Physician Shortage Threatens Patient Access, Quality
WHA Report calls for increases in medical school classes, more in-state residencies

The Wisconsin Hospital Association physician workforce report, “100 New Physicians a Year: An Imperative for Wisconsin,” was publicly released November 29 and received heavy media coverage. (View the report at: www.wha.org/pubarchive/reports/2011physicianreport.pdf.) The report raises concerns that a physician shortage is looming, unless aggressive action is taken now to avert a statewide crisis. The report suggests:

- Increasing the number of slots available in Wisconsin for physicians to complete a medical residency. The best predictor of where a physician will locate a practice is where he or she completes a medical residency. Nearly half of the physicians locate in the same state—often in the same town—where they complete a residency.
- Increasing medical school class size and admitting more in-state students to Wisconsin’s medical schools. If a medical student is in-state and if they complete a residency here, nearly 70 percent stay and practice medicine in Wisconsin.  

Aspirus, WCOM Explore Medical School in Wausau

Aspirus and the Wisconsin College of Osteopathic Medicine (WCOM) are investigating the possibility of developing a medical school in Wausau. Wisconsin currently has two medical schools, the University of Wisconsin School of Medicine and Public Health in Madison and the Medical College of Wisconsin in Milwaukee.

“This is just a preliminary discussion,” said Duane Erwin, president and chief executive officer for Aspirus. “The upside is great, though. A new medical school could help address a looming physician shortage, drive economic activity throughout the region, and increase access to excellent health care.”

WHA issued a report on November 29 on the state’s physician workforce, entitled “100 New Physicians a Year: An Imperative for Wisconsin.” (See related story above.) The report identifies key issues related to the physician shortage and identified strategies that will help avert a major shortfall. The report recommends an increase in the number of students that graduate from medical schools in Wisconsin. It also identifies several options for increasing the number of graduates, which could be accomplished by creating more opportunities for medical students in Wisconsin’s two existing medical schools, and/or by starting a third medical school. The WHA report is intended to facilitate a conversation among stakeholders on the best way to grow Wisconsin’s physician workforce. This dialogue is now taking on greater urgency at many levels throughout the state, and all stakeholders must play a role in achieving measurable progress toward addressing this serious and well-known challenge.

WHA President Steve Brenton described the physician shortage as a “looming crisis” and indicated “If we do nothing, we will not have enough physicians.”
HHS Reiterates Intent to Delay Stage 2 MU Compliance for Some Hospitals

Stage 2 rulemaking also delayed

On November 30, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius reiterated the Department’s intent to delay the proposed start of Stage 2 meaningful use requirements for the Medicare electronic health record (EHR) incentive program until fiscal year (FY) 2014 (October 1, 2013) for hospitals. Stage 2 was scheduled to begin in FY 2013 (October 1, 2012) for those hospitals that received their first Medicare incentive payment in FY 2011. (See www.hhs.gov/news/press/2011pres/11/20111130a.html.)

This announcement mirrored the recommendations of HHS’s Health Information Technology Policy Committee and HHS’s National Coordinator for Health Information Technology made in June to delay compliance with Stage 2 meaningful use by one year. (See www.wha.org/pubArchive/valued_voice/vv6-10-11.htm#12.)

The delay in compliance with Stage 2 meaningful use has become increasingly necessary due to delays in HHS’s rulemaking timeline for Stage 2 meaningful use. It is now anticipated that proposed rules defining Stage 2 meaningful use will not be released until February 2012 with final rules not enacted until mid-2012. Without a delay in compliance with Stage 2 meaningful use, those hospitals that attested to meaningful use in FY 2011 would have only a couple of months to implement the changes to their EHRs necessary to meet the original stage 2 compliance date.

It is important to note, however, that the intended Stage 2 meaningful use compliance delay would only apply to those hospitals that attest to meaningful use in FFY2011. For hospitals that attest to meaningful use in FFY 2012, the timeline for compliance with Stage 2 meaningful use remains October 2013.

The delay in compliance with Stage 2 meaningful use does not affect the 5010 or ICD-10 compliance dates. All covered entities should be preparing for the January 1, 2012 compliance date for the 5010 electronic claim form and the October 1, 2013 compliance date for the ICD-10 coding nomenclature. Penalties for lack of 5010 compliance will not occur until March 31, 2012.

If you have any questions, contact Matthew Stanford at 608-274-1820 or mstanford@wha.org.

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**Updated Medicare Incentive Timelines**

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<th>First Medicare Payment Year</th>
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<tr>
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*Reflects HHS’s intended delay of Stage 2 compliance.*
President’s Column

It’s December, so it Must be Time for Another Physician Payment Crisis

The annual “doctor fix” has become a poster child for just how dysfunctional the federal budgeting process has become. Once again this year, unless federal lawmakers act before the New Year, the nation’s physicians will see their fees for treating Medicare patients slashed—this time by 27 percent. And that from a program that already pays doctors, especially primary care doctors, far less than the cost of providing care.

In Washington it is called “the SGR problem” and it dates back to the 1990s when Congress passed a formula-driven global budget for Medicare physician payment. The complicated formula is breached annually and instead of permanently fixing the problem, Congress patches over the growing mess with one-time money. It’s kind of like filling a pothole—the size of the problem grows until another “fix” is required the next year.

For 2012, a one-year fix will require $22 billion—that’s $22 billion that will either have to be found via new revenue (won’t happen) or via “offsets” (aka cuts) from different expenditure lines. A permanent fix of the SGR would require $300 billion over 10 years.

The conventional wisdom in D.C. is that the 27 percent payment cut will be blocked and a crisis averted. But it is now early December and no clear pathway to resolution of the matter has been identified. The clock is ticking.

So how will the “doc fix” be paid for? Maybe through Medicare provider cuts. At least that’s the disconcerting consensus position among pundits and insiders. One idea would have physician specialists absorb big cuts to partially fund a “fix” that would freeze current payments for primary care docs. Hospital reductions are also on the table, despite the already beleaguered condition of hospital payments that are slated to pay for much of PPACA. It’s not a pretty picture.

One matter not getting much discussion is growing grassroots physician angst about dealing with Medicare. Wisconsin seniors have no idea how difficult it is right now in many parts of the nation to find a primary physician—and it’s not just a supply side issue that’s driving that dynamic—it’s the economics of taking on new Medicare patients.

Washington D.C.-based budget politics, along with a creaky Medicare fee-for-service program may soon lead to a Medicare access crisis. And that could come at the same time millions of newly-covered lives are demanding access. Who will take of these patients?

Steve Brenton
President
Rep. Suder at Ministry St. Joseph’s Hospital (Marshfield)

State Representative Scott Suder (R-Abbotsford) met with senior leaders and toured several areas at Ministry St. Joseph’s Hospital in Marshfield. With the redrawing of the legislative maps for the 2012 elections, the Ministry Saint Joseph’s Hospital campus will be represented in the Assembly by Majority Leader Scott Suder. Hospital leaders welcomed Rep. Suder, whom has visited the campus many times previously.

“For years, Scott has treated the medical campus as a constituent, so it is a comfortable transition for us to prepare for the new legislative boundary,” noted Brian Kief, hospital president.

During his visit, Rep. Suder met with the administrative team at the hospital, viewed the new hyperbaric oxygen chambers and spent time with the nuclear medicine leaders.

Hospital leaders were able to also discuss important hospital issues, including the Medicaid program, during Rep. Suder’s time at the hospital.

Rep. Brooks Visits Reedsburg Area Hospital

Recently State Representative Ed Brooks (R-Reedsburg) stopped by the Reedsburg Area Medical Center (RAMC) for a visit. During his time with staff, Brooks was able to get a better understanding of how legislative or other policy proposals being discussed, such as those to the Medicaid program, will impact his area’s hospitals.

President & CEO Bob Van Meeteren was able to specifically discuss the Medicaid program with Rep. Brooks and explain how issues at both the federal and state levels would impact small, Critical Access Hospitals like RAMC and what that would mean to the community.
ICD-10 Impact on Reimbursement and Hospital Finances, Webinar Dec. 14

It has been predicted that the reimbursement impact of the ICD-10 transition could be as significant as the transition to APCs in 2000. Even though not all the facts and figures are now known, there are ways to examine and predict the financial impact of the ICD-10 transition on your organization.

On December 14, WHA is offering a webinar to focus on the steps your hospital should be taking now, before October 2012, before October 2013, and beyond, to minimize what could otherwise be a significant financial impact to your hospital’s revenue stream.

Attendees will learn what commercial payers are doing to prepare for ICD-10, what changes will occur with Medicare reimbursement, how ICD-10 will impact failed billing, discuss if all payers will be using ICD-10, and how to understand and describe a reimbursement roadmap.

This webinar is part of a four-part webinar series focused on helping hospital executives and their ICD-10 team leaders understand the magnitude of the ICD-10 implementation, the financial and clinical impact of the transition on your organization, and be better prepared for on-time implementation.

The four sessions include:

1. **Budget Development and Budget Review for ICD-10 Readiness**
   An audio recording of this November 16 session is available for purchase.

2. **Understanding Reimbursement Changes and the Financial Impact of the ICD-10 Transition**
   December 14, 2011 ** 12:00 PM – 1:00 PM CST

3. **The Value of Strategic Planning for ICD-10 Readiness**
   January 18, 2012 ** 12:00 PM – 1:00 PM CST

4. **Assessing Your Vendors for ICD-10 Readiness**
   February 15, 2012 ** 12:00 PM – 1:00 PM CST

A team can register for the full four-part webinar series (for a discounted fee) or for individual sessions. An audio recording of each presentation is available to registered attendees at no extra cost, to share at a more convenient time with ICD-10 transition team members who are unable to participate on the scheduled dates. A full brochure describing the four sessions and online registration are available at: [http://events.SignUp4.com/ICD10Impact11-12](http://events.SignUp4.com/ICD10Impact11-12).

Updating Your Chargemaster for 2012 the Focus of December 15 Seminar

Registration is still open for the WHA-sponsored seminar “Getting the Chargemaster Ready for 2012,” scheduled December 15 in Wisconsin Dells. This seminar will focus on the 2012 reporting requirements, as well as CPT and HCPCS coding revisions and additions impacting the Chargemaster.

There are over 500 known CPT changes for 2012, and it is anticipated that CMS will have an equal number of HCPCS changes. As in previous years, nearly every ancillary department of the hospital will be impacted by the coding changes, and this session will focus on the requirements for updating the facility’s Chargemaster and on strategies for educating your department staff.

Chargemaster/APC coordinators, coding staff, office managers, CFOs, and others who are responsible for charge generation processes are encouraged to attend this WHA-sponsored event. A full brochure and online registration are available at [http://events.SignUp4.com/Chargemaster12](http://events.SignUp4.com/Chargemaster12).
Physician Leadership Training Offered March 9-10

Early bird discount now available

The seventh annual “WHA Physician Leadership Development Conference,” is scheduled Friday, March 9 and Saturday, March 10, and registration is now open. This year’s event will again be held at The American Club in Kohler. The full conference brochure, with agenda, registration and resort information, is included in this week’s packet. Online registration is available at http://events.SignUp4.com/12PLD.

A discounted “early bird” registration fee is available to those registering by January 20. Additionally, a “host” registration option is available to those hospital representatives/management leaders who would like to accompany their physicians to the conference but do not need CME credit.

This popular conference offers nationally-recognized faculty to assist in developing physician leadership skills and facilitating the transition of your physicians from clinicians to physician leaders. Physician leaders must represent both clinical and managerial interests, and each year at this event, presenting faculty from the American College of Physician Executives (ACPE) focus on important leadership skills that help physician leaders to move beyond their clinical training and take a new approach to managerial decision-making and problem solving.

ACPE is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. ACPE designates this live activity for a maximum of 12 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

WHA Offers Regional Seminars Focused on Physician Documentation Improvement

Early Bird Discount Available Through December 15

In March 2012, WHA is offering live one-day seminars, in five regional locations, focused on physician documentation improvement for ICD-10. Although there are many areas of preparation important to a successful transition to ICD-10, ensuring detailed physician documentation may be the most vital of them all. Proper physician documentation is critically important because of its direct bearing on a hospital or clinic’s revenue cycle and ability to report quality outcomes appropriately.

Hospital leaders should encourage their physician leaders, physician liaisons, clinic managers, coding supervisors and managers, clinical documentation specialists and other ICD-10 implementation team members to attend one of these regional sessions. Those registering by December 15 will receive an “early bird” discount.

Each session will be identical, so attendees can choose the date and location most convenient for them. Each will be presented by Lynn Kuehn, a Certified Coding Specialist for Physicians (CCS-P) and an AHIMA Certified ICD-10-CM/PCS trainer.

The seminar will be offered in five regional locations across Wisconsin:

- March 13 – Country Springs Hotel, Waukesha
- March 14 – Tundra Lodge, Green Bay
- March 15 – Grand Lodge by Stoney Creek, Wausau
- March 20 – Holiday Inn, Eau Claire
- March 22 – Glacier Canyon Lodge, Wisconsin Dells

Partnering to Strengthen Your Impact

By: Julie Hladky, CHIPP Research and Support Specialist, Wisconsin Association of Local Health Departments and Boards (WALHDAB)

Throughout the continuous process of improving the health of the community, your efforts will be more effective if community members and agencies are actively involved in the process. Partnering or collaboration is an essential element of effective community change.

Why Partner
In order to have an impact on the overall health of the community, it is necessary to take a broad look at the health needs of the community. Engaging a wide variety of stakeholders will result in a more robust and thorough picture of the often complex health needs to be addressed. In addition, stakeholders—both agencies and individuals—bring resources and perspectives to the table that may be critical in ensuring your success in impacting the selected health issues. Finally, full engagement of partners leads to a true sense of shared ownership, which means collaborators are not only share ownership of the process but also the responsibility for addressing the health issues identified.

“Engaging the community will not only improve your assessment and implementation strategies, it can lead to successful collaborations for addressing community health needs. Productive and meaningful community engagement throughout can lead others to take ownership of needs that cannot be addressed by the hospital.” (Catholic Health Association - USA)

Who to Partner With
The current IRS guidelines for Community Health Needs Assessment (CHNA) state that hospitals must take into account input from (at minimum):

- Persons with special knowledge of or expertise in public health
- Federal, tribal, regional, state, or local health or other departments or agencies
- Leaders, representatives or members of medically underserved, low-income, and minority populations

Additional colleagues that would be valuable to include are: education (schools and post-secondary), law enforcement, business representatives, and the faith community. Also consider any organization that has a stake in the top health issues in your community.

Organizations in the community that regularly assess the major health and social needs of the community may want to co-sponsor the CHNA process with you. This collaboration will help to use resources efficiently and speak with one voice as a community. Organizations to consider in this light include: public health departments, United Way, UW-Extension, Community Action Program (CAP) agencies, and federally-qualified health centers (FQHCs).

When to Partner
Key points in the process at which to engage community stakeholders include:

- Before starting the CHNGA – with agencies that are interested in co-sponsoring the efforts
- During the assessment phase – reviewing and prioritizing among the health issues in the community
- In action planning and implementation – depending upon the top priority issues chosen, additional input may be needed to plan effective implementation strategies and leverage appropriate resources.

How to Partner
When organizations form a new collaborative relationship around community health improvement, recommended steps for an effective partnership include:

- Understand each other’s mission and purpose; then create a shared vision and goals.
- Form an organizational structure that will work for your community (ex: steering committee, task force, and implementation teams)
- Determine clear roles and responsibilities and levels of authority (for sponsors and participants)
- Establish protocols for decision making and conflict resolution
- Create a communications plan

(Source: Association for Community Health Improvement) (continued on page 8)
Involving Average Citizens
In addition to organizational representatives, it is valuable to actively engage community members who are themselves, of course, stakeholders in the health of the community. Beyond inviting participation in the formal process, community members can also be included using outreach techniques such as community focus groups and key informant interviews—in assessing top community needs and in designing effective strategies for reaching community members. For more guidance on these techniques, see: [www.health.state.mn.us/communityeng/needs/needs.html](http://www.health.state.mn.us/communityeng/needs/needs.html).

Finding Your Potential CHNA Co-sponsors
- Local United Way: [www.unitedwaywi.org](http://www.unitedwaywi.org)
- Local UW-Extension offices: [www.uwex.edu/about/cooperative.html](http://www.uwex.edu/about/cooperative.html)
- CAP agencies: [www.wiscap.org](http://www.wiscap.org)
- FQHCs: [www.wphca.org/Members-and-Membership/chc-map.html](http://www.wphca.org/Members-and-Membership/chc-map.html)

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- Consideration be given to forgiving medical school tuition expenses and tuition-related debt as an incentive to practice in Wisconsin.
- Improving the coordination of health care delivery across care settings and move toward a multi-disciplinary team approach to ensure that patients have access to the level of care they need, when and where they need it.

Health reform will have a dramatic impact on the physician workforce. The Congressional Budget Office (CBO) estimates that nationally, over 30 million more adults and children will gain access to coverage. Recruitment of physicians from other states, historically a key source for new physicians, will be much more difficult for Wisconsin providers because of the pressure in other states to provide care to more people.

Changes in the way health care is delivered will also be precipitated by health reform as “medical homes” are established to coordinate a patient’s care, which also increase the need for more primary care physicians.

“Health reform has the potential to make it even more difficult for Wisconsin to compete for physicians as all states will find they cannot keep up with their communities demand for medical services,” according to WHA President Steve Brenton. “If we do nothing, we will not have enough physicians.”

The report’s lead author, George Quinn, WHA’s senior policy advisor, said while there is a universal need for more family medicine physicians, there are pockets in Wisconsin where specialists are now in short supply, a condition that will worsen in the future.

“We’ve had a very good recruiting year at Affinity. So, why are we concerned?” said Mark Kehrberg, MD, senior vice president and chief medical officer at Affinity Health System in Menasha. “We were fortunate this year, but that is not always the case. We have had shortages in infectious and pulmonary disease specialists. We are located in the area of Wisconsin with the third largest population, so we need more specialists and primary care physicians to match the needs of our aging population.”

Kehrberg, a member of the WHA Task Force that worked on the report, said, “We have to be precise and recruit the right number of physicians in the right specialties to the right locations. We can’t afford to get it wrong because a full 15-20 percent of those physicians are needed in rural areas. We must start planning now and continue our efforts well into the future.”

(continued on page 9)
Charles Shabino, MD, WHA senior medical advisor, said Wisconsin’s two medical schools—the University of Wisconsin School of Medicine and Public Health (UWSMPH) and the Medical College of Wisconsin (MCW)—educate and graduate 340 medical students each year. Only 36-40 percent of those graduates stay in Wisconsin.

“We need to bring in about 900 new doctors a year, and now we’re only getting about 150 of those from our own medical schools,” according to Shabino. “We currently import 720 out-of-state physicians each year. The good news is we have been relatively successful at doing that. The bad news is, going forward, the demand for physicians nationally is going to hurt our ability to recruit.”

The report cautions that unless Wisconsin is able to recruit 100 more physicians, over and above the number of physicians that are currently coming into or staying in the state after completing a residency, Wisconsin will quickly fall behind. If that happens, the wait to see a physician could be longer in all areas of the state, but rural settings and inner city Milwaukee will be hardest hit.

**Rural, Inner City Areas Most at Risk**

St. Clare Hospital in Baraboo runs a family practice rural residency program. Their experience has shown that this model is successful in keeping physicians in rural communities.

“I like to live ‘rural’ and so I think it is important that we have someone to take care of the people in our communities. The workforce shortage is magnified for the rural and inner city areas of the state,” according to St. Clare President Sandy Anderson. “Thanks to our commitment to our rural residency program, 84 percent of the physicians who complete a residency with us stay in the Baraboo area.”

“Wisconsin is a national leader in many aspects of health care,” Anderson said. “It is time for us to step up and be a leader in the education and training of our future physicians.”

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Pregnant, unemployed and homeless
Sarah learned the meaning of a true friend – someone who is there for you during hard times.

Sarah’s friend, a hospital patient, met with a financial counselor at the Aurora West Allis Medical Center, asking for advice and to advocate for Sarah, a woman she befriended who was in severe distress. Sarah was homeless, pregnant and unemployed, with no resources to pay her living expenses. The hospital patient explained that she took Sarah in and that Sarah pays her back by house cleaning and helping out when she can.

The hospital patient then told the financial counselor that she was worried because Sarah had no prenatal care, was older and high risk, and had been having “a lot of pain in her stomach.” The financial counselor’s immediate reaction was to send Sarah to the Emergency Department. But Sarah, who was in the lobby waiting area, refused to do so because she did not have insurance and said she needed to wait until she had financial support.

The financial counselor helped Sarah submit an application to the Aurora Helping Hand financial assistance program and got temporary assistance for Sarah until a more permanent program such as BadgerCare could kick in. With that, Sarah was able to see a doctor within two days.

The friend and Sarah, now also a patient, returned to thank the financial counseling staff. One of the financial counselors said, “I was given a card that was beautiful and heartfelt. It was so touching, and it made me excited for the next patient to come along, so we can continue to help one another.”

Aurora West Allis Medical Center

B-r-e-a-t-h-e
Chronic obstruction airway disease (COAD) is a pair of commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air both to and from the lungs, causing shortness of breath. It could be fatal if left untreated.

A 60-year-old female Green Bay resident came in the Emergency Department at the Aurora BayCare Medical Center for COAD. She was uninsured, unemployed and received Social Supplemental Income (SSI) for disability. She had recently lost her Medicaid coverage due to issues that can be characterized as “red tape.”

The financial counselor met with the patient and provided her with the Aurora Helping Hand financial assistance program application. Due to the severity of her medical condition, within days the patient was approved for a 100 percent discount. The patient was able to stay in the hospital and breathe easier without having to worry about medical bills, on top of her other financial challenges.

Aurora BayCare Medical Center, Green Bay
**Helping others to help themselves**

Paul is a married man and holds down two part-time jobs trying to make ends meet for his wife and himself. His wife is disabled, receives a Social Security income, and is on Medicare. Paul’s jobs do not offer health insurance benefits to part-time employees so he is without any insurance benefits.

Paul has been ill for quite some time and is now suffering from end stage renal disease. He was recently approved to receive Part B Medicare but does not receive Social Security income. Paul is a proud man and tried to pay the bills for services prior to his Medicare eligibility himself; however, these bills were out of reach on his family’s modest income. Holy Family Memorial’s Community Care assistance was able to help Paul with his medical debt, prior to being eligible for Medicare, enabling him to concentrate on getting well. He is paying his Part B Medicare monthly premiums with his modest income thereby maintaining his Medicare Part B coverage.

**Holy Family Memorial Hospital, Manitowoc**

**A disabled tribal veteran**

A 47-year-old U.S. Army disabled tribal veteran, who is self-employed as a mechanic and earns $450 per month, came into the Aurora Medical Center of Manitowoc County Emergency Department (ED) for a gastrointestinal blockage. It was determined that he needed surgery. He met with a financial counselor to discuss payment options. Upon full evaluation, the patient qualified for a 100 percent discount through the Aurora Helping Hand financial assistance program, relieving this gentleman of more than $15,000 worth of medical bills and allowing him to seek regular treatment with a pathologist and follow-up outpatient testing.

**Aurora Medical Center in Two Rivers**

**With hope there is help**

His hands were sweaty and shaking as he tried to figure out what to do when his girlfriend told him he was going to be a father. How would he support his baby when he has his own medical problems to take care of?

These thoughts were haunting a 21-year-old Milwaukee male patient at Aurora St. Luke’s Medical Center who came to the Emergency Department for help to “man up” to his responsibilities. He had health issues related to substance abuse, and it was quickly apparent he needed to be hospitalized. Unemployed and without income, he was not eligible to apply for BadgerCare coverage until the child is born. Meanwhile, his mother provided financial support, room and board to him.

The patient and his family were given the Aurora Helping Hand financial assistance application, which they were able to complete and return quickly – and gratefully.

On the ninth day of his hospitalization, a financial counselor who worked with patient was notified by an RN Case Manager that he would need antibiotic treatment for several weeks after discharge to recover completely. The doctor was ready to discharge the patient, but would not do so until he could be certain the patient was eligible for Aurora’s Helping Hand financial assistance program. Despite a heavy volume of Helping Hand applications, and due to the severity of his condition, his application was expedited and the young man was approved for 100 percent assistance for his inpatient stay and follow-up medications.

**Aurora St. Luke’s Medical Center, Milwaukee**

Submit community benefit stories to Mary Kay Grasmick, editor, at mgrasmick@wha.org.