Recipient co-payments for Medicaid outpatient hospital services are generally limited to $1 per visit under federal law. With a federal waiver, co-payments of up to $10 per outpatient visit may be charged for non-emergency use of an ER but EMTALA and prudent lay person standards both still apply. Medicaid co-payment regulations prohibit providers from denying access to Medicaid services due to a patient's inability or unwillingness to make a co-payment. And, Medicaid provider reimbursement is reduced by the amount of co-payment regardless of whether providers can actually collect them. We believe that the folks using the emergency room frequently are unlikely to pay the co-payment.

Similarly, placing arbitrary caps on the number of emergency room visits allowed for a recipient would simply increase the amount of uncompensated care because the EMTALA and prudent lay person standards will remain in effect.

CONCLUSION

As the analysis of the Wisconsin Primary Care Association and Wisconsin Hospital Association demonstrates, high ER use is not confined to Medicaid. And, Medicaid won't be able to address the problem in its entirety. Nonetheless, this administration is committed to reducing or eliminating abuse of the system while continuing to provide essential access to emergency care.

I have attached a copy of the Executive Summary of the HMO ER Workgroup as an Appendix to my testimony.

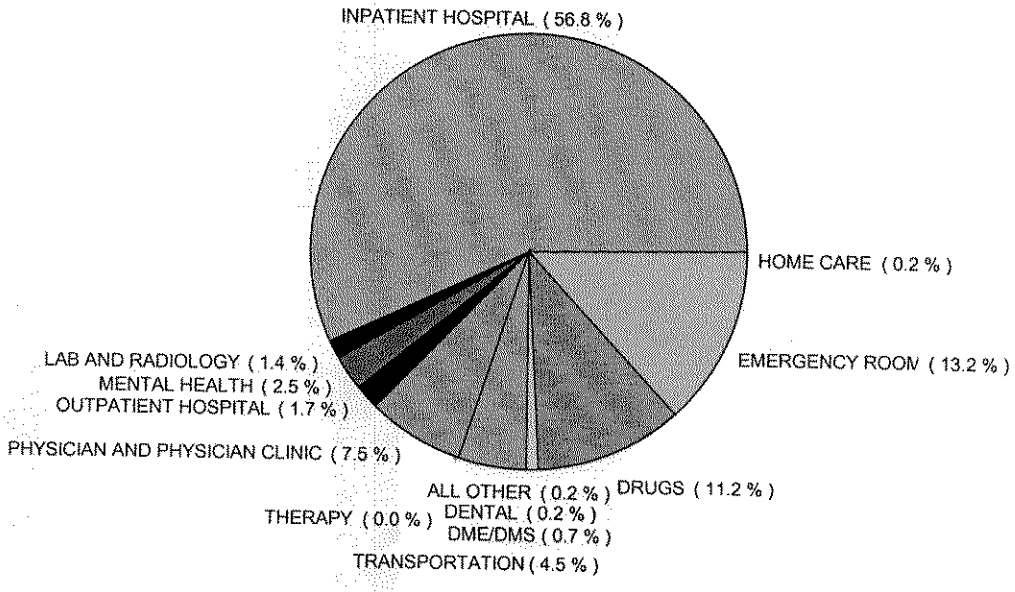
I will be happy to answer any questions.

WISCONSIN MEDICAID CLAIMS EXPERIENCE – 43 HIGH ER UTILIZERS IN FISCAL YEAR 2002

SeniorCare, Family Planning Waiver, Managed Care and Nursing Home Expenditures Excluded

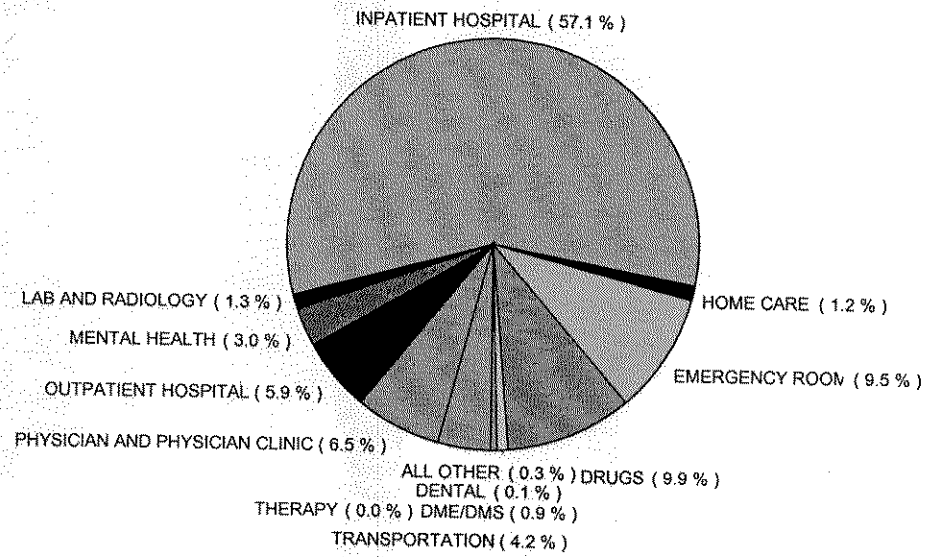
2002

Category of Service	Amount Paid
ALL OTHER	$6,589
DENTAL	$4,344
DME/DMS	$19,056
DRUGS	$320,013
EMERGENCY ROOM	$379,091
HOME CARE	$4,820
INPATIENT HOSPITAL	$1,627,868
LAB AND RADIOLOGY	$40,505
MENTAL HEALTH	$71,551
OUTPATIENT HOSPITAL	$49,375
PHYSICIAN AND PHYSICIAN CLINIC	$213,440
THERAPY	$324
TRANSPORTATION	$127,943
Sum:	**$2,864,916**

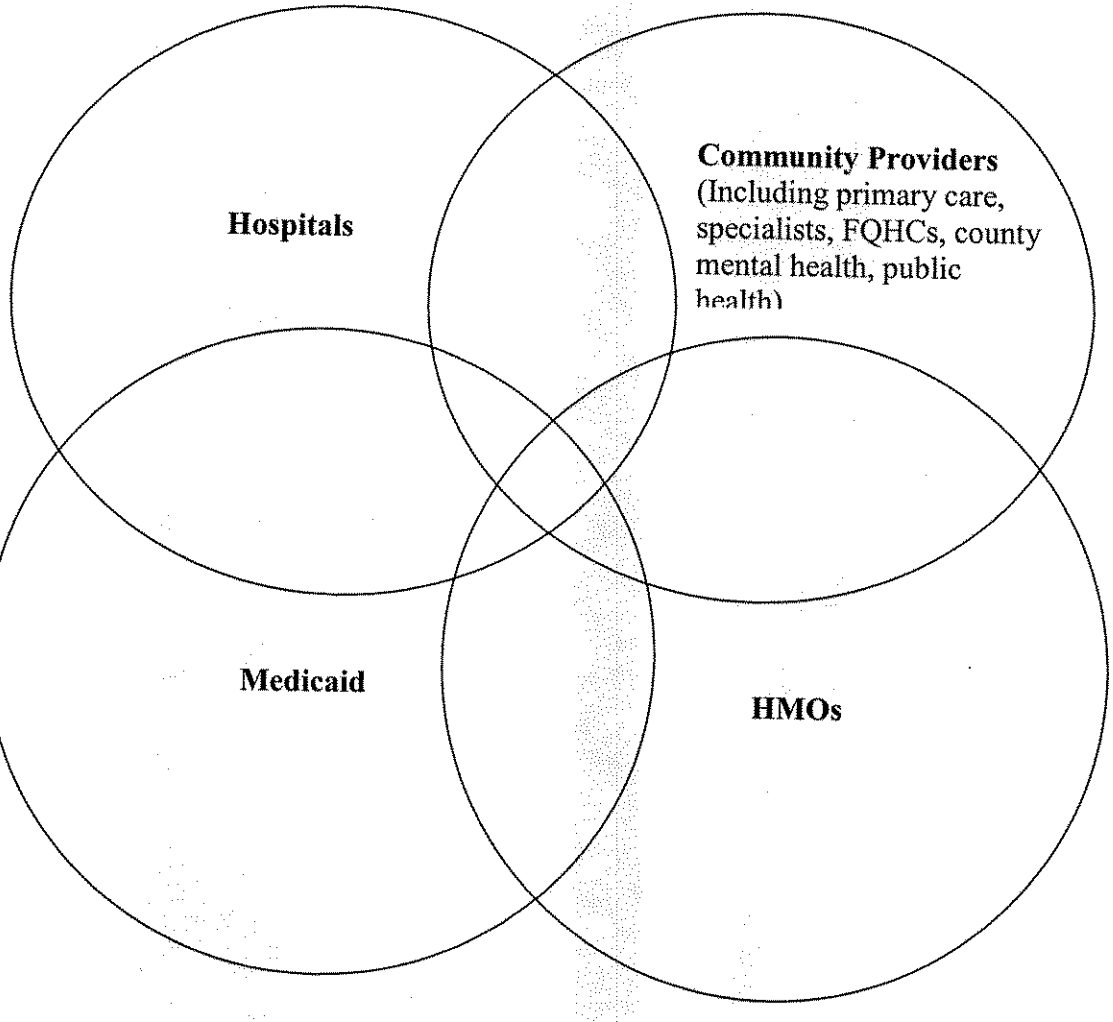


2003

Category of Service	Amount Paid
ALL OTHER	$8,311
DENTAL	$2,209
DME/DMS	$22,611
DRUGS	$257,772
EMERGENCY ROOM	$245,455
HOME CARE	$30,974
INPATIENT HOSPITAL	$1,482,891
LAB AND RADIOLOGY	$34,000
MENTAL HEALTH	$77,188
OUTPATIENT HOSPITAL	$153,722
PHYSICIAN AND PHYSICIAN CLINIC	$169,686
THERAPY	$279
TRANSPORTATION	$110,047
Sum:	**$2,595,146**



Hospital ER Utilization
Stakeholder Roles in a Comprehensive Solution



Triage
Incentives
- Patients
- MDs

Referrals
Patient education
Alternatives to ED care
Care plan for high utilizers

Office Locations
Office Hours
Availability for walk-ins
Patient education
Referrals
Call schedules

Patient education
Lock-in
Care management and coordination
ID high utilizers
Payment policy
Coverage policy
Copayments – within federal limits
Provide information

Provider network
Primary care
Specialists
Patient education
Care management and coordination
Referral
ID high utilizers
Patient counseling and follow-up

DO06048

Division of Health Care Financing
Joint Audit Committee Testimony
June 24, 2004

Executive Summary

This report is based on recommendations developed by the Emergency Room (ER) Work Group, which was formed at the request of Department of Health and Family Services (DHFS) Secretary Helene Nelson.

The ER Work Group, representing clinicians, HMOs, the State, ERs, and other interested parties, was convened to provide key stakeholders an opportunity to discuss and develop strategies that address increasing the appropriate utilization of ER services by Medicaid and BadgerCare HMO enrollees. The Work Group focused on individuals who visit the ER for non-emergent conditions and/or for conditions that could be treated more appropriately in an alternative setting. The Work Group agreed that it is important to both ensure that HMO recipients receive appropriate and needed care and increase cost effectiveness.

During the ER Work Group meetings, participants acknowledged that most people visiting the ER do so with emergent conditions. However, data indicates that some people disproportionately use the ER for non-emergent conditions and/or make multiple visits within a short time period. As the Work Group examined the issue of appropriate ER utilization, they identified patient, program and system factors that all contribute to unnecessary ER visits. The recommended goals of the Work Group address all three of these factors.

The ER Work Group agreed on four goals to increase the appropriate utilization of ER services:

> **Goal 1:** Provide Medicaid and BadgerCare HMO enrollees with education and specialized referral to ensure the most medically appropriate care in the most medically appropriate setting.
>
> **Goal 2**: Make prescription data easily accessible to providers and use it to identify Medicaid and BadgerCare HMO enrollees inappropriately seeking or using prescriptions.
>
> **Goal 3**: Identify Medicaid and BadgerCare HMO enrollees at risk for inappropriately using ER services. Implement guidelines, protocols, and strategies to provide alternatives in which to receive medically necessary care.
>
> **Goal 4**: Increase access to medical care outside of ERs.

ER Work Group recommendations are intended to be implemented for all HMO Medicaid and BadgerCare enrollees in rural and urban areas in Wisconsin. However, a lack of administrative funds precludes immediate implementation of the Work Group's recommendations for all HMO Medicaid enrollees. Therefore, the Work Group discussed grant funded pilot projects to explore the feasibility of their recommendations. Members of the ER Work Group expressed a commitment to convene in smaller groups to develop work plans for various strategies, implement pilot projects and other initiatives, and address related issues deemed outside the scope of the Work Group.

Recommended pilot projects include:

1. A pilot program in an urban area, most likely Milwaukee, that includes expanding case management (Goal 1), sharing pharmacy information (Goal 2), and developing alternatives to the ER for immediate care for select diagnoses (Goal 4).

2. A pilot program in a rural/urban area (Wausau, Green Bay, Eau Claire, La Crosse), that includes expanding case management (Goal 1), sharing pharmacy information (Goal 2), and developing alternatives to the ER for immediate care for select diagnoses (Goal 4).

3. A pilot program in an urban area that makes a qualified professional available 24 hours a day, 7 days a week for ERs to contact for assistance in finding and arranging appropriate treatment follow-up after ER visits or as alternatives to further ER care (Goal 3).

DHFS is currently researching opportunities to fund the costs of conducting follow-up activities to implement the recommendations of the ER Work Group.

Fact and Fiction:

Emergency Department Use and the Health Safety Net in Maricopa County

- *Local emergency departments are overrun by the uninsured and people who are in Arizona illegally.*
- *People go to the ED because they don't have anyplace else to go.*
- *Most ED overuse is caused by treating conditions that could be treated more efficiently elsewhere.*

Are these statements fact or fiction? What factors contribute to these perceptions? What are the implications for health care access, quality and cost, and how does ED use relate to the condition of the overall health safety net in Maricopa County?

As part of the Robert Wood Johnson Foundation's (RWJF) national *Urgent Matters* initiative, St. Luke's Health Initiatives extended its recent efforts to look at problems that plague trauma centers, emergency departments (EDs) and the primary care safety net in Maricopa County.[1] The underlying premise is that these components ought not to be viewed as separate and distinct in their own right, but should be framed within the context of an *integrated system of care*. In this light, problems that plague EDs illustrate how the components work – or don't work – together to provide a tapestry of health safety net services that often vary widely across communities based on local capacity and system responsiveness.

This report summarizes the findings of two limited SLHI research studies that look at ED use in three central Phoenix-area hospitals: St. Joseph's Hospital and Medical Center, Maricopa Medical Center and John C. Lincoln Health Network – North Mountain Hospital.[2]

- The first study analyzes discharge data for all ED visits over an approximate 12-month period.
- The second study assesses ED utilization from the patient perspective through on-site interviews of patients waiting to be seen in the ED during one week in December 2003.
- The results illuminate the fact – and the fiction – of ED use, drawing on both hospital encounter data and patient interviews to both answer and raise questions about how the system can best meet the needs of those who depend on safety net providers – and of all people who need ED and primary care services.[3]
- The studies underscore the central point that ED use specifically – and the health safety net generally – is driven by local demographic characteristics that often vary widely across communities.

THE 'BIG BOX'

As a community resource, the 'safety net' refers to health care providers that, either by mandate or by mission, organize and deliver a significant level of health care and related services to the poor and uninsured. Not surprisingly, emergency departments figure prominently in that definition. Some view EDs as the "ultimate" safety net because they are available to everyone at all hours, every day of the year, regardless of ability to pay. In that respect, they might be considered the 'Big Box' of health care: the place where consumers perceive they can get everything under one roof, anytime they need it.

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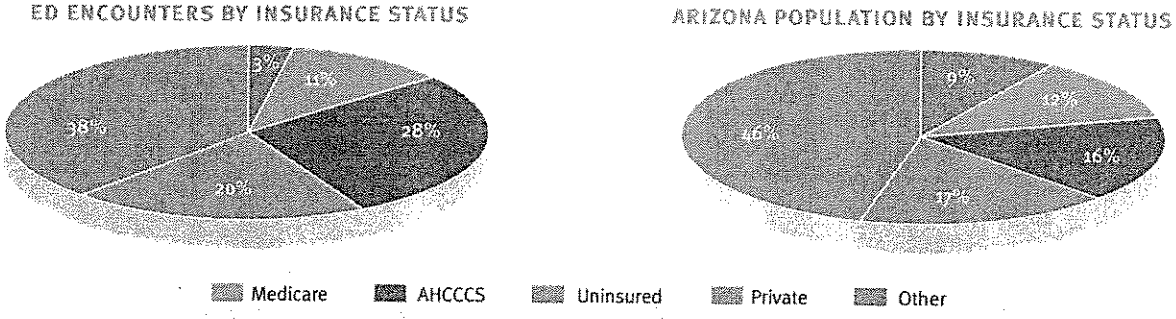
A Special Publication from St. Luke's Health Initiatives

APRIL 2004

OVER TIME: ED UTILIZATION (N = 149,851)

ED Use: Insurance Status

To determine use patterns at specified EDs, researchers queried the *Maricopa Health Information Project (M-HIP)*, an integrated database of aggregated medical encounter data spanning multiple years and multiple providers.[4] These results were compared to general Arizona population data by insurance source.[5]

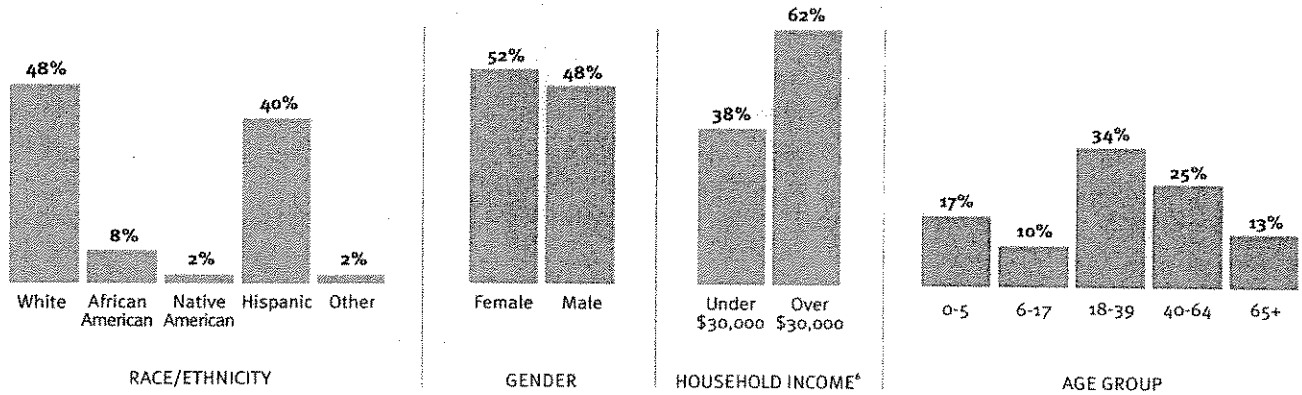


Contrary to popular belief, ED use is not necessarily driven by indigent and uninsured patients who have no other place to obtain care:

- On average, uninsured patients comprised 20% of ED use in these selected facilities, compared to 17% of the total Arizona population. As one might expect, the percentages vary by facility and location.
- In the hospitals studied, Medicaid (AHCCCS) patients accounted for 28% of all selected ED visits, compared to 16% in the total population. Again, this varies by location.
- Medicare patients' use of selected EDs is generally comparable to their percentage of overall population insurance status. Persons with private insurance used these specific EDs slightly less (38%) than their general population status (46%).
- All told, patients with private insurance, Medicare or AHCCCS comprised 80% of ED encounters in the selected facilities.

While we do not break out the differences in insurance status by individual EDs in this report, it bears repeating that the demographics of the service areas of specific facilities impact to a significant degree the insurance status of users. This underscores the larger point that any assessment of the larger health safety net starts at the local community level.

ED Use: General Demographics



ED Use: Medical Acuity

Encounter data for all ED visits at three Phoenix-area hospitals that occurred over approximately twelve months provided the baseline dataset for the analysis of use by medical acuity. Data were analyzed according to an algorithm developed by researchers at New York University[7] that classifies ED visits according to the following acuity categories:[8]

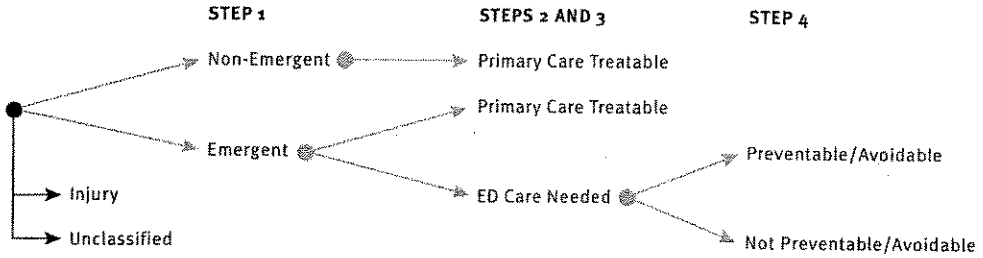
NON-EMERGENT – PRIMARY CARE TREATABLE The patient's initial complaint, presenting symptoms, vital signs, medical history and age indicated that immediate medical care was not required within twelve hours.

EMERGENT – PRIMARY CARE TREATABLE Treatment was required within twelve hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting.

EMERGENT – ED CARE NEEDED – PREVENTABLE/AVOIDABLE Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.).

EMERGENT – ED CARE NEEDED – NOT PREVENTABLE/AVOIDABLE Emergency department care was required, and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

ED CLASSIFICATION PROCESS

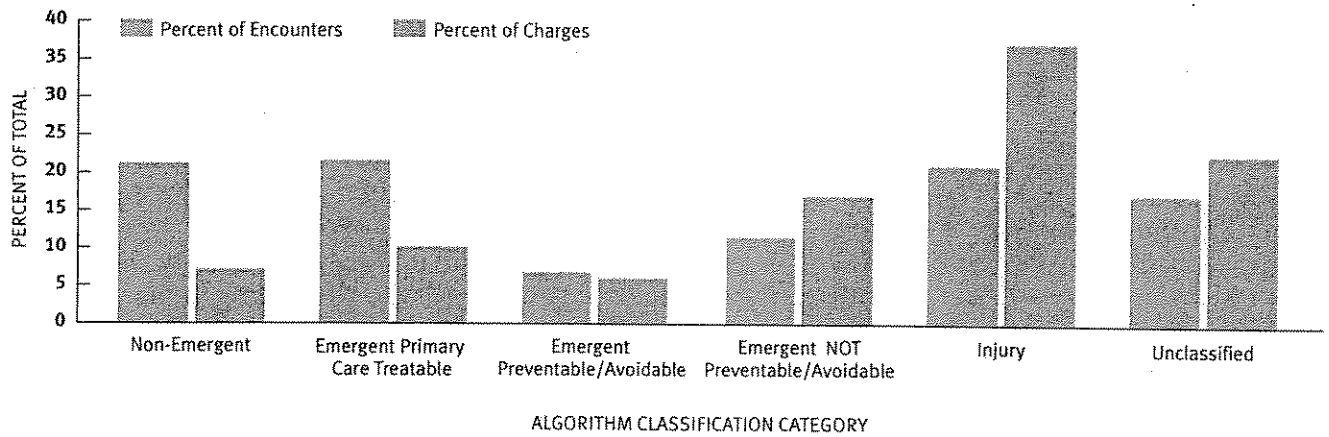


Acuity Type and Charges

For AHCCCS, privately insured and uninsured patients, the plurality of visits are for non-emergent/primary care treatable conditions, and account for 43% of visits across all payor sources. According to the algorithm, these conditions do not need attention within the next twelve hours and, therefore, do not need to be seen in an ED if primary care is otherwise available to the patient. Emergent conditions that could have been avoided with timely access to primary care services account for another 7% of all ED visits, leading to the conclusion that approximately 50% of ED visits might have been addressed in a primary care setting.

Emergent conditions that were not preventable, along with injuries, accounted for approximately 33% of all ED visits. However, they accounted for 54% of total ED charges. In contrast, non-emergent visits and visits that were emergent but could have been prevented or avoided accounted for 50% of all encounters – but generated 23% of total ED charges. The data are insufficient to support conclusions about the cost effectiveness of providing care for non-emergent and emergent/preventable conditions, since it depends not only on revenues generated, but on resources used.

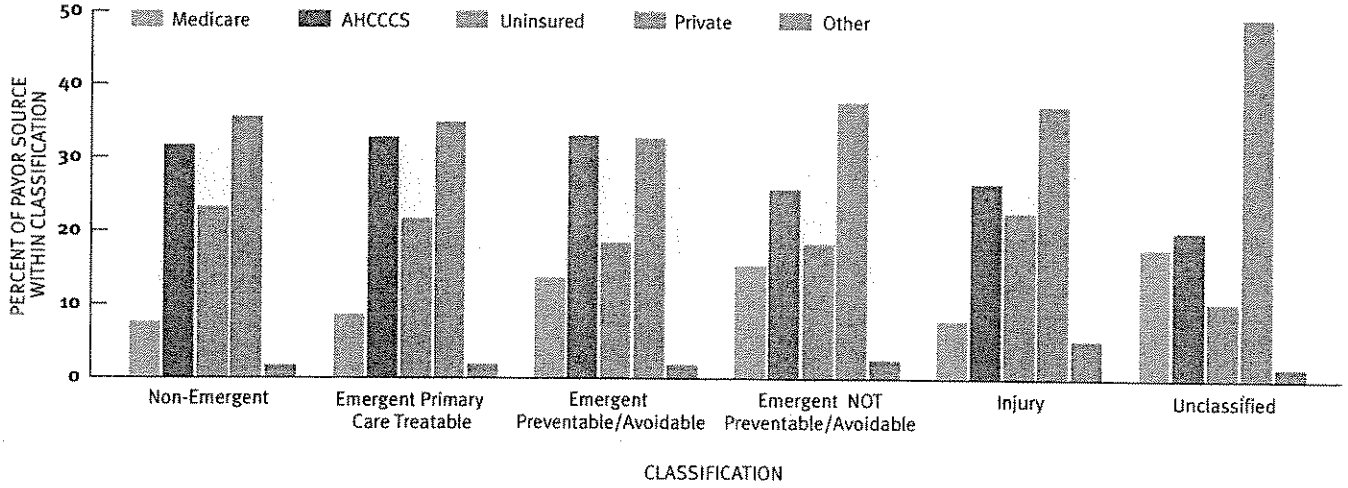
ED ENCOUNTERS BY ACUITY TYPE AND RELATED CHARGES



Acuity Type and Payors

It is also of some interest to look at the breakout of payor sources within each of the acuity classification categories. Within the non-emergent and emergent, but primary care treatable classifications, privately insured patients are the largest single group, followed closely by AHCCCS members. Utilization patterns of the privately insured and AHCCCS enrollees are similar across algorithm classification categories. Privately insured patient volume exceeded AHCCCS client volume by small but significant margins in all but one of the categories. Comparatively speaking, Medicare patients are not high users of ED services. Use by the uninsured, while significant, falls well below privately insured and AHCCCS use. The caveat – and it's an important one – is that the payor mix at each facility reflects the demographics – including insurance status – of the local community.

ED ENCOUNTERS BY ACUITY TYPE AND PAYORS



ED Use: Patient Flow

A separate analysis of M-HIP data revealed that EDs are the busiest between 8:00 a.m. and 4:00 p.m. on weekdays (especially Mondays) – a period when physician offices and primary care clinics are open. A total of 44% of all ED encounters were between 8:00 a.m. and 4:00 p.m., with another 37% between 4:00 p.m. and midnight, and 19% of visits between midnight and 8:00 a.m.

ED USE BY PATIENT FLOW

ED Time Period	Percent of Patient Visits
8 a.m. – 4 p.m.	44%
4 p.m. – 12 a.m.	37%
12 a.m. – 8 a.m.	19%

ED Use: Frequency

It is often assumed that uninsured persons who are frequent users of EDs present a strain on ED capacity. The data, however, indicate that only a small percentage of the uninsured had three or more visits in a twelve-month period, and the frequency of ED use was comparable to that of people with insurance. This finding is consistent with other recent research studies, which conclude that "Frequent ED users do not appear to use the ED as a substitute for their primary care but, in fact, are a less healthy population who need and use more care overall."[9]

ED USE BY FREQUENCY AND PAYOR

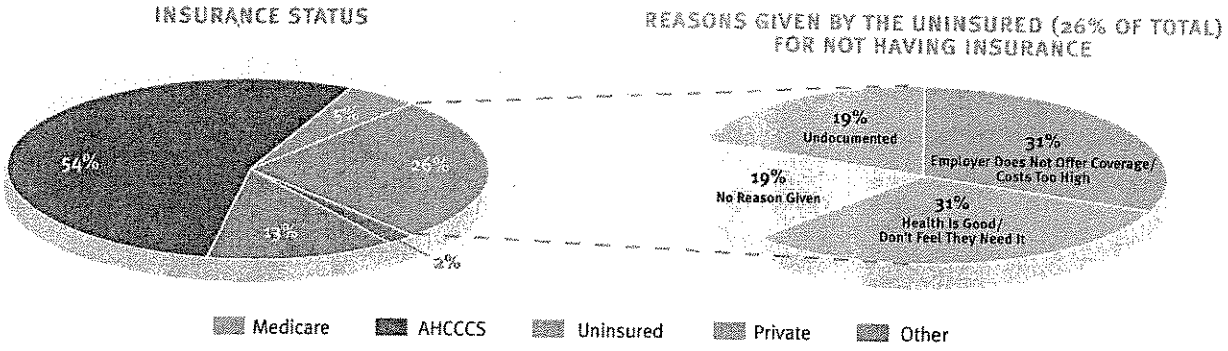
Insurance Status	1 ED Visit	2 ED Visits	3+ ED Visits
Private	78%	14%	8%
AHCCCS	75%	16%	9%
Medicare	72%	17%	11%
Uninsured	86%	11%	3%

A SLICE IN TIME: ED PATIENT SURVEY RESULTS (N = 482)

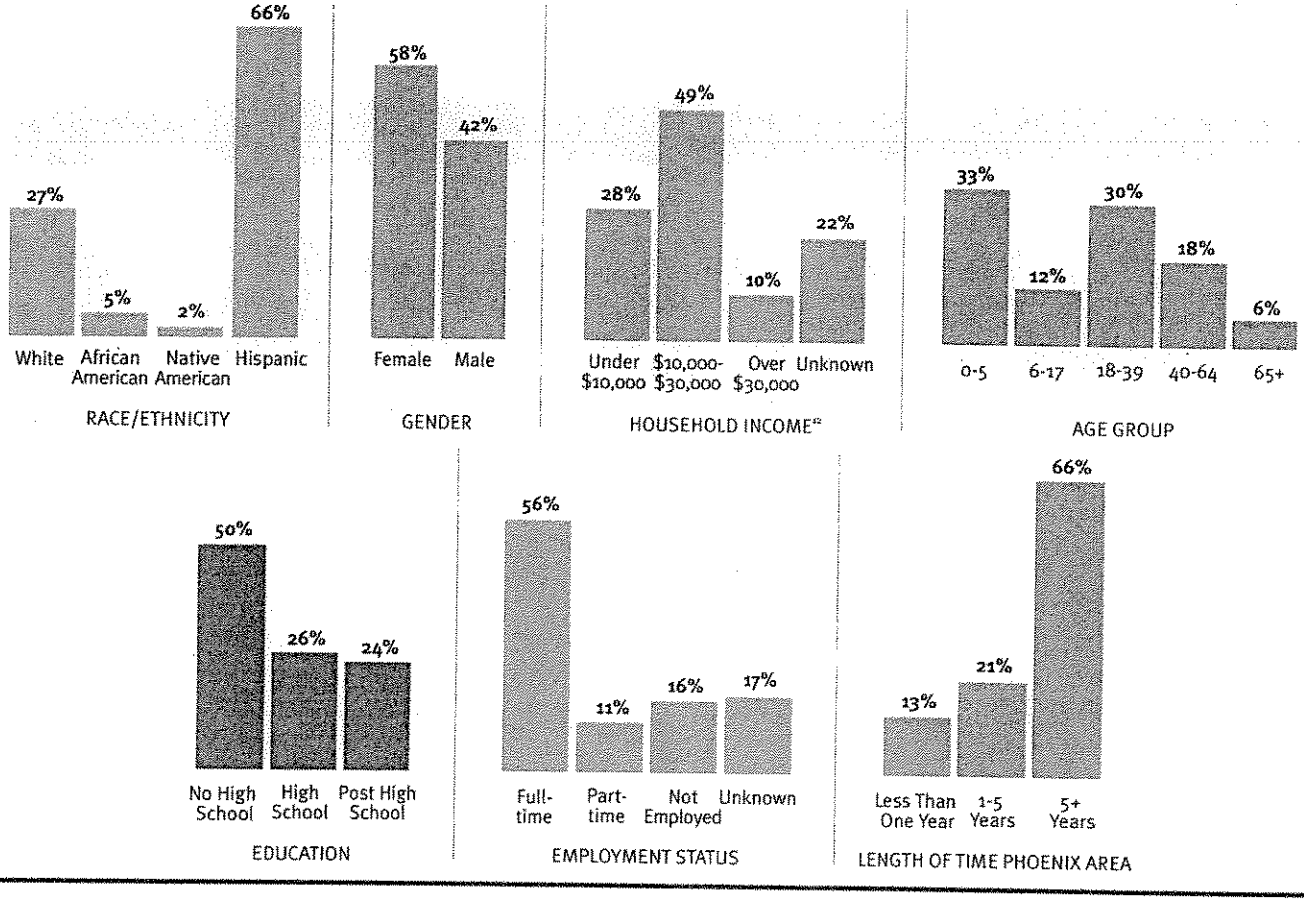
ED utilization data provide information about who is using the ED for what types of conditions, and at what cost. But the data don't tell us *why* people often see the ED as their *preferred* source of care – even when they readily admit that the situation is not an emergency.[10] In order to better understand the relationship between ED use and the primary care system, we asked patients why they sought care in the ED.

A sample of almost 500 patients waiting to be seen at the three selected hospital EDs were interviewed in both English and Spanish over the course of one week in December 2003. The interview process pre-selected only those patients with non-emergent conditions.

Patient Survey: Insurance Status[11]

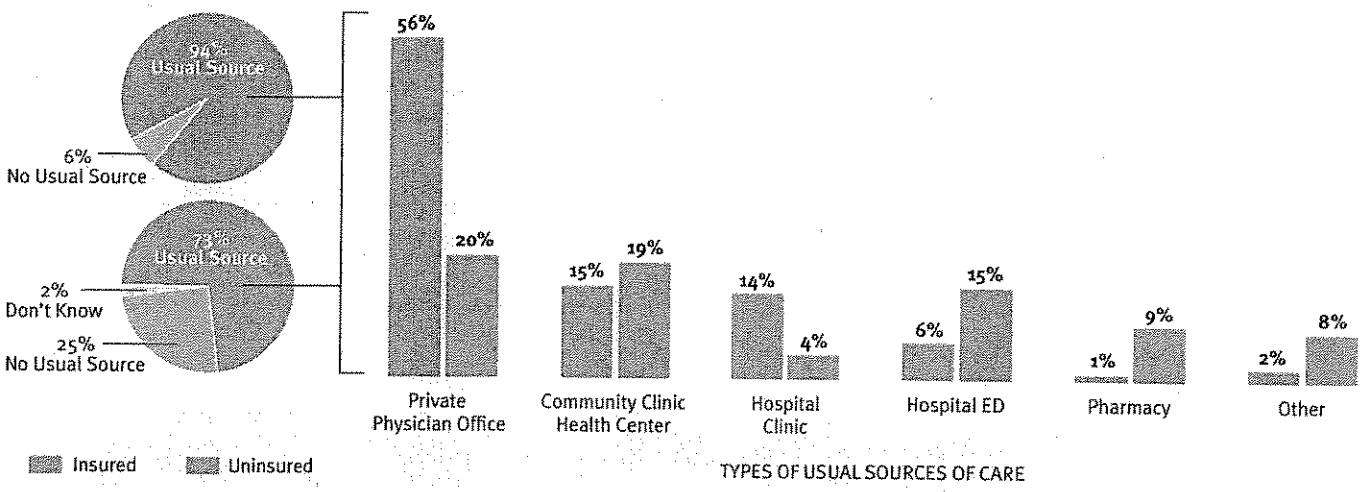


Patient Survey: General Demographics



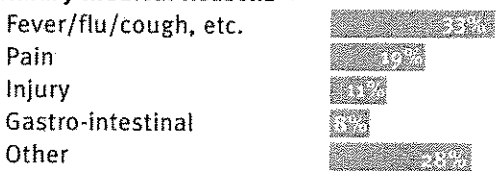
Patient Survey: ED Use

USUAL SOURCE OF CARE AND TYPES OF USUAL SOURCES OF CARE

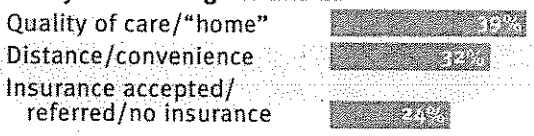


REASONS FOR SEEKING CARE IN THE ED

Primary Medical Reasons

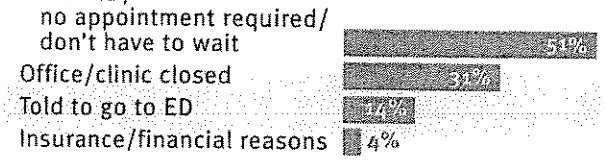


Primary Reason to go to *this* ED



Contacted Medical Personnel Prior to Coming to ED

Reasons for Not Going to Usual Source of Care*



*Does not include those without a usual source of care.

DURATION OF MEDICAL PROBLEM

Few hours	21%	2-3 days	21%	Over one week	9%
One day	23%	4-7 days	19%	Over one month	7%

Preliminary Observations

Insurance Coverage

- EDs are primarily used by persons with some type of health insurance (80%). Those without health insurance represent just 20% of the volume of the selected EDs – roughly comparable to the percentage of the uninsured in the general population. While the percentage of uninsured persons varies across EDs, the common perception that Arizona EDs are overrun with uninsured patients is not supported by this study.
- Even though the uninsured are not the primary users of EDs on an absolute basis, they utilize EDs more than insured patients on a relative basis. For example, more uninsured patients report using the ED as their "usual source of care" (15%) than insured patients (6%). The uninsured are less likely than the insured to utilize physician offices and hospital clinics as a usual source of care. Fully 53% of the uninsured survey participants had not seen a primary care provider in the past year, compared to 20-28% of insured survey participants. While the uninsured had more one-time visits to the ED than insured users (by about 10%), they had fewer repeat visits.

Wisconsin Association of Health Plans

June 24, 2004

To: The Honorable Carol Roessler, Co-Chair, Legislative Audit Committee
The Honorable Sue Jeskewitz, Co-Chair, Legislative Audit Committee
Honorable Committee Members

From: Kelly M. Rosati, JD,
Government Affairs Consultant

Re: Legislative Audit Bureau Letter of January 30, 2004
Regarding Hospital Emergency Department Services by
Medical Assistance Recipients

Thank you for the opportunity to comment on the January 30, 2004 Audit Bureau Letter regarding the use of hospital emergency department services by medical assistance (MA) recipients.

Wisconsin HMOs are proud of their tremendous record of service to Wisconsin's MA recipients. Not only has it been documented that HMOs provide better quality care than MA fee-for-service, but HMOs have also saved taxpayers hundreds of millions of dollars since the program's inception. In 2003, the MA/HMO program saved taxpayers $65 million, up from $35 million just two years earlier in 2001.

HMOs deliver documented better care in the key areas of access and quality. Examples include more primary care services, lower rates of hospitalization for pediatric asthma, higher rates of well-child visits, and higher rates for mental health/substance abuse evaluations.

Because of their integral role in the success of the Wisconsin's MA program, HMOs were among the stakeholders convened by the Department of Health and Family Services Emergency Room (ER) Work Group. The goal of the ER Work Group was to develop strategies to reduce inappropriate use of ER services by MA recipients. The final recommendations of the Work Group will likely soon be released by DHFS and could serve as a framework for addressing the issues raised in the Audit letter.

The Legislative Audit Bureau Letter documented the increase in ER visits by MA recipients. The letter also astutely points out the increase in aggregate ER utilization by MA recipients is driven by an increase in MA enrollment. In other words, when there are more people, there are more visits.

Enrollment increases in MA HMOs exceed the enrollment increases in MA FFS, hence the greater increase in ER visits for MA HMO enrollees.

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We agree with much of the information contained in the audit, however, we would like to offer several important points of clarification.

Data Analysis

Page 1 – In the data analysis paragraph three-fourths of the way down the page, the audit letter indicates complete data from emergency department visits paid for by HMOs were only available during FYs 2000-01 and 2001-02. This is false. These are the only years for which encounter data were available. However, aggregate utilization data from HMOs were available during the same years in which fee for service data were reviewed. Additionally, because FYs 2000-01 and 2001-02 were the first years of encounter data submissions, there were likely anomalies in the data, which were worked out in the subsequent years as the process was refined.

Payments to HMOs

Page 5-As the audit letter correctly indicates, the increase in state payments to HMOs over the five-year period was driven largely by the increase in enrollment. (Medical trend increases and drug costs also played a role.)

In lay terms, this means HMOs were paid more because they were asked to provide care for more people.

The savings provided by HMOs to the government actually increased during the same time the aggregate payments increased. The increase in government expenditures for MA if HMOs were not serving the population would have been at least 10% higher than the increase noted in the report.

An example may be helpful. According to a 2002 Milliman USA Inc., report, from 2001-2003, Medicaid HMOs saved government $156 million (all funds) in the Medicaid program. This $156 million would have been spent in addition to the increase in payments to HMOs reported during that three-year period.

We believe this information provides vital context in which to evaluate the issue of increased payments to Wisconsin HMOs.

Population Mixes & ER Utilization

Page 10- It is important to keep in mind that mothers with children under two years of age are disproportionately enrolled in HMOs versus fee-for-service. In fact, most people in this category are enrolled in HMOs. Moms of young children are frequent ER users. Additionally, as W2 has led to more moms in the workforce, those moms are less able to take their preschool children to the physician during the day, but rather go to the ER because of the difficulties of their work schedules. This also likely played some role in the increased visits.

In addition, because new members spend at least two to three months in fee-for-service before being enrolled in HMOs, they are counted in both denominators (HMO and FFS), but with proportionately more time (and thus the opportunity for more ER visits) while

enrolled in the HMO. Rather than using the count of total eligible individuals for the denominator, it would be a more accurate comparison if the denominator had been the number of member months for each population.

Future Considerations

Financial Incentives

Page 15 – While it is true that use of ER departments by uninsured patients leads to cost shifting, there is another underlying financial incentive alluded to but not discussed in detail in the letter. Not only has the increase of ER visits not affected the availability of ER facilities, but ER departments are better off financially with more visits. However, as with other stakeholders in the health care financing and delivery systems, most ER departments are interested in people receiving the proper care at the proper time in the proper setting.

Access Issues

Page 16-There appears to be a suggestion that counties without ER departments may be underserved. This is not always the case. Many of these border counties are served by ER departments in neighboring states. For example, Pierce County is served by Fairview Red Wing and Regina Medical Center border hospital on the Minnesota border. Iron and Vilas counties are served by a hospital in Ironwood, MI. Border status hospitals are not concerned with state lines and people in the neighboring state often have good access to ER departments just outside the county line.

Thank you for the opportunity to provide comments on the Legislative Audit Bureau letter on the use of ER department services by MA recipients. Wisconsin HMOs look forward to continuing our very successful partnership with the state of Wisconsin delivery high-quality, cost-effective care to Wisconsin's MA recipients and especially look forward to cooperating on new strategies to ensure the appropriate use of ER services.

Wisconsin HMOs' Success in Medicaid and BadgerCare: Government Cost Savings and Better Health Care Quality

Prepared by:

Timothy S. Barclay, FSA, MAAA
Consulting Actuary

February 22, 2002

Milliman USA, Inc.

Wisconsin HMOs' Success in Medicaid and BadgerCare:
Government Cost Savings and Better Health Care Quality

Section I
Executive Summary

HMOs have become an increasingly important part of Wisconsin's Medicaid and BadgerCare programs because they produce direct government cost savings, increase member access to medical providers and improve quality of care.

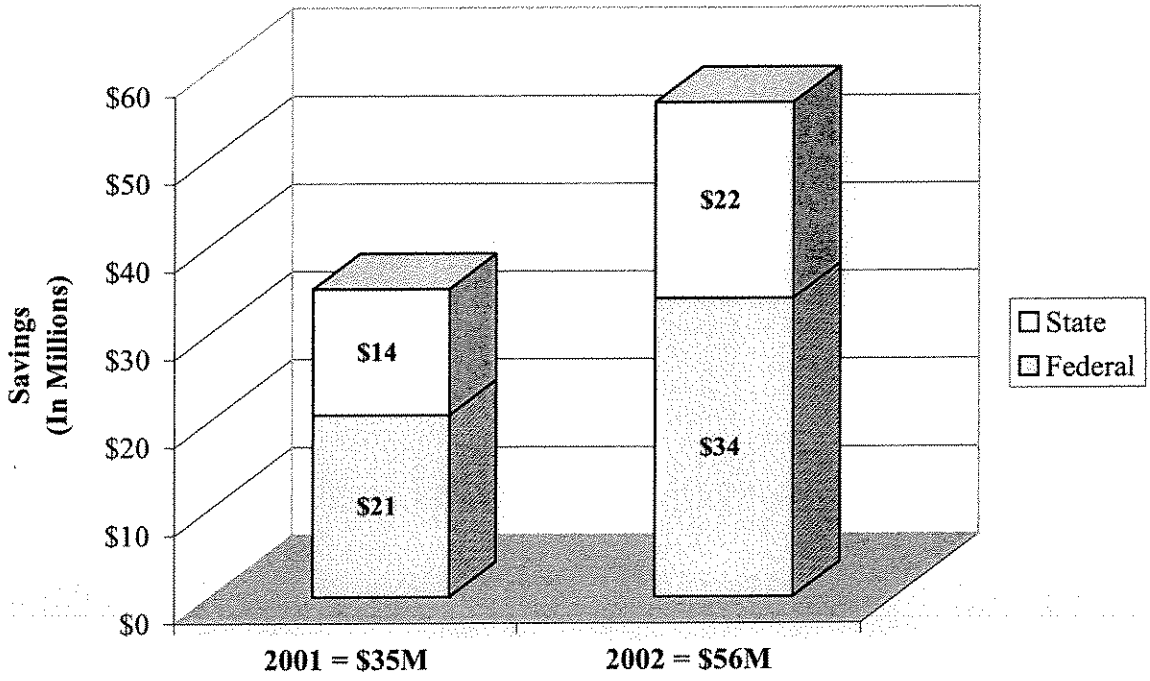
Members now have an HMO option in nearly all counties, with sufficient HMO capacity in many areas to make HMO enrollment mandatory. The successful expansion of Medicaid/BadgerCare managed care is largely due to the value that Wisconsin's HMOs bring to the enrollees and to the State.

- Direct government cost savings as a result of contracting with HMOs are estimated at $56 million in 2002, up 60% from $35 million in 2001. Chart 1 illustrates the direct government cost savings in both years.
- Although HMOs are paid less than fee-for-service (FFS) equivalent costs to deliver an equivalent benefits package, HMOs incur expenses that for the most part have no parallel in the FFS system. It is estimated that participating HMOs will spend approximately $200,000 on interpreter services and $840,000 on education and outreach efforts in 2002. These expenditures address some of the major barriers to care that enrollees in the FFS system face, and undoubtedly contribute toward HMOs' superior performance over the FFS system on key preventive care measures.
- Encouraging patient relationships with a primary care physician (PCP) establishes a "Medical Home" for each HMO member. This leads to increased preventive care and the provision of routine services in the most clinically appropriate and economically efficient setting. The FFS system, on the other hand, is not in a position to counsel members or encourage PCP relationships. It is not surprising, therefore, that access to primary care services is much better within HMOs. Chart 2 shows the degree to which HMOs outperform the FFS system on this critical measure.
- Utilization management and disease management programs serve to improve the quality of care, the efficient use of resources and the quality of life for members. Again, these programs, to a large extent, have no parallel within the FFS system. Table 1 summarizes many of the utilization management and disease management efforts used by HMOs to accomplish these goals.

- The recent state-sponsored Consumer Assessment of Health Plans (CAHPS) study shows that Medicaid HMO members' satisfaction exceeds the national average for HMOs. Chart 3 illustrates these satisfaction survey results.

This executive summary should not be relied upon outside the context of the entire report.

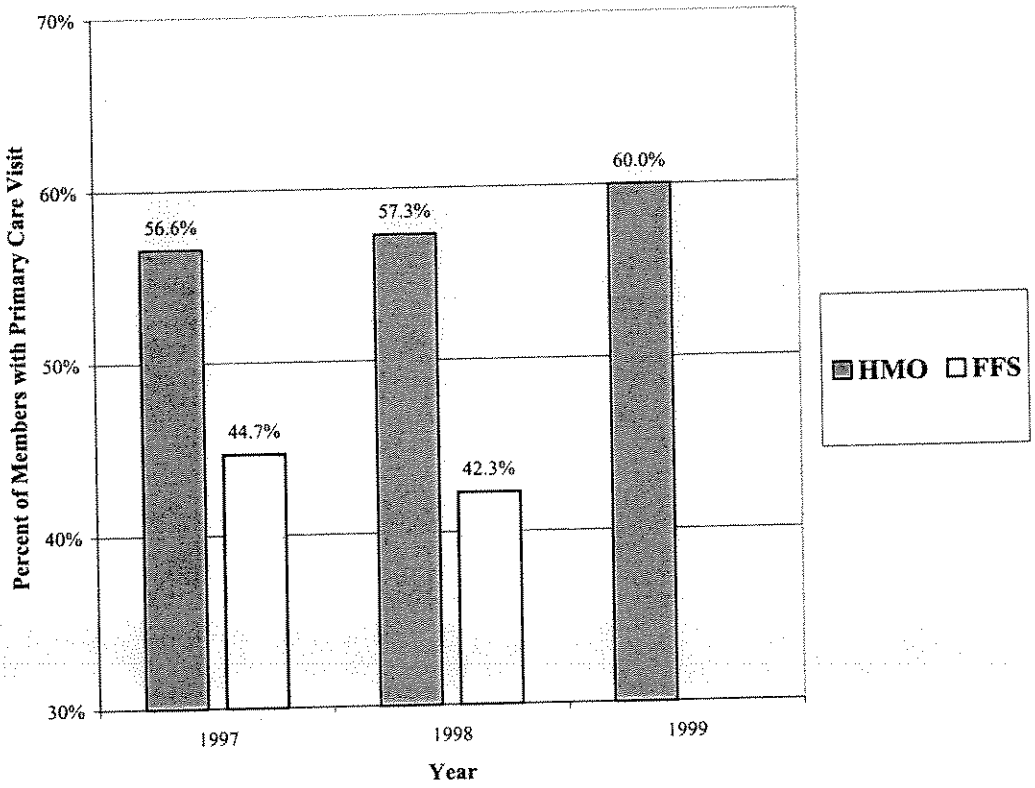
Chart 1
Direct Government Savings Provided by HMOs
2001 vs. 2002



Source: Milliman USA calculations based on Wisconsin DHFS data (see pages 19-20)

Chart 2

Wisconsin HMOs Outperform Fee-For-Service
At Least One Primary Care Visit, All Ages



Source: Wisconsin DHFS
1999 fee-for-service data not available

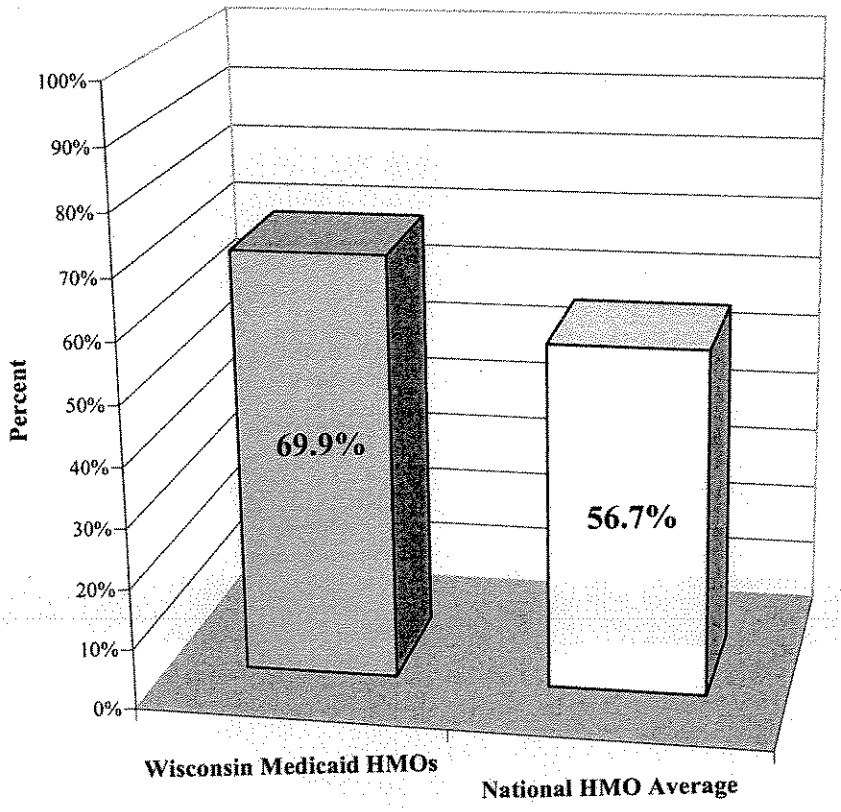
Table 1

HMO Utilization and Disease Management Programs

Utilization Management	Targeted Disease Management
• Large-case management	• Diabetes
• Concurrent review	• Hypertension
• Coordination of home health, skilled nursing and hospice	• Coronary artery disease
• Chronic disease management	• Asthma
• Referral management, or prior authorization, for specialist physician services	• Depression
• Discharge planning	• High-risk pregnancy
• Prior authorization of inpatient stays, designated procedures and durable medical equipment	• Smoking cessation
• Prescription drug management	• Breast cancer
	• Hepatitis C

Chart 3

Percent of Enrollees Who Give Their HMO an 8 to 10 Rating
(Wisconsin Medicaid HMOs versus National HMO Average)



Rating Scale: 0 = Worst; 10 = Best

Source: 1999-2000 Consumer Assessment of Health Plans Survey

The Wisconsin Medicaid/BadgerCare HMO Success Story

Wisconsin HMOs are proud of their record of providing government cost savings and high levels of health care quality and customer service. However, their ability to maintain or improve on these achievements depends on adequate payment for their services. If enrollments continue to increase and payments continue to lag behind inflation, individual HMOs may be forced to reevaluate their level of participation in the program.

A 2002 Milliman USA, Inc., report documented Wisconsin HMOs' success in the Medicaid and BadgerCare programs:

- Direct government **savings provided by HMOs increased 60 percent** from 2001 to 2002, and another 16 percent from 2002 to 2003.
- The **discount provided by HMOs** as a percentage of expected fee-for-service (FFS) cost increased **from 7.9 percent in 2001 to 10.7 percent** in 2002. DHFS now estimates the discount for 2003 at 11.4 percent.
- Payments to HMOs are not keeping pace with the cost of care, particularly within the BadgerCare population. **The expected monthly FFS cost for BadgerCare jumped $26.09 in 2002, from $131.48 to $157.57, more than four times the increase in payments to HMOs.**
- Not only are the state's Medicaid and BadgerCare costs lower when enrollees receive their health care through HMOs, the **costs are far more predictable** because the state has no risk for variations in utilization.
- This HMO predictability is especially advantageous now, at a time when the state is experiencing financial difficulty and **rapidly increasing Medicaid/BadgerCare enrollments** (seven percent increase from October 2002 to October 2003).
- Wisconsin **Medicaid HMO enrollees are highly satisfied** compared to national averages.
- Wisconsin **HMOs outperform the FFS system** in several key areas of access and quality, including primary care services, lower rates of hospitalization for pediatric asthma, higher rates of well-child visits, and higher rates for mental health/substance abuse evaluations.
- Despite being paid less than FFS equivalent costs, **HMOs incur expenses that have no parallel in the FFS system**, such as education and outreach services and foreign-language interpretation services.

Government Savings Up 86%

$35 million	2001
$56 million	2002
$65 million	2003

HMO Discounts Increasing

2001	7.9%
2002	10.7%
2003	11.4%

BadgerCare Payments Lag Behind Medical Inflation

Payments to HMOs	+$6.39
Inflation	+$26.09

(increases per month in 2002)

Medicaid/BadgerCare HMO Enrollments Up 7%

October 2002	316,139
October 2003	339,062

Medicaid/BadgerCare HMO Enrollees are Highly Satisfied

WI Rating	70%
National Average	57%

(Ratings of 8-10 on a 0-10 scale; 10=best)

WISCONSIN HOSPITAL ASSOCIATION, INC.

June 24, 2004

TO: Members of the Joint Committee on Audit

FROM: Bill Bazan, Vice President, Metro Milwaukee, for WHA

RE: Emergency Department Usage by Medicaid HMO and Uninsured Patients

Emergency Department (ED) services provide a true safety net for meeting the health care needs of Wisconsin residents regardless of their insurance and economic status. These services are necessarily expensive since they are needed to meet unexpected demands and volumes for all persons that present themselves for care exhibiting a wide range of symptoms, diseases and emergent situations. However, over the past three years, our hospital emergency departments are seeing more and more non-emergent patients that could be treated in more appropriate primary care clinic settings.

The Milwaukee County Primary Care Access Initiative (the Initiative), a collaboration between the five health care systems in the County (Aurora, Covenant, Children's, Columbia St. Mary's, and Froedtert Community Memorial) and the four Federally Qualified Health Centers (16th Street, Milwaukee Health Services, Westside, and Healthcare for the Homeless) was formed to develop a comprehensive plan for enhancing primary care access for the underserved in Milwaukee County. Our Initiative focused on finding primary care homes for Medicaid and uninsured patients as alternatives for the more expensive emergency departments. Two health policy considerations drove our Initiative:

- By increasing primary care access (including extending clinic hours and creating new primary care sites), more uninsured and Medicaid consumers can find primary care homes and not utilize emergency departments, which are more expensive. We wanted to address not only the "cost shifting" issue, but address wellness and **disease management interventions**, as well.

- By developing and expanding primary care capacity, the health status of the Medicaid and uninsured patient will have a chance to improve. Our Initiative plans to develop and implement a process that will flag frequent users of emergency departments who need a primary care home more than emergent care and direct them to the appropriate clinical setting for that care.

Our Initiative will submit a grant proposal to the Health Resources and Services Administration (HRSA) in October, which will call for a three-year national demonstration project to enhance primary care capacity in Milwaukee County. We are asking for $8.85 million that will go entirely to the four FQHCs for expansion. Our stated outcome is to open up 32,000 new primary care slots for Medicaid and uninsured patients. Our plan has received the enthusiastic support of HHS Secretary Tommy Thompson, as well as bi-partisan support from Wisconsin legislators.

(over)

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Policy Considerations and Actions Needed:

1. Develop a triage and referral system to assure that a primary care follow-up visit to an appropriate provider outside the ED is made following each ED visit by Medicaid and uninsured patients.

2. Identify high frequency ED users for targeted case management, especially those with chronic diseases.

3. Work in partnership with the Medicaid HMOs in implementing care management strategies for Medicaid enrollees.

4. Collaborate with the Medicaid HMOs in reviewing their policy to pay a "primary care rate" of $30 to hospitals for many ED visits.

5. Recognize and do not financially penalize the tremendous work the hospital and its ED physicians and staff provide as the "safety net" for all ED encounters. **High utilization of ED services by Medicaid patients coupled with low reimbursement contributes greatly to the cost shifting and increased health care costs that are occurring today. The latest available data (2002) shows that there were 186,588 ED encounters by Medicaid HMO enrollees and 84,369 encounters by uninsured patients in Milwaukee County hospital emergency departments. This is out of 429, 069 total ED encounters.**

6. Adding a co-pay or encounter fee that the Medicaid patient would have to pay in order to lower utilization could have little, if any, impact. While laudable in intent, it is likely such cost sharing measures will simply go unpaid, though care will still be given. This would only contribute to the cost shifting onto the private sector that is already occurring. **DHFS, in collaboration with our hospitals, the Medicaid HMO providers, and the Milwaukee County Primary Care Initiative Alliance, should work together to seek and implement systemic changes to the high utilization of hospital emergency departments by Medicaid enrollees for non- emergent care.**

Wisconsin Chapter
American College of
Emergency Physicians

TO: Senator Carol Roessler, Co-Chair
Representative Suzanne Jeskewitz, Co-Chair
Members, Joint Legislative Audit Committee

FROM: Richard J. Shimp, M.D., FACEP, *President*
Howard J. Croft, M.D., FACEP, *Chair-Government Relations/Public Policy*
Richard H. Paul, *Executive Director*

DATE: June 24, 2004

RE: Legislative Audit Bureau Report: Use of Emergency Department Services by Medical Assistance Recipients

The Wisconsin Chapter – American College of Emergency Physicians, whose 370-plus members provide care around the clock in emergency departments throughout the State of Wisconsin, appreciates this opportunity to offer comments on the recent Legislative Audit Bureau report (dated January 30, 2004) concerning the use of emergency department services by Medical Assistance recipients. Above all, we appreciate the interest and concern of policymakers in this subject, and we hope that the report itself and the Legislative Audit Committee's hearing on the report will be steps in an ongoing effort to develop solutions to growing problems that threaten Wisconsin's emergency medical care system. WACEP has expressed increasing concerns about the fragile state of our emergency care system, which is quite literally the *health care safety net* for all Wisconsinites. We pledge to continue to work with policymakers on constructive measures that will help to maintain and strengthen this safety net before it further frays and gives way.

Key Report Findings

The study undertaken by the Legislative Audit Bureau was prompted by concerns about increasing use of emergency departments by Medical Assistance (MA, or Medicaid) patients and about the cost associated with emergency services. According to the report, the volume of MA patients seen in emergency rooms has indeed increased in recent years – but this is *primarily the result of higher overall MA caseloads.*

CONCLUSION: The Medicaid caseload has grown far more in recent years, percentage-wise, than has the population of the State of Wisconsin. Patients come to the ER today as MA patients; several years ago many of those same patients would come to the ER with private insurance. Although the report did not directly examine changes in ER patients' collective insurance status or payor mix, our members' experience coupled with the LAB's findings of increased MA enrollment strongly support the conclusion that many patients have lost private, employer-sponsored health insurance and have moved onto MA (often via BadgerCare). These

patients are not more likely to use emergency services than when privately insured, *unless as MA patients they have difficulty accessing non-emergency care.*

The LAB report also found that a very small number of MA patients use emergency services with great frequency. Many of these patients have serious chronic and disabling medical conditions such as sickle cell anemia or uncontrolled diabetes with complications. Others suffer from mental illness, drug abuse, and other medical and psychosocial problems.

CONCLUSION: This group of patients stands out from the mainstream and may prompt assertions that emergency services are being "overutilized" or "inappropriately utilized." In reality, however, while highly visible and with individually compelling circumstances, this patient population as a whole is not a major contributor to overall emergency department use and cost. Steps can and should be taken to reduce these patients' needs for emergency services. Such steps require collaboration between emergency physicians, hospitals, managed care organizations, state and local officials, and other care providers, and must address issues ranging from improved medical management for chronic disease patients to better alternatives for persons experiencing a mental-health crisis. *We must take care, however, to avoid the fallacy that reducing ER utilization among this small group of patients will solve the underlying systemic problems.*

Another key finding of the LAB report is that while the numbers of patients enrolled in MA managed care increased substantially from 2000-01 to 2001-02, there was an even greater proportionate increase during that time in the number of MA managed care enrollees visiting an emergency department at least once in the year. The report did not find a similar increase in multiple visits to emergency rooms, however.

CONCLUSION: We believe this phenomenon reflects the difficulty of many MA managed care enrollees in obtaining access to timely primary care. These patients end up in the emergency room out of necessity. *Whether in managed care or fee-for-service, more Medicaid patients are turning to emergency departments for needed medical care because they are unable to obtain access to that care outside the emergency room.*

The Problems Are Everyone's Problems

The Legislative Audit Bureau's report does an excellent job of presenting an objective picture of MA recipients' use of emergency department services. These statistics, however, have implications far beyond the MA program.

For emergency medical services, the Medicaid program, its policies, and its patients are inextricably linked with the rest of the population – more so than in practically any other area of health care. To the extent that the Medicaid program affects the provision of emergency medicine, it affects it for everyone, not only for Medicaid patients. Unlike other Medicaid program areas, where access for Medicaid patients may be limited without affecting access for other patients, emergency medical services are available and accessible to all, or to none.[1] If the

[1] In most medical services and health care programs, providers and programs may choose the patient population they wish to serve. Providers may conclude that they need to limit the numbers of Medicaid patients served because of, e.g., Medicaid's under-reimbursement. This scenario creates obvious problems for the Medicaid patients seeking those health care services, but typically it does not directly affect the non-Medicaid patient's access to the service

Medicaid program supports its share of the emergency medical system, it supports the safety net for all citizens. Conversely, when Medicaid fails, ultimately the entire safety net unravels.

- Under federal law (EMTALA[2]), emergency departments must see all patients who come to the emergency room and must provide, at minimum, "screening and stabilization" regardless of a patient's insurance coverage or ability to pay. "Screening and stabilization" is the largest part, if not the totality, of an emergency room visit. In practice, Wisconsin emergency physicians treat the patient first, and address the patient's financial circumstances later. This is as it should be. Limiting or refusing care to patients because of their status as Medicaid patients is not a viable option.
- If an emergency room becomes overcrowded, all patients needing care are affected, not just those on Medicaid. Patients wait based on urgency of their conditions, not based on how many Medicaid slots are allotted per day.
- If an emergency department ceases to be financially viable given its patient and payor mix, it can only shift costs to those who can pay more – or close its doors. The ER does not, by and large, control its patient mix.[3]

The Canary in the Coal Mine

Years ago, miners carried a caged canary with them as they descended into a mine: the canary's loss of consciousness or death was the miners' early warning that oxygen was in short supply. The emergency department is the canary in the coal mine for the rest of the health care system, warning us of the problems looming ahead. The LAB report is another wake-up call, pointing to problems that first surface or become readily apparent in the emergency care system. Among these warning signs:

- A larger portion of our population is forced to rely on Medicaid rather than private insurance for health care coverage.
- Many of these Medicaid patients, because of their Medicaid status, have difficulty obtaining care outside the emergency room and are forced to turn to emergency services. Although another care system or setting may be preferable in the abstract, in reality these patients' use of the emergency care system is not "inappropriate;" rather, they are using the emergency room as a safety net.
- The proportion of patients who lack any insurance coverage, including Medicaid, is likewise growing, and placing the same strains on the emergency care system.
- The private-pay base of emergency room patients is shrinking while the pressure to cost-shift to that base increases, due to inadequate reimbursement from Medicaid and other public payors.

(although there are ripple effects). Emergency rooms, by contrast, are intended to serve all who come through the door.

[2] EMTALA is the Emergency Medical Treatment and Active Labor Act.

[3] There is certainly a role for patient education to improve patients' awareness of, and motivation to use, non-emergency services in some situations. However, the relative size of the patient population that can be appropriately "redirected" is quite small in proportion to the totality of patients seeking emergency care; the availability and accessibility of non-emergency services is also a crucial factor in any attempt to change the ER patient population.

Temperature and pressure rising

Can Wisconsin's emergency medical care system absorb these increasing pressures without help? We ask you to consider some of the other demands on emergency medicine – which, if met, serve to benefit the whole population – and the cumulative effects of requiring more from a system while devoting fewer resources to that system:

- The threat of bioterrorism, not a factor for most emergency departments a few years ago, is now very real, and we look to our emergency medical care system to deal effectively with this threat.
- Advances in medical science have made it possible to save lives and to greatly reduce disability, *if* patients receive prompt, high-quality emergency medical care, for conditions which were not considered "fixable" in years past.
- Emergency physicians are increasingly called upon to address a wide array of psychosocial crises and their sequelae, as well as typical medical emergencies, in the absence of other resources to manage those crises.

The Consequences of Inaction Are Severe

While the LAB report addresses emergency medical care use among Medicaid patients, for emergency departments it is impossible to separate Medicaid and non-Medicaid patients. There is no single solution that will reduce Medicaid utilization and costs in the emergency rooms of Wisconsin, although there are a number of steps that can be taken. Of equal if not greater importance, however, is the need to heed the warning signs that our emergency medical care system faces mounting challenges. The LAB report, and the interest of policymakers in its findings and significance, have given us an opportunity to take steps now to address these challenges. Let us not wait until the system becomes sicker, as will inevitably happen if we do nothing.[4]

WACEP recognizes that various efforts aimed at addressing some of the problems discussed herein are currently underway or in the formative stages. We support the efforts of others as well as the significant work of our own members in this vein, and will continue to work collaboratively with other interested parties. However, given the complexity and multi-faceted nature of these problems, we believe that ongoing direct leadership and oversight by policymakers is necessary if the LAB report is to be a catalyst for change rather than an end in itself. We respectfully request, therefore, that a legislative committee task force (e.g., a joint task force of the Senate and Assembly Health Committees) or a Legislative Council study committee be named to carry on with this issue.

The Wisconsin Chapter of the American College of Emergency Physicians thanks you for your concerns, and stands ready to work with you to ensure that Wisconsin citizens throughout our state continue to have access to the finest possible emergency medical care.

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[4] The experiences of many communities throughout the country, where trauma centers and emergency rooms have closed, and the publication of numerous national studies and reports on these issues, all support the conclusion that failure to act to protect and strengthen our emergency medical system will have dire consequences for this system.

Wisconsin Medical Society
Your Doctor. Your Health.

TO: Members, Joint Audit Committee

FROM: Alice O'Connor & Mark Grapentine

DATE: June 24, 2004

RE: ER Use by Medicaid Patients

On behalf of more than 10,000 members statewide, thank you for this opportunity to provide feedback on January's Audit Letter Report regarding Use of Emergency Department Services by Medical Assistance Recipients.

The audit does a tremendous job putting the facts in order: ER use is greatly increasing, costs are increasing, and a small number of patients drive a disproportionate share of those costs. While the audit did not include an analysis of the MA patients' necessity of utilizing ER services, there is ample real-world experience supporting the belief that not all ER patients need that level of immediate care.

The question left by the audit is: *what next*? Today we would like to alert the Committee to two initiatives in California that might prove interesting for Wisconsin to mimic. These initiatives have led to patient empowerment, cost savings and more appropriate use of emergency room services.

An UCLA/Johnson & Johnson Health Care Institute initiative found that when Head Start parents are provided with easy-to-understand health care guidance, unnecessary emergency room and clinic visits dropped dramatically. A combination of a pilot project and follow-up training sessions, including providing the parents with the book "What to Do When Your Child Gets Sick," resulted in a 48 percent reduction in emergency department visits and a 37.5 percent reduction in clinic visits. We have attached a press release on the study and the study itself, published in the *Journal of Community Health*.

While the parents in the study said they felt confident about taking care of their child's minor illnesses before the training, over half of these parents did not know what to do for a child having a temperature of 99.5 degrees Fahrenheit. Following the training, 90 percent of parents reported they used the book provided them – some as often as four times in six months. An impressive 84 percent of parents said that after training, they felt more at ease taking care of their children.

A similar education project could be helpful in Wisconsin. In anticipation of this hearing, we recently asked our physician members who work in ERs to send us their thoughts about Emergency Room utilization and potential improvements. One member, a department of emergency services medical director, shared his own anecdote about a publication his family received in Illinois that gave the basics about minor illness care for kids. "To this day," the physician told us, "my wife, who doesn't like to bug me about these things, still uses the book." He indicated that parents who were better educated on what steps to take at home before they consider a trip to the emergency room would also eliminate unnecessary costs and help parents to understand that not every childhood ache and pain requires a trip to an ER.

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Even though emergency rooms have become the safety net for the uninsured, low income and those without a primary care physician, the current delivery model places tremendous pressures on a system that cannot necessarily match patient expectations. Our concerns about access to care continue to grow.

Furthermore, when more costly non-emergency care is provided – usurping resources for actual emergencies – the existing fragile system is burdened with unnecessary costs, sometimes resulting in a shortage of specialty physicians the patient may need. Patients do not understand that just because they need a specialist, not every MA-HMO has contracts with needed specialists. In some areas, the physician shortage is so severe that even if ER physicians look to their provider network, needed specialists simply do not exist in a geographic area.

What is positive about a basic book for parents is that it shifts a cultural belief that one must always go to an emergency room if there is a problem. This could help utilization numbers statewide. In California, usage dropped significantly for the target group. While it educates parents, at the same time the book could serve as a tool kit of sorts to guide parents in better ways to triage symptoms and try "over the counter" and common sense solutions.

Perhaps the State could partner with the Wisconsin Medical Society and relevant medical specialty societies or academies in the production of an easy-to-read, jargon-free manual for taking care of children's minor illnesses. As the state's leading physician-member organization, we could help facilitate statewide distribution of such a publication into clinics, emergency rooms and the like. The state could also distribute the manual to other targeted groups such as Head Start parents, day care centers, schools, etc.

Another suggestion that has bigger ramifications than just emergency care is something that California has recently implemented: placing MA patient pharmaceutical information on a Web site physicians can access. For patients who may "doctor shop" or be unaware of the different medicines they are on, the Web site allows a physician to see all prescriptions for a particular patient, when, and for what duration. Similar to the goals of the state's immunization directory for children, we believe this could reduce duplication of services and foster less confusion, especially for patients who may not keep their own medical records.

The Wisconsin Medical Society would welcome the opportunity to work with DHFS to help address system problems and seek creative problem solving. The Society believes it is wrong to assign blame to individuals who seek the use of emergency rooms, even in non-emergencies. In the mind of that patient, it may seem like an emergency, absent the knowledge about better choices that could be made. We would instead seek to collaborate so that parents and patients could be educated and take a more active role in how they establish criteria that separates true emergencies from the more ordinary.

The State of Wisconsin has an excellent opportunity to take a leadership role in bringing all the stakeholders together in a spirit of collaboration and partnership. While the challenges are complex, the Society believes there also is ample opportunity to take some of the strain off of what has become universal health care via emergency rooms.

Emergency room physicians will continue to provide care while they cost shift to stay afloat. But as the shortage of physicians continues to get worse in Wisconsin, this problem will need many stakeholders at the table.

Thank you again for the opportunity to share our thoughts inspired by this fine audit. As always, please feel free to contact us with your questions or thoughts. Alice O'Connor can be reached at aliceo@wismed.org or by phone at 442.3767. Mark Grapentine can be contacted via markg@wismed.org at 442.3768.

UCLA/Johnson & Johnson
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NEWS RELEASE

UCLA study shows Medicaid costs can shrink significantly when Head Start parents are trained to handle kids' common ailments

Parent health literacy and education = Fewer emergency room, clinic visits, plus big boost in confidence

LOS ANGELES, Calif., April 15, 2004 – Medicaid costs for a child's trip to an emergency room or clinic can be reduced annually by at least $198 per family when Head Start parents are provided with easy-to-understand health care guidance, according to a first-of-its kind study by the UCLA/Johnson & Johnson Health Care Institute.

The Institute's goal is to train approximately 12,000 Head Start families nationwide by 2005, which could mean a significant savings to Medicaid of nearly $2.4 million annually in direct costs associated with unnecessary emergency room and clinic visits. Using $200 as the average cost for a visit to a hospital's emergency room and $30 for a clinic visit, researchers at UCLA estimate that the savings could reach many millions per year if funds were available to provide health literacy training for the nearly one million families served by Head Start. Most Head Start parents depend on Medicaid for their health care needs.

Parents who participated in the UCLA/Johnson & Johnson Health Care Institute's pilot and follow-up training sessions became better informed about their children's health, reducing by 48 percent the number of unnecessary trips to an emergency room and by 37.5 percent to a clinic for routine illnesses, such as a cold, cough or mild fever. This also translated to a dramatic drop in the number of lost days at work (43 percent) and at school (41 percent).

Further, the studies documented a profound improvement in parents' confidence in trusting their own good judgment. Parents reported universally that, for the first time in their lives, they had the know-how to take charge of their children's health care needs.

"Head Start parents, like all good parents, want only the best for their children. Our studies showed that by raising the health literacy of Head Start parents, they could immediately apply that knowledge to become the first line of defense in taking care of their children's health," said Ariella Herman, Ph.D., Senior Lecturer of Operations and Decision Sciences at the UCLA Anderson School of Management and lead investigator of the studies. "The findings could have far-reaching implications in bringing down Medicaid costs."

Inspired by Head Start Directors

Entitled *Ensuring Positive Health Outcomes in Head Start Children and Families,* the research by Dr. Herman was inspired by Head Start Directors who were graduates of the Head Start-Johnson & Johnson Management Fellows Program held at the UCLA Anderson School of Management. Founded in 1991, it is the only executive management program of its kind.

In 2000, a survey of Head Start-Johnson & Johnson Fellows from around the U.S. revealed a shared concern: parents simply lacked the time and basic health care knowledge to become better informed about their children's health. The Fellows, all Head Start Directors themselves, believed that if parents could become better informed about fundamental health issues, it could lead directly to healthier outcomes for their children.

Started as a pilot project in 2001, The UCLA/Johnson & Johnson Health Care Institute will enter its third year in April 2004 at the annual meeting of the National Head Start Association in Anaheim, Calif. By the end of 2005, the Health Care Institute estimates it will have trained 79 agencies, 790 staff and 11,600 parents.

"We are extremely proud of our programs for Head Start directors and the impact that they have had on the lives of thousands of mothers, fathers and young children," said Alfred T. Mays, Worldwide Vice President of Corporate Contributions and Community Relations for Johnson & Johnson. "With the right training and tools, we are all empowered to achieve personal and business goals and to make healthier decisions. That's what we've seen in the over 900 directors who have become Johnson & Johnson Fellows."

The UCLA/Johnson & Johnson Health Care Institute's 10-year goal is to serve 400,000 Head Start families, reaching approximately half the Head Start agencies in the U.S.

Findings of the pilot study, which involved 400 parents, are available in the June 2004 issue of the *Journal of Community Health.*[1]

What to Do at 99.5°

In the pilot and follow-up studies, involving 1,600 parents at 14 Head Start agencies, Johnson & Johnson gave parents a medical reference guide, *What To Do When Your Child Gets Sick,* by Gloria Mayer, R.N., and Ann Kuklierus, R.N. Designed for readers with low health literacy, the guide offers easy-to-understand information on more than 50 common childhood medical issues, from fevers and minor scrapes to chicken pox and head lice.

Head Start parents were surveyed about their family's health care habits three months prior to the training and six months afterward; at the outset, 80 percent said that they did not have a single childcare book at home to reference for help when a child fell ill.

Prior to the training, parents said they were "very confident" about taking care of their sick children. Yet the study found that 49 percent said they would take their child to a clinic for a

[1] The pilot study found that by training 10,000 Head Start families nationwide, Medicaid could potentially save nearly $2 million in unnecessary E.R. and clinic visits annually.

runny nose and cough rather than provide care at home. Over 50 percent of parents did not know what to do with a child who had a temperature of 99.5 degrees Fahrenheit.

Parents surveyed post-training were, in practice, more confident, with 90 percent reporting that they used the book, some as often as four times in six months. In addition, 84 percent of parents said they were now more at ease in taking care of their child's health care needs.

Proper Training, Better Quality of Care

From the start, an objective of the UCLA/Johnson & Johnson Health Care Institute training was 100 percent parent participation. Historically, Dr. Herman said, Head Start parents faced significant barriers in taking advantage of any type of training offered by Head Start agencies, such as not having childcare or transportation, or working two jobs.

Participating Head Start agencies were allocated funds to ensure 100 percent parental involvement. Agencies turned the training sessions into easily accessible events, offering transportation, on-site childcare and meals, plus copies of the book.

According to Mernell King, former director of the Head Start program in Hannibal, Missouri, which participated in the pilot and follow-up study, "personal empowerment" has been the greatest impact for the families. "The program is a miracle for Head Start families, saving lives and money in our community and giving parents the knowledge to act as primary teachers and nurturers of their children," said Ms. King.

# # #

Johnson & Johnson is the world's most comprehensive and broadly based manufacturer of health care products, as well as provider of related services, for the consumer, pharmaceutical and medical devices and diagnostics markets. The Company is headquartered in New Brunswick, NJ. (www.jnj.com)

In 1991 Johnson & Johnson and UCLA joined to strengthen the entrepreneurial management skills of Head Start Directors through training at the UCLA Anderson School of Management's top-ranked Harold Price Center for Entrepreneurial Studies. The UCLA/Johnson & Johnson Health Care Institute was formally established in 2003 to determine strategies for assisting Head Start families in gaining health care knowledge and to study the impact of health literacy in assuring children are receiving the best health treatment possible. (www.anderson.ucla.edu/community/headstart/hci.html)

Johnson & Johnson Fellows of note include Helen Taylor, who later became the Head Start Associate Commissioner in Washington, D.C., and Ron Herndon, current chairman of the National Head Start Association; Manda Lopez, executive director of the National Migrant and Seasonal Head Start Association; Amanda Bryans, director of operations for the Head Start Bureau; and Lawrence Pucciarelli, director for the Head Start State Collaboration for Rhode Island, among others.

(For more information please visit the Health Care Institute website at www.anderson.ucla.edu/community/headstart/hci.html.)

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REDUCING THE USE OF EMERGENCY MEDICAL RESOURCES AMONG HEAD START FAMILIES: A PILOT STUDY

Ariella D. Herman, PhD; Gloria G. Mayer, RN, EdD, FAAN

ABSTRACT: The objective of this study was to determine whether self-care training with Head Start parents can improve their ability to manage the healthcare needs of their children measured by utilization of emergency department (ED) and physician services. Four hundred and six families in Head Start agencies were included in the study. Parents were given a low-literate self-help book entitled *What To Do When Your Child Gets Sick*. The study design included using multiple-choice, pre-and post-intervention survey data. In a six month follow-up, parents who received the book reported a 48% reduction in ED visits and a 37.5% reduction in clinic visits. More research is needed to determine if this self-care tool and additional training can have a significant impact on inappropriate use of medical resources.

KEY WORDS: literacy; self-care; survey; Head Start;emergency department.

INTRODUCTION

Use of hospital emergency departments (EDs) is on the rise. According to the National Hospital Ambulatory Medical Care Survey, the volume of ED visits in the United States increased by 14% from 1992 to 1999, from 89.8 million to 102.8 million per year.[1] Although patients visiting the ED are often treated for acute medical problems and severe injuries, the ED is also used as a safety net for those lacking access to primary healthcare. And these ED visits are expensive: the average cost of a non-urgent visit is roughly $200, approximately 2 to 3 times the cost of a regular doctor or clinic visit.[2] On average, it has been estimated that hospital EDs absorb a $46 loss per patient visit.

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The Promise of Self-Care

Many ED visits, especially those involving young children, are for nonurgent conditions such as cold symptoms or mild fever. Parents who are better informed about the appropriate use of the ED can help to decrease unnecessary visits, bringing costs down and lessening the burden on the overtaxed emergency medical system. In fact, evidence has been mounting about the benefits of self-care and health promotion for people across the life cycle.[3,4,5] By acquiring better self-care skills, patients can more actively participate in shaping the conditions that influence their health and that of their families and children.

Good self-care knowledge and training of parents can help to reduce unnecessary or inappropriate healthcare utilization. In a Swedish study,[6] mothers were given a self-care booklet and a self-care educational session about young children's minor illnesses. Of the 572 study participants, those mothers who read the child care section followed recommendations about when to seek (and not to seek) medical care significantly better than did those who had not read it ($p < .003$). Mothers who read the booklet were less likely to seek medical care when not recommended compared to those who did not read it ($p < .001$).

UCLA and Johnson & Johnson

Such interrelated issues of self-care, parental knowledge, and the appropriate use of medical resources coalesced in a U.S. study commissioned by Johnson & Johnson in 2000. Researchers at the University of California, Los Angeles (UCLA), were asked by Johnson & Johnson to survey alumni of the Head Start-Johnson & Johnson Management Fellows Program to gather data about the current health-related practices of Head Start agencies, identifying the most challenging operational issues for incorporation into future offerings of the fellows program curriculum. The program, conducted by the Anderson School of Management at UCLA and funded by Johnson & Johnson and the Head Start Bureau, is a training program established in 1991 to develop and strengthen the management skills of Head Start directors.[7]

In the 2000 survey, it was found that Head Start healthcare coordinators identified parenting skills as the most critical community risk factor affecting the health or mental status of low-income children, along with poverty and substance abuse.[8] In fact, parental knowledge was judged to be a substantial obstacle to the ability of children to obtain the appropriate health services. According to the survey, Head Start parents are unedu-

cated or misinformed about healthcare practices and lack the time to obtain the appropriate services for their children.

In response to these findings, UCLA and Johnson & Johnson launched this pilot study to educate Head Start parents so they can properly manage the health needs of their children. Recent research findings led the study team to select a self-care model that would be effective for a population of Head Start families, many of whom lack basic health literacy and do not have a firm grasp of medical terms and concepts. The self-care tool chosen for the study was the book *What to Do When Your Child Gets Sick*, by Gloria G. Mayer, RN, and Ann Kuklierus, RN, part of a series of easy-to-read self-help books published by the Institute for Healthcare Advancement (IHA).[9] Designed for readers with low health literacy (books in the series range from a third- to a fifth-grade reading level and are available in English as well as Spanish and Vietnamese translations), *What to Do When Your Child Gets Sick* offers easy-to-understand information on more than 50 common childhood medical problems, from fevers, infections, and pinkeye to heat rash, broken bones, bites, and poisoning.

Past surveys have shown high satisfaction with the book. A telephone survey of 256 caregivers of low-income English- and Spanish-speaking patients who received the book showed that more than 90% kept the book, used it multiple times, understood its contents, and avoided medical intervention for a common problem.[10] Anecdotal reports by survey participants noted that 5.1% of those who used the book reported that it had saved them a trip to the doctor's office.[10] Independent surveys of IHA books by Molina Healthcare of California and Northwest New Jersey Maternal and Child Health Network validated these findings.[10]

The objective of the following pilot study was to educate Head Start parents to properly manage the health needs of their children. The original purpose of the study was twofold: (1) to evaluate the impact of healthcare training by measuring results before and 6 months after training and (2) to measure the effectiveness of two different training models (a train-the-trainer model and a model in which parents were trained directly). The survey data presented in this article speak only to the first purpose; a future article will discuss which of the two training models was found to be more effective.

METHODS

The study consisted of 4 phases beginning in June 2001 and completed in August 2002. During the first phase, surveys were developed and

the 4 Head Start sites were identified. These were located in Hannibal, Mo.; Contra Costa, Calif.; Long Beach, Calif.; and El Monte, Calif. Phase 2 consisted of baseline surveys and training programs. In phase 3, data were tracked and focus groups were conducted. In phase 4, the surveys were conducted and results were analyzed by the principal investigators and researchers in the Anderson School of Management.

Volunteer sites were solicited from Head Start-Johnson & Johnson Management Fellows alumni. Four sites were selected based on the quality of the directors and their ability to recruit participants. The original goal at each site was a sample size of 100 participants, though 2 sites had slightly less and 1 slightly more. It was hoped that each site would have an equal division of participants in the control group (those who received the book only) and the intervention group (those who received the book plus training). Table 1 shows a breakdown of the number of participants in the intervention and control groups at each of the 4 participating Head Start agencies, along with a breakdown by racial classification and the primary languages spoken at each site.

Participants were identified by the name of the child and some parents had multiple children in Head Start programs. Head Start agen-

TABLE 1

Study Groups

	Hannibal, MO	*Contra Costa, CA*	*Long Beach, CA*	*El Monte, CA*	*Total*
Intervention Group	51	31	104	50	236
Control Group	37	68	15	50	170
					406
Children Served	392	1749	1614	1316	
Demo-graphics					
African-American	18%	23%	40%	3%	
Asian	1%	23%		4%	
Caucasian	79%	12%		2%	
Hispanic	2%	33%	60%	88%	
Native American	0%	0%		0%	
Other	0%	9%		3%	
Primary Language	English	Spanish	English	Spanish	

cies individually marketed the study to their clientele. Each agency offered incentives of dinner and other gifts, including the self-help book, to encourage parents to give their time. All participants completed a survey prior to receiving the complimentary dinner, after which those in the intervention group proceeded to the training class and those in the control group went home. A total of 406 parents filled out the pre-intervention survey, which was administered in person at each of the sites; 224 filled out the post-intervention survey.

RESULTS

Pre-intervention Surveys

During the pre-assessment phase, Head Start healthcare coordinators were asked a series of questions to determine their beliefs about the parents' attitudes and behaviors. Twenty-seven coordinators responded. When asked how often they believed Head Start parents used a book to learn about their children's health, only 4 (13%) responded "very often"; 9 (34%) responded "sometimes." Roughly half (14/27) responded "never." Of the 406 parents who answered the pre-assessment survey (intervention and control), almost 75% (300/406) noted that they did not have any books on child health. Only 106 (26%) responded that they did have such a book, suggesting that the coordinators' estimates were fairly conservative.

When asked whether the *What to Do* book seemed easy to understand, 19 (70%) of the coordinators responded "very easy"; 24 (90%) predicted that the book would be a useful intervention tool. Roughly the same number of coordinators (88%) responded that Head Start parents were "very interested" in the healthcare of their children. (An additional 12% guessed that parents were "somewhat interested.") However, approximately two thirds of the coordinators (17/27) felt that Head Start parents were only "somewhat confident" when it came to their children's health. By contrast, 7 (25%) felt that these parents were "not confident" and only 3 (11%) felt that that they were "very confident." More than 90% of the coordinators responded that Head Start parents were either "very anxious" (14/27) or "anxious" (11/27) about their children's medical care, suggesting that they may believe that these parents are eager to learn appropriate methods for dealing with their children's healthcare in general.

Along similar lines, approximately 78% of parents (315/406) responded that they were "very worried" when their children got sick. Yet

despite the assessments of the healthcare coordinators (with only 11% responding that parents were "very confident" about their children's healthcare), a total of 385 Head Start parents (95%) claimed they were "very confident" they could take care of their children when they became sick. A total of 294 parents (72%) replied that they "usually knew what to do" when a child was ill.

However, the parents' responses to several non-emergency medical conditions yielded surprising results about their knowledge concerning appropriate avenues for treatment. When asked what they would do if their child had a runny nose or cough, 49% (199/406) said they would take the child to the clinic or make an appointment with the doctor. One third (33%) responded that they would keep the child home from school. Very small minorities would look in a book (1%), ask family or friends what to do (1%), or call 911 or take the child to a hospital ED (2%). Roughly 14% (57/406) reported that they would "do nothing and wait." Similarly, when asked what they would do if their child had a temperature of 99.5° F, most parents responded that they would either take the child to a clinic or make a doctor's appointment (44%) or keep the child home from school (26%). Eighteen percent (73/406) responded that they would "do nothing and wait." Overall, then, the Head Start parents seemed unsure about the appropriate response to these mild condition.

Follow-Up Surveys: Impact of the Book and Training

The post-intervention survey was conducted 6 months after the original survey and composed of the same 49 questions, but with the addition of 6 questions about the What to Do book itself. In the follow-up survey, 70% more parents now reported that they had a book on child's health, and 38% more reported that they relied frequently on the advice of a healthcare book when their children became sick.

Most parents claimed to have used the book and had a positive experience with it. A total of 145 (96%) rated the book as "very easy to understand," with none reporting that it was "hard to understand" and only 3% reporting that they had not used the book. One hundred twenty-two parents (81%) found the book to be "very useful" and 26 (17%) found it useful "sometimes." Only 2% reported that they had not used the book in response to a question about the book's usefulness ("If you used this book, how useful was it?"). In response to the question "If you used this book, what would make the book better?" roughly 42% of the parents (63/151) thought the book was "perfect the way it is," and 32% (48/151) felt it would be helpful to "add more information." With 13% of parents (20/

151) recommending that the authors "add more pictures," more than half (51%) seemed curious to learn more, either by indicating their general desire for "more information" and more pictures (a combined total of 45%) or by suggesting that the authors "make [the book] longer" (6%). Seventy-one percent of respondents (107/151) claimed to have used the book "frequently," with 67% (101/151) rating the book "very well liked." (One third of parents [33%] found the book to be "okay.")

According to the survey, exposure to the self-care book or to the book with additional training affected the way many parents accessed their health information. Before the intervention, about half of the parents (52%) claimed to derive health information "from the doctor or clinic." Following the intervention, however, only 18% claimed to access health information this way—a decrease of 34%. The effects of the training were evident in parents' responses to the question "When your child is sick, where do you first go for help?" In the control group (those who received the book without the additional training), 69% responded that they would "call [their] child's regular doctor or health phone line." In the intervention group, however, which received both the book and training in how to use it efficiently, 58% responded that they would "look in a book," with only 28% reporting that they would "call [their] child's regular doctor or health phone line." (Only 1% of those in the control group responded that they would "look in a book" first.) Eight percent of those in the control group had noted that they would "take [their] child to the emergency room," whereas only 3% of those in the intervention group claimed they would take that route when a child was sick. (Seventeen percent in the control group would "call family or friends," whereas only 7% in the intervention group chose that option.) Overall, then, 6 months following the intervention more parents claimed they would turn to a book and fewer claimed they would take a child to the clinic or ED in response to a perceived illness.

Table 2 shows the relative percent changes of parents' reported responses to mild conditions before and after the intervention, including what they would do if their child had a fever of 99.5° F, had an earache, was vomiting and had diarrhea, or had a runny nose and a cough. In each case, more parents would look in a book and fewer would call 911, go to the ED, or go to the doctor or a clinic.

Parents' confidence levels seemed to be positively affected by the book and training. When asked whether they felt confident caring for their child's healthcare needs after reading the book, 84% responded that they were "more confident after reading the book" and 16% felt "the same after reading the book." According to the parents who responded to the

TABLE 2

Parent Responses Pre and Post Intervention

HEALTHCARE IMPACT–Parent Responses

	% Change Pre vs. Post			
Method of Treatment	*99.5° Fever*	*Earache*	*Vomit & Diarrhea*	*Runny Nose/Cough*
Other	–12%	–2%	–20%	12%
Do Nothing and Wait	15%	2%	4%	–18%
Keep them Home from School	–10%	15%	9%	–2%
Look in a Book	13%	13%	17%	19%
Call 911/Go to Emergency Room	–3%	–4%	–2%	–5%
Go to Doctor/Clinic	–6%	–27%	–8%	–12%

follow-up survey, post intervention they made 161 fewer visits to the doctor or clinic ($p < .01$); 67 fewer calls to the doctor ($p < .03$); and 32 fewer visits to the ED ($p < .01$) (Figures 1 and 2).

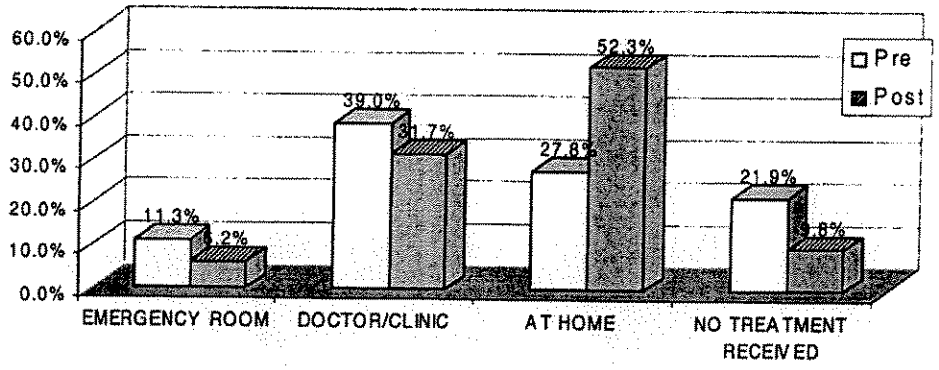
DISCUSSION

These results suggest that Head Start parents could benefit psychologically from training and access to a self-help book like *What to Do When Your Child Gets Sick*. And it seems clear that fewer unnecessary ED visits would have a positive fiscal impact on all stakeholders involved in emergency medical care, from patients to insurance companies.

The self-care tool and training program examined in this pilot study seemed to result in fewer visits to the ED as a primary treatment for a child's illness. Before the intervention, these Head Start families reported 66 visits to the ED; after the intervention, that number dropped by 32 visits to 34, a 48% reduction. Based on the $200 estimated cost for a single visit to the ED, this reduction translates into a cost savings of approximately $6,400 over 6 months and—extrapolating that figure—$12,800 over 1 year for those in the pilot group. This group was composed of 226 families; therefore, we estimate an average cost savings of $57 per

FIGURE 1

Coordinator responses to where child was seen.

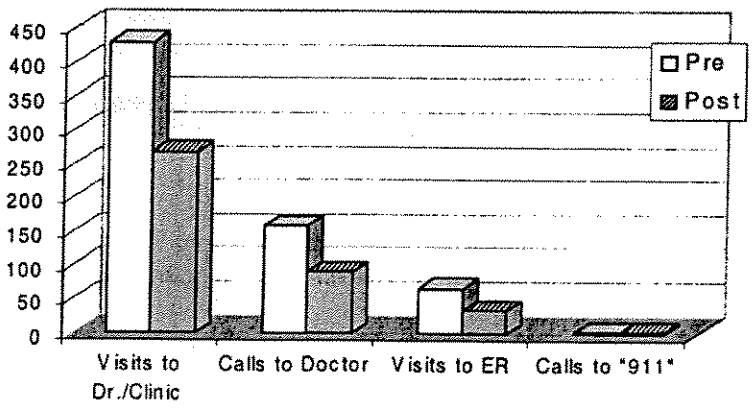


family annually. If a family achieved this savings on all the children in the family, the savings would be significantly higher. In addition, increasing the number of families trained should increase the savings accordingly.

The number of clinic visits also decreased during the study period. Before the intervention, Head Start families made 429 clinic visits. Following the intervention, 268 were reported. This is a 37.5% decrease in clinic visits. Because the average cost of a clinic visit is approximately $30, a

FIGURE 2

Parent responses on where child treated.



decrease of 161 visits translates into a total cost savings of $4,830 over 6 months and $9,660 over 1 year. Combining the savings in ED visits with the savings in clinic visits results in a $22,360 annual savings, approximately $99 per family trained by the Head Start coordinators.

In qualitative terms, use of this self-help book and the corresponding training program could have other advantages apart from those mentioned above. More knowledgeable parents keep better track of children's immunizations, decreasing unnecessary vaccinations and ensuring that their children are protected from debilitating illnesses. Better-informed parents provide improved well-child care for young toddlers and take better care of their future children, from conception through adolescence. Such parents might save time and money with their newfound ability to provide minor healthcare to family members, critically thinking through various healthcare options when a child is sick or taking advantage of preventive measures and less costly treatments when the time comes. In general, more knowledgeable parents raise children who miss fewer days of school, perform better academically, and lead happier and healthier lives—all important factors for at-risk children and children in general.

Study Limitations

Behavior change is a complex process that is often difficult to achieve and sustain. Health professionals realize that, in their work to encourage healthy behaviors, they are competing against powerful forces involving social, psychological, and environmental conditioning. Dean and Kickbush[11] view self-care as a continuum of caring for the self (or dependents) to enhance health, prevent disease, evaluate symptoms, and restore health. They see this continuum as organized by the perceptions, decisions, and options available to each individual. Lacking a more complex psychological profile of this specific population, our data on the beliefs and attitudes of Head Start families are necessarily tentative and limited.

The survey data used in this study present interesting indications of the impact of improved self-care skills on the healthcare behavior of parents. The data have three general limitations: 1) there is possible response bias due to the reduced number of post surveys collected (224) in comparison to the pre-surveys (406), which also limits the relevance of p values; 2) there was self-selection in the Head Start programs that participated as well as the parents at each location; and 3) the responses of the health coordinators are second-hand regarding the behavior of the parents.

CONCLUSION

Use of an easy-to-read, easy-to-understand self-care book on children's healthcare had a positive impact on parents' confidence and knowledge of basic medical interventions. Most Head Start parents and healthcare coordinators had a positive view of the book and believed it could be useful as an intervention tool. Over the 6-month period between the initial survey and the follow-up survey, parents in the 4 Head Start agencies made 34 fewer visits to the ED and 161 fewer visits to a clinic, relying more on information found in the book when their children became sick. Better utilization of medical resources, especially the ED, can help all parties involved: the sickest patients can receive more timely and appropriate medical care, healthier patients can receive better follow-up and helpful education in the clinic setting, hospitals can equip themselves to provide fiscally responsible and optimized medical care to their patients, and payors can reduce unnecessary costs related to inappropriate resource utilization.

In view of the diverse nature of self-care behavior, however, it seems unlikely that a single set of factors will be able to explain all forms of self-provided healthcare. More research is therefore necessary to determine whether a direct cause-effect relationship exists between the reduction in ED visits reported here and the availability of health information geared toward those with low health literacy, though these preliminary results are encouraging.

ACKNOWLEDGMENT

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Wisconsin Medical Society

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JUN 2 9 2004

TO: Co-Chairperson Carol Roessler, Co-Chairperson Suzanne Jeskewitz and Members, Joint Audit Committee

FROM: Alice O'Connor

DATE: June 25, 2004

RE: Wisconsin Hospital Association–Wisconsin Medical Society Physician Shortage Report

As a follow-up to Thursday's hearing (June 24), I am providing an additional copy of the Wisconsin Hospital Association – Wisconsin Medical Society's Physician Shortage Report.

As always, please feel free to contact me with your questions or thoughts. I can be reached at aliceo@wismed.org or by phone at 442.3767.

Regards,

Alice O'Connor

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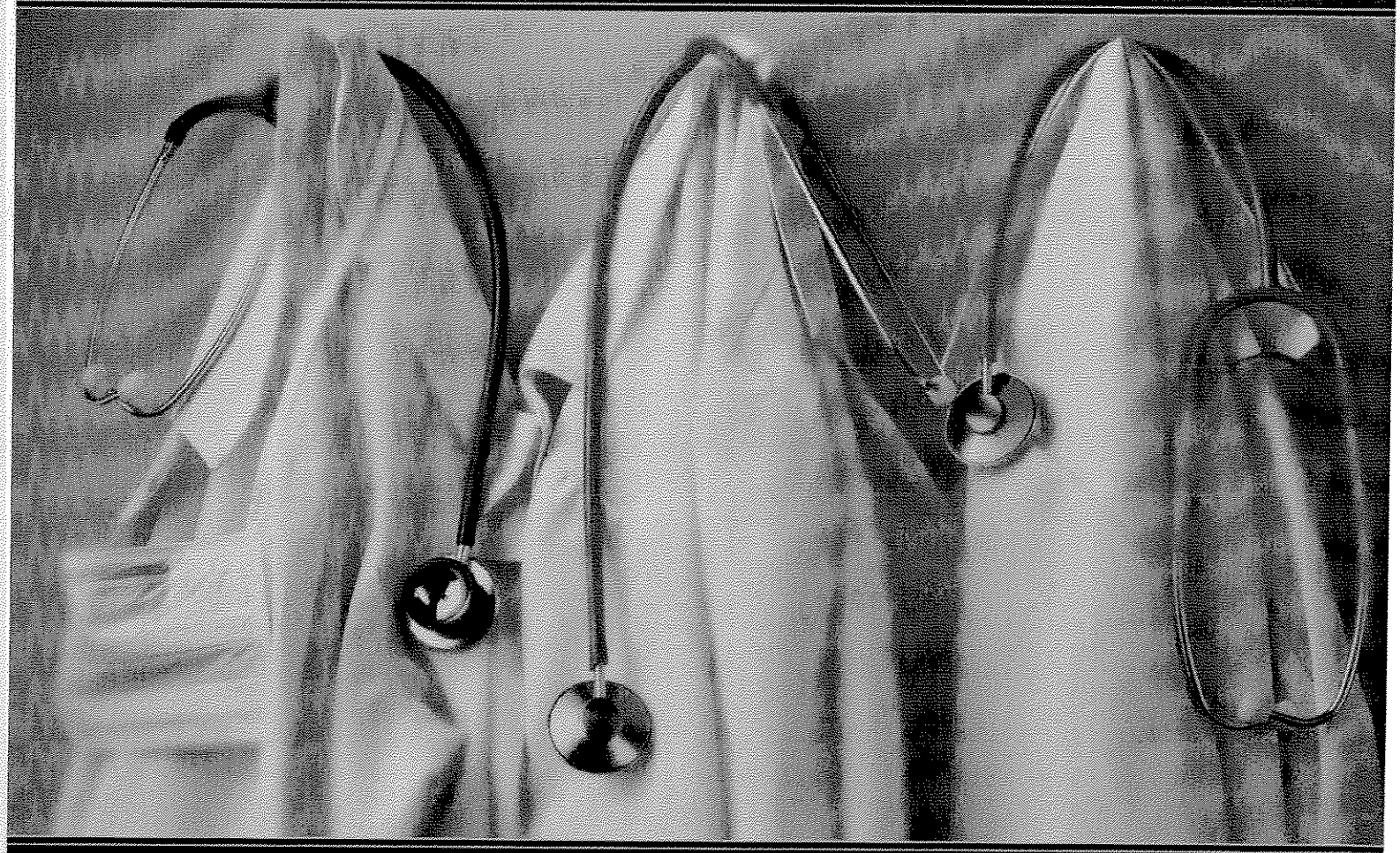
Who Will Care For Our Patients?

Wisconsin Takes Action to Fight a Growing Physician Shortage



A report by the Wisconsin Hospital Association and the Wisconsin Medical Society.

Who Will Care For Our Patients?

Wisconsin Takes Action to Fight a Growing Physician Shortage

March 2004

A report by the Wisconsin Hospital Association and the Wisconsin Medical Society

Executive Summary

In early 2003, the Wisconsin Hospital Association, together with the Wisconsin Medical Society, established a Task Force on Wisconsin's Future Physician Workforce. The charge to the Task Force was:

- Undertake a needs assessment of current and future physician supply and distribution issues.
- Identify factors that are impediments to meeting those needs.
- Find specific strategies that will help assure adequate future access to physicians for Wisconsin patients and communities.

The work plan included the following tasks:

- Understand the current supply of physicians in Wisconsin.
- Identify and understand issues relating to estimating physician demand.
- Estimate the current and future demand/need.
- Identify strategies for meeting the specific needs.

Task Force membership included representation from physician practice groups, the Wisconsin Medical Society, the Wisconsin Academy of Family Physicians, hospitals and health systems, the medical schools in Wisconsin and others. Four meetings were held. Information and data were shared that represented a number of perspectives on the issue. This final report provides a comprehensive set of recommended solutions to the physician shortage problem.

Conclusions Regarding Physician Supply

After reviewing existing data and analysis, the Task Force concluded that an unmet current need exists for physician services and that the problem will likely grow worse in the future unless aggressively managed.

The current supply is not sufficient when measured several different ways:

- There is a shortage of primary care physicians in rural Wisconsin and inner city Milwaukee.
- In general, non-primary specialty physicians are in demand and are hard to recruit on a statewide basis.
- General surgeons and radiologists are critically needed in rural areas.

These unmet needs are projected to grow even more in the future. By 2015, we anticipate demand for physicians to grow:

- By an additional 13.5% for primary care physicians.
- At rates exceeding 20% for all other physicians.

At the same time, physician supply is projected to lag even further, due to projected negligible growth in Wisconsin's physician workforce over the next 10 years. This compares to a projected increase in population of 8.8%, with demographic factors expected to drive demand for health care services in excess of that total.

Our Action Plan

A number of major changes are necessary to have a sufficient number of physicians to meet the anticipated demand in the future. These changes focus on:

- Enrolling students in medical schools who will practice in Wisconsin.
- Developing new care delivery models.
- Retaining physicians in and attracting physicians to Wisconsin.
- Targeting and enhancing funding for medical education.
- Creating an infrastructure to guide medical education in Wisconsin.

Goals and Action Steps

GOAL I: Recruit, enroll and train in Wisconsin's medical schools individuals who are likely to practice in Wisconsin, with particular attention towards underserved parts of Wisconsin.

Action Steps:

- Increase the number of students in medical school.
- Establish goals for medical schools to set and achieve targets for successful recruitment and retention of students from underserved areas.
- Create regional specialty training networks to expose trainees to underserved areas.
- Develop/replicate programs that attract to medical school, students most likely to practice in underserved areas.
- Create a programmatic focus or a "School within a School" to focus on underserved areas.
- Start promoting health careers at the middle school level.

GOAL II: Develop care delivery models that will enhance and leverage physician resources.

Action Steps:

- Provide funds for pilot projects demonstrating "team care models."
- Conduct pilots and studies of alternative delivery models.
- Prepare medical students and residents to work with advanced practice providers.
- Investigate potential mentoring opportunities using retired, part-time and administrative physicians.
- Evaluate shortening the timeframe for medical education.

GOAL III: Create policy and practice that encourages physicians to enter and remain in practice in Wisconsin. Create similar policies to encourage physicians to return to Wisconsin to practice.

Action Steps:

- Create funds for loan forgiveness for physicians to stay in the state after their residencies.
- Establish incentives to ensure specialists are adequately dispersed across the state.
- Identify and publish best practices for recruitment and retention.
- Maintain Wisconsin's favorable medical malpractice environment.
- Ensure adequate payment rates to support physician recruitment.
- Provide monetary incentives to address selection of locale and specialty.

GOAL IV: Provide for adequate and targeted funding for medical education.

Action Steps:

- Increase state funding for medical education.
- Increase Medicaid GME and tie increases to Task Force goals.

GOAL V: Develop an infrastructure to guide medical education policy in Wisconsin.

Action Steps:

- Create a Wisconsin advisory council to monitor, predict and recommend activities to maintain an adequate supply of physicians for Wisconsin.
- Create a process to maintain adequate data about physician supply and demand.

Conclusion

These goals and action steps require the efforts of Wisconsin's medical schools, the provider community and policy makers to enact changes in medical education and physician practice. If that work is successful, we can be assured that our future physician workforce will be able to provide needed services to all of Wisconsin's citizens.