2021-
2022

GHC-SCW POPULATION HEALTH MANAGEMENT

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

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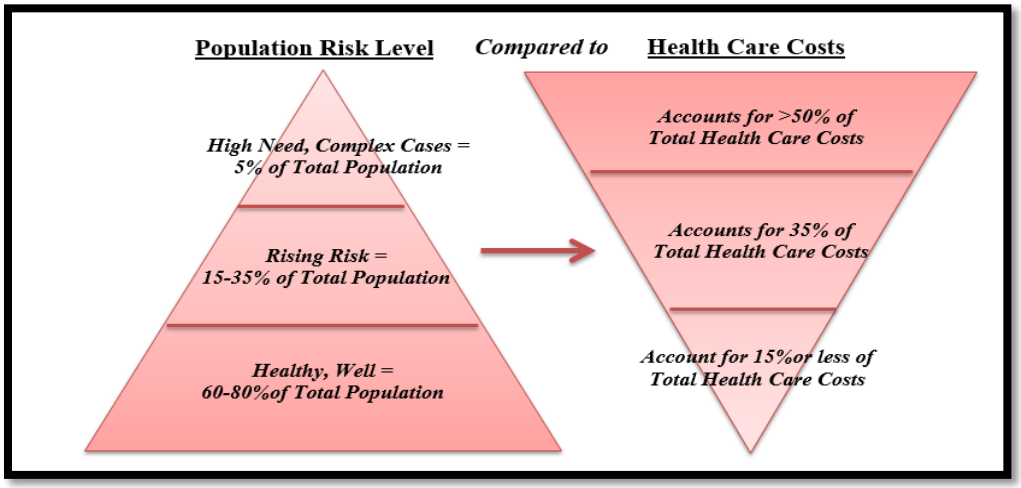
Group Health Cooperative of South Central Wisconsin

Population Health Management (PHM)

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

I. Strategy

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



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

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

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

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

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

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.

In the tables that follow, program or service outreach can be any one or combination of types of contact: US Postal Mail, Secure Messaging (MyChart) or Telephonic. BadgerCare* is the State of Wisconsin Medicaid HMO and may involve pay for performance measures for this target population.

KEEPING MEMBERS HEALTHY						
Metric	**Target Population**	**MY 2018**	**2019-2020 Goal** Percentile Natl All LOB's	**MY 2019**	**2021-2022 Goal** Percentile Natl All LOB's	**Program or Service**
Annual Flu Vaccinations	Staff Model HMO	69.5 %	≥ 75 %	70.1 %	≥ 75 %	Outreach Flu Clinics
Cervical Cancer Screening	Women 21-64 HMO Members	87.10 %	≥ 82.09 % 90th	87.10 %	≥ 82.42 % 90th	Outreach
Breast Cancer Screening	Women 50 -75 HMO Members	76.02 %	≥ 79.34 % 90th	76.89 %	≥ 79.43 % 90th	Outreach
Colorectal Cancer Screening	HMO Members 50 +	74.21 %	≥ 74.02 % 90th	87.10 %	≥ 82.42 % 90th	Outreach
Prenatal Care	HMO Members	97.1 %	94.17 % 90th	97.81 %	≥ 94.65 % 90th	Outreach
	BadgerCare*	74.7 %	87.1 % 75th	100 %	≥ 87. 6 % 75th	Outreach OB Medical Home
Postpartum Care	HMO Members	86.86 %	≥ 87.92 % 90th	94.65 %	≥ 91.73 % 90th	Outreach
	BadgerCare*	32.5 %	≥ 69.3 % 75th	78.36 %	≥ 69.8 % 75th	Outreach OB Medical Home
CIS Combo 3 Immunizations	BadgerCare*	57.95 %	≥ 74.7 % 75th	77.27 %	≥ 74.5 % 75th	Outreach
IMA Combo 1 Immunizations	Staff Model HMO	83.70 %	≥ 90.51 % 90th	84.18 %	≥ 90.75 % 90th	Outreach
IMA Combo 2 Immunizations	BadgerCare*	44.95 %	75th	48.08 %	≥ 40.4 % 75th	Outreach

MANAGING AT RISK AND HIGH RISK MEMBERS						
Metric	**Target Population**	**MY 2018**	**2019-2020 Goal** Percentile Natl All LOB	**MY 2019**	**2021-2022 Goal** Percentile Natl All LOB	**Program or Service**
Diabetes A1c < 8.0 (CDC)	HMO Members Diabetes Registry	59.67 %	≥ 66. 18 % 90th	59.67 %	≥ 66. 34 % 90th	Outreach Diabetes Educators Complex Case Mgmt. Disease Mgmt.
Controlling High Blood Pressure (CBP)	HMO Members HTN Registry	77.62 %	**≥** 73.72 % 90th	77.62 %	**≥** 76.95 95th	Outreach Disease Mgmt. Clinical Pharmacy
Asthma Control Testing Rate	HMO Members Asthma Registry	30. 1 %	Improve ACT testing rate among GHC-SCW practitioners from baseline	26. 5 %	30- 40%	Outreach Clinical Pharmacy Asthma Educator Disease Mgmt.
Cigarette Use Percentage of Membership	HMO Members Cigarette Use Registry	5.2 % 3266/62949	Decrease percentage of current smokers from baseline	5.1 % 3240/62418	Decrease percentage of current smokers	Smoking Cessation Program Outreach

PATIENT SAFETY						
Metric	**Target Population**	**MY 2018**	**2019-2020 Goal** Percentile Natl All LOB	**MY 2019**	**2021-2022 Goal** Percentile Natl All LOB	**Program or Service**
Opioids at High Dosage (HDO)	Opioid Use Registry	3.70 % (50th 3.76)	≥ 2.93 % 66th	5.13 % 33rd (5.87) 50th (4.78)	≥ 4.78 % 50th	Opioid Safety Program
Opioids MP-MP&MP (UOP)	Opioid Use Registry	2.42 % (25th 2.48)	≥ 2.11 % 33rd	2.12 % 10th (2.58) 25th (1.76)	≥ 1.61 % 33rd	Opioid Safety Program
Lead Screening	BadgerCare*	65.9 %	≥ 80 % 75th	68.18 %	≥ 81.0 % 75th	Outreach

OUTCOMES ACROSS SETTINGS						
Metric	**Target Population**	**MY 2018**	**2019-2020 Goal** Percentile Natl All LOB	**MY 2019**	**2021-2022 Goal** Percentile Natl All LOB	**Program or Service**
Plan All Cause Readmissions (PCR)	HMO members who had an inpatient hospital stay ≥ 3 days	0.8215	≤ 0.7376 33rd	0.3882 75th (0.4188) 90th (0.3535)	≤ 0.3535 90th	Care Coordination Outreach

MANAGING MULTIPLE CHRONIC CONDITIONS				
Metric	**Targeted Population**	**Measurement Year**	**Goal**	**Program or Service**
Patient Activation Measure (PAM) Average Score	Members enrolled in Complex Case Management	Opening versus Closing of a Case	Increase average PAM scores for level 1 thru 3 by > 3 points	Complex Case Management

II. Integrating with Community Resources

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

Prediabetes

GHC-SCW recommends that members age 40-70 who are at-risk for developing diabetes (based on clinical screening criteria) are referred to the evidence-based YMCA Diabetes Prevention Program. The program helps promote healthy eating and encourages physical activity to prevent the onset of type 2 diabetes and is available in English or Spanish.

Small groups of participants will meet initially for 16 weekly sessions. These one-hour sessions will focus on educating participants about healthy diet and exercise habits, improving coping and problem-solving skills and will allow opportunity to discuss other issues surrounding the symptoms of diabetes.

Following the 16 weekly sessions, small groups meet once per month with their health coach to stay motivated and focused on their individual goals. 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.

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 2 ½ hours a week for six weeks. Classes are highly participative, where mutual support and success build 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 also 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 GHC-SCW's Care Management program can be found on the Care Management page at www.ghcscw.com. In addition to the list of community resources maintained by GHC-SCW, web access to databases such as *Aunt Bertha* and *United Way of Dane County 2-1-1* have been made accessible to GHC-SCW staff in the *Clinical Resources Dashboard* within Epic. The health plan also has Community Service Coordinators to help connect staff model members to local resources such as housing, food banks, public benefits, transportation, etc.

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

V. Eligibility and Informing Members

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

In addition, GHC-SCW members are informed of the programs and services listed in *Section I* through a variety of methods including: USPS mail, secure MyChart messages or telephonic reminders. Staff model members receive communications based on their documented preference in their medical chart. If no preference is indicated, communications default to first send via MyChart if an account is active or via USPS mail if not yet activated. Members who believe they received a notice or care gap reminder in error or would like to be removed from mailing lists are directed to contact their care team or the Quality Management Department to be excluded from future contact. In some cases, a patient will meet inclusion criteria for a registry, but the care team may determine they should not be included and would go through a documented process to remove them to be re-evaluated later should their coverage remain active.

Members must meet specific criteria to qualify for GHC-SCW's 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.

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. GHC-SCW's health plan operations are supported by sophisticated information systems, electronic medical records and business software tools that help with the execution of the right care at the right time by using information from sources such as:

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

Population Assessment

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

As a public health partner in the Healthy Dane collaborative, our cooperative also uses the UW Health 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 Community Health Implementation Strategy (CHIS) approved by UW Hospital & Clinics Authority Board identified Maternal and Child Health (specifically low birth weight and outcome disparities among African American mothers) as the number one (1) priority in Dane County and GHC-SCW participates within the collaborative on this public health initiative.

GHC-SCW's member population is annually assessed for:

- All ages including children and adolescents through 17 years of age within the commercial and exchange HMO product lines, and the subpopulations, State of WI Medicaid (BadgerCare) and Federal Employee Health Benefits (FEHB) enrollees.
- Multiple chronic conditions, severe injuries, or disabilities
- Individuals with severe and persistent mental illness (SPMI)
- Utilization or cost information to determine areas of most critical need or impact
- Social determinants of health (unhealthy behaviors, food, financial or housing insecurity)

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

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

Activities and Resources

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

Our Community Care department has social workers on staff who support patients, other employees, or outside providers to assist through the 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 Community Care or other GHC-SCW staff may offer include:

- Connecting members to transportation
- Connecting at-risk members with shelter or food security programs
- Connecting patients/members to pharmaceutical or financial assistance programs
- Referral to or promotion of community resources based on need

As a community partner, GHC-SCW is actively participating with the YWCA in promoting health equity and has developed training in cultural competency and made affirming LGBTQ people a priority across the cooperative. GHC-SCW also partners with other organizations whose work aligns with the Community Health Implementation Strategy to address maternal and child health disparities such as the March of Dimes and the United Way of Dane County through charitable giving initiatives and in-kind support that directly impacts and supports local community based organizations.

Segmentation

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

GHC-SCW, at least annually, segments the entire commercial and exchange HMO membership during our *Population Assessment* by ranking the top clinical episodes by cost or frequency to give the organization a broad understanding of conditions that are most prevalent or of potential focus for complex case management. Other specific reports list previous and current risk categories to help case managers see which patients have rising risk. While certain registries GHC-SCW uses technically do not stratify the entire population, they are the heart of our population health management program and the basis of targeted interventions or potential outreach opportunities.

The organization's approach begins with first understanding our patient population and secondly, having the information, processes and tools needed to effectively analyze and manage risk and quality. 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®). This tool can also help GHC-SCW manage cost and utilization. The key objective here is to evaluate our population of members at risk for incurring higher than average levels of utilization. Prospective risk scores are used to plan for future risk (utilization) while predictive risk scores incorporate utilization patterns in addition to diagnosis-based illness burden to predict total risk (expenditures). Member risk score and predicted expenditure (based on each risk model) can be displayed in an aggregate report that stratifies by level such as Low, Moderate, and High.

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

Subset of Population	*Targeted Intervention for which eligible*
Medicaid-BadgerCare: Females	OB Medical Home Program (Prenatal & Postpartum)
Diabetes diagnosis and a cardiovascular diagnosis or recent event (not solely hypertension)	Complex Case Management
Diagnosis of Substance Use Disorder (alcohol, opioids, or other drugs)	Complex Case Management
Under 18 with a psychiatric related admission in the past 2 months	Complex Case Management
Over 18 with chronic medical conditions and a psychiatric related admission in past the 2 months	Complex Case Management
Diabetes Registry Epic	Disease Management
Hypertension Registry QMI0010050	Disease Management
Asthma Registry QMI0017050	Disease Management
Cigarette Use Registry Epic	Smoking Cessation Outreach
Opioid Use Registry Epic	Opioid Safety Program
Asthma related UC, ER or Hospitalization "Asthma Risk score > 3 "	High Risk Asthma Care Coordination
Adult Female ≥ 18 years	Preventative Outreach; immunizations, screenings, over-due tests, or labs etc.
Pediatric Female	Preventative Outreach; immunizations, well child visits, over-due tests, or labs
Adult Male ≥ 18 years	Preventative Outreach; immunizations, screenings, over-due tests, or labs etc.
Pediatric Male	Preventative Outreach; immunizations, well child visits, over-due tests, or labs

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 software system that is a clinical decision support resource associated with improved outcomes. Embedded links to UpToDate® 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 through increased consistency in delivery.

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

Data Sharing

Transmission of member data to the provider or practitioner that assists in delivering services, programs, or care to the member is the definition of data sharing. Being an integrated delivery and insurance system affords GHC-SCW the benefits of data sharing from both insurance operations and clinical care as we

have access to Epic® medical records as well as claims information. Epic® Care Link and Care Everywhere functionality allows data sharing with other regional health system partners.

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

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

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 also shares care gap reports for State of WI Medicaid BadgerCare with external providers at 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®. Some examples of decision support aids used by GHC-SCW providers geared toward high cost and high preference conditions include several orthopedic procedures and PSA screening for prostate cancer, among others. Ten different consult orders will prompt a Best Practice Alert in the EMR for the provider to offer an SDM aid to the patient. These are:

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

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

Practice Transformation Support

GHC-SCW supports its practitioners in meeting their population health management goals through frequent technology related upgrades to the electronic medical record, sharing best practices across the organization and supporting our employees financially in pursuing and accessing learning opportunities such as webinars or conferences or other continuing education.

VIII. Wellness and Prevention

At GHC-SCW, we have always been committed to whole person care for our members. This means health and wellness. GHC-SCW's ManageWell member wellness program is part of a comprehensive PHM strategy and focuses on promoting health with the primary aim of lowering the total cost of health care by slowing the increase of risk. Most GHC-SCW members including subscribing members and their spouses/significant others who are 18 and older are eligible to participate in the wellness program. GHC-SCW BadgerCare (Medicaid) enrolled members and members with Medicare as their primary coverage and GHC-SCW as their secondary coverage are also eligible to participate in the program however some incentive restrictions may apply. The ManageWell platform is highly customizable and creates personalized experiences for participants that choose to opt-in by registering. The program incentivizes members by earning points to be well through completion of various activities.

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

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

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

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

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

IX. Complex Case Management

GHC-SCW intervenes with eligible members though its Complex Case Management (CCM) program. Our CCM program provides proactive, medically appropriate, cost effective, coordinated care to members with complex medical / 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 continuum of care management for medically necessary services through primary care and GHC-SCW Utilization Management (UM).

GHC-SCW's CCM program is led by a Medical Director and Care Management Department Manager who is supported by a Case Manager Team Lead along with dedicated Registered Nurses and Social Workers who work as case managers. The organization encourages and assists case managers to obtain professional certification through the Commission for Case Manager Certification; CCMC.

GHC-SCW offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other programs. Case managers contact the member and/or caregiver telephonically. 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 referring to GHC-SCW Clinical Pharmacy Program.
- Case management plan development with performance goals in which the member will achieve self-management and demonstrate improved adherence.

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

Access to Case Management

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

- Medical management referrals that come from other organizational programs such as our health line, GHCNurseConnect, or utilization management activities.
- Discharge planners from hospitals who identified 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 experiencing transitions of care due to change of insurance to ensure ongoing services (medical and/or behavioral health) without interruption.
- Various reports (i.e. daily census and facility readmissions)

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

- Website https://www.ghcscw.com/health-insurance/complex-case-management
- Internally to staff on the Intranet
- Member, practitioner, and staff electronic communications and/or postal mailings
- Provider Newsletter "Practitioner Update"
- Member Newsletter "HouseCall"
- Case Management brochure available in GHC-SCW Clinics where members receive care

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

The following is the most recent update to our referral criteria and processes:

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

- Have primary, current coverage through GHC-SCW insurance (including Commercial HMO, PPO, POS and BadgerCare Medicaid members) **AND**
- Have a diagnosis of diabetes **AND**
- Recent admission for a cardiovascular event (such as CABG, MI, cardioversion, stenting) **OR**
- A diagnosis of cardiovascular disease (such as CHF, coronary artery disease).

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

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

GHC-SCW's Care Management Department also offers ***Care Coordination*** for members who do not want Case Management but could benefit from brief intervention and services (less than two months). Care Coordination is available *only* for members living with substance use disorders (SUD), behavioral health challenges, and/or a dual diagnosis. The goal of care coordination is to quickly connect members to appropriate providers and community resources. To be eligible for Care Coordination members *must* have GHC as their primary insurer. Members who do not have GHC insurance can still receive assistance through our Community Care department.

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

Experience with Case Management

GHC-SCW obtains feedback from across the spectrum of involvement with the population health management program using member experience surveys (or focus groups) specific to the complex case management program (or other PHM programs) that, at a minimum, determine the:

- Overall satisfaction with the program
- Member experience with program staff
- Member opinion on the usefulness of disseminated information
- Member ability to adhere to recommendations
- Percentage of members indicating the program helped them achieve their goals

The complex case management member experience survey is offered to members opting in upon case closure allowing the organization to obtain feedback from the participating member/caregiver. 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.

Feedback is also gained and analyzed through the following processes:

- The Patient Activation Measure (PAM) is a licensed survey tool which assesses member knowledge, skills, and confidence for self-management. This survey is conducted with members upon *opening* and *prior to closing* the case to help determine areas of patient knowledge when they begin case management and allows the organization to assess the effectiveness of our service prior to closing.

- Insurance Operations (Member Services) tracks comments or complaints about member experience with all aspects of the health plan. Any complaints that impact PHM programs or the case management team are directed to the respective department managers. Member Services also evaluates all complaints and appeals at least annually to identify opportunities to improve member satisfaction. The report compiled is presented to the CSQC and is used to identify opportunities for improvement if stated goals are not met.

X. PHM Impact: *Measuring Effectiveness, Improvement & Actions*

GHC-SCW shall measure the effectiveness of its population health management strategy by conducting a comprehensive analysis of relevant clinical, utilization/cost and experience measures that align with the focus areas outlined within *Section I*. Measures may focus on one segment of a population or include the entire population identified as eligible for interventions and annually shall include:

- One (1) clinical outcome or process measure
- One (1) utilization or cost measure
- Member experience with CCM (see *Section IX)* plus at least one other program or service noted in *Section I.*

The individual clinical or utilization measures that will be annually reported shall be identified by the organization's Director of Quality and Population Health and/or other members of the CSQC. For each measure indicated, the report shall clearly define 1) why the measure is relevant, 2) the specifications/methodology for the data collected and 3) compare results with an established threshold,

goal, or benchmark. Each quantitative analysis shall trend prior performance if a previous measurement was performed and include a qualitative analysis if stated goals are not achieved.

The comprehensive report shall be presented annually to the Clinical and Service Quality Committee (CSQC). The CSQC may recommend interventions, if applicable, or develop an improvement process to increase performance related to member experience or satisfaction. GHC-SCW shall use the annual PHM impact analysis to prioritize opportunities and develop a plan to act on at least one aspect to improve its overall PHM strategy, should it be deemed necessary.

XI. Acknowledgments

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