic, they can be offered the program and referred to this intensive behavioral health counseling program.

Diabetes

GHC-SCW offers all members who have diabetes, participation in Diabetes Bootcamp. Participants meet every other week for a total of seven sessions. The program provides education from a variety of healthcare professionals who share tips and help facilitate group discussion about living with diabetes. The topics covered include healthy eating, understanding short- and long-term risks of diabetes (including eye health), strategies for healthy coping, physical activity, self-monitoring and medication management. Members learn about this opportunity through their practitioners, and it is also listed on our website.

Chronic Pain

The Center for Disease Control estimates that 21% of adults in the United States, or nearly 51.6 million people, live with a chronic pain condition. This can impact your ability to work, attend school, participate in social outings and enjoy hobbies. Losing engagement in these activities can harm your mental health and worsen pain.

Pain is a multi-faceted experience influenced by biological, psychological and social factors. Managing persistent pain requires a personalized care plan. Managing pain often requires a team that may include a primary care physician, physical or occupational therapist, massage therapist, psychotherapist, or other specialty provider. The treatment plan often involves multiple approaches such as medications, exercises, education, braces, assistive devices and rest.

For GHC-SCW members facing chronic pain, GHC-SCW now offers members a new program called COMPASS for adults 18 and older. The program includes five 90-minute sessions that include education, group activities and discussion time. The

program offers members a chance to be with other members who are facing similar challenges.

Additionally, Care Management staff may refer members to the UW Pain Clinic for group meetings with different pain management supports through the help of health psychologists.

Hypertension

GHC-SCW pharmacies provide the blood pressure monitors to Commercial members who have an elevated blood pressure. These monitors are sold at a discounted rate to make them more affordable, and some members will work directly with a clinical pharmacist to learn how to use them, as well as work through medication needs in collaboration with their practitioner. Members who do not work with Clinical Pharmacy are given written instructions on how to use the monitors when they purchase them or through MyChart.

Additionally, GHC-SCW Clinical Pharmacy continues to offer self-measured blood pressure (SMBP) loaner program through Clinical Pharmacy. Patients can be referred by their practitioner, nursing staff, or self-referred by Clinical Pharmacy. Any member with hypertension or suspected hypertension is eligible. They are given a blood pressure monitor to use at home for 8 weeks and instructed on how to properly check their blood pressure at home, as well as how to enter the readings in MyChart. The Clinical Pharmacy team then follows up with the patient on their home blood pressure readings.

Foundations Intensive Outpatient Program (IOP)

GHC-SCW offers this evidence based, multidisciplinary and multimodal program for adults with behavioral health diagnoses. The program benefits patients who are either stepping down from higher levels of care or could use more intensive services than outpatient therapy and medication management. Members are referred by psychiatrists, primary care practitioners or other mental health practitioners. Referred members complete a comprehensive assessment and spend the majority of time with peers in a group therapy session, learning and practicing skills while exploring symptoms and experiences in a safe environment. Virtual sessions are also an option for those who do not have the ability to attend in person due to transportation needs or other concerns.

Clinical Resources

GHC-SCW utilizes SharePoint to provide our clinical care teams with disease or condition specific resources that can help support their care of members with specific needs and also to support members when they need assistance accessing services or resources available to them.

The Care Team Resources page includes information about diabetes resources, medication assisted treatment program resources, asthma resources, smoking cessation resources and others. The Care Coordination resources page allows staff to access information about community health programs, social work services available at the clinics and in the community.

GHC-SCW also employs two clinical social workers embedded in GHC-SCW staff model clinics, who can assist with referrals to community agencies who may be able to assist members with specific needs in the community.

3. Data and Information Sharing with Providers and Practitioners

GHC-SCW uses the Epic electronic medical record (EMR) with reporting tools for sharing data and information between Primary Care, Urgent Care, nursing staff, Behavioral Health, and other care team members. The system also has interoperability with other local health care system providers, including hospital systems. This technology is fundamental to providing patient centered care.

Panel management tools are enabled so that medical staff can quickly order routine lab tests and send reminders about important health services that are needed. Practitioners can review Epic's MyPanel Metrics (MPMs) to monitor their member panels.

With Epic's *"Healthy Planet"* functionality and tools, such as condition specific registries and metric-based dashboards, clinic staff can compare their performance to organizational benchmarks, as well as the performance of others. Dashboard metrics are selected by key internal clinical quality committees, stakeholders, the Chief Medical Officer and Associate Medical Director of Informatics and Population Health. Most Epic registries and dashboard components update weekly.

At minimum, the practitioner-level metrics are updated on a quarterly basis. To the extent possible, metrics are built to align with HEDIS® and MIPS, and 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 practitioner engagement toward achieving better health outcomes for our members.

Practitioners and care teams also receive weekly newsletters which may include specific measures of focus and process improvement updates, based on organizational performance.

GHC-SCW utilizes Epic tools to coordinate services and programs for members and patients with chronic disease, complex health needs, or those who would benefit from clinical pharmacy services. These programs are coordinated internally to enhance care delivery. GHC-SCW does not delegate population health management functions to external entities.

Coordination of Member Programs

Case Management staff at GHC-SCW use the Compass Rose tool within Epic to coordinate care management services. Care plans and related documentation are entered directly into a member's EMR. When a member is enrolled in Complex Case Management, primary care practitioners are notified through specific icons in the EMR. The icons alert practitioners to the member's case management enrollment status, highlighting specific needs such as SDoH and prompt practitioners to review dedicated episodes of care created by the Case Manager.

The GHC-SCW Clinical Pharmacy Program employs similar documentation practices to coordinate services with primary care practitioners. The program includes multiple components designed to optimize medication use, support disease prevention, and manage chronic conditions such as diabetes and hypertension.

Clinical Pharmacists operate under collaborative practice agreements that authorize them to adjust medication, order and monitor lab tests and provide patient education. As with case management, all documentation is recorded in the EMR, allowing practitioners to view documentation of services received by any member.

4. Eligibility and Informing Members

GHC-SCW maintains a public facing website page related to health management. The site provides information about available programs and services, and how to opt in or out. Members are also informed about services through newsletters or other

communication methods, such as social media and sometimes by their health care practitioners.

Information about applicable programs and services is provided to members through various direct contact methods, including:

- U.S. Postal Service (USPS) mail
- Secure MyChart messages
- Text Messaging
- Telephone Outreach

Members can set their communication preferences in their MyChart account. If no preference is indicated, communications will default to MyChart (if the account is active); otherwise, USPS mail will be used. If a member believes they received a notice or care gap reminder in error, or no longer wishes to receive outreach, they

are instructed to contact their care team or the Quality Management Department to opt-out of future communications.

Complex Case Management

To qualify for Complex Case Management services, members must meet specific criteria (*see page 19*). Case Management staff review reports and data to identify eligible members. After a thorough chart review, case managers reach out by phone to provide information about available services and offer the opportunity to enroll or opt out.

Additional details are available on our website at:
https://ghcscw.com/members/help-managing-complex-conditions/

5. Population Identification

Data Integration

GHC-SCW relies on robust, reliable data to foster a culture of continuous improvement. Data is leveraged across all business functions to enhance decision making and operational efficiency.

By combining data from multiple sources across clinical sites and insurance domains, we create links between systems to better coordinate care. Health plan operations are supported by advanced information systems, EMRs, and business

software tools. These systems enable the delivery of timely, appropriate care by utilizing data from sources such as:

- **Medical and Behavioral Health claims or encounters**
- **Pharmacy claims**
- **Laboratory results**
- **Medical Imaging**
- **Electronic Health Records (EMR)**, integrated between practitioners and providers through Care Everywhere, Care Link and Share Everywhere functionality within Epic.
- **Health services programs within GHC-SCW**, such as Utilization Management, Care Management or NurseConnect.
- **Data warehouses or other advanced data sources**, such as chronic disease or population-based registries, data sharing with Wisconsin Immunization Registry (WIR), a database which records and tracks immunization dates of Wisconsin children and adults.

GHC-SCW launched a large-scale project to transform the organization's business intelligence and data integration structure in 2023. The organization continues to work to fully leverage Epic's Caboodle system and retire our Enterprise Data Warehouse. The bulk of the work was completed in 2025, and full completion is expected in 2026.

Population Assessment

GHC-SCW utilizes a variety of data sources to identify the characteristics and needs of our member population. This includes the use of population management tools that analyze medical and pharmaceutical claims data to support targeted care strategies. These tools, combined with other member-level data, help identify key demographic factors such as age, gender, race, ethnicity, and SDoH information that may highlight at risk populations with specific needs.

SDoH are known contributors to overall well-being, such as socioeconomic circumstances, physical environment, health behaviors, and barriers to accessing care. Understanding these factors enables GHC-SCW to better tailor services and interventions to support vulnerable populations.

GHC-SCW uses relevant health plan data and/or EMR data to prioritize programs or interventions best suited to the characteristics of our membership. The needs of our member populations are surveyed by evaluating:

- All ages within the Commercial, Exchange and Medicaid HMO lines of business

- SDoH needs-transportation, food insecurity, financial hardship and housing insecurity
- Two relevant subpopulations that share common characteristics with the total membership
- Chronic conditions or disabilities
- Serious mental illness
- Serious emotional disturbance
- Racial and ethnic diversity and associated disparities
- The overall language profile, to identify members with limited English proficiency and associated disparities

Our annual population assessment helps identify the highest needs of our members in addition to identifying individuals or groups who may benefit most from targeted strategies. The assessment also informs the development of population health programs, outreach methods and other initiatives, such as determining eligibility for Complex Case Management.

GHC-SCW is a public health partner in the Healthy Dane Collaborative and participates in and uses the local Community Health Needs Assessment (CHNA) as a source of current and population data about our Dane County community. The CHNA is conducted every three years to identify and prioritize the health issues of greatest concern in our surrounding community.

A new assessment released in 2025 revealed that diabetes and heart disease continue to be significant issues in our community, and breast cancer incidence rates are increasing. Anxiety and depression rates are worsening along with substance use. Unintentional injury, such as falls, is showing to be worsening as well. The needs from the assessment are complex and the collaborative is committed to working together on improvement opportunities.

Activities and Resources

To meet the needs of our members, GHC-SCW analyzes our annual population assessment results, reviews the PHM strategy, associated activities and integrates community resources where needed. Internal stakeholders or committees may make recommendations to update PHM activities or resources and take into consideration changes to programs or services, qualifying criteria or staffing ratios

for complex case management, clinical training requisites or other external resource needs.

Over the years, the organization has improved the collection of SDoH data. The information obtained from our members has allowed us and continues to help us evaluate our members' specific needs. This is valuable information that will guide us to resources that will improve their overall experience and quality of care.

Specific needs have been identified which will impact health outcomes for those with chronic conditions. The latest data highlights that members with diabetes and hypertension have significant food insecurity and that transportation is a gap that must be considered when planning interventions for all members and patients.

Social Workers in our Population Health Department and our BadgerCare Plus Coordinator support our members and patients by connecting them to resources with the goal of improving overall member experience and quality of care. The most frequently offered resources are:

- Transportation
- Food Programs
- 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."

At GHC-SCW, we believe that fostering a health system rooted in belonging and community is essential to building a healthier population.

Equity-focused subcommittees and workgroups regularly review initiatives across both insurance and care delivery functions. Senior leaders, managers, and clinical staff work together to identify any unfair or remediable differences affecting our member population. When disparities are found, action plans may include updates to strategic goals, adjustments to population health activities, or the allocation of resources to address the issue.

GHC-SCW's strategic plan through 2026 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 2026 that enhance our giving philosophy and cultivate health equity across our community.

The 2026 tactics will focus on developing a community and employer-based clinical service outreach program that may include a mobile health care unit and attain the 75th percentile on 7 of 10 BadgerCare Plus pay-for-performance HEDIS® measures.

Segmentation

Segmentation involves dividing our member population into meaningful categories, while risk stratification uses risk status to identify members who may benefit from intervention. Together, these processes support the full continuum of care, with tailored interventions based on data sources, illness severity, test results or other inclusion criteria.

GHC-SCW uses a variety of reports and registries to identify who may benefit from targeted preventive outreach. These tools also help identify candidates for case management or chronic disease interventions, using data from both the health plan and clinics.

Epic registries-such as those for diabetes, chronic opioid use, hypertension and asthma offer detailed insights into subpopulations including patients medically homed with a GHC-SCW Primary Care Practitioner.

Preventive registries include all actively enrolled members who have a GHC-SCW HMO plan. These registries are the heart of our Population Health Management Program. They are built using member level data based on inclusion rules (see GHC-SCW Healthy Planet Tools) which consider factors like coverage status, legal sex and current age. These registries enable bulk outreach communications and lab orders.

While other registries stratify the entire population, many are used for targeted outreach based on medical or behavioral health diagnoses, prescribed medications, health behaviors, or utilization patterns that may signal a rising risk.

Our segmentation analysis is customized to our local HMO population, informed by clinician expertise, and prioritizes the most pressing population health needs. GHC-SCW regularly convenes experts across the organization to examine whether racial bias may exist in our methodology-and to take steps to mitigate its impact.

2026 Population Health Management (PHM) Program Strategy

Primary Registries and Reports

Population Subset	Line of Business	Targeted Intervention
Pregnant Females	Medicaid HMO	OB Medical Home
Medically Complex Members	Commercial, Exchange and Medicaid HMOs	Complex Case Management
Behavioral Health and/or substance use disorder	Commercial, Exchange and Medicaid HMOs	Complex Case Management
Diabetes Registry	Commercial, Exchange and Medicaid HMOs	Disease Management
Hypertension Registry	Commercial, Exchange and Medicaid HMOs	Disease Management
Asthma Registry	Commercial, Exchange and Medicaid HMOs	Disease Management
Cigarette Use Registry	Commercial, Exchange and Medicaid HMOs	Outreach
Opioid Use Registry	Commercial, Exchange and Medicaid HMOs	Chronic Opioid Treatment
Asthma related UC, ER or Hospitalization (asthma risk scores >3)	Commercial, Exchange and Medicaid HMOs	High Risk Asthma Coordination
Adult Female (18 years or older)	Commercial, Exchange and Medicaid HMOs	Preventive outreach, immunizations, well child visits, overdue tests, labs, etc.
Pediatric Female	Commercial, Exchange and Medicaid HMOs	Preventive outreach, immunizations, well child visits, overdue tests, or labs
Adult Male (18 years or older)	Commercial, Exchange and Medicaid HMOs	Preventive outreach, immunizations, well child visits, overdue tests, or labs
Pediatric Male	Commercial, Exchange and Medicaid HMOs	Preventive outreach, immunizations, well child visits, overdue tests, or labs

GHC-SCW completes an annual Population Assessment of our entire membership to identify potential disparities related to race, ethnicity, or SDoH. This assessment incorporates various demographic and contextual factors, including age, sex,

employer, ethnicity, language, product line, race, and when applicable, risk panel, such as staff model versus non-staff model. Additionally, we may evaluate clinical episodes by cost and/or frequency to gain a broader understanding of prevalent conditions and identify opportunities for targeted complex case management.

Our Case Management Program is available to all HMO members who meet established criteria, with participation being voluntary. Case Managers use a variety of reports to help identify individuals who may benefit from care coordination.

Where applicable, GHC-SCW leverages tools developed by Optum, to align members with appropriate interventions and optimize the use of plan resources to achieve the greatest health impact. Optum's Outcomes and Quality Measures (OQM) tool, and its associated data warehouse, provides clinical intelligence to help support improved care delivery and compliance. These tools use advanced algorithms to identify patients with chronic or acute conditions, as well as those who may benefit from targeted quality improvement efforts based on Healthcare Effectiveness Data and Information Set (HEDIS®).

6. Delivery System Support

Practitioner Support

Managing members with emerging risk and multiple chronic illnesses

- GHC-SCW's practitioners have access to evidence-based guidelines at the point of care to support clinically sound decision making. GHC-SCW utilizes *UpToDate,* a clinical decision support resource associated with improved outcomes. Embedded links within the Epic EMR provides clinicians with seamless access to *UpToDate,* supporting treatment recommendations, lab result interpretation, and patient education directly at the point of care. These decision support tools help reinforce standards of care known to improve practitioner and patient satisfaction.
- The Clinical Content Committee regularly reviews internal policies to ensure they remain relevant, current and accurate, and supports the maintenance of the Clinical Resources Dashboard within Epic. Nursing staff also have access to *Lippincott® Solutions*, a comprehensive suite of clinical decision support tools and continuing education resources that promote evidence based care and improve clinical quality.
- The committee also ensures that guidelines from respected organizations-such as the American Diabetes Association, American Psychiatric

Association, US Preventive Services Task Force, and American College of Obstetrics and Gynecology- are incorporated into strategies addressing chronic medical conditions, behavioral health and preventive care.

Keeping members healthy

GHC-SCW practitioners are supported by GHC-SCW Quality staff and nursing teams to help manage the needs of our members. MPMs allow a practitioner to generate bulk outreach to their members who need immunizations, cancer screenings, lab work or other services that can impact the health of our members.

Addressing patient safety

Transition of Care

GHC-SCW has a dedicated transition of care nurse, who coordinates hospital discharge follow-up and educates members on how they can avoid readmissions and complications after discharge. The nurse contacts members who have recently discharged for follow up and communicates with the member's primary care practitioner to request recommendations as needed. The nurse will also schedule members for follow-up appointments. In 2026, the Transitions of Care Department will be expanded to help facilitate proactive care transitions and organization sustainability. Current pilot projects involving emergency room and postpartum outreach will end and be transitioned into this department.

Behavioral Health triage

GHC-SCW Primary Care practitioners and Behavioral Health team by collaborating to ensure members who are screened in Primary Care are immediately triaged when a member has an elevated PHQ 9 score or screenings indicate an elevated risk for self-harm.

Pain Management

To support members receiving opioid treatment for pain, GHC-SCW clinical nursing and pharmacy staff work directly members to help meet the requirements of their medication contract. This includes scheduling quarterly visits with their practitioner, completing urine drug screens and conducting pill counts. These activities are designed to reduce risk and support safer prescribing practices by lowering daily morphine equivalents.

Shared Decision Making Aids

Shared Decision Making (SDM) aids are especially valuable for conditions with multiple treatment options, as they enhance patient understanding, outline valuable treatments and present potential outcomes. These tools also promote meaningful dialog, helping align treatment decisions with patient preferences.

GHC-SCW provides evidence based SDM from ***Healthwise,*** an online resource that meets International Patient Decision Aids Standards (IPDAS).

Practitioners have access to SDM content within Epic, enabling them to offer decision making aids prior to specialist referrals, surgical consultations, or diagnostic testing. Topics include:

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

Members may receive printed SDM materials during office visits or by mail and can also access SDM tools and a comprehensive health information library through their GHC MyChart account and through *Healthwise* on our GHC-SCW website. *Healthwise* offers interactive resources to our members on topics such as healthy weight, tobacco cessation, and encouraging physical activity, healthy eating, avoiding risky alcohol consumption and identifying depression symptoms.

Practice Transformation Support

GHC-SCW is committed to advancing practice transformation through targeted investments and strategic initiatives that enhance clinical care, practitioner engagement, and technology integration. Key activities include:

Technology and Infrastructure

- **EMR Enhancements:** Upgrading the EMR to support improved clinical workflows, data capture and interoperability.

- **Provider Dashboards***:* Dashboards are continually being updated to give practitioners real time data to monitor performance metrics, patient panel outcomes and population health indicators. Practitioners can run reports to identify patients on their panel with chronic conditions who may need additional outreach or connections to available resources.

Professional Development and Certification Support

- **Funding for CME and MOC:** Allocating resources to support Continuing Medical Education (CME) and Maintenance of Certification (MOC), ensuring that practitioners stay current with clinical guidelines and innovations.
- **Monthly Primary Care Conferences:** GHC-SCW dedicates time for practitioners to gather to learn from each other, hear about organizational goals relating to quality and equitable health outcomes and learn from highly trained specialists and experts who share evidence based practices that can support primary care practitioners' individual practices.

Innovation in Clinical Practice

AI Integration: To stay current with important advances in technology, GHC-SCW is exploring how we can support our practitioners through the use of Artificial Intelligence (AI). In 2025, a small number of GHC-SCW practitioners participated in a pilot project which used the Epic AI Charting tool. This advancement reduces the need for practitioners to type or jot down notes and enables them to better focus on patient care. As the technology improves and matures, more GHC-SCW practitioners will benefit from this technology.

Additionally, the organization has created an AI focused committee to help evaluate appropriate uses of AI within the organization and to ensure compliance with federal and state requirements.

Committee Involvement

GHC-SCW practitioners are invited to participate on a variety of committees, including committees focused on managing members and patients who may have chronic conditions(s) or other circumstances that impact their quality of care.

Data Sharing

Providing timely and actionable data supports our practitioners in providing high quality care to our members and patients.

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As an integrated care delivery and insurance system, GHC-SCW benefits from access to both insurance data, including medical records and claims information through Epic. The Epic Care Link and Care Everywhere functionalities enable secure data sharing with our health system partners, enhancing care coordination. Additionally, the Wisconsin Immunization Registry is integrated into our Epic system, allowing for bidirectional information sharing with the most up to date immunization records of our members. This helps to reduce care gaps.

Additionally, Epic reporting tools give practitioners timely insights into utilization events, such as urgent care visits, emergency room encounters and hospital admissions, supporting practitioners in developing informed and responsive care plans.

In 2025, Psychiatry notes were added to Care Everywhere, to better align accessibility with other medical care and will continue to offer practitioners

GHC-SCW clinic staff utilize a variety of Epic dashboards and registries that allow care teams to review information prior to and during a scheduled appointment to assist in care coordination. These same dashboards and Epic reporting capabilities help to proactively provide the right patient care at the right time. For example, our Quality Management team shares care gap reports with GHC-SCW practitioners across our delivery system.

GHC-SCW Case Managers document directly into the Epic EMR. Their encounters indicate any change in care plans, resources or programs members are referred to. The members' practitioner has direct access to all progress notes, and any referrals made to outside resources. Utilization reports are also sent to practitioners, so they are aware of when members have been to the hospital, urgent care or emergency room.

GHC-SCW receives the Wisconsin Statewide Health Information Network (WISHIN) activity reports. This report provides admission and discharge information for GHC-SCW BadgerCare Plus membership. GHC-SCW uses this information to help identify members in need of follow up visits after recent Emergency Room visits or inpatient discharge.

7. Wellness and Prevention

GHC-SCW's ManageWell® wellness program is key part of a comprehensive PHM strategy, focused on promoting member health and reducing overall healthcare costs by slowing the progression of risk. Most GHC-SCW members-including

subscribing members and their spouses or significant others aged 18 and older-are eligible to participate with some exceptions. Information and resources are available at https://ghcscw.com/member-owner-rewards/wellness-rewards/.

The ManageWell® platform is highly customizable, offering a personalized experience for members who choose to opt in by registering. Participants earn incentives by completing a variety of wellness activities, accumulating points as part of their journey to better health.

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

- Health Risk Assessment
- Preventive Health (e.g. Flu shot, annual physicals)
- Setting SMART goals
- Health Education visits
- Dental Cleaning
- Weight management and coaching programs*
- Exercise and Sleep Trackers
- Community Supported Agriculture (CSA)

The ManageWell® program operates on a quarterly cycle, with points resetting at the beginning of each quarter. Incentives are paid based on the level achieved by the participant and are distributed after the claims from the prior quarter have been processed. To promote wellness, GHC-SCW members also receive discounts on massage, acupuncture, and other health education classes.

8. Complex Case Management

Our Complex Case Management (CCM) Program is a short-term service with the goal of graduating a member from the program within a year. Members may opt out of the program and have a right to decline participation.

The CCM Program provides proactive, medically appropriate, cost effective, coordinated care to members who have complex medical and/or behavioral health conditions. Members who are interested in accessing CCM are evaluated against current criteria to determine their eligibility. If a member does not qualify for CCM, they have the opportunity for care coordination through primary care in collaboration with Utilization Management.

GHC-SCW's CCM program is led by a Medical Director and the Care Management Department Manager. The program is staffed by a Case Manager Team Lead (RN), who manages all medically complex cases and a licensed Social Worker, who

addresses behavioral health and substance use disorder needs. GHC-SCW supports and requires its case managers to obtain professional certification through the Commission for Case Manager Certification (CCMC).

Case managers engage members and/or caregivers via telephone or virtual visits. Services may be provided directly by the case manager or coordinated through other entities. These services include, but are not limited to:

Care coordination: Arranging appointments, facilitating communication between specialists and primary care practitioners, and connecting members to community resources.

Medication reconciliation: Educating members about their medications and referring to Clinical Pharmacy when needed.

Case management planning: Collaboratively developing care plans with member defined goals that promote self-management and adherence to a plan of care between the member and their practitioner. ***Access to Case Management***

GHC-SCW offers multiple pathways for members to be considered for case management services, including but not limited to:

- **Internal referrals** from GHC-SCW practitioners
- **Member self-referral** or caregiver requests
- **Discharge planning** from hospitals who identify members with complex conditions requiring immediate case management, or with special needs
- **Transitions of care** when new members are identified as needing ongoing care for medical and or behavioral health services without interruption
- **Business Intelligence or Epic reports** indicating recent ER activity, facility readmissions, specific condition reports, etc.
- **Risk stratification tools** focused on using the potential of risk or risk status to identify individuals with rising risks for intervention

Our Complex Case Management Program information is communicated to members and practitioners in a variety of ways:

- GHC-SCW's external website
- GHC-SCW's internal SharePoint page
- Member, practitioner, and staff communications through electronic communication or by US Mail
- Practitioner newsletters and communications

- New practitioner orientation

To be enrolled in case management, members must live in the state of Wisconsin, have GHC-SCW as their primary insurance payor and meet **one or more** of the following criteria:

- Have five (5) or more health conditions which require specialty care
- Struggle with alcohol, opioids, or recreational drug use
- Be over the age of 18 with chronic health conditions and a recent psychiatric admission
- Be under the age of 18 with a recent psychiatric admission

The Care Management Department staff may offer case management at their discretion.

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 members to appropriate resources based on need.

Data Sharing with Practitioners

GHC-SCW Care Management works directly in Epic, allowing practitioners to access all case management progress notes, referrals, care coordination and other details needed to effectively care for their patients.

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

Member Experience with Case Management

GHC-SCW gathers member feedback on the CCM Program through experience surveys tailored to case management and care coordination from members whose cases have closed. These surveys are offered to all members who have opted into the program and have completed at least the initial assessment. The survey is also sent to all members who have opted in to the case coordination program and have participated in a minimum of two phone calls with a case manager.

Member feedback helps assess overall satisfaction, goal achievement, and personal experiences with staff. The survey results are used to evaluate program effectiveness and guide continuous improvement efforts.

The Clinical and Service Quality Committee (CSQC) reviews CCM survey results annually to assess performance against established goals. If goals are not met, the Care Management Manager conducts a causal analysis and initiates appropriate improvement strategies.

9. Population Health Management Impact

Population Health Management strategies are evaluated by conducting an annual comprehensive analysis of performance against established goals. Measures may focus on one segment of a population or include the entire population eligible for interventions. The analysis includes:

- One clinical outcome measure by product line
- One clinical utilization measure by product line
- Member experience with CCM (*see section 9*) plus at least one other program or service offered that is relevant to members in each, or one, or more product lines.

All reported measures are reviewed by the Director of Quality and Population Health and/or members of the Clinical and Service Quality Committee (CSQC). Each impact report must clearly define:

- The relevance of the measure
- The specifications and methodology used for data collection
- A comparison of results against established thresholds, goals or benchmarks

Where applicable, the analysis will include performance trends over time and a qualitative analysis if goals are not met. Based on the findings, the CSQC may establish new goals, recommend targeted interventions, or initiate improvement processes to improve performance related to member experience or any evaluated metric.

2026 Population Health Management (PHM) Program Strategy

Keeping Members Healthy Commercial (C) and Exchange (E) HMO Percentiles are National all LOB *Triple rated measures are in blue*					
Metric	**Target Population**	**MY2024 Rate**	**Current Percentile**	**Goal**	**Program**
Adult Immunizations					
AIS-E Influenza	Age 19-65	40.54 **C** 32.44 **E**	>90th	90th	Outreach
AIS-E Td/Tdap	Age 19-65	39.15 **C** 38.78 **E**	Between 33rd-66th	90th	Outreach
AIS-E Zoster	Age 50-65	40.42 **C** 35.77 **E**	>90th	90th	Outreach
AIS-E Pneumococcal	Age 66+	53.96 **C** 60.00 **E**	Between 33rd-66th	90th	
Child/Adolescent Immunizations					
IMA Combo 1	Age 13	82.24 **C**	Between 33rd-66th	90th	Outreach
IMA Combo 2	Age 13	55.23 **C** 39.13 **E**	>90th	90th	Outreach
CIS Combo 10	Age 2	69.10 **C** 47.62 **E**	>90th	90th	Outreach
Cancer & Other Screenings					
Cervical (CCS-E)	Female Age 21-64	75.88 **C** 76.16 **E**	Between 75th-90th	90th	Outreach
Breast (BCS-E)	Female Age 50-74	76.58 **C**	Between 33rd-66th	90th	Outreach
Colorectal (COL-E)	Total	62.28 **C**	Between 33rd-66th	90th	Outreach
Colorectal (COL-E)	Age 46-50	56.21 **C**	90th	90th	Outreach
Colorectal (COL-E)	Age 51-75	64.39 **C**	Between 33rd-66th	90th	Outreach
Chlamydia (CHL) Total	Eligible 16-24	40.65 **C**	Between 10th-33rd	90th	Outreach
Maternal Health					
Prenatal (PPC)	Female	94.16 **C**	>90th	90th	N/A
Postpartum (PPC)	Female	95.62 **C**	Between 75th-90th	90th	Outreach
Utilization					
Well Child (WCV) Total	Ages 3-21	60.09 **C**	Between 33rd-66th	90th	Outreach
Well Child (W30)	15-30 months	91.09 **C**	Between 75th-90th	90th	Outreach

2026 Population Health Management (PHM) Program Strategy

Well Child (W30)	First 15 months	87.88 **C**	>75th	90th	Outreach

Managing at Risk and High Risk Members **Commercial HMO** Percentiles are National All LOB ***Triple rated measures are in blue***					
Metric	**Target Population**	**MY2024 Rate**	**Current Percentile**	**Goal**	**Program or service**
Diabetes					
Diabetes Glycemic Status < 8.0% (GSD)	Diabetes Registry	74.21 **C**	90th	75th	Outreach Clinical Pharmacist
Diabetes BP Control (BPD)	Diabetes Registry	77.62 **C**	Between 75th-90th	75th	Outreach Clinical Pharmacist
Diabetes Eye Exams (EED)	Diabetes Registry	58.64 **C**	Between 75th-90th	90th	Outreach
Statin Therapy (SPD initiation)	Diabetes Registry	65.99 **C**	Between 33rd-66th	90th	Outreach Clinical Pharmacist
Statin Therapy (SPD adherence)	Diabetes Registry	81.19 **C**	Between 75th-90th	90th	Outreach Clinical Pharmacist
Cardiovascular					
Controlling High Blood Pressure (CBP)	Hypertension Registry	73.48 **C**	Between 75th-90th	75th	Outreach Clinical Pharmacist

Patient Safety **Commercial HMO**					
Chronic Opioid Treatment (COT) *Current value data is staff model members all products*					
Metric	**Target Population**	**Measurement timeframe**	**Percentage**	**Goal**	**Program**
Urine Drug Screening UDS*	Opioid Use Registry	Q2 2025	78%	≥ 80 %	Chronic Opioid Treatment Program

2026 Population Health Management (PHM) Program Strategy

Quarterly Visit Completion COT**	Opioid Use Registry	Q2 2025	76%	≥ 80 %	Chronic Opioid Treatment Program

* Percent of patients who had 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 HMO** *Percentiles are National All LOB*					
Metric	**Target Population**	**MY2024 Rate**	**Current Percentile**	**Goal**	**Program**
Plan All Cause Readmissions (PCR) 18-64	HMO members who had an inpatient hospital stay ≥ 3 days	1.26 **C**	<10th	75th	Care Coordination Outreach Complex Case Management
Follow Up Within 7 Days After Hospitalization for Mental Illness (FUH) Total	Members age 6 years or older who had an inpatient stay for a diagnosis of mental illness or intentional self-harm	52.83 **C**	Between 33rd-66th	75th	Outreach

Managing Multiple Chronic Conditions **Commercial HMO**				
Metric	**Target Population**	**Measurement**	**Goal**	**Program**
Percentage of members indicating program helped them	HMO members opting in and enrolled in CCM	Closing Survey	80 %	Complex Case Management

2026 Population Health Management (PHM) Program Strategy

Keeping Members Healthy
Medicaid HMO
Percentiles are National All LOB
Triple weighted measures are in blue
Measures marked with an asterisk are Pay for Performance Measures- Goal ≥ 75th*

Metric	Target Population	MY2024 Rate	Current Percentile	Goal	Program
Adult Immunizations					
AIS-E Influenza	Age 19-65	23.40	>75th	66th	Outreach
AIS-E Td/Tdap	Age 19-65	39.58	Between 33rd-50th	66th	Outreach
AIS-E Zoster	Age 50-65	25.93	>75th	66th	Outreach
Child/Adolescent Immunizations					
Combo 3 (CIS)*	Age 2	55.48	<10th	75th	Outreach
Combo 10 (CIS)	Age 2	35.62	>75th	66th	Outreach
Combo 2 (IMA)*	Age 13	36.57	50th	75th	Outreach
Cancer and Other Screenings					
Cervical (CCS)	Female Age 21-64	62.77	Between 66th-75th	66th	Outreach
Breast Cancer Screening (BCS-E)	Female Age 50-74	51.88	Between 10th-33rd	66th	Outreach
Colorectal (COL)	Total	43.68	Between 50th- 66th	66th	Outreach
Colorectal (COL)	Age 46-50	32.82	Between 50th- 66th	66th	Outreach
Colorectal (COL)	Age 51-75	49.58	Between 66th-75th	75th	Outreach
Chlamydia (CHL) Total	Age 16-24	52.69	Between 50th- 66th	66th	Outreach
Maternal Health					
Prenatal (PPC)*	Female	80.16	Between 10th-33rd	75th	NA
Postpartum (PPC)*	Female	76.98	33rd	75th	Outreach
Utilization					
Well Child (WCV)* Total	Ages 3-21	41.33	<10th	75th	Outreach

2026 Population Health Management (PHM) Program Strategy

Well Child (W30)	15-30 months	56.83	<10th	75th	Outreach
Well Child (W30)	First 15 months	38.00	<10th	75th	Outreach

Managing at Risk and High-Risk Members
Medicaid HMO
Percentiles are National LOB
Triple weighted measures are in blue
Measures marked with an asterisk are Pay for Performance Measures*

Metric	Target Population	MY2024 Rate	Current Percentile	Goal	Program
Diabetes					
Diabetes Glycemic Status < 8.0% (GSD)	Diabetes Registry	69.08	>75th	≥ 75th	Outreach Diabetes Educators Complex Case Mgmt.
Diabetes BP Control (BPD)	Diabetes Registry	67.11	Between 10th-33rd	≥ 75th	Outreach Diabetes Educators Complex Case Mgmt.
Diabetes Eye Exam (EED)	Diabetes Registry	55.26	Between 33rd-50th	≥66th	Outreach
Diabetes Glycemic Status >9% (GSD) **Lower is better*	Diabetes Registry	23.68	<10th	≥25th	Outreach Diabetes Educators Complex Case Mgmt.
Cardiovascular					
Controlling High Blood Pressure CBP*	Hypertension Registry	60.13	Between 10th-33rd	≥ 75th	Outreach Disease Mgmt. Clinical Pharmacy

Patient Safety

Chronic Opioid Treatment (COT)
Current value data is staff model members all product lines

Metric	Target Population	Measurement timeframe	Percentage	Goal	Program
Urine Drug Screening UDS#	Opioid Use Registry	Qtr 2 2025	78%	>80%	Chronic Opioid Treatment Program
Quarterly Visit Completion COT##	Opioid Use Registry	Qtr 2 2025	76%	>80%	Chronic Opioid Treatment Program
Lead Screening *Pay for Performance Measure - Goal ≥ 75th*					
Lead Screening (LSC)*	Age 9 mo-2 years	64.38	33rd	≥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

2026 Population Health Management (PHM) Program Strategy

Outcomes Across Settings Medicaid HMO Percentiles are National All LOB *Measures marked with an asterisk* are Pay for Performance Measures- Goal ≥ 75th*					
Metric	**Target Population**	**MY2024 Rate**	**Current Percentile**	**Goal**	**Program**
Follow Up Within 30 Days After Hospitalization for Mental Illness (FUH) Total*	Members age 6 or older who had an inpatient stay for a diagnosis of mental illness or intentional self-harm	63.64	Between 33rd-50th	>75th	Outreach
Plan All Cause Readmissions (PCR) 18-64	HMO members who had an inpatient hospital stay ≥ 3 days	1.1881	<10%	≥50th	Care Coord. Outreach Complex Case Mgmt.

Managing Multiple Chronic Conditions Medicaid HMO				
Metric	**Targeted Population**	**Measurement**	**Goal**	**Program**
Percentage of members indicating program helped them	HMO Members opting in and enrolled in CCM	Closing Survey	80%	Complex Case Management

GHC-SCW adheres to quality provisions outlined in our Medicaid HMO contract with the State of Wisconsin Department of Health Services. As a participating Medicaid HMO under the BadgerCare Plus Program, we are subject to performance-based measures and specific requirements related to marketing and outreach. These contractual obligations have influence over strategy and outreach efforts.