News & Views

Citizen Advocacy Center

Second Quarter, 2007 A Health Care Public Policy Forum Volume 19 Number 2

MARK YOUR CALENDARS

October 29-31, 2007 – Seattle, Washington

CITIZEN ADVOCACY CENTER 2007 ANNUAL MEETING

CAC's 2007 Annual Meeting will be co-sponsored by the Washington State Department of Health. It will be held Monday, Tuesday, and Wednesday, October 29-31, 2007, at the Edgewater Hotel in Seattle, Washington. CAC meetings are open, and all interested parties are welcome. A Preliminary Program is available for download at ***www.cacenter.org***.

Notice: This issue of CAC News & Views is the second issue that is available for download from our website. When viewed onscreen in PDF format, the Table of Contents includes links to all of the articles.

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ROLE OF THE PUBLIC MEMBER

Hospital Boards Tackle Quality

In articles on March 2 and 5, 2007, ***Boston Globe*** (www.boston.com) staff reporter Christopher Rowland writes that the responsibilities of Massachusetts' hospital boards of trustees now include the prevention of errors in their facilities.

Traditionally hospital trustees have concentrated more on fund-raising and community relations than on clinical concerns. Now, Roland observes, hospital officials believe trustee involvement in error prevention will focus more attention on the policies and procedures that lead to mistakes.

According to Rowland, even medical staff, which carefully guards its control over clinical matters, sees the value of trustees becoming involved in patient safety, in part because it helps them recognize the need for devoting resources to the problem.

One hospital featured in the article is Baystate Medical Center where a consumer member of the board chairs the quality improvement committee and receives reports on medication errors, physician performance, and environmental conditions that could lead to errors. In other hospitals, trustees have tied CEO bonuses to evidence of success in reducing errors and instituting safety routines, such as hand-washing.

The Massachusetts Hospital Association embraces the trend and is developing a curriculum to teach hospital trustees how to ask tough questions about safety and to insist that information about errors is brought to the attention of the board.

Editorial Note: CAC News & Views is pleased to see this trend because it recognizes the importance of bringing the consumer perspective to bear on hospital-based patient safety initiatives. The trend also opens the door to possible collaboration between hospital boards of trustees and licensing and certifying bodies which also have patient safety and error prevention as a core mission. It seems to us that public members on boards that license and certify the multiplicity of professions that practice in the hospital setting are just the ones to initiate talks with hospital trustees about how they can reinforce each others' efforts to improve health care safety and quality.

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LICENSURE

Chiropractic Board Adopts Business Practice Rule

The Alabama State Board of Chiropractic Examiners announced several rule amendments in its April 2007 newsletter. One rule governs Non-chiropractic Practice Ownership and requires a currently valid permit for any office, clinic, or other place offering chiropractic services which is owned in whole or in part by a non-licensed person or entity. The rule's concluding paragraph reads:

> Any licensed chiropractor who offers or provides chiropractic services for or in a practice as defined in this rule without said practice having first obtained a permit or a timely renewal shall be considered to have engaged in Immoral or Unprofessional conduct. A practice permit shall be subject to the provisions of the Alabama Chiropractic Practice Act in regard to issuance and renewal of the permit or the acts or omission of any licensed chiropractor employed or otherwise engaged to offer or provide chiropractic services.

Editorial Note: Board members – especially public members – should always carefully examine the rationale behind rules having to do with business practices as opposed to licensee qualifications. In what ways does this particular rule protect the public health, safety and welfare? Or, is its effect simply to inject the board into business ownership matters not obviously related to licensee competence or quality of care?

Use of "Temp" Doctors on the Rise

A growing number of doctors are practicing as temporary substitutes to fill in for doctors who are ill, on vacation, on maternity leave, or for some other reason interrupting their practice. Five states offer temporary or *locum tenens* licenses for this purpose. These states are Alaska, Arizona, Nebraska, New Hampshire, and North Dakota. Some "temp" doctors are fully licensed in several states, enabling them to move around to find work.

The number of doctors working in temporary positions has doubled since 1997 to about 36,000 and the amount of money expended on *locum tenens* staffing has more than doubled since 2000. National placement services help hook up physicians with temporary vacancies.

States Consider Uniform Emergency Volunteer Health Practitioners Act

Kentucky has enacted and other state legislatures are considering adoption of the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA). As explained in the April 2007 issue of the Association of Social Work Boards' ***Association News***,

> Developed in response to the devastation of Hurricanes Katrina and Rita, the uniform law will allow state governments to give reciprocity to other states' licensees as emergency services providers during a declared disaster. Social workers were among the professions who found their volunteer efforts to help after the hurricanes hampered by lack of licenses to practice in the states that were hit.

The part of the act dealing with liability for professionals was held over for continued work this year by the National Conference of Commissioners on Uniform State Laws (NCCUSL).

The act, without the liability sections, was signed into law in Kentucky on March 23. At least eight other jurisdictions are somewhere in the process of getting it into their laws. In Colorado, the UEVHPA passed the House, and then passed the Senate in late March, with the Senate version returning to the House. In California, Oregon, and Tennessee, it has been in committee. In Mississippi and Maine, it has been introduced by a sponsor, but has gone no further. Mississippi will not act on it in this legislative year.

A hearing was held on the bill last fall in the U.S. Virgin Islands, but it had gone no further early in the year.

The version of the act passed by the commission last year establishes a system for the use of volunteer health practitioners that can function autonomously even when communication is disrupted, and provides safeguards to assure that practitioners are appropriately licensed and regulated.

It also allows states to regulate, direct and restrict the scope and extent of the services provided by these volunteers in emergencies. The act establishes a system that allows healthcare practitioners to register to provide services either before or during an emergency. It also authorizes healthcare facilities and disaster relief organizations working in emergency situations to use registered professionals and to rely on the registration system to confirm appropriate licensure. Registration through a number of existing systems would be valid, including with professional organizations…

SCOPE OF PRACTICE

Update: "Prescription for Pennsylvania"

The previous issue of ***CAC News & Views*** (Vol. 19, No. 1) carried an item about Governor Ed Rendell's plans to modify regulations to make health care more accessible and affordable. His plan envisions expanding the scope of practice of nurse practitioners, dental hygienists, nurse midwives, and other non-physicians. It would also alter insurance regulations so that non-physicians would be included in health care networks and be designated as primary care providers for insurance purposes.

The Pennsylvania House Professional Licensure Committee held hearings throughout the state during May 2007. The public had an opportunity to testify on regulations affecting pharmacists, physician assistants, nurses, dental hygienists, and nurse midwives. Details about Governor Rendell's proposal can be found at www.ohcr.state.pa.us.

California Considers Multiple Scope of Practice Bills

Sacramento Bee reporter, Dan Walters, wrote an article on May 7, 2007, citing numerous scope of practice bills pending before the California legislature. An attempt by psychologists to gain authority to prescribe psychotropic drugs (SB 993)

didn't make it out of committee. Dental hygienists are seeking authority to practice independently and have their own licensure board (SB 534). Nurse practitioners and physician assistants want to be able to practice more independently of physicians (AB 1436).

Physical therapists are seeking the right to practice without a prior physician referral (AB 1444). Two bills would expand acupuncturists' scope of practice to include hands-on body treatments and light therapy (SB136 and AB 636). Drug and alcohol counselors would become a state-licensed profession under AB 1367, and professional counselors would gain licensed status under AB 1486. Information about these bills can be found at www.leginfo.ca.gov/.

Association of Academic Health Centers Weighs in on Scope of Practice

Editorial note: The following item is excerpted from a paper published by the Association of Academic Health Centers (AAHC) in May 2007. Entitled,* State Actions and the Health Workforce Crisis, *the report was written by AAHC staffer Michal Cohen Moskowitz. The paper looks at workforce decision-making by Departments of Health, educational institutions, labor and workforce bodies, governors, and legislatures in eight states: California, Georgia, Massachusetts, Maryland, Montana, Nebraska, New York, and Texas. The following excerpt draws from the introductory paragraphs and the discussion of licensure and credentialing. The entire report is available from AAHC, 1400 16th Street, NW, Suite 720, Washington, DC 20036; (202) 265-9600; www.aahcdc.org.

Current and forecasted shortages in the health workforce have generated calls at many levels of policymaking to analyze problems and identify resolutions. Given changing health workforce demographics, looming retirements of health professionals, and increased demand for health services as the Baby Boomer generation ages, experts have estimated that the nation will need to produce 6 million new members of the health workforce by 2014 to replace retiring workers and fill new positions.

Given the critical role that states play in developing the workforce, the Association of Academic Health Centers (AAHC) has examined state policies and programs related to the health workforce as part of a three-year Josiah Macy Jr. Foundation funded study. Through education, financing, and regulation of health professionals, states leverage much influence over the development and practice of the health workforce. Thus, state action is critical not only in resolving current shortages but also in producing and sustaining a workforce for the future….

Licensure and Credentialing

Statutes and rules governing the practice of health professionals are determined both by state legislatures and professional boards. In consultation and cooperation with those boards, states have enacted regulatory changes that affect the supply and practice of health professionals.

Scope of Practice: Changes in health professionals' scope of practice have been demonstrated as one way to improve access to care in the face of workforce shortages. However, scope of practice changes continue to be highly contentious and often provoke conflict between professions.

Nurse practitioners, physician assistants, optometrists, dental hygienists, and other health professions have increasingly expanded their scope of practice over the last five years. Since 2002, psychologists have gained the ability to prescribe medication in two states nationwide, and advocacy for prescription rights continues in other states. State legislatures in 31 states faced proposed expansions to the scope of practice of varied allied health professions in 2006 alone.

Recent scope of practice changes were evident in the eight states profiled. Through laws enacted since 2001, dental hygienists can now provide treatment independently of a dentist's supervision, generally in public health settings, in four of the eight states (CA, MT, NY, and TX). Also within that time frame, two of the eight (NE and MT) have adopted laws allowing nurse anesthetists to practice without supervision. Pharmacists can now perform collaborative drub therapy management in six of the eight states (CA, GA, MD, MT, NE, and TX).

Licensure Requirements: State professional boards oversee the licensure of health professionals in each state, and states have struggled with the impact of state-specific licensure on the workforce. Licensure, the most rigorous method of regulating professions, establishes entry-to-practice requirements for health professionals. Differences in licensure requirements may pose barriers to migration of health professionals between states. Yet states have argued that state-specific licensure also enables states to maintain standards of competence for professionals and provides a revenue source for state professional boards.

In recent years, certain professional associations have advocated successfully that states adopt mutual recognition models enabling professionals to carry over their licensure from one state to another. In 2000, the National Council of State Boards of Nursing implemented the Nurse Licensure Compact, whereby participating states enable nurses to practice in one state if licensed in another state. Twenty states, including three of the eight profiled states (MD, NE, and TX) now participate.

The initiation of new licensures also shapes the workforce as individual professions emerge and develop. For example, New York passed legislation authorizing the licensure of four new mental health

professions in 2002, and authorized licensure of two more professions – clinical laboratory technologists and cytotechnologists – in 2004….

Overlapping Scopes of Practice Raise Legal Issues

Editorial Note: The following article is excerpted from Dale Atkinson's "Counsel's Column" in the August 2006 American Association of Social Worker Board's (ASWB)* Association News. *Mr. Atkinson, Esq. is a partner at the law firm Atkinson and Atkinson which is counsel for the ASWB. He is also the Executive Director of the Federation of Associations of Regulatory Boards (FARB).

Overlapping scopes of practice in related professions are often difficult for the public to sort our and, at times, can present interesting legal issues for regulatory boards themselves.

Practice acts are drafted to respect the fact that an ancillary profession (or professions) may also infringe upon the identified scope of practice. Ultimately, the question arises as to what board has "jurisdiction" over such practitioners and where the authority lies to administratively discipline those accused of violating the law.

Generally these issues arise in accusations of unlicensed practice of a profession, as in the case of an individual licensed in one profession who may be practicing outside the scope of the license and in the scope of another profession. As has been presented at numerous ASWB conferences and as the topic of previous newsletter articles, it is essential that social work boards possess the statutory authority to administratively discipline "individuals" or "persons," rather than the very limiting capacity to regulate licensees and applicants. The ASWB Model Social Work Practice Act identifies and includes board jurisdiction over all persons.

However, issues may arise regarding the authority or jurisdiction of one board to discipline an individual who is licensed by multiple boards. The issues become especially complex where there are overlapping scopes of practice and differing standards imposed on practitioners from each respective profession. Consider the following:

An individual was licensed both by the Psychology Board as a psychological associate (LPA) and by the Board of Licensed Professional Counselors as a professional counselor (LPC). He maintained separate practices providing group therapy to adult sexual offenders as an LPC, while also performing contract work as a LPA for Medicaid clients through a county mental health center. In fact, the licensee took comprehensive measures to keep his two practices distinct and separate….

The licensee confirmed that at all times he was engaged as an LPA, he worked under the supervision as required by law…. But, he admitted that when practicing as a LPC, he was not supervised in such practice for a period of about four years.

Eventually, the licensee informed the Psychology Board that he wished to discontinue his LPA practice, which triggered an investigation by that board (which) found probable cause that the licensee had engaged in activities in the scope of his LPC practice that required supervision for a LPA…. The board found wrongdoing and placed the practitioner's license on probation for two years….

The appellate court identified the issue as whether the Psychology Board can require a LPA licensee to be supervised in his APC practice by virtue of his LPA license, despite the fact that such activities need not be supervised under his LPC license. In its assessment, the appellate court first examined the language of the Psychology Practice Act which, in pertinent part, provides that the act precludes the Psychology Board from preventing "qualified members of other professional groups from rendering services consistent with their professional training and code of ethics, provided they do not hold themselves out to the public by any title or description stating or implying that they are psychologists or are licensed, certified, or registered to practice psychology."

Under the clear language of the statute, the court questioned whether the Psychology Board was authorized by statute to sanction its licensees for activities permitted by another applicable practice act… (T)he court held that the statutory language did not support empowering the Psychology Board in such a manner…, (that) licensees would be forced to adhere to the most onerous requirements, even if the practice fell squarely within the practice act of the additional license…, (and) that the Psychology Board did not have the authority to discipline a LPA for activities of a LPC permitted under the counseling statutes…

CONTINUING COMPETENCE

ABMS Announces Milestone in Maintenance of Competence Programs

The American Board of Medical Specialties (ABMS) announced in December 2006 that each of its 24 member boards had received approval of their maintenance of certification (MOC) programs. Program development continues to be ahead of original projections, according to ABMS which said that "this extraordinary achievement demonstrates the Member Boards' dedication to the program and their commitment to quality care."

The ABMS Website explains that:

> MOC Is the Path. Better Care Is the Destination.
>
> …Decades back, achieving certification required successfully completing a single examination process in a particular specialty. Once completed, a physician could refer to him or herself as a "Diplomate" or "board certified" for the rest of his or her career. The MOC process, in contrast, is designed to be ongoing throughout the course of a physician specialist's career.

…Ultimately, it should be recognized that the measure of physician specialists is not merely that they have been certified, but also how well they keep up to date in their specialty. That's why ABMS and the Member Boards developed a program involving continuous professional development called Maintenance of Certification as a formal means of measuring a physician's continued competency in his or her certified specialty and/or subspecialty, rather than merely passing an examination once every six to ten years. MOC is a response to the rapid pace of research and technological changes in the medical field and the drive toward improving the overall care and safety of patients.

MOC: Six Competencies, Four Basic Components

MOC focuses on the six general competencies which have been deemed necessary for physician specialists:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communications skills
- Professionalism
- Systems-based practice

The six competencies are incorporated into four component categories and adopted by all ABMS Member Boards as the model for recertifying their physician specialists.

Part I: Professional Standing
Physicians must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories or Canada.

Part II: Lifelong Learning and Self-Assessment
Physicians are required to participate in educational and self-assessment programs that meet specialty specific standards set by the Member Boards for its physician diplomates to provide quality care in that specialty.

Part III: Cognitive Expertise
Physicians must prove, through formalized examination, that they have the fundamental, practice related and practice environment related knowledge to provide quality care in a particular specialty.

Part IV: Practice Performance Assessment
Physicians are evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

While its member boards continue with their specific plans to implement MOC, ABMS' attention is now focused on how to communicate the value of MOC to everyone. The *Building Bridges to MOC* communications program has been developed to facilitate this task. Launched at the September 2006 ABMS Assembly Meeting, *Building Bridges to MOC* will be a featured agenda item at future meetings.

"Implementing MOC requires an unprecedented level of collaboration and communication among ABMS, the Member Boards and our collaborative partners," said Stephen Miller, MD, MPH, president and chief executive officer of ABMS.

"Successful implementation will require broad cultural, workflow and technology changes much different from the way we operate today."

For a complete report on the first *Building Bridges to MOC*, visit https://system.netsuite.com/core/media/media.nl?id=592&c=362273&h=eeb596a7ed405e7d8066&_xt=.htm.

Nursing Organization Studies LPN/VN Core Competencies

The National Council of State Boards of Nursing (NCSBN) released the results of a post-entry level practice analysis of Licensed Practical Nurses and Vocational Nurses (LPN / VN) in December 2006. The objective of the research was to determine whether there are core competencies shared by LPNs and VNs in all work settings that could provide a basis for a continued competency assessment.

The researchers surveyed 20,000 LPN/VNs about such factors as practice setting, primary specialty, shifts and hours worked, client ages and types, and demographic information about the nurses themselves. They also studied the representativeness of the activities reported by the respondents, the applicability of the reported activities to a particular practice setting, and the frequency and importance of activity performance.

The findings reported by the researchers "indicate that the activities that LPN/VNs perform are similar regardless of facility, nursing specialty practice area, years of experience and/or geographic region. Information from this study can be used to determine if there is a core set of LPN/VN activities that can be used to determine core competencies."

International Council of Nurses Examines Regulation, Competency Development and Role Definition

An issue paper entitled, ***Regulation, Roles and Competency Development***, written in 2005 by Rosemary Bryant for the International Council of Nurses provides an overview of three elements of the practice of nursing: regulation, competency development, and role definition. "Initial and continued competence are particularly relevant today," writes Bryant,

> …as there is pressure by the public for more transparency in health professional regulation and for greater consumer involvement. This has implications for the trio of educators, regulators, and employers. If the notion of regulation in its broadest definition is viewed as the starting point and safe competent care as the end point, the other elements such as education of nurses, initial and continuing competence, employer responsibilities, role definition, overlap and skill mix all interact to reach the end point. What is unambiguous in this rich interplay is the obligation and responsibility of professional nursing organizations to participate in all of these elements.

Bryant, a nurse and the Executive Director of Australia's Royal College of Nursing, makes 16 recommendations based on her research. These include:

- In order for professional self-regulation to be sustained, consumers must be part of that regulation.
- Nursing regulation needs to be transparent and flexible enough to reflect the changing work environment and the development of new roles.
- Nurses need to remain competent throughout their working lives and, to achieve this there is a need for the development of assessment methods.
- Nurse education programs at undergraduate, postgraduate and continuing education levels need to be developed jointly by employers, regulators, and the nursing profession.
- The structural elements of nursing curricula need to be inherently flexible to enable adaptation to changes in service delivery.
- Some aspects of nurse education should take place in collaboration with other health professionals, particularly in specialties where multiple health professionals practice side by side.
- Shared competencies between nurses and those with whom their roles overlap need to be developed.
- Skill mix research needs to include the effects of changed roles on clinical outcomes.
- The introduction of changed nursing roles needs to be negotiated with both the profession and nursing regulators.
- Methodologies that enable application in a wide variety of settings need to be developed that can accurately assess long-term patient outcomes and patient satisfaction.

The complete report can be accessed at www.icn.ch/global/issue1Regulation.pdf.

IN-DEPTH

Virginians Believe a Current License Means Current Competence

> As documented evidence of quality problems in the nation's healthcare system continues to mount, the state of quality has become a major public policy issue. Quality problems are pervasive, occurring across all care settings and delivery models. On average, Americans receive recommended care only slightly more than 50 percent of the time, experience preventable medical mistakes, and too often, receive care with little or no demonstrated value.

So begins a report entitled ***Strategies to Improve Health Care Quality in Virginia: Survey of Residents Age 50+*** which was released on May 24, 2007 in Richmond, Virginia by the Commonwealth's chapter of AARP. ***(The full report is available at www.aarp.org/research/)***

Echoing the Institute of Medicine (IOM) recommendation that ongoing licensure and certification should reflect lifelong learning and an evaluation of competencies, AARP has come out in support of the notion that:

…consumers and patients need reassurance from state licensure boards that doctors and other health professionals who treat them continue to maintain their skills and proficiency in their respective fields after initial licensure.

The survey conducted by AARP Virginia in August 2006 was a first step toward advancing this AARP policy goal. The survey was administered to Virginians aged 50 and older to assess (1) their understanding and knowledge of existing licensure requirements related to ongoing competence and (2) the acceptability of various system changes that could improve healthcare quality in the Commonwealth.

This In-Depth Feature focuses in on four findings in the AARP Virginia Report:

- Most respondents incorrectly believe the Commonwealth periodically assesses the current competence of health care professionals.
- An overwhelming majority of respondents believe health care professionals *should* be required to demonstrate their current competence as a condition of license renewal.
- Nearly one-third of respondents have been involved in a situation where a medical error was made in their own or a family member's care.
- Slightly more than half of the respondents are "extremely" or "very" satisfied with the health care they and their families receive.

Most respondents incorrectly believe the Commonwealth periodically assesses the current competence of health care professionals.

Respondents were asked to identify three factors they consider to have the most impact on health care quality. A doctor's "quality, experience, competence and knowledge" was selected most often (23 percent of responses), followed by "cost/price" (22 percent) and "insurance coverage" (21 percent).

The next question asked respondents to choose which of the following statements best represents their understanding of the meaning of being licensed:

- The health care professional **was competent** when the license was first issued.
- The health care professional **is** currently **competent** regardless of when the license was issued.

More than half (52 percent) of respondents incorrectly believe that being licensed means that the health care professional is currently competent.

A follow-up question asked whether the respondents believe that health care professionals practicing in Virginia are required to "be periodically re-evaluated to show that they are currently competent to practice safely." More than two-thirds (68 percent) of respondents said, "Yes."

In other words, they incorrectly believe that health care professionals are currently required to demonstrate they have up-to-date knowledge and skills needed to provide quality care.

In fact, the Commonwealth of Virginia does not presently require health care professionals to demonstrate up-to-date knowledge and skills.

An overwhelming majority of respondents believe health care professionals *should* be required to demonstrate their current competence as a condition of license renewal.

Ninety-five percent of respondents responded in the affirmative when asked whether they believe "all licensed health care professionals in Virginia should be required to show they have the up-to-date knowledge and skills needed to provide quality care as a condition of retaining their license."

Respondents were read a list of possible processes that could be used to assure that health care professionals continue to be well-qualified and asked to say whether they consider each process to be extremely important, very important, somewhat important, not very important or not at all important. In a follow-up question, they were asked how often licensed health care professionals should be required to perform each of the listed processes.

- Eighty-one percent of respondents believe it is either extremely or very important that health care professionals be required periodically to pass a **written test** of medical knowledge. Thirty-seven percent believe such a test should be administered every two years; forty-one percent believe the test should be administered every five years.
- Seventy percent of respondents believe it is either extremely important or very important that health care professionals receive **high ratings from colleagues** with whom they work. Forty-four percent believe this evaluation should occur every two years; thirty-five percent believe it should occur every five years.
- Seventy-three percent believe it is either extremely or very important that health care professionals receive **high ratings from their patients**. Forty-seven percent believe patients should rate their health care providers every two years; thirty-two percent believe this should occur every five years.
- Ninety percent believe it is either extremely or very important that health care professionals be **periodically re-evaluated to show that they are currently competent to practice safely**. Thirty-nine percent believe that professionals should be re-evaluated every two years by their licensing board; forty-five percent believe this re-evaluation should occur every five years.

Nearly one-third of respondents have been involved in a situation where a medical error was made in their own or a family member's care.

Thirty percent of the respondents indicated that they or a family member had experienced a medical error. Sixty-eight percent say neither they nor a family member has encountered a medical error.

Ninety-five percent of respondents believe that requiring doctors, nurses, pharmacists and other medical professionals to show periodically they are currently competent would be a good way to help reduce the incidence of medical errors.

Slightly more than half of the respondents are "extremely" or "very" satisfied with the health care they and their families receive.

Asked to rate the quality of care they and their families receive, slightly more than half of the respondents are "extremely" (15 percent) or "very" (39 percent) satisfied. Thirty-three percent are "somewhat" satisfied. Seven percent are "not very" satisfied and six percent are "not at all' satisfied.

Editorial Note: CAC believes the findings from the AARP Virginia survey reinforce the need to more closely align public policy with the public's expectations. If the population of Virginia is representative, more than half of the nation's health care consumers 50 years of age and older believe incorrectly that licensing authorities periodically evaluate the current competence of licensees. Fully ninety-five percent believe that this should be the case.

The discrepancy between the public's desire for periodic evaluation of professional competence and the failure of states to deliver exposes a deficiency in the healthcare regulatory system which, in CAC's view, deserves the immediate attention of state legislatures. The purpose of requiring health care professionals to demonstrate their current competence as a condition of relicensure would be to "raise all boats," not necessarily to identify "bad apples."

The survey findings that show a high degree of satisfaction with the health care they are receiving indicate that the "bad apples" are few and far between. Still, the documented problems referenced at the beginning of this article underscore that requiring across-the-board demonstrations of current competence would provide the public with a fabric of safety and quality protection that more than half the public believes is already there and nearly all of the public believes should be there.

Long an advocate of continuing competency requirements for licensure renewal, CAC is pleased that a membership organization such as AARP has committed to bring this issue to the states. For additional reading on this topic, visit www.cacenter.org and click on PUBLICATIONS > CONTINUING COMPETENCY REQUIREMENTS to link to:

Implementing Continuing Competency Requirements for Health Care Practitioners - 2006.

Maintaining and Improving Health Professional Competence: The Citizen Advocacy Center Road Map to Continuing Competency Assurance - 2004

Measuring Continuing Competence of Health Care Practitioners - 2001

MEDICAL ERRORS AND PATIENT SAFETY

States Evaluate Success of Patient Safety Initiatives

In January 2007, the **Minnesota** Department of Health published its third annual public report of ***Adverse Health Events in Minnesota.*** According to the report, the number of adverse events reported by hospitals increased 50% between 2005 and 2006. The number of reported patient deaths due to medical errors doubled during that period from 12 to 24.

Of the 188 facilities subject to the reporting requirement, only 49 (26%) reported adverse events during the reporting period (40 hospitals, 7 surgical centers, and 2 regional treatment centers). These facilities reported 154 adverse events, an average of 12.8 per month or about three per week. Twenty-three percent of the events resulted in patient harm, 20 percent led to patient death or serious disability. Of the deaths, 12 were due to falls, three were suicides, two were caused by a malfunctioning product, 2 were related to patient elopements, and two were related to medication errors.

Pressure ulcers (48) and objects left behind after surgery (42) accounted for more than half the reported events. Other categories included wrong-site surgery (23), falls (12), other surgical events (9), medical events (6), criminal events (4), and other (10).

Detailed tables break down reported events into different categories: surgical (74), product-related (4), patient protection (5), care management (55), environmental (12), criminal (4).

The authors of the report stress the importance of looking beyond the numbers to learn the root causes of errors and design strategies for preventing a recurrence. The report lists the following factors contributing to errors:

- Communication 53.2%
- Training 42.9%
- Fatigue/scheduling 9.7%
- Environment/equipment 43.5%
- Rules/policies/procedures 58.4%
- Barriers 20.1%

The report examines in some detail the root causes of errors related to surgical events, case management events (pressure ulcers and medication errors), and environmental events. The full report can be found at: http://www.health.state.mn.us/patientsafety .

The **New Jersey** Department of Health and Senior Services issued its ***Patient Safety Initiative 2005 Summary Report*** in September 2006. New Jersey Health care facilities are required to report preventable serious errors resulting in death or serious disability. They are encouraged to voluntarily report near misses and less serious events.

There were 397 event reports in 2005, 376 of which met the statutory requirement for mandatory reporting. Most hospitals reported between one and five events. The report cautions that:

> A hospital with a higher number of reports may be a larger hospital, a less safe hospital, or a more safe hospital that is vigilant about finding and reporting serious medical errors.

The largest category of reported events involved care management (38%) and environment (35%). The remainder involved surgery (17%), patient protection (5%), and a product or device (5%). The root cause analyses found the most frequent contributing factors to be:

- Communication among staff members 60%
- Care planning process 39%
- Physical assessment of the patient 36%
- Staff orientation and training 35%
- Patient observation procedures 28%
- Communication with patient/family 17%
- Equipment maintenance and management 15%
- Physical environment 14%
- Behavioral assessment process 8%
- Staff competence/credentialing 8%

The full report can be found at www.NJ.gov/health/hcqo/ps.

The **Pennsylvania** Patient Safety Authority released its ***Annual Report for 2006*** in April 2007. The report showed that more than 500 changes had been made by the state's health care facilities in response to *Patient Safety Advisories*, but that more work is needed to improve patient safety. Pennsylvania facilities submitted a total of 195,832 incident reports in 2006, an increase of 26,000 reports over 2005. Of these, 3.5 percent (6,937) were serious events involving patient harm, ranging from minor, temporary harm to death. Reported events with harm decreased slightly, but reports of near misses increased in 2006.

Events leading to harm most often involved complications related to procedures, treatments and tests (14% of reports). Other reports involved errors related to procedures, treatments, or tests (24%), falls (17%), medication errors (23%), skin integrity (11%), adverse drug reactions (2%), equipment/supplies/devices (2%), transfusions (1%), and other (6%).

The full report can be found at www.psa.state.pa.us.

The **Indiana** Department of Health issued a preliminary version of its first report under the Indiana Medical Error Reporting System. The final report will be issued in August 2007 when complete statistics from 2006 will be available. Thus far, the 287 facilities in the state that are subject to the reporting requirement have reported 77 events, 72 in hospitals and 5 in ambulatory surgery centers.

The most commonly reported error is pressure ulcers (23 reports). Second in frequency is retention of a foreign object after surgery (21 reports). Third most common is surgery on the wrong body part (9 reports). The full report can be found at: www.in.gov/isdh/regsvcs/mers/pdf/FinalMedicalErrorPreliminaryReportFor2006-March-6-2007.pdf

A private company, **HealthGrades**, issued its ***Fourth Annual HealthGrades Patient Safety in American Hospitals Study*** in April 2007. The study is based on Medicare patient records in 2003-2005. Approximately 1.16 million patient safety incidents occurred during that period in over 40 million hospitalizations. Patient safety events increased by a rate of 2.0 incidents per 1,000 hospitalizations between 2003 and 2005.

Of the 284,798 deaths among Medicare beneficiaries who were involved in a patient safety incident, 247,662 were deemed by HealthGrades as potentially preventable. They also found that beneficiaries treated at the most highly rated facilities had a 40% lower chance of experiencing a patient

safety incident than beneficiaries receiving treatment at the lowest rated facilities.

Of the 16 types of patient safety incident studied by HealthGrades, ten increased in frequency between 2003 and 2005. These are: decubitus ulcer, iatrogenic pneumothorax, selected infections due to medical care, five different post-operative adverse events, accidental puncture or laceration, and transfusion reaction. There were improvements in complications of anesthesia, death in low-mortality DRGs, failure to rescue, foreign body left in during procedure, post-operative hip fracture, and post-operative hemorrhage or hematoma.

The full report can be found at www.healthgrades.com.

The **Joint Commission** also collects information from its accredited hospitals on "sentinel events" and the root cause analyses conducted to find out why they occurred and learn how to prevent them. These statistics are available on the Joint Commission Web site (www.jointcommission.org/SentinelEvents/Statistics/).

The Joint Commission's root cause analysis statistics give insight into practitioner-related variables. For example, staff-related factors identified in root cause analyses conducted in 2004 were (in descending order of frequency): orientation and training process, competency assessment process, adequacy of staffing, staff supervision, staff skill mix, and nursing leadership issues. These same factors were identified in root cause analyses conducted in 2005, but significantly less often, except in the case of competency assessment process, which decreased from about 45% to about 32% of root cause analyses and was the most cited staff related factor in 2005.

Patients Define Medical Errors Broadly

A study published in the January 2007 issue of the ***Joint Commission Journal on Quality and Patient Safety*** (www.jcinc.com) found that patients define medical errors more broadly than traditional clinical definitions. Patients, the study found, include communication problems, practitioner responsiveness and falls in their definition of medical errors. The press release announcing the study concludes that:

> The findings point out the need for physicians and other health care professionals to clarify what patients mean when they talk of an "error" or "mistake." The study of more than 1,600 patients at 12 Midwestern hospitals also shows the importance of explaining exactly what is meant by the term "medical error" if patients are to be effectively engaged in programs to prevent them.

The researchers found that a majority of patients studied feel a high level of medical safety, but 39 percent experienced concern about at least a single type of medical error during their hospitalization. Those more likely to be concerned include middle-aged patients, parents of pediatric patients, African-Americans, patients with long hospitalizations and more severe illnesses and those admitted through the emergency department. Patients treated in small and rural hospitals had fewer concerns, regardless of the severity of illness.

Not surprisingly, a strong link was found between concern about medical errors and patient satisfaction with the hospital experience. The press release mentions additional findings from the study, including:

- the need for additional research into the factors that generate concerns among patients about medical errors,
- how best to encourage patients to express these concerns, and
- what strategies effectively reassure patients about their medical safety.

Incorporating patient attitudes into safety programs could help prevent medical errors and enhance patient satisfaction with their health care experience.

Editorial Note: The study's primary author, Thomas E. Burroughs, PhD, made the point we were hoping to see: "The study underscores that patients and clinicians can have different views of the things that constitute a medical error. For patients, clear communication and responsiveness are particularly important. If these are lacking, patients may view this as a medical error. It is important that clinicians recognize these differences, and the importance of communication and responsiveness." We agree with Dr. Burroughs. Good communication – between clinicians and patients and between members of the care-giving team -- is widely recognized as an important element of quality care, whether or not its absence meets a strict definition of "medical error." Why should this concern licensing and certifying bodies? Because they are in a position to assess clinical skills, including communication. Medical boards recently began requiring passage of a clinical skills test as a condition of licensure. Other professions should consider doing the same.

Misdiagnosis Found to be Common Error

Research published in the October 3, 2006 ***Annals of Internal Medicine*** (www.annals.org) found that basic diagnostic failings contribute to a significant number of medical errors. Researchers reviewed 307 closed medical malpractice cases of which 181 allegedly involved diagnostic errors. The research was supported by the Agency for Healthcare Research and Quality (www.ahrq.gov), which describes the findings as follows:

> A study of 307 closed malpractice claims shows that many missed or delayed diagnoses of outpatients lead to dire outcomes. In some cases, diagnosis of a serious condition like cancer was delayed more than a year. Over half (59 percent) of these errors were associated with serious harm, and 30 percent resulted in death. Cancer was the diagnosis involved in 59 percent of the errors, chiefly breast (24 percent) and colorectal (7 percent) cancer. The next most commonly missed diagnoses were infections, fracture and heart attacks.
>
> The most common breakdowns in the diagnostic process were failure to order an appropriate diagnostic test (55 percent), failure to create a proper follow-up plan (45 percent), failure to obtain an adequate history or perform an adequate physical exam (42 percent), and incorrect interpretation of diagnostic tests (37 percent) by physicians, radiologists, or pathologists. In some cases, clinicians failed to check on test results or to communicate them to patients, or they did not schedule a

necessary follow-up appointment. In other cases, patients failed to keep an appointment to find out or follow up on abnormal test results.

Missed cancer diagnoses were more likely than other missed diagnoses to involve errors in the performance and interpretation of tests. Primary care physicians were centrally involved in most diagnostic errors. The findings reinforce the need for system interventions, such as clinical decision support systems that include alerts and reminders, to reduce these problems.

Pharmacists Intervene to Prevent Errors

Another study funded by the Agency for Healthcare Research and Quality (www.ahrq.gov) and conducted by researchers at the University of Colorado Health Sciences Center studied calls made by pharmacists over a two-week period to clarify the contents of a prescription. One-fifth of the callbacks were to clarify dosage (because it was either unclear or missing altogether), and could have prevented patient harm from inappropriate dosages. Other callbacks involved administrative rather than safety issues.

Errors Continue to be Linked to Long Work Hours for Residents and Nurses

Research published December 12, 2006 in the online journal ***PLoS Medicine*** (http://medicine.plosjournals.org) reveals that medical interns and residents continue to work long hours and expose patients to medical errors due to fatigue. Building on a recent randomized controlled trial in critical-care units which showed that the elimination of extended-duration work shifts (≥24 h) reduced the rates of significant medical errors and attentional failures, lead researcher Laura K. Barger PhD and her colleagues conducted a Web-based survey, across the United States, in which 2,737 residents in their first postgraduate year (interns) completed 17,003 monthly reports.

The study assessed whether extended-duration shifts worked by interns are associated with significant medical errors, adverse events, and attentional failures in a diverse population of interns across the United States. The interns in the study were more than three times as likely to report at least one fatigue-related preventable adverse event during the months in which they worked one to four extended shifts. Interns working five or more extended-duration shifts per month reported more attentional failures during lectures, rounds, and clinical activities, including surgery and reported 300% more fatigue-related preventable adverse events resulting in a fatality.

Another study, published in the September 6, 2006 issue of the ***Journal of the American Medical Association*** (JAMA), assessed the frequency of perceived medical errors among internal medicine residents at Mayo Clinic Rochester and the effect of those errors on the interns' quality of life. Based on data from 184 residents, Colin P. West MD, PhD and colleagues found that 20 percent of the study participants reported one error during the study period, six percent reported two errors, and eight percent reported three or more errors. Those who reported self-perceived errors were three times more likely to exhibit symptoms of depression, burnout, and reduced empathy.

Two studies of hospital nurses find that long work hours by critical care nurses and the stress and fatigue associated with care-giving at home play a role in hospital errors.

The first study, by L. D. Scott and colleagues, appeared in the ***American Journal of Critical Care*** 2006;15: 30-37 (http://ajcc.aacnjournals.org). Data obtained from a random sample of critical care nurses in the United States indicated the hours worked, the time of day worked, overtime hours, days off, and sleep-wake patterns. On days worked, the respondents completed all work-related questions and questions about difficulties in remaining awake while on duty. Space was provided for descriptions of any errors or near errors that might have occurred. On days off, the nurses completed only those questions about sleep-wake patterns, mood, and caffeine intake.

The 502 respondents consistently worked longer than scheduled and for extended periods. Longer work duration increased the risk of errors and near errors and decreased nurses' vigilance. The researchers conclude that their findings support the Institute of Medicine recommendations to minimize the use of 12-hour shifts and to limit nurses' work hours to no more than 12 consecutive hours during a 24-hour period.

The second study, also led by L. D. Scott, was published in the ***Journal of Nursing Administration***, February 2006 (http://www.jonajournal.com). The researchers found that fatigue and stress levels were significantly higher among nurses caring at home for both children and elders. However, nurses providing elder care at home were more fatigued, sleep-deprived, and likely to make errors at work.

Scott and colleagues conclude that "these findings underscore the importance of restorative sleep interventions and fatigue countermeasures for hospital staff nurses involved in dual care- giving roles. Limiting overtime and applying circadian principles to hospital scheduling processes would ensure a more alert workforce, minimize health risks for nurses, and maximize the safety of those in their care."

DISCIPLINE

Fatal Error Sparks Debate over Punitive Measures

The Following item posted by Anthony Vecchione on May 7, 2007 is reprinted from Drug Topics, www.drugtopics.com.

The Ohio State Board of Pharmacy has just revoked the license of a staff pharmacist at Rainbow Baby's and Children's Hospital in Cleveland after a two-year-old patient died as a result of a chemotherapy overdose. The board concluded that the pharmacist did not follow proper hospital procedures regarding the supervision of a pharmacy technician who prepared the chemo agents, which included diamminedichloroplatinum (cisplatin) and etoposide.

The pharmacy board took no disciplinary action against the technician because Ohio does not license or register pharmacy technicians. The technician resigned in the aftermath of the incident.

William Winsley, R.Ph., M.S., executive director of the board, said both the pharmacist and the technician were experienced and had done the preparation many times. However, he said, "the pharmacist failed to adequately check the technician's work." The pharmacist involved in the incident was terminated shortly after the event took place about a year ago and took a position at a community pharmacy. There, according to Winsley, he has

been involved in at least 13 more errors. Winsley added that in this particular case, revocation of his license was justified based upon all the evidence and not just the one error that occurred at Rainbow. Winsley noted that the board makes its decision based on the evidence and the demeanor of the witnesses.

The tragic incident has reopened the debate over whether or not punitive measures should be enforced against healthcare practitioners who are involved in fatal errors. Some patient safety experts insist that punitive action does not get to the root of the problem because most errors are rooted in a failed system. "There are lots of measures you could build into the system to prevent the type of problem that occurred in Ohio," said Michael Cohen, R.Ph., president of the Institute for Safe Medication Practices (ISMP). Cohen said that investigators need to take a look at whether or not the hospital's procedure may have contributed to this type of error.

Bob Parsons, R.Ph., executive VP of the Ohio Society of Health-System Pharmacists, said he was a little surprised that the state board revoked the pharmacist's license. "It's always been my impression that revocation of a license was for the worst of the worst—someone who flagrantly and knowingly puts the public in danger." Parsons added that even if the results of an error are serious, remediation would be more appropriate than permanently removing a pharmacist from the profession.

Ron Dziedzicki, general manager and senior VP of operations at University Hospitals Case Medical Center in Cleveland, of which Rainbow is a part, said the hospital has a system in place to prevent this type of error. "There was actually a process in place that we've used for a long time, and in this instance it appears the pharmacist chose not to follow that standard process and policy." Winsley agreed that while system failures often contribute to errors, in this particular instance, it was not the case. "Could the hospital have done anything to prevent this from a system standpoint? In the pharmacy board's opinion, we could not find any way to fault the system."

The issue of whether pharmacy technician certification and standardization of training is needed has also come to the fore as a result of the Rainbow tragedy. Winsley pointed out that the technician in this case was certified by CVS' technician training program, but that the program does not focus on the types of tasks that health-system pharmacists are involved in. He added that even if techs take the Pharmacy Technician Certification Board (PTCB) exam, the training would not qualify them as IV admixture technicians.

Janet Teeters, R.Ph., director, accreditation services, at ASHP, said ASHP is behind education and training prior to certification. ASHP accredits technician training programs and is pushing for standardized training for pharmacy technicians. "There needs to be some standardized training of

technicians who are getting involved with very serious drugs, and they need to understand more about it." Teeters noted that PTCB is looking at added qualifications that would target a pharmacy technician's work environment. For instance, a pharmacy technician working in retail would focus on claims adjudication, whereas technicians working in a health-system setting would receive additional training in aseptic techniques and IV preparation.

Winsley said that the minutes of the board of pharmacy hearing regarding the Rainbow Hospital incident will be posted in mid-May on its Web site: www.pharmacy.ohio.gov.

Oversight of Paramedics Found to be Faulty

Los Angeles Times staff writers Rich Connell and Robert Lopez wrote in an investigative column on May 6, 2007 that "There is no guarantee that (California) rescuers who err, including EMTs, will be reported, investigated, or disciplined." The reporters cite a case in which neither Fire Department rescuers nor private ambulance technicians flushed the eyes of an auto accident victim (despite her requests), allowing battery acid and other chemicals to burn her corneas. The victim sued.

The reporters write that the incident never came to the attention of regulators, because the victim chose the tort system and the Fire Department and ambulance authorities neglected to notify regulators, despite a county requirement that they report potentially serious incidents. Further investigation by Connell and Lopez led them to the following conclusions:

- Oversight of paramedics and emergency medical technicians (EMTs) in California is "haphazard at best, with nothing to ensure that potentially problematic cases are reported and investigated, or that errant rescuers are held to account;"
- The state system is not set up to consistently recognize poor performance or dangerous patterns;
- There is no reliable system for reporting problems or processing complaints (of the 30 paramedics disciplined by the Los Angeles Fire Department in the last two years, none was reported to the state);
- Disciplinary actions across regions in the state are inconsistent;
- Communications breakdowns are common among regulators and within Fire Departments;
- Even when mistakes and poor performance are identified, regulators are often slow to act.

Investigative Article Questions Drug Company Hiring of Disciplined Docs

A front-page article by Gardiner Harris and Janet Roberts in the June 3, 2007 ***New York Times*** (www.nytimes.com) questioned the ethics of pharmaceutical companies hiring doctors who have been disciplined by their state medical boards to give marketing lectures and, more serious, to work on clinical trials for new medications. Doctors who oversee clinical trials should, it is generally believed, be of the highest caliber and ethics.

The featured doctor in the story is Faruk Abuzzahab, a psychiatrist who had been disciplined by the Minnesota Board of Medical Practice for "reckless, if not willful disregard" for the welfare of his patients. Abuzzahab discharged one such patient

from the hospital when he refused to become a participant in a clinical trial. The patient committed suicide two weeks later. Abuzzahab continues to receive payments from pharmaceutical companies for overseeing clinical trials.

The ***Times*** reporters identified at least 103 doctors disciplined or criticized by the Minnesota board who subsequently received payments from drug companies ranging from $1,250 to $475,000 between 1997 and 2005. Of these, 39 were disciplined for inappropriate prescribing, 21 for substance abuse, 12 for substandard care, and 3 for mismanaged of drug studies. At least 38 doctors received pharmaceutical company compensation while still under sanction by the board.

Editorial Note: This story is a reminder of the importance of bringing creativity to the drafting of consent agreements and other disciplinary orders. Given the incidence of doctors with prescription-related offenses going on to work for pharmaceutical companies, boards would certainly be justified in writing prohibitions against such employment into their disciplinary sanctions. Such prohibitions are especially important, in our view, in relation to work on clinical trials. We urge public members to encourage their boards to seriously consider such a course of action. We also urge the public members serving on the Institutional Review Boards (IRBs) that oversee clinical trials to be more discriminating about the doctors they retain to work on clinical trials.

The same day as the* Times *article, the* Baltimore Sun *ran an article by Chris Emery pointing out that drug companies invest about $19 billion each year to promote their products to medical students. The article suggests that medical schools should enact clear policies insulating medical students from being wooed by pharmaceutical companies. Public members are in a position to urge their boards to publicly endorse the adoption of such policies by health professional schools.

Various States Criticized for Lax Doctor Discipline

Several state medical boards have come in for criticism in major newspapers for slow or weak disciplinary activity. On April 8, 2007, the ***Delaware State News*** faulted the Delaware Board of Medical Practice for lenient discipline of a Dr. Villabona who pled guilty to sexual molestation charges involving two eleven-year-olds twenty years prior. He also lost a civil suit in 2006 filed by a patient who alleged he had sexual relations with her.

As of the date of the article, Villabona continues to practice psychiatry in Delaware under a probationary order ending in 2010 under which the doctor must disclose his sexual misconduct to patients and may not treat minors, even with a chaperone. When the order expires in 2010, Villabona will be permitted to treat minors with a chaperone present. Two other cases cited in the article involved fatalities after two doctors failed to diagnose cancer. Neither doctor was disciplined by the medical board.

Virginia's Board of Medicine took hits from the ***Virginian-Pilot***, the ***Richmond Times Dispatch*** and the Newport News ***Daily Press***. Nancy Young of the ***Virginian-Pilot*** (April 1, 2007) and staff writers for the ***Times Dispatch*** (April 8, 2007) and the ***Daily Press*** (April 18) fault the state's regulatory board for failing to meet Governor Timothy Kaine's goals for more efficient processing of complaints. The medical board took an average of 436.5 days to resolve complaints during the last quarter of 2006. The board did have a large increase in the number of complaints (from

2,039 to 3,160) in the last fiscal year, without commensurate increases in staff.

In Florida, the ***Palm Beach Post*** chastised the Board of Medicine for taking 36% fewer disciplinary actions in 2006 than it had in 2005 (523 compared to 834). Board executive, Larry McPherson, said the reason for the discrepancy is that in 2006, the board began considering first-time citations for minor infractions to be non-disciplinary.

QUALITY OF CARE

Commonwealth Fund Gives US Health System Poor Grades

The Commonwealth Fund's comparison of the health care systems in Australia, Canada, Germany, New Zealand, the United Kingdom and the United States ranks the U.S. system last for quality, access, and efficiency. ***Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*** by Commonwealth Fund president Karen Davis, Ph.D., and colleagues includes surveys of patients and primary care physicians about their medical practices and views of their countries' health systems. The authors say the poor performance in the U.S. reflects its status as the only county in the study without universal health insurance coverage. The following excerpt is taken from the report's Executive Summary. The full report is available at: www.cmwf.org .

Executive Summary

The U.S. health system is the most expensive in the world, but comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance. This report, which includes information from primary care physicians about their medical practices and views of their countries' health systems, confirms the patient survey findings discussed in previous editions of *Mirror, Mirror*. It also includes information on health care outcomes that were featured in the U.S. health system scorecard issued by the Commonwealth Fund Commission on a High Performance Health System.

Among the six nations studied—Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States—the U.S. ranks last, as it did in the 2006 and 2004 editions of *Mirror, Mirror*. Most troubling, the U.S. fails to achieve better health outcomes than the other countries, and as shown in the earlier editions, the U.S. is last on dimensions of access, patient safety, efficiency, and equity. The 2007 edition includes data from the six countries and incorporates patients' and physicians' survey results on care experiences and ratings on various dimensions of care.

The most notable way the U.S. differs from other countries is the absence of universal health insurance coverage. Other nations ensure the accessibility of care through universal health insurance systems and through better ties between patients and the physician practices that serve as their long-term "medical home." It is not surprising, therefore, that the U.S. substantially underperforms other countries on measures of access to care and equity in health care between populations with above-average and below average incomes.

With the inclusion of physician survey data in the analysis, it is also apparent that the U.S. is lagging in adoption of information technology and national policies that promote quality improvement. The U.S. can learn from what physicians and patients have to say about practices that can lead to better management of chronic conditions and better coordination of care. Information systems in countries like Germany, New Zealand, and the U.K. enhance the ability of physicians to monitor chronic conditions and medication use. These countries also routinely employ non-physician clinicians such as nurses to assist with managing patients with chronic diseases.

The area where the U.S. health care system performs best is preventive care, an area that has been monitored closely for over a decade by managed care plans. Nonetheless, the U.S. scores particularly poorly on its ability to promote healthy lives, and on the provision of care that is safe and coordinated, as well as accessible, efficient, and equitable.

For all countries, responses indicate room for improvement. Yet, the other five countries spend considerably less on health care per person and as a percent of gross domestic product than does the United States. These findings indicate that, from the perspectives of both physicians and patients, the U.S. health care system could do much better in achieving better value for the nation's substantial investment in health.

NCQA Issues Standards for Measuring Physician Clinical Quality

On May 17, 2007 the National Committee for Quality Assurance (NCQA) published an expanded set of measures, guidelines and technical specifications to allow for standardized, equitable assessment of physician practice quality. The new specifications are based on HEDIS®, the most widely used performance measurement tool in health care.

The new HEDIS Technical Specifications for Physician Measurement include more than 40 measures of clinical quality as well as standards for the measurement of the cost of care. The specifications also provide standardized methods of data collection at the physician office level using electronic data systems such as electronic medical records in addition to administrative claims data and paper medical records.

"Today, making objective, reliable comparisons on physician quality is quite challenging," said NCQA Vice President for Performance Measurement Joachim Roski, PhD, MPH. "Our approach builds on our proven track record in health plan assessment as well as the experience of physician practices, health plans and community collaboratives to create a fair, equitable set of measures and guidelines supporting performance measurement at the physician practice level."

NCQA's popular Physician Recognition programs currently recognize more than 5,000 doctors nationwide for excellence in diabetes and heart/stroke care, as well as clinical information management.

To order a copy of the Specifications for Physician Measurement in either electronic or hard copy form, contact NCQA Customer Support at (888) 275-7585, or visit NCQA's Web site at www.ncqa.org.

Nurses' Working Conditions Linked to Patient Infections in ICUs

Hospitals that have better working conditions for nurses are safer for elderly intensive care unit (ICU) patients, according to a recent report, led by Columbia University School of Nursing researchers that measured rates of hospital-associated infections. Hospital associated infections are the number six cause of death in the United States (CDC March 2007). Nurses, as the largest workforce in the nation's hospitals, are in a unique position to positively impact the safety of ICUs if systematic improvements to their working conditions can be made.

A review of outcomes data for more than 15,000 patients in 51 U.S. hospital ICUs showed that

- ICUs with high nurse staffing levels (the average was 17 registered nurse hours per patient day) had a lower incidence of infections.
- Higher levels of overtime hours were associated with increased rates of infection and skin ulcers. On average nurses worked overtime 5.6 percent of the time.

Reported in the June issue of ***Medical Care***, the findings support the notion that a systematic approach aimed at improving nurse working conditions will improve patient safety. "Nurses are the hospitals' safety officers," said Patricia W. Stone, Ph.D., M.P.H., R.N., assistant professor of nursing at Columbia University Medical Center and the study's first author. "However, nursing units that are understaffed and that have overworked nurses are shown to have poor patient outcomes. Improvements in nurse working conditions are necessary for the safety of our nation's sickest patients. With the looming nursing shortage, hospitals direly need to address working conditions in order to help retain current staff now and recruit people into nursing in the future."

The researchers used nurse surveys and objective measures of staffing, overtime and wages with payroll data. They also looked at hospital profitability and magnet accreditation (a national recognition program for nursing excellence in hospitals). Patient outcome data came from the Centers for Disease Control and Prevention (CDC) National Nosocomial Infection Surveillance system and Medicare files.

After careful review, findings revealed that ICUs with higher staffing had a lower incidence of central line associated bloodstream infections (CLSBI), a common cause of mortality in intensive care settings. Other measures such as ventilator-associated pneumonia and skin ulcers, which are common among hospitalized patients who cannot move regularly, were also reduced in units with high staffing levels. Patients were also less likely to die within 30 days in these higher-staffed units. Increased overtime hours in ICUs were associated with increased rates of another common hospital-associated infection, catheter-associated urinary tract infection, as well as increased rates of skin ulcers on patients.

The researchers recommend increasing the availability of highly-qualified float nurses through cross training. This would allow

hospitals to more appropriately staff their ICUs and further develop the skills of nursing staff based on other units.

For more information about the study, visit www.cumc.columbia.edu.

ETHICS

Dental Board Member Expert Witnesses Raise Ethical Questions

The May 1, 2007 issue of the ***Austin American-Statesman*** (www.statesman.com) carried two articles by staff reporter, Mary Ann Roser, raising questions about the conduct of members of the Texas State Board of Dental Examiners. Specifically, dental board members have acted as expert defense witnesses in court cases against dentists who also have cases pending before the licensing board.

Interviewed for the article, the dental board members said they saw nothing wrong with the practice because they simply recuse themselves when the accused dentist's case comes before the dental board. Attorneys who spoke to reporter Rosen acknowledged that being a dental board member enhances the credibility of expert witnesses with the jury.

In contrast, the Texas Medical Board is considering a proposed rule that would require its board members to get approval from the board's executive committee before accepting appointment as an expert witness.

Editorial Note: CAC News & Views sees a clear conflict of interest when board members serve as expert witnesses while serving on a licensing board, not only because the accused practitioner may have a case pending in both venues, but also because of the implication that the practitioner speaks with added authority because of his or her position on the regulatory board. We hope public members will be attentive to this potential conflict and urge their boards to ban this practice. The Texas Medical Board will be taking a step in the right direction if it approves the proposed restrictions, but we would prefer to see a clear prohibition.

Physician Self-Referral Remains a Problem

A study entitled, "Physician Self-Referral: Banned, But Surprisingly Common" was published in April 17, 2007 on the ***Health Affairs*** Web site. Written by public policy professor Jean Mitchell of Georgetown University, the study provides the first empirical evidence of how often physicians are stretching federal and state laws -- and perhaps breaking them -- by referring patients to imaging providers with whom they have a financial relationship.

"Laws enacted during the early 1990s to curb physician self-referral were a major step toward addressing the concerns about these arrangements; however, they contain exceptions that could enable self-referral to reappear," writes Mitchell.

Mitchell gathered information on all providers (physicians, hospitals, and independent diagnostic testing facilities) that billed a California insurer in 2004 for three types of diagnostic imaging scans, either "globally" for both the scan and its interpretation or just for the "technical" components of the scan itself. These diagnostic procedures were magnetic resonance imaging (MRI); computed tomography (CT); and positron-emission tomography (PET).

Overall, Mitchell found that 33 percent of the providers who submitted either global or technical bills for MRI scans were non-radiologist physicians practicing in small

and medium-size groups and engaged in self-referral. In 2004, these self-referral providers accounted for 11.5 percent of total MRI volume in California reimbursed by the insurer. For CT scans, such self-referral physicians represented 22 percent of the providers who submitted global or technical bills to the insurer but less than 7 percent of statewide volume paid for by the insurer. Self-referral physicians accounted for 17 percent of the providers who submitted global or technical bills to the insurer for PET scans but more than 25 percent of statewide volume paid by the insurer. For all three highly reimbursed technologies, the share of statewide volume stemming from self-referrals paid for by the insurer had increased dramatically since 2000.

These kinds of arrangements have recently been subject to heightened scrutiny by federal and state law enforcement authorities, but Mitchell says that the self-referral situation is probably worse today than it was in 2004. She also notes that arrangements tailored to fit exceptions in self-referral bans extend beyond the three types of advanced imaging procedures examined in this study and include other types of services such as clinical laboratory tests. Further, anecdotal evidence strongly suggests that self-referral arrangements designed to fit exceptions in current law are not limited to California…

Given the abundant evidence that physician self-referral leads to increased utilization and cost, Mitchell says that her findings "should be of considerable concern to policymakers, employers, insurers, and consumers who recognize the need to control rapidly escalating health care spending." Mitchell's article can be found at http://content.healthaffairs.org.

Editorial Note: Clearly enforcement of existing prohibitions on physician self-referral is inadequate. We encourage medical boards across the country to consider whether and in what ways they have the power to help identify cases of self-referral and enforce prohibitions against the practice.

IN THE COURTS

Jury Finds Pharmacies Negligent

In December, 2006 a South Carolina jury awarded $7.7 million to a patient who lost the use of her only kidney after a local pharmacy gave her five times the prescribed dose of medication. A second pharmacy involved in the error settled with the plaintiff for an unknown amount while the jury was deliberating.

The patient, Tiffany Phillips, was prescribed an anti-rejection steroid after receiving a kidney transplant. The Eckerd pharmacy where she filled the prescription did not have enough in stock, so the pharmacist called a nearby CVS pharmacy to fill the prescription. A miscommunication resulted in the patient being told to take 1250 milligrams a day for three days, instead of 250 milligrams per day. After the overdoses, Phillips had to undergo two more kidney transplants, she is unable to use dialysis, and she is unable to have a third transplant.

The computer system at CVS caught the error, but an employee used manual override to fill the prescription with the incorrect dosage information. CVS said that no employees had been disciplined over the incident. The jury awarded $2.7 million in damages and $5 million in punitive damages, because Eckerd never acknowledged any wrongdoing.

Editorial Note: Where was the board of pharmacy in this situation? Surely, a CVS employee's decision to manually override a computer warning would warrant an investigation by regulators, as would the failure of the Eckerd pharmacy to notice such an unusual dosage.

Governor Vetoes Legislation Exempting Health Care Practitioners from Lawsuits

Kansas Governor Kathleen Sebelius vetoed legislation on April 20, 2007 that would have prevented some lawsuits against health care providers. Enacted with the backing of the Kansas Medical Society, the bill was a response to a state Supreme Court ruling that the state's Consumer Protection Act (CPA) applies to health care providers.

The medical society contended that the CPA did not apply to doctors because they are regulated by the State Board of Healing Arts and can be sued for malpractice. A Kansas Coalition for Consumer Protection, including the trail lawyer's association and the state AARP, among others, opposed the legislation and was pleased by the governor's veto. Governor Sebelius' veto message said that if allowed to become law, the legislation would harm consumers and would induce other professions to seek similar protection from lawsuits.

CAC'S ANNUAL MEETING

CAC's 2007 Annual Meeting will be co-sponsored by the Washington State Department of Health. It will be held Monday, Tuesday, and Wednesday, October 29-31, 2007, at the Edgewater Hotel in Seattle, Washington. CAC meetings are open, and all interested parties are welcome. A Preliminary Program, which includes a registration form, is available for download at *www.cacenter.org*.

The Edgewater Hotel is located at 2411 Alaskan Way, Pier 67, Seattle, WA 98121. This is Seattle's only waterfront hotel, with dramatic views of Elliott Bay, the Olympic Mountains, and the downtown skyline. The Edgewater Hotel features knotty-pine furniture, river-rock fireplaces, and urban and wilderness landscapes just outside your hotel window.

The Beatles stayed at the Edgewater Hotel during their 1964 world tour. With the installation of a cyclone fence around the property, fanatic fans tried swimming to the hotel. A famous photo was taken here, as the Beatles fished from the window of room 272.

The Edgewater Hotel is also host to Six Seven restaurant, which combines Pacific Northwest seafood cuisine with contemporary Pan-Asian and American influences. Six Seven features inspired cuisine crafted with local ingredients, including regional seafood, native herbs and local produce.

For reservations at The Edgewater Hotel, call (800) 624-0670 between 8:00 am and 8:00 pm. To receive the $159.00 conference

discount, tell them that you are with the Citizen Advocacy Center group. **Room availability is limited, so make your reservation as soon as possible,** and no later than September 28, 2007.

The Seattle Aquarium will host our Tuesday evening reception. A nationally recognized aquatic educational center within walking distance of The Edgewater Hotel, the Aquarium was built on Pier 59 in 1977 by the City of Seattle, and it serves three-quarters of a million visitors annually. After undergoing major renovations, the new "Window on Washington Waters" exhibit opened on June 22, 2007. Join us for hors d'oeuvres and beverages from 7:00 pm until 8:30 pm.

TO REGISTER FOR CAC'S ANNUAL 2007 MEETING IN SEATTLE, WASHINGTON, PLEASE COMPLETE THIS FORM AND MAIL OR FAX IT TO:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

Name:		
Title:		
Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Fax:		
Email:		

PAYMENT OPTIONS:

1) **Send us a check made payable to CAC for the appropriate amount. Our Federal ID number is 52-1856543;**
2) **Provide us with your email address to pay using Paypal or any major credit card. We will email a payment link to you;**
3) **Provide us with a purchase order number so that we can bill you; or complete the following form if paying with Visa or MasterCard:**

Name on Credit Card:
Credit Card number:
Credit Card expiration date:
Purchase Order Number:

	Early Bird Rate before September 28, 2007	**after September 27, 2007**
Subscribers to *CAC News & Views*: ***To subscribe visit www.cacenter.org***	☐ **$395.00**	☐ **$445.00**
Non-Subscriber registration fee:	☐ **$445.00**	☐ **$495.00**

Will you attend the Public Member Training Session on Monday afternoon? ☐ **YES** ☐ **NO**
There is no fee for this session

Will you join us for a reception at the Seattle Aquarium on Tuesday evening? ☐ **YES** ☐ **NO**
There is no fee for this party

CANCELLATION POLICY:

100% refund if cancelled before September 28, 2007.
50% refund if cancelled after September 27, 2007 and before October 15, 2007.
NO REFUND if cancelled after October 14, 2007.

Room availability is limited, so
REGISTER AND MAKE HOTEL RESERVATIONS EARLY!