



## Legislative Fiscal Bureau

One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

---

June 8, 2007

Joint Committee on Finance

Paper #372

### **Health Care Quality and Patient Safety Council and Grant Program (DHFS -- Health Care Quality Fund)**

#### *Bill Section*

[LFB 2007-09 Budget Summary: Page 240, #4]

---

#### **CURRENT LAW**

In November, 2005, Governor Doyle created the Board for eHealth Care Quality and Patient Safety (Board) under Executive Order 129, and directed the Board to review issues surrounding the creation of an ehealth information infrastructure in Wisconsin, and to develop recommendations for: (1) identifying existing ehealth resources, including funding sources, to support the development of a statewide ehealth information structure; (2) identifying technology options, and their advantages and disadvantages, for a statewide health information infrastructure; (3) insuring options for serving consumer health information needs; (4) insuring health information privacy and security in electronic health information exchange; (5) facilitating statewide adoption of electronic health record standards to enable health information exchanges across the state and nationally; and (6) creating organization and governance structures for a statewide ehealth information infrastructure. The Governor's Executive Order creating the Board reflected heightened interest at the state and national level in the potential benefits health information technology (HIT) may offer to the country's health care delivery system.

On December 1, 2006, the Board released its final report, entitled *Wisconsin eHealth Action Plan*. That report contains a five-year plan for statewide adoption of an electronic health information infrastructure by 2012. The administration indicates that the Governor's recommendations to create a Health Care Quality and Patient Safety Council, and to provide funding to promote ehealth initiatives, are based on the Board's December 1, 2006 report.

## GOVERNOR

Provide \$10,000,000 SEG annually from the health care quality fund (HCQF) to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information. Create a continuing appropriation in DHFS for this purpose.

Create a Health Care Quality and Patient Safety Council (Council), attached to DHFS, which would consist of the following members: (a) the Secretary of the Department of Administration, or his or her designee; (b) the DHFS Secretary, or his or her designee; (c) the Secretary of Employee Trust Funds, or his or her designee; (d) an employer who purchases health care for employees; (e) a representative of the Wisconsin Health and Hospital Association; (f) a physician; (g) a representative of the health insurance industry; (h) a representative of a major health care provider system; and (i) a health care consumer advocate. All council members, except those identified in (a), (b), or (c) would be appointed by the Governor for two-year terms. The initial terms of the remaining members would be staggered, as set forth in the bill. The DHFS Secretary would serve as the chairperson of the Council, and would appoint chairpersons for subcommittees on patient care, consumer interest and privacy, public health, and statewide health information exchange and interoperability.

Direct the Council, acting in an advisory capacity, to lead implementation efforts for an action plan for health care quality and patient safety by doing all of the following: (a) identifying strategies and actions necessary to attempt to achieve goals established by the Institute of Medicine of the National Academy of Sciences for health care that is safe, effective, patient-centered, timely, efficient, and equitable, and to extend health care information systems statewide so as to optimize the improvement of health care quality, safety, and efficiency within a reasonable period of time and with reasonable financial investment; and (b) considering the most cost-effective means of implementing a statewide integrated or interoperable health care information system, including assessing the benefits of an integrated or interoperable system for supporting rapid deployment of health care providers, creating points of reference for performance indicators among health care provider organizations for organizational improvement, and reporting to the public on health care quality, safety, and efficiency data for consumer and purchaser decision making.

Require the Council to advise the DHFS Secretary on all of the following: (a) a communication and marketing plan; (b) recommendations, annually, to improve the committee organizational structure of the Council; (c) the distribution of funding to entities to promote the health information technology agenda of the Governor; and (d) whether a health facility or a participating health institution that seeks financial assistance from the Wisconsin Health and Educational Facilities Authority (WHEFA) demonstrates progress in improving medical information systems technology.

Require the Council by January 1, 2008, and at least annually thereafter, to report to the Legislature and to the Governor on the Council's plans, activities, accomplishments, and

recommendations. Require that any subcommittee of the Council align its work with recommendations of the American Health Information Community (a panel that provides advice to the U.S. Department of Health and Human Service on information technology).

Require the DHFS Secretary to determine whether a health facility or a participating health institution that seeks financial assistance from WHEFA demonstrates progress in improving medical information systems technology, and to inform WHEFA of his or her determination. In making that determination, direct the Secretary to consider as a factor the advice of the Council. Require WHEFA to inform the Secretary of any health facility or participating health institution that seeks financial assistance from WHEFA, and prohibit WHEFA from providing any such financial assistance unless the Secretary determines that the health facility or participating health institution demonstrates progress in improving medical information systems technology.

## **DISCUSSION POINTS**

1. It is estimated that total health care spending in the United States in 2005 approached \$2 trillion, or 16% of gross domestic product. Studies indicate that both in absolute terms and in terms of gross domestic product, the United States spends more on health care than other industrialized countries. According to an article in *Health Affairs* magazine entitled, *Health Care Spending and Use of Information Technology in OECD Countries*, per capita health spending in the United States in 2003 was almost two and a half times greater than the comparable median for the thirty countries in the Organization for Economic Development (OECD). That same article states that in 2003, the percentage of United States gross domestic product devoted to health care spending (15%) was significantly higher than the median for the OECD countries (8.4%). Other studies project that health care spending in the United States will continue to outpace growth in gross domestic product, and could rise to 20% of gross domestic product by 2015.

2. In addition, a 1999 study by the Institute of Medicine (IOM) indicated that as many as 98,000 people in the United States die each year from medical error, and a lack of coordinated care was a major factor. A 2006 IOM study found that drug-related errors harmed about 1.5 million people each year, and the extra medical costs of treating drug-related injuries that occur in hospitals amounted to \$3.5 billion annually. Other statistics indicate that: (a) patients that have illnesses with known treatments, such as heart attack medications, receive appropriate care only 54.9% of the time (Hussey, et al. 2004); and (b) medical errors occur in approximately 7% of hospital admissions and lead to serious injury in about 3.7% of total hospitalizations (McGlynn, et al., 2003; IOM, 1998). According to a 2005 report by the Oregon Health Policy Commission, quality and safety problems result in approximately 57,000 deaths, 41 million sick days, and \$11 billion in lost productivity annually. Though many factors contribute, a significant cause is inadequate access to information and resulting waste, fragmentation of care, and errors. For example, a 2005 study found that missing information compromised about 13% of all clinical encounters (Smith, et al.).

3. These statistics have led to an increased focus on the potential health and economic

benefits health information technology (HIT) can offer to the country's health care delivery system. The term "health information technology" has been defined as, "the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, and knowledge for communication and decision-making." Examples of HIT include electronic health record systems, laboratory information systems, administrative and billing systems, and workflow systems.

4. Numerous health care providers lack the information systems necessary to coordinate a patient's care with other providers, share required information, monitor compliance with preventive actions and disease management guidelines, and measure and improve performance. Also, consumers generally lack the information they need about costs or quality to make informed decisions about their care. Historically, health care providers have documented and delivered health care using paper records, but paper records have a number of disadvantages, including availability to only one person at one time, frequent illegibility, inability to be accessed from remote locations or at the time and place they may be needed, low utility in measuring quality of care, and segmentation because of multiple volumes and storage sites. Consequently, many health care industry participants and experts view electronic health records and health information interoperability as part of a solution to improve health care quality, safety, and reduce costs.

5. Some studies have concluded that the United States lags behind other industrialized countries with respect to the implementation of HIT. According to statistics cited in *Wisconsin eHealth Action Plan*, approximately 28% of primary care doctors in the United States use electronic medical records, compared to 98% in the Netherlands, 92% in New Zealand, 89% in the United Kingdom, and 79% in Australia. In addition, only 23% of doctors in the United States receive computerized alerts for potential harmful drugs or interactions compared to 93% of doctors in the Netherlands, 91% in the United Kingdom, and 87% in New Zealand.

6. At the national level, the renewed focus on HIT is reflected in the President's April 27, 2004, Executive Order that created the Office of the National Coordinator for Health Information Technology (ONCHIT), and charged that Office with developing an industry and federal government-wide strategy for widespread adoption of HIT, and to translate that into substantial quality and efficiency improvements within a decade. One of the President's stated goals is for most Americans to have access to secure electronic health records by 2015. There are not universally-accepted definitions for the terms electronic health record (HER) and electronic medical record (EMR). *Wisconsin eHealth Action Plan* uses the terms interchangeably, and defines them as, "a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making." Other sources draw a distinction between EMRs and EHRs, with the former defined as an electronic replacement for paper charts that is the legal record of patient encounters within a single health care delivery system or practice, and the latter defined as a longitudinal electronic record of patient information that may consist of information from many locations or sources, and that contains patient demographics, progress notes, problems, medications, medical history, immunizations, laboratory data, and radiology reports.

7. In 2005, the U.S. Department of Health and Human Services (HHS) formed the

American Health Information Community (AHIC), a federal advisory committee made up of private and public sector leaders to make recommendations to the HHS Secretary on how to accelerate adoption of interoperable HIT in a smooth, market-led way. Interoperability refers to the ability of different information technology systems and software applications to communicate, to exchange data accurately, and consistently, and to use the information that has been exchanged. Concerns about the interoperability of the many different HIT systems that currently exist, and that are available in the marketplace, have been identified as one of several barriers to more widespread investment by health care providers in HIT. Part of the AHIC's charge is to develop standards that will foster the interoperability of current HIT systems, and to develop a process whereby EHR products will be certified as meeting certain base-line criteria for functionality, security, and interoperability.

8. Consistent with the goal of fostering greater interoperability between HIT systems, ONCHIT is also working to develop a nationwide health information network (NHIN). The purpose of the NHIN will be to facilitate communication and interoperability between Regional Health Information Organizations (RHIOs). *Wisconsin eHealth Action Plan* defines an RHIO as an independent corporation established to operate an exchange of clinical health information among competing stakeholder organizations supporting multiple case uses. The five-year action plan set forth in *Wisconsin eHealth Action Plan* calls upon the state to foster the creation of up to four new RHIOs in Wisconsin (the Wisconsin Health Information Exchange, an RHIO in Southeast Wisconsin, already exists, and the plan calls for its support).

9. In addition to these federal initiatives, there is also increased interest in the potential benefits of HIT at the state level. According to a September 25, 2006, report by eHealth Initiative entitled *Improving the Quality of Healthcare Through Health Information Exchange*, in 2005 and 2006, thirteen states passed legislation that called for the creation of a commission, committee, council, or task force to provide leadership or recommendations on HIT and/or HIE, and fifteen states passed legislation that called for a study, set of recommendations, strategies, or a plan for HIT adoption and/or HIE. In addition, 10 Governors, including Governor Doyle, signed executive orders intended to facilitate improvements in the healthcare system through HIT.

10. The eHealth Initiative report also indicates that in 2005 and 2006, eight bills in seven states passed and became law that either authorized or appropriated funding for HIT or HIE-related activities. In Minnesota, the state provided \$1.5 million in matching grants in FY 2006-07 to establish interoperable EHRs in rural and underserved areas of Minnesota. For 2007-08 and 2008-09, the state recently increased funding for HIT initiatives to a total of \$14 million over the biennium, with \$7 million appropriated for grants (requiring a 1:3 match by recipients), and \$7 million in loans. According to the Director of the Minnesota Department of Health's Center for Health Informatics, funding will again be focused on collaborative HIT projects in rural and other underserved areas of the state. The Director indicated that Minnesota has also enacted a requirement that all health care providers in the state have EHRs by 2015.

11. According to *Wisconsin eHealth Action Plan*, Wisconsin may be well-positioned for widespread implementation of HIT. For example, one national survey indicated that 25% of office-

based physicians in the United States reported using EMR systems in 2005, while a separate study found that 38% of Wisconsin primary care practice sites claimed to be using an EMR system. One possible reason for Wisconsin's relatively higher rate of EMR usage is the concentration of Wisconsin physicians in larger group practices. Figures cited in *Wisconsin eHealth Action Plan* indicate that 80% of Wisconsin physicians work in practices with 10 or more physicians, while the national percentage is only 9.7%. To date, larger practices and institutions have been more apt to invest in HIT than their smaller counterparts. *Wisconsin eHealth Action Plan* also reports the results of a recent survey indicating a large number of HIE projects currently operating in the state.

12. There have also been numerous studies designed to estimate the potential costs and benefits that might result from widespread adoption of HIT in this country. In a report prepared by the Lewin Group, Inc. entitled *Health Information Technology Leadership Panel, Final Report*, the authors summarized a number of studies that have examined the potential cost savings that could be achieved through HIT. Those findings included estimates that EHRs could reduce lab and radiology test ordering by 9-14%, reduce ancillary test charges by 8%, reduce hospital admissions at an average cost of \$17,000 per admission) by 2-3%, and reduce excess medication by 11%. The Lewin report also cited studies that indicate EHRs can decrease physician visits by 9%, as well as studies of ambulatory care settings that indicate that would save \$112 billion a year. Legislative Fiscal Bureau (LFB) Paper #324 (Electronic Medical Records Tax Credit) contains an extensive review of many of the studies that have sought to estimate the potential costs and benefits associated with a widespread implementation of an interoperable HIT system.

13. LFB Paper #324 also discusses studies that have sought to estimate some of the potential public health benefits that could be achieved through such a system. For instance, a study by the RAND Health Information Technology Project Team measured health benefits by analyzing two kinds of interventions used to enhance health: disease prevention and chronic disease management. HIT would assist disease prevention by scanning patient records for risk factors and recommending preventive services, such as vaccinations. The effects of disease prevention were estimated by increasing five selected preventive services as follows: (a) increased influenza vaccinations at an estimated cost of \$134 million to \$327 million annually would prevent 5,200 to 11,700 deaths; (b) increased pneumonia vaccinations costing \$90 million per year would prevent between 15,000 and 27,000 deaths; (c) increasing breast cancer screening for \$1 to \$3 billion annually would prevent between 2,200 and 6,600 deaths each year; (d) increased cervical cancer screening costing \$152 million to \$456 million each year would prevent 533 deaths each year; and (e) increasing colorectal cancer screening at a cost of \$1.7 billion to \$7.2 billion could prevent 17,000 to 38,000 deaths. A program of HIT-enhanced prevention and disease management could also change the incidence of chronic conditions and their complications. The HIT system can be used to identify patients requiring tests and other services, and patients could use remote monitoring systems. Effective disease management can reduce the need for hospitalization. Considering potential long-term illnesses such as cardiovascular disease, cerebrovascular disease/stroke, diabetes, emphysema, and cancers associated with smoking, the study estimated how combinations of lifestyle changes and medications that reduced the incidence of these conditions would affect health care use, spending, and outcomes. The estimated combined savings from long-term prevention and management, and reduced acute care due to disease management was \$147 billion a

year.

14. Some observers have questioned the magnitude of the savings attributed to HIT. Many of these concerns relate to the interoperability of competing HIT systems, and to the possibility that EHR may increase documentation time among physicians. Other observers note that the magnitude of the annual savings projected in some studies reflect the savings that could be achieved from a fully integrated, interoperable HIT system. Again, the reader is referred to LFB Paper #324 for a more in-depth discussion of the studies that have addressed these issues.

15. One generally-recognized barrier to greater private sector investment in HIT to date is the relatively high start-up costs of establishing an EHR system. *Wisconsin eHealth Action Plan* cites estimates placing the cost to deploy HIT and HIE across the entire spectrum of health care in the United States from \$115 billion for the HIT costs to \$156 billion for the connectivity infrastructure required for a NHIN, to \$276 billion for all providers to achieve full HIE. Allocating roughly 2% of those costs to Wisconsin suggests a total statewide investment of \$2.3 billion to \$5 billion. *Wisconsin eHealth Action Plan* also estimates the per physician cost to acquire and start up an EHR system at \$20,000 to \$40,000.

16. *Wisconsin eHealth Action Plan* contains a five-year plan to achieve significantly greater adoption of HIT and HIE in Wisconsin. That action plan consists of four components.

17. The first component is to establish an eHealth technology platform in Wisconsin by encouraging the widespread adoption of HIT and use of electronic health records systems. The plan identifies several strategies to achieve that goal, including providing start-up funding for safety-net providers and small and/or rural providers that are not able to afford them, by offering education and technical assistance, and by endorsing standards for these systems to minimize the risk associated with purchasing decisions.

18. To establishing an eHealth technology platform in Wisconsin, the action plan would also have the state foster the creation of regional (sub-state) HIEs to enable exchange of patient information by focusing early on timely patient information for providers when and where they need it for patient care - for example, comprehensive information on patient allergies, medications, and past diagnoses, by supporting the Wisconsin Health Information Exchange in Southeast Wisconsin, and by encouraging the development of up to four new RHIOs throughout the state. With respect to those new RHIOs, the action plan would limit state funding to organizations that meet the following criteria: (a) have at least one million people in their geographic area; (b) are willing to serve all members (not limited to one vendor or subset of payers or providers); (c) have an independent status with broad governance including public and private sector representatives and strong consumer representation; (d) comply with state and national standards for interoperability and that are committed to statewide and nationwide network development; (e) employ policies and systems to assure privacy, security, and confidentiality of health information, include public health agencies; and (f) have a well-developed and viable business plan. As part of establishing an ehealth platform in Wisconsin, the state would also develop statewide health information exchange services that would, among other things, serve as the link between RHIOs, other states, and the NHIN, and

set standards and policies for health information exchange consistent with national standards.

19. The second component of the five-year action plan is to stimulate the development, alignment, and implementation of value-based purchasing policies and actions across the public and private sectors. This would include encouraging the creation of formal partnerships between payers and providers to develop standard requirements for reimbursement, including new Pay for Quality incentives, to leverage the purchasing power of state government to encourage providers to adopt HER systems and to participate in HIE, and to seek federal and foundation support to develop and model these systems for the nation. The plan also calls for a contract between DHFS, ETF, and the Wisconsin Health Information Organization to build a data repository to track outcomes, quality and cost of episodes of care for quality improvement, public reporting, and public health assessment functions.

20. The third component of the action plan is to link HIT and HIE plans to prevention and disease management activities. Aspects of this component would include developing a routine health risk assessment and member agreement for the medical assistance population to guide taking personal responsibility for health and health care, actively promoting the use of chronic disease management tools by safety net providers, continuing to strengthen care management strategies across the medical assistance population in general, establishing biosurveillance capabilities across the public and private sectors for rapid outbreak detection, management and recovery, and assuring the interoperability of HIT/HIE with Wisconsin's Public Health Information Network.

21. The fourth component of the action plan is to take an incremental approach that includes closely monitoring progress and adjust strategies and activities as needed.

22. Building on the recommendations in *Wisconsin eHealth Action Plan*, the Governor's bill would create the Council, and provide \$10 million SEG annually from the HCQF to fund the adoption of health care quality and patient safety information technology and to develop exchanges of health information. The Council would be required to lead the state's implementation efforts for an action plan for health care quality and patient safety. Under the bill, the Council's role would be only advisory. For instance, regarding the funding for ehealth initiatives, the Council's role would be to advise the DHFS Secretary with respect to the distribution of funding to entities "to promote the health information technology agenda of the Governor."

23. The Committee could reasonably decide that the bill's provisions regarding the distribution of funding for ehealth initiatives lacks specificity. For example, while the administration has indicated that DHFS intends to award funding pursuant to a competitive grant process, nothing in the bill requires such a process. Furthermore, the bill does not specify any criteria the DHFS Secretary must apply when distributing those funds. Instead, the bill simply directs the Council to advise the Secretary on several issues, including whether the distribution of funds will "promote the health information technology agenda of the Governor."

24. To address the lack of explicit standards and procedures in the bill, the Committee could modify the Governor's recommendations by requiring DHFS to employ a competitive grant



process when awarding any funding for the initiatives envisioned under the bill. In addition, the Committee could require DHFS to promulgate rules that establish criteria that must be applied in that competitive grant process.

25. The Committee could also modify the Governor's proposal by requiring that some or all of the recommended funding be awarded in the form of matching grants or loans, instead of outright grants. According to the Director of the Minnesota Department of Health's Center for Health Informatics, the ehealth funding initiative recently enacted in Minnesota requires that one-half of the funding be awarded in grants that require a 1 to 3 match by the recipient (a match that can be satisfied either by cash or by in-kind contributions), and the other one-half of the funding will be distributed in the form of loans. If the Committee decides to proceed in that fashion, it could require DHFS to promulgate rules that set forth the details of any such matching or loan requirements.

26. With respect to the creation of the Council itself, the Committee also has several options. It could approve the Governor's recommendation to create the Council. The Committee could also decide, however, to not create the Council, in which case current DHFS staff and resources dedicated to health information technology issues could continue to advise the DHFS Secretary with respect to those matters, including the distribution of any funds appropriated to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information.

27. Finally, the Committee could delete the provision in its entirety.

## ALTERNATIVES TO BILL

### A. Funding for ehealth Initiatives

1. Approve the Governor's recommendations to provide \$10,000,000 SEG in 2007-08 and 2008-09 from the HCQF to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information, and to create a continuing appropriation in DHFS for this purpose.

ALT A1	Change to Bill Funding	Change to Base Funding
SEG	\$0	\$20,000,000

2. Modify the Governor's recommendation by providing \$5,000,000 SEG in 2007-08 and 2008-09 from the HCQF to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information.

<b>ALT A2</b>	<b>Change to Bill Funding</b>	<b>Change to Base Funding</b>
SEG	-\$10,000,000	\$10,000,000

3. Modify the Governor's recommendations by providing \$10,000,000 GPR in 2007-08 and 2008-09 to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information.

<b>ALT A3</b>	<b>Change to Bill Funding</b>	<b>Change to Base Funding</b>
GPR	\$20,000,000	\$20,000,000
SEG	<u>- 20,000,000</u>	<u>0</u>
Total	\$0	\$20,000,000

4. Modify the Governor's recommendations by providing \$5,000,000 GPR in 2007-08 and 2008-09 to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information.

<b>ALT A4</b>	<b>Change to Bill Funding</b>	<b>Change to Base Funding</b>
GPR	\$10,000,000	\$10,000,000
SEG	<u>- 20,000,000</u>	<u>0</u>
Total	-\$10,000,000	\$10,000,000

5. In addition to any of the alternatives above, modify the Governor's recommendations by requiring DHFS to use a competitive grant process when awarding funding for initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information, and by requiring DHFS to promulgate rules that establish criteria that must be applied when awarding grants through that competitive process.

6. In addition to any of the alternatives above, modify the Governor's recommendations to specify that all funding provided by DHFS shall require a 25% match requirement for all grant recipients, and require DHFS to promulgate rules with respect to that matching requirement.

7. In addition to any of the alternatives above, modify the Governor's recommendations to specify that all funding provided by DHFS shall be provided in the form of loans, and require DHFS to promulgate rules with respect to those loans.

8. Delete all funding and all provisions related to such funding.

<b>ALT A8</b>	<b>Change to Bill Funding</b>	<b>Change to Base Funding</b>
SEG	- \$20,000,000	\$0

**B. Creation of the Health Care Quality and Patient Safety Council**

1. Approve the Governor's recommendations regarding the creation of the Health Care Quality and Patient Safety Council.

2. Delete the Governor's recommendations regarding the creation of the Health Care Quality and Patient Safety Council.

Prepared by: Eric Peck