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👉 Statutory reports to the legislature

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ... PUBLIC HEARING - COMMITTEE RECORDS

2011-12

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Health...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
 - (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
 - (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2013)

DEPARTMENT OF EMPLOYEE
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State of Wisconsin
Governor Scott Walker

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SERVICES
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June 27, 2011

The Honorable Jeff Stone
Chairman, Committee on Health
314 North, State Capitol
Madison, WI 53702

The Honorable Garey Bies
Chairman, Committee on Public Health and Public Safety
216 North, State Capitol
Madison, WI 53702

Dear Representatives Stone and Bies:

Wis. Stat. § 153.05 (2s) directs the Department of Health Services and the Department of Employee Trust Funds to jointly prepare an annual report on the activities of the Wisconsin Health Information Organization (WHIO). The Departments are required to submit this report to the standing committees of the Legislature with jurisdiction over health issues.

WHIO is a national leader in using electronic health information to drive changes in the health care system. There are presently about 60% of Wisconsin's covered lives, commercial and Medicaid, included in the WHIO Data Mart. WHIO is actively negotiating with the Centers for Medicare and Medicaid Systems to obtain Wisconsin's Medicare data which represents most of the present gap in covered lives in the WHIO data. Thirty-seven organizations have access to the Data Mart, and this represents 28 members or subscribers, their owners, or wholly owned subsidiaries, or research organizations.

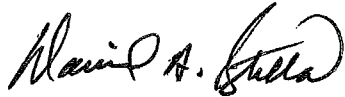
In 2010, WHIO launched a payment reform initiative focused on the design and implementation of health care reimbursement methodology that rewards value over volume of services delivered. This initiative identified and is targeting areas for reform focused on preventive, chronic, and acute care services and is using the WHIO Data Mart to support the initiative. WHIO has continued to use its data mart for physician performance reporting and to report on comparative pricing for consumers as required in 2009 Wisconsin Act 146. As a result of the groundbreaking work done by WHIO and eventually the availability of clinical data through statewide health information exchange, both public and private sector health care purchasers will have the ability to measure the quality and price of health care services and use that information to increase the value of future purchases.

Representatives Stone and Bies
June 27, 2011
Page 2

WHIO is also an excellent example of a collaborative public-private partnership and an extremely important initiative for Wisconsin to achieve transparency in health care and promote better health care outcomes for the people of Wisconsin. WHIO's efforts to convene a statewide conversation around payment and delivery system reform are commendable, and WHIO's Partnership for Healthcare Payment Reform will help Wisconsin move toward rewarding quality patient outcomes and creating incentives for more cost-effective care, not just more care. We continue to be fully committed to working in partnership with the other health care stakeholders across the state through WHIO.

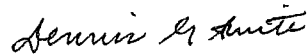
Please find enclosed the third annual report on the activities of WHIO. If you have any questions, please contact Denise Webb, State Health IT Coordinator, at (608) 267-6767.

Sincerely,



David Stella, Secretary
Department of Employee Trust Funds

Sincerely,



Dennis G. Smith, Secretary
Department of Health Services

Enclosures

Annual Report to the Wisconsin Legislature
on
the Wisconsin Health Information Organization (WHIO)

Submitted by the Department of Health Services and the Department of Employee Trust Funds

May 2011

Background

In 2008, the Department of Health Services (DHS) and the Department of Employee Trust Funds (ETF) entered into a contract with the Wisconsin Health Information Organization (WHIO) to serve as the data organization defined in Wis. Stat. § 153.01 (3g). WHIO was formed to collect and aggregate health care claims data into a centralized repository (“Data Mart”) and subsequently analyze and report on the delivery of health care in Wisconsin.

WHIO is a collaborative, public-private partnership established in 2005 to drive improvements in the quality, safety, efficiency, and cost of health care. WHIO is governed by a multi-stakeholder board that includes providers, purchasers, insurance payers, and state agencies. Board members include representatives from the following organizations:

- DHS
- ETF
- Anthem Blue Cross Blue Shield of Wisconsin
- Dean Health System
- Greater Milwaukee Business Foundation on Health
- Humana
- Marshfield Clinic
- The Alliance
- UnitedHealthcare of Wisconsin
- Wisconsin Education Association (WEA) Trust
- Wisconsin Physicians Service (WPS) Health Insurance
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
- Wisconsin Hospital Association (WHA)
- Wisconsin Medical Society (WMS)

WHIO’s initial goal was to create a centralized repository of aggregated administrative medical and pharmacy claims data for Wisconsin. This data is used by member organizations to generate comparative performance reports for providers, evaluate population health, and perform additional analysis on the delivery of health care. WHIO’s longer term goal is to develop and disseminate public reports on health care quality, safety, and efficiency.

WHIO Operations

WHIO and its founding members signed a three-year, \$4.8 million contract with Ingenix Consulting (Ingenix) on March 31, 2008. This contract tasked Ingenix with responsibilities for constructing and hosting the Data Mart and developing the data analysis and reporting tools. Ingenix is a health and human services consulting organization with significant experience working with hospitals, physicians, health plans, employers, government agencies, and pharmaceutical companies. In response to successful performance under the initial agreement, WHIO renewed the contract with Ingenix effective January 1, 2011 for services through December 31, 2013.

Ingenix delivered the first version of the Data Mart to WHIO on December 2, 2008. This version of the repository included claims data submitted by Anthem, Humana, UnitedHealthcare, WEA Trust, and WPS. Since that time eight more health plans have begun to contribute data to the Data Mart. All data contributing organizations must comply with a rigorous, standard data submission process. The Wisconsin health insurers voluntarily agree to submit their data and make a significant resource investment to prepare their data to meet the WHIO Data Mart standards.

To assure compliance with federal and state patient privacy, confidentiality, and anti-trust laws and regulations, Ingenix removes all patient, commercial payer, and employer identifiers from the WHIO Data Mart in the claims data aggregation process. The WHIO Board developed and approved a Data Use Agreement in December 2008, which guides the appropriate use of the Data Mart by WHIO and all member organizations. The Agreement is revisited annually to ensure it continues to comply with current law and incorporates the policies developed by WHIO.

There are presently about 60% of Wisconsin's covered lives included in the WHIO Data Mart. To improve the ability to produce comprehensive comparative performance reports for health care providers throughout the state, WHIO is pursuing the capture of health care claims data from as many sources as possible. However, WHIO recognizes it will be impossible to capture all medical care activity through insurance claims. WHIO is actively negotiating with the Centers for Medicare and Medicaid Systems to obtain Wisconsin's Medicare data which represents a significant portion of the present gap in covered lives in the WHIO data.

The Data Mart contains a rolling 27 months of data and is updated every six months. Each new version is referred to as Data Mart Version (DMV) followed by the sequential number of the edition. DMV2 contained claims data from October 1, 2006 – December 31, 2008. DMV3 was released in April 2010 and contained claims data from October 1, 2007 – December 31, 2009. It also included two new data contributors: Wisconsin Medicaid Fee-for-Service (FSS) and Gundersen Lutheran Health Plan. Version 4 of the Data Mart was released to WHIO members and subscribers in October 2010. DMV4 added four new data contributors and the Medicaid HMO data to further enrich the comprehensiveness of the information. The four new contributors were Mercy Care, Group Health Cooperative (GHC) of South-Central Wisconsin, Dean Health Plan, and Security Health Plan. Data Mart Version 5, released April 11, 2011,

included two additional data contributors, Physicians Plus Insurance Corporation and Network Health Plan. A summary of DMV5 General Facts is attached for reference.

DHS worked through the State’s Medicaid fiscal agent (HP Enterprise Services) and Medicaid Management Information System (MMIS) administrator to develop the technical specifications and queries necessary to extract Medicaid data for inclusion in the Data Mart. To assist WHIO users in distinguishing between different types of Medicaid members, the system allows for the data to be grouped by Product Type (i.e., FFS, HMO, Dual FFS, and Dual HMO). Data Mart Version 4 included claims for all Medicaid product types.

With each release of the Data Mart, the volume of aggregated data increases and becomes more meaningful and useful for the WHIO users. The table below shows the increase in data available after each data mart release. WHIO expects substantial growth with each subsequent release.

Type of Data	DMV1	DMV2	DMV3	DMV4	DMV5
# of Data Contributors	5	5	7	11	14
# of Members	1.5M	1.6M	2.8M	3.4M	3.7M
# of Medical Claims	39M	54M	102M	207M	233.5M
Episodes of Care	5.9M	7.3M	11.1M	18.8M	21.5M
Reporting Period	1/1/06 – 3/31/08	10/1/06 – 12/31/08	10/1/07 – 12/31/09	4/1/08 – 3/31/10	10/1/08-12/31/10

The next release of the Data Mart is scheduled for October 2011 and will include two new data contributors: Unity Health Plan and Health Tradition Health Plan, leaving only GHC-Eau Claire as the remaining Wisconsin domiciled health plan not contributing claims data.

Physician Engagement

Throughout 2009 and 2010, WHIO focused on physician outreach and engagement by encouraging physician groups to participate in the system configuration assignment and reporting templates associated with the WHIO Data Mart. WHIO has created a standard format for provider performance reporting to assist in building awareness of the data as well as gaining acceptance of the WHIO data in the provider community. This report summarizes information at the practice group site and compares overall quality and cost performance of a practice site specialty group relative to their peers across the state. It includes the morbidity index and breaks down resource use by type of service based on fixed fees and relative to peer group. These reports are made available at no cost to physicians and are distributed by the Wisconsin Medical Society and WHIO. A copy of the standard provider performance report is attached as reference.

In addition, the Wisconsin Medical Society supports WHIO’s physician engagement efforts by facilitating multiple Wisconsin Health Improvement Zone – Community Improvement Dialogues (WHIZ – CIDs). Each group includes 15 physicians, both primary care and specialists, as well as nurses, social workers, psychologists, employer representatives, researchers, and data analysts who meet monthly to look at the WHIO data and discuss how it can benefit provider practices

and increase value to their patients. The WHA has also contributed to engaging providers by hosting four regional meetings that included as many as 35 organizations at each meeting to present WHIO concepts and demonstrate the reporting tool as a key business asset for their organizations. The Rural Wisconsin Health Cooperative has held membership-wide orientation and training sessions for their members.

The WHIO Clinical Advisory Panel has offered two statewide webinars for physicians to inform them on WHIO data methodologies and concepts. These have had significant participation and future webinars are scheduled.

On May 13, 2011, WHIO held its First Annual Symposium offered to all Wisconsin healthcare stakeholders. WHIO presented learning panels on how users are integrating the findings from the WHIO data into their business models. They featured Thedacare, WMS, Aurora and the WCHQ. WHIO will be offering more training on concepts and methodologies.

Partnership for Healthcare Payment Reform

In 2010, WHIO launched a payment reform initiative focused on the design and implementation of a health care reimbursement methodology that rewards value over volume of services delivered. It involves stakeholders from the payer, provider, purchaser, and consumer perspective. The Partnership for Healthcare Payment Reform has identified and targeted areas for reform focused on preventive, chronic, and acute care services. This project is a substantial undertaking. More than 150 medical providers from across the state are participating in work groups charged with designing and implementing pilot programs to test the effectiveness of new payment models. A summary of progress to date is attached for reference.

Sales and Marketing

Adequate and recurring revenue remains a challenge. Prior to 2009, WHIO depended exclusively on the contributions of member organizations and the State contract for revenue. Increasing membership is paramount to WHIO's long-term sustainability and serves two purposes: advancing the sources of data for aggregation and reporting, and increasing revenue. As described earlier, new data contributors joined WHIO in 2010 and paid membership fees resulting in \$265,000 annually. All agreements are 3-year commitments.

Subscriptions add an additional source of revenue. Aspirus became the first subscriber in late 2009. Bellin Health Care Systems, Northeast Wisconsin Health Value Network (NEWHVN), Prevea Clinic, Aurora and ThedaCare have since purchased subscriptions. Collectively, these sales resulted in \$370,000 in revenue in 2010. Several other subscriptions are currently being negotiated, setting WHIO on its way to become a self-sustaining organization built on providing value to its stakeholders. Presently 37 organizations have access to the WHIO Data Mart. This represents 28 members or subscribers, their owners or wholly owned subsidiaries, or research organizations. Annual revenue from these organizations results in \$1,580,000 from subscription fees and members dues.

In order to continue to promote and market the Data Mart, WHIO engaged Wood Communications Group to produce a website (www.wisconsinhealthinfo.org), marketing collateral, talking points, media attention, and public relations campaigns. All of these communication mediums have assisted with promotion and visibility of the WHIO Data Mart and contributed to additional membership and subscriber sales.

WHIO is also investigating opportunities that may be available through federal stimulus funding for health care quality and technology. WHIO recently presented the WHIO Data Mart at a University of Wisconsin (UW) workshop along with other Wisconsin organizations to educate and inform researchers about the various data available to them as grant funding opportunities arise.

As another source of revenue, WHIO is partnering with research organizations. With such an expansive data set, research organizations such as the Dartmouth Institute for Health and Policy and the Brookings Institute are considering leveraging WHIO's data for cost and quality measurement projects. WHIO has received funding from a UW-Madison Department of Population Health Sciences grant to use WHIO data for a research project evaluating potential regional disparities in care of diabetic patients.

Member Education

WHIO has an opportunity to support its members, subscribers, and the physician community by proving how the WHIO data can help solve strategic business problems. WHIO has produced organization-specific presentations designed to answer common business questions to demonstrate how the data and analytical software can be leveraged for their organizations. WHIO also conducts user group meetings and webinars where users provide input to presentations to ensure a common understanding of the data and tools available through the Data Mart.

Training webinars for new users of the Data Mart are held each month and advanced training topics are scheduled as needed for those users who want to gain an in-depth understanding of the data and tools.

WHIO Membership

WHIO works continuously to expand its membership. Presently, there are 21 organizations participating in the initiative; 14 of which contribute data to the Data Mart. The health plans that are members of WHIO that are not yet contributing data have committed to contributing their data in the future. See the attached WHIO Fact Sheet for a complete list of members.

Consumer Reporting

As the Data Mart continues to expand and the reporting capability improves, WHIO is able to generate meaningful reports for public distribution. In conjunction with the WMS and the Wisconsin Manufacturers and Commerce Association, WHIO has prepared presentations for Wisconsin's eight Regional Development Corporations and 12 largest Chambers of Commerce.

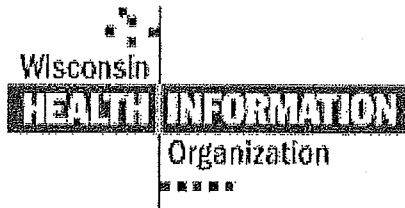
DHS used WHIO data to identify medical conditions and services for reporting requirements in 2009 Wisconsin Act 146. These data are required to be posted by each medical organization for consumer information and comparative pricing.

In May, the WCHQ will publish on its public website data and information on four medical conditions in Wisconsin using data obtained from the WHIO data mart. The four medical conditions are: diabetes, asthma, hypertension, and normal labor and delivery.

In addition to the WCHQ website, consumers will be exposed to WHIO data from a number of sources including the WMS WHIZ – CIDs project and the WHIO First Annual Symposium.

Attachments

1. DMV5 General Facts
2. Sample Provider Performance Report
3. Partnership for Healthcare Payment Reform Progress Summary
4. WHIO Fact Sheet



DMV5 General Facts

	DMV4	DMV5
Members Included [^]	3,436,661	3,730,210
% WI Population*	58.0%	62.8%
Claims Included	207.1M	233.5M
% Commercial Claims	40%	42%
% Medicaid FFS Claims	29%	26%
% Medicaid HMO Claims	20%	19%
% Medicare Claims	11%	13%
Claim \$ Included (Std. Cost/Billed)	\$28.9B / \$51.6B	\$32.2B / \$59.3B
Episodes of Care	18.8M	21.5M
Episodes of Care in PNA	2.3M	2.7M
Providers Included	88,171	93,245
WI Providers in Peer Definition	19,301	19,272

[^]All individuals included in data mart for Impact Intelligence. There were 3,259,919 and 3,532,463 WI individuals in DMV4 and DMV5, respectively.

*Estimated 1-1-2010 at 5,621,847



Affiliation Group Profile
Presented by WHIO

Specialty Patterns of Care

For the 12 Months
Ending 9/30/2010

Affiliation Group

Affiliation ID: M10201561020156
Affiliation Description: MARSHFIELD CLINIC

Peer Group

Peer Group Number of Episodes: 448,360
Peer Group Name: WHIO PCP (Internal Medicine)

Key Statistics

Number of Providers: 67
Number of Episodes: 24,137
Case Mix Episodes: 1.05

Overall Quality Index: 1.06
Overall Cost Index, Episode: 0.64

Confidence Intervals for the Index

Overall Quality Index: 1.05 to 1.06 **
Overall Cost Index, Episode: 0.62 to 0.65 **

Statistical significance of difference between index and peer group average: * p<0.10; ** p < 0.05

Episode Case Mix Summary

Top 10 ETGs, by Total Cost (Completed Episodes of Care)

ETG Family Description	Episodes			Encounters (Per 1000 Episodes)	
	Episodes	Actual Cost / Episode	Peers Cost / Episode	Actual Encounters / 1000 Episodes	Peers Encounters / 1000 Episodes
Ischemic heart disease	887	\$4,526.30	\$3,125.98	18,471	18,138
Hypertension	4,140	\$801.74	\$804.30	10,235	13,471
Diabetes	1,548	\$1,459.34	\$1,791.55	15,433	20,186
Hyperlipidemia, other	4,517	\$358.13	\$406.50	4,713	6,165
Chronic renal failure	477	\$2,853.55	\$1,770.40	8,282	9,045
Congestive heart failure	200	\$5,574.21	\$4,933.43	24,087	22,087
Chronic obstructive pulmonary disease	267	\$3,737.16	\$2,956.87	15,800	16,190
Obesity	1,952	\$488.25	\$432.29	4,317	4,239
Bacterial lung infections	170	\$3,832.88	\$3,090.69	8,606	9,384
Asthma	462	\$1,182.61	\$1,282.49	8,857	11,182
All Others	9,518	\$761.31	\$664.67	5,928	6,658
All Episodes	24,137	\$997.69	\$895.71	7,761	9,214

Quality Measures

As of the End of the Report Period
(Members Must be Continuously Enrolled with Plan a Minimum of 12 Months)

	Number of Quality Opportunities		Rates		Index
	With Compliance	Total	Actual Rate	Peer Rate	Quality Index
Cardiology					
Beta-Blocker Tx (NS)					
Pt(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	2	5	0.40	0.50	0.80
CAD					
Pt(s) on a statin.	373	451	0.83	0.81	1.02
CAD					
Pt(s) w/ a myocardial infarction in the past who are on a beta-blocker.	112	134	0.84	0.79	1.06
CHF					
Pt(s) on a beta-blocker.	66	75	0.88	0.79	1.11
CHF					
Pt(s) on an ACE-inhibitor or acceptable alternative.	60	69	0.87	0.74	1.17
CHF (NS)					
Pt(s) w/ CHF and atrial fib on warfarin.	37	45	0.82	0.74	1.12
Endocrinology					
Diabetes					
Pt(s) that had at least 2 HbA1c tests in last 12 reported mos.	876	998	0.88	0.77	1.14
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age that had an annual screening test for diabetic retinopathy.	170	993	0.17	0.45	0.38
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age that had annual screening for nephropathy or evidence of nephropathy.	899	993	0.91	0.83	1.09
Diabetes (NS)					
Pt(s) 18 - 75 yrs of age with a LDL cholesterol in last 12 mos.	932	993	0.94	0.84	1.12
Orthopedics and Rheumatology					
LBP Imaging (NS)					
Pt(s) w/ uncomplicated low back pain that did not have imaging studies.	46	70	0.66	0.75	0.88
Otolaryngology					
Pharyngitis (NS)					
Pt(s) treated w/ an abx for pharyngitis that had a Group A streptococcus test.	15	16	0.94	0.77	1.22
Preventive and Administrative					
Breast CA Scrn (NS)					
Pt(s) 42 - 69 yrs of age that had a screening mammogram in last 24 rpt mos.	559	627	0.89	0.80	1.11
Chlamydia Scrn (NS)					
Pt(s) 16 - 24 yrs of age that had a chlamydia screening test in last 12 rpt mos.	62	121	0.51	0.51	1.01
Psychiatry					
Depression Med Mgmt (NS)					
Pt(s) w/ a new episode of depression that remained on an antidepressant med during the 12 week acute tx phase.	38	56	0.68	0.65	1.04

Specialty Patterns of Care

Reporting Period : 10/1/2008 - 9/30/2010

Affiliation Group ID: M10201561020156

Affiliation Group Name: MARSHFIELD CLINIC

Depression Med Mgmt (NS)

Pt(s) w/ a new episode of depression that remained on an antidepressant med during the 6 month acute tx phase.	24	56	0.43	0.47	0.90
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Mental Illness - FU (NS)

Pt(s) hosp for mental illness that had an outpt follow-up encounter w/ a mental health practitioner w/in 30 dys after discharge.	0	3	0.00	0.55	0.00
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Pulmonology

Asthma (NS)

Pt(s) w/ presumed persistent asthma using an Inhaled corticosteroid or acceptable alternative.	73	81	0.90	0.89	1.02
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Bronchitis, Acute (NS)

Pt(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	17	85	0.20	0.21	0.97
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COPD Exacerbation (NS)

Pt(s) 40 years of age and older with COPD exacerbation that received a bronchodilator within 30 days of the hospital or ED discharge.	52	65	0.80	0.80	1.00
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COPD Exacerbation (NS)

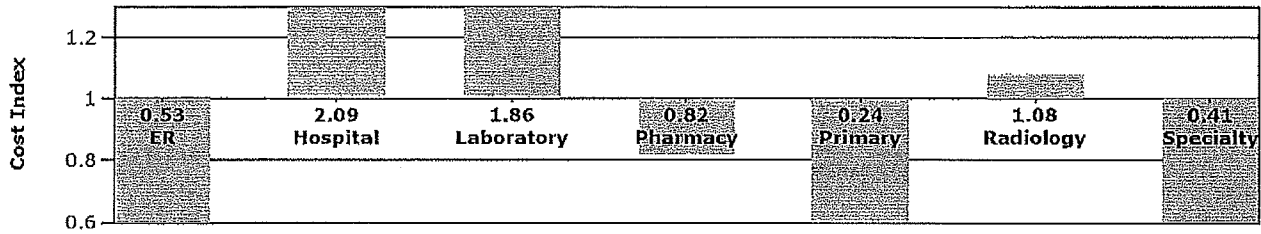
Pt(s) 40 years of age and older with COPD exacerbation that received a systemic corticosteroid within 14 days of the hospital or ED discharge.	44	65	0.68	0.62	1.08
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URI (NS)

Pt(s) w/ a dx of URI that did not have a presc for an abx on or 3 dys after the initiating visit.	36	38	0.95	0.89	1.06
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Total	4,493	6,039	0.74	0.73	1.02
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Cost Index Summary, by Service Category



Cost and Utilization Summary Measures

Profiled Costs

	Actual Encounters	Peers Encounters	Actual Cost / Episode	Peers Cost / Episode	Cost / Episode Index	Actual Total Cost
ER	837	1,228	\$10.22	\$19.19	0.53	\$246,698
Hospital Services	50,849	14,809	\$556.95	\$266.33	2.09	\$13,443,134
Laboratory	21,148	13,565	\$86.37	\$46.44	1.86	\$2,084,677
Pharmacy	89,990	115,337	\$209.06	\$255.03	0.82	\$5,046,032
Primary Care Core	8,976	36,727	\$29.47	\$123.37	0.24	\$711,204
Radiology	4,045	2,974	\$46.98	\$43.44	1.08	\$1,133,922
Specialty Care	11,475	37,758	\$58.65	\$141.90	0.41	\$1,415,546
Total	187,320	222,398	\$997.69	\$895.71	1.11	\$24,081,213

Overall Cost Index: 0.64

Utilization Rates Per 1,000 Episodes

	Actual	Peers	Index
Specialist Visit Rate	292	1,155	0.25
Other Specialty Care Rate	104	309	0.34
Radiology Procedure Rate	187	183	1.02
MRI Procedure Rate	5	7	0.75
Laboratory Procedure Rate	978	935	1.05
Overall Prescribing Rate	3,728	4,778	0.78
Generic Prescribing %	94%	94%	1.00
ER Visit Rate	21	43	0.48
Admits per 1000 Episodes	151	38	3.99
Days per 1000 Episodes	261	155	1.68
Average Length of Stay	1.73	4.10	0.42

Episode Detail and Analysis

Hypo-functioning thyroid gland

Total Specialty Episode Costs: \$513,216

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	1,147	\$447.38	\$23.76	\$8.23	\$164.64	\$9.63	\$91.02	\$148.71	\$13.9
Peers		\$492.08	\$121.18	\$41.42	\$100.69	\$14.38	\$36.70	\$174.50	\$3.20
Index			0.20	0.20	1.64	0.67	2.48	0.85	0.43

Encounters per 1000 Episodes

Actual			259	178	1,232	23	1,895	5,167	7
Peers			1,243	1,190	1,158	32	532	6,884	10
Index			0.21	0.15	1.06	0.73	3.56	0.75	0.63

Diabetes

Total Specialty Episode Costs: \$2,258,569

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	1,548	\$1,459.34	\$52.46	\$58.10	\$193.32	\$21.89	\$410.28	\$710.29	\$13.00
Peers		\$1,791.55	\$241.15	\$263.30	\$71.63	\$33.95	\$161.72	\$982.33	\$37.49
Index			0.22	0.22	2.70	0.64	2.54	0.72	0.35

Encounters per 1000 Episodes

Actual			685	614	1,435	49	3,674	8,936	40
Peers			2,915	3,555	924	51	847	11,794	100
Index			0.23	0.17	1.55	0.96	4.34	0.76	0.40

Hyperlipidemia, other

Total Specialty Episode Costs: \$1,617,550

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	4,517	\$358.13	\$15.60	\$1.70	\$116.45	\$4.31	\$31.90	\$187.73	\$0.44
Peers		\$406.50	\$64.18	\$8.67	\$46.00	\$5.85	\$9.25	\$271.85	\$0.70
Index			0.24	0.20	2.53	0.74	3.45	0.69	0.63

Encounters per 1000 Episodes

Actual			194	90	785	4	1,048	2,590	2
Peers			745	582	523	6	222	4,084	2
Index			0.26	0.15	1.50	0.67	4.72	0.63	0.82

Hypertension

Total Specialty Episode Costs: \$3,319,269

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	4,140	\$801.74	\$23.37	\$26.12	\$74.82	\$46.03	\$386.47	\$238.61	\$6.33
Peers		\$804.30	\$174.50	\$112.68	\$46.56	\$54.44	\$144.02	\$254.51	\$17.59
Index			0.13	0.23	1.61	0.85	2.68	0.94	0.36

Encounters per 1000 Episodes

Actual			315	255	710	122	2,031	6,779	24
Peers			2,011	1,603	442	113	720	8,535	46

Index	0.16	0.16	1.61	1.08	2.82	0.79	0.52
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Chronic sinusitis

Total Specialty Episode Costs: \$137,684

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	427	\$322.76	\$41.79	\$26.54	\$9.11	\$51.24	\$88.03	\$98.37	\$7.68
Peers		\$419.39	\$124.58	\$65.99	\$5.71	\$48.29	\$17.36	\$146.57	\$10.90
Index			0.34	0.40	1.59	1.06	5.07	0.67	0.71

Encounters per 1000 Episodes

Actual			473	221	81	161	1,294	2,858	23
Peers			1,439	708	70	113	226	3,498	39
Index			0.33	0.31	1.16	1.42	5.73	0.82	0.60

Acute bronchitis

Total Specialty Episode Costs: \$85,435

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	458	\$186.54	\$29.56	\$12.35	\$6.26	\$37.34	\$59.03	\$37.99	\$4.02
Peers		\$200.76	\$103.68	\$18.96	\$2.30	\$7.80	\$10.46	\$47.23	\$10.32
Index			0.29	0.65	2.72	4.78	5.64	0.80	0.39

Encounters per 1000 Episodes

Actual			389	178	71	360	1,020	1,745	24
Peers			1,279	298	37	66	152	1,817	38
Index			0.30	0.60	1.92	5.47	6.72	0.96	0.63

Asthma

Total Specialty Episode Costs: \$545,973

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	462	\$1,182.61	\$54.26	\$106.66	\$10.22	\$60.81	\$403.11	\$528.75	\$18.81
Peers		\$1,282.49	\$154.69	\$207.12	\$14.38	\$29.42	\$222.85	\$604.20	\$49.85
Index			0.35	0.51	0.71	2.07	1.81	0.88	0.38

Encounters per 1000 Episodes

Actual			616	823	95	307	2,038	4,915	62
Peers			1,857	2,024	101	141	643	6,281	134
Index			0.33	0.41	0.94	2.17	3.17	0.78	0.46

Joint degeneration, localized

Total Specialty Episode Costs: \$507,136

Cost per Episode	# of Episodes	Total	Primary Care Core	Specialty Care	Laboratory	Radiology	Hospital	Pharmacy	ER
Actual	522	\$971.06	\$23.82	\$49.49	\$16.98	\$236.72	\$545.04	\$95.69	\$3.31
Peers		\$936.48	\$135.65	\$201.52	\$34.22	\$206.72	\$184.01	\$163.17	\$11.20
Index			0.18	0.25	0.50	1.15	2.96	0.59	0.30

Encounters per 1000 Episodes

Actual			257	569	181	782	1,862	2,162	17
Peers			1,471	2,283	181	690	566	3,755	35
Index			0.17	0.25	1.00	1.13	3.29	0.58	0.49

Report Introduction and Interpretation**Patterns of Care**

This section gives an overview of the performance of the report entity for the 12 month period ending on the date in the banner of the section. Note that claims paid in the 3 months after that date for dates of service in those 12 months prior to the date are included in the data. All comparisons in the report are with the report entity peer group, based on a peer definition centered on a specialty. The peer group defines how and what episodes and quality measures are attributed, as well as how those episodes are attributed. For example, a specific subset of ETGs and quality measures are assigned to the peer group General Surgery. The Peer Group Name identifies the comparison group for the report. Note that the episode information on which all of this report is based is for completed, non-outlier episodes that ended during the last 12 months of the report period. Episodes may be attributed to only one provider in a peer group, but may be attributed to more than one peer group.

Number of Providers: This field, in a group report only, reports the number of providers in this peer group with the same affiliation ID, who had episodes attributed during the 12 month reporting period.

Number of Episodes: The total number of complete, non-outlier, within the peer group definition episodes attributed to the providers included in the report during the 12 month reporting period

Case Mix Episodes: This ratio expresses the relative health risk represented by the report entity's attributed episodes compared to that represented by the attributed episodes for the peer group. Episode Risk Groups (ERGs) are used for the calculation. Thus, a value equal to 1 would indicate that the disease burden for the episodes attributed in this report is exactly the same as the disease burden for all of the episodes captured by all members of the peer group.

Overall Quality Index: This ratio represents the relative performance of the report entity on the set of evidence-based medicine measures included in the peer group definition compared to the performance of the peer group as a whole. The set of rules included for primary care is quite large, approximately 250 rules, spanning a number of disease entities. The higher the index, the better the performance of the report entity relative to the peer group on these measures. This ratio will usually be different from the Quality Index in the Quality Measures section of the report as that index only represents the relative performance for the subset of measures included in that section of the report.

Overall Cost Index, Episode: This ratio represents the costs for the episodes attributed to the report entity relative to the average costs for the peer group for the exact same set of episodes, with the comparisons made at the episode severity level. The lower the number, the lower the costs are for the report entity relative to the peer group for the set of episodes. Note that all claims are standard priced, eliminating contractual payment differences as drivers of cost differences throughout the report. Cost differences are driven by units of service and mix of services for an episode of care. The overall cost index is adjusted across the peer group by weighting at the service category level to account for differences in estimated impact of control by a peer group specialty (see Cost Index Summary, by Service Category section of the report explanation).

Confidence Intervals: Each index has a range that reflects the 90% confidence interval around the index value. The confidence intervals are used to indicate the reliability of the value. A 90% confidence interval represents the 90% statistical probability that the value actual value lies within that interval. As a general rule, the more episodes or EBM measures the narrower the confidence interval.

The asterisks associated with the confidence intervals represent the statistical significance of the difference between the index and the peer group average, expressed as a p value. This is attempting to answer the question, "is this entity's performance truly statistically different from peers?" The peer group index is 1.0. One asterisk, representing $p < 0.10$, would indicate that the answer to that question is yes, as the 90 % confidence interval does not include 1.0. Two asterisks, representing $p < 0.05$, would indicate that the answer to that question is a statistically stronger yes, as the 95% confidence interval does not include 1.0.

Episode Case Mix Summary

This section of the report is a tabular summary of the top 10 episode families by total cost (number of episodes times average standard cost per episode for the report entity). This provides an overview of those episodes that contribute the most to costs of care for the report entity. Note that the term actual throughout the report should be interpreted as the standard priced result for the report entity for cost measures and the actual encounters for the report entity for encounter measures. These results will be compared to the standard priced results and encounter results for the peer group for the exact same set of episodes, with the comparisons made at the episode severity level.

Quality

WHIO, in conjunction with its Clinical Advisory Panel, has chosen a subset of the evidence-based medicine quality measures to be displayed in this section of the report. The measures in this report are only for rules associated with the episodes attributed to the report entity. Thus, if an internist affiliated with the entity in the report cares for a diabetic, but the diabetic's episode of care is attributed to an endocrinologist and does not meet the threshold (thirty percent of services) for attribution to the internist, the EBM measures for which that diabetic met the inclusion criteria would NOT be included in the internist's report. They would be included in the entity report that includes the endocrinologist. The Number of Quality Opportunities in this section contains, in the total column, all patients who had an episode attributed to the report entity who met the requirements for inclusion in the quality measure denominator. The actual rate is the rate for the report entity, and the peer rate is the rate for the entire peer group. The quality index is the actual rate divided by the peer rate. The quality index total represents the index only for the rules displayed in the Quality Measures section of the report. It will typically be different than the Overall Quality Index in the Specialty Patterns of Care Section, which represents performance across all of the EBMs included in the peer group definition. Indices on individual quality measures should only be considered meaningful if there are sufficient numbers in the total opportunities column.

Cost and Use

The 3 subsections of this report contain cost and utilization information for the report entity. Every claim that is part of an episode attributed to the report entity or the peer group is allocated into one of the seven service categories, based on CPT/Revenue code, place of service, rendering provider and ordering provider. This section of the report provides a ratio of the standard pricing results for the report entity relative to the exact same mix of episodes, compared at the severity level, for the peer group. This, combined with the next section of the report, helps to illuminate specific drivers of cost variation from the peer group. Examples of services that are included in the different categories are:

Hospital Services: All inpatient facility services; Outpatient facility services, including surgery, diagnostic (other than imaging and lab), and facility-based PT/OT; DME/MedSurg supplies

Radiology: Facility and professional components of radiology services, excluding therapeutic radiology. Selected diagnostic x-rays performed or ordered by a primary care provider are also excluded (these are assigned to Primary Care Core per below)

Laboratory: Facility and professional components of laboratory and pathology services, excluding selected lab tests performed or ordered by a primary care provider and typically performed in a PCP/physician office

ER: Professional and facility components of ER services

Primary Care Core: Evaluation and management services rendered by a primary care provider (office visits, nursing home visits, preventive care - does not include inpatient visits, ER visits or consultations); CXR, abdominal XR, and sinus XR; Minor lab procedures; Minor procedures and diagnostic tests, including diagnostic endoscopy, EKG and pulmonary function tests

Specialty Care: Evaluation and management services rendered by a physician other than a primary care provider; Diagnostic testing (other than lab and radiology); Allergy tests; Physical medicine and rehab; Professional component of surgery and anesthesia; Chemotherapy

Pharmacy: All pharmacy claims

The summary and measures subsection provides the cost and encounter detail that drove the service category indices in the previous subsection. Again, the values labeled actual represent the performance of the report entity. See portion of Episode Cost and Detail labeled "Using the cost and encounters ratios." The Actual Total Cost column provides the ability to get a sense of the relative importance of a particular service category variation to the overall cost variation for the report entity. For example, a total cost for a service category of \$50,000 with a cost index of 2.0 represents \$25,000 of cost variation (1.0 for the peer group would be \$25,000), while a total cost for a different service category of \$500,000 with a cost index of 1.25 represents \$100,000 of cost variation (1.0 for the peer group would be \$400,000). Note that that Overall Cost Index in this section is the same as in the Specialty Patterns of Care overview and is different, in most cases, from the Cost/Episode Index. That is because the Overall Cost Index is compiled from service category indices that are weighted depending on the peer group specialty. For example, the Primary Care Core category is weighted higher for an internist than for a general surgeon, while the Hospital category is weighted higher for a general surgeon than for an internist.

Utilization Rates Per 1,000 Episodes

This utilization rates subsection provides additional detail for helping to hone in on report entity cost variation. Some of these rates tie directly to the service categories in the Cost Index Summary above. The rates reflect results for the report entity (actual) relative to the exact same mix of episodes, compared at the severity level, for the peer group. Note that the results are reported as rates per 1,000 episodes as opposed to per 1,000 patients. The exception to this is the generic prescribing rate, which is defined as number of generic prescriptions divided by the number of prescriptions for which a generic rate is available for the episodes attributed to the report entity. Prescriptions for which a generic is not available are not included in the denominator. This can result in different rates than those seen in other generic calculation rates performed across all prescriptions. The index is calculated by dividing the actual rate by the peer rate. A higher index for generic prescribing rate would generally be considered better performance, while lesser utilization indices for the other metrics would typically be considered better performance. Note that the three inpatient measures may not be consistent with the Hospital service category above, as inpatient services are only one component of that category and typically represent less than half of the costs for the category.

Episode Detail

This section contains information similar to that in the Cost and Utilization Summary Measures section, except at a level of detail of the episode family. These are specific to the peer group, reflecting the most common episode families for that peer group, and there can be up to eight episode families displayed in a report. The Total Specialty Episode Costs represent the standard pricing costs for all of the episodes in that episode family attributed to the report entity. The comparisons are exactly the same as in the Cost and Utilization Summary and can be used similarly to determine the significant drivers of any cost variation and whether that variation is being driven by units or mix of services.

Using the cost and encounters ratios:

The encounters category can encompass a wide variety of unit types, ranging from E&M visits to units of chemotherapy administered. While caution should be exercised in some categories due to unit type variety, comparing the cost index in a service category with the relative ratio of the encounters can help illuminate whether units of service or mix of services is driving variation. For example, if the cost index is 1.5 in pharmacy where the actual encounters are 1,500 and the peer encounters are 1,000, it is likely that the cost variation of 50% (1.5 represents 50% more than the 1.0 of peers) is being driven by units (in this case prescriptions, most likely), rather than mix of services (more expensive medications). The ratio of actual encounters to peer encounters is 1.5 (1500/1000), exactly the same as the cost ratio. If in this case the actual encounters were 1,000, and the peer group encounters, 1,500, the encounter ratio would be 0.67 (1000/1500), making it very likely that mix of services was driving the cost variation of 50%.

Again note that comparisons at the episode family level should only be considered meaningful if there are sufficient numbers of episodes (a minimum of 30 has been suggested by some authorities).



The Partnership for Healthcare Payment

Reform (PHPR, formerly known as the Wisconsin Payment Reform Initiative or WPRI) was initiated nearly one year ago under the sponsorship of the Wisconsin Health Information Organization (WHIO). Recognizing that advancing the goal of better health care at lower cost requires the engagement of health care providers, payers, employers, and consumers, WHIO convened a meeting in early 2010 of more than 170 health care providers, payers, employers, and state officials. This meeting launched three large work groups that are developing payment reform pilot projects, designed to build on Wisconsin's impressive track record of advancing quality and transparency in health care.

Providers and purchasers alike are motivated to conserve scarce health care resources. Similar to the Medicare bundled payment projects currently under development, the PHPR will pilot new payment models for certain acute and chronic care services. The preventive pilot project is on hold until 2012, although it is expected that the chronic care pilots will test some prevention strategies as well. These pilots are designed to test how bundling of payments and other strategies will work, how changes in reimbursement methods can be complemented by changes in physician, health system, employer and consumer decision making, and how best to facilitate wide spread transition from volume-based reimbursement to value-based reimbursement.

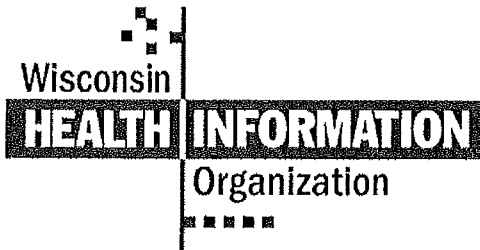
For nearly twelve months, more than 100 PHPR work group participants from across Wisconsin have been engaged in designing pilot projects in **acute** and **chronic** care. The Acute Care work group will pilot a bundled payment for total knee replacement, modeled after a similar project underway under the direction of the Integrated Healthcare Association in California. The Chronic Care workgroup is focusing on care for adults with diabetes for its first pilot project and proposes using

a shared savings model that will transition over time to a global payment.

These pilots are experiments. The intention is to test ideas and processes; to find out what works and what needs adjustment. The final product is intended to be scalable to include other medical conditions and places of service as well as expanded geographic regions. The work groups are finalizing the design of their projects. Pilots are expected to begin mid-2011.

PHPR work groups include more than 100 clinicians, health care administrators, insurance company leaders, and employers. The PHPR effort is supported by a Steering Committee comprised of the volunteer chairs of the workgroups and subgroups, as well as a number of WHIO Board members. Organizations represented on the PHPR Steering Committee include:

Wisconsin Hospital Association
Wisconsin Medical Society
Wisconsin Academy of Family Physicians
Wisconsin Collaborative for Healthcare Quality
Greater Milwaukee Business Foundation on Health
ThedaCare
The Alliance
Monroe Clinic
WEA Trust
Bellin Health
NEWHVN
WPS Health Insurance
Gundersen Lutheran Health System
Anthem Blue Cross Blue Shield of Wisconsin
Holy Family Memorial
Humana
Ministry Health
Wisconsin Department of Health Services



FOUNDERS

Anthem Blue Cross
Blue Shield of
Wisconsin

Greater Milwaukee
Business Foundation
on Health

Humana

The Alliance

United Healthcare of
Wisconsin

WEA Trust

WPS Health Insurance

Wisconsin
Collaborative for
Healthcare Quality

Wisconsin Medical
Society

Wisconsin Department
of Health Services

Wisconsin Department
of Employee Trust
Funds

Wisconsin Hospital
Association

FACT SHEET

A more transparent, rational health care market is the most effective way to achieve improvements in quality, affordability, safety and efficiency of health care in Wisconsin

What is the Wisconsin Health Information Organization?

- WHIO is a voluntary partnership that brings together key health care stakeholders in Wisconsin to develop a statewide data mart of health care information that spans providers and systems. The goal is to use the data to improve the quality, affordability, safety and efficiency of health care delivered to patients in Wisconsin.
- The WHIO Health Analytics Exchange is an all-inclusive, central repository for health care claims data that supports tracking, analysis and measurement of entire episodes of care that can be used in determining value based on quality measures and cost over time.
- WHIO collects and aggregates data that spans multiple systems and settings, including the physician office, outpatient services, pharmacy, lab and hospital. This data reflects both Commercial and Medicaid patient claims.
- The data mart holds a rolling twenty-seven (27) months of administrative claims data. This scope of data allows providers to compare their personal performance over time and to their peers at any point in time, identify best practices and make quality improvements.
- WHIO is an inclusive organization inviting key health care stakeholders to participate in and influence the health care transparency initiatives and dialogue that are emerging every day in Wisconsin, and across the nation. WHIO provides a forum and a vehicle for these stakeholders to participate in important decisions that will determine the nature and operation of transparency in Wisconsin.

Who is participating?

- WHIO's Founding Members include Anthem Blue Cross Blue Shield of Wisconsin, the Greater Milwaukee Business Foundation on Health, Humana, The Alliance, United Healthcare of Wisconsin, WEA Insurance Trust, WPS Health Insurance, the Wisconsin Collaborative for Healthcare Quality, the Wisconsin Medical Society, the Wisconsin Hospital Association and the State Departments of Health Services and Employee Trust Funds.

- The following regional health plans have also become members and contribute their claims data to the Health Analytics Exchange: Group Health Cooperative of South Central Wisconsin, Gunderson Lutheran Health Plan, Mercy Care Insurance Company, Health Tradition Health Plan, Dean Health Plan, Security Health Plan, Network Health Plan, and Unity Health Plan
- Subscribers to the WHIO Health Analytics Exchange include most major Wisconsin medical and hospital systems.
- Research partners include: Dartmouth Atlas of Healthcare, Engelberg Center for Health Care Reform - Brookings Institution, University of Wisconsin Population Health Institute and the American Board of Medical Specialties (ABMS).

How is it funded?

- Start up funding was provided through Founding Members contributions of \$3 Million and a State service contract for data aggregation and reporting worth \$1.65 Million.
- Today, WHIO is a private-public initiative funded through membership dues, annual subscription fees and a service contract with the State of Wisconsin valued at \$250,000 per year.

What's in the Health Analytics Exchange?

- The first production version of the data mart was released in August, 2009 and included 1.6 million members with \$9.3 billion in standardized costs.
- Updated versions of the Exchange are released every six months in April and October.
- The current version (DMV5) was released in April of 2011 and contains 3.7 Million patient records representing 62% of Wisconsin's population, 234 Million claims records representing \$60 Billion in billed costs and more than 90,000 unique providers of medical services, devices and supplies.
- Patient, payor and employer information is de-identified to allow broad access to the data and distribution of results.
- Servicing Physician, Practice Group and facility information is available to support comparative performance reporting.

For more information about WHIO, please contact:

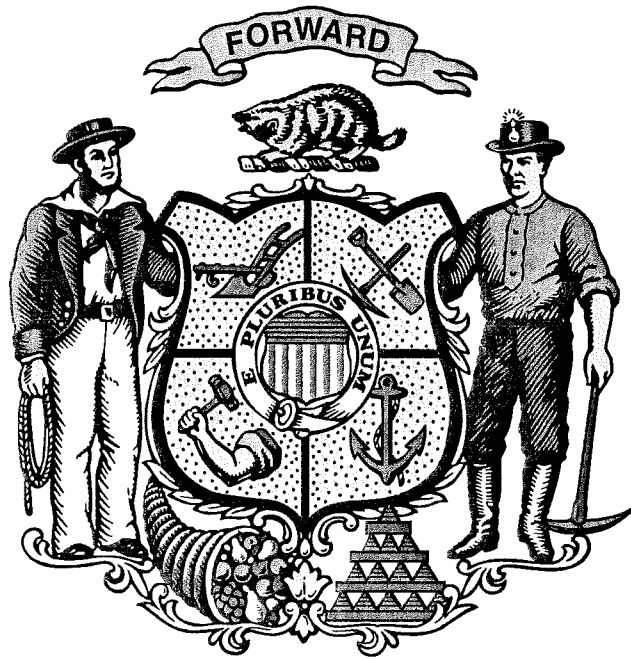
Julie Bartels, CEO

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(608) 512-8373 | jwm50@tds.net

www.WisconsinHealthInformation.Org





State of Wisconsin
Department of Health Services

Scott K. Walker, Governor
Dennis G. Smith, Secretary

July 15, 2011

The Honorable Garey Bies
Chair, Public Health Standing Committee
Wisconsin Assembly
Room 216 North
State Capitol
Madison, WI 53708

The Honorable Jeff Stone
Chair, Health Standing Committee
Wisconsin Assembly
Room 314 North
State Capitol
Madison, WI 53708

Dear Representatives Bies and Stone:

The Department of Health Services is pleased to submit to you, as required by s.253.115 of the Wisconsin Statutes, the annual report on the status of Universal Newborn Hearing Screening (UNHS) in Wisconsin. In 2010, 100% of the hospitals with birthing facilities had an implemented hearing screening program and 98.7% of babies born in Wisconsin were born in a facility that offers UNHS. Of the 67,284 babies born in Wisconsin in 2010, 98.5% were born in a hospital, and 1.4% were born at a free-standing birth center or at home. Currently 97% of babies are screened prior to one month of age, with a 0.3% rate of refusal. The statewide average rate of infants who do not pass the newborn hearing screen in 2010 was 2.2%, which falls within the American Academy of Pediatrics recommendation of less than 4%.

Hearing loss is the most common congenital birth defect, affecting an estimated 200 babies annually in Wisconsin. If hearing loss is left undetected, it will impede speech, language, cognitive and social development. The Wisconsin Sound Beginnings (WSB) Program continues to work toward meeting its goal of ensuring that 100% of babies born in Wisconsin are screened for hearing loss and referred to appropriate intervention services when necessary. The success of the WSB Program is reflected in the data provided above.

The WSB Program is improving all areas of early hearing detection and intervention through a variety of activities such as community quality improvement initiatives, parent to parent support and working with partner agencies to promote a sound beginning for Wisconsin's children.

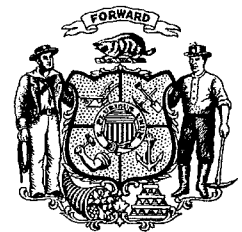
Sincerely,

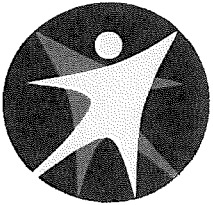
A handwritten signature in cursive script that reads "Dennis G. Smith".

Dennis G. Smith
Secretary



WISCONSIN STATE LEGISLATURE





State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

July 9, 2012

Robert J. Marchant
Senate Chief Clerk
B20 SE Capitol
Madison, WI 53702

Patrick E. Fuller
Assembly Chief Clerk
17 West Main Street, Room 401
Madison, WI 53703

Dear Mr. Marchant and Mr. Fuller:

The Department of Health Services is pleased to submit to you and the legislature the State Emergency Medical Services Plan. The plan was prepared by the Division of Public Health-EMS Section, as required by s.256.08 Wis. Stats.

Wisconsin's EMS System continues to grow and mature. Over the past two years, it has strengthened partnerships and completed an administrative rule revision. It is now focused on strengthening and improving the system. Significant objectives included in the plan include:

- Facilitate a National Highway Transportation Safety Administration technical assessment of the Wisconsin EMS system and correlate results with the previous reports. Move to address overarching issues identified within the assessment report.
- Develop a strategic plan in coordination with the EMS Board and EMS stakeholders to educate policymakers regarding the importance of the emergency medical services system, including the financial and resource threats to its ongoing viability.
- Develop a broad-based public information and education plan that would target, in part, policymakers and the general public. Among other topics, this should address emergency medical services and trauma systems.

The EMS system continues to develop its primary mission "...to ensure that the highest quality and standards of pre-hospital emergency medical care is available to all citizens of and visitors to Wisconsin."

Sincerely,

Handwritten signature of Dennis G. Smith in cursive.

Dennis G. Smith
Secretary

Enclosures

JUL 10 2012

2012 – 2014

WISCONSIN

EMERGENCY MEDICAL SERVICES

PLAN



Submitted by: Brian Litza, Chief

**Department of Health Services
Division of Public Health
Bureau of Communicable Diseases and Emergency Response
Emergency Medical Services Section**

2012 – 2014 WISCONSIN EMERGENCY MEDICAL SERVICES STATE PLAN

The 2012 – 2014 Wisconsin Emergency Medical Services Plan is prepared in accordance with s.256.08, Wisconsin Statutes, which directs the Department of Health Services to prepare a state emergency medical services plan and to identify priorities for changes in the state's emergency medical services system for the two years following preparation of the plan. Under s. 13.172 (2) of the statutes, the Department shall provide a copy of the state emergency medical services plan biennially to the legislature.

The National Highway Traffic Safety Administration (NHTSA), the Health Resources and Services Administration (HRSA) national *EMS Agenda for the Future*, and the Wisconsin State Health Plan, *Healthiest Wisconsin 2020* provided the guidance and vision for the 2012 – 2014 Wisconsin Emergency Medical Services Plan. The plan supports Wisconsin's overall goal for the future, to achieve an effective, efficient, and integrated Emergency Medical Services (EMS) System for the state.

There are ten essential components of an optimal EMS System. Listed below are each of those components, a description of each component, and the plan for priorities to improve Wisconsin's EMS System. In comparison to the previous plan there are reoccurring priorities that continue to be issues. This plan addresses those continuing issues.

1. REGULATION & POLICY

To provide a quality, effective system of emergency medical care, each state EMS system must have in place comprehensive enabling legislation with provision for a lead EMS agency. This agency has the authority to plan and implement an effective EMS system, and to promulgate appropriate rules and regulations for each recognized component of the EMS system (authority for statewide coordination; standardized treatment, transport, communication and evaluation, including licensure of out-of-hospital services and establishment of medical control; designation of specialty care centers; PIER programs). There is a consistent, established funding source to adequately support the activities of the lead agency and other essential resources which are necessary to carry out the legislative mandate. The lead agency operates under a single, clear management structure for planning and policy setting, but strives to achieve consensus among EMS constituency groups in formulating public policy, procedures and protocols. The role of any local/regional EMS agencies or councils who are charged with implementing EMS policies is clearly established, as well as their relationship to the lead agency. Supportive management elements for planning and developing effective statewide EMS systems include the presence of a formal EMS Medical Director, a Medical Advisory Committee for review of EMS medical care issues and an EMS Advisory Committee (or Board). The EMS Advisory Committee has a clear mission, specified authority and representative membership from all disciplines involved in the implementation of EMS systems.

Priorities for Improvement

- Develop a strategic plan in coordination with the EMS Board and EMS stakeholders to educate policy-makers regarding the importance of the emergency medical services system, including the financial and resource threats to its ongoing viability.

- Explore an alternative distribution model for the Funding Assistance Program consistent with state statutes.
- Develop in cooperation with EMS stakeholders and the Department a stable funding initiative to support the infrastructure of the Wisconsin EMS system.

2. RESOURCE MANAGEMENT

Central coordination and current knowledge (identification and categorization) of system resources are essential to maintain a coordinated response and appropriate resource utilization within an effective EMS system. A comprehensive State EMS Plan exists which is based on a statewide resource assessment and updated as necessary to guide EMS system activities. A central, statewide data collection (or management information) system is in place that can properly monitor the utilization of EMS resources; and data is available for timely determination of the exact quantity, quality, distribution and utilization of resources. The lead agency is adequately staffed to carry out central coordination activities and technical assistance. There is a program to support recruitment and retention of EMS personnel (both volunteer and career).

Priorities for Improvement

- Facilitate a National Highway Transportation Safety Administration technical assessment of the Wisconsin EMS system and correlate results with the previous reports. Move to address overarching issues identified within the assessment report.
- Develop programs for continuing the recruitment and retention of volunteer EMS personnel.
- Verify submitted ambulance service operation plans through periodic, on-site evaluations.
- Study and report on the EMS role and needs in disaster management. Develop guidelines on how EMS should integrate with the Wisconsin Emergency Management plans already in existence.
- Coordinate with the trauma system development.
- Explore and assist areas of the state that have difficulty staffing ambulance calls and explore regionalization options.

3. HUMAN RESOURCES AND TRAINING

The *EMS Education Agenda for the Future* is a vision for the future of EMS education and a proposal for an improved structured system to educate the next generation of EMS professionals. It includes a vision of improved efficiency in the national EMS education process, with enhanced consistency in education quality and increased entry-level graduate competence.

To ensure that the patient care provided by EMS is part of the overall management of the ill or injured patient, innovative approaches to education must be employed. These innovations must address the quality, content and accessibility of the education programs, both for initial training and for ongoing continuing education of EMS providers and provide enhancement as needed to meet the medical needs of patients in Wisconsin.

Priorities for Improvement

- Complete the transition to the National EMS Scope of Practice and National EMS Education Standards.
- Research the provision of initial and continuing education through various educational delivery options including distance learning.
- Investigate and prepare recommendations on the concept of minimum competencies versus curriculum adherence.
- Support the training centers in obtaining paramedic program accreditation in preparation for the transition to the national education standards.

4. TRANSPORTATION

Safe, reliable ambulance transportation is a critical component of an effective EMS system. The transportation component of the State EMS Plan includes provisions for uniform coverage, including a protocol for air medical dispatch and a mutual aid plan. This plan is based on a current, formal needs assessment of transportation resources, including the placement and deployment of all out-of-hospital emergency medical care transport services. There is an identified ambulance placement or response unit strategy, based on patient need and optimal response times. The lead agency has a mechanism for routine evaluation of transport services and the need for modifications, upgrades or improvements based on changes in the environment (i.e., population density). Statewide, uniform standards exist for inspection and licensure of all modes of transport (ground, air, water), as well as minimum care levels for all transport services (minimum staffing and credentialing). All out-of-hospital emergency medical care transport services are subject to routine, standardized inspections, as well as "spot checks" to maintain a constant state of readiness throughout the state. There is a program for the training and certification of emergency vehicle operators.

Priorities for Improvement

- Continue to prompt the Wisconsin Department of Transportation to open TRANS 309 to adjust the ambulance equipment standards.
- Complete development of administrative rules that would provide direction for air transport.

5. FACILITIES

It is imperative that the seriously ill patient be delivered in a timely manner to the closest, appropriate facility. The lead agency has a system for categorizing the functional capabilities of all individual health care facilities that receive patients from the out-of-hospital emergency medical care setting. This determination should be free of political considerations, is updated on an annual basis and encompasses both stabilization and definitive care. There is a process for verification of the categorizations (i.e., on-site review). This information is disseminated to EMS providers so that the capabilities of the facilities are known in advance and appropriate primary and secondary transport decisions can be made. The lead agency also develops and implements out-of-hospital emergency medical care triage and destination policies, as well as protocols for specialty care patients (such as severe trauma, burns, spinal cord injuries and pediatric emergencies) based on the functional assessment of facilities. Criteria are identified to guide interfacility transport of specialty care patients to the appropriate facilities. Diversion policies are developed and utilized to match system resources with patient needs; standards are clearly

identified for placing a facility on bypass or diverting an ambulance to another facility. The lead agency has a method for monitoring if patients are directed to appropriate facilities.

Priority for Improvement

- Develop and publish a list of hospitals and their specialty care designations. Specifically identify those facilities designated as primary stroke centers, S-T elevation myocardial infarction (STEMI) centers, and trauma designated facilities.

6. COMMUNICATION

A reliable communications system is an essential component of an overall EMS system. The lead agency is responsible for central coordination of EMS communications (or works closely with another single agency that performs this function), and the State EMS Plan contains a component for comprehensive EMS communications. The public can access the EMS system with a single, universal phone number, such as 9-1-1 (or preferably Enhanced 9-1-1), and the communications system provides for prioritized dispatch. There is a common, statewide radio system that allows for direct communication between all providers (dispatch to ambulance communication, ambulance to ambulance, ambulance to hospital, and hospital to hospital communications) to ensure that receiving facilities are ready and able to accept patients. Minimum standards for dispatch centers are established, including protocols to ensure uniform dispatch and standards for dispatcher training and certification. There is an established mechanism for monitoring the quality of the communication system, including the age and reliability of equipment.

Priorities for Improvement

- Review and comment by the EMS Board and Department regarding statutory language for certification of dispatchers and dispatch centers developed by the Governor-appointed Interoperability Communications Standards Group.
- Finalize the revisions to the State EMS communication plan and disseminate to EMS providers.

7. PUBLIC INFORMATION AND EDUCATION

To effectively serve the public, each state must develop and implement an EMS public information and education (PI&E) program. The PI&E component of the State EMS Plan ensures that consistent, structured PI&E programs are in place that enhance the public's knowledge of the EMS system, support appropriate EMS system access, demonstrate essential self-help and appropriate bystander care actions, and encourage injury prevention. The PI&E plan is based on a needs assessment of the population to be served and an identification of actual or potential problem areas (i.e., demographics and health status variables, public perceptions and knowledge of EMS, type and scope of existing PI&E programs). There is an established mechanism for the provision of appropriate and timely release of information on EMS-related events, issues and public relations (damage control). The lead agency dedicates staffing and funding for these programs, which are directed at both the general public and EMS providers. The lead agency enlists the cooperation of other public service agencies in the development and distribution of these programs, and serves as an advocate for legislation that potentially results in injury/illness prevention.

Priorities for Improvement

- Develop a broad-based public information and education plan that would target, in part, policy makers and the general public. Among other topics, this should address emergency medical services and trauma systems.
- Continue to develop the EMS website to be the primary source of information regarding Wisconsin EMS.

8. MEDICAL DIRECTION

EMS is a medical care system that involves medical practice as delegated by physicians to non-physician providers who manage patient care outside the traditional confines of office or hospital. As befits this delegation of authority, the system ensures that physicians are involved in all aspects of the patient care system. The role of the State Medical Director for EMS is clearly defined, with legislative authority and responsibility for EMS system standards, protocols and evaluation of patient care. A comprehensive system of medical direction for all out-of-hospital emergency medical care providers (including basic life support) is utilized to evaluate the provision of medical care as it relates to patient outcome, appropriateness of training programs and medical direction. There are standards for the training and monitoring of direct medical control physicians, and statewide, standardized treatment protocols. There is a mechanism for concurrent and retrospective review of out-of-hospital emergency medical care, including indicators for optimal system performance. Physicians are consistently involved and provide leadership at all levels of quality improvement programs (local, regional, statewide).

Priorities for Improvement

- Continue to enhance the required credentials of EMS medical directors, based upon the level of the EMS programs involved.
- Develop periodic, statewide and regional forums for local EMS medical directors to meet with the state EMS medical director and other Bureau staff, discuss common issues, and share solutions, and exploit electronic options for facilitating continual interaction among EMS medical directors.
- Translate the current medical director course into an interactive and measurable program that can generate a course completion certificate.
- Collaborate with EMS for Children on issues related to children.

9. TRAUMA SYSTEMS

To provide a quality, effective system of trauma care, each state must have in place a fully functional EMS system; trauma care components must be clearly integrated with the overall EMS system. Enabling legislation should be in place for the development and implementation of the trauma care component of the EMS system. This should include trauma center classification (using ACS-COT, APSA-COT and other national standards as guidelines), triage and transfer guidelines for trauma patients, data collection and trauma registry definitions and mechanisms, mandatory autopsies and quality improvement for trauma patients. Information and trends from the trauma registry should be reflected in PIER and injury prevention programs. Rehabilitation is an essential component of any statewide trauma system and hence these services should also be considered as part of the classification process. The statewide trauma system (or trauma

system plan) reflects the essential elements of the model trauma care system plan. The goals of the WI trauma system are to ultimately prevent injuries from occurring and to reduce the severity of injuries once they do occur.

Priorities for Improvement

- Support the state trauma system with the deployment of the updated triage and transport guidelines.
- Support continued collaboration with the WI trauma system.

10. EVALUATION

A comprehensive evaluation program is needed to effectively plan, implement and monitor a statewide EMS system. The EMS system is responsible for evaluating the effectiveness of services provided victims of medical or trauma related emergencies; therefore the EMS agency should be able to state definitively what impact has been made on the patients served by the system. A uniform, statewide out-of-hospital data collection system exists that captures the minimum data necessary to measure compliance with standards (i.e., a mandatory, uniform EMS run report form or a minimum set of data that is provided to the state); data are consistently and routinely provided to the lead agency by all EMS providers and the lead agency performs routine analysis of this data. Pre-established standards, criteria and outcome parameters are used to evaluate resource utilization, scope of services, effectiveness of policies and procedures, and patient outcome. A comprehensive, medically directed statewide quality improvement program should be established to assess and evaluate patient care, including a review of process (how EMS system components are functioning) and outcome.

Priorities for Improvement

- Provide summary feedback information, derived from submitted data, to the state's EMS provider agencies.
- Develop a process (evaluation tools) to evaluate all EMS system activities and incorporate into existing committee work.
- Prepare for the transition from the National EMS Information System data set version 2.0 to 3.0.
- Create standard reports of system data to be used as indicators of the EMS system status.

Special Component - PREPAREDNESS FOR LARGE SCALE EVENTS (Public Health Emergency)

As shown in the previous plan with the 2009 H1N1 influenza emergency, the State of Wisconsin needs to be prepared for large scale public health emergencies. The integration of EMS within these activities is essential in assuring a coordinated response when the time is needed.

Priorities for Improvement

- Assure state and regional involvement of EMS in emergency response plans.
- Prepare and disseminate proper guidance to the EMS community in response to any declared public health emergency.
- Assure continued involvement in after-action planning activities that result from evaluations of operations to better prepare for future events.