Initial business case for coordinated team-based care

Executive summary

August 19, 2016

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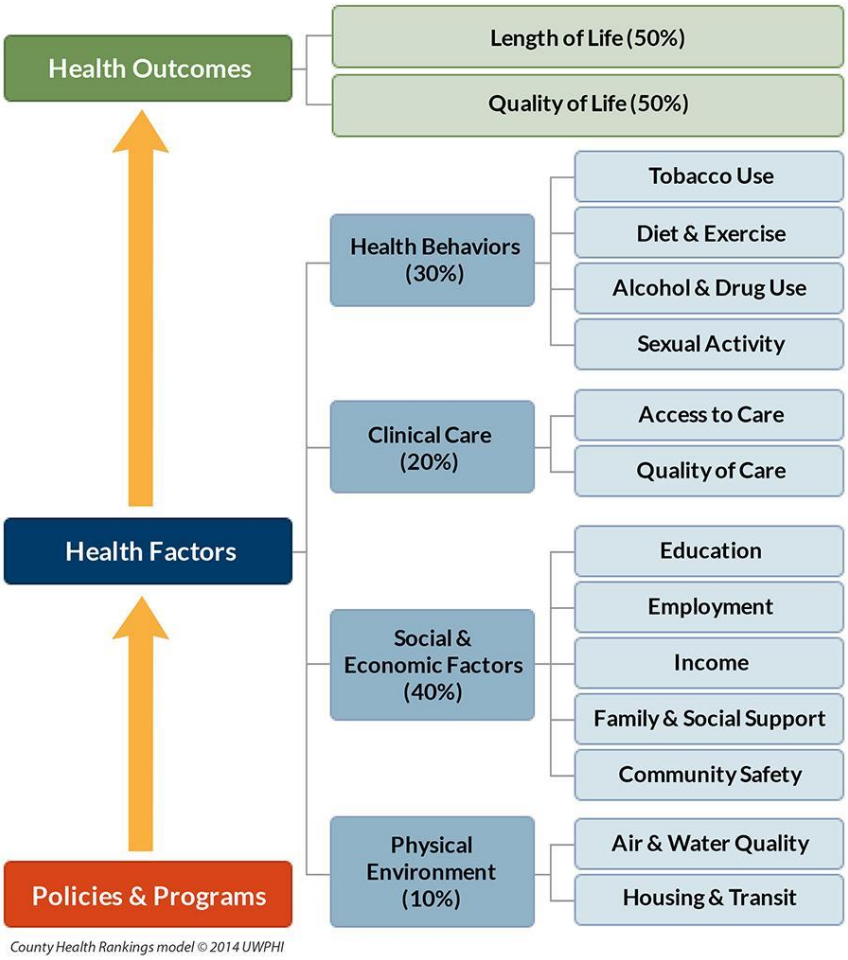
The United States spends more per capita on healthcare than many other Western countries, yet our health outcomes continue to lag behind. Similar to the rest of the nation, Wisconsin is challenged by a variety of health issues, driving costs into the billions of dollars annually. Meanwhile, patients 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 healthcare 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 developing 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 together across health issues. Children's Health Alliance of Wisconsin is facilitating this initiative and has organized a coordinated-team based care committee to prepare this business case.

The committee 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 patients. The following components are included in this business case:

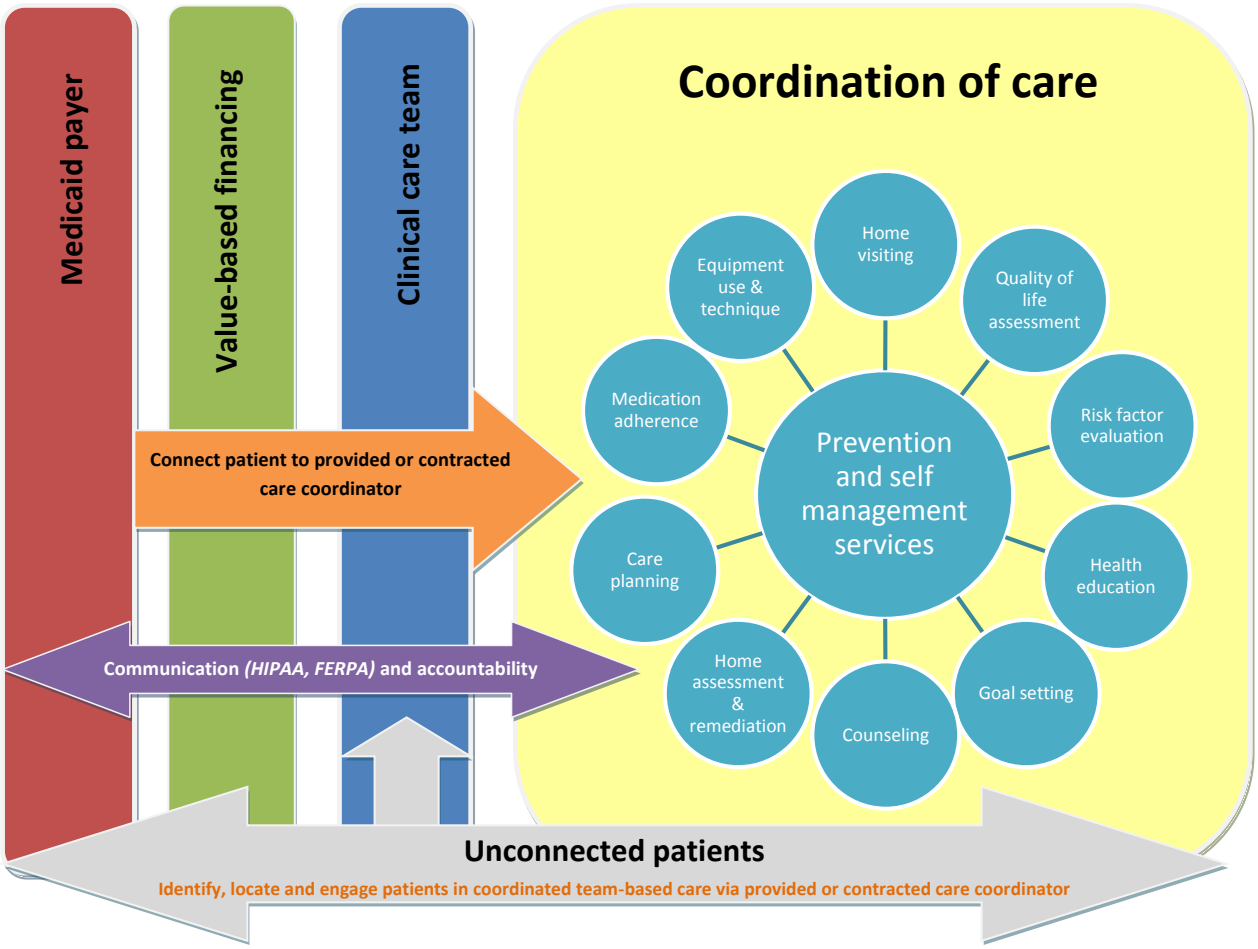
- Cause for concern in Wisconsin
- Proposed solution
- National and local evidence and return on investment (ROI)
- Capacity of resources and infrastructure available
- Financial impact and quality improvement

The evidence included throughout this initial 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. 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 on page 5 bridges the gap between clinical care services, and prevention and self-management services through value-based financing. Moving from left to right in the framework, the Medicaid payer (e.g., Medicaid fee-for-service, health plans, managed care organizations, direct contract) utilizes value-based financing to fund all the services needed to improve health outcomes, assuming the clinical care team functions as the team lead. The clinical care team is responsible for providing clinical services and "prescribing" needed prevention and self-management services. A care coordinator is responsible for working with patients to ensure they are connected to prescribed services. The care coordinator could be a member of, or contracted by, the clinical care team to provide coordination of care. The professionals providing prevention and self management services also could be part of, or contracted by, the clinical care team. Communication must occur throughout this process with respect to Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA). Also, accountability measures must be in place to ensure high-quality care is provided by all parties.

There is a subset of Medcaid patients who primarily use emergency care services and are not engaged in the larger health care system, thus driving increased costs and decreased health care outcomes. In this framework a care coordinator would be responsible for engaging these patients in clinical care and prevention and self-management services.

Coordinated team-based care framework



Our ultimate 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.