Healthiest Wisconsin 2020 Everyone Living Better, Longer, is the public health agenda that identifies priority objectives for improving health and quality of life. Through a coordinated approach, we can strengthen our capacity to improve health across the lifespan, eliminate health disparities snd achieve health equity.

HEALTH SYSTEMS ACTION TEAM

VISION

We aim to promote, coordinate, and support clinical prevention efforts adopted by key partners to implement proven, effective, and quality services to improve health outcomes for individuals given a diagnosis of chronic disease and/or are at highest risk for hypertension, heart disease, stroke, and diabetes of all races, ethnicity, gender, sexual preference, and disability.

POPULATION HEALTH CHALLENGE

Chronic Diseases have a huge impact on mortality in Wisconsin. Today, 7 of the 10 leading causes of death are due to chronic diseases-accounting for approximately two of every three deaths annually (McKenna and Collins, 2010). People with chronic disease or associated risk factors often require extensive medical care. The direct costs are estimated to the Wisconsin Medicaid system totaling $1.15 billion annually. In 2010, Wisconsin spent between $2.5 to $7.1 million dollars on chronic diseases and the costs are projected to substantially rise over the next six to ten years from approximately $7.1 million in 2010 to over $13 million in 2020. (CDC Chronic Disease Cost Calculator, 2010). The cost of cardiovascular disease was higher than the associated costs of cancer and diabetes.

The burden of the projected increase in chronic disease expenditures is ultimately passed on to local and Tribal communities. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion" (U.S. Department of Health and Human Services, 2010). Simply put, a health disparity is an important difference in health outcomes between populations due to factors beyond individual behaviors. Individual behavior accounts for approximately 30% of health outcomes (University of Wisconsin Population Health Institute, 2014). Others have noted that over half of deaths can be attributed to individual behavior (Mokdad et al., 2004). While increasing healthy individual behavior is important in creating healthy communities, accounting for factors like education, income, race, gender, the environment, and social policies is needed in intervention development as these variables also impact health outcomes.

ACTION TEAM FOCUS

The Health Systems (HS) Action Team supports the work of the Wisconsin Chronic Disease Prevention and Control Framework. The HS Action Team has representation from varied stakeholder organizations and agencies. Initial work of the team does not include full representation of groups though their participation in future years will be connected through workgroups, other Action teams, team-based patient-centered care and EHR as they evolve.

The HS Action team exists to address interventions of emerging evidence-based/ best practices, federal and state requirements, which will improve delivery and use of clinical/ community and other proactive services in order to prevent diseases detect diseases early; reduce or eliminate risk factors and mitigate and/or manage complications. Health Systems

interventions improve the clinical environment to more effectively deliver quality preventive services and help Wisconsinites effectively use and benefit from those services. The intention of the HS Action Team is to serve as a vehicle for partnership, collaboration, strengthening of communication, feedback, and technical expertise. Specific recommendations will be forwarded to the Leadership Group to advance and improve health outcomes.

Adoption of multiple approaches/interventions in sustainable health care settings by promoting policies, practices for team based and patient centered medical/health homes for patients with HTN and diabetes will be encouraged. The use of data and EHRs toward implementation of environmental approaches addressing underlying causes, early detection and management of chronic diseases; foster systems that support patient education to incorporate disease management and control through the use of self-management plans/apps/resources and education available toward healthy lifestyle choices.

PRIORITIES ***DRAFT***

1 Care within the health systems setting – Team- Based Care (patient- centered medical home)
2 Care transitions to community – Self Management Care with Clinical Support and community resources
3 Clinical Technical Assistance – Recommendations for Clinical Guidelines
4 System-based Care Utilizing EHR – HIT (improved health outcomes)

MEASURABLE OBJECTIVES OR INDICATORS

TO BE DETERMINED

IMPORTANT RESOURCES

1 DHS - Living Well with Chronic Conditions, plus many others
2 CDC - Million Hearts
3 American Heart Association
4 Diabetes: Centers for Disease Control and Prevention, www.cdc.gov/diabetes; American Diabetes Association, www.diabetes.org; National Diabetes Education Program, http://ndep.nih.gov/ or www.yourdiabetesinfo.org
5 MetaStar - Atrium website (Revisions pending)
6 WCHQ - Data
7 FDA - Consumer Health Information

ACTION TEAM PROGRESS

Plan | Implement | Communicate

	Actions	Timeline
Plan	Convene stakeholders, map assets and gaps	JUNE 2014
	Identify resources and potential strategies	JULY 2014
	Analyze, discuss & prioritize strategies	NOVEMBER 2014
	Collectively decide on priorities	NOVEMBER 2014
Implement	Develop action plan (objectives, milestones, accountability, how progress will be measured)	JANUARY 2015
	Implement action plan and monitor progress	JANUARY 2015
Communicate	Monitor and evaluate progress	THROUGHOUT THE YEAR – MILESTONE REPORTS PROVIDED AT EACH TEAM MEETING
	Communicate and promote results	JUNE 2015

SUPPORT THE ACTION TEAM – ACTION OPPORTUNITIES

1 Interested in both educational and financial resources which support the implementation of team-based care and self-management programs for chronic disease.
2 As people receive information of value related to chronic disease or the health systems setting, please forward to our attention so that we may disseminate and share information.
3 Workgroups will be formed and will offer opportunities for collaboration/participation to address specific interventions

ACTION TEAM POINT OF CONTACT

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ALIGNMENT WITH CDC CHRONIC DISEASE PREVENTION STRATEGIES AND MEASURES (1305)

Promote reporting of blood pressure and A1C measures; and as able, initiate activities that promote clinical innovations, team-based care, and self-monitoring of blood pressure

Proportion of health care systems reporting on National Quality Forum (NQF) Measure 18

A) Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance

B) Increase the institutionalization and monitoring of aggregated/ standardized quality measures at the provider and systems level

- Proportion of health care systems with EHRs appropriate for treating patients with high blood pressure
- Proportion of health care systems with EHRs appropriate for treating patients with diabetes
- Proportion of patients that are in health care systems that have EHRs appropriate for treating patients with high blood pressure
- Proportion of patients that are in health care systems that have EHRs appropriate for treating patients with diabetes
- Proportion of health care systems reporting on NQF18
- Proportion of health care systems reporting on NQF 59

Increase engagement of non-physician team members (i.e., nurses, pharmacists, and patient navigators) in hypertension (HTN) and diabetes management in health care systems

- Proportion of health care systems with policies or systems to encourage a multi-disciplinary team approach to blood pressure control
- Proportion of health care systems with policies or systems to encourage a multi-disciplinary team approach to A1C control
- Proportion of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to blood pressure control
- Proportion of patients that are in health care systems that have policies or systems to encourage a multi-disciplinary approach to A1C control

Increase use of self-measured blood pressure monitoring tied with clinical support

- Proportion of health care systems with policies or systems to encourage patient self-management of high blood pressure
- Proportion of patients that are in health care systems that have policies or systems to encourage patient self-management of high blood pressure
- Proportion of adults with high blood pressure in adherence to medication regimens
- Proportion of adults with patients with diabetes in adherence to medication regimens
- Proportion of patients with high blood pressure that have a self-management plan (may include medication adherence, self-monitoring of blood pressure levels, increased consumption of nutritious food and beverages, increased physical activity, maintaining medical appointments)
- Proportion of adults with known high blood pressure who have achieved blood pressure control
- Decreased proportion of PWD with A1C >9
- Age-adjusted hospital discharge rate for diabetes as any-listed diagnosis per 1,000 persons with diabetes