☞ **05hr_SSC-HCR_Misc_pt12**

☞ Details: Review of Health Care in Western Wisconsin. Hearing held in Eau Claire, Wisconsin on May 11, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

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) (August 2012)

Gundersen Lutheran

Written Testimony of

Gundersen Lutheran

TO THE

Select Committee on Health Care Reform

Public Hearing
Thursday, May 11, 2006
10:00 AM
Chippewa Valley Technical College
Business Education Center, Auditorium Room M-103
Clairemont Campus, 620 W. Clairemont Ave.
Eau Claire, WI 54701

Joan Curran, M.B.A.
Executive Director, External Affairs & Special Projects
Gundersen Lutheran
1900 South Avenue
La Crosse, WI 54601
(608) 775-4347
www.gundluth.org

5/12/2006

Gundersen Lutheran Testimony
Improving access and efficiency in healthcare

We regret being unable to attend this hearing in person, as Gundersen Lutheran is deeply interested in sharing our vision of health care reform for Western Wisconsin. In our absence, we submit the following written testimony for distribution to the Committee members and hearing attendees.

There are two important principals in discussing the rising cost of healthcare.

- Multiple inter-related factors contribute to the rising costs of health care. Any solution will need to take into account the related causes or we will not be able to generate feasible solutions.

- Since health care reform is a complicated issue, the optimal approach is to identify and utilize the best data in order to generate reliable solutions.

Four major actions must be taken:

1. **Healthcare** has the first responsibility. Health care providers need to improve quality and increase efficiency – this has a direct and significant effect on health care costs. Although much has been done, there are many more opportunities to accomplish this, and it should be of highest priority for the healthcare industry.

   Example: The Wisconsin Collaborative for Healthcare Quality (WCHQ) and the Wisconsin Hospital Association (WHA) have made significant efforts to lead the nation in transparency and quality improvement.

2. **Employers** should participate in improving the health of their employees. Employers must also understand that they also pay for those who have no insurance.

   Example: Local and national employers have been able to slow the rise of premiums by actively engaging their employees and healthcare providers.

3. **Government** has a responsibility to cover the uninsured and develop an adequate baseline of coverage for all its citizens. Currently, the neediest populations – namely, the uninsured and Medicaid enrollees – receive care using the most expensive access (emergency rooms and critical care services) for routine treatment. Ensuring basic elements of coverage for preventive and disease management services is a first step.

   Example: We are the only developed country in the world with such a huge portion of uninsured citizens.

4. The **public** also is responsible for the rising cost of healthcare due to lifestyle choices that add significant costs to healthcare. Examples include obesity, smoking, minimal exercise and lack of disease management. Patients, employers, healthcare providers and the government can coordinate efforts to promote preventive health care – if accomplished, this is proven to considerably reduce overall health care costs.

   Example: Gundersen Lutheran could work with the Health Science Consortium, county health departments, local elected officials, local employers, and the media to coordinate public health education campaigns.

5/12/2006


FORWARD
E PLURIBUS UNUM

Stegall, Jennifer

Subject: FW: Public Hearing of 5/11/06: written testimony

From: Asbjornson, Karen
Sent: Thursday, May 11, 2006 11:40 PM
To: Stegall, Jennifer
Subject: FW: Public Hearing of 5/11/06: written testimony

CR email - written testimony (instead of testifying) for Select Committee on Health Care

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From: Rolf & Esther [mailto:skoghin@triwest.net]
Sent: Thursday, May 11, 2006 11:31 PM
To: Sen.Roessler; Sen.Darling; Sen.Miller; Sen.Erpenbach; Sen.Olsen; Sen.Brown
Cc: Ben Boardman; Mike Taft; Kay Brauner
Subject: Public Hearing of 5/11/06: written testimony

DEAR SENATORS:

Today my wife and I attended the public hearing of the Senate Select Committee on Health Care Reform in Eau Claire. We were present from 10:00AM until after 2:00PM without having the opportunity to speak or the apparent prospect of that opportunity within the next hour should we have chosen to wait still longer. We chose to leave having been advised by a couple of the legislative aides present that an alternative was to submit our comments in written form via e-mail. What follows, then, is what I hope you will accept as my considered testimony to your committee and in essence what I would have said to you in person had circumstances allowed me to do so.

I address my remarks to you as an ordinary citizen and health care consumer, not as a representative of the health care industry or of a health care profession or of the insurance industry as were so many of your witnesses today. Parenthetically, I should hasten to add that one of the criticisms I would offer of the hearing process as I experienced it today is that it did not seem to encourage the participation of the general public. The hearing was not well publicized and was held at a time of day when almost no one save those who have a professional need to know about and participate in such an event could have managed to attend. Frankly, if decisions regarding health care reform are left solely to the insiders and the existing health care establishment, those of us who experience the reality of health care from the consumer perspective can probably expect no meaningful and fundamental reform any time soon. Consequently, it is important to me to address you all as a citizen member of the Jackson County Ad Hoc Health Committee.

Earlier this year a group of citizens in Jackson County, including physicians, who were concerned about what they all agreed is our health care crisis decided to invite the community at large to a public meeting to begin a grassroots exploration with one another of problems in the health care system and possible solutions to those problems. The purpose of this citizen endeavor was not to engage in an academic exercise to arrive at theoretical solutions or bland recommendations but was rather to inform a plan of action whereby average

citizens would hopefully ultimately find a way to bring about what both their national and state legislatures seemed unable to generate: real , basic health care reform. The community forums began in January, and from the beginning they attracted a surprising number of people (dozens per meeting) for a small rural county. The meetings were non-partisan affairs attended by democrats and republicans alike, including politicians from both parties (representatives Gronemus and Musser; Congressman Kind). The common denominator of those in attendance was the perception of the existence of health care problems demanding action to be resolved. These public forums occurred periodically throughout the winter and in fact even now continue to generate interest and enthusiasm as indicated by the fact that yet another is scheduled for June.

After identifying specific problems in the health care system, the citizen participants of the health forums began to examine possible solutions and invited guest experts and advocates to address them explaining specific proposals to reform health care. Based on all of this it has now become the consensus opinion of the health care forum participants and the Ad Hoc Health Committee drawn from forum participants that the single most reasonable and meaningful answer to the question of how best to reform health care is for Wisconsin to move as quickly as possible to implement single-payer universal health care. Further, it appears that to do so does not necessitate futher investigation or bill crafting by the legislature requiring an extended period of time. Implementing responsive and responsible universal health care is as simple as the legislature finally taking up and passing SB388/AB807 as it could have and should have already done. Answers to all the questions of how such a single payer system as that envisioned by SB388 can be affordable and how it can assure quality of care to everyone are indeed out there, ladies and gentlemen. We were able to get those answers from Drs. Linda and Eugene Farley and from Senator Miller, and I suspect these same people would be willing to provide those same explanations to your committee and the full legislature as well.

In coming to its health care conclusions the Jackson County Ad Hoc Health Care Committee has proceeded from the conviction that health care is fundamentally not an industry in the social and economic landscape nor is it in personal terms a privilege or a perk. Indeed, for us the first principle of health care reform is that health care is a basic human right shared by all, and we agree, then, that the basic measure of health care reform is the degree to which it ensures the right to quality care for each and every one of us. Proposals, like many that we heard today at your committee hearing, which begin from a first principle of trying as much as possible to preserve the existing framework of access to health care through insurance are destined to do so at the expense of universal access. Efforts to improve health care through efficiencies and to reduce the need for health care services through education and prevention are laudable but are no substitute for real reform of a system that nationally spends 30% of its resources on administration; that often focuses on screening people out of the health care system rather than on actually providing care and services; that prices its services beyond the ability of individuals, groups, and employers all to afford; that leaves 45 million people uninsured altogether; and, that no longer ranks anywhere near the top of the world rankings of health care systems for quality of care and access.

The Jackson County Ad Hoc Health Committee is proud of and encouraged by what it has already accomplished to date as a purely spontaneous grass roots local movement. We are highly motivated and committed to perservere in our efforts to realize the goal of health care reform ensuring universal coverage within the State of Wisconsin. We are further encouraged by the interest shown in our efforts by ordinary people from other counties throughout Wisconsin who have heard about and attended some of our health care forums in

Jackson County this year. We are currently in the process of forming an outreach subcommittee whose purpose it will be to share our experiences with people in other counties who are interested in adopting a similar grassroots community process to address health care reform in their own counties. In brief, the health care crisis will not simply disappear without serious reform, nor will we, the grassroots health care reform movement, go away until our work of enabling real reform is accomplished. We invite you to hear our message and to join our movement by developing, introducing, and supporting legislation mandating universal health care!!!

Sincerely,

Rolf Skogstad

N10926 DeGroot Road
Hixton, WI 54635

WISCONSIN STATE LEGISLATURE

5/18/06

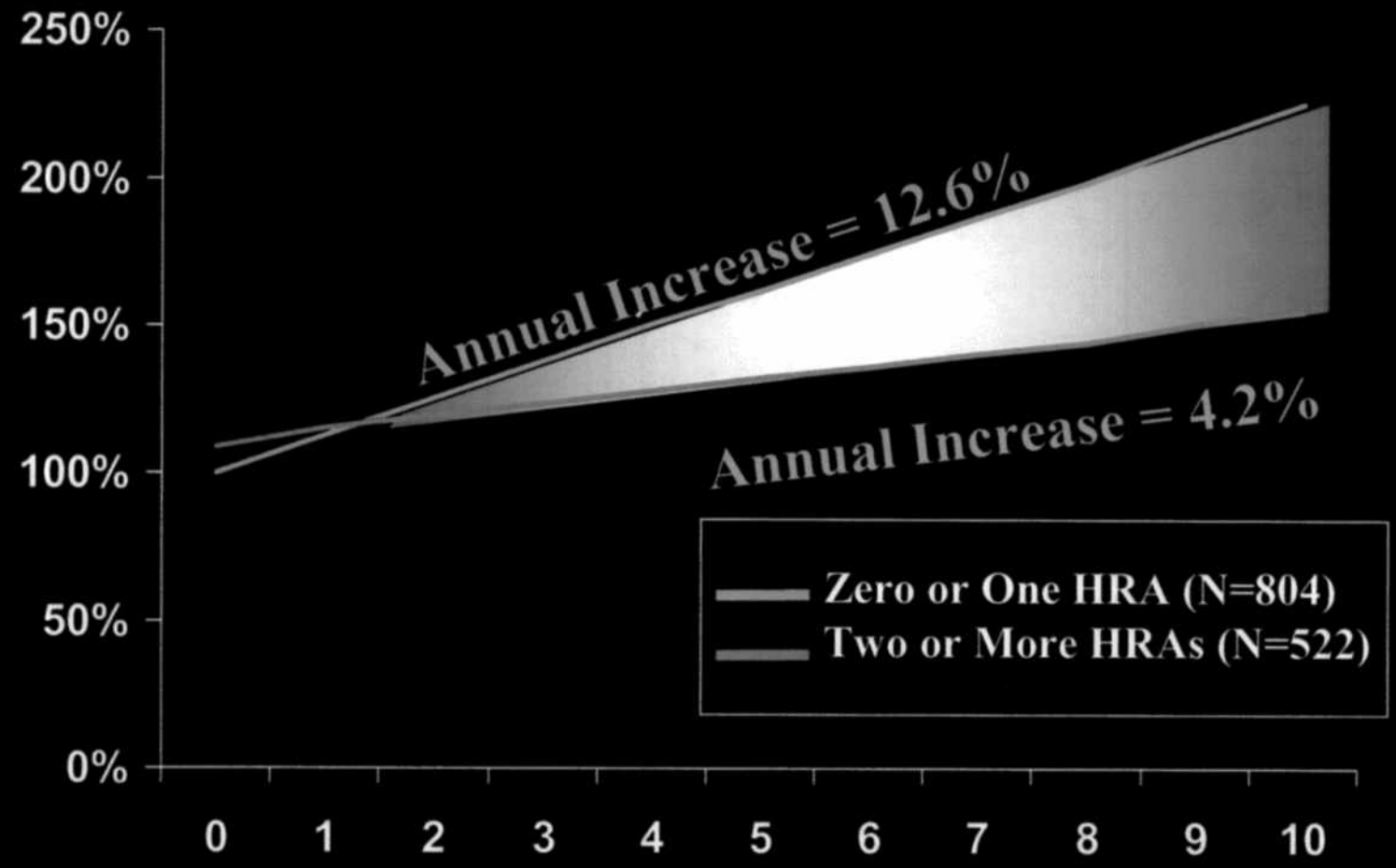
Vaughn dropped

$6 per CK

Payment to the

Law Clinic pending.

Cost Savings Associated with Program Involvement from 1985 to 1995



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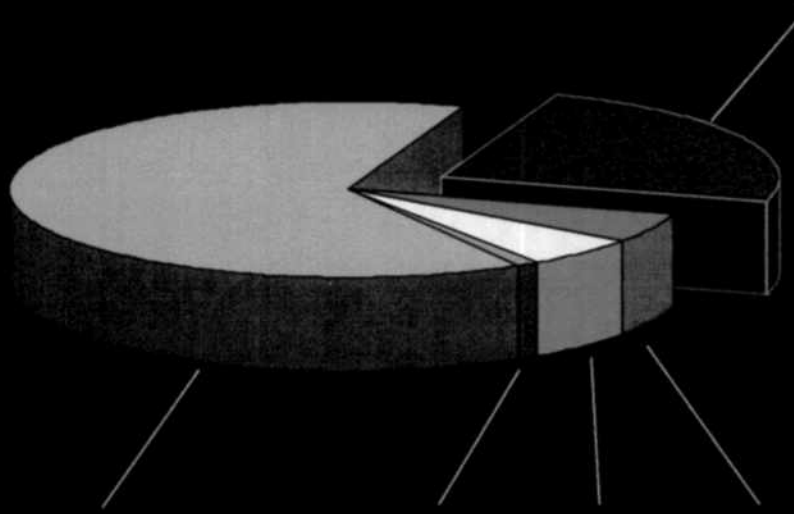
Relative Costs of Poor Health: Total Value of Health

Direct Costs:

Medical & Pharmacy

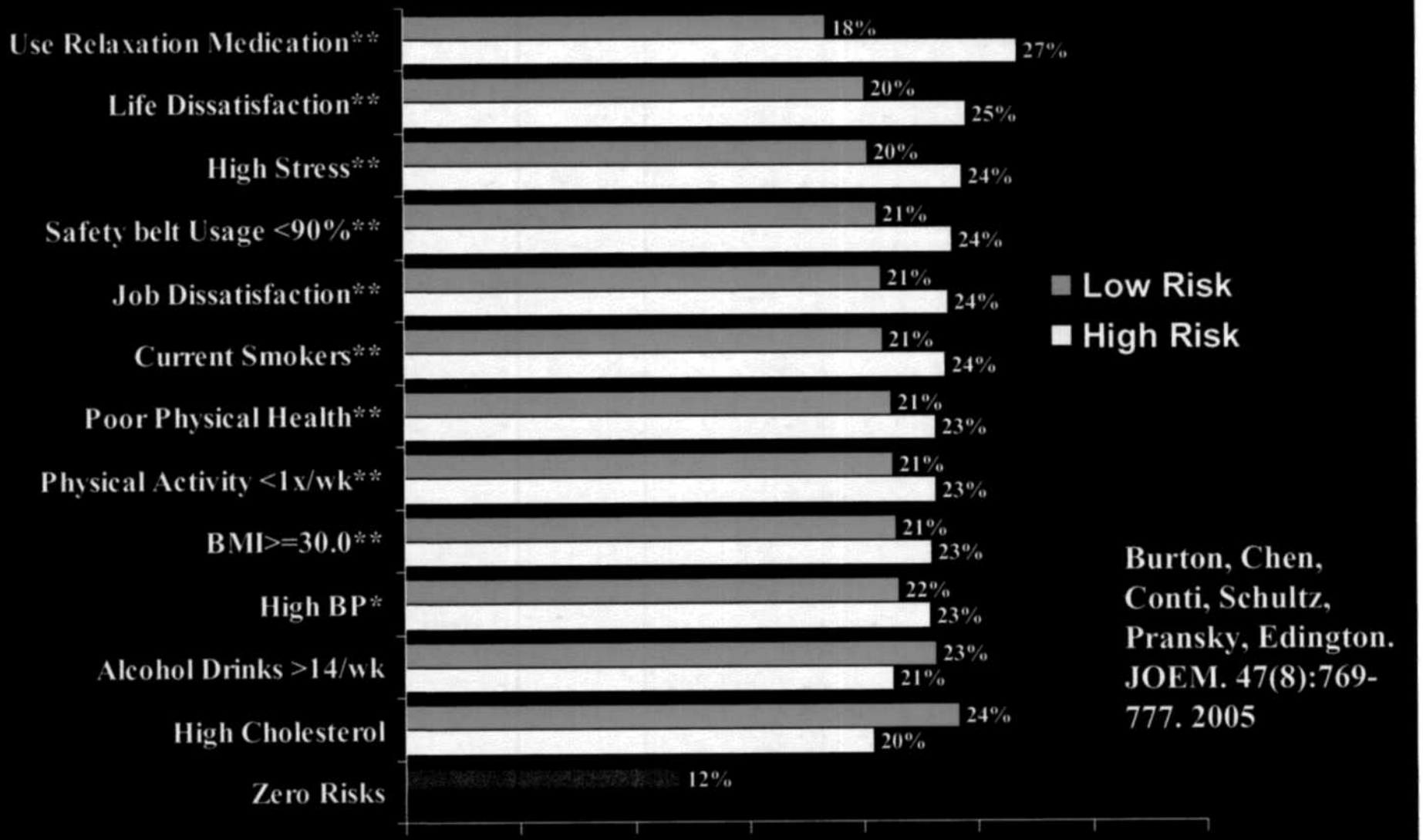


Indirect Costs:

Presenteeism LTD STD Absenteeism

Edington, Burton. A Practical Approach to Occupational and Environmental Medicine (McCunney). 140-152. 2003

Estimated Loss of Productivity by Risk Status



Burton, Chen, Conti, Schultz, Pransky, Edington. JOEM. 47(8):769-777. 2005

*p<.05, **p<.01

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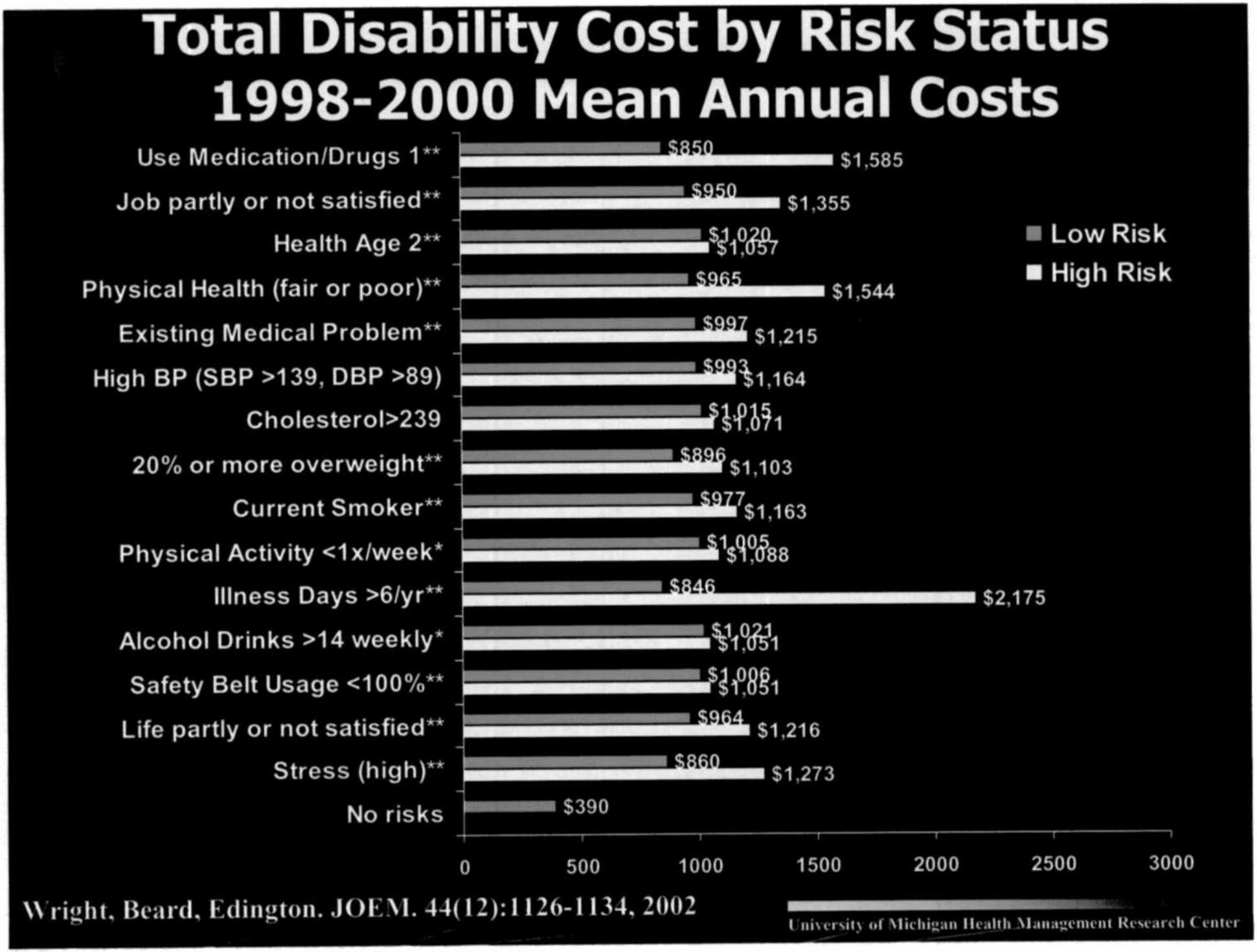
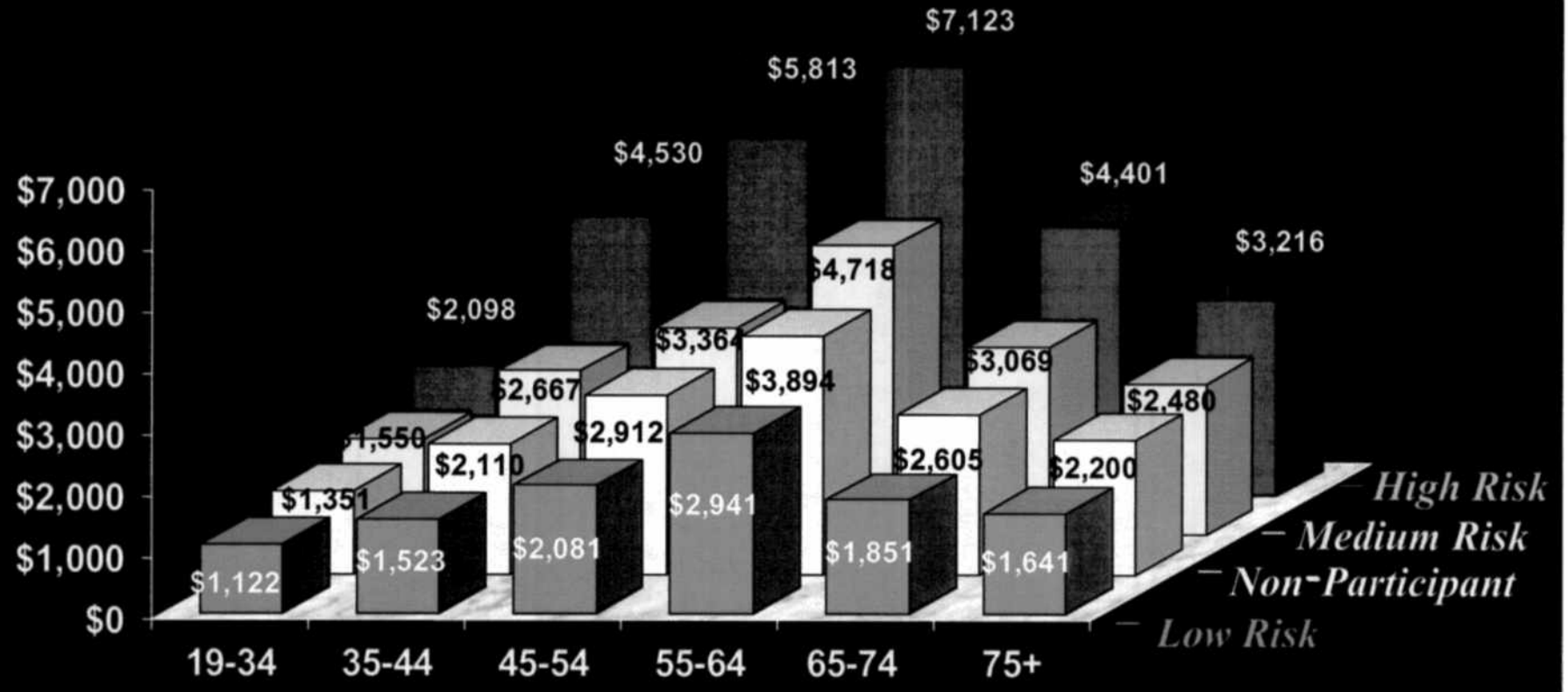

Total Disability Cost by Risk Status
1998-2000 Mean Annual Costs
Use Medication/Drugs 1**
$850
$1,585
Job partly or not satisfied**
$950
$1,355
Health Age 2**
$1,020
$1,057
Physical Health (fair or poor)**
$965
$1,544
Existing Medical Problem**
$997
$1,215
High BP (SBP >139, DBP >89)
$993
$1,164
Cholesterol>239
$1,015
$1,071
20% or more overweight**
$896
$1,103
Current Smoker**
$977
$1,163
Physical Activity <1x/week*
$1,005
$1,088
Illness Days >6/yr**
$846
$2,175
Alcohol Drinks >14 weekly*
$1,021
$1,051
Safety Belt Usage <100%**
$1,006
$1,051
Life partly or not satisfied**
$964
$1,216
Stress (high)**
$860
$1,273
No risks
$390
Low Risk
High Risk
0
500
1000
1500
2000
2500
3000
Wright, Beard, Edington. JOEM. 44(12):1126-1134, 2002
University of Michigan Health Management Research Center

Costs Associated with Risks
Medical Paid Amount x Age x Risk



Edington. AJHP. 15(5):341-349, 2001

Health Risks and Behaviors

Health Risk Measure	High Risk Criteria
Alcohol	More than 14 drinks/week
Blood Pressure	Systolic >139 mmHg or Diastolic >89 mmHg
Body Weight	BMI≥ 27.5
Cholesterol	Greater than 239 mg/dl
Existing Medical Problem	Heart, Cancer, Diabetes, Stroke
HDL	Less than 35 mg/dl
Illness Days	>5 days last year
Life Satisfaction	Partly or not satisfied
Perception of Health	Fair or poor
Physical Activity	Less than one time/week
Safety Belt Usage	Using safety belt less than 100% of time
Smoking	Current smoker
Stress	High

OVERALL RISK LEVELS	
Low Risk	0 to 2 high risks
Medium Risk	3 to 4 high risks
High Risk	5 or more high risks

From *The One-Minute Manager Balances Work and Life*

The Professor's Dozen*

	YES	NO
1. I love my job most of the time.	☐	☐
2. I take good safety precautions such as using a seatbelt in a moving vehicle.	☐	☐
3. I am within 5 lbs. of my ideal weight.	☐	☐
4. I know three methods to reduce stress that do not include the use of drugs or alcohol.	☐	☐

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From The One-Minute Manager Balances Work and Life

The Professor's Dozen*

	YES	NO
5. I do not smoke.	☐	☐
6. I sleep six to eight hours each night and wake up refreshed.	☐	☐
7. I engage in regular physical activity at least three times per week (including sustained physical exertion for 20-30 minutes, i.e., walking briskly, running, swimming, biking, plus stretching and flexibility activities.	☐	☐
8. I have seven or fewer alcoholic drinks per week.	☐	☐

From The One-Minute Manager Balances Work and Life

The Professor's Dozen

	YES	NO
9. I know my blood pressure and cholesterol.	☐	☐
10. I follow sensible eating habits. (Eat breakfast daily; limit salt, sugar and fats; limit eggs, whole milk, breakfast meats, cheese and red meats; eat adequate fiber and few snacks).	☐	☐
11. I have a good social support system.	☐	☐
12. I maintain a positive mental attitude.	☐	☐

Corporate Health Management Programs as a Serious Economic Strategy: Learnings

1. Risk and Disease Identification: Know your target population
2. Success metric 1: Percent Participation (80%,60%,40%)
3. Success metric 2: Percent of the Population at Low Risk (70+%)
4. Effective strategies: Low-Risk Maintenance and Risk Reduction
5. General concept for outcome measures: Benefits follow #2 and #3
6. Specific to outcome measures: Effective Programs Equal Benefits

Overall Strategy: Manage the Person,
not the risk or the disease.

IHCIS

Integrated Healthcare Information Services, Inc. (IHCIS) is a recognized leader in providing innovative predictive modeling and information solutions to the healthcare industry. IHCIS' products empower organizations to improve their performance at all levels. The result is more cost-effective and higher quality healthcare. Organizations use IHCIS' Impact software suite to measure performance, predict future medical costs and identify at-risk patients, enabling targeted proactive medical management and financial initiatives. IHCIS, founded in 1996, is headquartered in Waltham, MA with offices in Londonderry, NH. For more information, please visit www.ihcis.com.

Address: 70 Parmenter Road
Waltham, MA 02453-5855

Phone: (781) 647-1858

Web Page: www.ihcis.com

Email:

Categories: Disease Management, eHealth/Business, Technology Solutions

Services: Information Systems/Technology, Predictive Modeling

IMPACT PRO – (IHCIS) Predictive Modeling

Your organization needs powerful solutions that provide you with insight into the factors driving your members' health and financial outcomes: the diseases and conditions affecting them; how members manage their health; the resources available to advise and service them; and the financial implications of these choices.

Impact Pro is a multi-dimensional, episode-based predictive modeling and care management analytics solution designed to allow health plans to utilize clinical, risk, and administrative profile information to provide more targeted health care services to those members who will benefit most and to set the most appropriate price.

IHCIS clients around the country benefit from the power of Impact Pro to support care management and underwriting functions:

- Disease management programs
- Medical underwriting
- Consumer-driven health information tool development
- Financial settlement assistance
- Pay-for-Performance implementation
- Reimbursement modeling and rate setting
- Predictive modeling care management workflow integration
- Clinical best practice implementation
- Outcomes reporting
- Return on investment analysis
- Workflow optimization solutions

UNIVERSITY OF MICHIGAN
Health Management Research Center

HEALTH ASSESSMENT

A program sponsored by WEA TRUST

NAME

ADDRESS

CITY STATE ZIP

SAMPLE

MARKING INSTRUCTIONS

- DO NOT FOLD.
- USE NO 2 PENCIL ONLY.

Complete each question as best you can by marking the best response.

Your results will be kept strictly confidential.

1 SUBSCRIBER # (see insurance card)

2 Are you the school
- ○ Employee
- ○ Spouse

3 SEX
- ○ Male
- ○ Female

4 AGE (At last birthday)

5 Are you pregnant?
- ○ Yes
- ○ No
- ○ Does Not Apply

If Yes, complete questionnaire based on your health condition and lifestyle before pregnancy.

6 HEIGHT (without shoes)

7 WEIGHT (without shoes)

8 What is your blood pressure now?

Systolic (top number) Diastolic (bottom number)

○ I'm not sure

9 What is your total cholesterol level? (based on a blood test) mg/dl

○ I'm not sure

10 What is your HDL cholesterol (good cholesterol) level? (based on a blood test) mg/dl

- ○ Good/ normal
- ○ Bad
- ○ I'm not sure

11 What is your blood glucose (sugar) level? (based on a blood test)

- ○ I'm not sure

Fasting
- ○ Yes
- ○ No
- ○ I'm not sure

DO NOT WRITE IN THIS AREA

254424

Turn the page.

12 CIGARETTE SMOKING

How would you describe your cigarette smoking habits?

- ○ Still smoke ➲ Go to question 13
- ○ Used to smoke ➲ Go to question 14
- ○ Never smoked ➲ Go to question 15

13 STILL SMOKE

cigarettes per day

(Go to question 15)

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

14 USED TO SMOKE

Years

How many years has it been since you smoked cigarettes on a fairly regular basis?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

What was the average number of cigarettes per day that you smoked in the 2 years before you quit?

- ○ less than 9
- ○ 10-15
- ○ 16-19
- ○ 20+

15 OTHER FORMS OF TOBACCO

Do you smoke or use

pipes?	○ Yes	○ No
cigars?	○ Yes	○ No
smokeless tobacco?	○ Yes	○ No

16

How often do you use drugs or medication (including prescription drugs) which affect your mood or help you to relax?

○ Almost every day ○ Sometimes ○ Rarely or never

17

Drinks

How many drinks of alcoholic beverages do you have in a typical week? (one drink = one beer, glass of wine, shot of liquor or mixed drink)

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

18

Times last month

How many times in the last month did you drive or ride when the driver had perhaps too much to drink?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

19

In the next 12 months, how many thousands of miles will you probably drive or ride in each of the following?

A. Car, truck, van or SUV

- ○ 0-2,000 miles
- ○ 2-5,000 miles
- ○ 6-10,000 miles
- ○ 11-15,000 miles
- ○ 16-20,000 miles
- ○ 21-30,000 miles
- ○ more than 30,000 miles
- ○ does not apply

B. Motorcycle

- ○ 0 - 1,000 miles
- ○ 1,000 miles
- ○ 2,000 miles
- ○ 3,000 miles
- ○ 4,000 miles
- ○ more than 4,000 miles
- ○ does not apply

20 What percent of the time do you usually buckle your safety belt when driving or riding?

- ○ 100%
- ○ 90-99%
- ○ 80-89%
- ○ less than 80%

21 On the average, how close to the speed limit do you usually drive?

- ○ Within 5 mph of the speed limit
- ○ 6-10 mph over the limit
- ○ More than 10 mph over the limit

22 On a typical day how do you usually travel? (mark only one)

- ○ Sub-compact or compact car
- ○ Mid-size or full-size car, or minivan
- ○ Truck, van, full-size van or SUV
- ○ Motorcycle
- ○ Other

23 Each day, how many servings of food do you eat that are high in fiber, such as whole grain bread, high fiber cereal, fresh fruits or vegetables? (serving size: 1 slice bread, ½ c vegetables, 1 medium fruit, ¾ c cereal)

- ○ 5-6 servings a day
- ○ 3-4 servings a day
- ○ 1-2 servings a day
- ○ Rarely / never

24 Each day, how many servings of food do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods or eggs? (serving size: 3 ½ oz meat, 1 egg, 1 oz/slice cheese)

- ○ 5-6 servings a day
- ○ 3-4 servings a day
- ○ 1-2 servings a day
- ○ Rarely / never

25 In the average week, how many times do you engage in physical activity (exercise or work which is hard enough to make you breathe heavily and make your heart beat faster) and is done for at least 20 minutes? Examples include running, brisk walking or heavy labor, e.g. chopping, lifting, digging, etc.

- ○ Less than 1 time per week
- ○ 1 or 2 times per week
- ○ 3 times per week
- ○ 4 or more times per week

Turn the page. ➡

26 **In general, how satisfied are you with your life (include personal and professional aspects)?**

- ⬭ Completely satisfied
- ⬭ Partly satisfied
- ⬭ Mostly satisfied
- ⬭ Not satisfied

27 **Would you agree you are satisfied with your job?**

- ⬭ Agree strongly
- ⬭ Agree
- ⬭ Disagree
- ⬭ Disagree strongly
- ⬭ Does not apply

28 **In general, how strong are your social ties with your family and/or friends?**

- ⬭ Very strong
- ⬭ About average
- ⬭ Weaker than average
- ⬭ Not sure

29 **Considering your age, how would you describe your overall physical health?**

- ⬭ Excellent
- ⬭ Very Good
- ⬭ Good
- ⬭ Fair
- ⬭ Poor

30 **How many hours of sleep do you usually get at night?**

- ⬭ 6 hours or less
- ⬭ 7 hours
- ⬭ 8 hours
- ⬭ 9 hours or more

31 **Have you suffered a personal loss or misfortune in the past year? (For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)**

- ⬭ Yes, two or more serious losses
- ⬭ Yes, one serious loss
- ⬭ No

32 **How often do you feel tense, anxious, or depressed?**

- ⬭ Often
- ⬭ Sometimes
- ⬭ Rarely
- ⬭ Never

33 **During the past year, how much effect has stress had on your health?**

- ⬭ A lot
- ⬭ Some
- ⬭ Hardly any
- ⬭ None

34 **In the past year, how many days of work have you missed due to personal illness?**

- ⬭ 0
- ⬭ 1-2 days
- ⬭ 3-5 days
- ⬭ 6-10 days
- ⬭ 11-15 days
- ⬭ 16 days or more
- ⬭ Does not apply

35 **During the past 4 weeks how much did your health problems affect your productivity while you were working?**

- ⬭ no health problems
- ⬭ none of the time
- ⬭ some of the time
- ⬭ most of the time
- ⬭ all of the time
- ⬭ Does not apply

36 **In the <u>past 2 weeks</u>, how much of the time did your physical health or emotional problems make it difficult for you to do the following?** Mark the "Does Not Apply to My Job" box only if the question describes something that is <u>not</u> part of your job.

	all of the time (100%)	most of the time	half of the time (50%)	some of the time	none of the time (0%)	does not apply to my job
Work the required number of hours	○	○	○	○	○	○
Start on your job as soon as you arrived at work	○	○	○	○	○	○
Repeat the same hand motions over and over again while working	○	○	○	○	○	○
Use your equipment (i.e., phone, pen, keyboard, computer mouse)	○	○	○	○	○	○
Concentrate on your work	○	○	○	○	○	○
Help other people to get work done	○	○	○	○	○	○
Do the required amount of work on your job	○	○	○	○	○	○
Feel you have done what you are capable of doing	○	○	○	○	○	○

37 **How many hours did you take off from work over the past 2 weeks to take care of sick children, parents or other relatives? (This might include taking children to doctor's appointments, staying home with a sick child or parent or calling doctors or health insurance companies.)**

○ Does not apply

Hours

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

38

Do you have:	never	in the past	have currently	Are you currently taking medication	Are you currently under medical care
Allergies	○	○	○	○	○
Arthritis	○	○	○	○	○
Asthma	○	○	○	○	○
Back Pain	○	○	○	○	○
Cancer	○	○	○	○	○
Chronic bronchitis/ emphysema	○	○	○	○	○
Chronic pain	○	○	○	○	○
Depression	○	○	○	○	○
Diabetes	○	○	○	○	○
Heart problems	○	○	○	○	○
Heartburn or acid reflux	○	○	○	○	○
High blood pressure	○	○	○	○	○
High cholesterol	○	○	○	○	○
Menopause (women only)	○	○	○	○	○
Migraine headaches	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Polycystic Ovary Syndrome (women only)	○	○	○	○	○
Stroke	○	○	○	○	○
Other condition	○	○	○	○	○

Turn the page.

39 **Do you have a family history (brother, sister, mother, father, grandparents) of:**

High Blood Pressure	○ Yes	○ No	○ I'm not sure
Heart Problems	○ Yes	○ No	○ I'm not sure
Diabetes	○ Yes	○ No	○ I'm not sure
Cancer	○ Yes	○ No	○ I'm not sure
High Cholesterol	○ Yes	○ No	○ I'm not sure

40 **When was the last time you had these preventive services or health screenings?**

	less than 1 year	1-2 years ago	2-3 years ago	3-4 years ago	5-6 years ago	7 or more years ago	Never	Don't know
Colon cancer screen	○	○	○	○	○	○	○	○
Rectal exam	○	○	○	○	○	○	○	○
Flu shot	○	○	○	○	○	○	○	○
Tetanus shot	○	○	○	○	○	○	○	○
Blood pressure	○	○	○	○	○	○	○	○
Cholesterol	○	○	○	○	○	○	○	○
For Women Only								
Pap Test	○	○	○	○	○	○	○	○
Mammogram	○	○	○	○	○	○	○	○
Breast exam by Physician or nurse	○	○	○	○	○	○	○	○
For Men Only								
Prostate exam	○	○	○	○	○	○	○	○

41 **In the past 12 months, how many times have you:** (For women who are pregnant, complete the questionnaire based on your health condition and lifestyle behavior before pregnancy)

	0	1-2	3-5	6 or more
Visited a physician's office or clinic	○	○	○	○
Gone to urgent care	○	○	○	○
Gone to the emergency room	○	○	○	○
Stayed overnight in a hospital	○	○	○	○
Used a 1-800 number for medical advice	○	○	○	○
Used a self-care book	○	○	○	○
Been treated with alternative medicine	○	○	○	○

WOMEN (Men go to question 48)

42 **How many women in your natural family (mother and sisters only) have had breast cancer?**

○ None ○ 2 or more
○ 1 ○ Don't know

43 **Have you had a hysterectomy operation?**

○ Yes ○ No ○ I'm not sure

PLEASE DO NOT WRITE IN THIS AREA

254424

44 **At what age did you have your first menstrual period?**

- ○ Younger than 12
- ○ 12
- ○ 13
- ○ 14 or older

45 **How old were you when your first child was born?**

- ○ Younger than 20
- ○ 20 to 24
- ○ 25 to 29
- ○ 30 or older
- ○ Does not apply

46 **I have had gestational diabetes or I have given birth to at least one baby weighing 9 lbs. or more.**

- ○ Yes
- ○ No
- ○ I'm not sure

47 **How often do you examine your breasts for lumps?**

- ○ Monthly
- ○ Once every few months
- ○ Rarely or never

MEN (Women go to question 49)

48 **How often do you examine your testicles for lumps?**

- ○ Monthly
- ○ Once every few months
- ○ Rarely or never

49 **Current marital status**

- ○ Single (never married)
- ○ Married
- ○ Separated
- ○ Widowed
- ○ Divorced
- ○ Other

50 **Race/Origin**

- ○ White (non-Hispanic origin)
- ○ Asian or Pacific Islander
- ○ Black (non-Hispanic origin)
- ○ American Indian / Alaskan Native
- ○ Hispanic
- ○ Other

51 **Highest level of education you have achieved**

- ○ Some high school or less
- ○ College graduate
- ○ High school graduate
- ○ Post graduate or professional degree
- ○ Some college

Turn the page.

52 In the next 6 months, are you planning to make any changes to keep yourself healthy or improve your health?

	Yes	No	Don't Know	Not Needed
Increase physical activity	○	○	○	○
Lose weight	○	○	○	○
Reduce alcohol use	○	○	○	○
Quit or cut down smoking	○	○	○	○
Reduce fat / cholesterol intake	○	○	○	○
Lower blood pressure	○	○	○	○
Lower cholesterol level	○	○	○	○
Cope better with stress	○	○	○	○

53 What is your phone number?

			–				–				
0	0	0		0	0	0		0	0	0	0
1	1	1		1	1	1		1	1	1	1
2	2	2		2	2	2		2	2	2	2
3	3	3		3	3	3		3	3	3	3
4	4	4		4	4	4		4	4	4	4
5	5	5		5	5	5		5	5	5	5
6	6	6		6	6	6		6	6	6	6
7	7	7		7	7	7		7	7	7	7
8	8	8		8	8	8		8	8	8	8
9	9	9		9	9	9		9	9	9	9

THANK YOU FOR YOUR PARTICIPATION.

DO NOT WRITE IN THIS AREA

254424


FORWARD
E PLURIBUS UNUM

(no date)

Good Morning

Introduction

My name is Shelley Ekblad and I am a nurse anesthetist from Eau Claire. This is the first time I have ever appeared at a public hearing like this, so I'm more than a little nervous. Please, therefore, bear with me.

I provide anesthesia care to approximately _____ patients annually. I have been a nurse anesthetist for ____ years. I really enjoy my work, and I find it to be very satisfying. It is an honor for me to help a wide range of people with their significant health care needs every day. I wouldn't trade places with anyone!

The typical nurse anesthetist has at least 7 calendar years of education and experience before becoming certified and registered. I have attached, for your ease of reference, a short description of the education of a nurse anesthetist.

Topics

I would like to briefly cover 3 topics today:

- Rural access to health care.
- Quality of care.
- the cost of health care

Each from the perspective of a nurse anesthetist in active practice.

Access to Care

First, let me begin with the issue of access to care.

- nurse anesthetists reside in over 200 villages, towns and cities throughout the state of Wisconsin. We live and work in 63 of the 72 counties of Wisconsin.
- nurse anesthetists provide quality anesthesia in many different settings, from major regional level trauma centers to local community hospitals. I have attached a map of the State of Wisconsin that shows how nurse anesthetists are spread out throughout the state.
- Wisconsin has approximately 127 hospitals that categorize themselves as 'General Medical and Surgical". Of these 127 hospitals 43% are critical access hospitals; Nurse anesthetists are the **exclusive** anesthesia providers in almost all of the 55 critical access hospitals in Wisconsin. Nurse anesthetists are providing the anesthesia services that enable rural hospitals, to provide surgical and birthing services. I have also attached a map that shows these hospitals.

Thus you can see that **nurse anesthetists are an essential resource for access to care in rural Wisconsin**.

Quality of Care

Let me move on to quality of care.

I am pleased to remind you that in June of 2005, Wisconsin became the 14th state nationally to exercise its state's right and allow nurse anesthetists to provide care independently to Medicare and Medicaid patients. This appropriately gave each hospital and surgery center in the state the ability to staff their anesthesia departments as they determine is in the best interests of the patients they serve. Removing unnecessary federal mandates and allowing state and local community control of decision-making, decreases health care costs by affording hospitals

important flexibility in providing care, including anesthesia care. I have attached for your ease of reference a copy of that important letter by Governor Doyle.

It is also important to note that PIC Wisconsin, the states largest medical liability underwriter, has acknowledged that there is no actuarial data indicating that the care provided by nurse anesthetists is distinguishable from that provided by anesthesiologists. There is not a single study to date that demonstrates a difference in outcome when comparing nurse anesthetist and anesthesiologist's care. Nurse anesthetists have been providing safe and high quality anesthesia care to the people of Wisconsin for decades.

I hope this ability to provide quality nurse anesthesia care continues in Wisconsin for many decades to come! We love our work, and we are very good at it!

Health care Costs

Allow me to move on to the critical issue of health care costs.

From an economic standpoint, nurse anesthetists are paid significantly less than are our anesthesiologists counterparts. This makes nurse anesthetist especially attractive to smaller healthcare facilities that are most likely located in rural areas across the State. In doing so, the expertise and cost-effectiveness of the nurse anesthetist is fully available to the Wisconsin patient community. (Attachment - Payment for Anesthesia Services).

And I can't resist saying, nurse anesthetists like me really enjoy the high quality of life that is available in rural Wisconsin communities!

Conclusion

Please allow me to conclude with a recommendation to your Committee. It is that nurse anesthetists continue to have the option to practice independently in both rural and urban areas of Wisconsin. **We are essential to rural health care. We provide safe and quality care. We are cost effective.** We don't ask anything of you, other than to allow us to continue to serve the health care needs of your constituents, who are also our good friends and valued neighbors.

Thank you for this opportunity to speak with you today. Thank you also for your commitment to the health care needs of our great state!

[Shelley to add her contact information here]

Education of Nurse Anesthetists in the United States - At a Glance

Education and experience required to become a Certified Registered Nurse Anesthetists (CRNA) include:

- A Bachelor's of Science in Nursing (BSN) or other appropriate baccalaureate degree.
- A current license as a registered nurse.
- At least one year's experience in an acute care nursing setting.
- Graduation from an accredited graduate school of nurse anesthesia. These educational programs range from 24-36 months, depending upon university requirements, and offer a master's degree.
- All programs include clinical training in university-based or large community hospitals.
- Pass a national certification examination following graduation.

It takes a minimum of seven calendar years of education and experience to prepare a CRNA. The average student nurse anesthetist works at least 1,694 clinical hours and administers more than 790 anesthetics.

Between 1,300 and 1,700 student nurse anesthetists graduate each year and go on to pass their certification examination.

Nurse anesthetists were among the first specialty nurses to require continuing education. CRNAs must be recertified every two years, which includes meeting practice requirements and obtaining a minimum of 40 continuing education credits.

The first organized program in nurse anesthesia education was offered in 1909. As of July 1, 2005 there are 95 nurse anesthesia programs with more than 1,100 clinical sites in the United States and Puerto Rico. These programs are affiliated with or operated by the school of nursing or health sciences department of a university.

The American Association of Nurse Anesthetists (AANA) implemented a certification program in 1945 and instituted mandatory recertification in 1978. The first certification examination was administered in 1945 to 92 candidates.

In 1952, AANA established a mechanism for accreditation of nurse anesthesia educational programs that has been recognized by the U.S. Department of Education since 1955.

In 1990, the U.S. Department of Health and Human Services published findings indicating a growing need for additional nurse anesthetists. Despite a present day workforce of more than 30,000 CRNAs, the vacancy issue remains a concern as demands for CRNA services grow.

Responding to the vacancy issue, nurse anesthesia educational programs and the AANA are aggressively seeking ways to meet societal needs by 2010.

http://www.aana.com/BecomingCRNA.aspx?ucNavMenu_TSMenuTargetID=101&ucNavMenu_TSMenuTargetType=4&ucNavMenu_TSMenuID=6&id=1018

Nurse Anesthetists at a Glance

Nurse anesthetists have been providing anesthesia care in the United States for over 125 years. Nurses first provided anesthesia to wounded soldiers during the Civil War. More than 90% of this country's nurse anesthetists are members of the American Association of Nurse Anesthetists (AANA).

Certified Registered Nurse Anesthetists (CRNAs) are anesthesia professionals who personally administer approximately 65% of all anesthetics given to patients each year in the United States.

CRNAs are the sole anesthesia providers in approximately two thirds of all rural hospitals in the United States, enabling these healthcare facilities to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100% of the rural hospitals.

According to a 1999 report from the Institute of Medicine, anesthesia care today is nearly 50 times safer than it was 20 years ago.

CRNAs provide anesthetics to patients in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by an anesthesiologist, it is recognized as the practice of medicine.

As advanced practice nurses, CRNAs practice with a high degree of autonomy and professional respect. They carry a heavy load of responsibility and are compensated accordingly.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. Military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. *The cost-efficiency of CRNAs helps control escalating healthcare costs.*

Across the country, nurse anesthetist professional liability premiums are 39% lower than 15 years ago.

Legislation passed by Congress in 1986 made nurse anesthetists the first nursing specialty to be accorded direct reimbursement rights under the Medicare program.

Approximately 49% of the nation's 34,000 nurse anesthetists who work full-time are men, compared with 8% in the nursing profession as a whole.

Education and experience required to become a CRNA include:

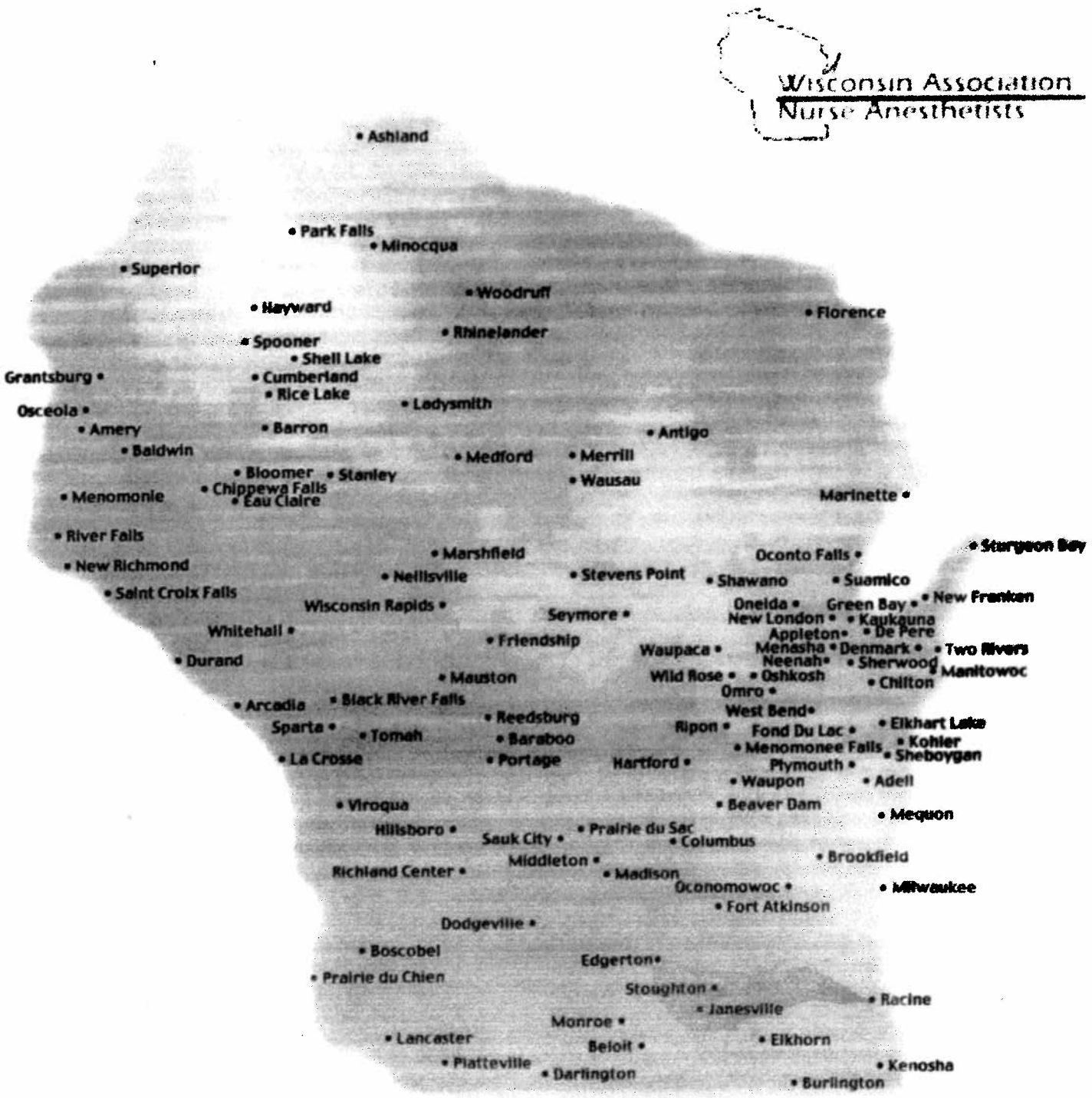
- A Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree.
- A current license as a registered nurse.
- At least one year of experience as a registered nurse in an acute care setting.
- Graduation with a master's degree from an accredited nurse anesthesia program. As of February 2006, there were 99 nurse anesthesia programs with more than 1,000 affiliated clinical sites in the United States. They range from 24-36 months, depending upon university requirements. All programs include clinical training in university-based or large community hospitals.
- Pass a national certification examination following graduation.

In order to maintain their recertification, CRNAs must obtain a minimum of 40 hours of continuing education every two years.

1998; Revised June 2004; Updated February 2006

http://www.aana.com/AboutAANA.aspx?ucNavMenu_TSMenuTargetID=179&ucNavMenu_TSMenuTargetType=4&ucNavMenu_TSMenuID=6&id=265

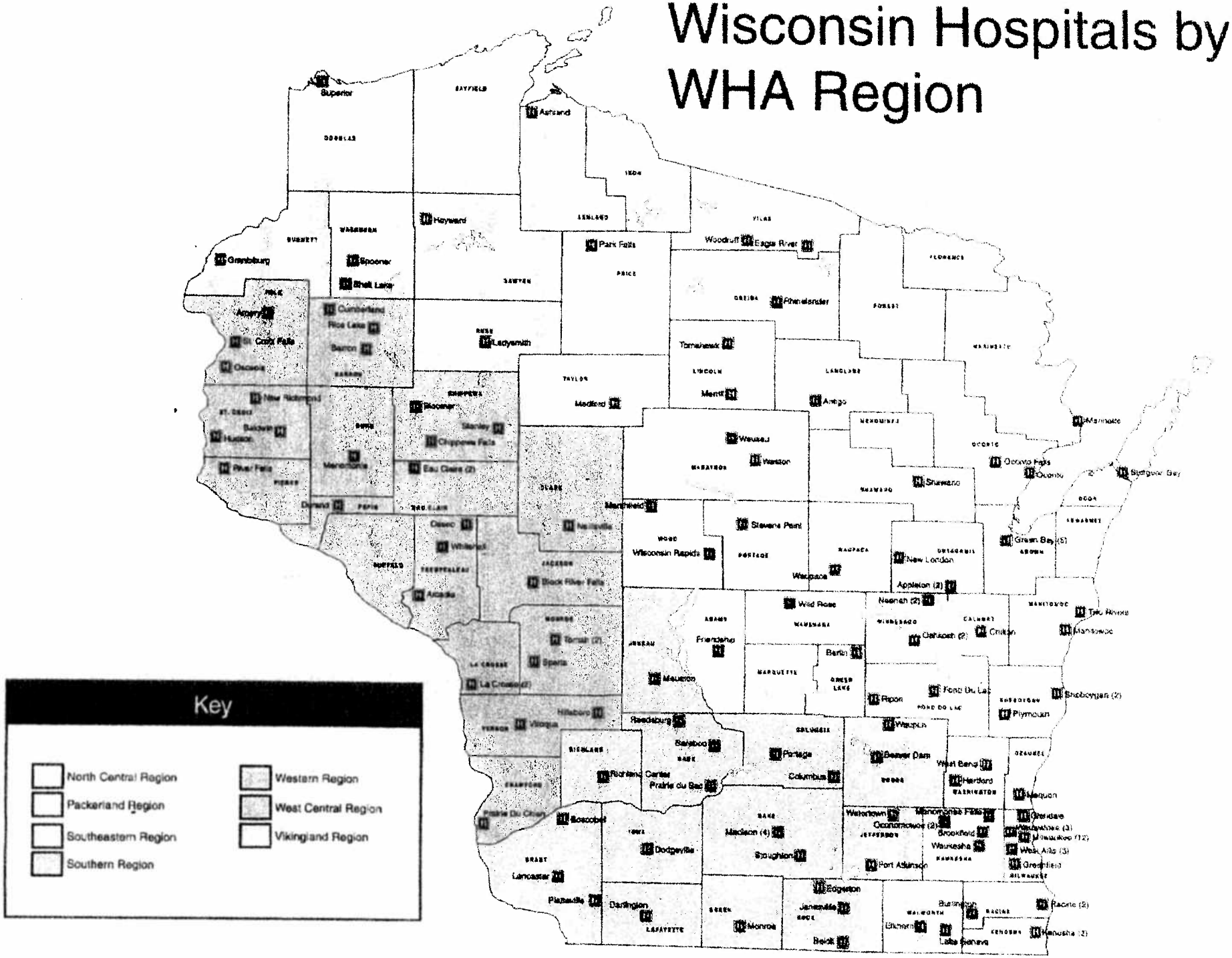
Wisconsin Association of Nurse Anesthetists



Members in Wisconsin – Where they live and practice

Source: Member Survey

Wisconsin Hospitals by WHA Region



JIM DOYLE
GOVERNOR
STATE OF WISCONSIN

June 6, 2005

Honorable Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
314G Hubert Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Mr. McClellan:

As delineated in 66 FR 56762-69, November 13, 2001, as Governor of the State of Wisconsin, I am requesting an opt-out from the federal requirement for physician supervision of Certified Registered Nurse Anesthetists (CRNAs). I attest and have concluded that this opt-out is in the best interests of Wisconsin's citizens, that the opt-out is consistent with Wisconsin law, and that I have consulted with the Wisconsin Medical Examining Board and the Wisconsin Board of Nursing about issues related to access to and the quality of anesthesia services in Wisconsin.

Sincerely,

JIM DOYLE
Governor

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983
WWW.WEGOV.STATE.WI.US

Payment for Anesthesia Services:

If I might take a moment and briefly explain how the payment for anesthesia services works and why nurse anesthetists are cost effective for health care organizations.

Medicare and Medicaid pay the same amounts for anesthesia services furnished by a nurse anesthetists or Anesthesiologists regardless of whether the nurse anesthetists is supervised by a physician.

Some third party payers reimburse nurse anesthetists at the same rate as they reimburse anesthesiologists; however, it is equally as important to point out that there are a notable number of payers that reimburse nurse anesthetists at a rate that is less than the reimbursement to anesthesiologists for the same services.

In the event that a nurse anesthetist is providing anesthesia services at the request of a physician *without an anesthesiologist*, it is more likely that the cost of that service will be less than had it been provided by an anesthesiologist.

Since Wisconsin law does not require physician supervision of nurse anesthetists, maintaining of this fact produces a reduction in the cost of anesthesia services to the government and or private payors since the scope of practice of a nurse anesthetist will not be restricted by the need for supervision by a physician. Nurse anesthetists who have a tendency to be a less costly provider than their MD counterparts, will be more able to provide anesthesia services in any practice setting.

A small example of what I mean:
Most nurse anesthetists are employees of hospitals and surgery centers.
Nurse anesthetists routinely re-assign there billing rights over to their employers.
These employers use this re-assigned reimbursement to offset the nurse anesthetist's salary and benefit expenses; the employer retains reimbursement that exceeds these expenses.

It is estimated that at minimum, nurse anesthetists make one half to one third the compensation of an anesthesiologist. For example, a hospital with anesthesia revenue of $500,000 annually, would have 40% more operating revenue available from their anesthesia revenue if they employed a nurse anesthetist.

Therefore, indirectly, the nurse anesthetists of Wisconsin increase the ability of Wisconsin's residents' access to quality healthcare services through their willingness to accept lower salaries, resulting in lower costs to their employers. The end result is a potential revenue surplus for their healthcare facility.
AT NO DECREASE IN QUALITY OF CARE!

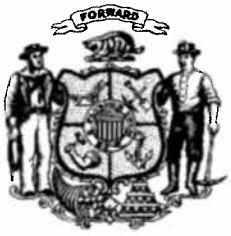
Wisconsin Association of Nurse Anesthetists

Shelley L. Ekblad, CRNA, M.S.
Certified Registered Nurse Anesthetist

3610 Parkside Circle East
Eau Claire, WI 54701

Home: 715-831-9415
Cell: 715-828-8977
dsaces@charter.net
E.C. Anesthesiologists #834-8721


WISCONSIN STATE LEGISLATURE


FORWARD

no date

Good Morning members of the Senate.

I wanted to first of all thank you for taking the time to hold a hearing in Eau Claire. I appreciate your hectic schedules and your commitment to public service.

My name is Denison Tucker and I am the President of Northwest Counseling and Guidance Day Treatment Programs. I have been involved in the health service business, specifically working in the area of mental health with children and families, since 1978 and created Northwest Counseling in 1998. We have 11 mental health day treatment programs ranging from Superior to Green Bay. I have attached a list of our locations along with my written testimony.

Our programs serve mentally ill children and teens verging on out-of-home placements or inpatient hospitalization. The majority of children referred to our day treatment programs are voluntary and are following treatment recommendations from medical clinics, therapy providers and social service agencies.

Our staff has worked intensively over the past several years to continuously improve services in order to meet increased MA standards and expectations for treatment. We have worked diligently to remove barriers that stand in the way of providing treatment to children living in underserved, rural areas.

The barriers to service compel my appearance today. Since our company has a program in Eau Claire, we contacted Senator Ron Brown. We expressed to him our concerns with the current language found in the Department of Health and Family Services Administrative Code. It is based on Senator Brown's recommendation that we are testifying.

We believe the some parts of the Code stand in the way of providing quality services, and through time actually defeat the original purpose for which it was drafted. We have raised our Administrative Code issues with DHFS. Attached to my written comments is a letter that our company provided to DHFS.

Our first concern lies with HFS 40.06(4)(h). This section states that other qualified mental health professionals shall have at least a bachelor's degree in a relevant area of education or human services and a minimum of 2 years' work experience serving children with mental health disorders, or a minimum of 6 years' work experience and training providing direct services to children with mental health disorders.

We believe the Agency would be better served by eliminating the work experience requirement for those with a bachelor's degree and reduce the work experience requirement to 4 years for those without a bachelor's degree. We also think a person with a master's degree and no experience should be included as an "other qualified mental health professional".

Our reasoning for requesting this amendment to the Administrative Code is based on recruitment problems. It is difficult, if not impossible, in rural locations, to find staffs that meet the statutory requirements. As currently written, the Code creates a "catch-22" scenario. The experience is required, yet a person does not have many opportunities to get the experience. It is like saying a teacher needs to have experience teaching before being hired as a teacher.

The second code provision which concerns us is HFS 40.06(4)(e). This section states that clinicians shall have a master's degree from a graduate school of social work accredited by the Council on Social Work Education, or a master's degree in behavioral science or a related field from a graduate program that meets nationally recognized accreditation requirements, with a minimum of 28 hours of graduate course credit in social service, marriage and family counseling, mental health theory, human behavior or a similar area of study, and shall have a minimum of one year of experience working in a clinical setting serving children with mental health disorders.

We think the Agency would be better served by eliminating the work experience requirement and amending the Code to state that a person with a master's degree would qualify as a mental health professional. Again, recruitment is difficult, if not impossible, in rural locations and a "catch-22" scenario is created.

The experience is required, yet a person does not have a large number of opportunities to get the experience. In addition, we have found that a person with his/her 3,000 hours tends to want to work in an outpatient setting rather than a day treatment setting. Also, when a person is qualified, they are not necessarily more competent or the best fit for counseling children.

The third code provision is HFS 40.07(1)(a)(5). This section of the Code mandates that Level One programs provide clinical services through either staff or outside services. One of the programs mandated is the requirement that two hours per week of occupational therapy services be provided through either registered occupational therapists, structured recreational or vocational services for each full-time client in the program.

This requirement is very, very expensive and an entity like ours spends large sums in attempting to provide the required occupational therapy services. In 2004, we spent over $11,000, just in advertising, trying to hire an occupational therapist to meet our needs in rural areas. Our experience is that occupational therapists do not have the necessary skills to work with children. Thus, large sums of money are exhausted to fulfill a requirement which has little benefit to children.

Through our experience with occupational therapists, we have also found occupational therapists shy away from the population we serve. In fact, even after the expenditure of thousands in advertising over a year's time period, we have not been able to recruit such professionals.

We believe money spent on occupational therapists would be better spent in other areas. For example, the expenditure on medical management would be more likely to satisfy the goals of the Agency. More resources spent in medical management would assist in keeping children in local communities and out of correctional facilities.

We realize what we are requesting from the Agency is a tall order. The Agency is still reviewing our correspondence and we expect they will be providing us with their position shortly. We believe the Agency will be in favor of changing the Code, as it truly is antiquated language that stands in the way of providing service to mentally ill children in rural areas.

Nonetheless, we wanted to appear before you today and provide you with information regarding a problem in Northern Wisconsin. Please know through Senator Brown's office we will continue to keep the Senate apprised of the Department's position on changing the Administrative Code.

Again, thank you for your time. I have attached contact information in case you have questions regarding my testimony. Thank you.

Denison Tucker, President
Northwest Counseling & Guidance Day Treatment Programs
203 United Way Drive
Frederic, WI 54893
(715) 327-4402

Northwest Counseling and Guidance Day Treatment Locations

Amery DT
PO Box 167
1096 Apple Avenue
Amery, WI 54001

Black River Falls DT
N6643 Cty Rd A
Black River Falls, WI 54615

Eau Claire DT
3203 Stein Blvd
Eau Claire, WI 54701

Ellsworth DT
PO Box 360
254 Chestnut Street
Ellsworth, WI 54011

Green Bay DT
123 South Van Buren Street
Green Bay, WI 54301

Marathon City Journey Program
2805 Emery Drive
Wausau, WI 54401

Menomonie DT
402 Technology Drive E.
Menomonie, WI 54751

Rice Lake DT
413 South Main Street
Rice Lake, WI 54868

Siren DT
PO Box 388
7670 Johnson Street
Siren, WI 54872

Stevens Point DT
525 4th Avenue
Stevens Point, WI 54481

Superior DT
1412 East 2nd Street
Superior, WI 54880

Wisconsin Rapids DT
110 24th Street South
Wisconsin Rapids, WI 54494

NWPAC & NWP III
203 Frederic Way Drive
Frederic, WI 54837

NWP I
PO Box 349
7818 Moline Road
Webster, WI 54893

NWP II
1661 Hams Road
Spooner, WI 54801

NWCGC - Outpatient
Amery Reg. Med. Center
225 Scholl Court
Amery, WI 54001

Northwest Counseling and Guidance Clinic

Mental Health and AODA Care Systems

April 13, 2006

Sinikka Santala, Division Administrator
Disability & Elder Services Division
Department of Health & Family Services
One West Wilson Street, Room 650
P.O. Box 7850
Madison, WI 53707-7850

RE: **Proposed Administrative Code Changes**

Dear Administrator Santala:

I wanted to provide formal correspondence to your office in regard to an Administrative Code matter and its impact on our company.

By way of background, Northwest Counseling and Guidance Day Treatment programs operate eleven (11) day treatment programs throughout Northern Wisconsin. The locations range from Superior to Ellsworth over to Green Bay. These programs primarily serve rural communities. Our Day Treatment program has developed a unique configuration of services and operates all-day programs from 8 a.m. to 4 p.m., five days a week.

Day Treatment targets mentally ill children and teens who are verging on out-of-home placements or intensive in-patient hospitalization. The majority of children referred to Day Treatment are voluntary and are following the advice or recommendations for treatment from medical clinics, schools, community therapy providers and social service agencies.

Through the years, Day Treatment has developed a collaborative model that provides a psycho-educational component for each participating child at no cost to taxpayers. Additionally, Day Treatment works closely with community providers to assist in transitional support placements and communicates regularly with local attending psychiatrists, family physicians or pediatricians and other therapeutic or social service providers.

Our staff has worked intensively over the past seven years to continuously improve in order to meet MA standards and expectations for treatment and service standards.

We have worked diligently to remove barriers which stand in the way of providing treatment to children living in isolated, underserved, rural and poverty-stricken areas. We believe no other day treatment provider in Wisconsin has worked harder or more consistently to deliver more services than our staff at Day Treatment.

There are some components in the DHFS Administrative Code, however, which make providing services very difficult. The purpose of this correspondence is to request a review of three sections of the Administrative Code which we believe, if amended, would promote cost efficiency for MA and advance the quality of service for children. None of the changes we are requesting would undermine therapeutic service. In fact, we believe addressing the following issues would enhance therapeutic quality and remove obstacles standing in the way of improved services.

1. HFS 40.06(4)(h). This section states that other qualified mental health professionals shall have at least a bachelor's degree in a relevant area of education or human services and a minimum of 2 years' work experience serving children with mental health disorders, or a minimum of 6 years' work experience and training providing direct services to children with mental health disorders.

Northwest Counseling and Guidance believes the Agency would be better served by eliminating the work experience requirement for those with a bachelor's degree and reduce the work experience requirement to 4 years for those without a bachelor's degree. We also think a person with a master's degree and no experience should be included as an "other qualified mental health professional".

Our reasoning for requesting this amendment to the Administrative Code is based on recruitment problems. It is difficult, if not impossible, in rural locations, to find staff that meet the statutory requirements. As currently written, the Code creates a "catch-22" scenario. The experience is required, yet a person does not have many opportunities to get the experience. It is like saying a teacher needs to have experience teaching before being hired as a teacher.

Further, if a person does meet the statutory requirements, it does not necessarily make them competent. Thus, the objective becomes satisfying the statutory requirements, as opposed to hiring employees who can work effectively work with mentally ill children.

We would like to solicit your support for a reduction or elimination of the work experience requirement, with the addition of a training plan for those employees having less than the 2 years of experience. A training plan could address the necessary areas to ensure staff knowledge and supervision, in lieu of the current experience requirement. In order to give the Agency security that employees without experience are receiving adequate training, an entity, like ours, could be required to complete the bulk of the training in the first three months of employment. We think this is a concept which would truly allow improved care for at-risk youth.

2. HFS 40.06(4)(e). This section states that clinicians shall have a master's degree from a graduate school of social work accredited by the Council on Social Work Education, or a master's degree in behavioral science or a related field from a graduate program that meets nationally recognized accreditation requirements, with a minimum of 28 hours of graduate course credit in social service, marriage and family counseling, mental health theory, human behavior or a similar area of study, and shall have a minimum of one year of experience working in a clinical setting serving children with mental health disorders.

Northwest Counseling and Guidance thinks the Agency would be better served by eliminating the work experience requirement and amending the Code to state that a person with a master's degree would qualify as a mental health professional. Again, recruitment is difficult, if not impossible, in rural locations and a "catch-22" scenario is created.

The experience is required, yet a person does not have a large number of opportunities to get the experience. In addition, we have found that a person with his/her 3,000 hours tends to want to work in an outpatient setting rather than a day treatment setting. Also, when a person is qualified, they are not necessarily more competent or the best fit for counseling children.

In lieu of the work experience requirement, we believe a strong mentoring program could provide the same level of service without eroding the safety of children. In further support of our concept, we also wanted to point out that clinicians are supervised by a psychologist, regardless of their work experience. Thus, a mentoring program combined with the already existing supervision would accomplish the goals of the Agency, while allowing entities like ours to provide services in rural areas.

3. HFS 40.07(1)(a)(5). This section of the Code mandates that Level One programs provide clinical services through either staff or outside services. One of the programs mandated is the requirement that two hours per week of occupational therapy services be provided through either registered occupational therapists, structured recreational or vocational services for each full-time client in the program.

This requirement is very, very expensive and an entity like ours spends large sums in attempting to provide the required occupational therapy services. In 2004, we spent over $11,000, just in advertising, trying to hire an occupational therapist to meet our needs in rural areas. Our experience is that occupational therapists do not have the necessary skills to work with children. Thus, large sums of money are exhausted to fulfill a requirement which has no benefit to children which the Code was designed to protect.

Through our experience with occupational therapists, we have also found occupational therapists shy away from the population we serve. In fact, even after the expenditure of thousands in advertising over a year's time period, we have not been able to recruit such professionals into our system. Although only a short term solution, we have been forced to initiate partnerships with school districts to solve part of this problem. If our client is still enrolled with a school district and specific occupational therapy is needed, we can coordinate with the school district to meet this requirement. However, this only satisfies a small percentage of our population.

Northwest Counseling and Guidance believes the money spent on occupational therapists would be better spent in other areas. For example, the expenditure on medical management would be more likely to satisfy the goals of the Agency. More resources spent in medical management would assist in keeping children in local communities and out of correctional facilities.

For all the reasons above, we think striking the occupational therapy provision from the Code makes sense. A possible alternative to the occupational therapist requirement would be when the state certification specialist meets with our program to discuss the vocational needs of clients, the treatment plan which is forged from those meetings should address any outstanding needs. Since the certification specialist already meets with our program regarding the needs of clients, it seems to us a discussion at the onset regarding any necessary services would be more beneficial than a blanket occupational therapy requirement.

Northwest Counseling and Guidance realizes the easy answer to the Agency for many of our concerns is the utilization of the waiver process. Our entity has filed multiple, multiple waiver requests spanning from 2001 through the present. Our requests for waivers have been based on common sense and what we believe were good candidates. Even after numerous requests, however, the agency has yet to grant a single waiver request. During our meeting, if necessary, I can provide you with copies of documents where waiver requests have been submitted and rejected.

In summation, we realize our proposal of asking the Agency to address the existing Administrative Code is a tall order. Nonetheless, we believe our proposed changes would truly further the mission and goal of the Department of Health and Family Services. As part of our proposal, we would like to establish a time and date to come meet with your office and have a discussion regarding whether pursuing changes to the Administrative Code is practical.

Northwest Counseling and Guidance believes by meeting with you directly, we can provide further information and clarification as to why changing the Code is truly in the Agency's best interests. Further, we want to express to you our commitment to working with your Agency in seeking changes.

Thank you in advance and please contact our General Counsel John Behling at 715/839-7786. John will work with your office in arranging a mutually beneficial time for us to meet.

Very truly yours,

NORTHWEST COUNSELING & GUIDANCE CENTERS

John Behling on behalf of D.T.

Denison Tucker
President

DT/rrn
cc: State Senator Ron Brown

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