



Rural Community-Based Palliative Care Wisconsin State Environmental Scan

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*MetaStar, Inc. prepared this document
as part of the Rural Community-Based Palliative Care Project.*



Rural Community-Based Palliative Care Project - This three-year project (2017-2020) is supported by Stratis Health to expand access to rural community-based palliative care services. Find practical tools to build and expand services in the Rural Palliative Care Resource Center (www.stratishealth.org/palcare). Copyright © 2018 Stratis Health, all rights reserved.

Section 1: Key Wisconsin Players and Stakeholders

- **National Trade and Professional Associations**
 - [National Hospice and Palliative Care Organization](#)
 - [Hospice Foundation of America](#)
 - [American Academy of Hospice and Palliative Medicine](#)
 - [American Academy of Hospice and Palliative Medicine \(AAHPM\)](#)
 - [Center to Advance Palliative Care \(CAPC\)](#)
 - [Hospice and Palliative Nurses Association \(HPNA\)](#)
 - [Respecting Choices](#)
 - [Patient-Centered Outcomes Research Institute \(PCORI\)](#)
 - [Center for Medicare & Medicaid Innovation \(CMMI\)](#)
 - [National Institutes of Health \(NIH\)](#)
 - [Agency for Healthcare Research and Quality \(AHRQ\)](#)
 - [National Palliative Care Research Center](#)

- **Wisconsin Trade and Professional Associations**
 - [Wisconsin Office of Rural Health](#)
 - [Wisconsin Primary Health Care Association \(WPHCA\)](#)
 - [Wisconsin Medical Society](#)
 - [Wisconsin Academy of Family Physicians \(WAFP\)](#)
 - [ARC Community Services, Inc.](#)
 - [Wisconsin Professional Homecare Providers](#)
 - [LeadingAge Wisconsin](#)
 - [WI Director of Nursing Council](#)
 - [Wisconsin Health Care Association \(WHCA\) and Wisconsin Center for Assisted Living \(WiCAL\)](#)
 - [Care Wisconsin](#)
 - [HealthInsight Advance Care Planning](#)
 - [Wisconsin Nurses Association](#)
 - [Wisconsin Research & Education Network \(WREN\)](#)

- **State Government**
 - [WI Division of Quality Assurance \(DQA\) Bureaus and Offices](#)

- **Health Care Systems and Organizations Providing Palliative Care**
 - [SSM Health at Home](#)
 - [PalliaHealth by Agrace](#)
 - [UW Health Palliative Care](#)
 - [UW Health Pediatric Palliative Care](#)
 - [UnityPoint Health Meriter Palliative Care](#)
 - [Froedtert Palliative Care Program](#)
 - [Heartland Care Partners Palliative Services](#)
 - [Interim Hospice and Palliative Care](#)
 - [Seasons Hospice Palliative Care](#)
 - [Hope Hospice and Palliative Care, Inc.](#)
 - [AllinaHealth Hospice and Palliative Care \(MN based\)](#)

- [Essentia Health Hospice and Palliative Care \(MN based\)](#)
- [Advocate Aurora Health Care, Aurora Sheboygan Clinic](#)
- [Ascension WI, Ascension WI South Region, Ascension Columbia St. Mary's, Ascension Columbia St. Mary's, Ascension Howard Young](#)
- [Aspirus Palliative Care, Wausau and Langlade Hospitals](#)
- [Gundersen Health System](#)
- [Horizon Home Care & Hospice](#)
- [Hospice Alliance](#)
- [Marshfield Clinic Health System](#)
- [Mayo Clinic Palliative Care](#)
- [Mercy Health Palliative & Supportive Care](#)
- [ProHealth Care Palliative Care](#)
- [Aseracare Hospice](#)
- [Community Care, Inc.](#)
- [HSHS Medical Group](#)
- [Care Partners Hospice & Palliative](#)
- [Rainbow Hospice and Palliative Care](#)
- [Tomah Memorial Hospital](#)
- [Unity Hospice](#)
- [LeRoyer Palliative Care](#)
- [Regional Hospice Services](#)
- [Adoray Home Health & Hospice](#)
- [ThedaCare Palliative Care Program](#)

- **Payers** (include those highly engaged, see Section 3)
 - [WEATrust](#)

- **Universities/Colleges/Other Training Resources**, e.g., Area Health Education Center (AHEC)
 - [Medical College of Wisconsin](#)
 - [Marshfield Clinic Palliative Medicine Fellowship](#)

- **Coalitions/Networks** (including spiritual organizations, such as coalitions of parish nurses)
 - [Wisconsin Nurses Association](#)
 - [Palliative & End-of-Life Care Nursing Coalition](#)
 - [WI Faith Community Nurse Coalition](#)
 - [Palliative Care Network of Wisconsin](#)
 - [Wisconsin Coordination of Care Coalitions](#)

- **Quality Improvement Organizations**, e.g., Quality Innovation Network - Quality Improvement Organization (QIN-QIO) and Hospital Improvement Innovation Network (HIIN)
 - [Lake Superior Quality Innovation Network](#)
 - [Wisconsin Hospital Association](#)

- **Other Rural Stakeholders** (including telehealth)
 - [WI State Law Telemedicine/Telehealth Definition](#)
 - [Wisconsin Issues New \(and Improved!\) Telemedicine Rules](#)
 - [UW Telehealth](#)
 - [Marshfield Clinics Telehealth](#)

- [Wisconsin Medical Society SCO-002 Regulation of Telemedicine](#)
- [Wisconsin Reimbursement SecureTelehealth](#)
- [National Telehealth Policy Resource Center - WI](#)

Section 2: Statewide Standards and Activities

1. Legislative References

- a. [Chapter DHS 131, Hospices](#)
- b. [Chapter 50.94\(1\)\(a\) Uniform Licensure & Chapter 50.90 Subchapter VI Hospices](#)

2. What standard, widely used, or mandated approaches to advance care planning and/or health directives does your state have?

- a. [Honoring Choices Wisconsin](#)
- b. [Respecting Choices](#)
- c. [Advanced Care Planning](#)

3. Does a legislatively mandated advisory board for hospice and/or palliative care exist in your state?

- a. [S.693 – Palliative Care and Hospice Education and Training Act](#) was introduced to the Senate on March 22, 2017 by Senator Tammy Baldwin but no action has been taken at this time.
- b. [H.R.1676 - Palliative Care and Hospice Education and Training Act](#) was introduced March 22, 2017 and was passed in the House. On July 24, 2018, it was received in the Senate and read twice and referred to the Committee on Health, Education, Labor, and Pensions.
- c. WI 2017 [Assembly Bill 633](#) was introduced on November 10, 2017, to repeal 15.197 (22m) and 146.695 (1) (a), (2), (3) and (5); to consolidate, renumber, and amend 146.695 (1) (intro.) and (b); and to create 15.197 (22m) and 146.695 of the statutes; relating to: establishing a palliative care council. On March 28, 2018, it failed to pass pursuant to Senate Joint Resolution 1.
- d. [WI 2017 Senate Bill 548](#) was introduced November 20, 2017, to repeal 15.197 (22m) and 146.695 (1) (a), (2), (3) and (5); to consolidate, renumber, and amend 146.695 (1) (intro.) and (b); and to create 15.197 (22m) and 146.695 of the statutes; relating to: establishing a palliative care council. On March 28, 2018, it failed to pass pursuant to Senate Joint Resolution 1.
- e. [Palliative Care Network of Wisconsin](#) does have a 14-member Board of Directors and has agreed to act as an advisory board for this project.

4. What networking and education offerings related to hospice and/or palliative care occur in your state (such as conferences, coursework)? Do these include a rural presence?

- a. [National Hospice and Palliative Care Organization Education Center](#)
- b. [National Hospice and Palliative Care Organization Online Learning](#)
- c. [Drexel University Online - Certificate of Advanced Study in Holistic Hospice and Palliative Care](#)
- d. [Medical College of Wisconsin Palliative Care Program in conjunction with Froedtert](#)
- e. [Marshfield Clinic Palliative Medicine Fellowship](#)
- f. [Education Resources Palliative Care Network of Wisconsin](#)
 - i. [Fast Facts and Concepts Core Curriculum](#)
 - ii. [Palliative Care Lectures](#)
 - iii. [Learner Assessment Tools](#)
 - iv. [Role Play Cases](#)

- v. [Curriculum Guides](#)
- vi. [Communication video](#)
- vii. [Other Educational Resources](#)
- g. [Annual Great Lakes Palliative care Conference](#)
- h. The Wisconsin Department of Health Services, Division of Quality Assurance provides the “FOCUS” conference each fall and periodically, they have had a session on Palliative Care.

5. How prevalent are provider certifications in palliative care in your state? Consider physicians, nurses, social workers, and other provider types.

- a. [Joint commission Certification for Palliative Care Programs](#)
- b. Since 2014, all physicians are required to complete a 12-month, accredited, hospice and palliative medicine fellowship to be eligible to take the [physician certification exam](#). As a nation 7,618 physicians were certified as of 2008.
- c. [Certification for Hospice Medical Directors](#)
- d. [Hospice and Palliative Nursing Certification](#)
- e. [Social Work Certification](#) and [Advanced Certified Hospice and Palliative Social Worker](#)
- f. [Chaplaincy Certification](#)
- g. Unable to locate Wisconsin-specific numbers for each of the above potential certifications.

6. State-specific policy landscape

- a. Under [Subchapter III of Wis. Stat. Chapter 154](#), an attending physician may issue a do-not-resuscitate order for a "[qualified patient](#)," as defined in [Wis. Stat. s. 154.17 \(4\)](#).
- b. As defined in [Wis. Stat. s. 154.17 \(2\)](#), a do-not-resuscitate order directs emergency medical technicians, first responders, and emergency health care facilities personnel to not attempt cardiopulmonary resuscitation on the person for whom the order is issued if that person suffers cardiac or respiratory arrest. The purpose of a do-not-resuscitate order is to ensure that medical care provided in the emergency department and out-of-hospital settings is consistent with the patient's desire and the attending physician's authorization.
- c. The [Wisconsin Donor Registry](#) allows a person to legally authorize the gift of their organs, tissues and eyes upon their death. This decision can save and improve lives through transplantation, therapy, research, and education.
- d. Wisconsin laws created two forms of advance directives for health care – the [living will](#) and the [power of attorney for health care](#).
- e. [Per 50.94\(1\) \(a\)](#). “Hospice care” means palliative care, respite care, short-term care or supportive care.
- f. [Per 50.90\(3\)](#), “Palliative care” means management and support provided for the reduction or abatement of pain, for other physical symptoms, and for psychosocial or spiritual needs of individuals with terminal illness and includes physician services, skilled nursing care, medical social services, services of volunteers, and bereavement services. “Palliative care” does not mean treatment provided in order to cure a medical condition or disease or to artificially prolong life.

7. What is the scope of telehealth use in your state related to palliative and end-of-life care?

- a. [Telehealth Policy Barriers Fact Sheet](#) discusses reimbursement, malpractice, licensing, HIPPA/privacy/security, prescribing, and credentialing and privileging. It also provides insight to future trends including mobile health and network adequacy. [Great Plains Telehealth Resource and Assistance Center](#) supports Wisconsin for the [National Consortium of Telehealth Resource Centers](#).
- b. There are 536 facilities and 485 providers using telehealth in Wisconsin. There are no critical access hospitals or providers of chronic disease management within the database.

- c. Through Medicare Learning Network, the Centers for Medicare & Medicaid Services (CMS) provides a booklet on Telehealth Services ([ICN 901705](#)) dated February 2018.

Of note:

[America's Care of Serious Illness 2015 State-By-State Report Care on Access to Palliative care in Our Nation's Hospitals](#), report, federal policy recommendations:

1. Congress
 - a. Establish palliative care centers that would develop and disseminate curricula relating to palliative care, support the training and retraining of clinicians in palliative care skills, support continuing education, and provide students with clinical training in appropriate sites of care.
 - b. Establish career incentive awards for palliative care physicians, nurses, social workers, and chaplains to foster interest in entering the field of palliative care, and to support clinician educators who can integrate palliative care into medical, nursing school, and postgraduate training curricula.
 - c. Reform Graduate Medical Education (GME) funding to support residency slots in high-value specialties like palliative care and explore a GME quality-improvement program to create incentive for skills training in patient-centered communication, team-based care, and pain and symptom management for all physicians, regardless of specialty.
 - d. Direct CMS to include palliative care measures in all relevant quality- and value-based programs, such as Medicare-sponsored Accountable Care Organization (ACO) measures, the Five-Star Quality Rating System for Medicare Advantage plans and CMS facility-based quality reporting and incentive programs. Measures should include, where applicable, both process and outcome measures to ensure that facilities have adequate resources in place to care for those with serious illness.
 - e. Allocate funding to develop quality measures that address communication, concordance of treatment with patient preferences and goals of care, and care transitions for those with serious illness, multi-morbidity and functional and cognitive impairment, and that are applicable across settings for use in new value-based payment models (CMS tasked also).
 - f. Support PCORI, NIH and AHRQ research that focuses on symptom relief, communication with those with serious illness, and developing and evaluating models of care delivery. Support the development of innovative palliative care delivery models (Patient-Centered Outcomes Research Institute [PCORI], Center for Medicare & Medicaid Innovation [CMMI], National Institutes of Health [NIH], Agency for Healthcare Research and Quality [AHRQ] tasked also).
2. PCORI, CMMI, NIH, AHRQ
 - a. Develop specific program announcements and requests for applications targeted to palliative care research priorities. These studies should include populations with functional and cognitive impairment and frailty. Implementation studies should have a plan for knowledge translation into practice.
 - b. Develop a Center for Scientific Review (CSR) study section that focuses on serious illness, beyond disease and biology-specific topic areas. Existing study sections that currently review research grant applications related to palliative care should have at least three members with content and methodological expertise in palliative care.
3. CMS
 - a. As CMMI is selecting and piloting new care models, ensure that palliative care is a component of care, quality measurement and payment for those with serious illness.
4. Wisconsin Policy Makers

- a. Create a multidisciplinary advisory board and/or task force to conduct a landscape analysis of available palliative care services to determine state capacity and develop appropriate recommendations for improving access to quality palliative care. Conducting a needs assessment and gap analysis is the foundation for strengthening access to palliative care at the state level.
- b. Direct the appropriate department to create quality standards for palliative care and insert these into the state's general licensure standards to ensure that palliative care programs operating within the state meet standardized minimum requirements.
- c. Provide the appropriate funding to establish palliative care training institutes in their state, ideally within an existing university health system, to develop appropriate curriculum, create requirements for training and provide opportunities for hands-on professional development. The institute should integrate this curriculum into undergraduate and graduate courses in medicine, nursing, social work, and chaplaincy. The institute should also provide continuing education for practicing midcareer health care professionals.

[Center to Advance Palliative Care Policy Resources page](#) provides a status update on each of these key areas.

Section 3: Payment Landscape for Palliative Care

Briefly describe the payer landscape in your state. Note whether palliative care is explicitly covered and/or if some services often related to palliative care may be covered. Coverage varies by state and by insurance company. You also may want to include a brief scan of any alternative payment models or other innovative/new approaches to offering health care services that may encompass palliative care, and/or information on the use of specific CPT codes that encompass some aspects of palliative care.

1. Medicaid

- a. Per [Q&As on the Increased Medicaid Payment for Primary Care CMS 2370-F](#), states are required by law to reimburse qualified providers at the rate that would be paid for the service (if the service were covered) under Medicare.
- b. Palliative medicine is included in family medicine, internal medicine, and pediatrics.
- c. Payment also will be made for primary care services rendered by practitioners working under the personal supervision of a qualifying physician.
- d. Writer was not able to locate Wisconsin-specific information.

2. Medicare (Traditional/FFS)

- a. Medicare does not have specific information on their website other than a mention of accepting palliative care to enter [hospice and respite care](#).
- b. Hospice and palliative care [specialty code is 17](#).
- c. Start the Conversation, [Who Pays for Palliative Care](#), notes that if an individual has Medicare Part B, it may cover visits, some treatments, and medications.
- d. Institute for Palliative Care article, [How is Community-Based Palliative Care Reimbursed via Medicare?](#), notes the difficulty and options.
 - i. Physicians, nurse practitioners, and physician assistants can submit bills based on time and intensity of services under fee-for-service Medicare.
 - ii. Physicians, nurse practitioners, and physician assistants can also be reimbursed for advance care planning conversations. In order to bill for advance practice nurse or physician assistant services under the provider number for the physician:
 1. The services cannot be delivered in hospital or long-term care settings
 2. The physician must perform initial visit and initiate the plan of treatment
 3. The physician must be physically present (in the building) and participating in a direct supervisory role, regardless of the scope of practices of the practitioners – it is a billing rule
 - iii. Clinicians can provide ongoing chronic care management — at least 20 minutes of clinical staff time directed by a physician.
 - iv. Transitional care management can be billed for up to 30-days to help a Medicare beneficiary transition from an inpatient hospital to their home or similar community setting.
- e. The Health Resources and Services Administration (HRSA) determines HPSAs, and the Census Bureau determines MSAs. You can access [HRSA's Medicare Telehealth Payment Eligibility Analyzer](#) to determine a potential originating site's eligibility for Medicare telehealth payment.
- f. Rural Health Information Hub, [Care Management Medicare Reimbursement Strategies for Rural Providers](#), includes guides on annual wellness visits, chronic care management, and transitional care management.

3. Health Plans (commercial, Medicare Advantage)

- a. Commercial health plans billing and reimbursement will vary depending on the insurance carrier and the requirements.
 - b. Payment Primer, [What to Know about Payment for Palliative Care Delivery](#), provided by the Center to Advance Palliative Care organization, explains the traditional payment model, risk, managing risk, and shifting risk to providers. Value-based scoring is discussed and demonstrated. Scorable Quality Measures table is from this document.
4. Veteran’s Affairs (VA)
- a. Since [Palliative Care](#) is part of the VHA Standard Medical Benefits Package, all enrolled Veterans are eligible IF they meet the clinical need for the service.
 - b. [Overview of Long Term Services and Supports](#) is available including palliative care.
 - c. Shared decision-making worksheets are provided including [Veteran Shared Decision Making Worksheet](#) and [Caregiver Self-Assessment Worksheet](#).
5. Use of palliative care-relevant HCPCS/CPT codes
- a. CMS through Medicare Learning Network provides a booklet on Telehealth Services ([ICN 901705](#)) dated February 2018 includes service and HCPCS/CPT Codes.
 - b. [Center to Advance Palliative Care](#) provides full access to CAPC tools and assistance for members.
 - i. Advance Care Planning (CPT code 99497 and 99498)
 - ii. Chronic Care Management
 - 1. (CPT code 99490) for at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
 - 2. (CPT code 99487) with the following required elements:
 - a. multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
 - b. chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
 - c. establishment or substantial revision of a comprehensive care plan;
 - d. moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
 - 3. (CPT code 99489) with each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).
 - iii. Transitioned Care Management (CPT code 99795 or 99496)
 - iv. Health Risk Assessments
 - 1. (CPT 96160), for administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
 - 2. (CPT 96161) for administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
 - v. [Additional Codes located:](#)
 - 1. 90785, “Interactive complexity for psychotherapy,”
 - 2. 90791 and 90792, “Psychiatric diagnostic evaluation, with or without medical services,”
 - 3. 96103, “Psychological testing administered by a computer,”
 - 4. 96120, “Neuropsychological testing administered with a computer,”
 - 5. 96127, “Brief emotional/behavioral assessment,”

- 6. 99201-99215, "Office/outpatient visits,"
- 7. 99324-99337, "Domiciliary/rest home visits,"
- 8. 99341-99350, "Home visits,"
- 9. 99366-99368, "Medical team conferences,"
- 10. 90625-90688, "Vaccine"
- vi. Cognitive Impairment Assessment
 - 1. (G0505) for cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, by the physician or other qualified health care professional in office or other outpatient setting or home or domiciliary or rest home
- c. For 2017, CMS has set the average payment amount for G0506 at [\\$63.88](#).
- d. For 2017, CMS has set the average payment amount (i.e., unadjusted for geography or individual physician bonuses and penalties) for code 99487 at [\\$93.67](#) and for code 99489 at [\\$47.01](#).
- e. The Journal of Palliative Medicine published in March of 2015 an article titled, [Top Ten Inpatient Palliative Medicine Billing and Coding Mistakes \(and How to Fix Them This Week\)](#).
 - i. Confusing ICD-9/ICD-10 Codes and CPT® Codes
 - ii. Ignoring the Tiny 'w' or 't' in Front of the RVU Codes
 - iii. Taking at Face Value that You Collect Only 40% of Your Charges
 - iv. Coding Exclusively on Time
 - v. Failing to Document the Medical Necessity for a Patient Visit
 - vi. Writing "Seen and examined. Agree with above" When Working with an Advance Practice Provider to Document a Split-Share Visit
 - vii. Billing for the Patient's Underlying Disease When Seeing a Patient on the Same Day as the Referring Specialist
 - viii. Believing that Medicare Will Know You are Providing a Separate Service from Your Colleague Based on the Content of Your Note
 - ix. Omitting Documentation of the Family History because "My Patient Is Elderly and It Is Not Relevant"
 - x. Cosigning Documentation Written by a Medical Student

TABLE 7: Scorable Quality Measures Relevant to Palliative Care

	Health Plans	Medicare Advantage Plans	Medicaid Plans	Accountable Care Orgs	Comp. Primary Care	Cancer Centers (OCM)
All-Cause Readmissions (all, unplanned)	X	X	X	X		
SNF All-Cause Readmissions				X		
Emergency Department Utilization	X	X			X	X
Hospitalization for Potentially Preventable Complications	X	X				
All-Cause Unplanned Admissions (for specific diagnoses)				X		
Ambulatory Sensitive Admissions (for specific diagnoses)			X	X		
Inpatient Utilization—General Hospital/Acute Care	X	X			X	X
Older Adult Screenings (e.g., function, fall risk, dementia, pain)		X (and HOS)			X	
Medication Reconciliation Post-Discharge		X				
Potentially Harmful Drug-Disease Interactions in the Elderly		X				
Use of High-Risk Medications in the Elderly		X			X	
Fall Risk Management		X				
Depression Measures: Utilization of the PHQ-9 to Monitor Depression Symptoms/ Depression Screening and Follow-up/ Depression Remission at 12 months	X	X		X	X	X
Relative Resource Use (specific diagnoses)	X	X				

Section 4: Data to Help Identify Needs

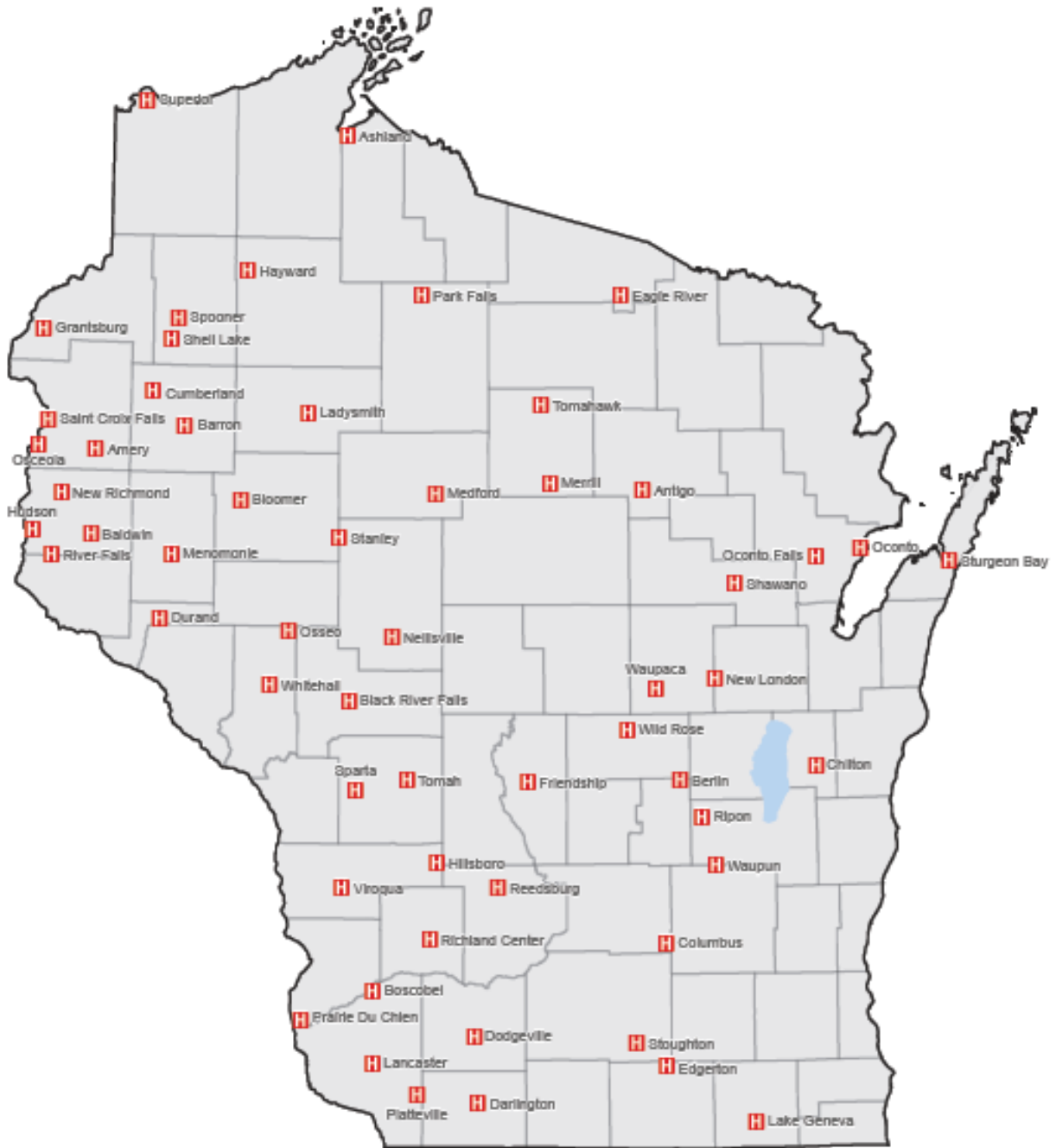
1. How are you defining 'rural' for purposes of this project?

- a. Forty-eight counties are known to have [health professional shortages](#).
- b. The 2017 [Rural Wisconsin Health](#) report provided by WI Office of Rural Health.
 - i. Forty-six counties are rural.
 - ii. Wisconsin is comprised of 69 percent rural land.
 - iii. Twenty-six percent of the population resides within a rural county.
 1. Coronary health disease hospitalizations is 3.5 per 1,000 people in a rural setting, which is higher than urban (2.6) and the state as a whole (3).
 2. New cancer diagnosis is 457 per 1000,000 people in a rural setting, which is lower than urban (474) and the state as a whole (468).
 3. Ten percent of rural adult residents report frequent physical or mental distress (defined as 14 or more days of poor health per month) which is consistent with urban and state statistics.
 4. Ten percent of rural adult residents are diabetic, which is higher than both urban and state (9%).
 5. Preventable hospital stays is 47 per 1,000 Medicare enrollees in the rural setting compared to urban (44) and state (45).
 6. Two percent do not receive heeded healthcare, which is consistent with both urban, and state.
 7. Twelve percent live below the Federal Poverty Line, which is consistent with both urban, and state.
 8. Twenty-eight percent of individuals who are 65 years of age or older live alone which is lower than both urban (30) and state (29).
- c. The 2016 [Municipal-level Urban-Rural Classification System](#) provided by the Wisconsin Office of Rural Health further defines by city, town, and villages within the state.

2. Per [Dartmouth Atlas of Health Care](#) for Wisconsin in 2014:

- a. Fifty-five percent of decedents were enrolled in hospice during the last six months of life.
- b. It is reported that \$28,717 total Medicare reimbursements per decedent occurred six months before death compared to national average of \$34,837. It is also reported that \$57,253 was spent the last two years prior to death compared to national average of \$69,289.

Critical Access Hospitals

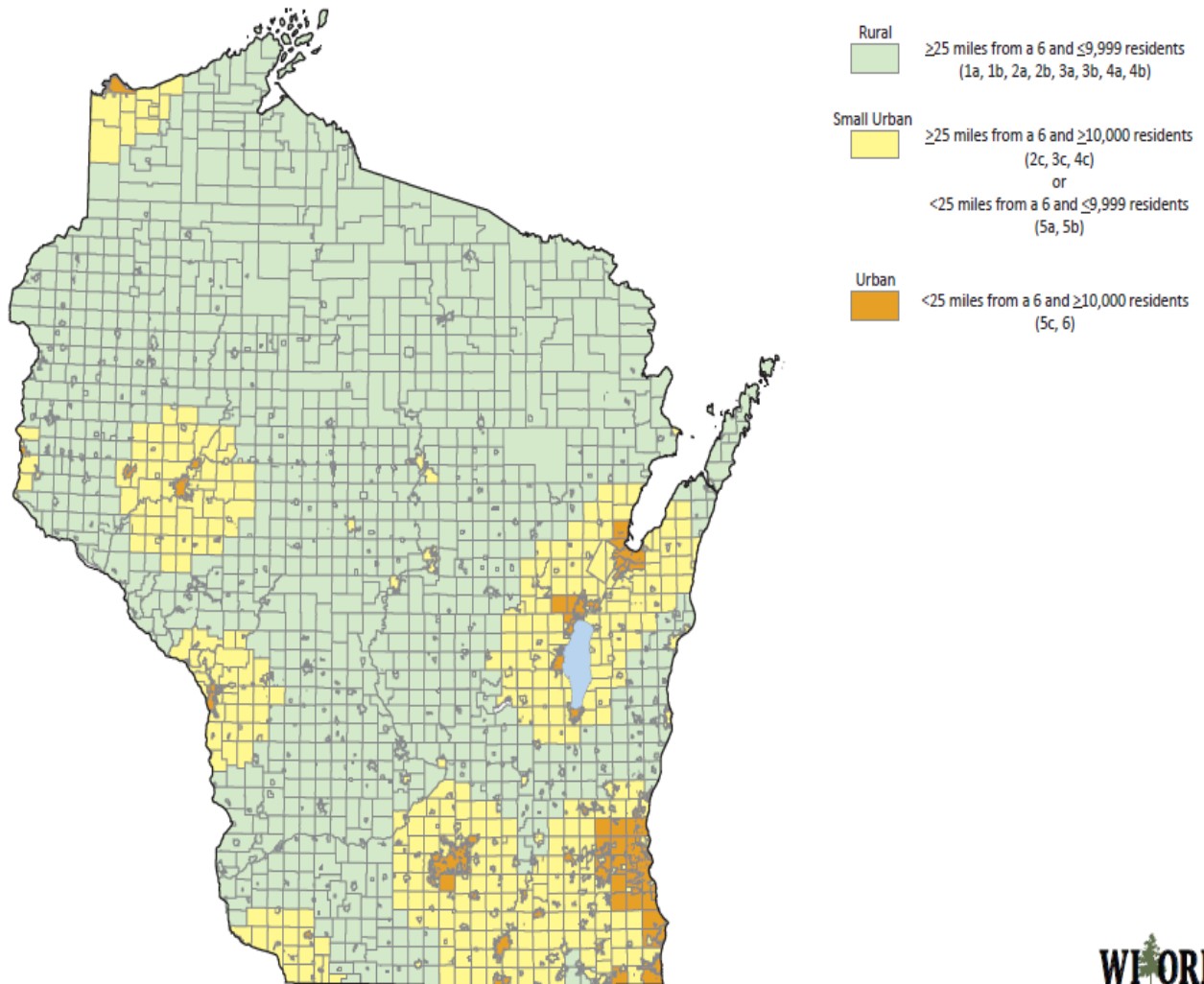


Source: Wisconsin Department of Health Services, August 2017





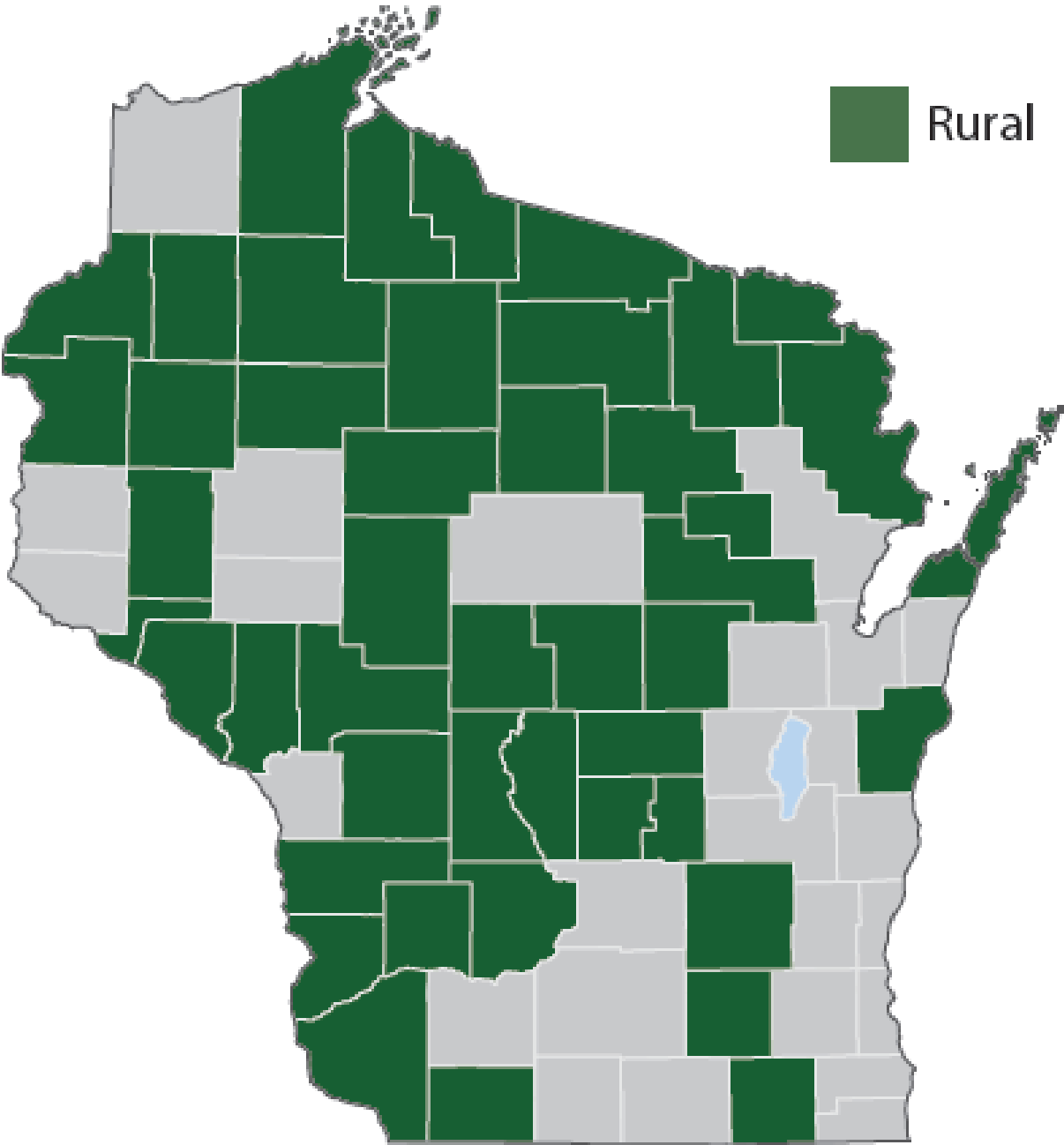
Municipal Urban-Rural Classification 3-class version (MURC3)



WI ORH
Office of Rural Health
August 2016

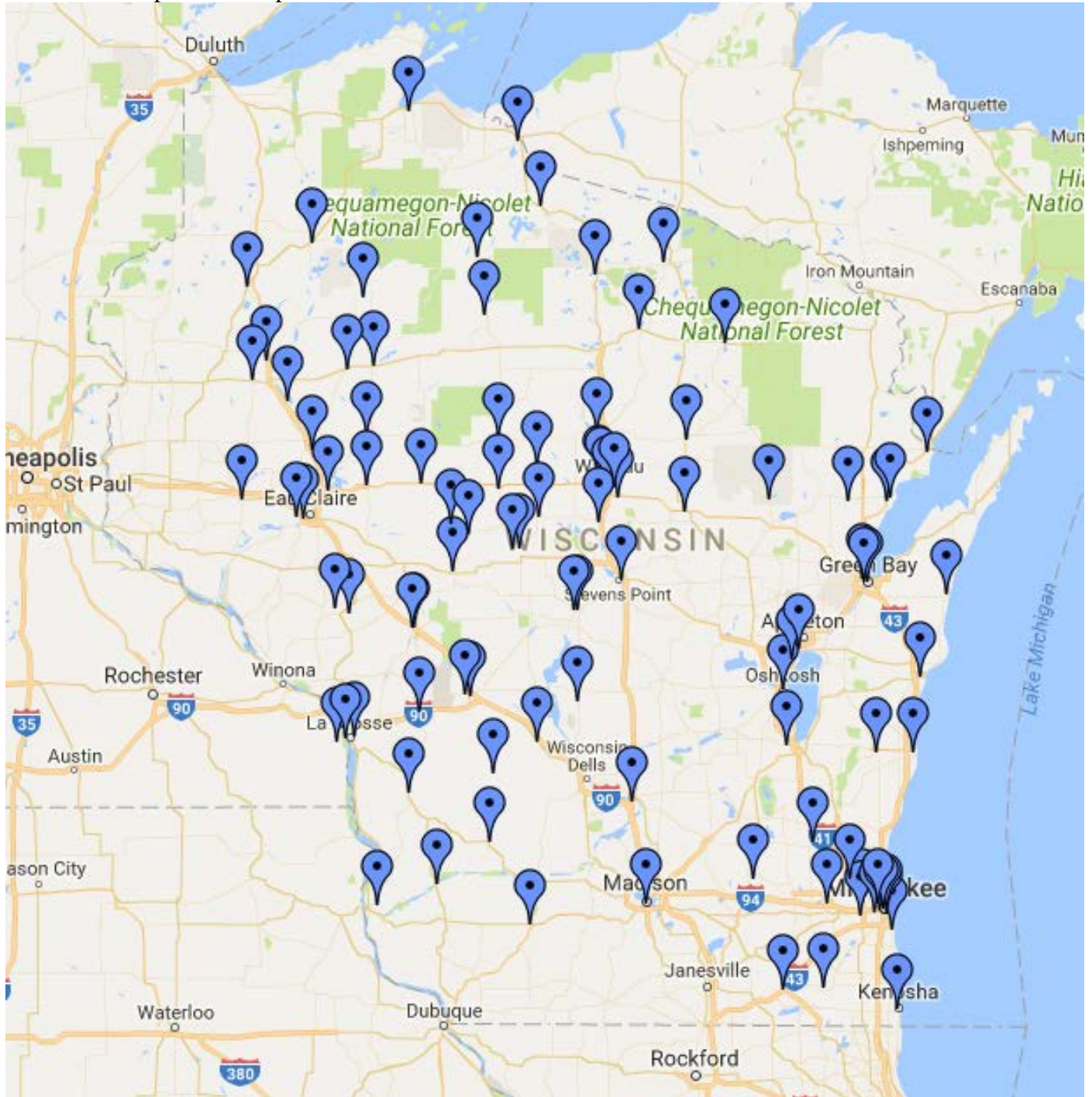
Source: <http://worh.org/sites/default/files/Municipal-level%20Urban-Rural%20Classification%20System.pdf>

Rural Counties per Wisconsin Office of Rural Health



Source: http://worh.org/sites/default/files/Rural%20WI%20Health%202017_0.pdf

WI Telehealth per 2009 Report



Source: http://www.rwhc.com/Papers/RWHC_TeleHealth.pdf

Section 5: Existing Rural Community-based Palliative Care Programs

1. Per the [America's Care of Serious Illness 2015 State-By-State Report Care on Access to Palliative care in Our Nation's Hospitals](#), Wisconsin received an "A" in the report with an overall grade of 87.7% of hospitals within the state having a palliative care program with 50 out of 57 hospitals responding the program is in place. The report further indicates that 88% (49/56) of nonprofit compared to 100% (1/1) for-profit hospitals provided this service. Sole Community Provider for 50 or more beds was 100% (4/4), 88% (7/8) for greater than 300 beds, and 63% (35/56) less than 50 beds. This data is considered in complete, as there are 132 hospitals in Wisconsin, thus 43% were reviewed to collect data for the report. They may have used the same hospitals to be consistent from year-to-year due to comparison between the 2008 and 2011 report cards.
2. Data collected through a hospital survey through the assistance of the Wisconsin Hospital Association and Wisconsin Office of Rural Health and a provider survey as distributed by Palliative Care of Wisconsin was organized by county. It was organized to include designation of acute care and critical access hospitals, long-term care facilities, hospice providers.
 - a. Sixty-four percent of counties are defined as rural (46/72).
 - i. Western region counties are 66 percent rural.
 - ii. Northern region counties are 93 percent rural.
 - iii. Northeastern region counties are 53 percent rural.
 - iv. Southern region counties are 64 percent rural.
 - v. Southeastern region counties are 25 percent rural.
 - b. Twenty-one acute care hospitals are located in rural counties. Range was zero to two with a median of zero and an average of .50.
 - c. Forty-three critical access hospitals are located in rural counties. Range was zero to three with a median of one and an average of .90.
 - d. Twenty percent of hospitals within the rural counties have a high re-admission rate.
 - e. One hundred and fifty-eight long-term care facilities are located in rural counties. Range was zero to 12 with a median of three and an average of 3.40.
 - f. Eighty-one hospice organizations are in Wisconsin. Range was one to 24 with a median of six and an average of seven in rural counties.
 - g. Thirty-three palliative care organizations are in Wisconsin. Range was one to 10 with a median of three and an average of 10 in rural counties. The only county without a known palliative care provider is Pepin (in the western region on the border of Minnesota).