WISCONSIN HOSPITAL ASSOCIATION

# The Valued Voice

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## Transfer of Hospital Data Collection Closer to Reality

### *Wisconsin "Data Revolution" Takes a Major Step Forward*

Last week marked what is, without question, the most significant development in the state's health data collection program in its 16-year history. On Friday, October 31, WHA President Steve Brenton and Department of Administration (DOA) Secretary Marc Marotta put pen to paper, signing the contract making transfer of hospital inpatient data collection from the Bureau of Health Information (BHI) to WHA official.

*Marc Marotta, Secretary, DOA, and Steve Brenton, President, WHA*

"This contract is validation of DOA's partnership with WHA and our commitment to produce hospital claims information in a more timely, cost-effective and innovative manner," said WHA President Steve Brenton. "This is truly a win-win for hospitals, employers and the public. We are appreciative of the legislative support and the fine partnership we have established with the Doyle administration on this effort."

Brenton also singled out Sen. Ted Kanavas (R-Brookfield) and Rep. Gregg Underheim (R-Oshkosh) for recognition. "Early on, it was Sen. Kanavas' vision on the Joint Finance Committee, and Rep. Underheim's openness to innovation that made the difference," said Brenton. "They deserve much of the credit for getting us to this point."

The contract marks the end of an intensive eight-month effort, which started when Governor Doyle essentially proposed eliminating both physician and hospital data collection in his 2003-05 state budget. But rather than support repeal, WHA realized an opportunity.

"We could have lobbied for repeal of this program as some wanted, but we believe in data and its role in the evolving consumer-focused health care system," said WHA's Eric Borgerding. "We jumped on this chance, rescuing this program from a decade of hospital-subsidized atrophy with the goal of making it more responsive to employers, consumers and providers. It was a long process, with lots of entrenched resistance, but so far we are very pleased." ***(Continued on page 6)***

## Know Your Legislators...

### Rep. Sheldon Wasserman (D-22)

*An Interview by Mary Kay Grasmick, WHA*

***Rep. Sheldon Wasserman (D-22) is passionate about issues related to health care technology and data. Not a surprise, as a physician, he knows this territory from the inside out. Wasserman recently shared his views with Valued Voice Editor Mary Kay Grasmick.***

**1. The WHA and Wisconsin Medical Society formed a Task Force to study the physician supply in Wisconsin. As a physician yourself, do you think Wisconsin will see a major shortage and what can we do to avert it?**

*Sheldon Wasserman*

There will be some regions of our state that will have a physician shortage. The rural and urban areas are likely to face this issue. I think the kinds of actions we can take to help alleviate these situations include offering some type of loan reimbursement programs to medical students if they agree to practice in shortage areas. We could also require a specific commitment from medical students, residents and fellows who want to have a specific residency or medical school spot. We know some specialties are sorely needed in rural areas, at the same time we have an over supply of specialists in other parts of the state. We need to find ways to direct physicians to the areas where they are needed most with a carrot approach. ***(Continued on Page 5)***

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## WHA Set to Collect Critical Workforce Data from Hospitals, Health Systems

The 2004 hospital personnel survey was mailed November 6 to all WHA members, addressed to the Human Resources Department. Data on Wisconsin's health care workforce is critically needed, and WHA member hospitals are the best source of the information that is necessary to address the workforce crisis. WHA is frequently asked to provide workforce related data to legislators, regulators and the news media. It is essential that we collect this information directly from the best source, Wisconsin's hospitals, because without it, assumptions can be made that are often inaccurate.

The form has been simplified and shortened. Be assured that information will be released in aggregate only on a state and regional level; no individual information will be released to any source.

There are several ways to fill out this year's survey:

- Fill in and return the paper survey to Judy Warmuth at WHA in the envelope provided.
- Fill the survey out on line by going to www.wha.org, click on Workforce, and go to 2003 Personnel Survey. Then, save the document and email it back to *jwarmuth@wha.org*; print the form and fax it to Warmuth at 608-274-8554; or mail it in the envelope provided.

**Please complete and return the survey by November 17, 2003.** If you have questions, contact Judy Warmuth at 608-274-1820.

## Physician Workforce Task Force Tackles Three Major Issues: Primary Care Distribution, Specialty Physician Supply, Physician Prep

Meeting in Madison October 31, members of the Task Force on Wisconsin's Future Physician Workforce identified three critical subjects they believe should be addressed and included in future recommendations from the group. The subject areas suggested for future study include the distribution of primary physicians, the supply of specialty physicians, and issues related to the preparation/education of future physicians.

Workgroups were organized during the meeting that focused on the development of content for what will be a major study on the looming physician shortage in Wisconsin. Along with the study, the group will also develop recommendations on actions that they believe will need to be taken to avert a major crisis in the availability of physicians in Wisconsin.

Carl Getto, MD, senior vice president, medical affairs, University of Wisconsin Hospital and Clinics, reported that the Council on Graduate Medical Education (COGME) commissioned an updated study of physician supply for the entire country. Highlights of that report are:

- The aging population in the USA, health issues associated with aging, and world economics will trigger a shortage of physicians.
- Family practitioners are the only medical specialists likely to practice in rural settings.
- The guideline of preparing the same number of primary care physicians as specialists (50-50 ratio) may need to be modified.
- Medical school enrollments must increase to meet the demand for physicians that will be needed by 2020.
- Restrictions on medical residents may need revision.

Members of the Task Force are from rural and urban areas of the state, and include representatives from the Wisconsin Medical Society and the Wisconsin Hospital Association. The Task Force has been charged to:

1. Undertake a needs assessment of current and future physician supply and distribution;
2. Identify factors that are impediments to meeting those needs; and,
3. Make recommendations to assure Wisconsin residents that they will have adequate future access to physicians.

The Task Force will convene again shortly after the first of the year to review the draft report and plan its distribution, and to finalize the recommendations that the Task Force believes will help avert or relieve a potential physician shortage of crisis proportions in Wisconsin.

## President 's Column

It's a small first step…but possibly a significant indication of what's to come.

Last week, House and Senate leaders negotiating the so-called Medicare reform bill agreed to a variety of very positive hospital payment provisions, including a full inpatient update for federal fiscal year 2004. Additionally, they agreed that hospitals participating in the voluntary quality initiative, through which hospitals report evidence-based quality data to a special CMS Web site, will receive the full market basket update for fiscal years 2005-2007.

***…they agreed that hospitals participating in the voluntary quality initiative… will receive the full market basket update for fiscal years 2005-2007.***

While it's a bit of a stretch to call this "value purchasing," it is indicative of the fact that Congress is serious about the public reporting of hospital-specific information and willing to put up fiscal incentives to get that accomplished.

It should be noted that hospitals ***not*** participating in the voluntary quality reporting would receive inflation minus .4%. Over a three-year period, that penalty would amount to real money for non-participating organizations. For Wisconsin hospitals, the news is good insomuch that hospitals representing over 95% of statewide inpatient admissions have already agreed to participate in ***CheckPoint℠***, a program that exactly parallels the voluntary CMS initiative (also known as the American Hospital Association's initiative).

***The time has come for the Medicare program to begin paying hospitals and physicians a meaningful incentive based on above-average performance as measured by high quality and, perhaps, by cost effectiveness.***

Real "value purchasing," however, must be defined as something far more significant than this feeble effort. The time has come for the Medicare program to begin paying hospitals and physicians a meaningful incentive based on above-average performance as measured by high quality and, perhaps, by cost effectiveness. Earlier this year, WHA suggested the notion that hospitals and physicians in states that have high rankings associated with quality and cost targets should receive a 5% "add on" as an incentive to retain outstanding performance. That concept was "shopped around" to members of the Wisconsin Congressional Delegation and their staff and received rave reviews.

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WHA and several other Upper Midwest state hospital associations are encouraging the American Hospital Association to place the value purchasing issue on the national public policy agenda. The notion of Medicare fee-for-service "reform" that recognizes quality and efficiency presents an exciting opportunity to create a new level of debate in Washington, D.C. And the fact that congressional leaders are embracing the voluntary public reporting initiative creates a new opportunity to engage that debate.

Steve Brenton
President

### Correction to Cost Report Advisory

**Please Note:** CMS will require every hospital to report information on the uncompensated care they provide for cost report periods ending on or after April 30, 2003. If you have questions, contact Brian Potter at WHA, 608-274-1820 or *bpotter@wha.org*

## Clinics, Other Health Facilities, Now Off Limits for Concealed Weapons . . .
### . . . *Assuming Bill Becomes Law*

In the October 24 issue of *The Valued Voice*, we reported that the Joint Committee on Finance had adopted a WHA-supported amendment to the concealed carry bill essentially declaring hospitals "off limits" to such weapons. While that hard-won amendment was very good news, it did not exempt non-hospital owned facilities, including clinics and physician offices, from the legislation.

In the early morning hours of Thursday, November 6, the Assembly did the unexpected, yet greatly appreciated, by adopting an amendment that not only maintains the hospital exemption from the concealed carry bill, but exempts virtually all health care facilities, including clinics and physician offices. Reps. Gunderson (R-Waterford), Underheim (R-Oshkosh), Wayne Wood (D-Janesville), Jeff Wood (R-Chippewa Falls) and Cullen (D-West Milwaukee), authored the amendment. The amendment was adopted on a vote of 98-1.

As amended, the Assembly passed the bill on a vote of 64-35, two votes shy of the necessary two-thirds majority needed in the 99-member Assembly to override the still likely veto by Governor Doyle. But stay tuned, because few things ever go entirely as anticipated under the "Marble Big Top."

## "Treated and Released" May Be Used to Describe Patient's "Condition"

The Office of Civil Rights (OCR) this week posted a new group of questions and answers regarding the HIPAA privacy rules to their Web site. Hospitals are encouraged to review the new information. Of particular interest is guidance on the release of condition reports related to "death" and "treated and released." According to the OCR:

> Question: Can the fact that a patient has been "treated and released" or that a patient has died, be released as part of the facility directory?
>
> Answer: The fact that a patient has been "treated and released" or that a patient has died, may be released as part of the directory information about a patient's general condition and location in the facility, provided that other requirements at 45 CFR 164.510(a) also are followed.

Hospitals are cautioned that while the OCR has issued clarification, Wisconsin law remains vague on the question of whether hospitals can release the fact that a patient has died. Hospital spokespersons should seek legal advice before changing policy in this area.

To view the new information visit www.hhs.gov/ocr/hipaa.

## IOM Panel Recommends Changes to Nursing Work Hours, Environment

A report released today by an Institute of Medicine (IOM) panel recommends work hour limits and other changes to the work environment for nurses to strengthen patient safety. The report proposes limiting nurses' working hours to less than 60 hours per week and 12 hours in any 24-hour period. It also recommends health care organizations reduce their use of temporary nursing staff, invest more in training and continuing education for nurses, and increase nurses' role in management and decision-making. The panel says regulators and health care leaders also should work to reduce workplace inefficiencies, such as excessive paperwork and documentation, which reduce the time nurses have to spend with patients. Pamela Thompson, CEO of the American Organization of Nurse Executives, said the report "highlights some important areas that we've already begun to address. Hospital and nurse leaders are working to redesign the work environment — through technology, training and retention efforts — to better support nurses as they work to deliver quality care to patients." AONE is the AHA's nursing affiliate. The IOM report is available at www.national-academies.org.

## *Continued from Page 1 . . . Wasserman Interview*

**2. We are in the midst of a data revolution led by health care providers in partnership with employers. What is your view of private sector efforts in this area, and what do you believe is the ongoing role of government?**

I think the marketplace is where data should be collected and disseminated. The State of Wisconsin should not be in the business of disseminating data, especially data that does not make sense. For example, the data that the Bureau of Health Information (BHI) currently collects from physicians' offices is flawed and does not meet the needs of the marketplace. The State has spent literally millions of dollars collecting data that is essentially worthless. In a short time period, we have seen the private sector collect data that people are interested in and can use, that increases the transparency of health care providers and is recognizable to consumers and employers as being valuable in measuring quality.

It is critical that we present health care information to consumers in terms they understand, like numbers and rates. We need to have data that measures quality, even in the physician's office.

Within the past year, the private sector including WHA and the Wisconsin Health Care Collaborative, has moved faster and accomplished more than the BHI Board has in the last six years. I applaud WHA for taking over the collection and dissemination of hospital data, and I congratulate Governor Doyle and his administration for having the foresight to put data collection in the hands of the private sector. I think WHA is going to do a great job.

**3. You have proposed to increase the amount of reimbursement hospitals receive from the Medicaid program if they implement computerized order entry. Why do you favor that approach instead of a mandate?**

It goes back to the fact that I do not think it's right for government to tell private business what to do, and then not pay for it. Sticks don't work, carrots do. And computerized physician order entry is the right way to go. Hospitals are just awakening to the fact that they have to invest in information technologies, just as the business sector did years ago. Groups like Leapfrog have identified CPOE as being one of the technologies that increases accuracy, decreases costs, and improves the safety and quality of care. Providers need to get on the bandwagon and move forward. It is a priority in our state to decrease the number of medical errors.

An increase in a hospital's Medicaid reimbursement is a carrot approach and it tells providers that they will not only get a financial bonus, but also the satisfaction of knowing they did the right thing. We are blessed with software developers in our state that can provide medicine with the latest clinical information technology. The computerization of medicine will move us into the 21st century.

**4. WHA has initiated a new quality initiative called CheckPoint℠ that will publicly report 10 clinical and 5 safety measures. What do you think of provider-led quality initiatives and their desire to share this information with the public and employers?**

I am 100% for it. I think WHA has taken a step forward in this area. It is good for hospitals, good for consumers, and good for employers to have this information. There will continually be a competition to include more data as people request it. The marketplace will play a role in the types of information that will be requested and provided in the future.

**5. Any other comments?**

The bottom line is that government has to provide a health care safety net. It needs to set guidelines to define good quality health care. These guidelines should encourage providers to move forward and embrace technological advances that help build transparency into the health care system. These efforts will help reduce costs and dramatically decrease medical errors that lead to needless fatalities. We would see a completely different landscape in health care if we implement new technology that reduces errors. As a physician, I am concerned about errors. If you look at institutions that have improved their information technology, such as the VA hospitals, you can see that they have successfully decreased costs while improving the safety and quality of care. We are on the verge of an information technology revolution in health care that should have occurred years ago. A revolution in information technology needs to happen today.

## *Continued from Page 1 . . . Transfer of Hospital Data Collection Closer to Reality*

WHA staff logged many hours not just lobbying the proposal, but also negotiating the intricate details of the subsequent contract. General Counsel Laura Leitch, Senior VP George Quinn, and the WHA Information Center's new vice president, Joe Kachelski, were instrumental in crafting the details of the agreement and preserving the intent of the legislation.

*From left: From the Department of Administration -- Sean Dilweg, Executive Assistant, James Johnston, Executive Policy and Budget Manager, and Marc Marotta, Secretary*
*From WHA -- Steve Brenton, Laura Leitch, and Eric Borgerding*

WHA will assume hospital data collection and dissemination starting with fourth quarter, 2003 data. In the meantime, BHI will continue to be solely responsible for collecting, processing, and reporting all third quarter 2003 data. There is much more to this story, so watch future issues of *The Valued Voice* for updates on the transition and news about the WHA Information Center.

Privatization of hospital data collection is just one of several exciting developments in the area of health information. WHA's CheckPoint[SM] project, the Collaborative for HealthCare Quality and other promising efforts, lead by the private sector, are setting a new and responsive pace.

"It's a crucial time in the world of health care information," said Brenton, "a time in which WHA intends to lead, not follow."