Wyoming Healthcare Commission
May 23, 2005
Riverton, Wyoming
Minutes

Attendance

T. Chris Muirhead, Chairman, Steve Mossbrook, Vice Chair, George Bryce, Marlene Ethier, Dr. Jack Glode, Carol Jenkins, Dixie Roberts, Jack Speight, Commissioners, Ken Vines, Insurance Commissioner, Dr. Brent Sherard, Wyoming Health Department Interim Director, Ex-Officio Commissioners, Anne Ladd, Executive Director, Emily Genoff, Assistant Director.

Introductions

Chairman Muirhead opened the meeting. He announced the resignation of Commissioner Paul Lang, who has been promoted and transferred from Black Thunder Coal near Wright to Arch Mineral's headquarters in St. Louis.

Presentations

Dr. Paul Ellwood of the Jackson Hole Group, presented the logic for using evidence based medicine as a quality improvement and cost containment tool – "Why is evidence based medicine an important tool and why is it so hard to implement?"

Dr. Ellwood talked about his experience in the medical field and the reasons he is working with a group advocating for change in healthcare delivery system practices. He reviewed the factors preventing change of today's entrenched medical treatment scenario and the history of efforts to reinvent the way medical care is managed.

It took 20 years for health management organizations (HMOs) to get a foothold and prevent escalation in price but there was no support for quality competition, he said. Price competition works. People are price sensitive when buying health insurance if they're healthy, and choose less expensive coverage. But there is little or no sensitivity to differences in real or perceived quality of care. HMOs lost ground gained in the management of price to the argument over quality, because providers argued that quality was compromised for the sake of saving money, Dr. Ellwood said. A recent survey showed that only about one third of physicians support revealing the quality of their work publicly. Most physicians are unaware of aggregate data related to their practices (i.e. patient demographics, trends, outcomes), he said. Simultaneously, efforts to monitor quality are largely ignored by consumers. Former President Clinton is an example – when diagnosed with heart problems, he elected to use a hospital publicly revealed in the New York Times as having poor cardiac surgery outcomes, Dr. Ellwood said. People who know there is a difference in the quality of practitioners choose to disregard information, believing their doctor is good enough.

Physicians make appropriate decisions 55 percent of the time, Dr. Ellwood said. Quality is going to have to be regulated. Physicians oppose "cookbook medicine" or using a checklist, like pilots do, to assure uniformity in practice. "We're going to have to demand adherence to some externally imposed quality standards. If you look at what tools there are that are available immediately, and practical, evidence based guidelines are it. What are evidence-based guidelines? Think of them as a branching decision tree or an algorithm," he said. Dr. Ellwood said that there are a variety of sources of guidelines to choose from, promulgated by academic institutions, provider groups, state coalitions.

As to the application of guidelines, early HMOs used them when deciding which patients were to be hospitalized and which ones weren't. The guidelines were discredited, however, as being promoted by a source (the HMO) with a conflict of interest. Therefore, insurance companies by themselves can't be responsible for choosing guidelines that are applied, Dr. Ellwood said. Voluntary application has low compliance. There are exceptions – there are tumor registries with cancer treatment guidelines. Employers have been a source of pressure. In northern California, there are a group of employers using "pay for performance" plans – if the physicians comply, they get extra reimbursement, he said.

"If you intend to pursue guidelines, first of all, find a credible source of guidelines. Don't invent them yourselves," Dr. Ellwood said. The "R" word will come up – that guidelines are a means of "rationing" care. It is essential that there be cost effectiveness analysis to support proposed guidelines. One such analysis is a standard based on "quality of life improvement." A valued is attached to the increase in life expectancy – somebody lives longer as a result of treatment, Dr. Ellwood said. An example is that when cervical cancer screening is done every four years, the "quality of life years" improvement is 50. If you do it every two years, the improvement is only 10. Not long ago, the recommended guideline for frequency of pap smears was reduced to every four years for healthy women, and there was an outcry, he said. "You have to be prepared for the resistance but in my view, it's worth it."

Technology makes it possible, with electronic health records, to attach guidelines that "pop up" when a provider enters information in a patient's file, Dr. Ellwood continued. Guidelines are dependent on the quality and quantity of data used as the basis for them. An example is pharmaceuticals and the trials conducted on them before they are made available to the public. In response to the issues of pre-maturity in clinical trials, David M. Eddy, M.D., in Aspen developed a program that relies on supercomputing that can predict what the guideline is going to be on the basis of early collection of outcomes, Dr. Ellwood said. The more data he has, the more accurate the prediction. A comparison would be weather prognostication. "The more information we have, the more powerful these tools will become."

Dr. Ellwood does not support "pay for performance" models for physicians. Economic incentive is too great for physicians to use technology to diagnose and treat patients. "If the physician owns part of an MRI machine and can make money from using it, what is

the incentive for not doing one if a patient complains of low back pain? You can't buy compliance," Dr. Ellwood said. He advised the Commission to find out if northern California has a business case for pay for performance. Link the availability of public subsidized insurance to guidelines adherence by the provider and the patient. One of the breakdowns in the HMO guidelines attempt was that the patients and providers both disliked them. "The user and the seller have to agree, by contract, that if they receive this special benefit from the government, they have to agree to the guidelines and abide by them," he said. Practical problems with implementing those types of contracts for reimbursement involve patients who are leaving the state for care, going to Utah, Colorado, Montana, and Nebraska, where rules can't be laid down for physicians by Wyoming.

Dr. Ellwood's recommendations:

- Establish an independent, quasi-public mechanism to select guidelines for application. The entity should have nothing to do with insurance companies. "If you want an example, look at the Federal Reserve," he said. "The only motivation should be picking the most powerful and useful guidelines."

- Tie the guidelines to some kind of state subsidized health insurance mechanism. "You could tie them to something like medical licensure but that doesn't have much application to the consumer and I don't think it's as powerful as the control of insurance. My favorite form of subsidy is reinsurance. We should be reinsuring healthcare across the board. When the expenditures of an individual exceed a certain level, reinsurance kicks in. That's an inexpensive way to get people more coverage.

- Eligibility for insurance for insurers and patients is contingent on adherence to the evidence based guidelines. Physicians are reimbursed for providing the care recommended by the guidelines, and not paid for care not recommended by the guidelines.

- Don't piecemeal the thing. Don't come up with recommendations that attack one piece. These recommendations address cost, quality and access or insurance. I don't think this Commission will be as useful as it could be unless it comes up with recommendations that combine these three issues.

Dr. Ellwood was asked if medical students are being taught to use clinical guidelines now. He said he doesn't know; although today's generation is very computer literate they don't seem to be willing to embrace using computers in their practices. The implicit assumption that physicians know whether they have helping their patients is erroneous, he said.

Dr. Sherard said the Wyoming Department of Health (WDH) is contracting with an entity in Oregon to use its data to establish a preferred drug list for Medicaid patients. Dr. Ellwood hypothesized that once physician behavior is changed and practice is adapted to

a preferred drug list, those actions will go beyond the treatment of Medicaid patients. Sen. Charlie Scott said in British Columbia – which was in part a model for the Oregon project that is being adapted for Wyoming's use – studies showed there was some change in practice by physicians.

But Dr. Glode said that there are at least five preferred drug lists in use in his practice as required by different payers (i.e. Medicaid, VA, Medicare, Great West). Physicians should be expected only to use one system and there are too many guidelines already in place. But Dr. Ellwood's idea crosses all specialties, Dr. Glode said. As envisioned, it wouldn't matter whether a diabetes patient were being treated by a nurse practitioner, cardiologist or internist, the same guidelines would be used as long as the IT systems were in place to track peoples' therapies.

Dr. Sherard he appreciates reference to use of "quality-adjusted life years" and similar measures of success that can be applied to public health practices such as immunization and clean water. "I don't see very much funding in proportion going into public health in comparison with medical treatment," he said. Dr. Ellwood agreed that America does not invest much as a country in public health research, instead focusing on medical treatment.

Claire Brockbank, of Segue Consulting, asked about research done by Dr. Hank Gardner for the Governor's Office showing that a specific disease can cost the state an enormous amount of money to treat but most of the cost is associated with co-morbidities. So how can those patients' myriad of conditions be treated using guidelines that apply to treatment of a single medical condition?

Most guidelines for cardiologists are for diagnoses, Dr. Glode said. They classify their guidelines into three categories: evidence-based, preponderance of opinion and "don't do it" (no support for that choice of treatment). "That's very helpful," he said. Workups are getting more expensive because technology is getting expensive and exploding into new areas.

The old notion was it was the doctor's job was to narrow the choices and go at things the most simply and least complex way possible, Dr. Ellwood said. Dr. Glode agreed and said that when he trained, cardiology work was mostly cognitive. Cardiologists coming out now are technicians, not "cognitions." The style of cardiology he practiced is going away. "The idea that we were going to create a pool of primary care internists is going away because they are choosing specialties instead. Now internists are coming from Eastern Europe," he said.

Russ Sword, CEO of Ashley County Medical Center and Brian Haapala, Stroudwater Associates (by telephone) presented the Balanced Scorecard for Small Hospitals and how the scorecard is being used in small rural hospitals across she country, and a case study of a small hospital in Arkansas, how they began, what it has meant to the institution in terms of recruitment, retention, financial performance and quality improvement (handouts available by email). Robert S. Kaplan and David P. Norton, authors of "Balanced Scorecard," looked at how scorecards can be used for management systems for financial

improvement. They wrote a book around one tool, “Strategy Maps.” An article written by a physician at Duke Children’s Hospital who wrote “Saving Money, Saving Lives,” brought Balanced Scorecards to the attention of Mr. Sword and Mr. Haapala.

Use of the Balanced Scorecards has helped hospitals have a common language for data collection and information sharing with peers. They now have specific networking opportunities to improve the quality within a specific area, he said. They can engage their staff on issues like what should we be doing differently, where are we inefficient and how can we become more efficient. Mr. Haapala said that of five hospitals using the scorecard, three have had significant financial “turnarounds,” making more money. However, one hospital indicated no change, suggesting there are variables within application of the scorecards that impact results.

In Pennsylvania’s Critical Access Hospitals, they are trying to look at the issues of effective patient safety systems (identifying, tracking and recording medication errors) with the Scorecard. The Scorecard provides a framework for choosing a common methodology for dealing with medication errors. Three specific issues a Scorecard can help with are the data, how hospital leadership is able to communicate strategy and engage people within the organization around that strategy, and to the extent that benchmarking is part of it – multiple parties come together and look at common measures. He cautions that benchmarking tends to raise a lot of questions.

Mr. Sword reviewed some of his experience with using data in general, and benchmarking specifically. The hospital he directs opened in 1998 and converted in 2004 to CAH status. Nonetheless, the hospital supports a variety of specialties and works hard to encourage people to view the facility not as a “Band-Aid station,” but as a full-service institution capable of providing the same quality and type of care as is offered in urban areas. The Balanced Scorecard is used over four different levels: staff and clinic satisfaction, business operations, quality of care, and patient satisfaction. When strategies addressing each of those areas are employed, the bottom line is financial improvement.

In- and out-patient surveys are conducted. Response rates are 70 percent to 80 percent. A survey was introduced as a routine part of the discharge process and assistance is provided to patients who need it. Employees are surveyed on a semi-annual basis for clinical and non-clinical staff. There are staff loyalty indexes built in (i.e. “would you recommend family members come to this hospital?”). He said the Scorecard must be used on an ongoing basis and is a means of asking questions answered with data already on hand that can be used more meaningfully. As a result of the Scorecard process, his organization has decided to outsource all patient billing, and is working on a reduction in the number of patient falls. He provided numerous other examples of how the Scorecard has resulted in change.

There is very little opportunity to address costs in small rural hospitals, Mr. Sword said. They do look at how other hospitals are doing in certain areas. But there is not a great opportunity to reduce costs – “we have to increase our patient volumes and spread the cost over greater populations,” he said, to reduce incremental costs. Mr. Haapala said the

goal is to make sure the patient gets to the right provider at the right time. “They’re making sure that patients have choices relative to where they get care.”

The Balanced Scorecard is one of any number of different ways hospitals can manage themselves. Discussion followed regarding Magnet Hospital status and Baldridge criteria as alternatives. The Balanced Scorecard is can be implemented without any external funding, while Magnet Hospital status application costs money, Mr. Haapala said. The Commission was talking about Magnet Hospital in the context of recruiting and retention healthcare professionals, Ms. Ladd said. Ms. Ethier said the underlying goals of Balanced Scorecard and Magnet Hospital programs are fundamentally different and therefore not comparable. Employee turnover is measured with the scorecard, Mr. Sword said, along with staff satisfaction. Turnover rates at his hospital are among the lowest in the state of Arkansas, partly because data is shared with employees. When asked to define rural, he said he is about an hour from any metropolitan area. The closest neighboring hospital is Monroe, La., with 60,000 people. His community has 6,000 and the county has 25,000 residents.

Mr. Haapala said that the Balanced Scorecard has not been adopted by the Critical Access Hospitals’ coalition in Arkansas but is provided by the Flex (Rural Hospital Medicare Flexibility Program designed to increase Medicare and Medicare reimbursement to some rural hospitals under certain parameters) program as an endorsed tool. Hawaii and Pennsylvania have used Flex dollars to provide training in the Balanced Scorecard methodology. Nebraska, Kansas, Montana, and Michigan CAHs are using the Balanced Scorecard framework to collect data from different hospitals and pulling it together in a benchmarking database. There is a lot of activity specifically within the guidance states got with their Flex funding. Discussion followed regarding patient outcome data and what improvements need to be made in the use of the Balanced Scorecard to monitor how patients do clinically.

Wyoming Hospital Association President Bob Kidd talked about the differences between CAHs and larger hospitals, medical care staff-to-patient ratios and types of care provided under what periods of time. Sen. Scott talked about how hospitals can expand and what limitations they have, compared with other businesses that have a lot of constant, fixed costs. Labor costs will rise in proportion to expansion, he said. Office of Rural Health Manager Lynne Weidel said CAHs are different because ERs can be staffed with mid-levels and inpatient facilities don’t have to be staffed unless there is a patient. The average length of stay is 96 hours. There is no intention that CAHs are going to provide a whole array of inpatient hospital services, although that varies by community demand and ability to staff. The under-pinning of a CAH is to provide access to basic services in remote communities.

Mr. Kidd said every hospital in Wyoming is using some facet of a Balanced Scorecard methodology. A comparative program for financial and clinical data was purchased for the state’s hospitals by the Hospital Association. Every hospital does clinical and patient surveys. Error reporting is not uniformly done although some data is being made public under new national requirements. The Department of Health is working on an error

reporting program. Dr. Glode said under-reporting even in mandatory systems is prevalent; they're going to resist the process until they feel safe, according to research conducted across the country. Ms. Ethier talked about the differences in outcomes for people receiving a treatment provided in a place where it is frequently delivered compared to a place where it is infrequently delivered. The focus of Magnet is patient outcomes. She said the cost of obtaining Magnet status is tied to getting a facility to the place where it needs to be to meet the Magnet criteria. Wyoming Medical Center budgeted $400,000 to $500,000 to implement the Magnet program but no one can tell them what it will cost to sustain it, Chairman Muirhead said.

Dr. Glode said Magnet is one way to do patient studies; there are going to be others. Hospitals have resisted outcome measurement programs because they have not had to. Core measures for Medicare are being ignored as well – but now that they are being publicly reported and that refusal to participate will change. He said that the Balanced Scorecard is a management tool but does not look at cost containment and that's not the motive of any hospital in the state because they are in survival mode. The Commission needs to understand that. By and large, the patients have not paid attention to quality measures, he said. Ms. Jenkins said she knows patients are looking at CMS data and are choosing to leave the state for care based on those measures for certain surgeries.

Sen. Charles Scott – Labor, Health and Social Services Committee

Sen. Scott said the Labor, Health and Social Services Committee, which he co-chairs with Rep. Doug Osborn, will devote its July 19 meeting to collecting public comment on mechanisms they can enact for containing healthcare costs. They are looking for specific things they can legislate, like the PharmAssist program. They have had some Committee turnover and are looking to educate new members on the reality of healthcare costs and what the opportunities are. The WHCC is welcome to bring suggestions. Talk to Jerry Laska at the Legislative Service Office and get on the agenda for the meeting, which probably will be held in Casper.

The Joint Executive Legislative Review of the Health Department was initiated with legislation this year and is led by Sen. Scott and Dr. Sherard. The issues at the core are the mechanics of budgeting, particularly for Medicaid. "We were getting in trouble with under budgeting and getting surprises," Sen. Scott said. "We also were concerned with the escalating cost of Medicaid. His perception is that the budget mechanics are worked out between the Governor and Medicaid without the need of external review, so we're left with the cost growth."

The Committee has teamed up with the Millbank Foundation which brought in Health Department directors from three other states. Wyoming's strengths and weaknesses were identified. One strategy is looking at capitalizing on potential federal funding through loopholes still left in Medicaid's program nationally. Another possibility is to redo the benefits package offered to Medicaid beneficiaries.

Radical Medicaid program overhauls are being received well in Washington, D.C., right now, Wyoming has been told. But another possibility is that if the feds are uncooperative, it might be a good time to walk away from the federal Medicaid program and its matched dollars. The program's structure right now is anti-family because qualification for maternity expenses is easier if women are unmarried. "There are some engines doing social things that we don't like," Sen. Scott said. "That would be a further reason to tell the feds good bye if we can't fix it." More intensive management of highest cost Medicaid clients is another strategy. But Wyoming already has a preferred drug list and is doing disease management – although it can be improved upon. The Joint Executive Legislative Review of the Health Department has a September deadline.

Mr. Bryce talked about how infusion of funds from the state to school districts allowed Natrona County to enroll more people in its healthcare coverage program. Sen. Scott said the state may not always be as wealthy as it is now, if the price of oil drops, state subsidies will fall. Healthcare costs are growing at three times inflation, a prescription to bankrupt any state in the union. All the states that have tried universal healthcare approaches have backed off. Asking consumers to "have skin the game," Mr. Bryce said, slows that cost growth.

Lynne Weidel, Wyoming Department of Health (WDH) State Office of Rural Health (SORH), Scott Hayes, WDH SORH Medicare Rural Hospital Flexibility Program Coordinator, and Tom Nordwick, Converse County Memorial Hospital CEO, presented quality improvement initiatives getting underway in Wyoming's Critical Access Hospitals (CAH). Ms Weidel said the SORH was formed by statute in the early 1990s. One of its most important functions of the office is working toward medical care access and getting the appropriate complementary healthcare services to Wyoming. The intent of the CAH program is to ensure or enhance the financial viability of hospitals in rural areas. Initially federal funding was available for feasibility study and then conversion of hospitals to CAH status. Most hospitals that can become CAHs in America have done so and now the focus is shifting to quality and performance enhancement in CAHs. Mr. Hayes reviewed the history of the Flex program and the requirements for CAHs. CAHs have to provide inpatient care and emergency care that is available 24 hours, with staff on call and available within 30 minutes, and laboratory and radiology services. CAHs receive cost-based retrospective reimbursement from Medicare.

Mr. Nordwick said "cost based" is not true coverage of costs because Medicare deducts administrative expenses and ineligible expenses. But CAHs are not limited to DRG-based reimbursement. The advantage of becoming a CAH depends on the size of the hospital and the patient mix. Douglas's hospital was about 41 percent Medicare/Medicaid patients. The hospital netted an additional $250,000 annually by converting, or about 15 percent to 20 percent of revenue. It's huge when the payer mix is weighted more heavily toward a Medicare patient base. Ms. Jenkins said another CAH administrator told her that cost-based reimbursement assures better predictability of revenue stream. Mr. Nordwick said that converting to CAH status didn't change the way they do business significantly. In the three years they've been CAH, they have not had to divert patients because they've had too many or because the length of stay was bumping against four days. Discussion

followed regarding the communities whose hospitals have not converted (Rawlins, Evanston, Kemmerer, Riverton, Lander, Rock Springs and Laramie). Some are considering applying for CAH status. Generally, CAHs are more profitable, more liquid, carry less debt, and increase utilization of their beds. Those with long-term care beds initially did not fare as well, but now are beginning to show better results.

The quality improvement focus now is being driven by an RFP for QI work with CAHs that results in broad-based baseline evaluation of QI in CAHs and addressing hospital quality and clinical indicators without duplicating current efforts. Recommendations are to come from the evaluation, implement recommendations and re-evaluate. A Rural Health Network is being developed that will allow for education of the state's CAHs about what networks can do for them, and build a network that fits Wyoming's needs that is coordinated with the tele-health network (WyNETTE) and the Hospital Association. There are national network grants available. Flex dollars also go to EMS system improvement and integration, training, and the trauma system. Rural Health Plan Development is required and Wyoming's plan will be updated.

Mr. Nordwick said that CAHs are involved in quality initiatives and reports on inpatient care of heart failure, acute myocardial infarction, surgical infection prevention, and pneumonia. The "100k lives Campaign" is being launched by VHA, Inc., and MHCC is participating. The Douglas hospital is looking at evidence-based medicine criteria by specialty for enhancement of the peer review program. Primary care and obstetrics have been analyzed; there are no magic bullets. He described his hospital's peer review process, which is 100 percent confidential. Clinical pathways are being looked at for total hips, total knees, shoulder surgeries and pneumonia. They have developed an internal medication error committee. Monthly statistics are reviewed for trends. Communication expansion at the hospital includes installation of PACS (picture archive and communication system), computed radiography, voice recognition free hand dictation, electronic medical records and a medication system interfaced with PYXIS. Community health goals include expansion of the hospital wellness program.

The Douglas Hospital is linked to the Lusk hospital for telemedicine coverage; emergency department doctors provide support to mid-levels in Lusk so that 24-hour medical coverage is available even when a doctor is not in the community in Lusk. He said that proposed expansions of the CAH program to specialty and larger hospitals.

Jan Bloom, Project Leader, and Kris Urbanek, DOQ-IT Coordinator, Mountain Pacific Quality Health Foundation, presented an update on their quality improvement/cost containment efforts in Wyoming. Ms. Bloom reviewed the history of MPQHF and the work being done under a contract with CMS to address quality measures and reporting in Wyoming's healthcare delivery system. Strategies in healthcare quality improvement in Wyoming include providing technical assistance to providers and practitioners.

A specific focus on nursing homes includes training on quality measures for post-acute pain, chronic pain and a decline in activities of daily living (ADLs). MPQHC is collaborating with hospitals on community-acquired pneumonia, acute myocardial

infarction, congestive heart failure and surgical infection prevention and preparing for public reporting of data. Physician office quality improvement is voluntary and targets diabetes, mammography, and flu and pneumonia immunization. Rural and underserved beneficiaries are reached through CAHs – the goal is to reduce disparity between CAHs and WMC and UMC (urban hospitals) specific to community-acquired pneumonia. Wyoming finished in the top five; the disparity was not only reduced but the CAHs overtook the urban hospitals and started doing a much better job. Consumer-focused activities include promoting healthful lifestyles and preventive care, informing people with Medicare about their medical rights and performing medical reviews when requested. A consumer advisory council provides advice on how to best reach Medicare beneficiaries.

Public reporting of performance data began with nursing homes in November 2002. Home health agencies were added in 2003 and hospitals in 2005. The organization's next scope of work is to advance on the work done already to add more improvement measures. For example, are 39 nursing homes in Wyoming; statewide improvement in 30 is expected in the number of pressure ulcers, use of physical restraints and depression screening. Hospital use of information technology will be tracked, in addition to surgical care improvement, appropriate care measures for myocardial infarction, pneumonia and congestive heart failure. The rural project will expand to a set of 12 quality improvement measures in CAHs. Doctors Office Quality-Information Technology (DOQ-IT) is expanding into improvement on clinical measures, reporting of clinical data to CMS's data warehouse, care process improvement and clinical information systems. Participating practices much have electronic health records or e-prescribing plus a registry, and demonstrate improvement in care processes in addition to using health information technology.

Underserved populations – defined as minorities – may not be targeted in Wyoming since 3 percent of the Medicare population may not fall into that category (Wyoming is slightly below that). If there is a project in Wyoming an effort will be made to address cultural and linguistic needs of those patients. Assistance will be provided to all Medicare Part D providers, practitioners and plans – not consumers.

Mr. Urbanek reviewed the goals of DOQ-IT, which is designed for small to medium practices. Technical assistance helps them look at ways to improve their practice with technology. For citizens, DOQ-IT is to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse drug reactions. Information loaded into the QualityNet Exchange allows providers to compare themselves with their peers nationally. To learn more, visit www.doq-it.org. There are seven physician practices signed up to work with CMS on electronic health records, which will provide varying levels of technical assistance free of charge but no implementation grants.

Subcommittee updates

Dr. Geoff Smith, Health Information Technology Technical Management Subcommittee (IT2) – The public comment meetings have been conducted in Casper, Cheyenne, Sheridan, Rock Springs, Cody and Buffalo, and another is slated in June in Jackson. Comments to date are that people generally accept electronic health records are useful to improving quality of care and emergent situations for special populations (i.e. older relatives, multiple conditions and prescriptions). Security is a concern, with people wanting reassurance that no one will be able to hack into the electronic health network, and privacy (protection of health records from employers is of particular concern). Who will pay for electronic health records, and the transition from paper to electronic records, also have been raised as issues. Mr. Mossbrook asked whether the scarcity of true members of the public from the meetings raises red flags about potential public reaction when electronic health records are implemented. Dr. Smith said people tend to react more when there are impacts that may affect them directly. Having a graduated implementation process may give some cushion against mass protest.

The Business, Governance, Legal and Sustainability subgroup has put together a vision statement that has been circulated and feedback has been given. There's a draft organizational structure that will be discussed in more detail this week or shortly thereafter. Once of the current representation models is that you generally divide up the board into segments like1/5 state government, 1/5 health care providers, and the remainder consumer groups, employers etc., or in the alternative 1/3 government, 1/3 health care providers, 1/3 consumers and/or their representatives. The majority of participation should come from the public, consensus suggests. A key stakeholders list has been drafted and a letter is going to be circulated inviting each to participate in a governance structure and the goal is to get the groups to convene in late June or early July to discuss forming an organization that would support a regional health information organization in the future. The organization can be ready to receive and disseminate any funding that may become available from the federal government or private foundations. This prevents any delay that might occur between now and when the Legislature can take action on bills that will solidify the implementation of electronic health records utilization in the state. The division of representation should come up at the stakeholders' meeting.

The IT2 Committee is in the last 90 days of its work. The frequency of meetings is increasing, correspondingly. Thursday an initial draft of the chapter of the planning draft regarding funding sources will be reviewed. He would like some of the chapters are complete and set aside to be readdressed later in the summer. Mr. Muirhead said in December he suggested IT1 would reactivate at this point as the study nears completion. Mr. Mossbrook said he can't take a role in IT1 since he's now chairing the Supply Side committee. Chairman Muirhead asked Carol and Jack to reenergize their focus to assure we're conforming to legislative intent.

Dixie Roberts, Medical Errors – Ms. Roberts and project manager Fran Cadez went to Washington, D.C., to look at a health court system that is being modeled nationally. The forum dedicated time to looking at where we are now. The Health Court system removes

the judicial system from the process, because it is administrative and there is no jury. Injuries are compensated based on schedules. Dr. Michelle Mello, an attorney and a Ph.D. at Harvard School went through the tort system and graded it using five principles: compensation, deterrence, corrective justice, efficiency, collateral effects. Ms. Roberts reviewed Dr. Mello's findings in "grading" the nation's tort system's dealings with medical injuries: Compensation -- D; deterrence – C; Corrective justice – B; efficiency – F; and collateral effects – D. The likelihood that the people who have been injured in the course of medical treatment is higher in an administrative system because attorneys would not be getting a share of the payment pie, and an attorney would not be required for getting a case into a venue where the patient's story can be heard. Negligence would not have to be proved, perhaps reducing defensive medicine and improving patient/physician relationships. The overall assessment of the administrative system is that it might be an improvement over the tort system. A visit to the Brookings Institute, a "think tank," resulted in no new fixed for the tort system. But Wyoming's work toward a health court has positioned it to be a pilot for the nation. The payments for damages in the tort system come solely from medical malpractice insurance but in an administrative system, there may be other sources.

Steve Mossbrook, Supply Side – Dr. Hank Gardner has supplied more data and as a result, his services have been retained by the Commission with a cap of $30,000. We're going to be asking him to drill down into his data and separate it into public/private analyses to allow for better understanding of the path to his conclusions.

The Nebraska Health Professions Tracking Center has been selected to do health professions tracking in Wyoming and they may subcontract with data collectors in Wyoming.

Chairman Muirhead and Ms. Ladd will meet with the Governor on June 29 to review the Commission's 20 two-page summaries of recommendations for healthcare delivery system enhancement and redirection. Conference calls are scheduled weekly between now and then, sometimes more frequently, to review all the two-page summaries and reduce them to a set of analyses of why the summarized proposals are significant to the delivery system in Wyoming that will then be considered by the full Commission at its June meeting. No presentations will be heard at the June meeting to allow for dedication of the Commission to the two pagers. Mr. Mossbrook asked the Commissioners to prioritize them and consider which are most worth emotional investment. Sen. Scott encouraged the Commission to be aware that "legislation from scratch" will be more time consuming than ideas for change or program expansion or redirection that will come from an agency as part of a budget request. Dr. Sherard said the Health Department will be able to provide feedback on ideas impacting that agency's work; Chairman Muirhead some resources may need to be allocated by Dr. Sherard's staff to assess potential cost and staffing needs for specific proposals.

George Bryce, Demand Side (Carol Jenkins) – The question of whether multiple sources can contribute to accounts used to purchase health insurance was researched and an organization in Washington, D.C., that wrote the regulations says that yes, there is no

glaring obstacle to that. A brand new regulation allows an additional two to three months for spending down Flex funds. We need to do away with use-it-or-lose-it provisions that do not allow consumers to "roll over" unspent health savings dollars year to year, Chairman Muirhead said. An RFP was let for a reinsurance study and a company should be selected within the next week.

Actuarial help is needed to look at being creative in using a reinsurance mechanism in Wyoming to improve the quality of care available to individuals and an RFP has been let that will result in a contract within the next couple of weeks for that work.

The committee is taking a holistic approach to patient care, "total health management," incorporating evidence based guidelines, chronic care (disease management) and earlier intervention/prevention. Two pagers are being worked on and a conference call will be held on May 31 at 4 p.m. to continue that effort.

Audience Comments and Questions

None received.

Adjourn

Next meeting: June 26-27, Bozeman Trail, Buffalo