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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)

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

July 11, 2012

Honorable Jeff Stone, Chairperson
Assembly Committee Health
Room 314 North, State Capitol
Madison, WI 53707

Dear Senator Stone:

I am pleased to send you the 2012 Wisconsin Birth Defect Prevention and Surveillance Program Biennial Report as required by s. 253.12 (4)(d) of the Wisconsin Statutes. The report identifies surveillance activities and programmatic strategies that are critical to improving birth outcomes and child health.

As you are aware, birth defects are a substantial cause of infant mortality and childhood morbidity. In addition, these conditions have a significant fiscal and financial impact on a child and his or her family, as well as the service system of care, schools and community. It is essential to have accurate, population-based data on birth defects. This information is needed to assess needs, plan interventions, and evaluate both the outcomes of prevention strategies and the resources for families who have a child with a birth defect.

Since 2004, the Wisconsin Birth Defects Registry has collected information on 87 selected birth defects identified in children from birth to age two. Between mid-2004 and the end of 2011, 70 organizations reported 4,891 birth defects to the registry. The reports show that cardiovascular birth defects are the most common type of condition. The Department has focused its attention on reporting through efficient data exchanges. As this method becomes the norm, compliance with the statute and report completeness continues to improve.

The Department continues expansion of two prevention initiatives that began in 2006 and 2012 respectively: a nutrition collaborative between WIC and the Birth Defects program called *Nourishing Special Needs Infants and Children* and a collaboration between the Marshfield Research Foundation *Wisconsin Stillbirth Services Program* and the Children's Health Alliance *Children's Death Center* that ensures families have access to bereavement counseling and services. Both programs have been presented at state and national conferences. The Wisconsin Birth Defect Prevention and Surveillance Program serves as a valuable asset to the Department in its efforts to strengthen birth outcome prevention activities, enhance child health outcomes, and facilitate family access to services.

Sincerely,

Dennis G. Smith
Secretary
Enclosures

WISCONSIN BIRTH DEFECT PREVENTION AND SURVEILLANCE PROGRAM
Report to the Legislature

June 2012

BACKGROUND

In the late 1980s, Wisconsin legislation created the Birth Defects Outcome and Monitoring Program. Physicians submitted paper-reports for birth defects, developmental or acquired disabilities, or severe sensory impairments of children less than six years old. Through a federal initiative in 1998, the Birth Defects Prevention Act directed the Centers for Disease Control and Prevention (CDC) to work with states to collect and analyze data on birth defects and provide information to the public about the prevention of birth defects. CDC provided funding to states to help achieve this goal.

The Wisconsin Birth Defect Prevention and Surveillance Program (WBDPSP) was established in May 2000, replacing the Birth Defect Outcome Monitoring Program by amending s. 46.82(1) and s.253.13(2) and repealing and recreating Wisconsin statute 253.12 to address limited reporting compliance. The law requires the Department of Health Services (DHS) to establish and maintain an up-to-date birth defects registry of diagnosed birth defects of any Wisconsin child age birth up to two years of age, requires reporting by pediatric specialty clinics and physicians, and protects the confidentiality of children born with birth defects. Although this registry is still a passive reporting system (no penalty for not reporting), it narrowed the reportable birth defects to a prescribed list of 87 conditions* (see endnote); established a 13-member Birth Defect Prevention and Surveillance Advisory Council; initiated primary prevention strategies to help decrease occurrence; provided for education about the prevention of birth defects; developed a system for referrals to early intervention; and limited service provisions.

In September 2000, DHS was awarded a three-year cooperative agreement from the CDC for the development of a secure, web-based Wisconsin Birth Defects Registry (WBDR) and the development of intervention and prevention capacities. This $330,000 grant ($110,000 per year) allowed for: the design of the WBDR, partnerships with two specialty centers to monitor heart defects, and the development of a structure for monitoring and prevention activities. The WBDR was developed in 2003, piloted at five sites, and rolled out statewide in mid-2004. Chapter HFS 116, Wisconsin Birth Defect Prevention and Surveillance System, contains the administrative rules developed by DHS, with an effective date of April 1, 2003.

The WBDPSP is required to maintain a birth defects registry of diagnosed birth defects of any Wisconsin child age birth to two years who is born in Wisconsin and/or receives health care services in Wisconsin.

The WBDR is a secure, web-based system that allows reporters to report one child with a birth defect at a time or upload multiple reports from an electronic medical records system. Reporters may also submit a paper form to the WBDR state administrator for inclusion in the registry. The WBDR collects information on the child and parents, the birth, referral to services, and diagnostic information for one or more of 87 reportable conditions. If parents withhold permission to report, names and addresses are not included in the report.

Physicians and specialty clinics are required reporters; hospitals are voluntary reporters. In practice, reports are usually submitted for multiple physicians by clinics, health care systems

and some hospitals. From mid-2004 through December 31, 2011, the WBDR received reports of 4,891 birth defects from 70 organizations. The parent permission requirement is an administrative barrier for some reporting organizations. In practice, some organizations simply report without attempting to obtain parent permission. This results in only 22% of the reports submitted with permission that therefore include the full name and address of the child. This practice makes it difficult to calculate an unduplicated count of children with birth defects or an unduplicated incidence of any birth defect. It is also nearly impossible to assess if birth defects are clustered in a particular geographic area.

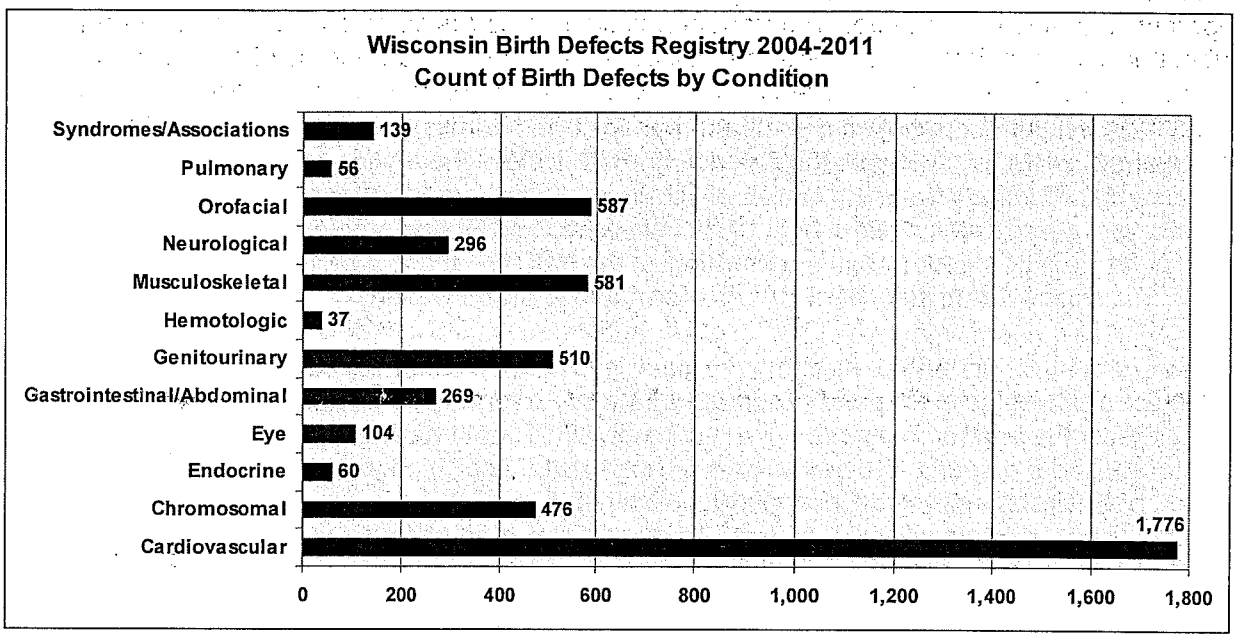
In 2004, a pilot project with Marshfield Clinic developed a process that allows organizations to upload multiple reports from their electronic medical records systems. Ongoing outreach and training opportunities resulted in Dean Health System's move to the electronic upload option in 2011 after all of Dean's clinics migrated to Epic software. They now report for all of their clinics centrally once a month. Children's Hospital of Wisconsin-Milwaukee developed a business protocol for the same method of reporting during 2011 and expects to begin using this protocol in 2012. WBDR staff has consulted with other organizations on the possibility of reporting from their electronic medical records. Experience shows that it takes a minimum of three years for an organization with a new electronic medical records system to discuss the option internally, develop a protocol, implement the protocol, test the upload procedure, and begin regular reporting. The result is more complete reporting on a regular schedule and a more efficient system for the reporter in the long run. (Attachment 1, Confidential Birth Defects Registry Report)

In 2000, $100,000 of state funding for the WBDPSP was provided through General Purpose Revenue (GPR) dollars; however funding was reduced by 10% to $95,000 during the Doyle administration department reductions. The **2009 Wisconsin Act 28 Budget Bill** enacted on June 29, 2009 changed the language of s. 253.12 (7) funding by allocating $95,000 annually from the surcharge on Wisconsin Birth Certificates appropriation account s. 20.435 (1) (gm).

HOW SERIOUS ARE BIRTH DEFECTS IN WISCONSIN?

- Birth defects are common, occurring in 1 out of every 33 births. About 2,000 babies with birth defects are born in Wisconsin every year.
- Birth defects are caused by a variety of different factors: genetic processes, environmental exposures, infections, obesity, as well as the use of alcohol, tobacco, prescription medications, or illegal drugs. Some appear to be multi-factorial with genetic predisposition plus environmental triggers. The causes of about two out of three birth defects are currently unknown.
- Birth defects are the leading cause of all infant deaths and stillbirths, accounting for approximately 150 to 200 deaths in Wisconsin every year.
- Approximately 20% of babies who die in the first year of life do so because of birth defects.
- Babies born with birth defects have a greater chance of illness and long term disability than babies without birth defects.
- Babies with birth defects are often born preterm, which increases the risk of death.
- At least one out of three pediatric hospital admissions is associated with birth defects or genetic conditions.
- The estimated lifetime cost related to birth defects in Wisconsin is estimated at $165 million each year for the 18 most significant birth defects.
- Birth defects are the fifth leading cause of years of potential life lost.

Between mid-2004 and the end of 2011, 4,891 birth defects were reported to the WBDR. The reports show that cardiovascular birth defects are the most common type of condition.



WHAT IS THE PURPOSE OF BIRTH DEFECT SURVEILLANCE?

To prevent birth defects, it is important to know more about what causes them. To identify causes, researchers and analysts need to know the frequency of individual birth defects and they need to compare the occurrence of specific birth defects to the presence of potential causative factors. Ongoing, real-time collection of birth defects is needed to continually assess whether birth defects are increasing, diminishing, or staying the same overall and whether individual birth defects are clustered in a particular geographic area. A core list of birth defects is reported to the National Birth Defect Prevention Network (NBDPN) annually and used to report on national birth defect incidence and trends. CDC cites birth defect surveillance systems as a leading contributor to reducing birth defects. The 2011 report to the NBDPN is included at the end of this report. (Attachment 2)

HOW IS WISCONSIN WORKING TO ADDRESS BIRTH DEFECTS?

Two staff from Title V Children and Youth with Special Health Care Needs (CYSHCN) provide limited support for the program, including registry administration, data analyses, family-support services, and prevention programming.

The CYSHCN epidemiologist administers the WBDR. She is a member of the NBDPN and attends annual training conferences to keep apprised of new information on birth defects. She is also a member of the NBDPN Data Committee and is working with newly developed national prevalence estimates to update Wisconsin's estimated prevalence statistics. A report of the cost of birth defects in Wisconsin is planned to be completed by the end of 2012.

The CYSHCN health promotion consultant manages and administrators the WBDPSP budget and agency contracts, oversees the Council on Birth Defect Prevention and Surveillance, is the liaison contact for the Wisconsin March of Dimes and other organizations concerned with birth defects, and coordinates several birth defect prevention programs and initiatives (i.e., Nourishing Special Needs). She is a member of the NBDPN and is a member of the NBDPN Ethics and Policy Committee working on bylaws and a strategic plan.

Researchers studying birth defects may request and receive summary birth defects registry reports or a dataset with properly executed data release forms and the permission of the state Birth Defects Registry administrator. Projects that WBDR data have supported include: 1) a UW graduate student research project on cleft lip and palate, and 2) ongoing participation with the Bureau of Environmental and Occupational Health in a multi-year Environmental Public Health Tracking Program project funded by the CDC that focuses on tracking birth defects incidence and investigating any relationship between birth defects and environmental hazards.

Birth Defect Prevention and Surveillance Program Outcomes

There are five Regional Centers for Children and Youth with Special Health Care Needs (CYSHCN) in Wisconsin:

1. Northeastern Regional Center for CYSHCN, Children's Hospital of Wisconsin-Fox Valley
2. Northern Regional Center for CYSHCN, Marathon County Health Department
3. Southeastern Regional Center for CYSHCN, Children's Hospital of Wisconsin, Inc.
4. Southern Regional Center for CYSHCN, University of Wisconsin-Waisman Center
5. Western Regional Center for CYSHCN, Chippewa County Department of Public Health

Each Regional Center has designated staff to access birth defect reports from the WBDR for their respective counties and regions. The information is used to assure children with birth defects and their families are contacted and referred to appropriate services.

The WBDPSP currently provides funding to the following prevention and family supports initiatives:

Birth Defects Nutrition Consultant Network (BDNCN)
The BDNCN is a collaborative program improvement initiative developed by the Wisconsin CYSHCN program, the Wisconsin Birth Defects Prevention and Surveillance program, and the Wisconsin Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program to build nutrition services capacity for the identification, intervention, and referral of infants and children (case management) with birth defects seen in WIC.

The BDNCN received state and national attention via presentations at the Wisconsin Public Health Association conference, the Wisconsin Dietetic Association conference, the National Birth Defects Prevention Network conference, the National WIC Association Conference, the National Association of County and City Health Officials conference, and the Association of

State and the Territorial Public Health Nutrition Directors meeting. In addition, the BDNCN has received many requests from public health agencies throughout the U.S. for copies of the CYSHCN Nutrition Toolkit.

Expansion of the BDNCN, named "Nourishing Special Needs," began in the fall of 2009 and includes a mentor and mentee component (peer nutrition consultation model). The monthly training is open to all WIC Project Sites, the CYSHCN Regional Centers, CYSHCN Hubs of Excellence, Birth to 3 providers, and others who are interested in nutrition issues for children with special needs and children with birth defects.

Evaluation of "Nourishing Special Needs" found that: WIC registered dietitians were frequently the first to identify the need for: 1) initial assessment, diagnosis, and referral for suspected health care problems; 2) additional specialized nutritional assessment and medical nutritional therapy; and 3) special formula or formula changes based on diagnosis.

Baseline data show that the "Nourishing Special Needs" sites currently serve only 15 percent of the Wisconsin statewide WIC client caseload, so expansion to other WIC agencies is essential to help meet access to service needs. Within the state WIC agency caseload, there are an estimated five thousand infants and children with special health care needs, of which 600-700 may have birth defects. In addition, sites demonstrated the following outcomes: 1) a three fold increase in identifying infants and young children with birth defects and other health care needs which accounted for almost half of the referrals to the Wisconsin Regional CYSHCN centers; 2) increased communication and collaboration with other local agencies and medical providers; and 3) improved nutritional care integration with early intervention programs that provided one fifth of the referrals to Wisconsin Birth to 3 program.

As a quality improvement initiative, an integrative model was developed and used to build local nutrition services capacity and to support the Food and Nutrition Services and the National WIC Association Value Enhanced Nutrition Assessment (VENA) counseling strategy to improve quality nutrition services. This model is used for education training at new sites. (Attachment 3, Identification and Intervention for Infants and Children with Special Health Care Needs)

In addition, the state program of the BDNCN provides:

- Training, technical assistance, monthly educational outreach programs and networking teleconferences/"live" meetings and workshop trainings.
- Annual pre-conference training coordination for BCNCN and other attendees at the National WIC Association Conference or State WIC Association conference. This year the conference will focus on the nutrition needs of children with genetic conditions.
- A repository for project data from SPHERE (Secure Public Health Electronic Record Environment) and ROSIE (Real-time Online Statewide Information Environment) computer programs.
- Maintenance of the BDNCN materials on state websites.
- Contract monitoring, oversight, and funding to 13 project sites.
- Participatory educational opportunities for the BDNCN at three Tertiary Neonatal and Pediatric Centers – Birth Defect Medical /Nutrition Specialty Clinics.

Through this quality improvement initiative, the BDNCN developed a system that addresses:

- Communication and facilitation of referrals to primary care, pediatric specialty care, Birth to 3, Wisconsin CYSHCN Regional Centers, economic assistance, and local dietitians providing medical nutritional therapy.

- Collaboration with healthcare providers to ensure documentation for the provision of special infant and pediatric formulas through WIC and for Medicaid reimbursement of nutritional products.
- Training and technical assistance, including the development of a Toolkit and Workbook, and a link to the Wisconsin CSHCN website.
- Data collection and utilization reports for program evaluation. (Attachment 1)

The Wisconsin Stillbirth Service Program (WiSSP)

The Wisconsin Stillbirth Service Program, located at the Marshfield Clinic Research Foundation, investigates the causes of stillbirth through referrals; provides diagnostic information and educational materials to medical personnel for counseling families with a child who died prior to birth; provides families with other support resources; supplies families and medical personnel with scientific and medical data; and distributes "Grand Rounds" presentation on stillbirth evaluations to birth centers in Wisconsin. WiSSP submits birth defect reports to the WBDR for any stillbirth in which a reportable condition is diagnosed.

Through a parallel contract objective to ensure statewide availability of bereavement and counseling services, the WiSSP and the Infant Death Center Children's Health Alliance of Wisconsin began collaborating on several similar projects to include opportunities and strategies to form common messaging, promote each other's grief and bereavement materials, and distribute resources statewide.

Wisconsin Pediatric Cardiac Registry

In 2010, the WBDPSP provided funding to the Wisconsin Pediatric Cardiac Registry to support changes to their protocol that would allow reporting of confirmed cardiac defects to the Wisconsin Birth Defects Registry. This project resulted in 519 reports to the WBDR.

Folic Acid Survey Module

Biennially, Wisconsin includes a folic acid survey module in the Behavioral Risk Factor Surveillance System survey. The folic acid module assesses folic acid awareness, communication of the folic acid message, knowledge of folic acid benefits, and consumption of multi-vitamins containing folic acid. The questions are offered only to women of childbearing age. Information from the folic acid module indicates that providing vitamins and education to low-income women is beneficial. Some reproductive health providers have changed their practice of care guidelines to ensure client access to multivitamins with folic acid.

Website

The Children and Youth with Special Health Care Needs Program - Birth Defect Prevention and Surveillance System Website is available at:
http://dhs.wisconsin.gov/health/children/birthdefects/index.htm.

SUMMARY

The Wisconsin Birth Defects Prevention and Surveillance program's work focuses on the three core functions of public health: assessment, assurance, and policy development. These core functions are applied in conjunction with the requirements set out in statute: provide an up-to-date birth defects registry that facilitates the identification of risk factors; ensure epidemiology; protect confidentiality; determine reportable birth defects through an Advisory Council; provide for primary prevention to help decrease occurrence; implement components that educate

populations about birth defects; and administrate systems that refer those with birth defects to early intervention and other support services.

Endnote

* A major challenge was creating a rational and consistent list of reportable diagnoses. The Birth Defects Advisory Council's Scientific Subcommittee was charged with this task. An initial list was developed based on a set of primary criteria requiring that the proposed birth defect should:
    - Conform to the statutory definition of a birth defect – a structural deformation, disruption or dysplasia, or a genetic, inherited, or biochemical disease that occurs prior to or at birth.
    - Usually be identifiable by two years of age (the limit of the statute).
    - Be a major anomaly (having medical, surgical or developmental significance).
    - Be of 'sufficient' frequency (birth prevalence) – an estimated prevalence of 1/30,000 births was selected; this would mean that two or more occurrences each year in Wisconsin would be expected.

The subcommittee attempted to make the resulting list consistent with data being collected elsewhere in the United States. The list does not include most conditions identified by current newborn bloodspot screening since ascertainment of these is virtually complete. The list was further reviewed by nearly three dozen pediatric sub-specialists (neurology, otolaryngology, hematology, urology, developmental medicine, neurosurgery, neonatology, orthopedic surgery, endocrinology, and cardiology). Their suggestions were analyzed by the Scientific Subcommittee creating the final list written into administrative rules. The list is reviewed annually.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-40054 (12/03)

STATE OF WISCONSIN
Bureau of Community Health Promotion

CONFIDENTIAL BIRTH DEFECTS REGISTRY REPORT

Completion of this form by physicians and pediatric specialty clinics is mandated under the provisions of sections 253.12(1) and 253.12 (2) of the Wisconsin Statutes. Completion of this form by hospitals is voluntary. Personally identifiable information collected on this form will only be used for matching and unduplication purposes.

1. Print firmly and neatly 2. Use pen only with dark ink 3. Print inside boxes 4. Fax/mail original form 5. Darken circles completely 6. Mark errors like this: ■

A. GENERAL INFORMATION

(1) **Is this report a new report or a correction or addition to a previous report?** O New O Correction

(2) **Has a Parental Consent Form been signed by a parent or guardian?** O Yes O No

(3) **Has a Referral Already Been Made to:**
Regional Children with Special Health Care Needs Center O Yes O No
Local Public Health Department O Yes O No
Local Birth to 3 Program O Yes O No
Other (specify): _____

B. REPORTER

Today's Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Name, Title, Telephone and E-mail Address of Person Completing Form

C. REPORTING SOURCE

Facility Name/Number, Address, City, State and Zip Code (stamp acceptable)

D. CHILD'S INFORMATION

Last Name

Date of Birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

First Name M.I. Medical Record Number

Street Address

City State Zip Code

Sex	Race (check all that apply)		Ethnicity
O Female	O American Indian or Native Alaskan	O White	O Hispanic or Latino
O Male	O Asian	O Other_____	O Not Hispanic or Latino
O Undesignated	O Black/African American	O Unknown	
	O Hawaiian/Pacific Islander		

List other names for child, if any

Birth	Birthweight	Gestational Age Estimate	Is Birth	Birth Order (if multiple)
O Live	O Grams O Pounds/Ounces	Weeks: ☐☐	O Single OTwin	O First
O Stillbirth > 20 weeks gestation	_____		O Other Multiple_____	O Second
			O Unknown	O Other (specify):

Place of Birth: Hospital Name/Code, Street Address, City, State, Zip Code

E. CHILD'S PRIMARY CARE PROVIDER

Name of Primary Care Provider, and Facility Name

Area Code ☐☐☐ Telephone Number ☐☐☐ - ☐☐☐☐

F. CHILD'S MOTHER

Last Name

Date of Birth (mm/dd/yyyy)

First Name

M.I.

Maiden Name

City (at time of birth)

State

Zip Code

Race (check all that apply)

O American Indian or Native Alaskan
O Asian
O Black/African American
O Hawaiian/Pacific Islander
O White
O Other _____
O Unknown

Ethnicity

O Hispanic or Latino
O Not Hispanic or Latino

G. CHILD'S FATHER

Last Name

Date of Birth (mm/dd/yyyy)

First Name

M.I.

Race (check all that apply)

O American Indian or Native Alaskan
O Asian
O Black/African American
O Hawaiian/Pacific Islander
O White
O Other _____
O Unknown

Ethnicity

O Hispanic or Latino
O Not Hispanic or Latino

H. DIAGNOSTIC INFORMATION

Last Name of Physician Making Diagnosis

Date of Diagnosis (mm/dd/yyyy)

First Name

M.I.

License Number

Specialty Area

Area Code

Telephone Number

Condition(s) prenatally diagnosed? O Yes O No O Unknown
Is child deceased? O Yes O No

If child is deceased, date of death (mm/dd/yyyy)

I. WISCONSIN BIRTH DEFECTS REGISTRY REPORTABLE CONDITIONS

Code

Reportable Condition (first 25 letters/spaces)

INSTRUCTIONS

CONFIDENTIAL BIRTH DEFECTS REGISTRY REPORT

(1) This report form is to be used by physicians, pediatric specialty clinics and hospitals to report birth defects for children up to age two. The report is mandated under the provisions of sections 253.12(1) and 253.12(2) of the Wisconsin Statutes. The information is submitted to the Wisconsin Department of Health Services, Bureau of Community Health Promotion, Children with Special Health Care Needs Program.
(2) Please fill out as much information as possible. Leave items **blank** if you don't have the information. Do not write "N/A" or similar in the spaces.
(3) This report can be submitted via the Internet. Refer to the website at: https://wbdr.han.wisc.edu for electronic forms and instructions.
(4) If completing the report on paper, fax to Elizabeth Oftedahl, CSHCN Epidemiologist, Bureau of Community Health Promotion at 608/267-3824. If sending by U.S. Postal Service mail, her mailing address is 1 W. Wilson Street, P.O. Box 2659, Madison, WI 53701-2659.
(5) Be sure to provide a name, title, telephone number and e-mail address for the person filling out the report so that person can be contacted if there are any questions.
(6) Use the list at the end of this page for section I of the report. If the reportable condition is longer than 25 letters and spaces, put in the proper code number and the first 25 letters and spaces of the reportable condition.
(7) Be sure the parent/guardian has signed a parental consent form (provided and maintained by you or your facility) before submitting the report. If the parent/guardian refuses to sign a consent form, you are still required to report. However, do not provide a name or address for the child or for the child's parents. Do provide date of birth, medical record number (if available), sex, race, ethnicity, birth outcome, birthweight, gestational age estimate, plurality and, if multiple, birth order information.
(8) Contact Elizabeth Oftedahl at 608-261-9304 if you have questions or comments. She can also be reached via e-mail at oftedej@dhs.state.wi.us

Wisconsin Birth Defects Registry Reportable Conditions

CARDIOVASCULAR
100 Atrial Septal Defect
101 Atrioventricular Canal/Endocardial Cushion Defect
102 Cardiac Arrhythmia (Congenital)
103 Coarctation of the Aorta
104 Hypoplastic Left Heart
105 Tetralogy of Fallot
106 Total Anomalous Pulmonary Venous Return
107 Transposition of the Great Vessels
108 Truncus Arteriosus
109 Valvular Heart Disease (Congenital)
110 Ventricular Septal Defect

CHROMOSOMAL
150 Down Syndrome
151 Klinefelter Syndrome
152 Trisomy 13
153 Trisomy 18
154 Turner Syndrome
155 Velocardiofacial Syndrome (22q Deletion Syndrome)
156 Other Chromosomal Anomaly *(not Down Syndrome, Klinefelter Syndrome, Trisomy 13, Trisomy 18, Turner Syndrome or Velocardiofacial Syndrome)*

ENDOCRINE
200 Hypothyroidism (Congenital)

EYE
250 Cataract (Congenital or Early)
251 Coloboma
252 Glaucoma (Congenital)
253 Microphthalmia/Anophthalmia

GASTROINTESTINAL/ABDOMINAL
300 Biliary Atresia
301 Gastroschisis
302 Hirschsprung Disease
303 Omphalocele
304 Pyloric Stenosis
305 Rectal/Colonic Atresia/Stenosis
306 Small Bowel Atresia/Stenosis
307 Tracheo-Esophageal Fistula/Esophageal Atresia

GENITOURINARY
350 Ambiguous Genitalia
351 Epispadias
352 Exstrophy of the Bladder/Cloaca
353 Hypospadias
354 Multicystic and/or Dysplastic Kidney
355 Obstructive Urinary Tract Defect *(not Posterior Valves; not Urethral Stenosis/Atresia)*
356 Polycystic Kidney Disease, Autosomal Dominant Form
357 Polycystic Kidney Disease, Autosomal Recessive Form
358 Polycystic Kidney Disease, Uncertain Form
359 Posterior Urethral Valves
360 Renal Agenesis/Hypoplasia
361 Urethral Stenosis/Atresia

HEMATOLOGIC
400 Hemophilia
401 Hereditary Spherocytosis
402 Von Willebrand Disease

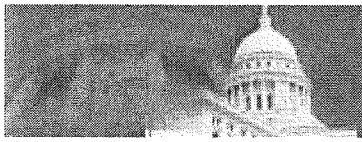
MUSCULOSKELETAL
450 Achondroplasia
451 Amniotic Bands
452 Arthrogryposis Multiplex Congenita
453 Bone Dysplasia/Dwarfism, Other *(not Anchondroplasia)*
454 Clubfoot (Congenital)
455 Hip Dislocation (Congenital)/Developmental Dysplasia of Hip (Congenital)
456 Hemivertebra
457 Osteogenesis Imperfecta
458 Scoliosis (Infantile) and/or Kyphosis
459 Reduction Deformity, Arm or Hand
460 Reduction Deformity, Leg or Foot

NEUROLOGIC
500 Anencephaly
501 Encephalocele
502 Holoprosencephaly
503 Hydranencephaly
504 Hydrocephalus (Congenital or Early)
505 Microcephaly (Congenital or Early)
506 Porencephaly
507 Spina Bifida
508 Spinal Muscular Atrophy (Infantile)

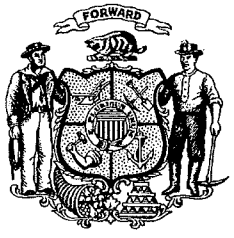
OROFACIAL
550 Choanal Atresia
551 Cleft Lip with or without Cleft Palate
552 Cleft Palate
553 Craniosynostosis
554 Microtia/Anotia

PULMONARY
600 Cystic Fibrosis
601 Diaphragmatic Hernia

SYNDROMES/ASSOCIATIONS
650 Angelman Syndrome
651 Beckwith-Wiedemann Syndrome
652 CHARGE Association
653 De Lange Syndrome (Cornelia De Lange Syndrome)
654 Marfan Syndrome
655 Noonan Syndrome
656 Oculoauriculovertebral Association *(including Goldenhar Association and Hemifacial Microsomia)*
657 Prader-Willi Syndrome
658 Robin Malformation Sequence (Pierre Robin Sequence)
659 Smith-Lemli-Opitz Syndrome
660 Sotos Syndrome
661 Stickler Syndrome
662 VATER Association
663 Williams Syndrome



WISCONSIN STATE LEGISLATURE



State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

July 24, 2012

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

Dear Mr. Fuller:

I am pleased to submit to the Legislature the enclosed report as required by Chapter 153, Wisconsin Statutes. Section 153.05(2m)(b) directs the Department of Health Services to biennially review the performance of the Wisconsin Hospital Association (WHA), the entity under contract to produce the reports under s. 153.05 (2m), and to report to the Legislature on the timeliness and quality of the reports produced by the Wisconsin Hospital Association Information Center (WHAIC).

The WHAIC produced all required reports in a timely manner using the most currently available annual hospital discharge data. The WHAIC continues to shorten the time between availability of the annual data set for analysis and web publication of these mandated reports.

Sincerely,

Dennis G. Smith
Secretary

Enclosure

Biennial Reports Produced by the Wisconsin Hospital Association Information Center under Ch. 153, Wis. Stats

Department of Health Services
June 15, 2012

Wisconsin statutes, s. 153.05(2m)(b), direct the Department of Health Services to biennially review the performance of the Wisconsin Hospital Association (WHA), the entity under contract to produce the reports under s. 153.05(2m), and to submit a report about the timeliness and quality of the reports produced by the Wisconsin Hospital Association Information Center (WHAIC).

The **Hospital Rate Increase Report** is a one-page Web-based spreadsheet showing the dates of hospital price increases that caused a hospital's gross patient revenue to increase faster than the rate of inflation (specifically, the federal government's consumer price index). State law requires Wisconsin hospitals to report price increases to the WHA Information Center and to the public via local newspapers. WHAIC periodically updates a Web-based spreadsheet throughout the calendar year. A final spreadsheet report was produced at the end of each calendar year, 2010 and 2011.

The **Uncompensated Health Care Report**, a Wisconsin Hospitals publication, provides annual uncompensated health care information for general medical surgical (GMS) hospitals, psychiatric hospitals, alcohol and other drug abuse (AODA) hospitals, and rehabilitation hospitals that are not state or federal facilities. The data source is the Annual Hospital Fiscal Survey, which includes uncompensated health care and fiscal information for one year. The WHAIC published the report covering fiscal year 2009 in January 2011. In August 2011, the WHAIC published a similar report for fiscal year 2010.

The **Health Care Data Report** (termed a "patient-level data utilization, charge and quality report" in the administrative rules) presents an annual summary of patient data on the utilization and charges at Wisconsin hospitals and freestanding ambulatory surgery centers (FASCs). The report is divided into three sections: 1) inpatient data, 2) ambulatory surgery data, and 3) emergency department data. In March and November 2011, the WHAIC published reports covering calendar years 2009 and 2010 respectively.

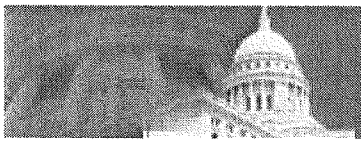
The **Guide to Wisconsin Hospitals** presents descriptive financial, utilization, and staffing data about individual Wisconsin hospitals, and provides summary and trend information for selected aggregate data. Data sources are the Hospital Fiscal Survey and the Annual Survey of Hospitals submitted annually by all Wisconsin hospitals. The WHAIC published the reports for fiscal years 2009 and 2010 in March and August 2011, respectively.

The **Wisconsin Inpatient Hospital Quality Indicators Report** provides information about procedure volume, utilization and in-hospital mortality for common conditions and procedures in GMS hospitals in Wisconsin. It is intended to provide information about the quality of care in Wisconsin GMS hospitals that will be used to make administrative and system changes to improve patient outcomes. The quality measures used in the report are derived from hospital data submitted to WHA by GMS hospitals for inpatient stays. In December 2010, the WHAIC published the report covering data years 2007-2009. In December 2011, following release of new Agency for Healthcare Research and Quality (AHRQ) quality indicators software, the WHAIC published the report covering data years 2008-2010.

WHA produced all required reports in a timely manner. The reports used the most currently available data, cited current research literature, and provided updated charts, graphs and information. The WHA Information Center enhanced the annual, fiscal, and uncompensated survey by integrating validation edits between the current and the previous year to make the information more useful. WHA is committed to continual improvement in these products and to timely release of the information. In addition, WHA added a representative from DHS to its Board of Advisors.

All reports, both current and historical can be viewed at www.whainfocenter.com.
In addition to the reports, the WHA worked to improve hospital data in the following ways:

- Added an Other Hospital Outpatient module to Pricepoint – a Web site allowing health care consumers to receive basic, facility-specific information about healthcare services and charges.
- The WHAIC has worked with hospitals extensively to facilitate the transition to the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10) Federal reporting requirement. All hospitals nationwide must be compliant with the Federal requirement by September, 2014.



WISCONSIN STATE LEGISLATURE

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

August 16, 2012

Jeffrey Renk
Assistant Senate Chief Clerk
Room B20 Southeast
Madison, WI 53702

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

Dear Mr. Renk and Mr. Fuller:

The Department of Health Services is pleased to submit the 2011 Annual Report to the Governor and the Legislature. The report is required by 2003 Wis. Act 33, SB 44, Section 2462, 255.15 (4).

Tobacco contributes to the deaths of 8,000 Wisconsin citizens every year and costs an estimated $4.5 billion in annual health care costs ($2.79 billion) and lost worker productivity ($1.72 billion). The Wisconsin Tobacco Prevention and Control Program (TPCP) is responsible for providing leadership, facilitating diverse partnerships around the state, and administrating funding and prevention program activities. The TPCP continues to invest in evidence-based strategies within a comprehensive effort to effectively reduce tobacco use and exposure.

Wisconsin continued its success during 2011 in preventing youth tobacco use and promoting tobacco addiction treatment, eliminating tobacco-related disparities, and eliminating exposure to secondhand smoke. Highlights include:

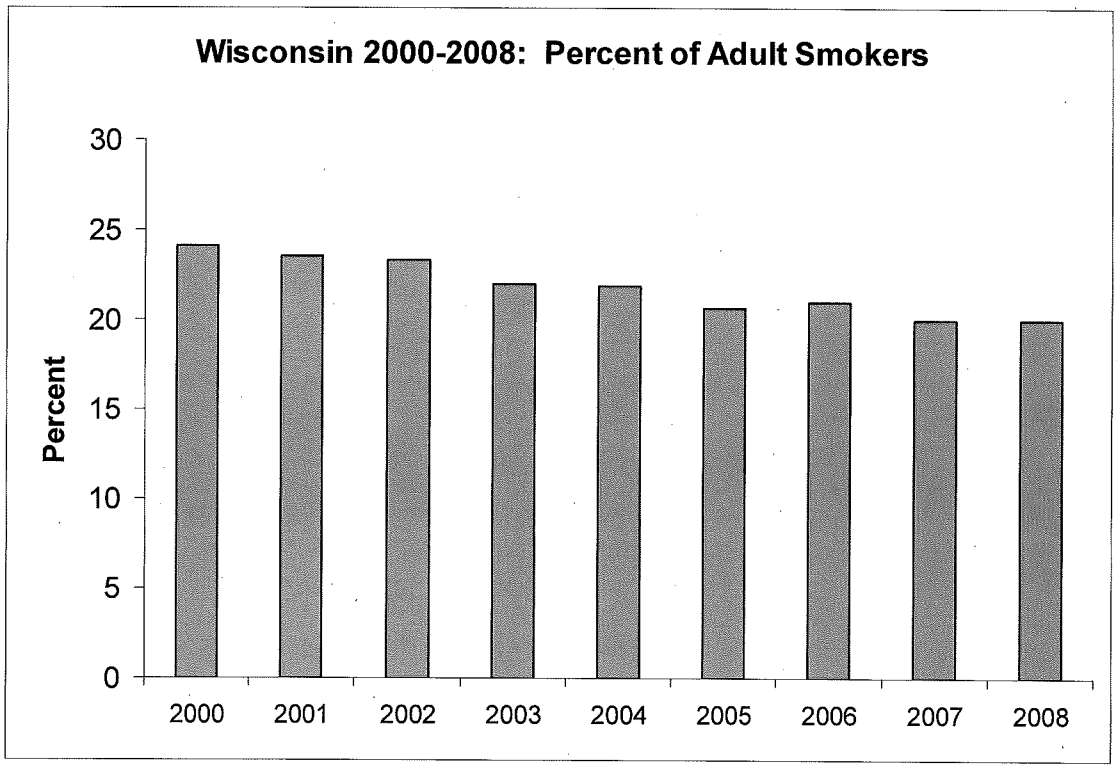
Youth

- The number of middle school students identified as current smokers has declined from 12% in 2000 to 3.9% in 2010, a 67% change.[1]
- The number of high school students who identified themselves as current smokers has declined from 32.9% in 2000 to 17.7% in 2010, a 46% change.[2]
- Youth access to tobacco products has declined substantially from 24.6% of establishments selling to minors in 2000 to 5.1% selling to minors in 2011.[3]
- The program was awarded a grant from the Federal Drug Administration (FDA) to enforce portions of the Federal Tobacco Control Act, which required the FDA to reissue the 1996 final rule, "Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco to Protect Children and Adolescents."

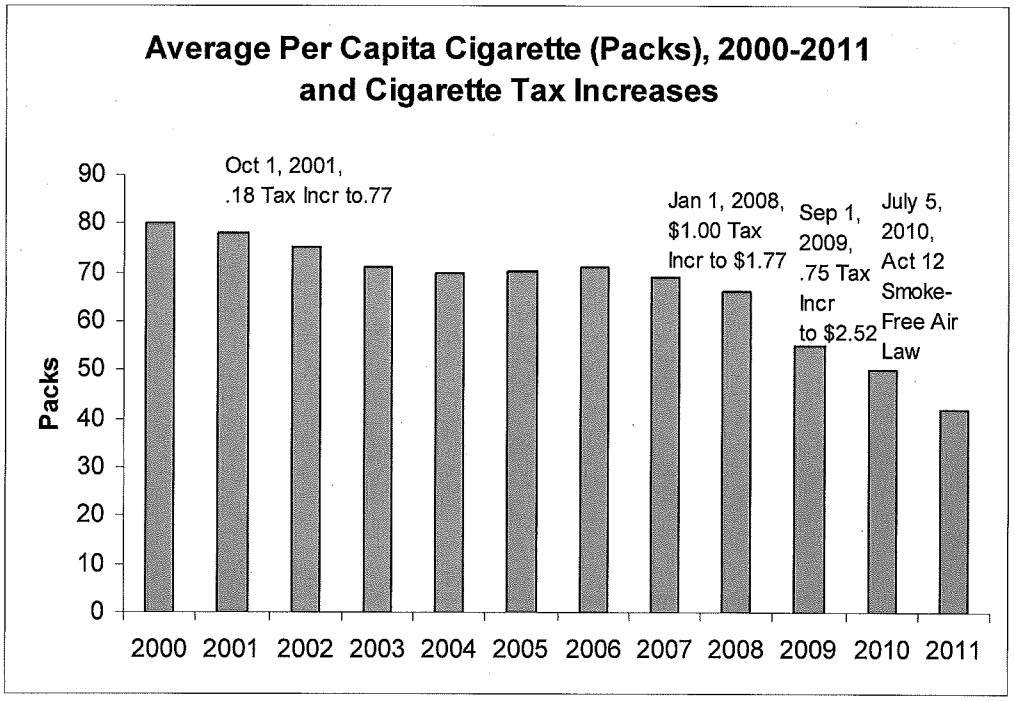
Adults

- In 2010, the smoking rate among adults was 22.3%, amounting to over 969,000 people.[4] Because weighting of the data changed in 2009-2010, it cannot be compared to trend data from 2000-2008. First, in 2009, cell phone responses were added to the survey methodology along with landline phone responses in order to obtain a better representative population sample of Wisconsin. Past surveys were collected via landline phones only. Second, the current statistical methodology used to calculate the prevalence rates does a better job of reflecting the characteristics of the entire population of Wisconsin.

  The table below depicts the percentage of adult smokers during the 2000 to 2008 time period. Weighting of the data changed in 2009-2010, which affected the rates and 2010 data therefore cannot be compared to trend data from 2000-2008.

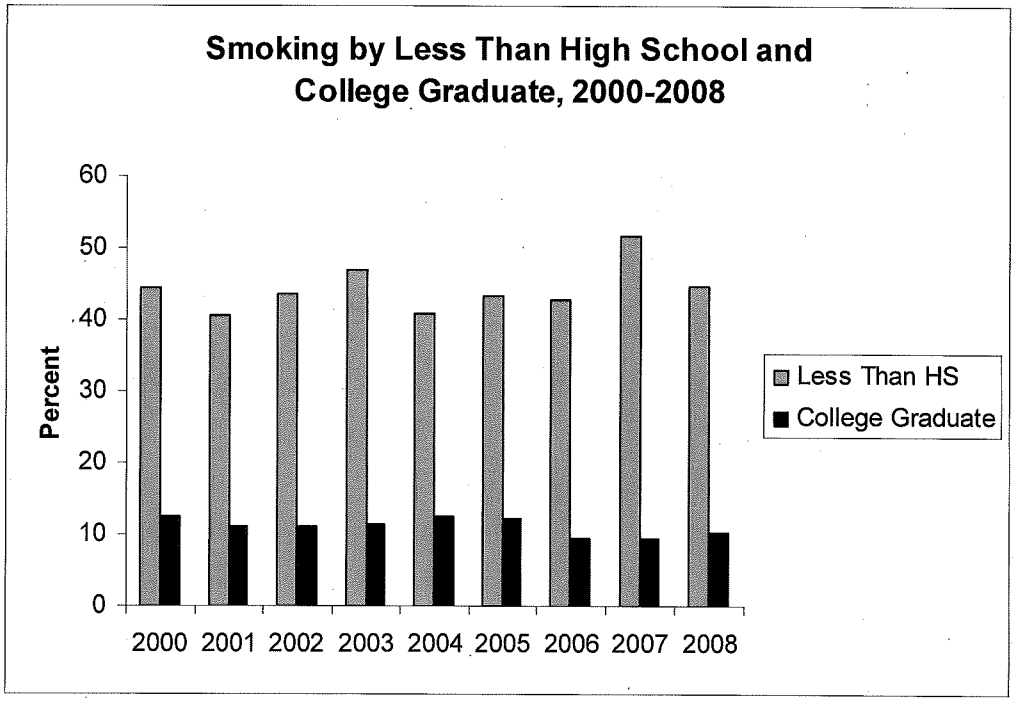


- Per capita consumption is declining from 80.0 packs sold per capita in 2000 to 42 packs sold per capita in 2011.[5]

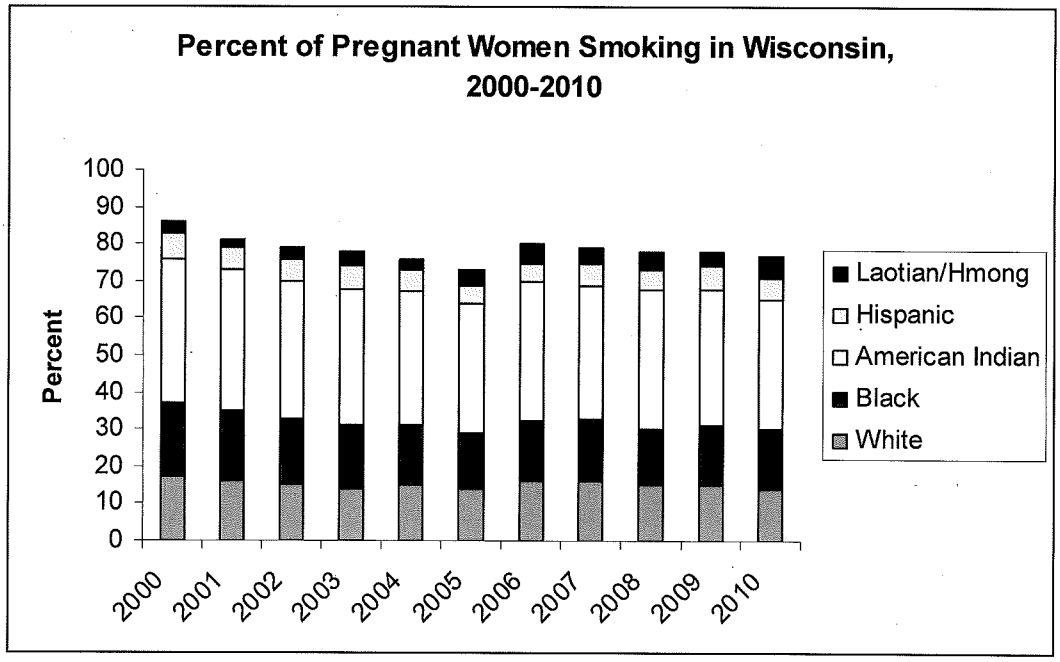


- In 2010, with respect to education, 33.3% of the population with less than a high school education were smokers, compared to 10.4% for college graduates.[6] As previously stated, because weighting of the data changed in 2009-2010, the data from 2010 cannot be compared to trend data from 2000-2008.

The following table depicts the percent of the population with less than a high school education who smoked and the percent of the population with a college degree who smoked during the 2000-2008 time period.

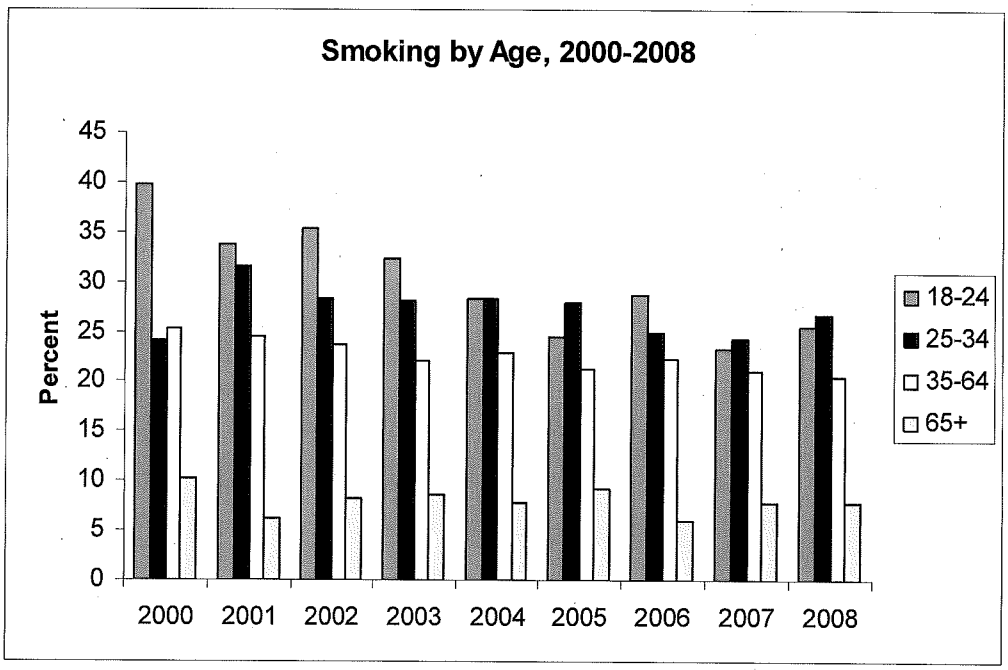


- In 2010, the population of pregnant women who were smokers in 2010 had the following racial breakdown: 14% White, 16% Black, 35% Native American, 6% Hispanic and 6% Laotian/Hmong. The overall percentage of pregnant women who smoked was 13%.[7]



- Smoking percentages by age are as follows: 18- to 24-year-olds had a smoking rate of 21.9%, 25- to 34-year-olds had a rate of 30.7%, 35- to 64-year-olds had a rate of 20.5%, and individuals 65 years of age or older had a rate of 6.7%.[8] As previously stated, because weighting of the data changed in 2009-2010, this data cannot be compared to trend data from the 2000 to 2008 time period.

The following table depicts smoking by age from the 2000 to 2008 time period.



- While smoking varies by age group, the overall adult smoking rate in Wisconsin decreased 21% from 2000 to 2008.

- Annually, nearly 7,000 Wisconsin residents died directly from smoking-related illnesses, with an additional 751 non-smoker deaths that were indirectly related to secondhand smoke.[9]

Treating Tobacco Dependence

- 9,591 individuals called the Wisconsin Tobacco Quit Line (1-800-Quit-Now) in 2011, which included a two-week supply of no-cost nicotine replacement therapy (NRT) and free counseling. The University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI) administers the program through funding from TPCP.[10]

- Since 2001, First Breath, a program of the Wisconsin Women's Health Foundation, has helped over 10,000 pregnant women quit smoking. This program, now a national model, integrates quitting strategies into existing prenatal care models and partners with local public health agencies and health care systems.[11]

- Through a collaboration with the Wisconsin Women's Health Foundation, UW-Center for Tobacco Intervention, and DHS's Division of Health Care Access and Accountability, the Centers for Medicare and Medicaid Services awarded Wisconsin a grant for $9.2 million over five years to reduce smoking rates among Medicaid enrollees, with a special emphasis on reducing the number of pregnant smokers. The Striving to Quit initiative will target BadgerCare Plus members in two regions of the state and BadgerCare Plus high-risk pregnant women in five counties. More than 8,000 adults and 3,000 pregnant women will be offered free smoking cessation counseling through the statewide Quit Line.

Smoke-Free Environments

- Since the smoke-free air law went into effect in all workplaces on July 5, 2010, 75% of surveyed Wisconsinites support the smoke-free law, and 91% say they go to bars and restaurants at the same frequency or even more often now that these types of establishments are smoke-free.[12]

- Less than 1% of Wisconsin's businesses have had smoke-free air compliance issues.[13]

- Wisconsin bars and restaurants with previously unhealthy air saw a 92% reduction in unhealthy air* after the smoke-free law took effect.[14]

Smoking Among Medicaid Beneficiaries

- The overall smoking rate for Wisconsin Medicaid enrollees is about 38%.[15]

- The Division of Health Care Access and Accountability calculates three tobacco measures for BadgerCare Plus enrollees annually: counseling only, pharmacotherapy only, and counseling and pharmacotherapy.

Wisconsin BadgerCare Plus Results
Among Members with Diagnosis of Tobacco Addiction

Tobacco Cessation MEDDIC Measures	2008	2009	2010
Counseling Only	55.0%	58.8%	60.1%
Counseling & Pharmacotherapy	32.2%	33.9%	32.2%

Please contact Vicki Stauffer at 267-3823 if you have any questions or need additional information. The report includes the relevant references.

Sincerely,

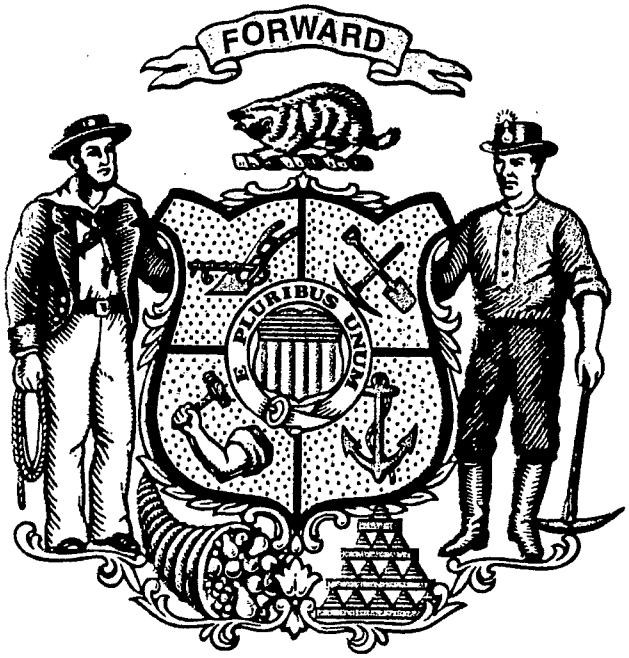
Dennis G. Smith
Secretary

Data Sources

1 Wisconsin 2010 Youth Tobacco Survey – Middle School.
2 Wisconsin 2010 Youth Tobacco Survey – High School.
3 State Fiscal Year 2012 Wisconsin Synar Report.
4 2010 Wisconsin Behavioral Risk Factor Surveillance Survey (BRFSS).
5 Wisconsin Department of Revenue Cigarette Tobacco Tax Report – January 2012.
6 2010 Wisconsin Behavioral Risk Factor Surveillance Survey (BRFSS).
7 Wisconsin Interactive Statistics on Health (WISH) Interactive Query System (www.dhs.wisconsin.gov/wish).
8 2010 Wisconsin Behavioral Risk Factor Surveillance Survey (BRFSS).
9 Burden of Tobacco in Wisconsin: 2010 Edition. Each year, approximately 15% of all deaths in Wisconsin are directly attributable to smoking; these include Lung Cancer, Other Smoking-Related Cancers, Cardiovascular Disease, & Respiratory Disease. Over 700 Wisconsin deaths are indirectly related to Secondhand Smoke Exposure, maternal Smoking, & Fires.
10 Wisconsin Tobacco Quitline Demographic Report, 12/1/2011 – 12/31/2011.
11 Wisconsin's Women Health Foundation – First Breath Program (www.wwhf.org).
12 2010 Wisconsin Behavioral Risk Factor Surveillance Survey (BRFSS).
13 Wisconsin Smoke Free Air Compliance Complaint Website.
14 Indoor Air Quality in Bars and Restaurants Before and After Implementation of the Smoke-Free Wisconsin Act, 2010. Before the law took effect, the mean air quality was very unhealthy with fine particulate matter levels at 160 micrograms/cubic meter. After the law took effect, the mean air quality was at good, with small particulate matter levels at 13 micrograms/cubic meter.

*The common standard of measurement of air quality is the amount of fine particulates or particles in the air. Tobacco smoke is the largest contributing factor to fine particulate matter indoors. Fine particulate matter is defined as particles smaller than 2.5 microns, or about one-tenth the width of a human hair. The small size of the particles is significant because they are able to penetrate deep into lung tissue and the walls of the arteries causing damage. According to Department of Natural Resources standards in order for air quality to be good/satisfactory there should be less than 35 micrograms of fine particulate matter/cubic meter.

15 Voskuil KR, Palmersheim KA, Glysch RL, Jones, NR. Burden of Tobacco in Wisconsin: 2010 Edition. University of Wisconsin Carbone Cancer Center. Madison, WI: March 2010.


FORWARD
E PLURIBUS UNUM

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

September 14, 2012

Mr. Jeffrey Renk
Senate Assistant Chief Clerk
Room B20 Southeast, State Capitol
Madison, WI 53702

Mr. Patrick Fuller
Assembly Chief Clerk
17 West Main, Suite 401
Madison, WI 53703

Dear Mr. Renk and Mr. Fuller:

Section 227.485(9) of the Wisconsin Statutes requires the Department to submit an annual report concerning decisions and resulting payments of attorney fees and related legal costs. Attorney fees and other legal costs are to be paid whenever the opposing party to an agency's Chapter 227 hearing prevails and it is determined that the agency's position was not substantially justified. The attached report reflects payments made during SFY 2012.

In addition, under s. 814.245(10), the Department is required to report any awards granted to the Department regarding frivolous motions brought against the Department. No motions of opposing parties were found to be frivolous in SFY 2012. Consequently, the Department has no awards to report.

Sincerely,

Dennis G. Smith
Secretary

Attachment

cc: Patty Lynch
Amy McDowell

1985 WISCONSIN ACT 52
Claims Under Sections 814.245 and 227.485, Wis. Stats.
Fiscal Year: July 1, 2011 to June 30, 2012

CASE NAME	CASE No.	AGENCY	ASSISTANT ATTORNEY GENERAL/ DHS ATTORNEY	OPPOSING COUNSEL	NATURE OF CASE/CLAIM	COSTS/FEES REQUESTED	AMOUNT AWARDED	DATE OF ORDER	APPEAL
Fritz, Leonard	CMGE/16537	DHS	None	Heather Poster	MA eligibility - community spouse	$2,305.11	$2305.11	4/27/12	No
Rose, Irene	CMED-28/115554 CMDV-28/115555	DHS	None	Jennifer E. Annen	MA eligibility – assets and divestment	$4,792.00	$3542.74	10/26/11	No
Rye, Harriet	CFCP/112587	DHS	None	Robert Bertram	Family Care eligibility - assets	$1,372.00	$969.64	12/22/11	No
Schwichtenberg, Colton	DMPA/116324	DHS	None	Mitchell Hagopian	MA eligibility – medical necessity	$6,847.62	$6,847.62	2/23/12	No

UW Health

University of Wisconsin
Hospital and Clinics

TO: **Governor Scott Walker**
UW Board of Regents President Brent Smith
DOA Secretary Mike Huebsch
Senate Chief Clerk Jeff Renk
Assembly Chief Clerk Patrick Fuller

FROM: **Donna Katen-Bahensky, President and CEO**
University Wisconsin Hospital and Clinics

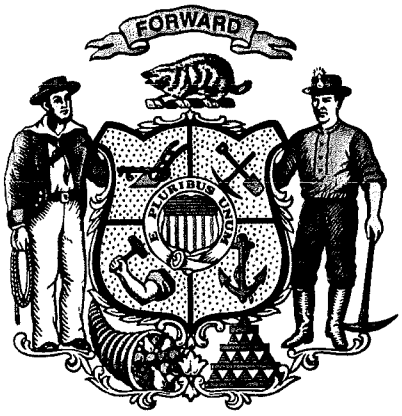
DATE: **October 1, 2012**

RE: **REPORT REQUIRED UNDER 233.04(1)**

Attached please find a copy of the UWHC Authority report on patient care, education, research, community service activities and a draft audited financial statement, as required by state law.

Please feel free to contact me if you have questions or desire additional information.

Thank you.


FORWARD

UW Health

University of Wisconsin
Hospital and Clinics

UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS
2011-2012 Annual Report

UW Hospital and Clinics (UWHC) continued in Fiscal Year 2011-2012 to be guided by the UW Health Strategic Plan, which officially launched in January 2010. The five-year plan established seven major goals aimed at achieving the overarching strategy of providing unsurpassed care to the people of Wisconsin and beyond. This report presents a summary of UWHC's accomplishments relative to each of the seven strategic goals, along with summary of overall financial performance and an overview of additional achievements in UWHC's educational, research and community service missions.

Throughout the year, UWHC continued to garner national recognition as a high-performing health care organization, workplace of choice and leader in quality, safety and patient satisfaction. This year's accolades included:

- Listed among the top 50 hospitals nationwide in seven medical specialties, according to *US News & World Report*, "America's Best Hospitals." In addition, ranked as high-performing in five additional specialties, and in July 2012 received additional ranking as the #1 hospital in the Wisconsin.
- American Family Children's Hospital ranked among the top 50 children's hospitals nationwide, according to *US News & World Report*, "Best Children's Hospitals Guide." AFCH received this ranking in seven pediatric specialties.
- Continuing Magnet® hospital status as designated by the American Nurses Credentialing Center.
- Named for fifth consecutive year among "100 Best Companies" in the nation by *Working Mother* magazine.
- Named by *Working Mother* magazine as one of the nation's 12 "Best Companies for Hourly Workers and 10 "Best Companies for Kids."
- Continued Stage 7 (of 0-7) status by Health Information Management Systems Society (HIMSS) for electronic health record implementation.
- Recognized as a *Get with the Guidelines* Silver Plus Performance Achievement Award winner by the American Stroke Association.
- Named to *Hospitals and Health Networks* list of "100 Most Wired," 2011.
- Selected as Best Hospital/Medical Center in Best of Wisconsin Business Awards, *Corporate Report Wisconsin*, 2011.
- UWHC Environmental Services department named the #1 Environmental Services department in the nation by the Association for Healthcare Environment (AHE) and Health Facilities Management—an official magazine of the American Hospital Association (September 2012).
- UWHC Pharmacy department recognized by American Society of Health System Pharmacists with 2011 Award for Excellence in Medication Use Safety.

ADDITIONS TO SENIOR LEADERSHIP TEAM

Due to a number of retirements and upward promotions, several new members joined UWHC's senior leadership team in FY 12. They are:

Christopher Green, MD,
Senior Vice President for Medical Affairs, Chief Medical Officer

Dr. Green served as interim CMO for eight months before assuming the role on a permanent basis in April 2012. He has been with UW Health for 28 years, developing a breadth and depth of experience that positions him well for this new career challenge. His previous professional appointments have included professor of pediatrics, associate chair for clinical affairs for pediatrics, vice chair of pediatrics, interim chair of pediatrics, and medical director. He has served on multiple committees, maintains teaching and clinical responsibilities and is widely published.

Dr. Green is board certified in pediatrics and pediatric pulmonology and holds a UWSMPH faculty appointment in the department of pediatrics, as well as an administrative appointment as Assistant Dean for Hospital Affairs. He is named among *Madison Magazine Top Docs 2012* and *Best Doctors in America 2011*. His focus on patient- and family-centered care and clinical quality make him a superb addition to the UWHC leadership team.

Beth Houlahan, MSN, RN, CENP
Senior Vice President for Patient Care Services, Chief Nursing Officer

Beth Houlahan, MSN, RN, CENP joined the University of Wisconsin Hospital and Clinics just prior to the beginning of FY12, as Senior Vice President of Patient Care Services, and Chief Nursing Officer. She brings experience in both academic and community hospitals, and in ambulatory and physician practice settings. Most recently, she served as Senior Vice President Patient Care Services at Mercy Medical Center, Cedar Rapids, Iowa, a 445-bed facility. In this role, she was responsible for clinical, operational and financial leadership for nursing and clinical inpatient and outpatient services for Mercy Medical at five campuses in Cedar Rapids, including an acute care facility, Medical Plaza, Alcohol and Drug Outpatient Treatment Center, and an Inpatient Hospice House.

Beth received her BSN from Mount Mercy College in Cedar Rapids, Iowa, and her MSN from the University of Iowa. She also completed the Johnson and Johnson Wharton Nurse Executives Fellowship program, and was active in the Iowa community, serving on a variety of community boards and professional organizations.

Sue Rees, DNP, RN, CPHQ, CENP
Vice President, Development, Nursing and Patient Care Services

Sue Rees, DNP, RN, CPHQ, CENP is the UWHC Vice President for Development, Nursing and Patient Care Services, a recently created role in nursing leadership. She has served in this role since February 2012.

Sue is responsible for the senior leadership of nursing and patient care services' quality, regulatory compliance, labor relations, facility planning, practice innovation, research, operations support, informatics, respiratory therapy, clinical nutrition, and education and development. She also represents UW Hospital and Clinics in its relationships with the UW-Madison School of Nursing. Sue joined UW Hospital and Clinics in 1990 as clinical nurse manager of general

surgery and trauma (F4/6). After three years in that role, she served for five years as clinical nurse manager of two units: general surgery and trauma (F4/6) and surgical specialties (F6/6). Sue then served as director of nursing quality, regulatory compliance, employee labor relations and facility planning for 13 years. In that role Sue was also responsible for infection control and nursing practice in the emergency department.

Sue received her bachelor of science in nursing and master of science from the University of Wisconsin-Madison. She received her doctor of nursing practice from Rush University, Chicago.

Ralph D. Turner
Vice President, Facilities and Support Services

Ralph D. Turner joined the University of Wisconsin Hospital and Clinics as Vice President, Facilities and Support Services in April 2012.

Ralph comes to UWHC with broad experience in hospitals and complex systems. Most recently, he served as Vice President, Support Services at Washington Hospital Center, Washington, D.C. In his role for this 926-bed trauma center, teaching and research hospital, Ralph was responsible for a $72 million operating budget and 600 staff members across a range of departments, including environmental services, biomedical engineering, facility engineering, food and nutrition services, patient and guest services, communications, protective services, parking management, life safety, central patient transport, design and construction management and nursing clinical support. Prior to joining Washington Hospital Center, Ralph served 22 years in the United States Army. He started his military career as Private First Class, repairing medical equipment in Army hospitals. He quickly advanced to sergeant, staff sergeant and graduated from Warrant Officers Candidate School. As a Warrant Officer, Ralph assumed positions at Army medical centers with responsibility for biomedical engineering, maintenance management, clinical engineering, construction management and logistics in a variety of locations.

Ralph received his undergraduate degree in business administration and management from the University of Maryland; his Masters of Public Administration from Troy University in Dothan, Alabama; and his Masters of Health Administration from the University of Maryland. He is also a Fellow in the American College of Healthcare Executives.

Jocelyn G. DeWitt, Ph.D
UW Health Vice President, Chief Information Officer
Jocelyn G. DeWitt, Ph.D, assumed the role of UW Health Vice President, Chief Information Officer in April 2012. Most recently, she served as Chief Information Officer for the University of Michigan Hospitals and Health Centers (UMHHC), the inpatient and ambulatory care clinical component of the University of Michigan Health System (UMHS). In that role, she was responsible for a $110 million operating budget, a $20 million to $150 million capital budget and a staff of 650 employees. This included enterprise and departmental applications, customer device engineering and support, server and mainframe management, network infrastructure and telephony for the University of Michigan Hospitals and Health Centers, as well as network infrastructure and server management for the medical school.

Jocelyn received her undergraduate degree from the University of Wisconsin-Madison; her Master of Science degree from Boston University; and her doctorate from the University of Illinois. She is widely published and is a member of several professional organizations including the American Medical Informatics Association; Association of American Medical Colleges'

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Jocelyn received her undergraduate degree from the University of Wisconsin-Madison; her Master of Science degree from Boston University; and her doctorate from the University of Illinois. She is widely published and is a member of several professional organizations including the American Medical Informatics Association; Association of American Medical Colleges'

several initiatives are currently underway to reduce hospital-acquired conditions, reduce 30-day readmissions and improve the patient experience. Among these are:

- **Hand hygiene** – A variety of initiatives from data collection and dissemination to instructional videos and an internal awareness campaign have emphasized staff compliance with CDC handwashing guidelines as well as patient and family education about the importance of hand hygiene.
- **Transitions of care initiatives** cover the gamut from (1) a hospitalist program to provide post-discharge outpatient transitional care to complex medical patients who have no access or limited access to a primary care physician to (2) discharge enhancements such as post-discharge phone calls to help ensure patients understand and comply with their home care instructions and medication regimens. These and other transitions of care initiatives are designed to ease the transition from hospital to home and thus reduce 30-day hospital readmission rates.
- **CLABSI prevention** – Central line-associated blood stream infections increase healthcare costs through excess lengths of stay and can result in significant patient morbidity and mortality. While infection is a known risk of central line use, **it is avoidable in most situations.** The UWHC CLABSI Prevention Initiative focuses on standardizing the insertion of all central lines at the UWHC using a care bundle approach consistent bundle approach that emphasizes five steps known to help reduce the occurrence of infections.
- **CAUTI prevention** – Catheter-associated urinary tract infections are another preventable hospital-acquired condition. UWHC has updated its catheter removal and bladder management protocols with best practices to help reduce the occurrence of these infections.

In ambulatory settings, the UW Health **Primary Care Pay-for-Performance** program continued in FY12 with incentive dollars distributed in August. The aim of the program is to more closely align quality and financial award, both for improvement and achieving quality targets. Improvement was seen over the previous year in general internal medicine and general pediatrics and adolescent medicine. Improvement targets were structured around measures reported to the Wisconsin Collaborative for Healthcare Quality (WCHQ). For adults these measures include screening for breast and colorectal cancers as well as effective screening and ongoing management for chronic conditions such as hypertension and diabetes, while in children, they focus more on immunization rates and completion of well child visits. Measures related to UW Health Avatar patient satisfaction goals are also included.

From a regulatory perspective, UWHC this year not only completed a laboratory survey, a disease-specific survey for transplant and many other focused surveys but also, from November 28 – December 2, 2011, a full hospital and home health triennial survey by the Joint Commission. At the conclusion of the survey President and CEO Donna Katen-Bahensky expressed her thanks to UWHC staff and added: "Most findings were documentation or policy-based and not directly related to patient care. Many findings were able to be addressed before the conclusion of the survey. The surveyors could really tell that everything we do is for the patient. They shared amazing stories of gratitude expressed by our patients and their families." Comments from the surveyors themselves included:

- *It is obvious that UW does not aspire to mediocrity.*
- *Meal cart process at night is Ingenious!!! Refrigerator on wheels. Filled at night. Centrally located. No food waste.*
- *KUDOS to Health Link EHR users. The best data communication roll up I've ever seen in my seven years as a surveyor.*
- MD Surveyor: *It was evident that strong communication skills and clinical care saved this patient's life.* The surveyor also mentioned that if he needs a VAD (ventricular assist device), he is coming here.

Service Excellence

The service excellence goal of the UW Health Strategic Plan focuses on improving the patient experience and on achieving a culture of patient- and family-centered care throughout the organization.

The organizations commitment to patient- and family-centered care was showcased in November 2011, when UW Health hosted the annual conference of the National Institute for Patient- and Family-Centered Care. American Family Children's Hospital hosted an open house for Institute participants, including tours and an introduction to the AFCH model of care, which defines patient- and family-centered processes at every phase of the patient experience -- from admission through rounding, transitions of care and discharge.

Patient- and family-centered care principles are also embodied in UW Hospital and Clinics adult inpatient settings via the hospital's **interdisciplinary model of care** (IMOC) which includes patients and families in the health care team's daily bedside rounds and also in interdisciplinary discharge rounds.
In addition, patient and family participation has continued to increase this year in **advisory councils** and in a variety of UW Health committees for organization-wide planning and decision-making. Patient and family advisors have been heavily involved in planning for UWHC's two main new facilities, the Digestive Health Center and the East Side Campus. The rapid growth of patient and family advisor involvement has sparked markedly increased demand for individuals to serve in these roles. As a result, UW Health has created a new patient/family coordinator role and is currently recruiting for the position.

In FY 11, UW Health Ambulatory clinics transitioned to a new survey vendor, Avatar, for collection of **patient satisfaction** data. Use of the new survey tool began Oct. 1, 2010, and by Feb. 1, 2012, sufficient data had been collected to provide valid individual reports to physicians. These initial reports distributed on Feb. 1, 2012, have since been followed by regular quarterly reports, and individual physicians who wish to do so can access their data, including patient comments, online via Avatar's secure web site.

In July, UW Health held its second annual Patient Experience Week, including a physician resource day with keynote speaker Stephen Beeson, MD, of the Sharp rees-Steely Medical Group in San Diego, as well as several of UWHC's own patient experience experts on topics ranging from having difficult patient conversations to treating every patient as a VIP and making quick quality connections with patients and families.

Clinical Priorities

The aim of the clinical priorities goal is an organization-wide model of care that is recognized not only for excellent clinical outcomes but also for innovation, academic excellence and interdisciplinary collaboration. The strategic plan identifies several areas in addition to UW Health's primary service lines as clinical priorities for development and implementation of this model. In FY11, the focal priorities were the UW Health Breast Center, the UW Health Digestive Health Center now under construction on the west side of Madison, and the new East Side Campus that will break ground in Spring 2013.

Breast Center

Breast Center progress has continued under the leadership of Dr. Lee Wilke, with an emphasis on integrating all breast care services within UWHC, as well as breast services at UW Health's 1 S. Park St. site and breast cancer care offered at the UW Carbone Cancer Center. At the same time, Dr. Wilke places a high priority on advancing the research agenda related to breast cancer and other aspects of breast health.

This year the center has completed a business planning process and begun working on implementation. The business planning process included:

- Stakeholder participation through steering and executive committees and working groups
- Rigorous financial analysis
- Environmental analysis
- SWOT Analysis
- Identification of goals, strategies and tactics to support successful implementation and ongoing operation

Patients were involved in development of the business plan and subsequent marketing plan currently being implemented. Quality measures have been identified and next steps are to finalize the organizational chart and rework positions descriptions to reflect and enhance integration in both imaging and outpatient clinic services between UWHC and 1 S. Park.

In addition, the center is working toward renewal of its accreditation by the National Accreditation Program for Breast Centers (NAPBC), which will occur in 2013.

Digestive Health Center

FY12 saw rapid progress in creation of the UW Health Digestive Health Center DHC. Closing on the University Crossing property at the corner of Whitney Way and University Avenue occurred in January 2012. Construction commenced promptly in February and has proceeded on schedule. The topping out ceremony to commemorate the placement of the final beam in the building's structure was held in June, and opening of the facility is anticipated in the spring of 2013.

The DHC brings together the disciplines of gastroenterology, hepatology, colorectal surgery and radiology in a truly comprehensive, innovative and multidisciplinary approach to digestive health. For patients, this means the ability to go to one convenient, easy-to-navigate location where they will have coordinated access to the full range of digestive specialists and services. The DHC will offer not only a state-of-the-art health care environment but also an innovative care delivery model that emphasizes care coordination and a truly patient- and family-centered experience.

The planning effort has been led by those who understand how health care teams of the future will need to function and who have expertise in health system design. To complement their knowledge, they are also engaging front-line staff and providers to ensure an environment that is professionally satisfying, efficient and supports interdisciplinary collaboration. In addition, we have engaged patients and families in the planning process, and will continue to engage them once the center begins operations.

East Side Campus

Progress has also been significant in planning for the new UW Health campus on the east side of Madison, to be located on a 42-acre parcel of land located in the American Center business park, at the intersection of Interstate Highway 90/94/39 and U.S. Highway 151. UWHC purchased the land in 2005 in anticipation of a time when more space would be needed to meet rising demand. Today, UWHC frequently operates at high census, and our current inpatient capacity will be exhausted by 2014, with no room for growth on the Highland Ave. campus. In addition, UWHC is now 32 years old and in need of renovation. The new facilities will allow the hospital to relocate some services to the east side, thus freeing space to make improvements that will keep 600 Highland Avenue a leading-edge facility. Finally, the east side campus will meet a demonstrated demographic need for both inpatient and outpatient

services on the east side, and will offer a convenient new geographic option for both local and regional patients.

The guiding principles for the new facilities call for a program that will provide improved quality of care, an improved patient experience and a reduce cost of care. Services planned for the east side are those commonly performed at both community hospitals and academic health centers. They are typically lower acuity, high volume services, more likely to be scheduled in advance, follow predictable plans of care and require less specialized support services.

When completed in 2015, the above program will be offered in a facility that houses approximately 88 inpatient beds and 14 operating rooms serving orthopedic and rehabilitation patients as well as other medical and surgical patients. A universal care center will comprise a 56-bed flexible care environment for outpatient diagnostic and treatment procedures as well as 24-hour urgent/emergent care. Other parts of the campus will house a 102-room outpatient clinic area and a fitness/wellness and sports performance pavilion.

To ensure the new east facility is designed for the future to be as innovative, efficient, flexible and patient- and family-centered as possible, UW Health has chosen Lean as the framework to guide the design of future workflows and of the space itself.

The planning has conducted via Lean workshops in which frontline physicians and staff, as well as patient/family advisors have done detailed analyses to determine ideal workflows that will allow us to provide quality care and an excellent experience for patients and families, while meeting our goal of cost benchmarks comparable to those of community hospitals.

Major Clinical Service Lines

UWHC's major clinical service lines – Cancer, Transplant, Heart/Vascular/Thoracic, American Family Children's Hospital, Orthopedics and Neurology/Neurosurgery – continued to operate as centers of excellence.

- **Cancer care** was again one of the seven medical specialties for which UWHC was recognized among the top 50 hospitals in the nation by U.S. News & World Report. As in previous years, clinical trials at the UW Carbone Cancer Center offered cutting edge treatments to thousands of participants. The center continues to maximize access to its cutting-edge treatment options through strong alliances with regional health care facilities. This year it announced plans to collaborate with SwedishAmerican Health System to build and operate a free-standing outpatient cancer center in Rockford, IL. The new SwedishAmerican Regional Cancer Center will offer services such as medical oncology, chemotherapy and infusion; advanced radiation therapy and medical imaging at one convenient location. Patients will have access in their home community to the latest clinical trials offered by the University of Wisconsin-Madison, as well as a full complement of holistic and support services for cancer patients. The original affiliation between the two organizations was announced in 2010. Regional affiliations are part of UW Health's strategic goal to be the premier provider of subspecialty care in Wisconsin and adjacent portions of bordering states.
- The UW **Transplant** program continues to achieve outstanding outcomes, when compared to regional and national peers. Survival rates for heart, liver, kidney and kidney/pancreas transplantation reflect performance that exceeds benchmarks in most categories.

  Supported by the efforts of the nationally recognized UW Organ Procurement Organization, the transplant program continues to exceed regional and national benchmarks in median time to transplant for waitlist patients.

To increase the number of patients who can experience the life-saving benefit of a kidney transplant, UW is working to expand its living donor program. Advantages to living donation include a scheduled procedure, better conditions for the surgery, improved patient survival and better long-term function of the transplanted organ. Through a national kidney exchange program, the UW Health Transplant Program offers options for patients who have an incompatible donor, making it possible for them to receive a living donor kidney transplant. The exchange program helps the deceased organ donor organ shortage by using organs from living donors who may otherwise be unable to donate, and helps patients who may have difficulty finding an appropriately-matched living donor.

With more than 50 transplant centers participating in this national program, the donor pool is greatly expanded which significantly increases the opportunity to find a compatible donor for a recipient.

- For the second straight year, **American Family Children's Hospital** ranked among the top 50 children's hospitals in *U.S. News & World Report*'s 2012-13 Best Children's Hospitals Guide. AFCH ranks in the top 50 in Cancer, Diabetes/Endocrinology, Gastroenterology, Neonatology, Orthopedics, Pulmonology and Urology.

  After extensive nationwide searches, UW Health announced the recruitment of Dan Ostlie, MD, to serve as the new surgeon-in-chief for American Family Children's Hospital. Dr. Ostlie comes to Madison after spending the past 12 years at Children's Mercy Hospitals and Clinics in Kansas City, most recently as Vice Chair of the Department of Surgery. He is board certified in surgery, pediatric surgery and surgical critical care medicine.

  In addition, American Family Children's Hospital's Pediatric Heart Program recently welcomed Petros V. Anagnostopoulos, MD, as director of Pediatric Cardiothoracic Surgery. Certified by the American Board of Thoracic Surgery and the American Board of Surgery, Dr. Anagnostopoulos completed two fellowships – one in cardiothoracic surgery at the University of Pittsburgh School of Medicine and a second in pediatric cardiac surgery at the University of California, San Francisco School of Medicine, where he was employed before coming to Madison.

  Construction began in January 2012 for an AFCH expansion that will house 26 additional beds, 14 in a new high-acuity surgical neonatal intensive care unit (NICU) as well as 12 pediatric intensive care beds. For flexibility and efficiency the ICU beds will have "step-down" capability to make them usable as general care beds when demand requires that level of care. The surgical NICU will be designed for the very sickest newborns (0-30 days old) who need complex surgeries not offered anywhere else in the region.

  The overall expansion plan also includes a cardiac catheterization and interventional radiology suite dedicated to the needs of infants, children and adolescents who need specialized heart and vascular care, as well as a dedicated pediatric suite offering state-of-the-art MRI and CT with fast, low-dose imaging. Finally, two additional operating rooms will be equipped and recovery room space added. The expansion will occur in stages and is targeted for completion in January 2014.

- In addition to offering a full range of programs from sports performance improvement and athletic training to traditional and robotic-assisted joint surgeries and sophisticated pediatric surgeries that give children a new chance at normal growth and physical development, **Orthopedics** has been heavily involved in planning for the east side campus. Ranked as high performing by *US News & World Report*, orthopedics will be the flagship service at the new facility, and orthopedic physicians and staff kicked off the detailed design phase with a week-long workshop held the last week of FY12.

- UWHC was named a high-performing hospital for cardiology and cardiac surgery by U.S. News & World Report. The **Heart, Vascular and Thoracic** service line is frequently among the first in the region to offer new procedures and treatments. This year, for example, HVT surgeons introduced transcatheter aortic heart valve implantation (TAVI), offering a new option for patients with heart valves deemed too damaged for surgery. Spring 2012 saw the first post-investigational use in Wisconsin of TEVAR (a stent used for thoracic endovascular aortic repair), performed on a trauma patient. This leading-edge use of TEVAR at UWHC aptly illustrates the benefits of clinical trials: The trials for TEVAR were performed at UWHC, putting us in an excellent position to begin using the new treatment option as soon as it was approved by the FDA.

  The HVT program also welcomed Mohamed Hamdan, MD, MBA, as the new head of the Division of Cardiovascular Medicine. Dr. Hamdan comes to UW Health after serving as Associate Chief of Cardiology and Director of the Arrhythmia Service and Clinical Cardiac Electrophysiology Fellowship Program at the University of Utah in Salt Lake City. Dr. Hamdan is an internationally-recognized expert in cardiac arrhythmias, with a research focus on atrial fibrillation and the autonomic nervous system.

- Among many advances in **Neurology and Neurosurgery** has been the continued expansion of UWHC's telestroke program, employing technology that allows UW Health stroke neurologists located in Madison to assist regional hospitals in diagnosis and treatment planning for patients who arrive at regional hospital emergency departments with a suspected stroke. The program, is continuing to expand in FY12, allowing patients in distant parts of the state to receive the same stroke assessment and treatment recommendations they could get at UWHC's comprehensive stroke center.

Geographic Strategy

Fulfillment of UWHC's statewide mission requires building relationships with referring hospitals and physicians throughout the state and developing outreach strategies that ensure our services are available to residents throughout Wisconsin. In some cases, relationships outside the state are essential for UW Health to fulfill its vision to be a national leader in health care. The geographic strategy goal of the strategic plan focuses not only on bringing regional and national patients to Madison, but also on outreach that brings UW Health experts to regional communities.

New outreach activities launched in statewide communities include:

- A UW Health-Beloit Health Systems collaboration agreement to identify opportunities to enhance care in the Beloit area.
- A pre-kidney transplant outreach service at Gundersen Lutheran Hospital, La Crosse.
- Cardiology outreach services at Mile Bluff, Mauston.
- Vascular surgery and Urology outreach services at the Prairie Clinic, Sauk City.
- UW Health-UW Carbone Cancer Center collaboration to build a regional cancer center in Rockford, IL (see cancer care above).

Use of technologies continues to be a major strategy to link services between Madison and the region. For example:

- Care Link, the Epic application that allows regional providers to access information about the care of patients they refer to UW Health, expanded this year to several new communities and medical practices:
  - Fox Valley Hematology & Oncology
  - Marshfield Clinic – Nephrology
  - Moundview, GI Associates

  - Neuroscience Group of NE WI
- As mentioned above, the UW Health Telestroke program continued to expand, adding among others SwedishAmerican Health System.
- UW Health e-Care, the virtual ICU program, continued service to regional hospitals through electronic tele-monitoring by intensivists and other ICU specialists based in Madison.
- Technology expertise supplied to the region is not limited to clinical care: MESH (Management and Education Services for Healthcare) reaches out to regional hospitals such as Rusk County Memorial Hospital in Ladysmith through installation of Patient Classification and Staffing System (PCSS) and Outpatient Scheduling and Staffing (OPSS). These help improve the quality of care in community hospitals by supporting staffing based on patient acuity, census variability and desired skill mix while supporting Joint Commission staffing effectiveness standards.

Primary Care

Primary care redesign continues at UW Health, assuming ever greater importance as the advent of accountable care elevates the role of primary care in health systems. As reported last year, FY11 saw the completion of significant early goals related to health maintenance, anticoagulation therapy and Health Link optimization. The fruits of these accomplishments have been seen this year. For example, in colorectal screening (part of the health maintenance initiative), UW Health now ranks second among the 19 provider groups statewide who report colorectal screening rates to the Wisconsin Collaborative for Health Care Quality.

Primary care redesign emphasis in FY12 has shifted to clinic and health care team workflows, building on the work of clinic Microsystems team that now exist in the majority of primary care clinics. These teams receive intensive training and coaching in a variety of team concepts and quality improvement methods to enable them to work at the clinic level to make improvements related to access, care management, efficiency and patient and team satisfaction.

Microsystem participants from multiple sites have now identified a series of ideal workflows related to the UW Health care model and a group of four clinics has been identified to pilot these workflows with the goal of refining them and spreading them to other primary care sites.

At the same time, primary care redesign continues to emphasize:
- patient engagement through involvement of patients in process improvement and through the formation of patient advisory groups at the clinic level, and
- pursuit of Patient-Centered Medical Home accreditation via the National Committee for Quality Assurance.

Best Work and Academic Environment

UW Health's strategic goal to be the best work and academic environment recognizes that all other goals rest on the need for a talented and highly committed workforce. Thus as we pursue all other aims, we must continuously recruit, hire and retain the best of the best. The activities below are directed at that result:

- UWHC conducted its annual employee engagement survey in February 2012 and received results in the closing weeks of FY12. Overall engagement levels held steady at 73 percent, and a new round of engagement action planning was underway as the year ended.
- Workplace planning and operational changes were ongoing throughout the year in response to state legislation that passed near the end of FY11 to eliminate the UWHC Board and transition all UWHC employees to UWHC Authority employee status. The same legislation eliminated collective

bargaining with unions following the termination of current collective bargaining agreements and made significant changes to the benefits structure for all UWHC Authority employees, since by state law, the UWHC Authority participates in the Wisconsin Retirement System's (WRS) health insurance and retirement plans. The UWHC human resources department is actively managing this transition and will continue to do so as individual collective bargaining agreements expire for the remaining two employee unions over the next two years.

- UW Health performance standards common to all UW Health entities were approved in FY11 and have been introduced to all faculty and staff in FY12. The standards will used as the basis for annual performance evaluations beginning in 2013.
- UW Health Wellness Options at Work has continued to expand participation and opportunities for employees to participate year round in activities geared toward fitness, weight management, stress reduction and nutrition.
- In keeping with UW Health's commitment to patient- and family-centered care, the human resources department has incorporated patient- and family-centered care questions in interview and screening forms and also has included patient and family advisors in the interview process for executive level hires.

Integration and Alignment

Although UWHC, UW Medical Foundation and UW School of Medicine and Public Health are separate organizations, our day-to-day operations intertwine, and the experience of patients and families rests on our ability to function as though we are a single clinical enterprise. In FY12 we took significant steps to increase the level of integration and alignment of our planning and operations:

- Building on the work of an Accountable Care Task Force in FY11, UW Health in early FY12 hired Dr. Jonathan Jaffery to serve as Medical Director for Delivery System Innovation. In this new role, Dr. Jaffery will advance the initiatives outlined in an accountable care operational blueprint developed by the task force – initiatives that will prepare UW Health to function effectively as an accountable care organization. At the conclusion of FY12, UW Health was in the process of forming a legal entity, UW Health ACO, Inc., in preparation for submitting to CMS an application to become a Medicare shared-savings ACO. This entity will serve as an administrative structure for the ACO and will not affect existing organizational structures or business or employment relationships within UW Health.

  The ACO will have a governance structure and serve as a mechanism for bringing together groups of providers and operational teams to deliver highly coordinated patient and family-centered care. UW Health ACO will serve not only Medicare beneficiaries but all our populations regardless of payer.

  Other progress in integration and alignment has occurred at the administrative level and also in the activities related to the strategic goals discussed above. To summarize:

  - Hiring of a UW Health Chief Information Officer to move all UW Health entities to a common information technology platform.
  - Development of a position description and formation of a search committee for a UW Health Medical Director for Ambulatory Care.
  - Reconfiguring of the UW Health Quality Council, co-chaired by the President and CEO of UWHC and the President and CEO of UW Medical Foundation.
  - Uniform UW Health clinical guidelines, protocols and Health Link clinical decision support tools, as a result of forming in FY11 the UW Health Center for Clinical Knowledge Management.

- Development of a uniform process to recruit, screen, select and orient UW Health patient/family advisors as part of UW Health's move toward patient- and family-centered care.
- Integration of breast care services across all UW Health sites.
- Launch of the UW Health Improvement Network for performance improvement.
- Collaborative process to nominate, select and present UW Health Physician Excellence Awards to four physicians each year.
- Microsystems improvements and Health Link optimization efforts that span all of UW Health.
- Common performance standards for all UW Health faculty and staff.
- An integrated employee wellness program and integrated planning and delivery of employee learning and development programs.
- Increasingly integrated planning and programs for employee health and influenza vaccination for health care workers.

EDUCATIONAL MISSION

Although perhaps best known for its outstanding Graduate Medical Education program, UWHC is also home to a highly regarded graduate program for nurses. Indeed, in June, the hospital became one of only nine programs in the nation to receive accreditation of its Nurse Residency Program (NRP). Since initiating the University HealthSystem Consortium/American Association of Colleges of Nursing national NRP at UWHC in 2004, the hospital has seen positive outcomes including a reduction in turnover and statistically significant improvements in adjustment to the RN role, organization/prioritization, and communication and leadership skills. The program offers participants a series of learning and work experiences as they transition into their first professional role. Nurse residents have consistently rated the NRP high in their evaluations at the end of the year, and over 690 nurses have successfully completed the program.

At the same time, FY 12 again saw the arrival of a new cohort of resident physicians and fellows entering multi-year Graduate Medical Education programs along side medical staff physicians. In addition, residency programs in pharmacy, physical therapy, nursing and hospital administration, along with dietetic internships, a fellowship in athletic training and training programs in ultrasonography, radiologic technology, emergency medical services and a host of other areas form a full array of offerings to ensure that Wisconsin has a highly trained cadre of future health care professionals.

RESEARCH MISSION

In a continued effort to become an increasingly data-driven organization, progress continued toward establishing a UW Health data warehouse, the Health Information Management Center (HIMC). Though still laying down its infrastructure and creating an initial set of data products, HIMC is on its way to becoming a full enterprise repository of electronically stored data, designed to be easily accessed by decision makers to facilitate reporting and analysis. The primary goal is to provide a single trusted source for data specifically geared toward the needs of the organization. Centralizing the process is known to lead to data that is well defined, reliable and accurate, highly accessible, quickly retrievable, and housed in a way that allows for cross-subject area analysis.

UWHC also continued this year to partner with the Clinical Translational Research Center of the UW School of Medicine and Public Health, located on the sixth floor of UWHC, to provide cutting-edge investigational treatments in an environment designed to help medical scientists conduct clinical research. Clinical trials, including promising cancer therapies remain an important component of UWHC's

partnership with the UW Carbone Cancer Center, which has several hundred clinical trials in progress at any given time. In FY12, trials in Alzheimer's disease, asthma, transplant, heart care, epilepsy, movement disorders, gastroenterology/hepatology and many other fields also offered patients access to promising new therapies.

UW Health and UW-Madison also received good news for our shared research mission when, following a highly productive first five years, the UW-Madison Institute for Clinical and Translational Research (ICTR) received a coveted five-year renewal by the National Institutes of Health. The renewal comes with a grant of $41.5 million, nearly the same amount that was given to ICTR in the initial round of funding in 2007. It is one of the largest grants ever awarded to the SMPH. In the next five years, ICTR will continue to cultivate the development of researchers who can conduct translational research—in which discoveries move quickly from the university to doctors' offices, clinics, hospitals and county health departments where they can benefit patients.

COMMUNITY OUTREACH/COMMUNITY BENEFIT

As in previous years, UWHC continued to devote significant effort and resources to provide health care for underserved residents of our communities. The numbers below demonstrate the tangible support our philanthropy and advocacy efforts provide. These activities reflect our mission to serve by expanding access and helping to overcome the barriers of finances, language and culture.

- Charity care (community care) at cost: $28.9 million
- Contributions to charitable organizations: $779,000
- Organizations contributed to: 193
- Total initiatives/events sponsored: 260
- Kohl's Safety Center: 3,600 visitors
- Safety products donated to low income families: 947
- Employee charitable contributions: $403,327
- Holiday Drive to Share:
    - Toys collected through Toys for Tots: 2,000
    - Families supported through Adopt-a-Family: 137
    - Meals for Second Harvest Food Bank: 70,362
- Friends of UW Hospital and Clinics' Love Lights: $15,000 raised

In addition, UW Health faculty and staff contribute hundreds of hours of work each year through the United Way days of Caring, and the hospital routinely makes in-kind donations of computers to Madison Schools and surplus medical supplies and equipment to international relief organizations. Free community health screenings and community education and prevention programs round out a robust presence in Madison and the region.

Taken together, all of these activities and many others, along with all aspects of uncompensated care for the year, yield a total community estimate of approximately $200 million.

FINANCIAL PERFORMANCE

Financial performance for the fiscal year ending June 30, 2012 improved over the prior year. Net income as a percentage of revenue, excluding the fair value gain/loss on investments and the fair value loss on swap agreements, was 8.6% compared to 7.3% for the fiscal year ended June 30, 2011.

Inpatient admissions increased 2 percent from the previous year to 27,325. Clinic visits were 4.3 percent higher than the previous year at 605,868. Emergency department visits came in 5.6 percent higher than the previous year at 46,276. Case mix index, an indicator of the severity of patient conditions, was 1.94 compared to 1.88 in the fiscal year ended June 30, 2011.

Governmental payers (Medicare and Medicaid) continue to grow as a portion of UWHC's overall business. Reimbursement from these payers does not cover the full cost of care. UWHC saw significant numbers of patients with little or no ability to pay, leading to charity care and bad debt for the year ended June 30, 2012 of $73.1 million, or 2.9 percent of gross revenue.

UWHC is in a strong position compared to other organizations in the health care industry. Days cash on hand finished at 217 compared to last year at 197. Days in accounts receivable ended at 44, an increase of one day compared to last year at 43. UWHC's bond ratings remain at A+/A1 with a positive outlook.

The final page of this report presents an additional summary of this year's financial performance.

LOCAL AND REGIONAL HEALTH CARE ENVIRONMENT

Tensions that began in FY11 between UWHC and Madison's Meriter Hospital have continued in FY12, often spilling into to the media and even into the legal arena, causing concern among patients and families.

In the final month of the fiscal year, Physicians Plus Insurance Corporation effectively ended the historic collaboration – known as "free-flow" – between Meriter's and UW Health's respective insurance companies (Physicians Plus Insurance Corporation and Unity Health Insurance). PPIC notified its members of coverage changes that begin January 1, 2013, and have three major impacts:

1. PPIC will no longer cover the cost of care by primary care doctors who practice at UWHC-owned and operated locations.
2. PPIC will no longer cover the cost of care by specialty doctors who practice at UWHC-owned and operated locations unless the visit is authorized in advance by PPIC.
3. PPIC will no longer cover the cost of tests such as blood tests and X-rays at UWHC-owned and operated locations, unless the tests are authorized in advance by PPIC.

Some exceptions to these rules have been negotiated and we continue to pursue other areas of agreement to help ensure that whenever possible patients can retain access to UW Health physicians and services and to Wisconsin's #1 rated hospital.

Despite the difficulties presented by this situation, UWHC has remained focused on its long-term strategic goals and is preparing for a new round of strategic planning to extend our vision another five years.

The Year Ahead

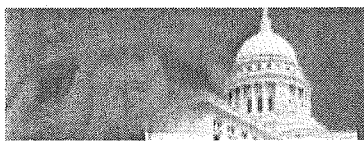
As we move forward in the face of these local market challenges and of the prospects for declining reimbursement and demands for increased accountability, we are again fortunate to be dealing from a position of strength in both clinical outcomes and financial health. We are also fortunate to have an extremely talented and dedicated workforce led by an outstanding senior leadership team. As we arrive at the specifics of our new strategic plan, it is safe to say that certain elements will remain consistent and unwavering:

- Patient- and family-centered care as a guiding philosophy and framework for service excellence;
- A focus through Lean and other quality improvement methodologies on maintaining and enhancing quality while removing inefficiencies, reducing costs and improving care coordination from primary care through advanced subspecialties;

- Progress with facilities projects to ensure we have adequate capacity for rising demand and a continuum of patient care settings so we can offer the right care in the right environment for diverse patient needs;
- Rapid evolution toward the operational and financial systems that will allow us to flourish as an accountable care organization;
- Continued effort to align operations, incentives and strategic goals among all UW Health partners, with the goal of providing patients and staff with a seamless UW Health experience regardless of the location where they work or receive care.
- Continued collaboration with regional partners and
- Continued diligent pursuit of our educational, research and community service missions.

Financial Performance 2011-2012
Financial summaries

	DRAFT AUDIT FY 2012	AUDITED FY 2011
University of Wisconsin Hospital and Clinics Summary of Financial Results for Fiscal Years Ended June 30, 2012 and 2011 ($000 omitted)		
Net Revenue	$1,200,929	$1,080,022
Expenses	1,099,460	1,015,474
INCOME FROM OPERATIONS	**101,469**	**64,548**
Investment and other non-operating income	13,865	16,583
Fair value gain/loss on investments	(2,718)	10,390
Fair Value gain/loss on swap agreements	457	1,947
Payment to UW School of Medicine and Public Health for capital expenditure support	(11,600)	(2,500)
	$ 101,473	**$ 90,968**
NET INCOME		
Net income as % of revenue, excluding fair value gain/loss on investments and fair value loss on swap agreements	8.6%	7.3%
University of Wisconsin Hospital and Clinics Summary of Financial Position as of June 30, 2012 and 2011 ($000 omitted)		
CURRENT ASSETS		
Cash	$ 53,387	$ 52,804
Patient & other accounts receivable	161,095	137,433
Inventories	8,475	8,483
Prepaid expenses	6,260	5,215
TOTAL CURRENT ASSETS	**229,217**	**203,935**
Investments	579,878	472,810
Net property & equipment	392,567	385,490
Other assets	69,033	57,481
TOTAL ASSETS	**$1,270,695**	**$1,119,716**
CURRENT LIABILITIES		
Current installments of long-term debt	$ 8,190	$ 7,840
Accounts payable & accrued liabilities	155,191	134,492
TOTAL CURRENT LIABILITIES	**$ 163,381**	**$ 142,332**
Long-term debt	$ 219,057	226,881
Other long-term liabilities	113,462	81,682
Net assets	774,795	668,821
TOTAL LIABILITIES & NET ASSETS	**$1,270,695**	**$1,119,716**
Net days revenue in accounts receivable	44	43
Long-term debt to total capitalization	0.23	0.26



WISCONSIN STATE LEGISLATURE

DEPARTMENT OF HEALTH SERVICES and DEPARTMENT OF CHILDREN AND FAMILIES
2010 Annual Report on Rehabilitation Review Requests under Wisconsin Statutes sections 48.685(5g) and 50.065(5g)*

REQUESTS RECEIVED BY THE DEPARTMENT OF HEALTH SERVICES

62	Pending requests at start of 2010
116	Requests received in 2010
178	Total requests

60	Approvals with standard conditions
8	Approvals with additional specific conditions
49	Denials (25 were for not following through on the process)
15	Rehabilitation reviews not required
0	Decisions deferred pending additional information
3	Applicants withdrew request
4	Approval & Denial
1	Approval & Deferral
27	Requests being screened for completeness or awaiting scheduling
4	No DHS jurisdiction; referred to proper reviewing agency
178	

REASONS FOR DHS APPROVAL

The applicants demonstrated sufficient evidence of rehabilitation in the areas of position related offense factors and the applicant's personal development and progress. Where applicable, standard conditions include: no (further) law violations, no (further) acts or threats of violence toward others, no offenses that lead to arrest or conviction or findings by a government agency of misconduct.

Additional conditions that may apply to more than one approval included:

Must receive retraining in resident rights and the proper use of restraints.
Must work under direct supervision for the first six months of employment.
Must continue with counseling and medication.
Approval for non-client residence at mother's day care facility only.
Able to work in housekeeping and laundry but not as a feeding assistant.
Must work only at sister's day care for the first 6 months after approval.

REASONS FOR DHS DENIAL

Lack of veracity.
Inability or unwillingness to take responsibility for the incident of substantiated physical abuse of a child and portrayed self as the victim.
Inability to clearly articulate why behavior that resulted in the governmental substantiated finding of physical abuse of a child was wrong.
Failed to indicate a complete understanding of methods and techniques for dealing with difficult clients.
Must remain financially stable so as not to jeopardize placement of client.
May not work as a sole caregiver.
Significant CPS history.
Applicant indicated that she would again resort to whipping as a valid form of discipline.
Failed to provide proof of completion of one course or training or other educational opportunity that focuses on proper transfer techniques and the importance of following care plans and facility policies and procedures to prevent injury.
Failed to provide personal reference checks from employers or co-workers who have specifically observed work.

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REASONS FOR DHS APPROVAL	REASONS FOR DHS DENIAL
	Provided no evidence of rehabilitation, such as public or community service, volunteer work, recognition by other public or private authorities for accomplishments or efforts or attempts at restitution, and demonstrated ability to develop positive social interaction and increased independence or autonomy of daily living.
	Employment history, including evidence of acceptable performance or competency does not exhibit rehabilitation.
	Knowingly worked as a caregiver while prohibited.
	Expressed no remorse or accountability for the incident.
	Continues to minimize event and blames others including the victim's roommate, LPN and facility owner and four other CNAs.
	Has had a recent criminal charge for retail theft. In addition, was recently convicted of issuance of worthless checks.
	As a foster parent, would have close and personal contact with children where there would be a significant opportunity to commit similar offenses.
	Failed to satisfactorily identify participation in treatment or other programs that would have addressed the cause(s) of behavior.
	Significant number, type and pattern of offenses committed.
	Failed to satisfactorily identify participation in treatment or programs addressing the causes of behavior and was unable to identify alternative strategies for coping with difficult children.
	Review of the documents received did not demonstrate rehabilitation.
	Failed to understand the importance of reviewing a resident's care card.
	Blamed a staffing shortage and relied on the resident's past condition and care needs instead of acknowledging responsibility to be aware of each resident's changes in condition and/or care needs.
	Was unable to clearly articulate why should have immediately notified a nurse of the resident's change in condition.
	Failed to understand the seriousness of using "short-cuts" when caring for residents.
	Failed to provide adequate supervision of dwelling.
	Minimized role and was not completely truthful about circumstances surrounding termination.

DEPARTMENT OF HEALTH SERVICES and DEPARTMENT OF CHILDREN AND FAMILIES
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REASONS FOR DHS APPROVAL	REASONS FOR DHS DENIAL
	Failed to identify alternative strategies for coping with children without other adult supervision. Failed to demonstrate an understanding of the impact of actions on the victim. Conviction for public benefits fraud and failure to make full restitution resulting in a judgment by the Department of Children and Families.

REQUESTS RECEIVED BY COUNTY DEPARTMENTS AND REPORTED TO DHS

1 denial, 10 approvals

REQUESTS RECEIVED BY CHILD PLACING AGENCIES AND REPORTED TO DHS

1 approval

REQUESTS RECEIVED BY SCHOOL BOARDS AND TRIBES REPORTED TO DHS

None were reported.

* Effective July 1, 2008, the Department of Health and Family Services (DHFS) became the Department of Health Services (DHS) and the DHFS Division of Children and Family Services became the Department of Children and Families (DCF)as a result of 2007 Wisconsin Act 20, the 2007-09 biennial budget bill. DHS has continued to utilize the skills, support and knowledge of its personnel to process all rehabilitation review applications. Thus, this report is for both DHS and DCF rehabilitation review decisions combined.