DEPARTMENT:	Quality Improvement
SUBJECT:	Population Health Management (PHM) Program
PRODUCT LINE:	All
POLICY NUMBER:	HM110
ORIGINAL POLICY EFFECTIVE DATE:	12/15/2020
LAST REVISED DATE:	5/12/2026
LAST REVIEWED DATE:	5/12/2026

Scope:

Ensure there is a cohesive plan for addressing member needs across the care continuum and outline and provide an overview of the structure and strategy for the seven NCQA standards for population health management which include:

1. PHM Strategy
2. Population Identification
3. Delivery System Supports
4. Wellness and Prevention
5. Complex Case Management
6. Population Health Management Impact
7. Delegation of PHM

Population Health Management Strategy

Strategy Description

GHC has a comprehensive strategy for population health management which includes the following components:

1. Goals and populations targeted for each of the four areas of focus.
2. Programs or services offered to members.
3. Activities that are not direct member interventions.
4. How member programs are coordinated.
5. How members are informed about available PHM programs.
6. How the organization promotes health equity.

Each of the components will be outlined in detail below.

Four Areas of Focus

The population health management program addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

1. Keeping members healthy

Pregnancy Program: This program focuses on education on the importance of post-natal care and coordinating care for the post-natal visit to ensure members have a follow up visit after delivery to address any concerns or issues. Relevancy of the measure: According to the CDC in 2023, only 76.1% of pregnant women initiated prenatal care and the preterm birth rate is 10.4%, which has not significantly decreased since 2014. Based on these statistics, there is opportunity to improve perinatal care and birth outcomes. Prenatal care can help prevent or reduce the risk of pregnancy complications and inform women about important steps they can take to protect their infant and ensure a healthy pregnancy. Care around the time of delivery and after the birth event is also important to ensure the health of mom and baby.

Target Population: Pregnant members identified by med stat code on the DHS enrollment file or from CPT and ICD 10 codes from claims that identify pregnancy

Outcome: Increase post-partum care rates in commercial and Medicaid (utilization measure)

Program Goal: 75th percentile for the postpartum rate of the Prenatal and Postpartum (PPC) HEDIS measure

Programs/Services:

a. Pregnancy Program: See Pregnancy Program policy and procedure.
b. Pregnancy Welcome Packet: Includes resources for pregnancy, delivery, and baby items

Activities:

Partnership with Ashland Clinic to provide telehealth visit to evaluate for any concerns after delivery and to increase post-partum care visits.

Partnership with Mayo Clinic Eau Claire to increase compliance with prenatal and postnatal visits.

2. Managing members with emerging risk

Hypertension Program: This program focuses on educating members about hypertension to improve blood pressure control.

Relevancy of the Measure: Hypertension is an important health challenge due to its high prevalence and strong association with cardiovascular disease. CDC estimates that hypertension affects about 119.9 million Americans and 8% of our members have a diagnosis of hypertension. Despite the health risks associated with uncontrolled hypertension, elevated blood pressure remains inadequately treated in the majority of patients. Helping members control their blood pressure will help reduce the risk of developing hypertension-related complications and overall mortality.

Program Goal: 75th percentile of the Controlling High Blood Pressure (CBP) HEDIS measure for commercial and Medicaid

Target population: Members with a diagnosis of hypertension who were not compliant based on the Controlling High Blood Pressure (CBP) HEDIS measure technical specifications

Programs/Services:

a. Hypertension Program
b. Distribute blood pressure recording logs
c. Distribute educational information on controlling hypertension
d. Comprehensive case management program for members who meet criteria for case management

Activities: Social media education on controlling hypertension

3. Patient safety or outcomes across settings:

Preventing Hospital Readmissions Program: Provides focused care management activities to members who were hospitalized for a mental health condition to improve coordination of care and prevent readmissions.

Relevancy of the measure:
According to AHRQ, 30-day readmission rates to U.S. hospitals for Medicaid members may be as high as 30%, 25%, and 20% for Medicaid, Medicare, and Commercial members respectively. In 2022, over one in five adults aged 18 and older in the U.S. had a mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Hospital discharge is a complex process representing a tie of vulnerability for members. Ineffective care transition processes lead to adverse events which leads to high hospital readmission rates and increased cost. Eighty percent of adverse events during transitions of care are a result of miscommunications between facilities. The Transitional Care Program ensures that transitions of care from the hospital setting to any lower level of care occur effectively and safely and ensure the member's needs are met to improve outcomes. Based on the above, there is opportunity for reducing readmission rates by improving transitional care processes for behavioral health admissions.

Outcome: Improve Follow-Up Within 30 Days Post-Discharge for mental illness

Program Goal: 75th percentile of the HEDIS goal for the Follow-Up after Hospitalization (30 day post-discharge) for Mental Illness (FUH) HEDIS measure

Target population: Members 6 years of age and older who were hospitalized for a mental health condition

Programs or Services:

a. Transitional Care Program
b. Outreach from a Patient Care Coordinator to coordinate follow up appointment

Activities:

a. Arbor Place clinic partnership provides telehealth visits for follow up after discharge to evaluate and ensure member's needs are met.
b. Clinic outreach for members with established mental health provider to coordinate follow up and discuss discharge.

4. Managing multiple chronic illnesses:

Relevancy of the measure: Comorbidities are associated with worse health outcomes, more complex clinical management, and increased health care costs. Substance abuse impacts about 11.2% of people in the United States according to the CDC and leads to significant physical, social, and psychological harm. Many members with depression use drugs as an inappropriate coping mechanism and therefore both conditions need to be managed to lead to improved outcomes. In 2024, 6.2% of our members have a diagnosis of substance abuse and will benefit from interventions to manage substance abuse and depression as a comorbidity.

Outcome: Increase follow up after ED visit for other alcohol and other drug abuse or dependence treatment-HEDIS FUA-30 measure Program Goal: 75th percentile goal for the HEDIS-FUA-30 measure

Target population: Members with an AODA diagnosis per HEDIS measure FUA-30 and a diagnosis of depression.

Programs or Services:

a. Substance Abuse Management Program. See SAMP policy
b. Comprehensive case management for members who meet criteria

Activities:

a. Social media posts on effective coping strategies and mental health topics including AODA.
b. Collaborate with county agencies and community-based organizations to provide resources for AODA issues.
c. Arbor Place clinic partnership provides telehealth visits for follow up after discharge to evaluate and ensure member's needs are met.

Coordination of Member Programs

GHC coordinates HMO and non-HMO programs and services across settings, providers, and levels of care to minimize confusion for members who may be eligible and contacted from multiple sources. Strategies used to coordinate programs and services include the following:

1. GHC coordinates care for hospitalized members during discharge and facilitates the transition by working with hospital discharge planners, members, and members support system.
2. Data is shared with providers and members to coordinate closure of gaps in care.
3. Care plans are shared with providers through mail and the Wisconsin HIE.
4. GHC's electronic care management platform allows staff to determine eligibility and enrollment in programs and tracks member outreach contacts so that staff can avoid duplication of services and adjust member contacts to avoid too frequent call attempts.
5. Interdisciplinary care teams for high-risk members in complex case management help coordinate services with the member's care team to reduce duplication of effort and confusion.

Informing Members

A number of strategies are utilized to inform members about the various programs and initiatives (including the PHM programs and services) as well as to encourage participation. Through participation in our programs, member's needs can be met and there will be improved health outcomes.
Members who are eligible to participate in the above programs are notified telephonically through real-time conversations and through mail. Call scripts and the mailed letter include how members became eligible for the program, how to use the program, and how to opt in or opt out of the program.

Members are also notified that program information is available on our website. This notification with a link to the program information is mailed to all members annually.
The following table summarizes the methods used to inform members about programs, how to use the program/service, and how to opt in when applicable:

Program/Service	Website	Telephone	Mailing	In person
Hypertension	X	X	X	X
Pregnancy	X	X	X	X
Transitional Care	X	X	X	
Substance Abuse	X	X	X	X

Promoting Health Equity

GHC's population health management program strategy is committed to improving health equity and strives for its processes to be absent of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically. One action item in 2025, for promoting equity in management of member care will be to standardize race/ethnicity questions and responses for our organization and implement standardized questions in all processes and evaluate the process. See Race/Ethnicity Question Standardization Timeline for detailed description.

Population Identification

GHC systematically collects, integrates and assesses member data to inform its population health management programs in order to identify the needs of its population and determines actionable categories for appropriate intervention.

Data Integration

Data is systematically collected and assessed from multiple databases and sources and integrated into our electronic care management system and analytics tool. Having the most complete data allows us to meet the member's needs. The following data types are integrated:

1. Claims and encounter data: Medical and behavioral health claims from providers feed into the claims system for all product lines. Encounter data and Fee-for Service claims from Wisconsin's Department of Health Services for Medicaid enrollees' feed into our data warehouse. Claims data is integrated into our electronic care management system and into our quality modules.
2. Pharmacy claims: Pharmacy claims from PBMs (Navitus, ETF; DHS; and Express Scripts (ESI), commercial) feed into our claims system and data warehouse and then are integrated into our quality analytics tool.
3. Laboratory results: Lead testing is received from the DHS Stellar database and integrated into our data warehouse. Labs are received during the HEDIS review process and entered into our HEDIS analytics tool. Labs received through care management processes are entered into our electronic care management system. Labs done through the HP program are integrated into an electronic care management system. Lab results obtained through a provider's EHR are integrated into our HEDIS analytics tool.
4. Health appraisals: Health risk assessments and health needs assessments are integrated into the electronic care management system. HRAs done through the HP Program are located in the HRA vendor's database.

5. Electronic health records: GHC has agreements with some providers to access EHRs. HEDIS data including laboratory data is entered into our data analytics software, to identify members who are missing services so that outreach can occur. The WISHIN Par report from Wisconsin's HIE is used to identify members who have had a hospitalization or ER visit for outreach and enrollment into programs.
6. Health service programs within the organization: The daily hospital census data from utilization management is used to identify members who may be eligible for case management and who require transitional care follow up with discharge assessment. Health Promotion coaches refer members who are eligible for disease management and complex case management. Member services refers members eligible for case management to the Health Management Department.
7. Advanced data sources: There is data transfer with WISHIN, the Wisconsin HIE. Lead testing results are transferred from Wisconsin's STELLAR database to GHC's database and immunizations are transferred from Wisconsin's immunization registry (WIR) to GHC's database to better identify member's who have completed services.

Population Assessment

At least annually, GHC uses data at its disposal (claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population. To determine the necessary structure and resources for the PHM program, the organization assesses its population, taking into consideration the characteristics of the population including the factors outlined below:

1. Characteristics and needs
   Characteristics and needs of the membership are assessed annually by claims data, HEDIS data, enrollment files data, and assessment data. Claim's data includes medical and behavioral health information as well as social determinants of health including ICD-10 codes to identify SDOH. Enrollment files include race/ethnicity data, which is the social determinant we focus on in our analysis. The HEDIS analytics tool identifies members who have gaps in care to identify members for program participation and for outreach.
2. Needs of child and adolescent members
   Members aged 2-19 have different health needs compared to adults. Regular health checks, lead screening and testing, and vaccinations are important services. Our data analytics platform is used to identify members who need these services or have not received these services. Outreach to both the member and provider occurs to these members to get services scheduled and to reduce barriers to obtaining these services. Vaccination and lead testing rates are reviewed monthly.
3. Needs of individuals with disabilities

Members with disabilities have intense resource needs. The health assessment addresses needs in this population which include transportation, food insecurity, housing, ADLs and iADLS, violence, social supports, language, education/literacy, race/ethnicity, hearing, and vision.

4. Needs of members with serious mental illness (SMI) or serious emotional disturbance (SED)
   Member with SMI or SED may have intense resource and care coordination needs. The health assessment addresses needs in this population, which include transportation, food insecurity, housing, ADLs and iADLS, violence, social supports, language, education/literacy, race/ethnicity, hearing, and vision. Medication non-compliance is a significant issue in this population and that is addressed with members. Many members require significant support systems and case management staff assess these needs and coordinate resources from the community, medical field, and family to ensure supports are in place.
5. Needs of members with of racial or ethnic groups
   Race and ethnicity data of our population is collected from enrollment files and entered into our database and claims system and feeds into our data analytics tool. This information is assessed to evaluate the racial and ethnic needs of our population. U.S. Census data on the racial/ethnic composition of the population is also used at times to supplement data.
6. Needs of members with limited English proficiency
   Member's language is collected from enrollment files and on health assessments and is entered into our database and electronic care management system respectively. Member's language needs (whether interpreter services are needed) and language preference is recorded in the member demographic section of the electronic care management system. Staff managing the members in our population health programs utilize our interpreter service when needed to outreach to members. This information is used in analyzing our population to determine the language needs of our members with limit English proficiency.
7. Needs of relevant member subpopulations
   Health assessments are used to identify subpopulations in our membership and the needs of the subpopulations. This data is analyzed annually. The subpopulations we currently analyze include pregnant women and members with a diagnosis of hypertension. These subpopulations were chosen because we have disease management programs for these subpopulations and there are significant opportunities to managing individuals with these conditions to reduce complications, improve health outcomes, and reduce health care costs. The two characteristics or needs of these subpopulations that we consider include race/ethnicity of the population and transportation needs.

Activities and Resources

The population assessment results of the populations identified above are reviewed and analyzed annually. The analysis includes a review of the PHM programs and outcomes, services and activities related to the

respective programs, community resources, and member's needs. The organization annually uses the population assessment to:

1. Review and update its PHM activities to address member needs.
2. Review and update its PHM resources to address member needs. The following resources are reviewed as part of the assessment of the above populations and include:
    a. Staffing ratios.
    b. Clinical qualifications.
    c. Job training.
    d. External resource needs and contacts.
    e. Cultural competency.
3. Review and update activities or resources to address health care disparities for one identified population.
    a. GHC uses assessment results to identify health care disparities among members of racial/ethnic minority groups and members with limited English proficiency in the populations identified above. In response to at least one discovered disparity identified during the analysis, GHC reviews and updates at least one program, service, activity or resource.
4. Review community resources for integration into program offerings to address member needs. During the population assessment, member's needs are identified and GHC determines community resources and community programs that can be used to meet those needs and connects members with these resources. GHC participates in a number of community partnerships and workgroups to improve the health of the communities we serve.

Segmentation

There are a couple of methods used for segmenting and stratifying membership. The segmentation helps to identify members eligible for programs and target interventions specific to their needs. A number of data sources are used to support our PHM strategy including enrollment file, claims, wellness reports, and health assessments. Healthcare data from different sources is brought together to stratify members based on their associated risk factors and to identify members who are eligible for clinical care intervention through comprehensive case management, disease management, and wellness programs. Our data analytics tool also identifies members who have gaps in care and these reports are used to identify members eligible for programs. A health assessment is used to identify members who are eligible for programs. The assessment of our population also includes an analysis of the HEDIS measures that have a reportable denominator. This ensures that we are addresses conditions that are prevalent in our population. Claims data is reviewed on an annual basis to analyze and assess membership. The table below outlines the data elements that are analyzed.

Subset of Population	Targeted Intervention	Number of Members	Percentage of Membership
Perinatal	Perinatal Program		
Diabetes	Complex Case Management/Diabetes Program		
Heart Failure	Complex Case Management		
Hypertension	Hypertension Program		
COPD	Complex Case Management		
Asthma	Complex Case Management/Asthma Program		
Substance Abuse	Substance Abuse Program		
Depression	Complex Case Management/Depression Program		
General Anxiety Disorder	Complex Case Management/Anxiety Program		

Assessing Segmentation Methodology for Racial Bias

Racial bias in segmentation methodologies can result in decisions that have a collective and disproportionately negative impact on historically underserved or excluded populations. GHC has a process in place to assess our segmentation methodology for racial bias. GHC's assessment will be to evaluate how racial bias may exist in our methodology. The steps to answer this question will include:

1. A literature review to learn about the origins and results of racial bias in segmentation, risk stratification, and resource allocation to better understand how racial bias exists in our methodology. By having a better understanding of this concept, we will be able to take steps to reduce racial bias. A literature review occurred in 2024. A literature review was conducted again in 2025 to identify new studies.
2. An inventory of best practices and evidence-based methods for assessing racial bias was created in 2024. The inventory was updated based on the literature review in 2025, to include 5 principles that should guide algorithm development and the phases of algorithm development that should be assessed for racial bias.

Delivery System Supports:

Practitioner or Provider Support

GHC works with our provider network to achieve population health management goals in a number of ways. These initiatives are outlined below:

1. Data Sharing:
    a. GHC sends gaps in care letters to providers that provides a list of their patients who are missing services such as colon cancer screening, breast cancer screening, cervical cancer screening, child and adolescent immunizations, and lead testing.
    b. Care plans for members who are on Medicaid are electronically sent to WISHIN (Wisconsin's Health Information Exchange) for providers to access and help coordinate services to ensure member's needs are met.
    c. Care plans for members in Complex Case Management are mailed to providers.
    d. Enrollment data is shared with contracted providers to assist them in delivering services and care for our members that are assigned to their clinic.
    e. Eligibility in our wellness programs is shared with our DPC clinic to coordinate wellness initiatives.
    f. Members eligible for telehealth visits for behavioral health and post-natal follow up are shared with Creative Counseling and Ashland clinic respectively to aid in member outreach.
2. GHC provides certified shared decision-making tools, makes them available to practitioners and members on GHC's website, and informs providers that the information is available online through the provider handbook.
3. Providing practice transformation support to primary care practitioners:
    a. Value based care delivery using shared savings with Marshfield Clinic Health System includes a bonus payment based on meeting quality measures and MLR goals. The goal is to foster practice transformation and efficiencies, improve health outcomes, and reduce health care costs.
    b. GHC supports practice transformation toward value-based care delivery. We have a number of provider contracts that are value-based payment arrangements whereby the provider receives a capitated payment for services.
    c. GHC works with SolidaritUs Clinic (a direct primary care clinic) to improve processes for increasing preventive care services. Quarterly meetings occur to review quality reports and implement initiatives.
4. Providing comparative quality information on selected specialties. Providers are informed through the Provider Handbook that comparative quality information is available on our website. Comparative quality information on selected specialties is shared as follows:
    a. Comparative data from Leap Frog for various surgical specialties is shared on our website.
    b. Provider Report Cards are shared with providers and include comparative data on HEDIS measures including childhood and adolescent immunizations rates, A1C rates in members

with diabetes, cervical and colon cancer screening rates, and pre-and post-natal visit rates. Members who are not meeting blood pressure goals are included on the report card.

c. GHC shares comparative quality data available from the Wisconsin Collaborative for Healthcare Quality (WCHQ) and this information is available on our website. The WCHQ is a multi-stakeholder consortium of healthcare facilities, insurers, governmental agencies, and advocacy groups that provides quality performance data and reports for improving quality.

5. Providing comparative pricing information on selected services: For our commercial membership we have comparative pricing information for high end imaging that is shared with network providers to help primary care providers direct to low-cost options within the network. Comparative pricing is not applicable to the Medicaid population.
6. Training on equity, cultural competency, bias, diversity or inclusion: Training to network providers on these topics is important in ensuring our members are treated according to CLAS standards. Educational assistance to our provider network on CLAS to help reduce health disparities in our membership. The Provider Handbook informs providers that CLAS information is available on the GHC website. Educating our provider network on CLAS standards ensures population health management goals are met by reducing barriers to care, addressing member's cultural beliefs, ensuring care is delivered to meet linguistic needs of members, and supporting education around gender neutrality.

Value-Based Payment Arrangements

1. GHC has a value-based payment arrangement with Marshfield Clinic. Marshfield Clinic's arrangement is a shared savings arrangement and payments are based on keeping costs below an MLR of 88% and if quality metrics are met an additional payment is made. The payment to Marshfield Clinic represents 0.8% of GHC's total payments to providers. The provider types in this arrangement include primary care and specialty providers, both medical and behavioral health.
2. GHC has a capitation-based payment arrangement with a direct primary care clinic whereby payments are not tied to delivery of services but take the form of a fixed per patient per month payment to the provider for delivery of primary care services delivered by primary care providers. The provider assumes full risk for costs above the capitation payment amount and retains all savings if costs fall below the capitation payment amount.

Wellness and Prevention:

Frequency of Health Appraisal Completion

Wellness services focused on preventing illness and injury, reducing risk, and promoting health are offered to members. The Health Risk Assessment or health assessment is an important initial step in evaluating member's needs and health risks. A Health Risk Assessment (health assessment) is completed annually and is used in a number of our programs. For details related to the health assessment in complex case management, please refer to the Complex Case Management Policy and Procedure. Details related to assessments used in the disease management programs and wellness program are in the respective policy and procedure. Details related to the Health Risk Assessment related to the Health Promotion Program, please see the Health Promotion Program Policy and Procedure.

Wellness and Prevention Focus

All population health programs (health education, disease management programs, and complex case management programs) educate members on the following prevention topics/services: adult immunizations, injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support.

Topics of Self-Management Tools

See Self-Management Tools policy and procedure.

Complex Case Management:

See Complex Case Management Process Policy

Population Health Management Impact:

GHC has a systematic process for evaluating the effectiveness of its PHM strategy which helps identify areas that need improvement to reach goals regarding improving population health.

Measuring Effectiveness

A comprehensive qualitative analysis of the impact of the PHM strategy occurs annually. The qualitative analysis includes:

1. A quantitative analysis with the following components:
    a. A review of the quantitative results for the respective measures outlined in Strategy Measures, a comparison to the respective benchmarks trended over time.
    b. Interpretation of the results for each outlined measure above which draws conclusions about the result's meaning.

2. A comprehensive qualitative analysis of all measure results as outlined in Strategy Measures which includes insight to our PHM program's effectiveness to assess potential initiatives to improve PHM outcomes.

GHC will evaluate the impact of our strategy by reviewing the following four Strategy Measures:

1. Member feedback will be assessed by evaluating the responses to a question on the satisfaction survey for the Hypertension program. Responses to the following question will be evaluated: "How would you rate the overall quality of the case management services you received?" The goal is to have at least 90% of members report Very Good to Excellent.
2. Member feedback will be assessed by reviewing the program satisfaction survey results for the Perinatal Program. The question from the survey that will be evaluated will be, "How would you rate the overall quality of the case management services you received?" The goal is to have at least 90% of members report Very Good to Excellent.
3. Utilization measures will be assessed by reviewing the postpartum rate of the Prenatal and Postpartum (PPC) HEDIS measure. Goal is 75th percentile for the postpartum rate of the Prenatal and Postpartum (PPC) HEDIS measure.
4. Clinical measures will focus on the outcome measure of controlling hypertension according to clinical practice guidelines using the HEDIS controlling blood pressure measure. Goal is 75th percentile of the Controlling High Blood Pressure (CBP) HEDIS measure.

Improvement and action

The annual quantitative and qualitative analysis as outlined above is used to review the PHM strategy and identify opportunities for improvement. GHC annually will identify at least one opportunity to implement, and this initiative will be outlined in the QAPI workplan.

Delegation of PHM: N/A

APPROVED: _____ Michele Bauer MD _____ DATE: 12/13/2025

REVISION HISTORY:

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Rev. Date	Revised By/Title	Summary of Revision
11/2/2021	Michele Bauer, MD, CMO	Updated stats for value-based payment arrangements
3/23/2022	Michele Bauer, MD, CMO	Updated Vantage payment arrangement. Removed Valera app information.
5/11/2022	Michele Bauer, MD, CMO	Clarified how members are informed of our programs/services. Updated Transitional Care Service. Updated activities for focus areas.
6/15/2022	Michele Bauer, MD, CMO	Added measures that will be analyzed as part of our annual evaluation
11/4/2022	Michele Bauer, MD, CMO	Updated partnership information for pregnancy program. Updated the PHM 1 strategy with new data. Added frequency of Health Risk Assessment.
4/3/2023	Michele Bauer, MD, CMO	Updated advanced data sources, value-based payment arrangements, practitioner supports, comparative quality, shared decision-making aides,
4/13/2024	Michele Bauer, MD, CMO	Updated program section and added health equity initiative.
12/13/2024	Michele Bauer, MD, CMO	Updated program section, value-based payments, and partnerships with behavioral health partner clinic.
12/13/2025	Michele Bauer, MD, CMO	Updated partnership arrangements. Updated information related to our data analytics tool. Updated section on segmentation and racial bias. Added the wellness and prevention topics that GHC educates members on.
5/12/2026	Michele Bauer, MD, CMO	Added details of how strategy measures will be evaluated.