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EDUCATIONAL EVENTS

July 21, 2020
The Surprisingly Robust Science of Self Compassion with Dr. Carrie Adair
Webinar

July 22, 2020
Being Present: The Science of Mindfulness
Webinar

New Analysis Finds Fundamental Flaws with Study on "Physician Value"

In a newly released white paper, Benefit Services Group, Analytics (BSGA) cautions that using incomplete data to rank physicians, as was done in a study released last December, is unlikely to improve health care delivery but could lead to unnecessary market disruption and undermine other, more credible efforts to identify best practices.

The original study was conducted by GNS Healthcare and funded by the Business Health Care Group (BHCG) and the Greater Milwaukee Business Foundation on Health. It used data from the Wisconsin Health information Organization (WHIO). In a webinar on June 17, BHCG again touted the results of the study, indicating they could be used to steer patients to specific providers, including "naming names" of providers listed in the study.

"Physicians support using robust data to evaluate and improve care delivery; health systems do that every day," WHA Chief Medical Officer Mark Kaufman, M.D. said. "While the study's intention to improve performance is laudable, unfortunately the study lacks the appropriate scientific rigor needed to be of much use in driving improvement."

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COVID-19: State Medicaid Enrollment Rising; Similar National Trend

WHA's Borgerding addresses payer mix challenges on WisBusiness podcast

The COVID-19 pandemic and the economic toll it has taken on the nation's and state's economy is likely an important factor behind a recent increase in the number of citizens enrolled in the state's Medicaid programs. Wisconsin Medicaid enrollment numbers have grown since the pandemic first took major effect in March 2020, with overall enrollment increasing by nearly 72,000 people from March to May. The largest increase was in the BadgerCare Plus program, with about 65,000 added to the rolls. This program includes children, pregnant women, parents/caretakers and childless adults.

WHA President and CEO Eric Borgerding discussed the challenges hospitals and health systems face under these "payer-mix" changes in this WisBusiness: The Podcast episode, first aired on June 19. Borgerding calls the COVID-19 pandemic "a one-two punch on health care right now," with hospitals first suffering significant revenue difficulties due to following federal directives to eliminate all non-emergency services and procedures in preparation for a possible COVID-19 case surge, and now facing further challenges as patients may move from employer-sponsored insurance to Medicaid or be uninsured altogether.

"As the general economy suffers and people lose their jobs and maybe lose their health insurance, or they transition onto a state government health care program like Medicaid where reimbursement for health care is far below the actual cost to provide

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(COVID-19: State Medicaid Enrollment Rising; Similar National Trend . . . Continued from page 1)

health care – that creates another financial pressure," Borgerding says on the podcast. "Payer mix is changing – it's shifting from commercial health insurance to either no insurance or government programs like Medicaid. Just at a time when health care is still reeling from the financial impacts of shutting down services during COVID, there's going to be this trailing financial impact."

As this story from the Pew Charitable Trusts points out, similar increases are occurring in Medicaid programs across the country. While Wisconsin's uninsured rate has historically been low – dropping from 11.3% in 2013 to 5.5% in 2018, which is the latest official data available – numerous studies examining the pandemic's potential effect on health insurance coverage consistently indicate that higher unemployment rates likely lead to increases in both Medicaid enrollments and in the number of uninsured. Various studies include research from the Advisory Board, a health policy brief from the Robert Wood Johnson Foundation and the Urban Institute, and an early April 2020 report from Health Management Associates.

Marshfield Clinic Health System Receives WHA's 2020 *Advocacy All-Star Award*

The Marshfield Clinic Health System is the Wisconsin Hospital Association's 2020 *Advocacy All-Star Award* recipient – the most prestigious member advocacy honor WHA bestows. The annual award is for demonstrating exceptional dedication to grassroots advocacy in partnership with WHA. While the award is usually presented at WHA's Advocacy Day in front of more than 1,000 hospital and health system advocates, the COVID-19 pandemic resulted in the award being presented virtually on June 23.

"This really is a gratifying award to receive because of how much work our health system puts into advocacy, and how important those efforts are to our organization – but also to rural health, particularly," Marshfield Clinic Health System CEO Susan Turney, M.D. said when accepting the award on behalf of her system. "Now more than ever we see the essential role of government and how it plays such a big impact in health care, and we need a seat at the table. And we DO have that by working with WHA – you help us advance our message every day.

"So we are proud to be a member," Dr. Turney said. "And we are also very fortunate to work with such a strong, such an effective advocacy organization."

In presenting the award, WHA President and CEO Eric Borgerding cited Marshfield Clinic's long list of grassroots and policy development efforts in the past year. From providing key telehealth information to a packed State Capitol hearing room filled with legislators and staff that helped spur bipartisan passage of important telehealth state law improvements, to regular participation in WHA's HEAT roundtable events with local legislators, Marshfield Clinic is "always willing to collaborate with other WHA members and staff to move our collective advocacy agenda forward," Borgerding said.

Presentation of WHA's 2020 Advocacy All-Star Award

"The great partnership between WHA and Marshfield Clinic Health System is not just on behalf of our two organizations," Borgerding said, "but truly a partnership that speaks for and represents all of Wisconsin's hospitals and health systems. For that, all of our members are grateful for the work that you've done."

The system is heavily involved in various WHA workgroups and councils that help advance sound health care public policy, including the Public Policy Council, Physician Leaders Council and WHA's Medicaid, telehealth and post-acute care work groups. Dr. Turney also serves on the WHA Board of Directors, which helps shape WHA's advocacy goals throughout the year.

"At Marshfield Clinic Health System, we have really made concerted efforts over the past several years to build our advocacy efforts in government relations," Dr. Turney said. "We are desperate for policies that can make delivering high-quality care in small communities sustainable. And I know that the effective advocacy efforts that you all have made will continue to create meaningful progress.

"I really want to thank you on behalf of Marshfield Clinic Health System – I'm honored to accept this award for the team," Dr. Turney said.

You can view the award presentation here.

Wisconsin Hospitals State PAC & Conduit Surpasses 100 Contributors

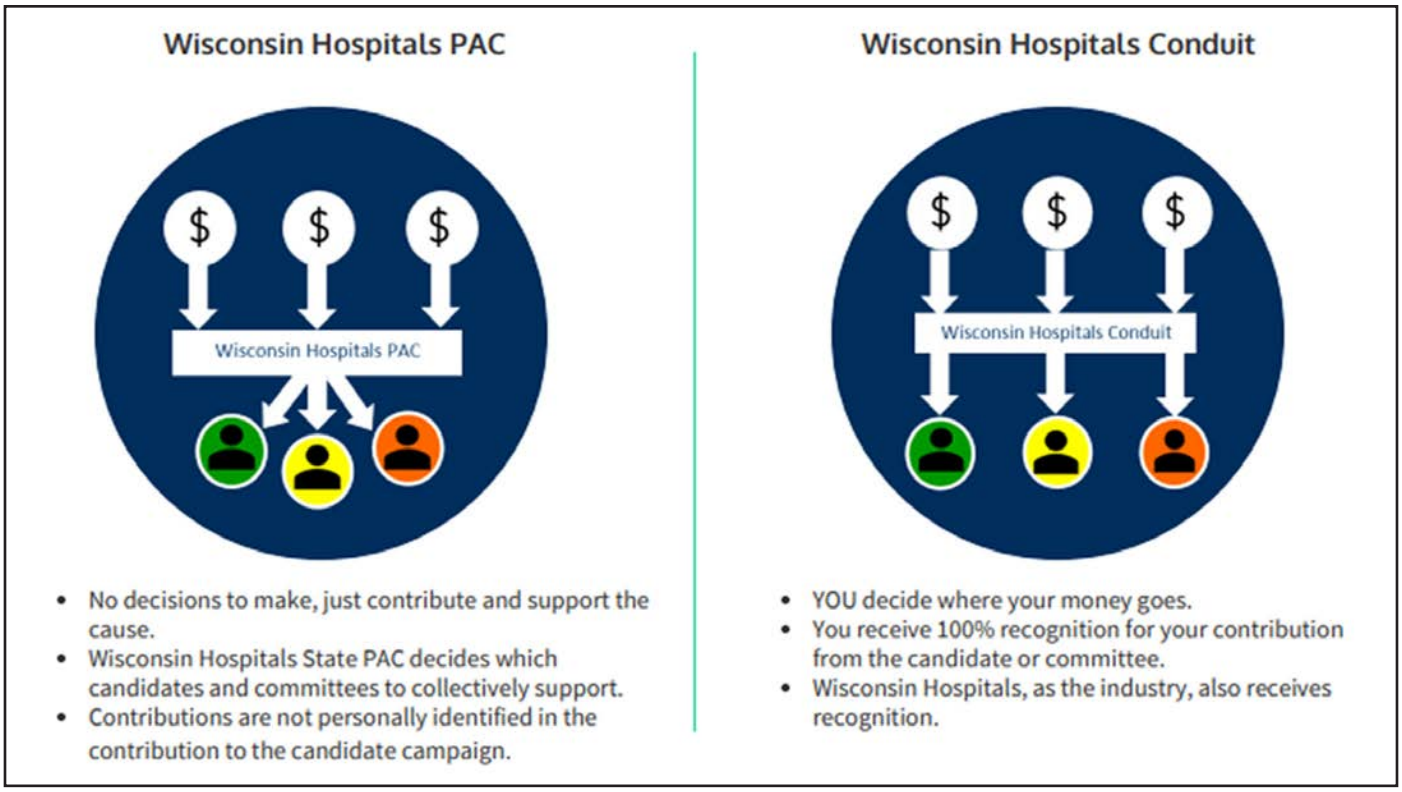
See the 2020 Contributor List

Wisconsin Hospitals State PAC & Conduit continues its fundraising campaign as the summer political season officially kicks off. As of June 25, the Wisconsin Hospitals State PAC & Conduit has raised $159,019 from 101 individuals. That is an average of over $6,116 contributed each week with an average contribution per individual of $1,574.

The Wisconsin Hospitals State PAC & Conduit supports candidates who understand the important role Wisconsin hospitals and health systems have, both as leaders in care delivery and as essential employers within the communities they serve.

"Joining together and contributing to candidates through the Wisconsin Hospitals State PAC & Conduit shows strong grassroots unity," WHA Vice President of Advocacy Kari Hofer said. "Contributors giving through the PAC, Conduit or both programs amplify hospitals' voices during this important election season."

Supporters of the Wisconsin Hospitals State PAC & Conduit 2020 campaign can contribute to the PAC, the Conduit or both online here.



See the full 2020 Contributor list on page 10 to see who made the list.

To make sure your name is on future contributor lists, make your personal contribution today at www.whconduit.com or by contacting Kari Hofer at 608-268-1816 or Nora Statsick at 608-239-4535.

Reminder: June 30 Disbursement Deadline

Individuals who participate in the Wisconsin Hospitals Conduit, where funds are directed to the candidates of the individual's choosing, are reminded of an important June 30 fundraising deadline for political campaigns. The June 30 deadline is a reporting deadline and an early show of support for candidates.

As individuals receive requests for campaign support from candidates for state office, remember your Wisconsin Hospitals Conduit funds can be used when making a contribution. To check your conduit balance or inquire about contribution opportunities, contact Nora Statsick at 608-239-4535.

WHA 2020 Nominating Awards Committee Seeking Nominations

Nominations are now being accepted for WHA's annual Distinguished Service Award and Trustee Award. These important awards recognize those who display leadership, dedication and professionalism to their community or the Association.

You may know someone in your region, in your hospital or on your board of directors who deserves such an honor. You now have an opportunity to nominate them for one of these annual awards:

- **Distinguished Service Award** – presented to a senior health care executive who has made an exemplary commitment to WHA, his/her hospital, and the communities he/she serves.
- **Trustee Award** – honors a trustee of a WHA member organization who has made an exemplary commitment to his/her community and to the organization on whose board he/she serves.

Administrators, trustees, senior managers, nurse leaders, volunteers and others are encouraged to review the criteria for the awards and consider nominating someone to receive one of these honors. Information on these two awards can be found on the WHA website.

The Nominating Committee will also make recommendations on new WHA Board members. WHA members interested in being considered for, or wish to submit a candidate for, an At-Large WHA Board seat or the Chair-Elect position should contact WHA President Eric Borgerding.

Please submit nominations for both the awards and WHA Board of Directors no later than Thursday, August 20.

WHA Telemedicine Work Group Reviews Policy and Reimbursement Changes, Discusses Policy Agenda

The COVID-19 pandemic spurred rapid implementation of major reimbursement changes for telehealth services, responding to the need to provide patients with services other than traditional face-to-face care. In what would normally take months or even years, changes in Medicare and Medicaid coverage and reimbursement were accomplished in a matter of weeks. At its virtual meeting on June 22, WHA's Telemedicine Work Group discussed the impact these changes have had on patient care, and patient and provider satisfaction with telehealth as a mode of providing health care. The work group also discussed the need to push for making many of these changes permanent.

Work group members reported that since the expansion of telehealth, patient satisfaction scores are some of the highest they have ever seen. Provider satisfaction with telehealth is also very high. Some providers report that patients feel more comfortable receiving health care in their home environment, which increases the patient's openness with their providers. This is especially true for patients receiving behavioral health services.

Another major advantage is patient convenience. Patients who face transportation barriers can more easily access health care services via telehealth. Telehealth services also eliminate inconveniences children with special needs experience, as they often travel to a clinic in special vehicles or with durable medical equipment. Patients who live in areas with poor broadband coverage have gained better access to health care due to reimbursement of audio-only health care services.

Key advocacy focus areas for WHA will include working with the state's Department of Health Services as it begins the process of drafting administrative rules outlining Medicaid coverage of telehealth, as authorized in 2019 Wisconsin Act 56, a WHA-backed law that expanded Medicaid coverage for telehealth. On the federal level, in light of CMS Administrator Seema Verma's recent statement that she "can't imagine going back" to pre-COVID Medicare telehealth coverage, WHA will be working closely with Wisconsin's congressional delegation to advocate for the necessary legislative and regulatory changes to make these policies permanent.

The Telemedicine Work Group will meet again in August. For further information on the work group, contact WHA's Laura Rose, Jon Hoelter, or Matthew Stanford.

WHA Expresses Strong Support to Wisconsin Congressional Delegation for Extending Telehealth Flexibilities

WHA President and CEO Eric Borgerding expressed WHA's strong support of extending key federal telehealth flexibilities under Medicare in a June 25 letter to Wisconsin's congressional delegation.

While the Trump administration is expected to extend emergency declarations to allow the expanded use of telehealth, there remains uncertainty as to how long these flexibilities will last and whether they may go away after emergency declarations expire. Borgerding noted that among the chief provisions in need of permanent extensions are the elimination of geographic and site restrictions.

"This pandemic has been a proof of concept of sorts as it has allowed us to unleash telehealth's true potential by allowing health care professionals to reach patients in their own home, regardless of whether they are in a rural or urban area," Borgerding said. "We have numerous stories of how this has at times led to even more successful encounters than prior in-person visits."

The letter further lists a number of additional priorities from members of WHA's Telemedicine Work Group, which has spent the last four years exploring how telehealth can improve access, enhance outcomes and reduce costs in health care. Among the additional recommendations: asking Congress and HHS to maintain the expanded list of services covered under Medicare, preserving the expanded list of additional practitioners able to provide those services, and continuing the additional allowable sites of Rural Health Centers and Federally Qualified Health Centers that help expand care to rural and underserved communities.

While acknowledging that audio-only telehealth may not be appropriate in all circumstances, Borgerding cautioned Congress and the Trump administration against arbitrarily restricting audio-only services. He noted reports from WHA's Telemedicine Work Group members that many areas of the state do not have proper broadband infrastructure to support video services, that some patients may lack the technology or know-how to handle video platforms, and that some patient visits have been more successful via audio as those patients have been more at ease on the phone rather than a video chat. Borgerding also encouraged telehealth to be treated the same as in-person services under Medicare, encouraging the federal government to continue paying the same rate for telehealth as it pays for in-person services, and noting that Wisconsin Medicare providers typically already are reimbursed at only 73% of what it costs them to treat Medicare patients.

WHA also encouraged Congress to work with commercial health plans to explore ways to maintain commercial coverage of telehealth, noting that Wisconsin hospitals and health systems are reporting uncertainty about whether commercial plans will cease existing coverage of many telehealth services once the public health emergency ends. Reimbursement under commercial plans has helped make certain telehealth services financially viable that otherwise may not have been if covered only under Medicare and Medicaid.

For more information, contact WHA Director of Federal & State Relations Jon Hoelter.

AHA to Appeal Decision Upholding Hospital Price Disclosure Rulemaking

A federal judge in the U.S. District Court for the District of Columbia on June 23 dismissed a lawsuit brought by the American Hospital Association (AHA) seeking to overturn an HHS rule mandating that hospitals publish their privately negotiated prices with commercial health insurers beginning on January 1, 2021. AHA plans to appeal the judge's decision on an expedited basis.

AHA's lawsuit was supported by amicus briefs from 37 state hospital associations, including WHA, as well as the U.S. Chamber of Commerce (see March 5, 2020 *The Valued Voice*). Together, all argued to the District Court that the rule exceeds CMS' rulemaking authority, is excessively onerous and burdensome, and will not achieve the stated purpose of the rule.

"The rule imposes these burdens for no useful reason; the disclosures will neither provide patients with any useful information nor serve CMS' purpose of lowering heath care costs," stated the U.S. Chamber of Commerce in its brief to the court. "Rather than imposing these burdens on hospitals, CMS would have better served its interests if it had instead promoted private-sector solutions for the price transparency issue."

"We are disappointed in today's decision in favor of the administration's flawed proposal to mandate disclosure of privately negotiated rates," AHA General Counsel Melinda Hatton said. "The proposal does nothing to help patients understand their

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(AHA to Appeal Decision Upholding Hospital Price Disclosure Rulemaking . . . continued from page 5)

out-of-pocket costs. It also imposes significant burdens on hospitals at a time when resources are stretched thin and need to be devoted to patient care. Hospitals and health systems have consistently supported efforts to provide patients with information about the costs of their medical care. This is not the right way to achieve this important goal.

"Today's decision was also premised on the erroneous conclusion that the 'standard charges' referenced in current [statute] can be interpreted to include rates negotiated with third-party payers," Hatton said. "While the Court ruled that this was a close call, that conclusion clearly does not reflect the experience of hospitals and health care systems."

As a result of the judge's ruling, the effective date of the rule requiring hospitals to publish their negotiated prices currently remains January 1, 2021. AHA has said it will appeal the decision to the D.C. Circuit Court of Appeals and is expected to seek a temporary injunction delaying the January 2021 effective date pending the appeal.

Contact WHA General Counsel Matthew Stanford if you have any questions regarding this litigation and the rule.

CMS Announces New Office Focused on Reducing Regulatory Burden

The U.S. Centers for Medicare & Medicaid Services (CMS) announced on June 23 the creation of a new Office of Burden Reduction and Health Informatics, with a stated goal to "permanently embed a culture of burden reduction across all platforms of CMS agency operations."

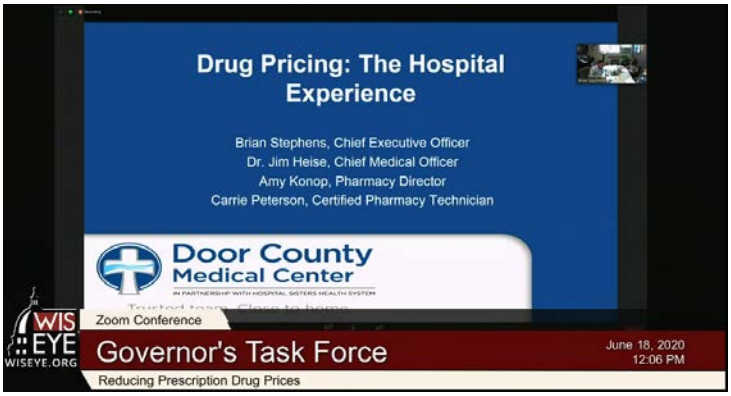
"The Office of Burden Reduction and Health Informatics will ensure the agency's commitment to reduce administrative costs and enact meaningful and lasting change in our nation's health care system," said CMS Administrator Seema Verma. "Specifically, the work of this new office will be targeted to help reduce unnecessary burden, increase efficiencies, continue administrative simplification, increase the use of health informatics, and improve the beneficiary experience."

Last year, WHA recommended several reforms to the U.S. Department of Health & Human Services (HHS) to reduce electronic health record (EHR) documentation burdens as HHS developed a strategic plan to reduce regulatory and administrative burden relating to the use of health IT and EHRs. In February, HHS released the final version of its *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*. CMS' June 23 announcement builds upon some of the recommendations in its February strategic plan.

According to CMS' press release, following the 2017 launch of its Patients over Paperwork Initiative focused on reducing unnecessary regulatory burden on health care providers, CMS' burden reduction efforts are expected to save providers and clinicians $6.6 billion and 42 million unnecessary burden hours through 2021.

CMS states the new Office of Burden Reduction and Health Informatics will "take a proactive approach to reducing burden, carefully considering the impact of new regulations on health care system operations," and will "work with the broader health care community to continue to make key administrative processes increasingly more efficient."

Hospital Drug Price Increases Addressed at Governor's Task Force on Reducing Prescription Drug Prices



The Governor's Task Force on Reducing Prescription Drug Prices met virtually June 18, hearing from both the American Hospital Association (AHA) and Door County Medical Center. In January 2019, the American Hospital Association issued a report, "Recent Trends in Hospital Drug Spending and Manufacturer Shortages." Mark Howell and Aaron Wosolewski of AHA presented the highlights of the report to the task force along with several recommendations to impact the high cost of pharmaceuticals. The 2019 report updates a 2016 report which was prepared for AHA by the National Opinion Research Center at the University of Chicago, which found

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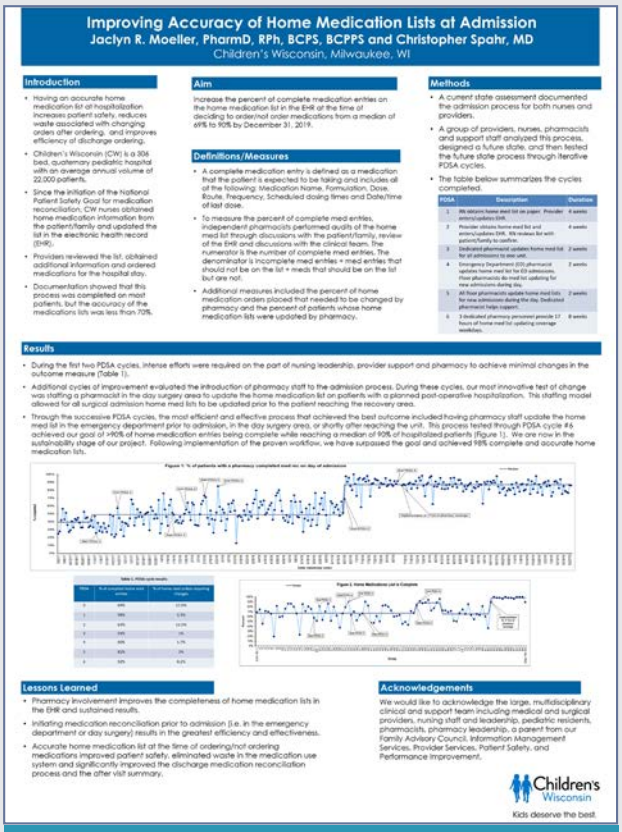
Member Quality Spotlight: Children's Wisconsin

Promoting medication safety

Special Note: Many WHA members proud of their quality improvement efforts had prepared special poster presentations that were to be displayed in the Capitol Rotunda during WHA's Advocacy Day 2020, which was cancelled due to the COVID-19 pandemic. WHA is pleased to highlight these efforts in today's and future editions of The Valued Voice.



Improving Accuracy of Home Medication Lists at Admission

Jaclyn R. Moeller, PharmD, RPh, BCPS, BCPPS and Christopher Spahr, MD

Children's Wisconsin, Milwaukee, WI

Introduction

- Having an accurate home medication list at hospitalization increases patient safety, reduces waste associated with changing orders after ordering, and improves efficiency of discharge ordering.
- Children's Wisconsin (CW) is a 306 bed, quaternary pediatric hospital with an average annual volume of 22,000 patients.
- Since the initiation of the National Patient Safety Goal for medication reconciliation, CW nurses obtained home medication information from the patient/family and updated the list in the electronic health record (EHR).
- Providers reviewed the list, obtained additional information and ordered medications for the hospital stay.
- Documentation showed that this process was completed on most patients, but the accuracy of the medications lists was less than 70%.

Aim

Increase the percent of complete medication entries on the home medication list in the EHR at the time of deciding to order/not order medications from a median of 69% to 90% by December 31, 2019.

Definitions/Measures

- A complete medication entry is defined as a medication that the patient is expected to be taking and includes all of the following: Medication Name, Formulation, Dose, Route, Frequency, Scheduled dosing times and Date/time of last dose.
- To measure the percent of complete med entries, independent pharmacists performed audits of the home med list through discussions with the patient/family, review of the EHR and discussions with the clinical team. The numerator is the number of complete med entries. The denominator is incomplete med entries + med entries that should not be on the list + meds that should be on the list but are not.
- Additional measures included the percent of home medication orders placed that needed to be changed by pharmacy and the percent of patients whose home medication lists were updated by pharmacy.

Methods

- A current state assessment documented the admission process for both nurses and providers.
- A group of providers, nurses, pharmacists and support staff analyzed this process, designed a future state, and then tested the future state process through iterative PDSA cycles.
- The table below summarizes the cycles completed.

PDSA	Description	Duration
1	We obtains home med list on paper. Provider enters/updates EHR.	4 weeks
2	Provider obtains home med list and enters/updates EHR. We review list with patient/family to confirm.	4 weeks
3	Dedicated pharmacist updates home med list for all admissions to one unit.	2 weeks
4	Emergency Department (ED) pharmacist updates home med list for ED admissions. Floor pharmacists do med list updating for new admissions during day.	2 weeks
5	All floor pharmacists update home med lists for new admissions during the day. Dedicated pharmacist helps support.	2 weeks
6	1 dedicated pharmacy personnel provide 17 hours of home med list updating coverage weekdays.	8 weeks

Results

- During the first two PDSA cycles, intense efforts were required on the part of nursing leadership, provider support and pharmacy to achieve minimal changes in the outcome measure (Table 1).
- Additional cycles of improvement evaluated the introduction of pharmacy staff to the admission process. During these cycles, our most innovative test of change was staffing a pharmacist in the day surgery area to update the home medication list on patients with a planned post-operative hospitalization. This staffing model allowed for all surgical admission home med lists to be updated prior to the patient reaching the recovery area.
- Through the successive PDSA cycles, the most efficient and effective process that achieved the best outcome included having pharmacy staff update the home med list in the emergency department prior to admission, in the day surgery area, or shortly after reaching the unit. This process tested through PDSA cycle #6 achieved our goal of >90% of home medication entries being complete while reaching a median of 90% of hospitalized patients (Figure 1). We are now in the sustainability stage of our project. Following implementation of the proven workflow, we have surpassed the goal and achieved 98% complete and accurate home medication lists.

Figure 1. % of patients with a pharmacy completed med rec on day of admission

Table 1. PDSA cycle results

PDSA	% of complete home med entries	% of home med entries requiring changes
0	69%	31.0%
1	78%	0.3%
2	84%	11.0%
3	94%	1%
4	95%	1.7%
5	92%	0%
6	98%	0.2%

Figure 2. Home Medications List is Complete

Lessons Learned

- Pharmacy involvement improves the completeness of home medication lists in the EHR and sustained results.
- Initiating medication reconciliation prior to admission (i.e. in the emergency department or day surgery) results in the greatest efficiency and effectiveness.
- Accurate home medication list at the time of ordering/not ordering medications improved patient safety, eliminated waste in the medication use system and significantly improved the discharge medication reconciliation process and the after visit summary.

Acknowledgements

We would like to acknowledge the large, multidisciplinary clinical and support team including medical and surgical providers, nursing staff and leadership, pediatric residents, pharmacists, pharmacy leadership, a parent from our Family Advisory Council, Information Management Services, Provider Services, Patient Safety, and Performance Improvement.

Children's Wisconsin

Kids deserve the best.

Click on image to enlarge this poster presentation

Accurate medication information is essential to providing safe and effective care. It can be challenging to determine what medications a patient takes at home and ensure an up-to-date list is kept in the electronic health record. Hospitals have integrated pharmacy into the admission medication reconciliation process in emergency department and preoperative phone calls. A comprehensive approach for all hospitalizations is often lacking. Limited literature is available regarding solutions for ambulatory clinics.

A large multidisciplinary clinical and support team was involved in this project, including medical and surgical providers, nursing staff, pediatric residents, pharmacists, pharmacy leadership, a parent, Information Management Systems, Provider Services, Patient Safety and Performance Improvement.

Pharmacy was integrated into the admission medication reconciliation process by completing medication histories on patients being hospitalized through the emergency room or pre-operative areas and throughout the hospital to reach the remaining patients. Pharmacy completes medication histories on >90% of all hospitalized patients resulting in the home medication list being 98% accurate. This change also resulted in a 98.5% reduction in the number of hospital home medication orders requiring interventions, 90% of discharge medication lists being accurate, and 90% of after-visit summaries being clear and without confusing information.

In the ambulatory clinics, targeted one-on-one training/coaching for RNs and MAs resulted in 80% of patients having all the medications listed on the home medication list and 90% of the medications managed by the clinic being complete and accurate. Children's Wisconsin is currently going systematically through each of the ambulatory clinics to provide the training/coaching.

Reaction from Local State Legislators:

Sen. Dale Kooyenga

"Children's Wisconsin has demonstrated another successful way that team-based care can be deployed to tackle the challenge of medication safety. It is a tribute to the culture of collaboration that Wisconsin's high-quality health care is known for, ensuring Wisconsin can maintain our ranking as one of the best states in the country to receive health care."

– State Senator Dale Kooyenga (R-Brookfield)

Have You Seen These New Titles on the WHA On-demand Learning Center?

WHA's On-demand Learning Center has some new learning opportunities for you! Some new titles are:

- Insights from the Frontlines: Caring for the Caregiver During COVID-19
- Resiliency Series: Psychological Safety – The Predictive Power of Feeling Supported When Things Go Wrong
- Will There be a Doctor in the House? Physician Supply, Demand and Staffing During and Post-COVID-19

The On-demand Learning Center offers timely, relevant, informative and educational learning that is available to you 24/7. You can access it whenever and from wherever you choose. If you have questions about the On-demand Learning Center, please direct them to WHA's Education department at education@wha.org.

Don't Miss These Live Webinars in July! Register Today

Does Your Strategy Pass the Stress Test? July 9/1-2 p.m.
Hospitals have long been known for their strength and stability as pillars of our communities. In times of tremendous change, this strength takes on a whole new meaning, especially when it comes to getting the "right" things done. Is your strategy stress proof? Are you laser-focused on the right things for communities, patients, employees and others? This session will assist you in taking a closer look at your strategy to identify the critical few priorities for a stress-proof approach. **Intended Audience:** All in a leadership position, including Board of Directors.

The Calm Person in the Boat: Leveraging Emotional Intelligence during COVID-19 July 23/1-2 p.m.
Fear can get in the way of our ability to think clearly, make good decisions and work effectively as a team. And yet this is exactly what we need to do right now to successfully navigate this crisis. Your team requires emotional intelligence-based tools to manage their brains and behavior under pressure so they can remain calm and form the kind of response your organization needs today. **Intended Audience:** All management staff, including human resources.

Will There be a Doctor in the House? Physician Supply, Demand and Staffing in the Era of COVID-19 July 28/1-2 p.m.
The COVID-19 pandemic has profoundly altered the health care industry and virtually every other aspect of the economy and of life in the United States. And yet, many of the underlying dynamics fundamental to health care remain. One of these is the time-honored fact that health care is provided by people, for people. The emergence of COVID-19 has not altered this fact, it has only made it more apparent. In this presentation, executives with the nation's leading physician search and consulting firm review the emerging methods that hospitals, medical groups and other health care facilities are using to retain and recruit medical staff during the COVID-19 pandemic. The program includes original data from a physician survey conducted by Merritt Hawkins in collaboration with The Physicians Foundation that tracks how physicians are being affected by and are responding to COVID-19. **Intended Audience:** Hospital CEOs, CFOs, medical directors, physicians, recruiters, medical liaison officers and trustees

For questions on these or any of WHA's educational offerings, contact us at education@wha.org.

(New Analysis Finds Fundamental Flaws with Study on "Physician Value" . . . continued from page 1)

BSGA found several shortcomings in the study, including that it used only one year's worth of data, which BSGA indicates is too short for credible analysis as most analyses use three to five years' worth of claims data. The study excludes half of the state's primary care providers, especially new physicians who have received the most current training from medical schools. The study also excludes 90% of the medical utilization provided by health systems.

Importantly, Wisconsin is unique in that much of the care in the state is provided through integrated systems. This means that the primary care physician is part of an overall team that helps manage care for a patient. In ignoring that, the study could result in worse outcomes, fragmented care, and have the exact opposite effect of what is intended.

The BSGA white paper was partially funded by the Healthy Wisconsin Alliance, Inc., an advocacy organization that informs the public about health care issues, attitudes and trends in Wisconsin and is affiliated with the Wisconsin Hospital Association.

If you have any questions, contact Dr. Kaufman or WHA Senior Vice President of Public Policy Joanne Alig.

1965 – Medicare and Medicaid

In 1965, five years into Warren Von Ehren's stewardship of WHA, President Lyndon Johnson signed the Medicare and Medicaid laws. For WHA, the passage of Medicare forever changed the face of the organization. WHA morphed from being largely an affinity organization into an organization focusing on Advocacy as its primary mission.

Between 1960 and 1965, the health coverage debate was a front burner issue in Congress, with dozens of proposals introduced and testimonies given by representatives of major organizations, including the American Hospital Association, the American Medical Association, and the AFL-CIO.

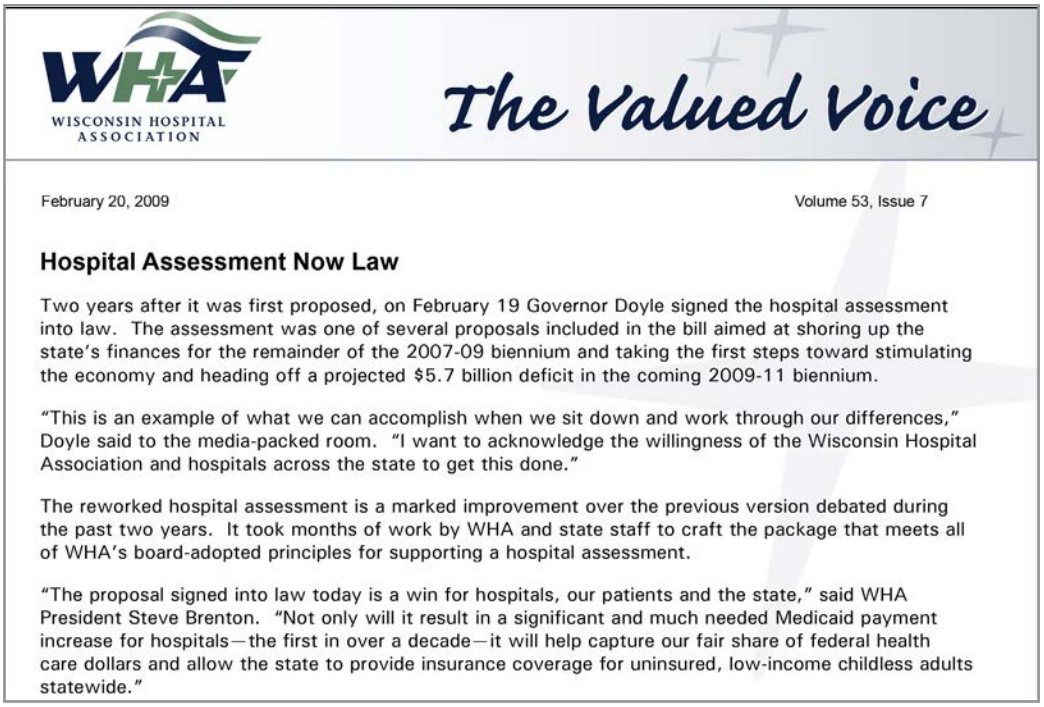
Debate over the program began two decades earlier when President Harry S. Truman sent a message to Congress asking for legislation establishing a national health insurance plan.

After Congress passed the legislation in the summer of 1965, President Lyndon Johnson signed the bill on July 30, 1965 with former President Truman at the Truman Presidential Library in Independence, MO, to recognize Truman's early effort to establish a national health insurance program. Former President Truman was enrolled as Medicare's first beneficiary and received the first Medicare card.

President Lyndon Johnson signs the Medicare Bill on July 30, 1965. President Harry S. Truman is seated next to him. Others looking on include Lady Bird Johnson, Vice President Hubert Humphrey and Bess Truman. (Photo courtesy of Lyndon B. Johnson Presidential Library, U.S. National Archives)

For WHA, Medicare advocacy has focused on payment adequacy to ensure patient access. And beginning with the passage of the DRG payment methodology in 1983, the issue of equity also took center stage as WHA led a national effort to focus on national Medicare payment disparities.

With Medicaid, payment adequacy and expanded coverage have been at the center of WHA advocacy activities. Efforts have included working with Gov. Tommy Thompson in 1999 to pass BadgerCare, crafting a hospital assessment with Gov. Jim Doyle's administration in 2009 that improved coverage and hospital payment, and focusing on enhancing the disproportionate share (DSH) program in more recent years.



WISCONSIN HOSPITAL ASSOCIATION

The Valued Voice

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Hospital Assessment Now Law

Two years after it was first proposed, on February 19 Governor Doyle signed the hospital assessment into law. The assessment was one of several proposals included in the bill aimed at shoring up the state's finances for the remainder of the 2007-09 biennium and taking the first steps toward stimulating the economy and heading off a projected $5.7 billion deficit in the coming 2009-11 biennium.

"This is an example of what we can accomplish when we sit down and work through our differences," Doyle said to the media-packed room. "I want to acknowledge the willingness of the Wisconsin Hospital Association and hospitals across the state to get this done."

The reworked hospital assessment is a marked improvement over the previous version debated during the past two years. It took months of work by WHA and state staff to craft the package that meets all of WHA's board-adopted principles for supporting a hospital assessment.

"The proposal signed into law today is a win for hospitals, our patients and the state," said WHA President Steve Brenton. "Not only will it result in a significant and much needed Medicaid payment increase for hospitals—the first in over a decade—it will help capture our fair share of federal health care dollars and allow the state to provide insurance coverage for uninsured, low-income childless adults statewide."

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(Hospital Drug Price Increases Addressed at Governor's Task Force on Reducing Prescription Drug Prices . . . continued from page 6)

that continued rising drug prices and shortages of critical medications are impacting patient care and straining hospital budgets and resources.

The updated report found that average total drug spending per inpatient admission increased 18.7% since 2016, with a greater increase for outpatient admissions than inpatient admissions. Hospitals experienced price increases of more than 80% across some classes of drugs, including chemotherapy drugs, opioid agonists and anesthetics.

Howell and Wosolewski presented some policy ideas endorsed by AHA that could curtail rising drug prices:

- Restrict "evergreening" – a practice by which a drug manufacturer makes minimal changes to a drug, such as dosing changes, and applies for a new patent.
- Enact federal legislation to make "pay for delay" illegal. This is a pharmaceutical industry practice that involves brand-name drug makers compensating their generic counterparts for holding off on marketing their versions of brand-name drugs.
- Expedite entry of generic drugs into the market.
- Limit orphan drug incentives (marketing exclusivity, research grants, tax incentives) to true orphan drugs which are used to treat rare health conditions, rather than allowing them to be marketed broadly to treat non-rare conditions.

Door County Medical Center (DCMC) CEO Brian Stephens and team members Dr. Jim Heise, chief medical officer; Amy Konop, pharmacy director and Carrie Peterson, certified pharmacy technician described the impact of rising pharmaceutical prices on DCMC. Stephens, who is a member of the Governor's Task Force, said that drug prices for DCMC increased 4.7% from 2018 to 2019. This 4.7% growth rate was accomplished despite steep increases in the price of commonly used drugs.

Dr. Heise and Ms. Konop illustrated the impact of drug price increases with a few examples:

- A single dose of Stelara, a drug to treat inflammatory bowel disease, is more than $22,000. The hospital experienced a 12% increase in the price of this drug in one year.
- NovoSeven, a hemophilia drug, costs $200,000 for one patient stay in the hospital.
- Naloxone (Narcan) counteracts the impact of an opioid overdose. The nasal spray costs more than $400 per dose, and the hospital experienced a 700% price increase for the generic version.
- Epinephrine, a drug to treat asthma attacks and allergic reactions, increased from $100 per dose to more than $300, due to patent exclusivity. Although there is now a generic version of the drug, the cost is still closer to $200 per dose.

Stephens reported DCMC dedicates a full-time staff member to daily monitoring and management of the drug supply chain in order to access vital drugs at the lowest price possible. Carrie Peterson, who holds this role at DCMC, said that drug availability is their top priority, followed by affordability. Stephens said it is essential to have someone like Peterson in every hospital to ensure they have necessary drugs on hand when needed.

Stephens expressed his support for the AHA recommendations presented to the task force and added that linking a price for drugs needed by a patient with the patient's electronic health record would be very helpful.

The task force will meet again in July to discuss potential policy recommendations in depth.

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