

WISCONSIN

Chronic Disease Quality Improvement Project

HEDIS® 2014 Summary Data





The Wisconsin Chronic Disease Quality Improvement Project is a collaborative partnership led by the University of Wisconsin Population Health Institute and the Wisconsin Department of Health Services, Division of Public Health, Bureau of Community Health Promotion, Chronic Disease Prevention Unit.

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Grant Funding

This project receives funding through the Wisconsin Department of Health Services, which was awarded a cooperative agreement from the Centers for Disease Control and Prevention to support states' efforts to promote health and to prevent and control chronic diseases and their risk factors. The funding supports implementation of evidence- and practice-based approaches to improve nutrition and physical activity, reduce obesity, prevent and control diabetes, and prevent and control heart disease and stroke with a focus on high blood pressure. Strategies are implemented within and across three domains: environmental approaches that promote health, health systems interventions, and community-clinical linkages. Strategies are designed to reach large segments of the population in partnership with a variety of organizations and inclusive of high-risk populations. Ultimately, targeted long-term grant outcomes include improved prevention and control of hypertension, diabetes, and overweight and obesity.

A Collaborative Partnership

The Wisconsin Chronic Disease Quality Improvement Project is a collaborative partnership that aims to improve care for and prevention of prevalent chronic diseases and their common risk factors, including hypertension, diabetes, and overweight and obesity. The group has diverse membership, including health plans, Wisconsin's chronic disease prevention and Medicaid programs, the University of Wisconsin Population Health Institute, and others working to prevent chronic disease across Wisconsin and improve the quality of care for those living with chronic disease. Forming and maintaining strong, active partnerships is a key component of the project. Members collaborate to improve the quality of chronic disease care and prevention.

The project is now in its sixteenth year. It began in 1998 as the Wisconsin Collaborative Diabetes Quality Improvement Project, with an initial focus on diabetes. Over the years, the focus expanded to include additional chronic diseases and their risk factors, and in 2013 the group was renamed the Wisconsin Chronic Disease Quality Improvement Project. This reflects an understanding of the benefit of a coordinated approach to chronic disease, since many chronic diseases and risk factors are interrelated.

Project Components

Evaluate and report on the quality of chronic disease prevention and care provided.

Quality of care data is voluntarily submitted by participating health plans, and it is analyzed and reported by the University of Wisconsin Population Health Institute. Each year, members review the data and use it to inform the group's work.

Share information, population-based strategies, and best practices. Members meet regularly to share information, discuss evidence-based approaches and best practices, and plan initiatives. The project provides a forum for sharing among health plans and other partners.

Collaborate to improve chronic disease care and prevention through quality improvement initiatives. Members work together to improve the quality of chronic disease care and prevention in Wisconsin. Data, evidence, and practices shared within the group are used to inform quality improvement efforts.



A GLIMPSE OF OUR PAST

1997-1998

The **Diabetes Advisory Group** is established and develops the Wisconsin Diabetes Mellitus Essential Care Guidelines. A HMO quality improvement workgroup is convened and begins using HEDIS® diabetes measures to evaluate implementation of the Guidelines.

2000

As the **Wisconsin Collaborative Diabetes Quality Improvement Project**, the group publishes its first annual report summarizing the HEDIS® results.

2001

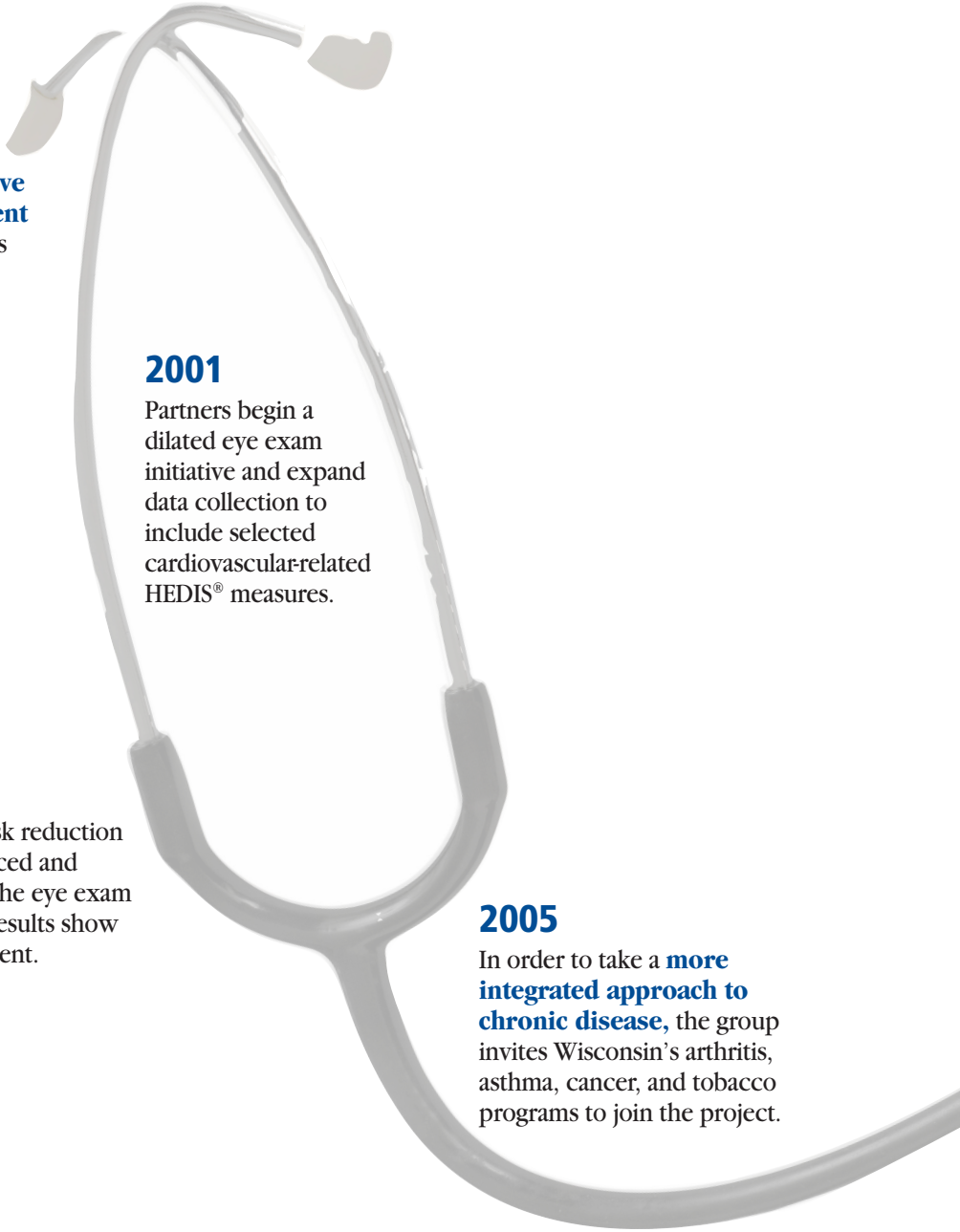
Partners begin a dilated eye exam initiative and expand data collection to include selected cardiovascular-related HEDIS® measures.

2004

A cardiovascular risk reduction initiative is introduced and partners continue the eye exam initiative. HEDIS® results show ongoing improvement.

2005

In order to take a **more integrated approach to chronic disease**, the group invites Wisconsin's arthritis, asthma, cancer, and tobacco programs to join the project.



2006

Wisconsin is recognized as the **top-performing state for three HEDIS® diabetes measures**. An eye exam DVD is produced and distributed in partnership with the Wisconsin Lions Foundation.

2009

Partners distribute vision simulator cards and letters to providers as part of the eye exam initiative, and they also discuss kidney disease and chronic disease self-management. Wisconsin is chosen as one of four states to participate in a **CDC chronic disease program integration pilot** and programs create a joint chronic disease work plan.

2013

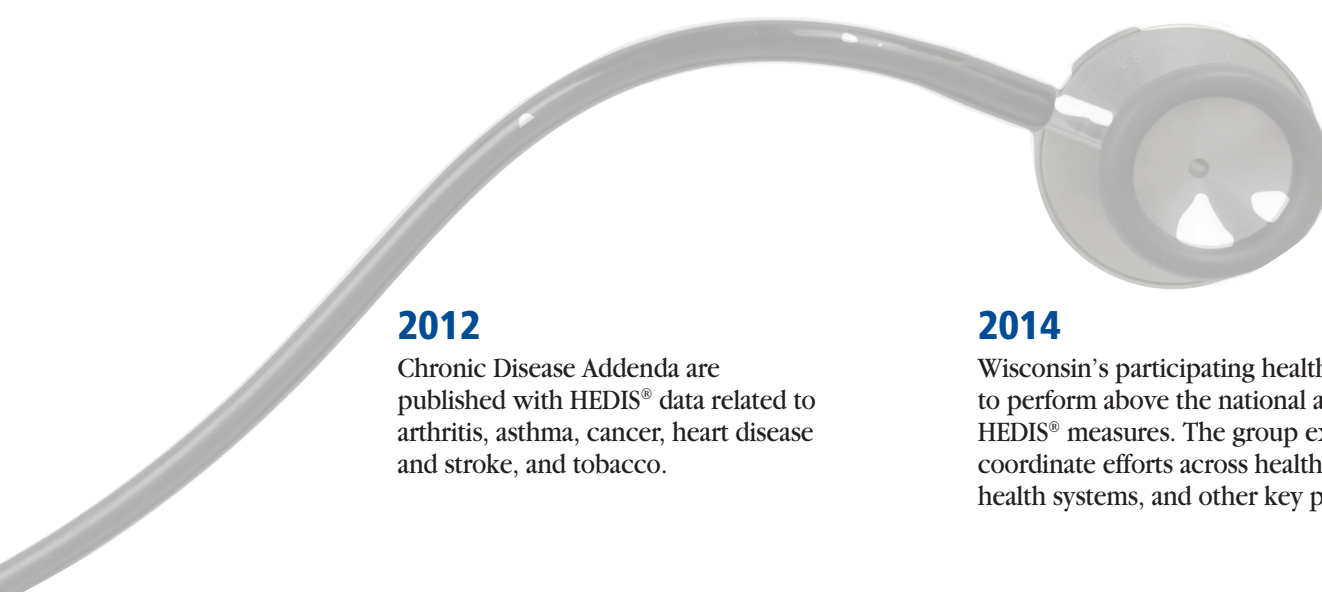
Recognizing the importance of a more coordinated approach to chronic disease, the group becomes the **Wisconsin Chronic Disease Quality Improvement Project** and continues to collect HEDIS® data for a variety of measures related to chronic diseases and their risk factors.

2012

Chronic Disease Addenda are published with HEDIS® data related to arthritis, asthma, cancer, heart disease and stroke, and tobacco.

2014

Wisconsin's participating health plans continue to perform above the national average on many HEDIS® measures. The group explores how to coordinate efforts across health plans, providers, health systems, and other key partners.



What is Chronic Disease?

According to the Wisconsin Department of Health Services, chronic diseases are “illnesses that last a long time, do not go away on their own, are rarely cured, and often result in disability later in life.”¹ The chronic diseases discussed in this report include diabetes, cardiovascular disease, cancer, obesity, asthma, rheumatoid arthritis, and depression.

Why are Chronic Diseases Important to Wisconsin?

High Impact

Chronic diseases affect many people. About 10% of adults in Wisconsin have diagnosed or undiagnosed diabetes.¹ Cardiovascular disease is common; results from the 2013 Behavioral Risk Factor Survey (BRFS) showed that 4% of adults in Wisconsin have coronary heart disease or angina, 4% have had a myocardial infarction, and 2% have had a stroke.² Cancer is also widespread, with 29,906 new cases of cancer diagnosed in Wisconsin in 2012.³

Chronic diseases cause the majority of deaths in Wisconsin, as well as significant pain, suffering, and disability. Seven of Wisconsin’s ten leading causes of death are chronic diseases. See Figure 2. Heart disease and cancer are the leading causes of death, and together they cause almost half of the deaths each year.⁴ Chronic diseases also cause significant morbidity. For example, stroke is a leading cause of serious long-term disability.⁵

Chronic diseases are costly. An estimated 80% of annual healthcare spending in the United States goes toward treatment of chronic diseases.⁶ The American Diabetes Association estimated that, nationally, one in every five healthcare dollars is spent on healthcare for diabetes and its complications.⁷ In addition to direct medical costs, there are significant indirect costs to individuals, private sector employers, and the government, such as lost wages and productivity.⁶

Shared, Modifiable Risk Factors

Chronic diseases can be prevented by focusing on a set of shared, modifiable risk factors. Nutrition, physical activity, and tobacco exposure are risk factors for many chronic diseases. Some risk factors, like genetics or age, cannot be changed – but nutrition, activity level, and tobacco use can be changed.⁶

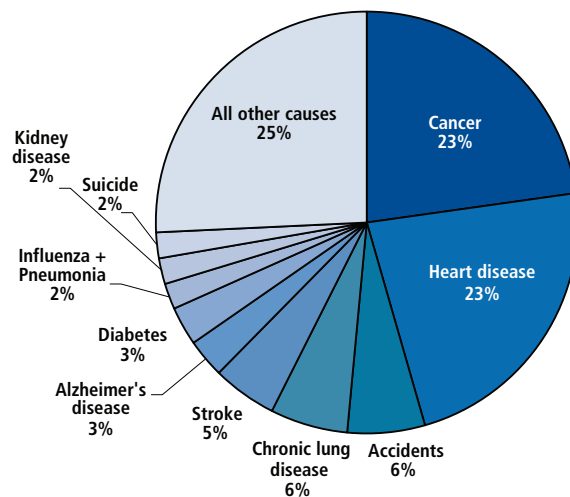
Many people are exposed to risk factors for chronic disease. BRFS data from 2013 showed that 67% of adults in Wisconsin were overweight or obese. About a quarter reported no leisure-time physical activity in the past month, and adults’ fruit and vegetable consumption was low.² Tobacco use is declining, but in 2013, 19% of Wisconsin adults were current smokers and 27% were former smokers.²

Opportunity to Make a Difference

These shared, modifiable risk factors have a huge effect on chronic disease. The American Cancer Society estimated that diet, physical activity, and overweight/obesity contribute to one third of cancer deaths in the United States, and that tobacco use is responsible for 87% of lung cancers.⁸ The World Health Organization estimated that eliminating these risk factors would prevent at least 80% of all heart disease, stroke, and diabetes, plus over 40% of all cancers.⁹

Prevention strategies can affect multiple chronic diseases. Because chronic diseases are interrelated and share risk factors, prevention strategies can potentially have a big impact on multiple health outcomes. There is an opportunity to make a major difference by implementing targeted, evidence-based approaches to prevent chronic disease and improve the quality of care.

Figure 2: Top Ten Causes of Death in Wisconsin



Data Collection and Analysis

The Chronic Disease Quality Improvement Project uses data provided voluntarily by participating health plans to examine performance on quality measures related to chronic disease. Plans submit data for selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS®), developed by the National Committee for Quality Assurance (NCQA). NCQA uses HEDIS® data to accredit health plans and evaluate the quality of care. NCQA's programs are voluntary but widely used, so this data was readily available for the Project to use. Use of HEDIS® measure specifications allows for standardized data collection, direct comparison of performance, and examination of trends over time.

Twelve Wisconsin health plans submitted HEDIS® 2014 data for care provided in 2013. Data was collected and analyzed for the measures listed at right, using NCQA's HEDIS® measure specifications.^{10, 11} To facilitate comparison between plans and with state and national data, figures in this report include:

HEDIS® 2014 Commercial Rate: This is each plan's percentage for care provided in 2013. These rates are submitted directly by plans.

Wisconsin Average: This is the average percentage for all of the participating plans that submitted data for care provided in 2013. The numerators and denominators that plans submitted are totaled and used to calculate this state-level average.

National Average: This is the nationwide average percentage for care provided in 2013 by commercial health maintenance organizations (HMOs). It comes from NCQA's *The State of Health Care Quality 2014* report.¹²

National 90th Percentile: This is the national 90th percentile for care provided in 2013 by commercial HMOs. It comes from NCQA's *The State of Health Care Quality 2014* report.¹²

HEDIS® 2014 Measures Collected by the Chronic Disease Quality Improvement Project

Comprehensive Diabetes Care

- LDL Cholesterol Control (<100 mg/dL)
- Blood Pressure Control (<140/80 mmHg)
- Blood Pressure Control (<140/90 mmHg)
- HbA1c Control (<7.0% for a Selected Population)
- HbA1c Control (<8.0%)
- Poor HbA1c Control (>9.0%)
- Retinal Eye Examination
- Medical Attention for Nephropathy
- LDL Cholesterol Screening
- HbA1c Testing

Cardiovascular Care

- Controlling High Blood Pressure (<140/90 mmHg)
- LDL Cholesterol Control (<100 mg/dL)
- Persistence of Beta-Blocker Treatment after Heart Attack
- LDL Cholesterol Screening
- Annual Monitoring for Members on Diuretics
- Annual Monitoring for Members on ACE-Is or ARBs

Cancer Screening

- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Non-Recommended Cervical Cancer Screening

Weight Assessment and Counseling

- Child/Adolescent BMI Percentile Documentation
- Child/Adolescent Counseling for Physical Activity
- Child/Adolescent Counseling for Nutrition
- Adult BMI Documentation

Smoking and Tobacco Use Cessation

- Discussing Smoking Cessation Medications
- Discussing Smoking Cessation Strategies
- Advising Smokers and Tobacco Users to Quit

Asthma Care

- Use of Appropriate Medications for People with Asthma

Antidepressant Medication Management

- Effective Acute Phase Treatment (12 weeks)
- Effective Continuation Phase Treatment (6 months)

Rheumatoid Arthritis

- DMARD Therapy for Rheumatoid Arthritis

Health Plans that Submitted Data for this Report

Twelve health plans from around the state voluntarily submitted HEDIS® 2014 data for this report. The locations of the plans' Wisconsin offices are shown on the map in Figure 1; note that most plans offer coverage in multiple counties.

The plans that submitted data are:

- Anthem Blue Cross and Blue Shield of Wisconsin - Waukesha
- Dean Health Plan - Madison
- Group Health Cooperative of Eau Claire - Eau Claire
- Group Health Cooperative of South Central Wisconsin - Madison
- Gundersen Health Plan - La Crosse
- Health Tradition Health Plan - La Crosse
- Humana Wisconsin Health Organization Insurance Corporation - Waukesha
- MercyCare Health Plans - Janesville
- Physicians Plus Insurance Corporation - Madison
- Security Health Plan of Wisconsin - Marshfield
- UnitedHealthcare of Wisconsin - Green Bay
- Unity Health Plans Insurance Corporation - Sauk City



Figure 1: Health Plans that Submitted HEDIS® 2014 Data.

② Number of providers in city

COMPREHENSIVE DIABETES CARE

HEDIS® 2014 data was collected for ten Comprehensive Diabetes Care measures for members with diabetes between the ages of 18-75 years. Results are summarized in Table 1 and Figures 3a-3h.

Outcome Measures:

Six outcome measures were used to examine control of hemoglobin A1c (HbA1c), cholesterol, and blood pressure levels among adult members with diabetes. Controlling blood glucose levels is a cornerstone of diabetes care, and the HbA1c level represents average blood glucose levels over several months.¹³ The American Diabetes Association reports that reducing HbA1c levels can lower the risk of many diabetes complications, with specific target values based on patient characteristics.¹³ Cardiovascular disease is a major contributor to morbidity and mortality for people with diabetes, and hypertension and dyslipidemia are frequent co-morbidities. The American Diabetes Association recommends blood pressure and cholesterol control to lower the risk of cardiovascular disease.¹³

Four process measures were used to assess whether members with diabetes received recommended care - HbA1c testing, cholesterol screening, medical attention for nephropathy, and retinal eye examinations. Diabetic retinopathy is a potential complication that can lead to blindness if untreated, and regular retinal eye examinations are recommended.¹³ Another potential complication is nephropathy, which occurs in 20-40% of people with diabetes and is the leading cause of end-stage renal disease.¹³ Risk can be reduced through glycemic and blood pressure control, and screening and medical intervention is essential.¹³



Table 1: HEDIS® 2014 Comprehensive Diabetes Care Measures

Measure	Wisconsin Plans' Range	Wisconsin Plans' Average	National Average	National 90th Percentile
Outcome Measures				
HbA1c Control (<7.0% for a Selected Population)	36-50%	43%	40%	47%
HbA1c Control (<8.0%)	59-73%	66%	59%	69%
Poor HbA1c Control (>9.0%) – Lower % desired	16-31%	22%	31%	19%
Blood Pressure Control (<140/80 mmHg)	49-66%	56%	43%	57%
Blood Pressure Control (<140/90 mmHg)	70-84%	76%	65%	78%
LDL Cholesterol Control (<100 mg/dL)	47-65%	54%	47%	57%
Process Measures				
HbA1c Testing	90-96%	94%	90%	95%
LDL Cholesterol Screening	83-90%	87%	85%	90%
Retinal Eye Examination	54-75%	67%	56%	74%
Medical Attention for Nephropathy	86-94%	90%	85%	91%

Figure 3a: HbA1c Control (<8.0%). The percentage of members 18-75 years of age with diabetes whose most recent HbA1c level is less than 8.0%.

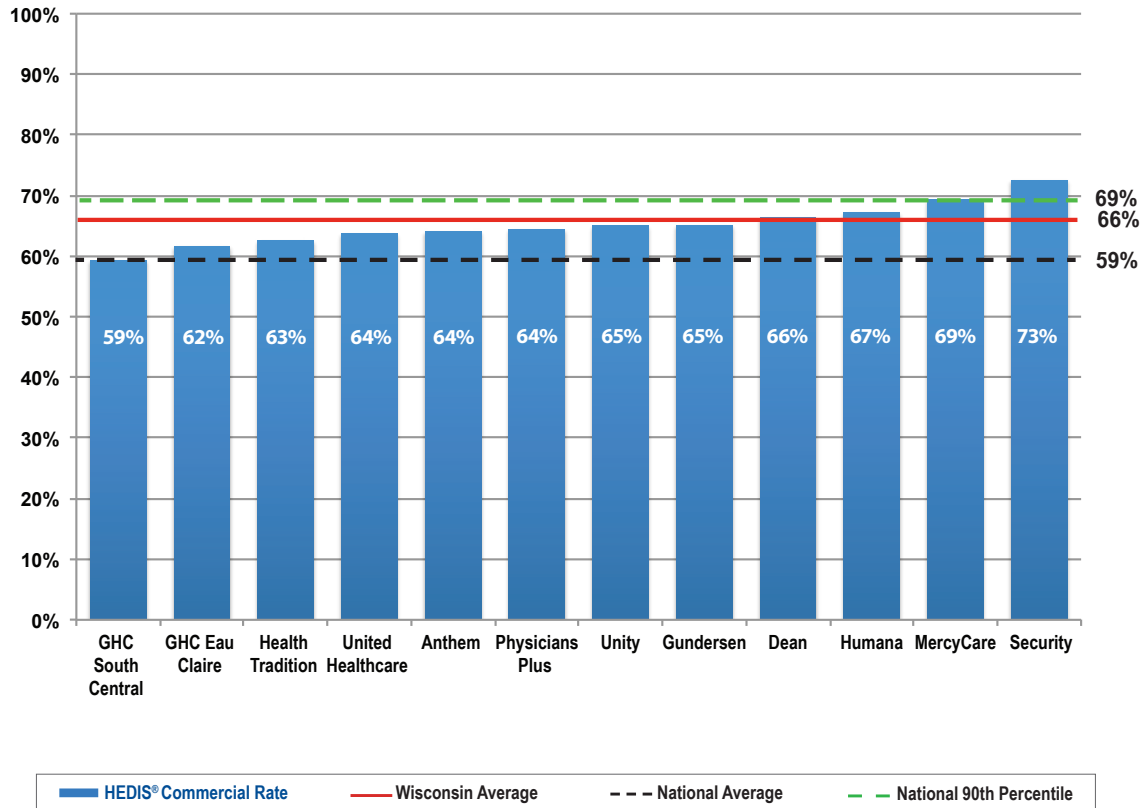


Figure 3b: Poor HbA1c Control (>9.0%). The percentage of members 18-75 years of age with diabetes whose most recent HbA1c level is greater than 9.0%. Lower rate desired.

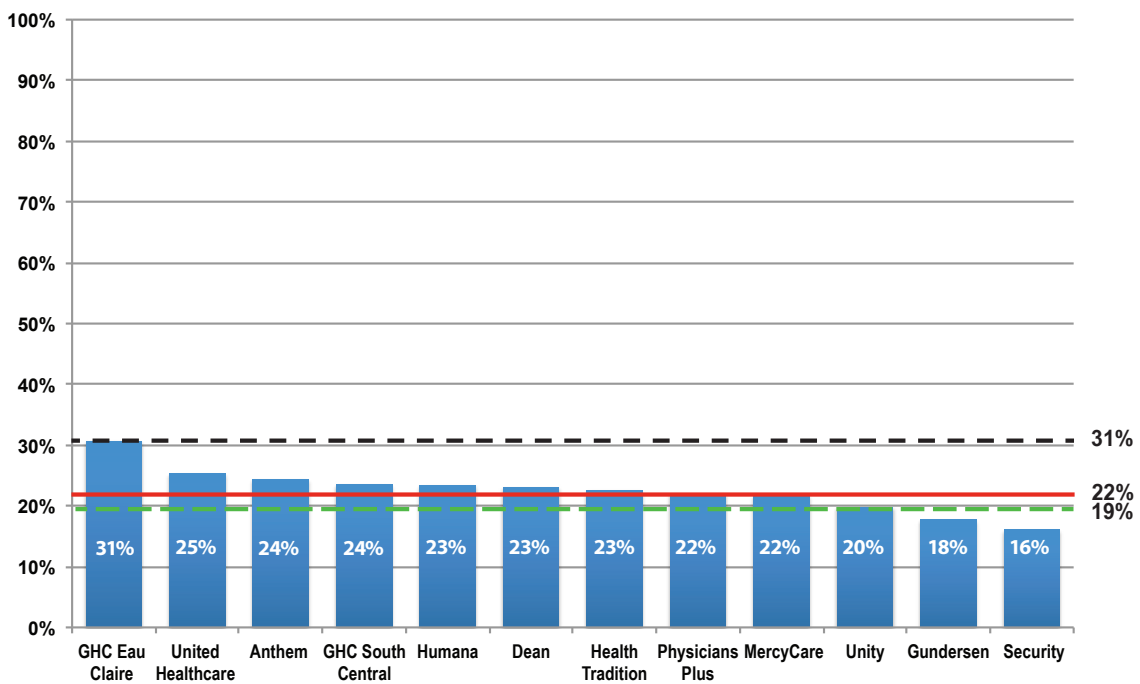


Figure 3c: Blood Pressure Control (<140/90 mmHg). The percentage of members 18-75 years of age with diabetes whose most recent blood pressure is less than 140/90 mmHg.

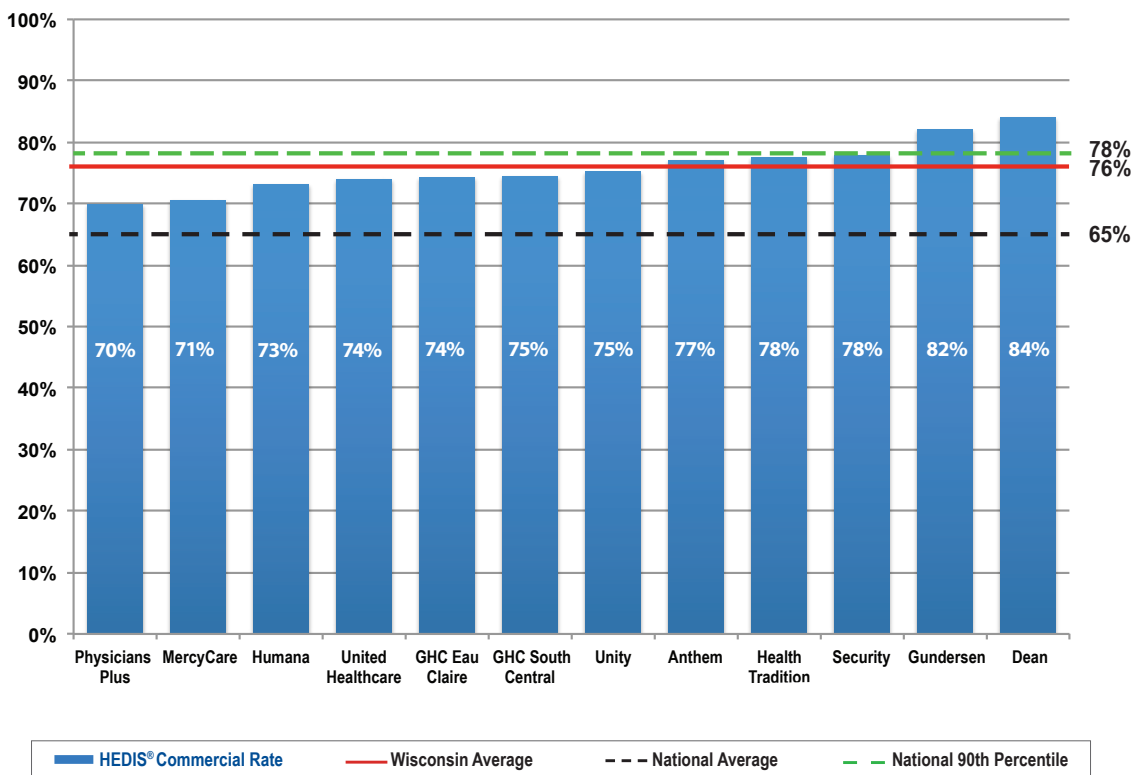


Figure 3d: LDL Cholesterol Control (<100 mg/dL). The percentage of members 18-75 years of age with diabetes whose most recent LDL cholesterol is less than 100 mg/dL.

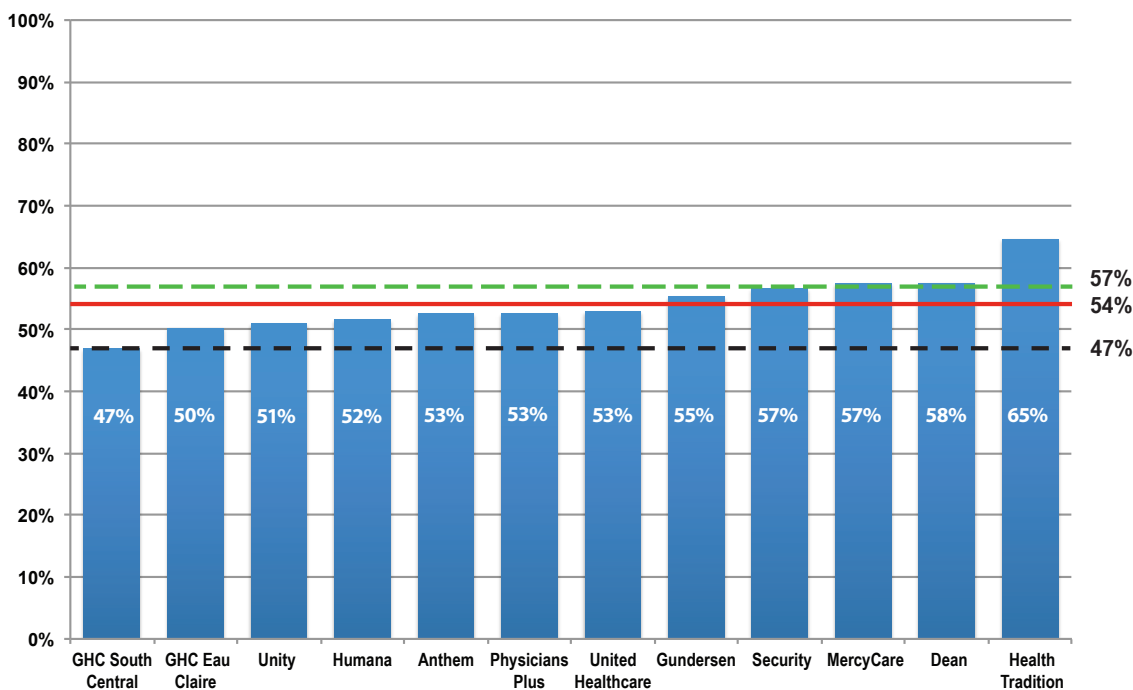


Figure 3e: HbA1c Testing. The percentage of members 18-75 years of age with diabetes who had a HbA1c test performed during the measurement year.

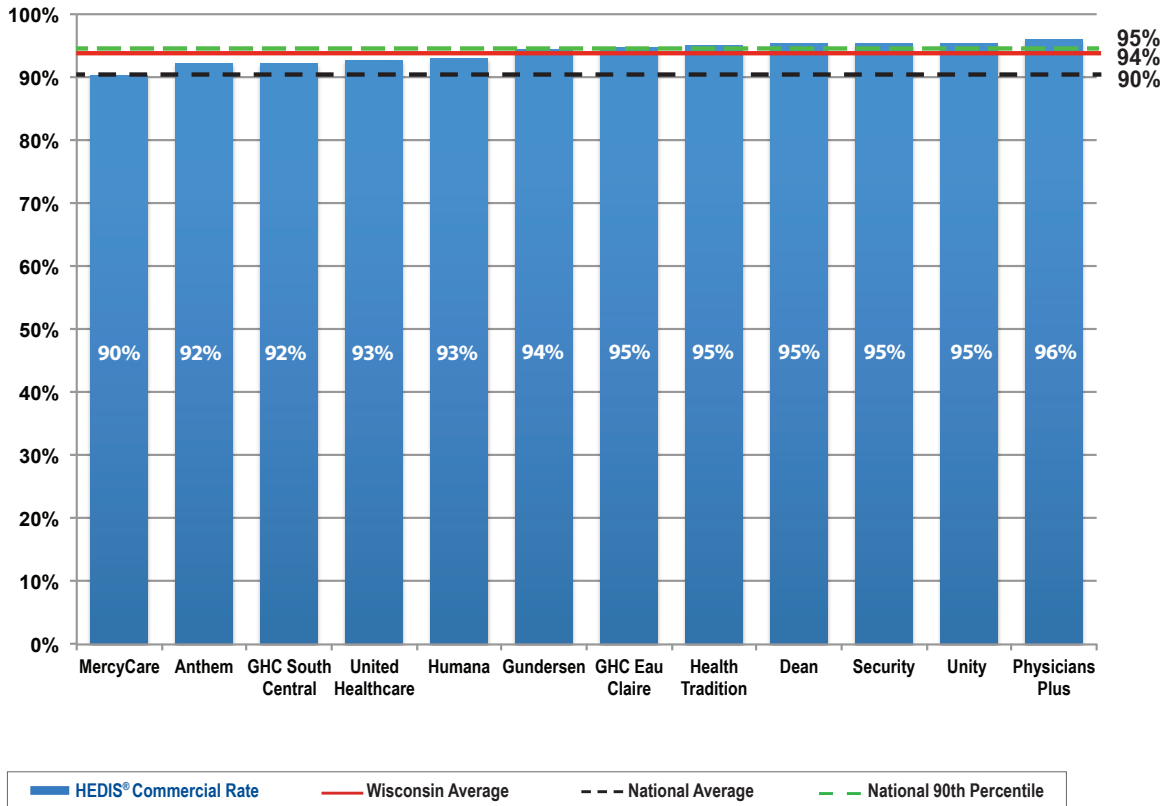


Figure 3f: LDL Cholesterol Screening. The percentage of members 18-75 years of age with diabetes who had an LDL cholesterol screening test performed during the measurement year.

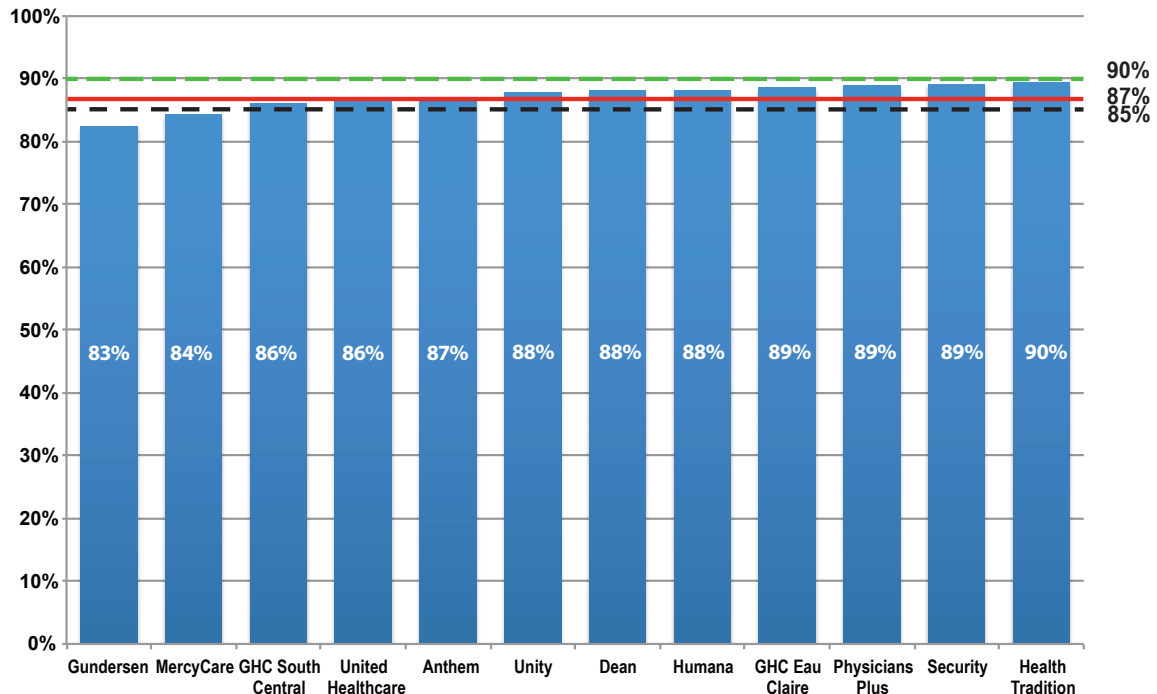


Figure 3g: Retinal Eye Exam. The percentage of members 18-75 years of age with diabetes who had an eye screening for diabetic retinal disease performed by an eye care professional.

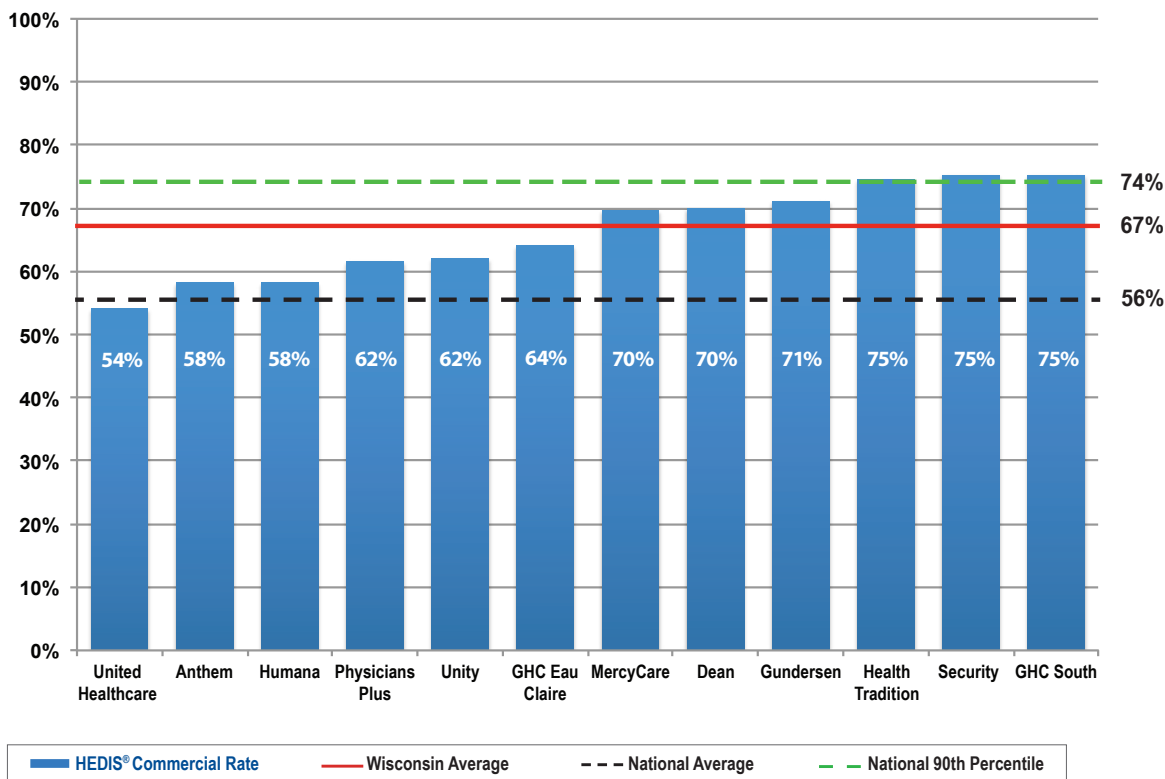
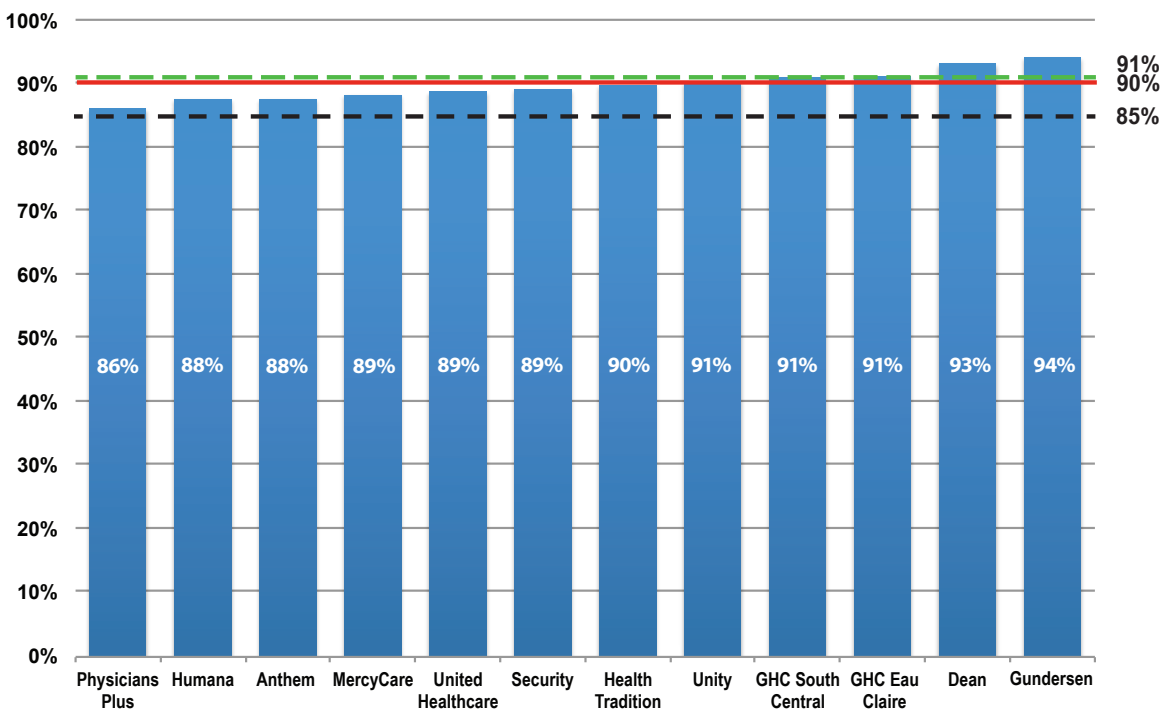


Figure 3h: Medical Attention for Nephropathy. The percentage of members 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy.



CARDIOVASCULAR CARE

Outcome Measures:

HEDIS® 2014 outcome measures were used to examine control of two cardiovascular risk factors, blood pressure and LDL cholesterol. While the Comprehensive Diabetes Care measures looked at these outcomes among adults with diabetes, these measures look at a broader population of members. Blood pressure control was assessed for all 18-85 year old members, and LDL cholesterol control was assessed for 18-75 year old members with cardiovascular conditions. Results are summarized in Table 2 and Figures 4a-4b.

Both blood pressure and cholesterol are risk factors for cardiovascular disease. High blood pressure leads to increased incidence of and mortality from both ischemic heart disease and stroke.^{14, 15} National guidelines issued in the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC-7) recommend a target blood pressure of less than 140/90 mmHg for the general public and more stringent guidelines for those with higher risk.^{14, 15} Dyslipidemia, reflected in abnormal cholesterol and lipid levels, is another risk factor that is important in both primary and secondary prevention of cardiovascular disease.¹⁶

Process Measures:

Data was also collected for four HEDIS® 2014 process measures related to care for members with cardiovascular conditions. One measure assessed whether members with cardiovascular conditions received cholesterol screening. Another measure examined persistence of beta-blocker use after a myocardial infarction. Two measures looked at whether members received annual monitoring if they were taking certain medications that are frequently prescribed to people with hypertension – diuretics and Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs). Results for these four measures are summarized in Table 2.

Table 2: HEDIS® 2014 Cardiovascular Care Measures

Measure	Wisconsin Plans' Range	Wisconsin Plans' Average	National Average	National 90 th Percentile
Outcome Measures				
Controlling Blood Pressure (<140/90 mmHg)	62-82%	72%	64%	77%
LDL Cholesterol Control (<100 mg/dL) for Patients with Cardiovascular Conditions	56-74%	66%	58%	71%
Process Measures				
LDL Cholesterol Screening for Patients with Cardiovascular Conditions	83-93%	88%	87%	92%
Persistence of Beta-Blocker Treatment After a Heart Attack	77-93%	87%	84%	92%
Annual Monitoring - Patients on Diuretics	80-87%	83%	83%	87%
Annual Monitoring - Patients on ACE-Is or ARBs	80-87%	83%	83%	88%

Figure 4a: Controlling Blood Pressure. The percentage of members 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mmHg).

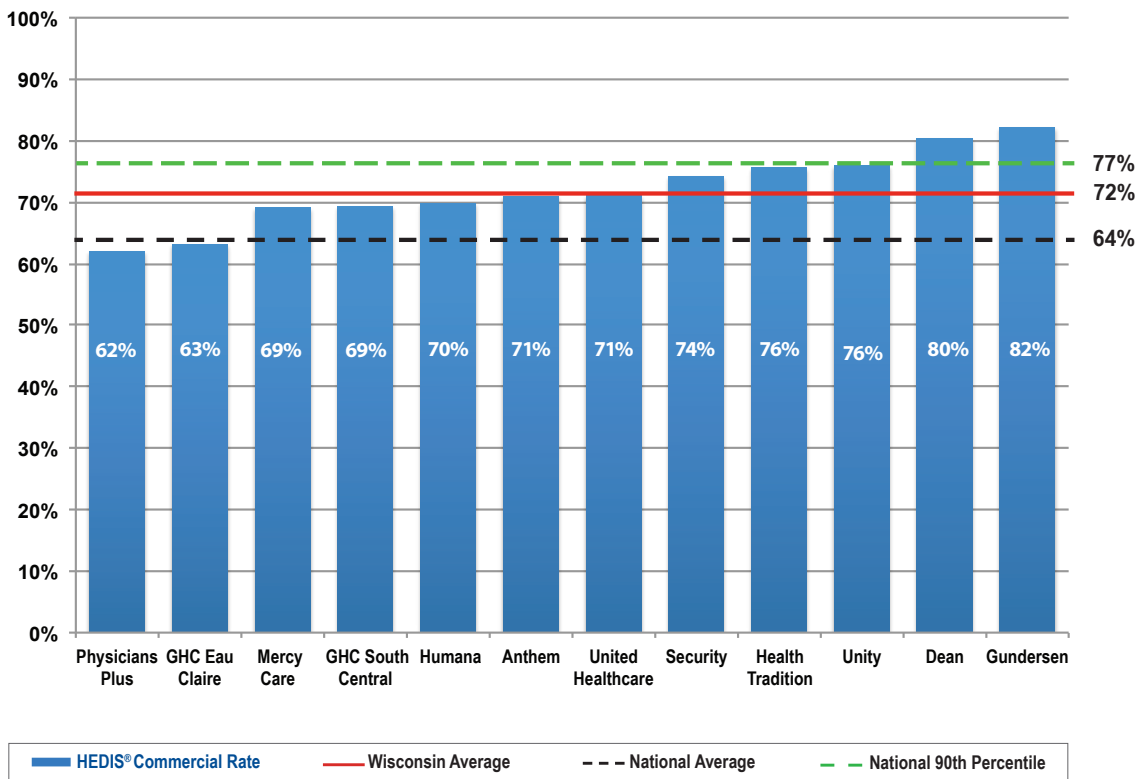
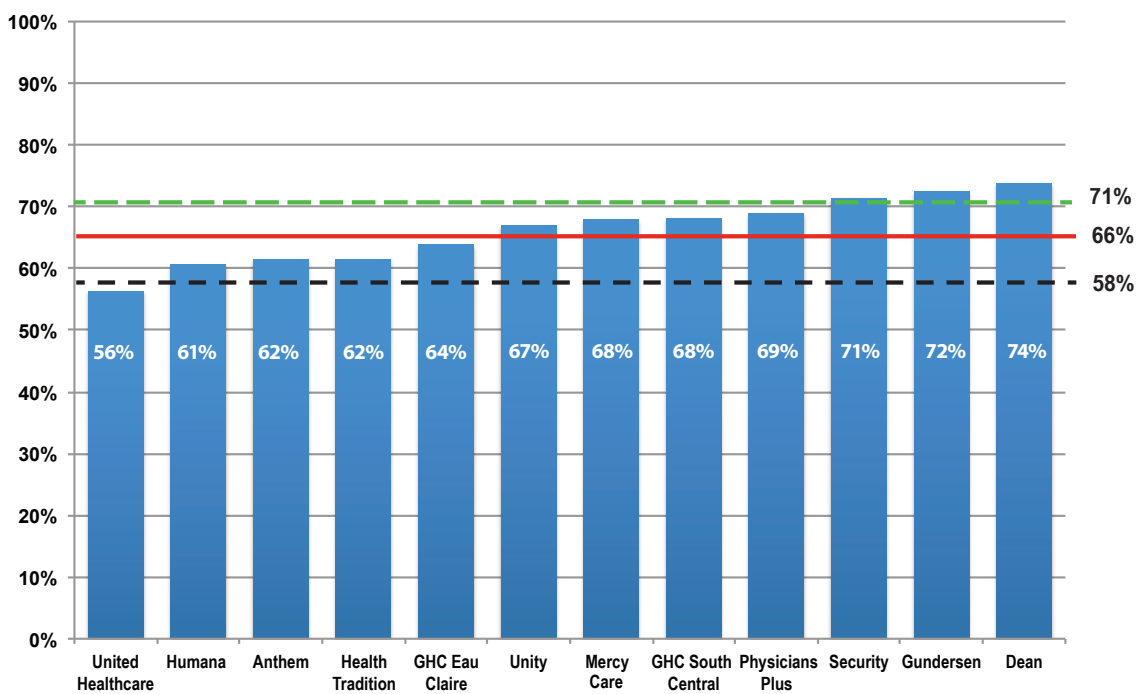


Figure 4b: LDL Cholesterol Control (<100 mg/dL). The percentage of members 18-75 years of age with cardiovascular conditions whose most recent LDL Cholesterol is less than 100 mg/dL.



CANCER SCREENING

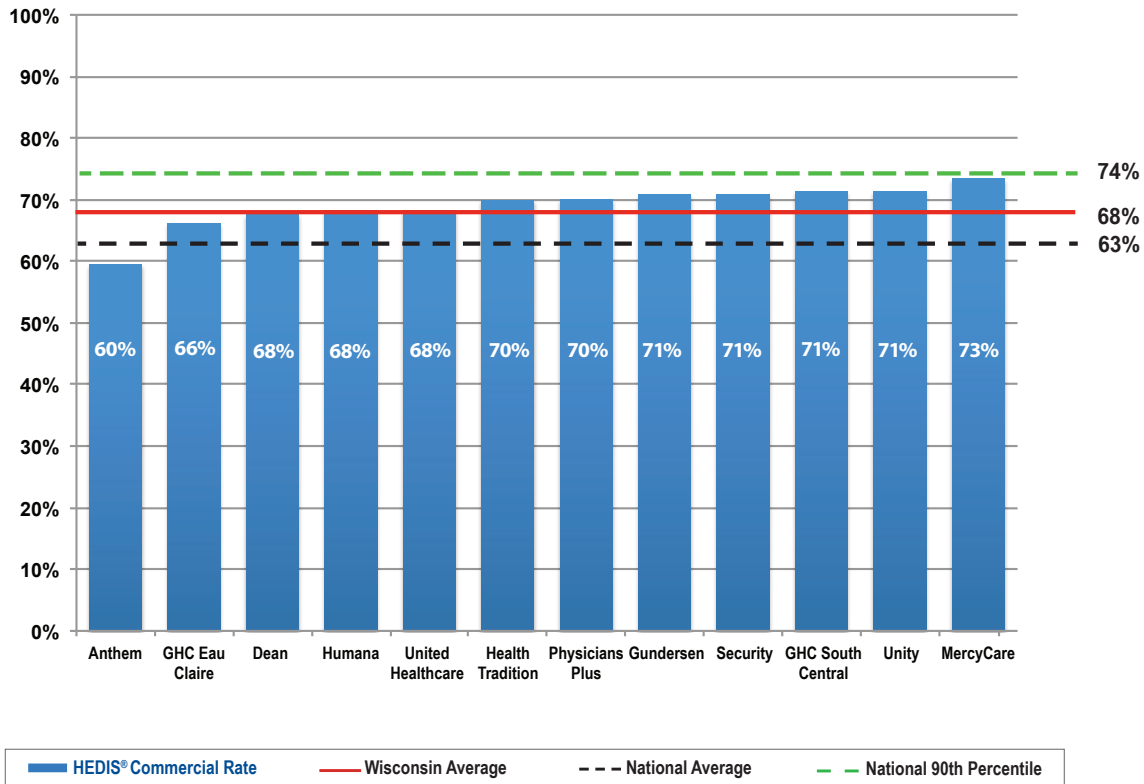
HEDIS® 2014 data was collected regarding colorectal and breast cancer screening. Early detection and treatment of both of these cancers can lead to better outcomes and decreased mortality.^{17, 18}

The United States Preventive Services Task Force recommends routine screening for colorectal cancer beginning at age 50 and screening mammography for breast cancer for women ages 50-74.^{17, 18} Plans submitted data for two HEDIS® 2014 measures to evaluate the percentage of members that received recommended screening for colorectal and breast cancer. See Table 3 and Figures 5a-5b for results.

Table 3: HEDIS® 2014 Cancer Screening Measures

Measure	Wisconsin Plans' Range	Wisconsin Plans' Average	National Average	National 90 th Percentile
Colorectal Cancer Screening	60-73%	68%	63%	74%
Breast Cancer Screening	68-85%	76%	74%	82%

Figure 5a: Colorectal Cancer Screening. The percentage of members 50-75 years of age who had appropriate screenings for colorectal cancer.



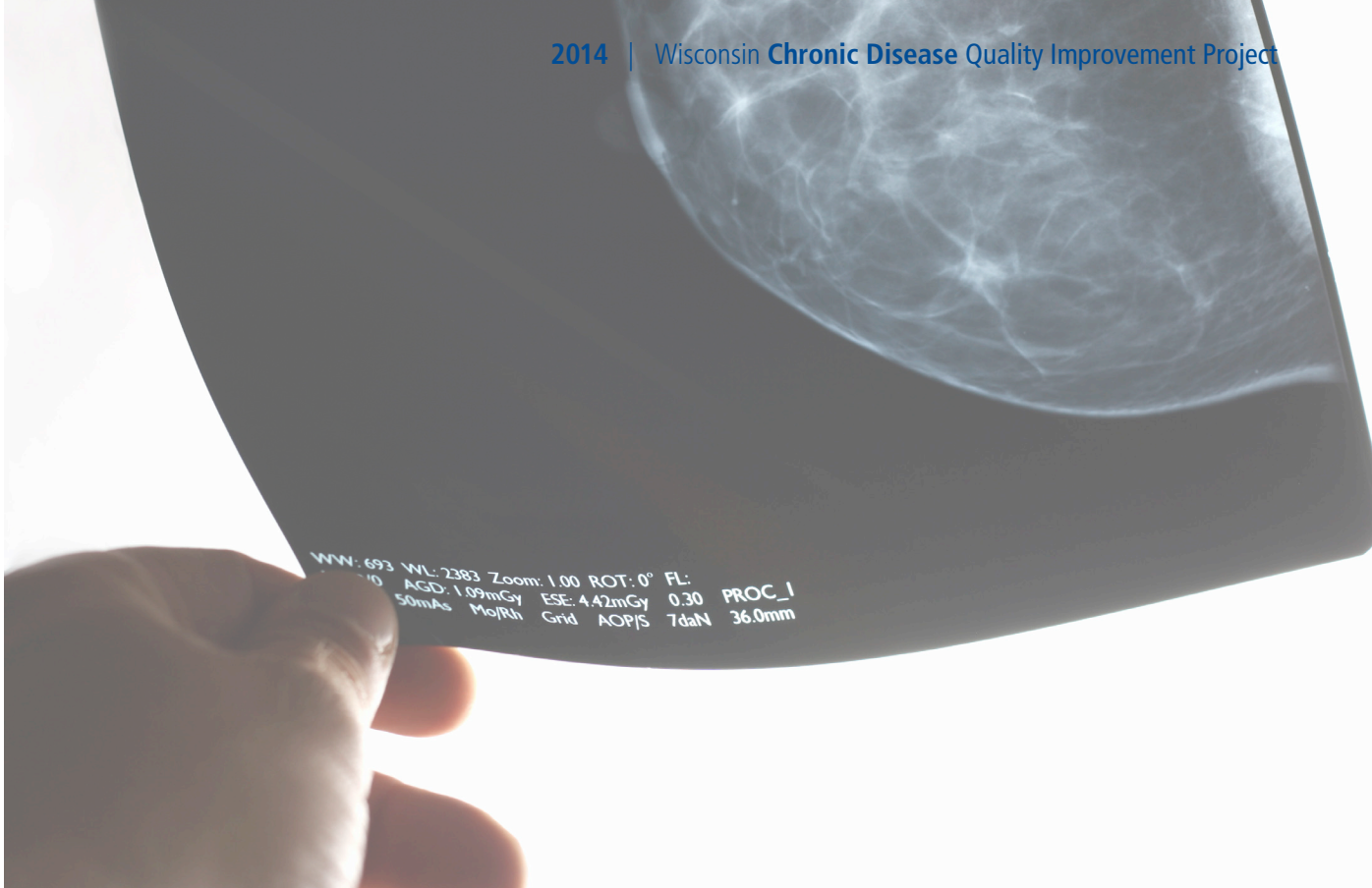
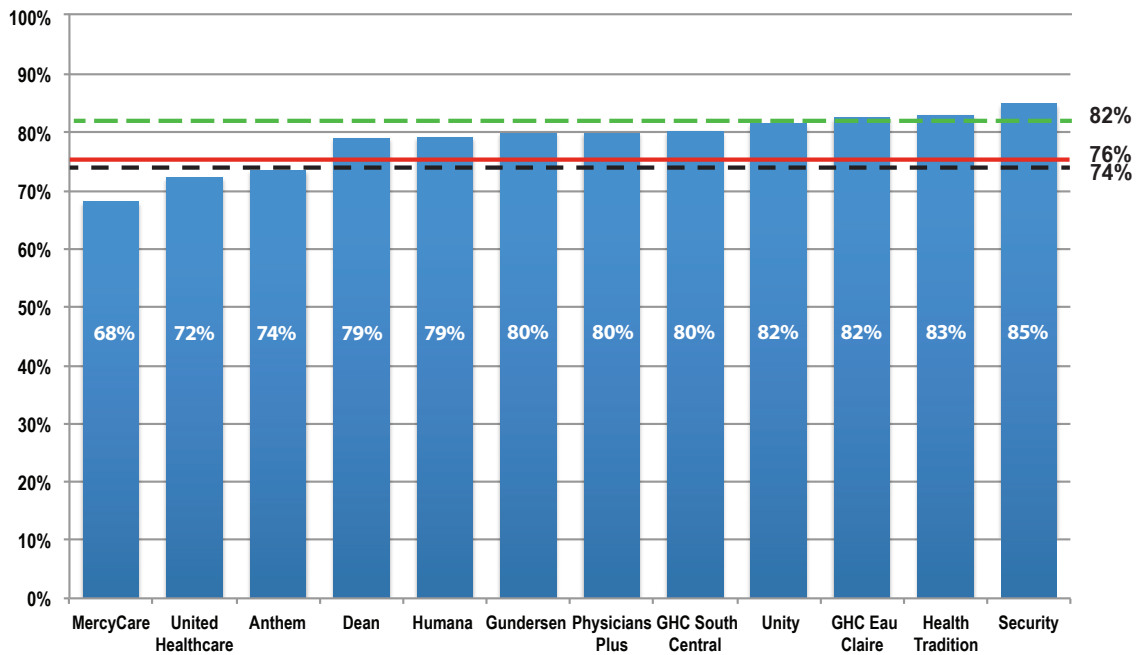


Figure 5b: Breast Cancer Screening. The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.



WEIGHT ASSESSMENT & COUNSELING

Weight, nutrition, and physical activity all affect the risk of chronic disease, and overweight and obesity are themselves chronic conditions. Data was collected for four HEDIS® 2014 process measures related to weight assessment and counseling. Two measures looked at the percentage of members whose body mass index (BMI) was documented, for adults and for children and adolescents. Two other measures were used to evaluate the percentage of children and adolescents with documentation of counseling for nutrition and physical activity. Results are summarized in Table 3, with detailed results in Figures 6a-6b for the two BMI measures.



Figure 6a: Adult BMI Assessment. The percentage of members 18-74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or year prior.

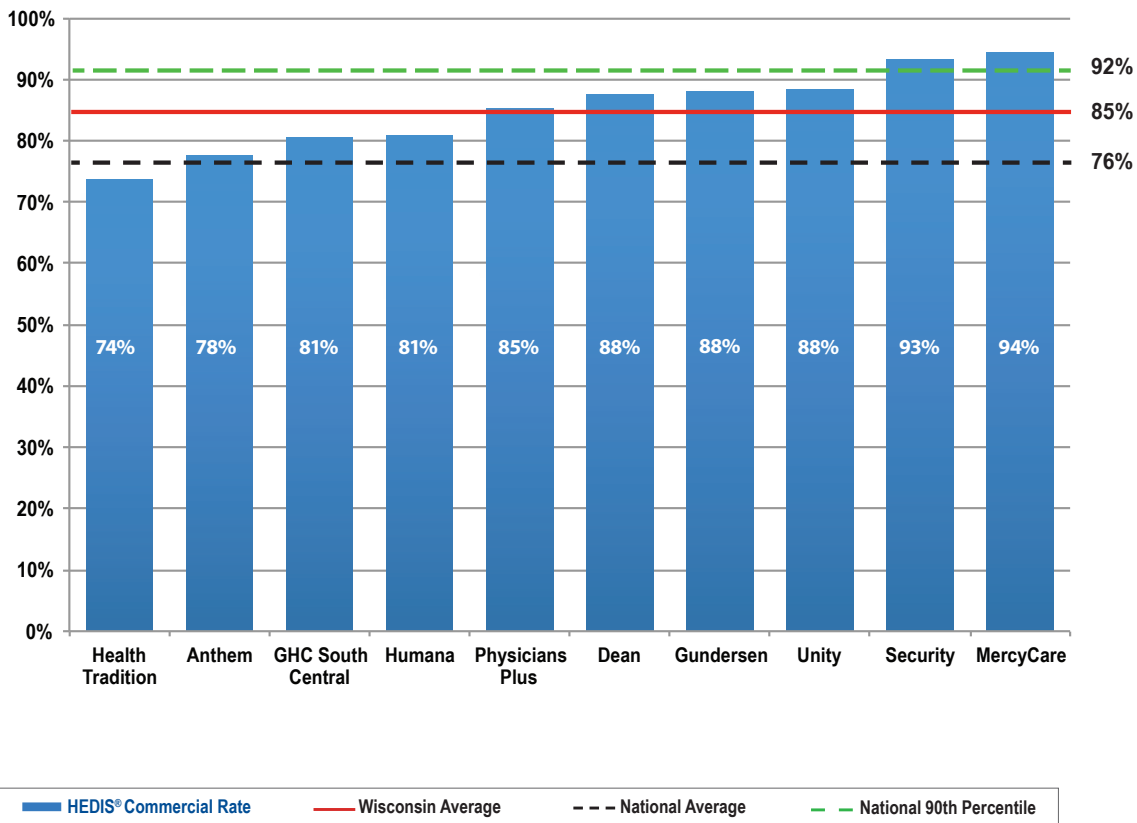
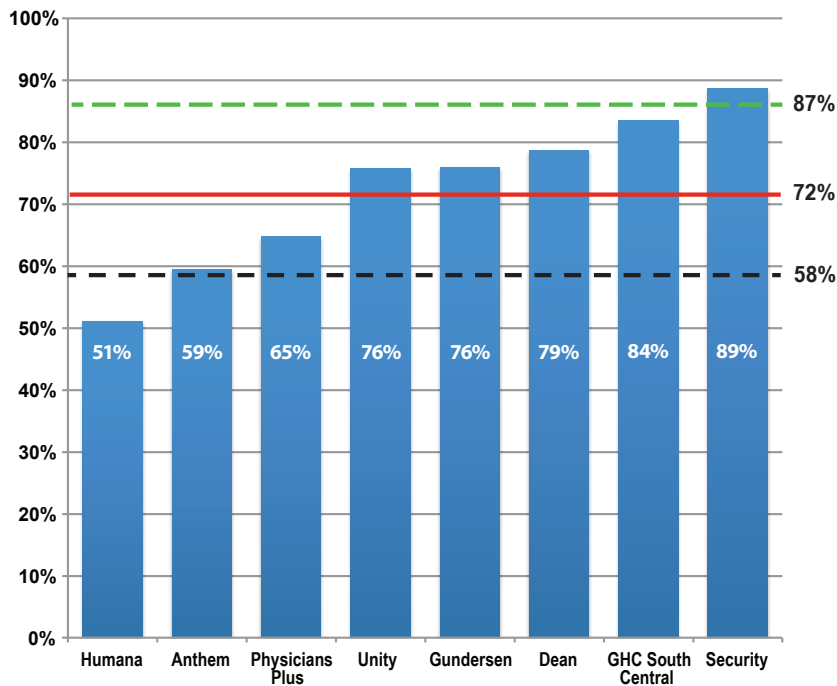


Table 3: HEDIS® 2014 Weight Assessment and Counseling Measures

Measure	Wisconsin Plans' Range	Wisconsin Plans' Average	National Average	National 90 th Percentile
Adult BMI Documentation	74-94%	85%	76%	92%
Child/Adolescent BMI Percentile Documentation	51-89%	72%	58%	87%
Child/Adolescent Counseling for Nutrition	48-81%	64%	57%	84%
Child/Adolescent Counseling for Physical Activity	43-81%	61%	54%	81%

Figure 6b: Child/Adolescent BMI Percentile. The percentage of members 3-17 years of age who had an outpatient visit and evidence of BMI percentile documentation.



Additional Measures

Data was also collected for several other HEDIS® 2014 process measures related to the quality of care received by members with certain chronic diseases or risk factors. Three measures were used to determine the percentage of members that received medical assistance with cessation of smoking and tobacco use. Four measures were related to the use and management of recommended medications for members with certain chronic diseases, including use of appropriate medications for asthma, management of antidepressant medications, and use of disease-modifying anti-rheumatic drug (DMARD) therapy for rheumatoid arthritis. See Table 4 for a summary of results for these measures.

Table 4: Additional HEDIS® 2014 Measures

Measure	Wisconsin Plans' Range	Wisconsin Plans' Average	National Average	National 90th Percentile
Medical Assistance with Smoking and Tobacco Use Cessation				
Discussing Smoking Cessation Medications	45-60%	52%	51%	63%
Discussing Smoking Cessation Strategies	37-49%	45%	47%	62%
Advising Smokers and Tobacco Users to Quit	62-78%	72%	77%	88%
Asthma Management				
Appropriate Medications for People with Asthma	81-94%	92%	92%	95%
Antidepressant Medication Management				
Effective Acute Phase Treatment	64-78%	70%	64%	N/A
Effective Continuation Phase Treatment	47-58%	53%	47%	N/A
Rheumatoid Arthritis				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	64-95%	89%	88%	95%



Summary

Twelve participating plans voluntarily submitted HEDIS® 2014 data for the Wisconsin Chronic Disease Quality Improvement Project. As a group, participating plans performed better than the national average on almost all measures – often well above the national average. In fact, for most measures, some plans performed at or above the national 90th percentile. The amount of variation between plans differed from measure to measure. Measures with the most variation between plans may have more room for future improvement, and the group strives to perform better overall and plans learn from each other. The Wisconsin Chronic Disease Quality Improvement Project offers participating plans a unique forum to share best practices and learn from each other's experiences.

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