Partnership for Value-based Coordinated Care

Children's Health Alliance of Wisconsin

Business case for coordinated team-based care

Second edition
April 2018

Table of contents

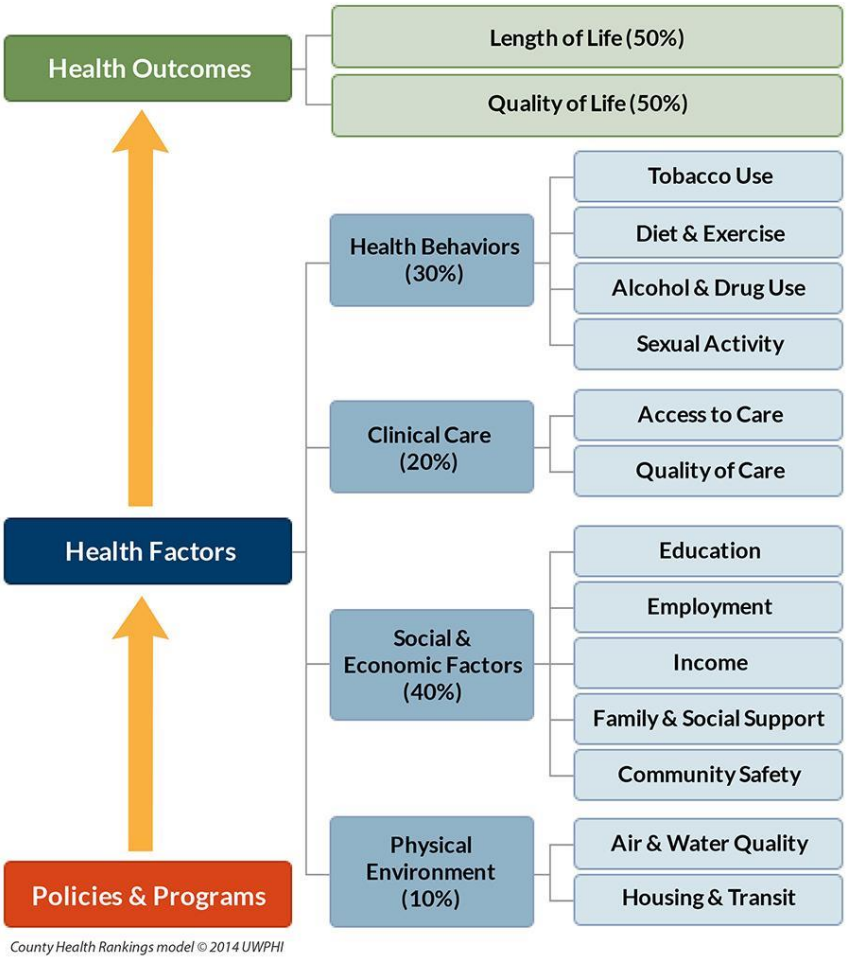
Executive summary

The United States spends more per capita on healthcare than many other Western countries, yet our health outcomes continue to lag behind. Similar to the rest of the nation, Wisconsin is challenged by a variety of health issues, driving costs into the billions of dollars annually. Meanwhile, patients need to overcome multiple barriers before achieving positive health outcomes and a better quality of life. Additionally, the clinical system is divided into sectors (e.g., professional categories, research) to improve and manage individual health issues. Prevention funding is disease specific, or categorical, and payment for services is built for individual diseases, or health domains. All of these factors contribute to the divided and inefficient manner in which health issues are managed.

This document was written to provide evidence and present a convincing argument for changing the manner in which health care is delivered and financed in Wisconsin. Please join us in these conversations to move Wisconsin's health care system to a coordinated team-based approach. In this document, we have captured what we know today about this fluid and dynamic system and have proposed a solution to the issues and inefficiencies we have identified.

Data shows the barriers for individual health issues are similar in nature. For example, to achieve an improved health outcome for asthma, a patient needs to know how to manage the disease, be able to access necessary services, understand how to take and pay for medications, and more. The same barriers are found in diabetes, cardiovascular disease, mental health, etc. The County Health Rankings model identifies four key components that contribute to overall health outcomes. These include health behaviors, clinical care, social and economic, and physical environment factors.

County Health Rankings model



Rather than develop individualized business cases to address health care inefficiencies for each health domain, the Wisconsin Public Health Association (WPHA) and the Wisconsin Association of Local Health Departments and Boards (WALHDAB) agreed to serve as the umbrella organization for partners to join across health issues. Children's Health Alliance of Wisconsin facilitated this initiative and organized The Partnership for Coordinated Team-based Care to prepare this business case.

The Partnership identified and developed the key elements included in this document in order to create a compelling argument for changing the way we currently deliver the full scope of care to individuals and families. The following components are included in this business case:

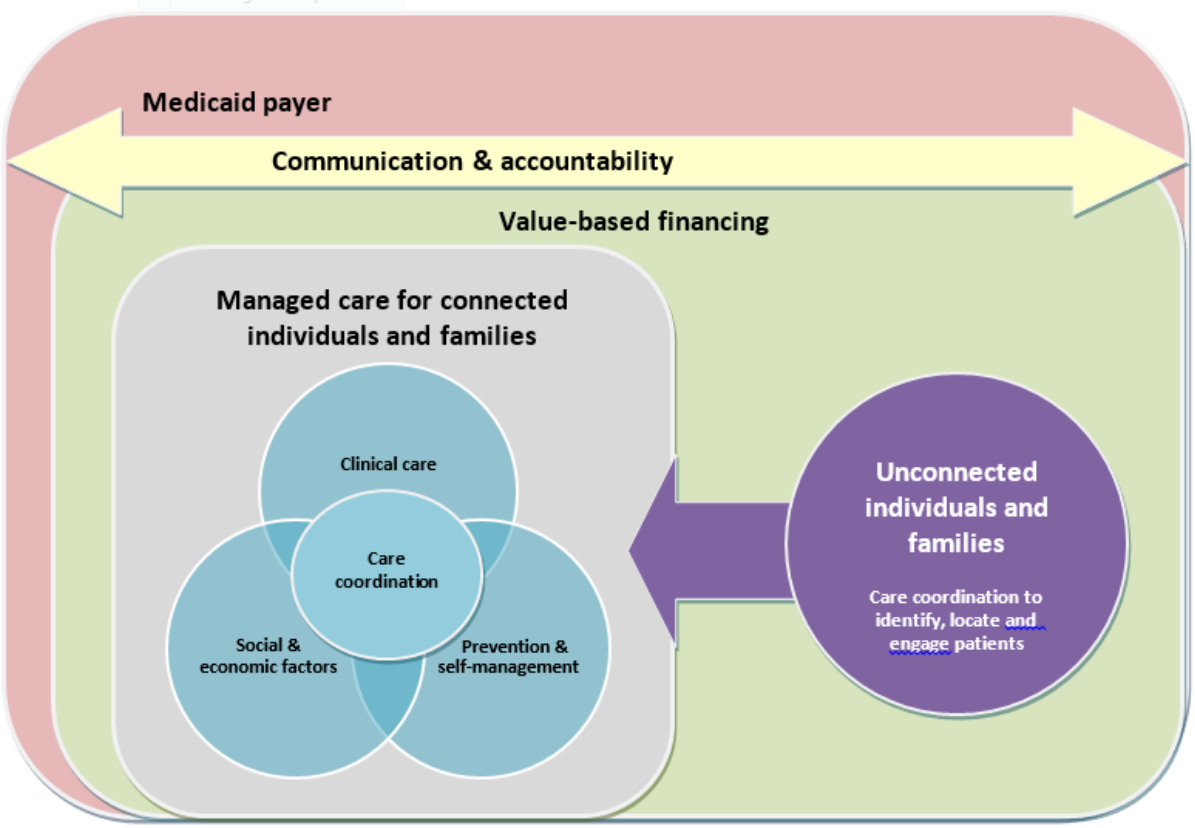
- Cause for concern in Wisconsin
- Proposed solution
- National and local evidence and return on investment (ROI)
- Capacity of resources and infrastructure available
- Financial impact and quality improvement

The evidence included throughout this document demonstrates that a coordinated team-based approach is a cost-effective way to improve health outcomes. Clinical care alone is not enough. Prevention services alone are not enough. Social and economic services alone are not enough. New financing strategies are not enough. We need to work together in a coordinated effort to truly impact the way we deliver care to patients and improve health outcomes in Wisconsin.

The coordinated team-based care framework offers a future state for Medicaid. The Medicaid payer (e.g., state-level, managed care, direct contract) would utilize value-based financing to fund all of the services needed to improve health outcomes. Communication and accountability would work across all the participating systems. Within Wisconsin's managed care system individuals and families would receive needed clinical care, prevention, self-management, social, and economic services to improve health outcomes. Care coordination[1] would be utilized to connect individuals and families to all the needed members of the care team and organize the care activities and services. For individuals and families who do not utilize traditional care systems, a different type of care coordination would be utilized to engage them in services and eventually transition them into managed care.

[1] Care coordination is a complex term with a variety of interpretations. The Partnership for Value-based Coordinated Care acknowledges the complexity of this term and defines care coordination specifically for the purposes of this Business Case. Please see the Glossary of Terms for the most current working definition.

Coordinated team-based care framework



Our goal at this stage is to secure mutual agreement that a coordinated team-based care framework, such as the one presented in this business case, is the appropriate path for Wisconsin. Please use this document to start the conversation and join us in building a structure for change in Wisconsin. We invite representatives from each sector of the health care continuum to participate in this exciting opportunity.

Glossary of terms

Affordable Care Act: Health reform legislation designed to extend health coverage to uninsured Americans, implement measures to lower health care costs, and improve system efficiency. Signed into law March 2010. [i]

Care coordination: The deliberate organization of individual and/or family care activities between two or more participants (including the individual and/or family) involved in an individual's and/or family's care to facilitate the appropriate delivery of clinical care, prevention, self-management, and social and economic services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Clinical care provider*: A person who is trained and licensed to give health care.[ii]

Managed care: A health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. [iii]

Patient engagement: Interventions designed to increase patient involvement and promote positive patient behaviors. [iv]

Payer: Any entity, other than the patient, that finances or reimburses the cost of health services. In most cases, this term refers to insurance carriers, other third-party payers, or health plan sponsors (employers or unions).[v]

Population health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group.[vi]

Primary care provider (PCP): A healthcare professional who provides definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care. This care may include chronic, preventive and acute care in both inpatient and outpatient settings.[vii]

Quality measures: Tools that measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.[viii]

Social determinants of health: Social determinants of health (SDH) are 'the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life' (WHO) [ix]. This includes economic and social policies, development agendas, social norms, and economic and political systems. All of which foster health inequities (WHO, CDC, HealthyPeople2020). [x] [xi]

Team-based Care: The provision of comprehensive health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their care givers – to the extent preferred by each patient – to accomplish shared goals within and across settings and/or partner organizations to achieve coordinated high-quality care.[xii]

Value-based financing: Payment arrangements that pay physicians, hospitals, medical groups, and other health care providers based on measures including quality, efficiency, cost, and positive patient experience. [xiii]

Business case for coordinated team-based care

Second edition

Introduction

Wisconsin is a wonderful place to work, live and play. However, while our health care system is of the highest quality, we can do better when it comes to coordination and delivery. Pieces of the health care system are fractured and critical partners often work in silos. Funding does not always cover the cost of providing all the services needed and families are frustrated by the lack of appropriate coordination among the multiple organizations serving them. These factors contribute to poor health outcomes and increased health care costs, especially for the Medicaid population. We need all partners to work together to improve accountability and develop a unified and coordinated system of care that is adequately financed.

Wisconsin's health care system is rapidly changing due to the Affordable Care Act and the movement toward value-based care and financing. Conversations are occurring at all levels to determine what this means and how it will and/or should be implemented in Wisconsin. The Wisconsin State Health Innovation Plan (SHIP) is an example of these collaborative planning discussions as noted below in the Wisconsin's SHIP vision and tenants.

> "Wisconsin's vision for the SHIP is statewide alignment and innovation to achieve better health and healthcare, and smarter spending in a statewide inclusive private-public partnership that is committed to sustainable transformation, and is confident that we can accomplish more through aligned collaboration than we can through isolated organizational efforts. Implementation of the SHIP will result in accelerated, impactful and sustainable improved health and higher value healthcare for Wisconsinites by:
>
> - Creating a shared vision for the future of health and healthcare
> - Promoting reciprocal accountability for complex problems of common concern
> - Facilitating shared learning, discussion and decision making through peer to peer networks
> - Identifying and disseminating best and better practices
> - Enabling transformation through health information technology, value-based payment models and transformation measurement"

This business case for coordinated team-based care directly connects to the SHIP's health systems design and performance objective 6.2 *Improve connections for people between clinic and community/social resources*. The SHIP discusses the importance of connecting people to community and social resources through organizational processes and information systems, in order to help people

meet their health, healthcare and life needs. The identified practices for creating linkages between clinical and community settings include:

- Expanding screening and referral through any health or social service entry point
- Linking and coordinating clinical settings and community resources[xiv]

The purpose of this business case is to present a Medicaid coordinated team-based care framework that aligns health partners in an adequately financed, unified system of care focused on improving health outcomes.

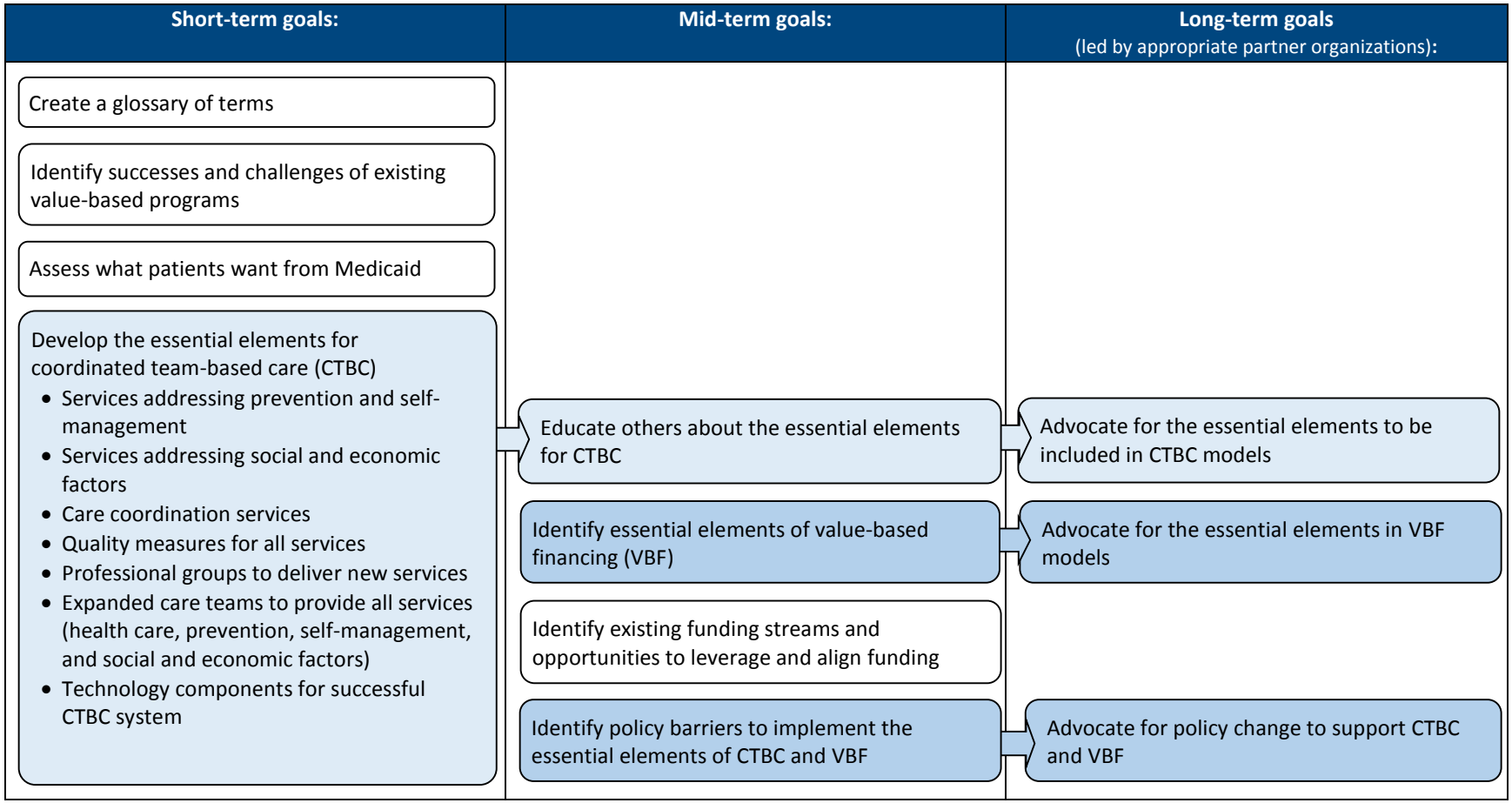
Acknowledgements

The Partnership for Value-based Coordinated Care (Partnership) is a collaborative effort working to achieve the goals described in Figure 1. The process for achieving these goals includes a shared space of learning and discussion, identifying information to include in this business case and identifying opportunities for collaboration.

The *Initial business case for coordinated team-based care* (released in August 2016) was written to provide evidence and present a convincing argument for changing the manner in which healthcare is delivered and financed in Wisconsin. Since then, the Partnership for Value-based Coordinated Care has continued to update the business case to incorporate new information and knowledge as it is shared. This business case update addresses the short-term goals of the Partnership identified on page 10. Current partners include (as of 4/4/18):

- Ageless Life Solutions
- AIDS Resource Center of WI
- Anthem Blue Cross Blue Shield
- Aurora
- Children's Community Health Plan
- Children's Health Alliance of WI
- Children's Hospital of WI
- DotCom Therapy
- Family Health La Clinica
- Fox Valley Advance Care Planning Partnership
- Great Rivers Hub
- Managed Health Services
- Milwaukee Fire Department
- Milwaukee Health Care Partnership
- Molina
- Pharmacy Society of WI
- Rural Health Initiative, Inc.
- Rural WI Health Cooperative
- Sixteenth Street Community Health Center
- Unite MKE
- United Healthcare
- United Way of Dane County
- Unity Health Insurance
- University of Wisconsin-Eau Claire, College of Nursing and Health Sciences
- WI Academy of Nutrition and Dietetics
- WI Association of Local Health Departments and Boards
- WI Asthma Coalition
- WI Center for Health Equity
- WI Coordinating Body of the American Association of Diabetes Educators
- WI Department of Public Instruction
- WI Division of Public Health
- WI Initiative to Promote Healthy Lifestyles
- WI Primary Health Care Association
- WI Medical Society
- WI Public Health Association

Figure 1. Partnership for Value-based Coordinated Care goals



Cause for concern in Wisconsin

Wisconsin is challenged with a variety of complicated health issues impacting a large number of residents that result in high costs as indicated in Table 1.

Table 1. Burden of health issues in Wisconsin (per year)

Burden in Wisconsin	Prevalence	Number of hospitalizations	Number of emergency department (ED) visits	Number of deaths	Cost
Alcohol use and related disorders	999,358 binge drinkers	48,578		1,529	$6.8 billion
	In 2011, excessive drinking in Wisconsin resulted in approximately 46,583 treatment admissions (e.g., substance abuse treatment programs), 60,221 arrests and 5,751 motor vehicle crashes. Wisconsin ranks number one in the U.S. for rates of binge drinking and number one for intensity of drinking. Of the $6.8 billion of total annual economic cost, $2.9 billion is borne by the government, including federal, state and local government agencies; $2.8 billion was borne by excessive drinkers and their family members and $1.1 billion was borne by others in society including private health insurers and employers.[xv]				
Arthritis	1.1 million[xvi]	646,521[xvii]			$2.4 billion[xviii]
	Arthritis comprises more than 100 disease types and rheumatic conditions. The 100 types of arthritis refer to many different conditions associated with joints, such as osteoarthritis, rheumatoid arthritis, systemic lupus, gout, bursitis, Lyme disease, carpal tunnel disease, and other conditions.[xix]				
Asthma	450,00 adults 100,000 children	4,992	18,642	76	$100 million in ED visits and hospitalizations
	Asthma is a chronic lung disease characterized by inflammation of the lungs with symptoms that include coughing, wheezing, shortness of breath and chest tightness. Asthma symptoms are responsible for decreased quality of life, sleep disturbances and an inability to carry out one's normal activities. Medical management of asthma in the state continues to fall short of the NIH asthma guidelines. The disproportionate burden of asthma and lack of adherence to treatment guidelines suggest that opportunities exist to enhance the care and health of people with asthma.[xx]				
Cancer	285,687 people*	17,819[xxi]		11,425[xxii]	$4 billion **
	* Cancer prevalence represents persons alive at a given date (2016) who were previously diagnosed with cancer. These estimates do not include carcinoma in situ (non-invasive cancer) of any site except urinary bladder, nor do they include basal cell or squamous cell skin cancers. [xxiii] ** Calculated using 2015 medical costs. Over the past 20 years the cost for cancer care has nearly doubled. This estimate is for direct medical care costs (all treatment costs) and does not include travel expenditures, cost of lost productivity, necessary child care, unpaid caretakers, and other nonmedical costs.[xxiv]				
Cardiovascular disease (CVD)	1.3 million adults have hypertension, a risk factor for heart attacks and strokes • 46.5 percent have controlled hypertension • 53.5 percent have uncontrolled hypertension	CVD: 165,308 Stroke: 14,603[xxv]		CVD: 11,660 Stroke: 2,468[xxvi]	$7.9 billion *
	CVD includes a variety of heart and blood vessel diseases, such as heart attack (coronary heart disease), congestive heart failure, high blood pressure (hypertension) and brain attack (stroke). CVD is the leading				

Burden in Wisconsin	Prevalence	Number of hospitalizations	Number of emergency department (ED) visits	Number of deaths	Cost
Cardiovascular disease (CVD) *continued*	cause of death among men and women of all racial and ethnic groups in Wisconsin. The greatest risk factor reported in Wisconsin adults was 73 percent of the adult population eating less than 5 servings of fruits or vegetables daily. Modifiable risk factors for CVD include overweight/obesity, high blood pressure, cholesterol, physical inactivity, cigarette smoking and diabetes. [xxvii] Chronic disease risk factors among Wisconsin adults (2011-2013): • 67 percent are overweight or obese • 47 percent participate in physical activity less than 150 minutes per week • 36 percent have a diagnosis of high cholesterol • 31 percent have a diagnosis of high blood pressure • 25 percent binge drink each month[xxviii] • 26 percent use any tobacco product[xxix] Of those with uncontrolled hypertension (estimated 689,000 Wisconsin adults), an estimated 275,000 are unaware they have hypertension, 110,000 are aware but untreated, and 313,000 are aware and treated. * Cost includes expenditures for office based visits, hospital outpatient visits, ED visits, inpatient hospital stays, dental visits, home health care, vision aids, other medical supplies and equipment, prescription medications and nursing homes.				
Chronic obstructive pulmonary disorder (COPD)	158,000 cases among adults	23,646	20,606	5,444	$712 million in inpatient hospitalizations[xxx]
	Chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema, is a chronic lung disease.				
Diabetes	624,000 people[xxxi]	7,463[xxxii]		1,331[xxxiii]	$6.1 billion annually $52.8 million[xxxiv] for children and adolescents
	People with pre diabetes have an increased risk of developing type 2 diabetes, heart disease and stroke.				
Drug use and related disorders	163,300 adults admit to using an opiate for non-medical purposes[xxxv]	15,454 drug-related hospitalizations*		633**[xxxvi]	$2 billion***
	Between 2004 and 2012, the proportion of drug deaths where heroin is mentioned increased five-fold, from 5 percent to 27 percent. Fifty-six of Wisconsin's 72 counties (77 percent) experienced increases in opioid-related hospitalizations for youth and young adults ages 12-25 between 2008 and 2012 * Drug-related hospitalizations include such diagnoses as drug psychoses, drug dependence, drug-related polyneuropathy, and accidental and purposeful poisoning by drugs. ** Deaths in 2012 as a direct consequence of illicit drug use. *** The estimated direct and indirect costs attributable to illicit drug use in four principal areas: crime, health, medical care and productivity.				
Injury		51,422	412,000	3,910[xxxvii]	$2 billion unnecessary medical costs[xxxviii]

Burden in Wisconsin	Prevalence	Number of hospitalizations	Number of emergency department (ED) visits	Number of deaths	Cost
Obesity and overweight	The burden of injuries among children and adults in Wisconsin remains significant. Injuries are the leading cause of death in Wisconsin residents ages 1-44 years and a significant cause of morbidity and mortality in all ages.				
	1,202,375 obese 1,593,435 overweight				$1.5 billion obese $751 million overweight[xxxix]
	Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, and poor health status[xl]				
Oral health	4,198 Head Start children ages 3 to 5 have untreated decay[xli] 195,200 adults aged 35-44 have lost a tooth due to decay or gum disease[xlii]		32,000 visits for non-traumatic dental complaints		$7 million in ED visits[xliii]
	Dental caries is a disease in which acids produced by bacteria on the teeth lead to loss of minerals from the enamel and dentin, the hard substances of teeth. If left unchecked, dental caries can result in loss of tooth structure, inadequate tooth function, unsightly appearance, pain, infection and tooth loss. From 2009-2011 only 52 percent of women went to a dental clinic during pregnancy.[xliv] During pregnancy women experience complex physiological changes that can adversely affect their oral health. Morning sickness, changes in diet and oral hygiene practices can lead to tooth demineralization and increased risk for dental caries, periodontal disease and gingivitis. The perinatal period also is a critical time to prevent dental caries for the infant as studies have documented that cariogenic bacteria that cause dental caries can be transmitted from mothers to infants. Maternal untreated dental caries increase the likelihood of dental caries in her children. Pregnancy is a period in a woman's life where preventive oral health care is extremely important not only for her health but the health of her child.				
Suboptimal breastfeeding	53,024 infants are not breastfed exclusively for six months			18 infants *	$221 million** • $164 million in premature deaths • $38 million in direct medical costs • $20 million in indirect costs
	In 2014, 84 percent of Wisconsin infants were ever breastfed and only 21 percent were exclusively breastfed for six months.[xlv] In 2014, the Wisconsin Women, Infants and Children (WIC) program served 52 percent of the 67,119 state births. Of those, 73 percent of infants in the WIC program were ever breastfed and 12 percent were exclusively breastfed for six months. By allowing breastfeeding rates to continue at their current levels Wisconsin incurs millions of dollars in excess costs and nearly 20 preventable deaths. * Calculated from national data in the burden report with Wisconsin at 1.7 percent of national births[xlvi] and assuming breastfeeding rates similar to national rates. Costs are in 2007 dollars and 2005 breastfeeding data. ** Calculations are based on a goal that 90 percent of U.S. families would comply with medical recommendations to breastfeed exclusively for six months as in the burden report. Diseases included in the cost analysis are necrotizing enterocolitis, otitis media, gastroenteritis, hospitalization for lower respiratory				

Burden in Wisconsin	Prevalence	Number of hospitalizations	Number of emergency department (ED) visits	Number of deaths	Cost
	tract infections, atopic dermatitis, sudden infant death syndrome, childhood asthma, childhood leukemia, type 1 diabetes mellitus and childhood obesity. [xlvii]				
Suicide		5,332[xlviii]	2,714	723	$900 million in medical and work loss costs[xlix]
	Suicide is the tenth leading cause of death in the state of Wisconsin. Wisconsin's public mental health system provides services to only 22 percent of adults who live with serious mental illnesses in the state. Wisconsin spent $108 per capita on mental health agency services in 2006, or $600.4 million. This was only 1.8 percent of total state spending that year. Many statistics fails to capture the number of people who only seek outpatient care following a suicide attempt or do not seek medical treatment at all. In 2013, among Wisconsin high school students, one out of seven seriously considered attempting suicide. At the societal level, suicides occurring during 2007-2011 were related to 22,000 years of potential life lost (YPLL) each year in Wisconsin. Suicide is the fourth leading cause of YPLL after unintentional injury, malignant neoplasm (cancer) and heart disease.[l]				
Tobacco	756,000 people			6,678[li]	$3.0 billion in health care costs * $1.6 billion in lost productivity[lii] ** $528 estimated yearly health care cost of cigarette smoking for every man, women and child
	Fourteen percent of Wisconsin women smoke during pregnancy. In addition to smoking, 10 percent of Wisconsin high school students currently use smokeless tobacco (chewing tobacco, snuff or dip). This is a 67 percent increase in smokeless tobacco use since 2012. *Annual health care costs are a result of diseases caused by smoking. **Lost productivity is due to illness and premature death from smoking-related illnesses. [liii]				
Unintended pregnancy	42,000 unintended pregnancies				$15.6 billion direct medical costs
	An unintended pregnancy is a pregnancy that is reported to have been either unwanted or mistimed and is associated with increased risk. Unintended pregnancy mainly results from not using contraception, or inconsistent or incorrect use of effective contraceptive methods.[liv] By averting unintended pregnancies and other negative reproductive health outcomes, publicly funded family planning services provided by safety-net health centers in Wisconsin helped save the federal and state governments $171.5 million in 2010. [lv]				

**This table is not an exhaustive list of health burdens facing Wisconsin. The table is intended to offer a snapshot of the current state of disease in Wisconsin.*

Total cost to Wisconsin

The Centers for Disease Control and Prevention (CDC) Chronic Disease Cost Calculator provides the cost of care for a variety of chronic disease in Wisconsin as indicated in Figures 2 and 3. Items to note about how this data is generated:

- "Annual expenditures are inflated to 2010 costs following recommendations from the Agency for Healthcare Research and Quality.
- Costs include expenditures for office-based visits, hospital outpatient visits, emergency room visits, inpatient hospital stays, dental visits, home health care, vision aids, other medical supplies and equipment, prescription medicines, and nursing homes.
- Payer populations are not mutually exclusive.
- Costs for 'all payers' are calculated independently of costs for Medicaid, Medicare, and private insurers.
- All results generated from the calculator are estimates. Actual costs may be larger or smaller than those reported."[lvi]

Figure 2. Annual cost for all payers by disease

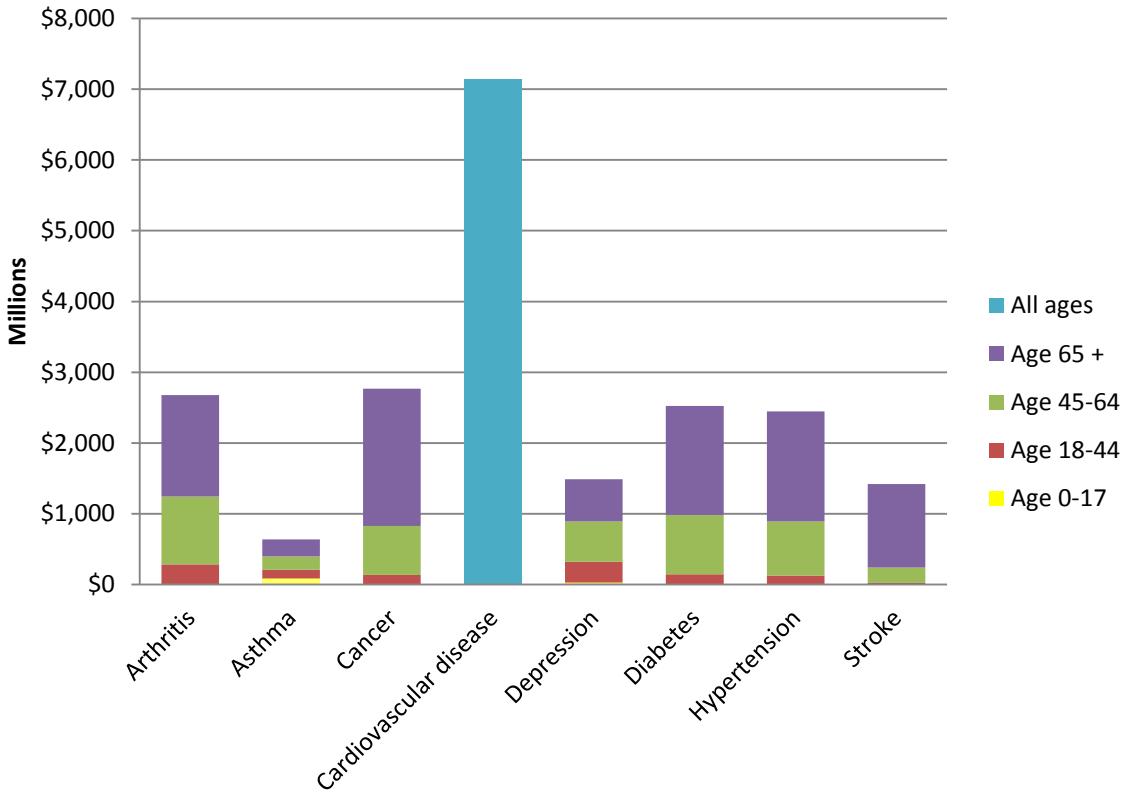
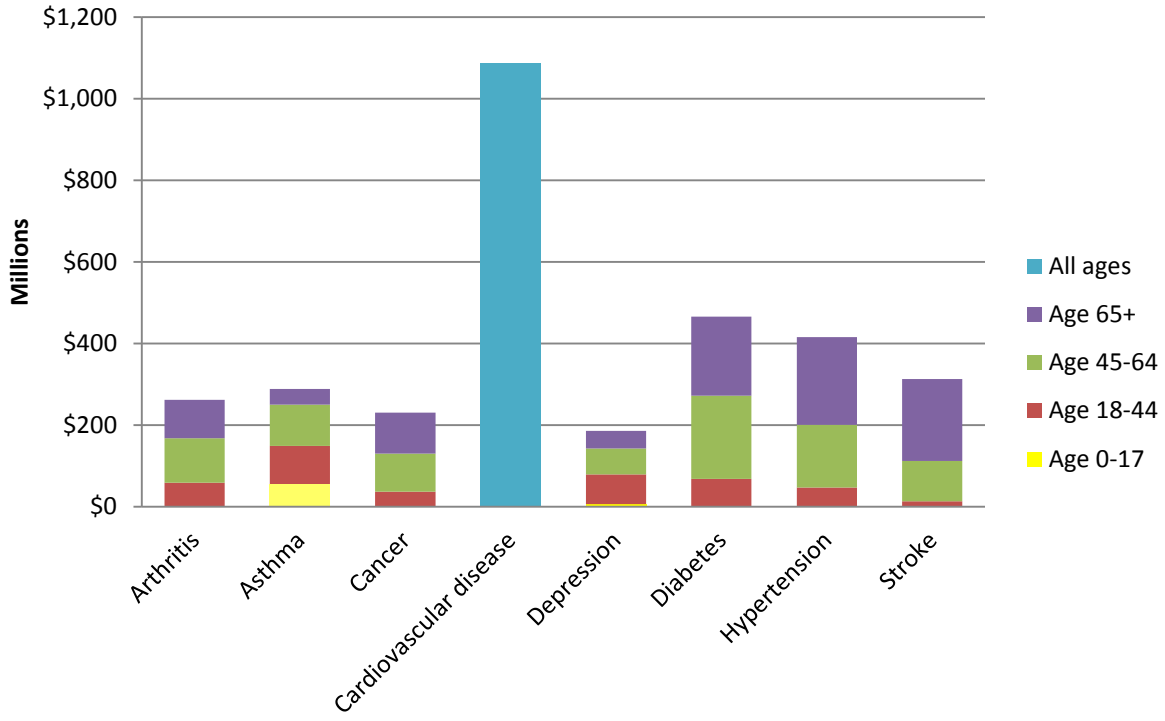


Figure 3. Annual Medicaid cost by disease



Beyond traditional health care

The County Health Rankings model (Figure 4) depicts four types of health factors, not including genetic factors, which impact health outcomes. These include health behaviors, clinical care, social and economic, and physical environment factors. The model also shows how much of an impact each factor has on health outcomes.

In today's health care system, the majority of current health care dollars are spent in clinical care, which has a 20 percent impact on health outcomes. The County Health Rankings model demonstrates the importance of health behaviors (30 percent impact), social and economic factors (40 percent impact) and physical environment (10 percent impact) on health outcomes. Factors effecting health, which sit outside traditional clinical care, are known as social and behavioral determinants of health.

Social determinants of health are, "conditions in the environments in which people are born, live, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risk" (Healthy People2020). These environments are shaped by overlapping social structures and economic systems that foster health inequities (CDC 2014). Some social determinants can be considered within the context of "place" or "location"; however, social determinants also include abstract concepts such as, social stability, cohesion, engagement and sense of security. Both the tangible (e.g. housing) and intangible (e.g. social integration) classifications of social determinants impact the health outcomes of individuals and the overall population. Table 2 outlines a variety of these determinants, how they impact Wisconsin and their importance to health outcomes.

Rectifying social determinants and health behaviors requires a multi-faceted, multi-disciplinary approach. Without addressing social determinants and health behaviors, we are neglecting to acknowledge roughly 70 percent of factors impacting health outcomes. Great programs are currently underway in Wisconsin, across a variety of health domains, to influence change. However, work remains to grow, integrate and reimburse these services within the clinical setting.

Figure 4: County Health Rankings model

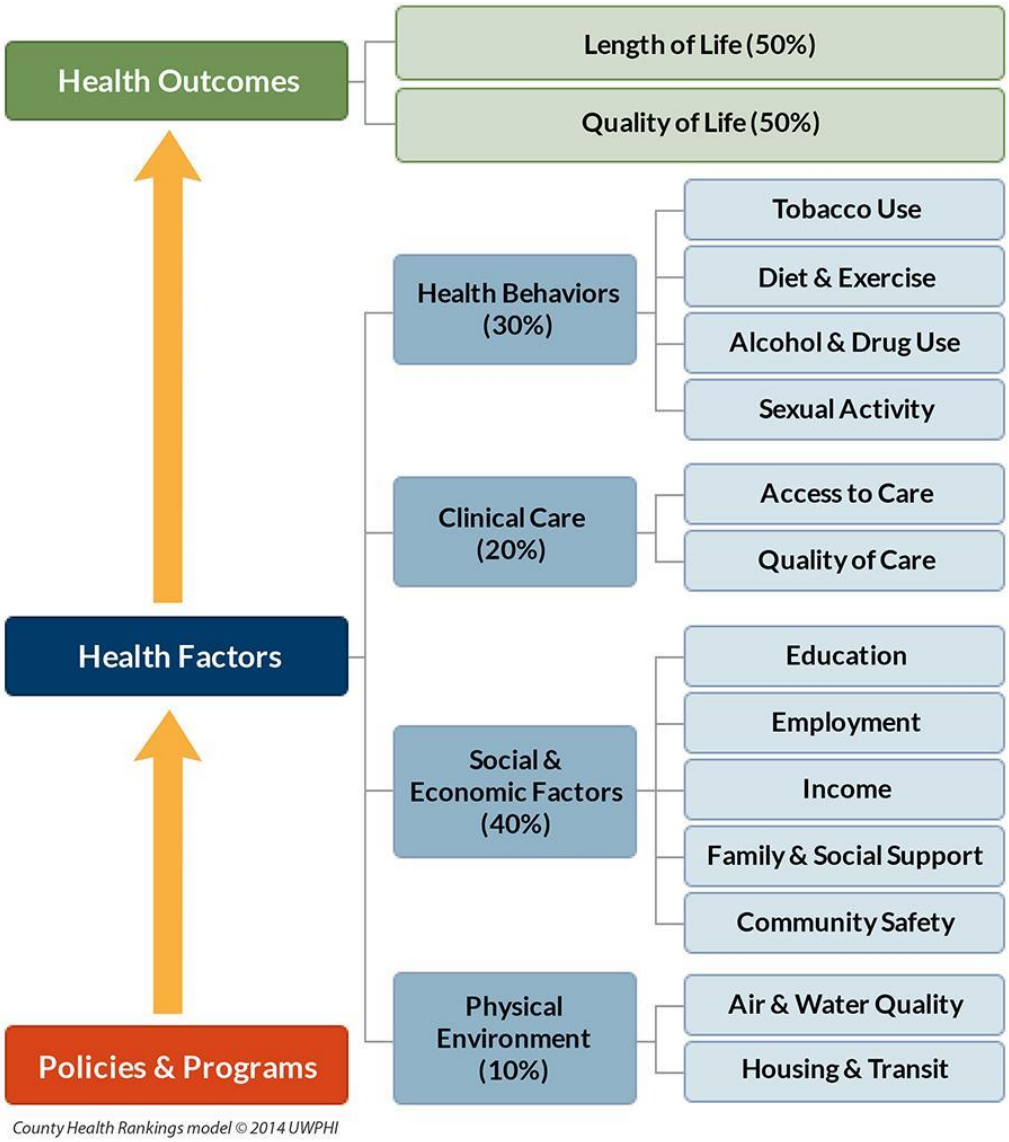


Table 2. Impact of social determinants and health behaviors in Wisconsin

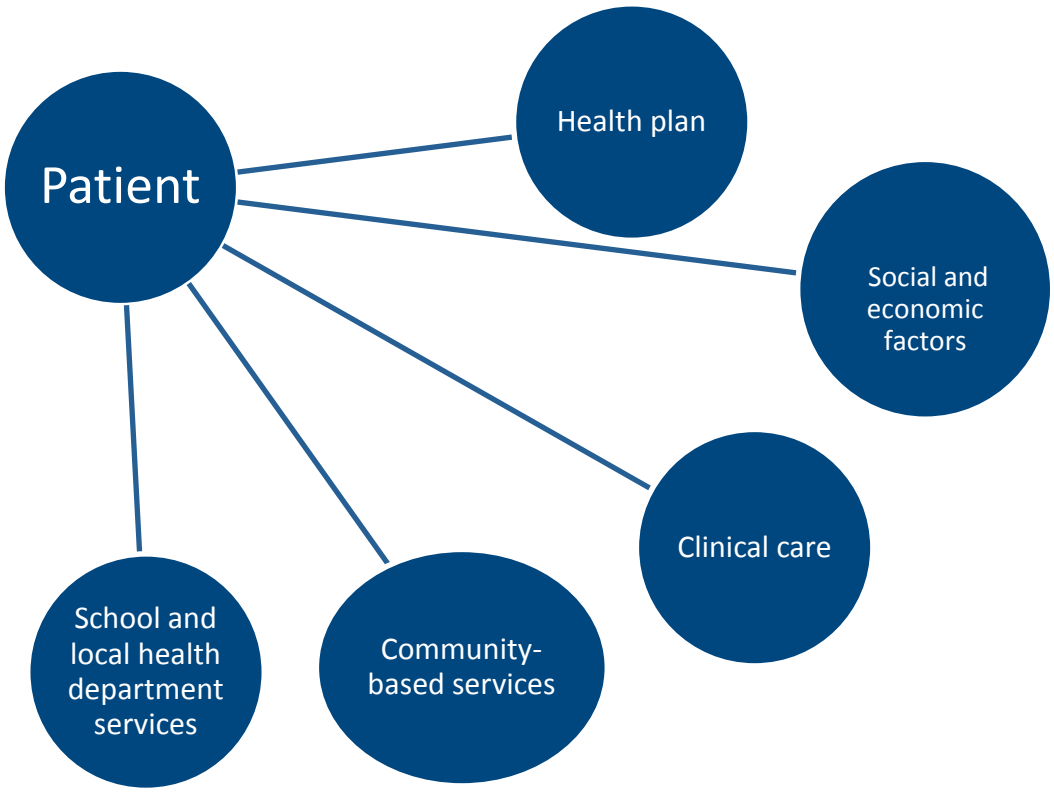
Determinant or health behavior	Wisconsin impact	Importance related to health
Community safety	**255 offenses** Reported violent crime offenses per 100,000 population (i.e., homicide, forcible rape, robbery, aggravated assault)	High levels of violent crime compromise physical safety and psychological well-being, along with exposure to chronic stress, which contributes to premature births or certain illnesses such as asthma. It also can deter residents from pursuing healthy behaviors such as exercising outdoors. [lvii]
Education	**88 percent** Ninth-grade cohort that graduates in four years	Evidence links maternal education with the health of her offspring. Parents' level of education affects their children's health directly through resources available to the children, and indirectly through the quality of schools that the children attend.[lviii]
	65. 9 percent Adults ages 25-44 with some post-secondary education	Years of formal education correlates strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.[lix]
	30 percent without skills **88 percent never catch up** Literacy – children entering kindergarten without skills needed to learn to read	Learning to read impacts more than just a child's school performance. It impacts rates of youth school retention, juvenile delinquency and teen risk behaviors[lx]
Employment	**6.7 percent** Population ages 16+ unemployed but seeking work	The unemployed population experiences worse health and higher mortality rates than the employed population. Limited access to care and an increase in unhealthy behaviors (e.g., alcohol, tobacco use, diet, exercise)[lxi]
Family support	**31 percent** Children living in a household headed by a single parent	Children in single-parent households are at risk for adverse health outcomes such as mental health problems (e.g., substance abuse, depression, suicide) and greater risk of severe morbidity and all-cause mortality than their peers in two-parent households. For lone parents, self-reported health has been shown to be worse than for parents living as couples and mortality risk also is higher. [lxii]
Income	**18 percent** Children under age 18 in poverty	Children in poverty experience greater morbidity and mortality than adults due to increased risk of accidental injury and lack of health care access. Risk also may be increased due to the poor educational achievement associated with poverty.[lxiii]
Physical inactivity	**21 percent** Adults aged 20+ reporting no physical activity for leisure	Decreased physical activity has been related to disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Inactivity causes 11 percent of premature mortality in the U.S.[lxiv]
Physical activity access	**83 percent** Population with adequate access to locations for physical activity	The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks and gyms are more likely to exercise.[lxv]
Social support	**11.8 memberships** Number of membership associations per 10,000 population (i.e., civic, sports, religious, political, business or labor organizations)	Poor family support, minimal contact with others and limited involvement in community life are associated with increased morbidity and early mortality. Social support networks have been identified as predictors of health behaviors, suggesting that individuals without a strong social network are less likely to make healthy lifestyle choices than individuals with a strong network. [lxvi]
Teen pregnancy	**27 births** Number of births per 1,000 female population ages 15-19	Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI). Teens also are more likely than older women to have a pre-term delivery and low birth weight baby, increasing the risk of child developmental delay, illness, and mortality.[lxvii]

Proposed solution

Coordinated team-based care

As depicted in Figure 5, the current health care system is disjointed with limited communication between providers and systems. A patient may be working with multiple providers and services, with little or no communication among the group.

Figure 5. Current health care delivery system



To improve the health of Wisconsin we need to move toward a model of patient-centered team-based care that extends beyond the clinical care model. The Institute for Healthcare Improvement defines team-based care as the "provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable." [lxviii]

Patient-centered team-based care

Patient-centered team-based care that extends beyond the traditional clinical care model to incorporate prevention, self-management, social and economic services would be critical to removing barriers and connecting health care silos. The Wisconsin Nurses Association released *Patient-centered team-based care in Wisconsin: A working conceptual model*, "to foster health care redesign that advances patient-centered team-based care and moves toward value-based care, improved patient health and safety, and

improved health of the population." This model describes the relationships within team-based care, with an engaged patient at the center, supported by three core elements. These elements include a high functioning team, an intra-professional and diverse workforce and a parent organization to provide support and infrastructure.[lxix]

The core elements of this model support patient-centered care, population health and engaged patients. They are critical to the successful implementation of the coordinated team-based care framework described below.

Coordinated team-based care framework

The coordinated team-based care framework (Figure 6) depicts a future state for Medicaid. The Medicaid payer (e.g., state-level, managed care, direct contract) would utilize value-based financing to fund all of the services needed to improve health outcomes. Communication and accountability would work across all the participating systems. Within Wisconsin's managed care system individuals and families would receive needed clinical care, prevention, self-management, social, and economic services to improve health outcomes. Care coordination would be utilized to connect individuals and families to all the needed members of the care team and organize the care activities and services. For individuals and families who do not utilize traditional care systems, a different type of care coordination would be utilized to engage them in services and eventually transition them into managed care. Examples of the types of services included in the framework are more fully defined in Figure 7.

Figure 6. Coordinated team-based care framework

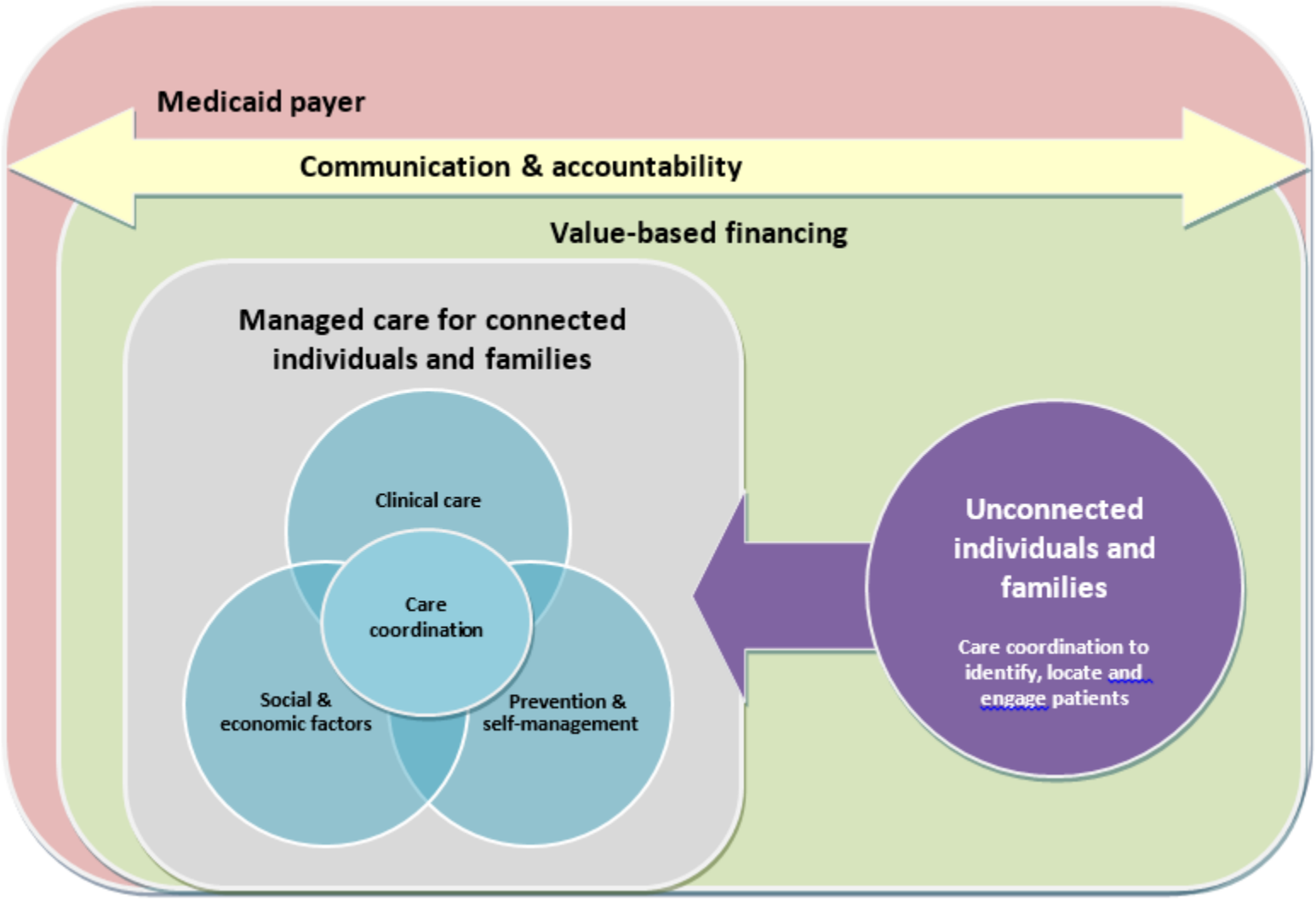


Figure 7: Services that address

<table>
<tr><th>Clinical care</th><th>Prevention and self-management</th></tr>
<tr><td>• Inpatient care
• Primary care
• Specialty care</td><td>• Behavior and risk factor assessment
• Care planning
• Counseling
• Equipment use and technique
• Goal setting
• Health education
• Home assessment and remediation
• Home visiting
• Medication adherence
• Quality of life assessment</td></tr>
<tr><th colspan="2">Social and economic factors</th></tr>
<tr><td>Education
• Child care subsidies
• Coping skills (e.g., stress)
• GED
• Health literacy assistance
• Higher education opportunities
• Job training
• Transportation (see transportation)</td><td>Employment/income
• Enrollment into benefit programs (see legal)
• Job training
• Transportation (see transportation)
• Workforce reintegration
• Working conditions (adequate, appropriate, safe)</td></tr>
<tr><td>Food and nutrition (quality)
• Access
• Affordability
• Child care meal programs
• Cooking skills
• School meal programs</td><td>Housing (adequate, appropriate, safe)
• Access
• Affordability
• Amenities: water, heat/AC, beds, bathrooms
• Conditions: damp, mold, building materials, crowdedness
• Safe neighborhoods
• Utility assistance</td></tr>
<tr><td>Legal
• Enrollment (e.g., health insurance, food assistance, child care assistance)
• Immigration support
• Job training
• Legal counsel
• Parole
• Reintegration
• Restraining order (personal safety)
• Transportation (see transportation)</td><td>Personal safety
• Emotional support (see social support)
• Housing (see housing section)
• Legal consultation (see legal)
• Working conditions (see employment)</td></tr>
<tr><td>Social/community support
• Child care
• Community volunteer
• Exercise facilities/gym
• Mental health support/screening
• Social associations
• Voting registration/civic participation</td><td>Transportation
• To child care
• To employment
• To health care appointments
• To legal aid
• To pharmacy
• To voting polls/civic participation
• Other means of transportation (e.g., bikes, bus passes)</td></tr>
</table>

Health professionals

To provide the full breadth of services in Figures 6 and 7, a greater number of health professionals would be required to serve in an expanded care team and financing model. Many of these health professionals are identified in Appendix 1. Each of these professional groups are licensed, certified or working toward certification. Additional information includes the estimated number in Wisconsin, examples of where these professionals are currently employed, which of the ten services above are delivered, how they are currently funded and whether there is any current Medicaid reimbursement for the services offered by these professionals.

Evidence base

The 6|18 initiative: Accelerating evidence into action

CDC created the 6|18 initiative to provide rigorous evidence about high-burden health conditions and associated interventions to inform the decisions of health care purchasers, payers and providers. "This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models." CDC has targeted six health conditions and 18 proven interventions. Figure 8 maps the six health conditions and indicates which of the proven interventions are already in place in Wisconsin.

Figure 8. Six health conditions identified in the CDC 6|18 initiative

High burden health condition	Evidence-based intervention
Reduce tobacco use	Expand access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and FDA-approved cessation medications—in accordance with the 2008 Public Health Service Clinical Practice Guidelines
	Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization
	Promote increased utilization of covered treatment benefits by tobacco users
Controlling high blood pressure	Promote strategies that improve access and adherence to anti-hypertensive and lipid-lowering medications
	Promote a team-based approach to hypertension control (e.g., physician, pharmacist, lay health worker, and patient teams)
	Provide access to devices for self-measured blood pressure monitoring for home-use and create individual, provider, and health system incentives for compliance and meeting of goals
Prevent unintended pregnancy	Reimburse providers for the full range of contraceptive services (e.g., screening for pregnancy intention; tiered contraception counseling; insertion, removal, replacement, or reinsertion of long-acting reversible contraceptives (LARC) or other contraceptive devices; and follow-up) for women of child-bearing age
	Reimburse providers or health systems for the actual cost of LARC or other contraceptive devices in order to provide the full range of contraceptive methods
	Reimburse for immediate postpartum insertion of LARC by unbundling payment for LARC from other postpartum services
	Remove administrative and logistical barriers to LARC (e.g., remove pre-approval requirement or step therapy restriction and manage high acquisition and stocking costs)
	Promote evidence-based asthma medical management in accordance with the 2007 National Asthma Education and Prevention Program guidelines
	Promote strategies that improve access and adherence to asthma medications and devices

Control asthma	Expand access to intensive self-management education for individuals whose asthma is not well-controlled with guidelines-based medical management alone
	Expand access to home visits by licensed professionals or qualified lay health workers to improve self-management education and reduce home asthma triggers for individuals whose asthma is not well-controlled with guidelines-based medical management and intensive self-management education
Prevent healthcare-associated infections	Require antibiotic stewardship programs in all hospitals and skilled nursing facilities
Prevent diabetes	Expand access to the National Diabetes Prevention Program, a lifestyle change program for preventing type 2 diabetes
	Promote screening for abnormal blood glucose in those who are overweight or obese as part of a cardiovascular risk assessment

Return on investment

In addition to the CDC 6|18 initiative an overall return on investment (ROI) assessment has been completed. ROI is a way to analyze and compare the costs of an investment with its benefits, in financial terms. According to the Agency for Healthcare Research and Quality, "a ROI analysis is a way to calculate your net financial gains (or losses), taking into account all the resources invested and all the amounts gained through increased revenue, reduced costs, or both." Taking an in-depth look into a program's ROI is an effective way to help health system leadership finalize decisions. ROI can be used during the planning process as a way to analyze the effects on revenue and operating costs. It also becomes a crucial tool during the evaluation process. Using ROI to assess a program's value can influence change moving forward.[lxx]

ROI is calculated by taking the return of an investment and dividing it by the cost of that investment. Results can be expressed as a ratio or as a percentage. For example, an ROI expressed as "1.90:1" means that for every $1 invested, $1.90 was gained back.

Appendix 2 provides information regarding preventive, self-management, social and economic services and programs from around the U.S. that have resulted in cost savings, or a positive ROI. These programs utilize a variety of healthcare professionals, and cover a wide range of health domains, or topics. The delivered prevention, self-management, social and economic services from Figure 4 are identified for each study.

Each of the featured programs in the ROI review had similar outcomes; however, each was reported differently. There also were differences in program design, duration, target population and purpose. Despite these differences, multiple themes surfaced during the study of these programs. Key findings include:

- Investing in preventive services can lead to a positive financial ROI.
- Certified health educators, community health workers, diabetes educators, and other health professionals are cost-effective.

- Health outcomes can be improved through the implementation of preventive services.
- Preventive services that result in a financial ROI can cover many health domains; examples include cardiovascular disease, low birth weight, diabetes and substance abuse.

Patient experience assessment

While the ROI data creates a compelling case for payers, we must not forget the catalyst for a coordinated team-based care approach, with reimbursement for comprehensive services, is rooted in a positive patient experience that improves health outcomes. An initial survey of Wisconsin residents, implemented through the Partnership for Value-based Coordinated Care, revealed a desire for coordinated care as an essential element of a positive health care delivery system. [lxxi]

The survey included a pre-assessment questionnaire, followed by one-on-one interviews with clients visiting a metropolitan community health center. The majority of respondents were between ages 45 and 64, and identified as Black/African-American (80 percent). Half (50 percent) of those interviewed were on Medicaid, 20 percent received Medicare benefits, 15 percent were uninsured, and 15 percent had private insurance. Participant incentives were distributed to those who completed the entire interview process. Each interview averaged 10-20 minutes in length. Although the results are not generalizable due to the limited sample size (n=20), they do offer an initial insight to the desired health care experience of Wisconsin residents.

Regardless of insurance provider, demographic makeup or previous experience with care coordination, the majority of survey participants noted an interest in care coordination services to organize their health needs. Cited reasons include the desire not to have to repeat their story to multiple people, the preference to have assistance navigating the nuances of Wisconsin's current health care system, and the ease of transitioning between various points of care.

Survey respondents also identified desired qualities of care coordination services. Respondents valued trust, communication and accessibility when working with a care coordinator. This is true of both individuals with previous experience with care coordination, and of those who had not utilized such services but had expressed interest in receiving that type of support. Seventy percent of respondents preferred a community health worker as their care coordinator; however, only 58 percent of respondents wanted the care coordinator to be physically located in the community. Thirty-two percent wanted the care coordinator located in their doctor's office. This variation in preference of professional status and location of the care coordinator is reflexive of the myriad of patient experiences that intersect with the health care system. To meet the needs of patients and families, clinical teams would benefit from extending their workforce to include professions such as community health workers or other professionals closely tied to each community.

Implementing solutions in Wisconsin

Wisconsin has taken steps in specific program areas toward expanding the team-based care model to include and integrate clinical care and prevention, self-management, social and economic services. We

can use these models as a guide and/or to expand this work to a larger population. Below are a few examples in Wisconsin where this type of work has been implemented.

HIV medical home. The AIDS Resource Center of Wisconsin (ARCW) was designated a patient-centered medical home in 2011 by the National Committee of Quality Assurance. The HIV medical home is a Wisconsin Medicaid program and was established as a result Wisconsin 2009 Act 221 and with funding available under the Affordable Care Act. Each patient is assigned to a primary care provider. This provider works with a team to coordinate care. The team could include mental health therapists, dentists, pharmacists and others.[lxxii]

The two goals identified for this program include:

- Reduce the risk of complicating opportunistic infections and improve health outcomes.
- Ensure the integration of oral health care and medical health care for HIV patients.[lxxiii]

ARCW considers an integrated medical home as one of the most critical components to a successful medical home model. The foundational elements at ARCW include:

- Co-location of services to maximize the care team's ability to support patients by providing multiple opportunities for reengagement
- Shared electronic health record with shared patient rosters among care team members
- Ability to extract meaningful data from the electronic health record with resources dedicated to high quality data management
- Collaborative practice environment where the clinical hierarchy is removed, thus fostering care teams that meet frequently and create individually tailored plans focused on outcomes

Foundational elements

- Co-location of services
- Shared electronic health record among team members
- Ability to extract meaningful data
- Collaborative practice environment

Program successes

- Significant suppression of HIV viral load
- Cost savings of estimated $4 million annually
- Increased data access

Program successes include:

- Significant suppression of HIV viral load overall and narrowed the disparities gap among patients of color and Caucasian patients
- Medicaid cost savings of an estimated $4 million annually
- Access to data through the use of an external population management tool

While the HIV medical home is successful, there are some continued challenges, such as:

- The total cost of care exceeds the per-member per-month payment. Grants and philanthropic dollars cover the additional costs of care.

- All ARCW patients are offered the medical home model of care. Services are financed through a variety of structures. Due to the high churn among Medicaid patients, it is sometimes difficult to keep track of which patients are eligible for the Medicaid HIV medical home billing.
- Staying in compliance with standards and ensuring accurate documentation is labor intensive for staff, thus taking time away from serving patients. ARCW would prefer to move toward outcome-based documentation.[lxxiv]

Care4Kids. Care4Kids is a Medicaid program developed by the Wisconsin Department of Health Services (DHS) and the Wisconsin Department of Children and Families (DCF), and administered in partnership by the program's certified health system provider, Children's Hospital of Wisconsin and Children's Community Health Plan. Care4Kids provides comprehensive coordinated health services for children in out of home care (i.e., foster care). The program recognizes the unique needs of children in foster care and coordinates care for the child in a way that builds relationships between clinical care providers and the child's caregivers to ensure the care is consistent, managed and organized through a comprehensive health care plan. The Care4Kids program was launched in 2014 in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties. This program operates under a "medical home" philosophy by establishing a primary care medical home team for each child designed to address each child's specific health care needs.

The program goals include:

- An integrated and comprehensive health service delivery system to include physical, behavioral and oral health care
- Timely access to a full range of developmentally appropriate services
- Quality care provided by a healthcare team that utilizes trauma-informed principles and evidence-based practices
- In collaboration with child welfare partners, coordinated transitional planning to assure continuity of care as children achieve permanency or age out of foster care
- Improved child well-being including physical, behavioral and mental health outcomes, increased positive permanency outcomes and enhanced resiliency[lxxv]

Care4Kids is an innovative and unique program to Wisconsin, with an average monthly enrollment of approximately 3,000 foster care children. This complex, high-cost population now receives comprehensive health care coordination services via the Care4Kids program and its partners using a primary care medical home model.

The Care4Kids program is currently establishing baseline outcomes utilizing 15 key outcome measures. Since its inception, several outcomes have shown improvement in both timeliness to care and overall completion rates with certain measures showing significant improvement.

While the Care4Kids partnership between DHS, DCF and Children's Hospital and Health System has experienced several initial successes, and continues to make progress toward achieving its goals, there are continued challenges including:

- Reporting is complex, detailed and labor-intensive based upon complexity of the population, reporting timelines and variety of reporting sources (e.g., claims, medical records)
- Overcoming barriers to package and share information among broader care team members (e.g., HIPAA, legal implications)
- Identifying the effective strategies to address social determinants that present barriers to improved health for the child and the child's caregiver and/or family
- Timely parental/guardian consent for mental health assessment and treatment
- While improvements in dental outcomes have been made overall, access to dental providers accepting Medicaid patients in Wisconsin remains a challenge
- Timely access to outpatient psychiatry care[lxxvi]

Obstetric medical homes (OBMH).
The OBMH initiative began in 2011 to reduce poor birth outcomes in southeast Wisconsin (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha Counties) and since has been expanded to Dane and Rock counties. DHS contracts with HMOs to recruit clinics. The program is available for both BadgerCare Plus and Medicaid Supplemental Security Income (SSI) pregnant women enrolled in a participating HMO.

In addition to the standard Medicaid payment, OBMH's receive $1,000 for

Initial program successes

- Collaborative initiative involving multiple public and private partners serving a complex population
- Promising initial success and ongoing progress with outcome measures
- Establishment of primary care medical home providers as "Centers of Excellence"
- Development of innovative processes for enrollees with acute conditions (e.g., polypharmacy interdisciplinary case review and initial risk triage stratification upon enrollment)
- Lower overall medical costs compared to planned budget
- Development of a comprehensive health care plan to share amongst the child's stakeholders to enhance collaboration

each woman who meets the following criteria, and is enrolled in the program.

- Enrolled in the first 16 weeks of pregnancy and remained continuously enrolled throughout the pregnancy
- Attended a minimum of 10 prenatal care appointments with the OB provider
- Remained continuously enrolled during her pregnancy, and
- Had a postpartum appointment within 60 days of delivery

An additional $1,000 is paid for each eligible enrolled member who meets all of the criteria and has a healthy birth outcome. This is defined as equal to, or more than, 5.5 pounds (2,500 grams), at least 37 weeks gestational age and no neonatal death within 28 days post-delivery.

For a clinic to become an OBMH the clinic must provide obstetric services to BadgerCare Plus or SSI HMO members and have an OBMH agreement with a participating HMO. The OB clinic must:

- Agree to adopt a team-based approach as defined by the DHS HMO contract. The care team shall include:
    - The OB provider who serves as the lead
    - A designated care coordinator
    - Other clinic staff (e.g., RN, medical assistant)
    - Other care providers, including primary care, specialists and behavioral health
    - Members or patients
- Agree to ensure the member receives comprehensive care, including medical and behavioral health care and that her psychosocial needs are met (e.g., referrals for housing assistance, domestic violence counseling)
- Promote patient self-management
- Develop an individual care plan and monitor activities
- Use an electronic health record system

To be enrolled in the OB medical home, a woman must be pregnant and meet one of the following criteria:

- Be less than 18 years old
- Be African American
- Be homeless
- Have a chronic medical or behavioral health condition which will negatively impact the pregnancy
- Had a prior poor birth outcome
    - Baby born at low birth weight (less than 2,500 grams or 5.5 pounds)
    - Baby born preterm (gestational age less than 37 weeks)
    - Neonatal/early neonatal death (baby died within the first 28 days)
    - Stillbirth (fetus died after 20 weeks gestation)
- Meet the criteria for inclusion in the DHS Birth Outcome Registry Network (BORN) report[lxxvii]

In an evaluation of the three-year pilot (2011 – 2013), term births in the treatment group of patients were higher in relation to the comparison clinics, but the difference was not statistically significant. Additionally, there were no meaningful program impacts on birth weight.

The initial pilot found a number of benefits including the observation that the "OBMH 'adds credibility' to the clinic's efforts and adds momentum toward developing an organized structure." The pilot helped clinics institutionalize and formalize practices. This systematic, structured process supported a number of improvements.

Additionally found in the evaluation of the pilot study were a variety of challenges. Based on these results DHS has taken multiple actions to improve the OBMH program.[lxxviii]

More recent outcome data found in the external quality review shows that the poor birth outcome rate declined in 2015 (11.9 percent) compared to 2014 (12.5 percent) and 2013 (13.0 percent).[lxxix]

Clinical benefits found from systematic, structured process

- Physicians have more time to provide clinical care and patient education
- Nurses spend more time with the patients doing patient education during the visit and know that patients will get the proper referral and follow-up
- More team-based approach, with better coordinated care, provides patients with more individualized attention
- Physician satisfaction increases with the support of the care coordinators

Wisconsin Pharmacy Quality Collaborative (WPQC). Limited reimbursement is currently received through the WPQC program for pharmacist interventions. WPQC-accredited pharmacies receive payment from participating insurance plans for medication therapy management services provided by pharmacists to eligible patients in the outpatient setting. The ultimate goal of the program is to resolve drug therapy problems, improve adherence and engage patients in their own care.[i] Program participants include Wisconsin Medicaid and United Way of Dane County for low-income seniors in Dane County.[ii]

During the pilot phase (2008-2010), with Unity Health Insurance and Group Health Cooperative of South Central Wisconsin, WPQC showed a 10:1 ROI for services, which directly affected medication cost. ROI was maintained at 2.5:1 when combining services, which also directly influenced medication cost and comprehensive medication reviews. "Pharmacist services contributed to a positive ROI via:

- Adherence to payer medication formularies when clinically appropriate
- Patient access to medications with decreased out-of-pocket costs contributing to increased adherence
- Proper use of medication devices, such as inhalers

- Avoidance of inappropriate medication regimens, reducing adverse effects and hospitalizations, while increasing adherence”[iii]

The WPQC program was funded by a CMS Health Care Innovation Award (2012-2015) and expanded statewide. DHS Division of Health Care Access and Accountability conducted an evaluation of the WPQC program in 2016, which showed a reduction in inpatient costs, suggesting that the program is improving member health[lxxx].

Taking into account successes and lessons learned from the featured programs in this document, Wisconsin can continue to design and implement innovative programs to meet the needs of its individuals and families.

Capacity

Coordinated team-based care could be provided and financed in a variety of ways. A mix of models to save money and achieve improved health outcomes may be utilized to reach fully the Medicaid patient population. These include a state health plan amendment, value-based payments, a state-based health information system, and private health information technology options. Details of these models are discussed below.

State health plan amendment

The Centers for Medicare and Medicaid (CMS) changed the rule for prevention services, which opens the door to implementing a coordinated team-based care framework. The CMS ruling "Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; exchanges: eligibility and enrollment" (CMS-2334-F) revised the regulatory definition of prevention services at 42 CFR 440.130(c), which became effective January 1, 2014. The rule allows state Medicaid programs to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. Each state must implement a health plan amendment to accept this rule in their Medicaid program.

Preventive services are defined as services recommended by a physician or other licensed practitioner of the healing arts, acting within the scope of authorized practice under State law to:

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency

While Medicaid is the target for this business case, there are examples from Medicare and private payers that could be utilized as models. It will require a variety of strategies to significantly impact the health outcomes of our most disparate populations.

Value based payment models

Value based payments are "payment arrangements that pay physicians, hospitals, medical groups, and other health care providers based on measures including quality, efficiency, cost, and positive patient experience." [lxxxi] Examples of these models include:

- **Medicare quality incentive program.** "Medicare quality incentive program is a pay-for-reporting program that gives eligible professionals incentives and payment adjustments if they report quality measures satisfactorily. Although the physician quality reporting system (PQRS) is a standalone program, it touches on other CMS programs that require quality reporting, such as the eRx Incentive Program, the electronic health records incentive program, the Medicare shared savings program, and the value-based payment modifier."

- **Pay-for-performance.** "In a pay-for-performance system, providers are compensated by payers for meeting certain pre-established measures for quality and efficiency. Pay-for performance-programs have been implemented by both Medicare and private insurers."
- **Accountable care organizations (ACO).** "Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."
- **Bundled payments.** "Episode or bundled payments are single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings."
- **Patient centered medical home (PCMH).** The PCMH is a team-based model based on the premise that the best healthcare begins with a strong primary care foundation, accompanied by quality and resource efficiency incentives. Patients in a PCMH have a personal provider, who along with his/her team, provides continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes. The PCMH section collaborates closely with the services in implementation efforts, policy development and the formal recognition process. The PCMH is a model of healthcare based on an ongoing, personal relationship between a patient, doctor and the patient's care team. Whatever the medical needs – primary or secondary, preventive care, acute care, chronic care, or end-of-life care – the patient has a medical "home"; a single, trusted doctor and care team, through which continuous, comprehensive and integrated care is provided."
- **Payment for coordination.** "This model involves payment for specified care coordination services, usually to certain types of providers. The most typical example of this is the medical or health care home model whereby the medical home receives a monthly payment in exchange for the delivery of care coordination services that are not otherwise provided and reimbursed."[lxxxii]

Health information systems

A critical piece to the coordinated team-based care framework is the exchange of health information. Currently, no single system has the capacity to manage all the health information and serve as a communication network among providers. However, there are a number of promising opportunities to consider. Wisconsin's health information exchange has the potential for expansion and could eventually serve as the communication platform for all parties involved in the coordinated team-based care framework.

- **Wisconsin Statewide Health Information Network (WISHIN).** WISHIN provides a health information network that currently connects participating physicians, clinics, hospitals, pharmacies and clinical laboratories. The purpose of this exchange is to provide timely, relevant information leading to better clinical decisions, less duplication, more effective transitions of care and reduced administrative costs.[lxxxiii] The WISHIN community health record (WISHIN Pulse) has the potential for expansion to include prevention, self-management, social and economic providers to view and exchange information. The types of information could be expanded to

include prevention, self-management, social and economic services as well as the practitioners providing these services. This expansion would improve communication between all providers to work as an effective team.

Health information technology

Other technology options are being discussed by key leaders representing health systems, payers and public health. These options could support execution of the coordinated team-based care framework. Several of these tools are described below.

- **Care Everywhere**. "Health Information Exchange between Epic systems. CareElsewhere is the health information exchange solution for sharing information between Epic and non-Epic systems. EpicCare Link is an online web portal that an Epic customer can give access to referring providers to receive view-only access to patients' care records." [lxxxiv]

- **Camden Health Information Exchange.** "Launched in 2010, the Camden Health Information Exchange (HIE) is a collaborative data-sharing effort to improve care delivery in Camden. The Camden HIE is a web-based technology offering participating local and regional health care providers secure, real-time access to shared medical information. For providers, having access to shared clinical information fosters improved care coordination and reduces unnecessary, costly duplication. For Camden Coalition staff, data from the HIE can identify individuals eligible for enrollment in the Coalition's intervention programs.

  Camden HIE participants include hospitals, primary care practices, laboratory and radiology groups, social service organizations, correctional facilities, and other licensed health care facilities and providers. In order to protect patient privacy, the Camden HIE is built and governed to ensure that only health care providers can access the personal health information of their patients." [lxxxv]

- **Epic Healthy Planet.** Epic Healthy Planet aims to consolidate information across systems to take the best care of your community. Epic software can be extended to independent practices and hospitals through Community Connect. Community providers can be kept in the loop with an integrated portal that lets them stay up-to-date with their patients, submit referrals, order labs and imaging, schedule visits, and more. Users can bring in data from any vendor source, including claims, revenue and other electronic health records (EHRs). Epic Healthy Planet creates a single longitudinal plan of care accessible to patients, providers, care managers, and affiliates. Providers can communicate with other EHRs and allow external providers to review and resolve care gaps through a web-based care management portal. The program engages the patient by providing access to key health data, self-service capabilities, and health and wellness reminders through an EHR-agnostic patient portal.

- **HealthConnect.Link**. "HealthConnect.Link is creating an online community of free and subsidized health and social services. The goal is to help low-income uninsured and underinsured patients access the help they need. Patients can make meaningful connections by

quickly identifying organizations close by that have the ability to provide the care they need." [lxxxvi]

- **Health Leads Reach.** Health Leads Reach is a purpose-built, cloud-based solution enabling health systems to manage and track the success of their social needs programs. The case management feature guides patients and providers from screening to intake to action plan. Providers can search thousands of nearby community resources, using intelligent filters to identify quickly the best resources for your patient. With more than 50 standard on-demand reports, providers can make more effective and dynamic treatment decisions for their patients. Case managers and patients can track progress through a plan of care. Integrated communications allow text or email directly in the program. Health Leads Reach is available through an internet connection, through any web browser on any device. This software passes numerous independent IT security audits and is trusted by some of the country's leading healthcare providers.

- **Healthify.** This software tool is for care managers, community health workers, and social workers to coordinate referrals with community-based organizations. Healthify is a software provider to health plans, hospitals, and provider networks working in low-income communities. Their platform can be used by care teams to make quick and accurate referrals for patients who need additional help from social services. Healthify identifies five services to help organizations manage the social determinates of health. Users on the Healthify Community Resource Platform can search, filter and refer to community organizations, social services and government benefits. Integration services are offered to make the user's experience seamless.

  The Referral Platform is an advanced tool for care teams to refer patients in need of social services to community organizations. Users can verify completed referrals by communicating directly with participating community services. Referral information is stored on the patient dashboard. Trends in community needs can be used to see the most common needs and service gaps in any community through an analytics dashboard. Feedback can be provided to community organizations about the resources from the users. Currently, the database has over 125,000 resources in 25 states. Patient-centered tools also are available including profiles, referral tracking and texting.

  An assessment platform can be used by care teams to determine psychosocial risk levels. An algorithm automatically recommends services to address those needs. Multiple assessments can be hosted in Healthify to fit all patient population's health needs.

- **MyHealthDirect.** MyHealthDirect is a data driven platform for referral management and online scheduling. MyHealthDirect coordinates care by consolidating referral activities into a single platform with real-time scheduling. The system automates scheduling workflows with business rules and enables providers to define appointment criteria. MyHealthDirect simplifies access for people across the healthcare system with the right provider match for online engagement. This

tool also visualizes trends and drives behavioral change to optimize capacity, outcomes and practice performance with actionable analytics.

- **NowPow.** NowPow connects health care to self-care by connecting people to high quality community resources. From stress management to smoking cessation, fitness classes to family planning, NowPow collects and shares detailed information on the services everyone needs to stay well and live long. NowPow creates customized community resource e-prescriptions that extend, complement, and complete care plans. Their technology includes seamless EHR integration, including Epic, so providers can automatically generate and deliver customized e-prescriptions at the point of care. While NowPow has an enormous inventory of resources, e-prescriptions are personalized to the patient based on their address, conditions, age, gender and language spoken to create customized service referrals.

  Patient engagement tools are embedded throughout the technology to nudge patients and keep self-care top of mind, increasing the likelihood of taking action. Any individual that extends care past the provider's office can use this tool to easily access self-care plans and customize them to meet the needs of their patients. Mobile-enabled applications empower patients and community health workers to create self-care plans and search for services in non-clinical settings. In the referral tracker tool, service providers update referral information, which allows care professionals to monitor patient activity and report on referral success rate.[lxxxvii]

- **One Chart.** "Cerner's community care management solution supports a person-centric approach of proactive surveillance, coordination, and facilitation of health services across the care continuum for populations with certain risks, diseases, complications, and high utilization. Cerner aligns with organizations to assist in analyzing and managing alternative payment model performance for: Medicare Shared Savings Program (MSSP), bundled payments, Medicare Advantage, clinically integrated networks (CINs), Medicaid Management Information Systems (MMIS), Delivery System Reform Incentive Payment (DSRIP) Program, Medicare Access CHIP Reauthorization Act (MACRA) and other state funded programs." [lxxxviii]

- **Pathways Community HUB Model.** The "Pathways Community HUB Model helps identify, care for, and track treatment outcomes of those at-risk in a coordinated, cost-effective manner. This model helps meet the goals of healthcare reform … and achieve an emphasis on preventative, rather than reactionary, care. The Pathways Community HUB Model cost-effectively meets the health, physical, behavioral and social needs of at-risk individuals." [lxxxix]

  "The Pathways HUB Connect database collects and retains the social determinants of health information gathered by the care coordinators using the Pathways processes. HUB administrative staff access the system through secure channels and manage the HUB operations, reporting and invoicing. Care coordinators access the system through the Pathways Mobile tablet applications, mobile tablets accessing the HUB portal through secure web

browsers, and directly via the user-enabled HUB portal that the HUB administration staff use. In this way, the HUB and the care coordinators are able to enter client information timely and available for use in real-time by other HUB users. ”

The Pathways Mobile application delivers the client caseload to the care coordinator. The application includes the entire pathway system and checklist for each client allowing the care coordinator to record information gained during client meetings.[xc]

Impact

As previously demonstrated, there is positive ROI when implementing prevention, self-management, social and economic services. Additionally, those working in the health care industry recognize that patients will not be able to improve their health outcomes unless basic needs are met (e.g., food, housing, education, transportation, social needs, health literacy). By connecting prevention, self-management, social and economic services to payers and clinical care providers through a value-based financing model we can better serve patients, improve health outcomes and decrease cost.

National quality measures

While achieving ROI is critical, it also is important to meet national quality standards, which are tied to financial incentives for payers and providers. The coordinated team-based care framework is designed to positively impact health outcomes and achieve quality standards. The framework proposes that coordinated-team based care functions within a value-based financing model. When shifting from fee-for-service to value-based payment models, the outcome measure rate, compared to a benchmark, determines payment. Thus, improvements in outcomes achieve higher reimbursement. This shift will change the health care model from quantity of services delivered to quality of care given. Quality measures, tied to payment, also incentivize care coordination activities beyond referrals. The types of quality measures used in care coordination should capture both process and outcome measures. Measuring both the process and the outcome can assist in demonstrating the impact of care coordination. The process and outcome measures should address all clinical, prevention, self-management, social and economic services.

By nature of disease, each chronic condition necessitates its own set of outcome measures. The various health care organizations and payers in Wisconsin offering clinical, prevention, self-management, social and economic services should use the same measurements to facilitate communication and accountability across sectors. Utilizing uniform measures builds a streamlined approach to evaluate performance outcomes and prevent measurement burden. Quality measures should be documented and collected in a discrete way that allows data-pulls and useful reporting. If all organizations adhere to similar measures, expectations and accountability are built into the various care models. This helps maintain a high standard of care and ensures consistency of care to all individuals and families.

Appendix 3 provides an assessment of the existing quality measures that are currently tied to payment, as well as other potential measures that could be used. As health care shifts its payment and delivery models, it is important to consider the most effective ways to measure change and health improvement. Currently, there are many recommended measures for health care systems to utilize but no national (Medicaid) standards to measure socioeconomic drivers of health. However, to ensure health outcomes are achieved, these measures need to be uniform across systems and address outcomes, not just service delivery.

Conclusion

Achieving population health entails providing a seamless alignment of the full array of services across the health care continuum. Wisconsin experiences a high-burden of health issues per year. These concerns not only put stress on the health care system, but also negatively affect the lives of Wisconsin's residents. We can improve care for Medicaid patients and families by working together in a unified, coordinated system of care that is adequately financed and accountable.

This document provides the evidence and presents a convincing argument that coordinated team-based care, within a value-based financing model, will produce improved health outcomes and reduce cost. It is intended to capture what we know today, but will continue as a fluid document that changes with Wisconsin's health care system, financing landscape and partner engagement.

At this stage, our goal is to secure mutual agreement that the coordinated team-based care framework presented in this business case is the appropriate path for Wisconsin. Please use this document to start the conversation and join us in building a structure for change in Wisconsin. We invite representatives from each sector of the health care continuum to participate in this movement to advance the health and well-being of Wisconsin.

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