Wyoming Healthcare Commission
Monday, September 22, 2003
Casper, Wyoming
Parkway Plaza

Attendance: Chris Muirhead, Chairman; Dr. Stacy Childs, John Vandel, Paul Lang, Ford Bussart, Carol Jenkins, George Bryce, Dr. Robert Volz, Commissioners; Dr. Deborah Fleming, Director, Wyoming Department of Health, and Ken Vines, Wyoming Insurance Commissioner, ex-officio Commission member; Diane Harrop, Emily Genoff, staff.

I. Meeting called to order, 9 a.m.

II Presentations

Maureen Humphreys, Director, Sheridan Veterans Administration

The VA is a large, integrated healthcare organization. In 1995-96, Dr. Kenneth Kaiser presided over a national policy forum and from that came good strategies for patient safety. The VA's focus is on quality with a very complex set of performance goals for preventive health and chronic disease management. Ms. Humphreys reviewed the VA's medical technology system, which helps identify and address medical errors. In order to encourage reporting of errors, the VA had to facilitate a cultural change within its provider community to move away from a focus on blame and punishment to prevention and openness. Staff has to be encouraged to report their errors; that practice cannot just be mandated. It should be done as a systems approach and as a real priority, rather than simply as a means of obtaining a new or renewed healthcare facility certification. A champion has to be found among clinical providers who are technology literate and can see the benefits before the system is actuated. In the VA's first six to eight months of its new system, there was amazing resistance among physicians. They have so successfully improved the system that now they could not pry it out of the physicians hands. The VA's technology allows their system to be 100 percent paperless. It allows both administration and clinical leadership and frontline physicians to extract reports on their patients and their care, and eliminates errors associated with handwritten notes. Not all physicians are adept at typing in progress notes and histories. The VA allows the use of dictation; about half of physicians still dictate longer progress notes. However, that is diminishing due to use of templates for certain reports. Physicians can do searches in the VA information management system for progress notes by authors, titles, and disease processes. Several people can review the chart at the same time. The VA's remote community clinics in Casper, Riverton, and Gillette, and contracted physicians in Powell were required starting in 1998 to all be on the VA's computer system. There are no more lost records. A physician in Casper can consult with a physician in Sheridan on the same patient at the same time. A year ago, the VA installed new radiology equipment that allowed it to turn Wyoming's radiology system over to the radiology department at the VA in Denver. The VA in Denver provides all radiology support. Physicians in Denver can conference with physicians in Sheridan over paperless radiology images. The VA has 24-hour real time service by the Denver VA. In many rural communities, that kind of

response is not necessarily evident in local hospitals. A medication bar code system has been implemented for two and a half years. Nationwide, the bar code system has reduced medication errors within VA health care facilities by over 90 percent. The VA is only on its second version of the bar coding system and there are still difficulties with it. The RNs have figured out how to work around the system, sometimes by necessity – like when a medication is delivered to the floor in a dose that wasn't ordered. The bar coding system took a tremendous amount of staff time to implement and it is not faster than doing it the old way. However, the impact on patient safety has been well worth the time and effort. As staff uses the system they become more adept. Computers are never up 100 percent of the time so the VA has had to develop contingency plans for computerized record and bar code administration. As long as contingency system is well designed, patient care is not compromised. Initially, the VA ran a dual system, which proved to be incredibly labor intensive. Nonetheless, staff was unaccustomed to not using paper and it was difficult for them to let go of. The VA uses a medical errors review system of analysis of both events and close calls. Individual events or close calls that are serious are subjected to a scoring methodology for deciding whether events are fully analyzed or reviewed instead in aggregate by a team of healthcare providers who were not involved in a patient incident -- along with patient safety manager. The Sheridan VA has done about 15 individual analyses in two years. They have found an amazing number of process improvements. Resulting policy changes and different kinds of staffing have really improved the overall quality of care. Quarterly, they review medication errors in aggregate. The staff in the areas that have done these aggregate reviews stay on the team from quarter to quarter and have designed processes for their own work area that have dramatically reduced the number of patient falls and medication incidents. They also did two failure mode effects analysis. Those are a risk assessment of some major process in the hospital. They, for example, selected bed rail entrapment for analysis and without a huge expenditure of funds -- by moving around of beds and mattresses – were able to totally eliminate bed rail entrapment issue. There are 147 beds at Sheridan VA; 50 are long-term care, 25 are medical beds and the rest are acute psych. They do not do surgery. Every hospital in the VA system operates patient safety system in the same way. All live under same rules. The VA uses telemedicine and telepsychiatry. Telehealth is especially important in a rural setting like Wyoming because it gives access to consultants Denver, Salt Lake City and other larger medical facilities' specialists and allows for a higher level of care that they can't otherwise necessarily provide in each clinic. Individual physicians practicing within scope of privileges are represented by the Justice Department in any alleged malpractice case. In seven years, the Sheridan VA has had just three tort cases. When the Riverton clinic was first opened, the facility did all laboratory tests in the local hospital, which isn't on the VA system. Lab values had to be hand entered into the electronic record, which was extremely cumbersome. The VA now ships all specimens to Denver. Ms. Humphreys was asked whether there are possibilities for spreading out its infrastructure to allow for its utilization in the care of non-veterans. She said the VA's appropriated dollars can only be used for the care of veterans. But there are sharing agreements in different places in the country where specialized services the VA has can be sold to private entities. Because there are waiting lists in VA system (300,000 veterans waiting for a first appointment) and funding shortfalls, access to non-veterans is more severely limited. Until all veterans can be accommodated, she doesn't see expansion to

other populations happening. In addition, the VA's information management system is unique. The automated systems are in a computer language that is no longer widely used. An off the shelf hospital record keeping system is not compatible with the VA system. There's a huge debate now in the VA as to whether there should be a switch to an "off-the-shelf" information management system that is compatible with other systems. All of the VA's tertiary clinics across from medical schools have a difficult time communicating. The Department of Defense has been adapting the VA's system for use in their hospitals. Ms. Humpreys said she anticipates a greater move to have collaborations with Department of Defense and other federal health care systems, like Indian Health Service. They are just starting a program through the University of Colorado health sciences system for tele-psychiatry. The VA is about to launch a program called "HealthE Vet" that will provide an Internet portal to vets that will enable them to access some of their own medical information. The "Health Hero," a little instrument that goes in the veterans' home telephone lines, is being used to track patients with congestive heart failure, diabetes, and post-traumatic stress disorder, and nine other disease processes. Ms. Humphreys said she was dismayed to see in results from a recent Wyoming Hospital Association administrators' survey that information management was of least concern. She thinks that should be way up on everyone's priority list because it has much to do with cost effectiveness and patient safety.

Robert Kidd, II, Wyoming Hospital Association President

(Handout, WHA925.pdf) Wyoming hospitals rely on medical staffs when something outside of the norm has occurred. People were reluctant to even do incident reporting because it was punitive. In the 1990s, when the American Hospital Association and other medical organizations started developing centers of excellence, they began working to replicate best practices and put in checks and balances in our hospitals. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reviews hospitals' medical errors reporting processes and holds the hospitals it certifies to a national standard. That hospital in Wyoming is being compared to every other JCAHO-certified hospital in the country. Medication errors are big problem that certainly probably that information technology can help with. Mr. Kidd said he applauds the Legislature and Healthcare Commission for working on the medical error issue. He was asked whether he thinks there is a correlation between tort reform and incident reporting. He said he thinks incident reporting is improved by tort reform.

Lisa Fink, director of process of improvement and accreditation of United Medical Center, Cheyenne

(Handout, UMC.pdf) An Institute of Medicine report in 1998 opened a lot of healthcare industry eyes and resulted in the development of a patient safety plan at UMC. The need to develop such a plan was questioned initially by medical staff, because they don't come to work planning to make any errors. But the plan has found to be helpful after staff have worked with it for a couple of years. Part of that plan is trying to develop a culture of safety that is non-punitive when errors are reported. UMC has seen an increase in incidents reported, particularly medication errors. Part of that is due to the fact that the hospital is participating in Netmarks, a national database that allows UMC to compare itself with other reporting hospitals across the nation. Ms. Fink said they use that for

improvement and it has been helpful in the medication area. They also track and trend other incidents, and it's helpful to have that automated. UMC – which uses automated bedside nursing stations -- is looking to upgrade its automation. JCAHO provides them with a framework for patient safety through standards. They use two processes -- failure mode analysis and preventive root cause analyses – that were developed in aviation and aeronautics industry. They review published national patient safety goals. They are developing education for patients and staff regarding patient safety. Nursing burnout is impacted by the patient safety plan because there is greater satisfaction among nurses involved in failure mode and root cause analysis. Ms. Fink said those nurses have been grateful to go through those analyses because it provides them with the ability to be able to talk about what occurred and is cathartic. She said she is not aware if it using that information, however, to recruit and retain nurses.

Jan Pope, Mountain Pacific Quality Health Foundation

(Handout, MPQHF.pdf) Mountain Pacific used to be known as a peer review organization and was perceived as being punitive. The review Mountain Pacific in those days looked on a retrospective basis at problem areas over time in a facility. Then there would be peer review by another physician and letters were sent to physicians and facilities regarding what was done what was not. In the last few years, the federal government realized progress wasn't being made in changing the medical errors reporting system. At that point, the focus was changed to that of a quality improvement organization (QIO). Mountain Pacific works on all of the quality initiatives in the hospitals, nursing homes, home health agencies, and physician offices. Ms. Pope said she has been in and out of those arenas constantly last four years working on projects. Mountain Pacific is finding a facility that is looking hard at doing a good job doesn't look at just one population, it looks at everybody. Mountain Pacific deals with chronic diseases, primarily congestive heart failure, acute myocardial infarction, pneumonia, and surgical infection. The intervention strategy is to help them capture those who end up in a wound clinic, and to find out whether the physician offices reporting back those they see in their offices, and finding ways and means to help them investigate find out why and make changes or adaptations to improve that level of care. Mountain Pacific maintains and works at what is known as the highest standard for those particular disease criteria. Every patient, for example, should have a certain standard of care if they have congestive heart disease. Wyoming has one of the best responses to a public reporting initiative of any state in the nation. She just came back from a national conference where she was thrilled to see how well Wyoming has responded to this initiative in comparison to other states that were there, and every state was represented. Now a lot more health care providers are signing up to participate. This initiative involves public reporting on quality measures. Public reporting has been difficult for physicians and facilities to look at and say that it's fair and needed. Now it has turned around and they're not looking at that as negative but as a positive way to look to see what can be done to try to make a difference. In Wyoming, there are 79 physicians signed up to do this initiative in their own offices and 30 more are getting ready. Participation is expected from almost 100 percent of hospitals, at least 39 nursing homes and all but six of home health agencies.

Wyoming does not have technology like it should have it in rural communities. Mountain Pacific is trying to do some training with WebX to encourage practitioners to use the Internet as a means of getting new information to staff when they cannot afford to travel or for other reasons they don't have the access always available to continuing medical education. Internet access in healthcare facilities should be directed. Ms. Pope said she believes reimbursement by Medicare is going to be tied to quality improvement in the future. Premiere Hospitals – which is a coop like VHA, Inc. – has contracted with the Centers for Medicaid and Medicare to be the pilot for this quality improvement initiative; it is basing results and outcomes on providing them with reimbursement differences. The top 10 hospitals will get a 2% bonus, the second 10 will get a 1% percent bonus and the top 50 will receive public recognition. They see that as quite an incentive. They are doing well. Will all of this impact malpractice tort reform? Ms. Pope said improving healthcare facilities' processes should be a part of the change process. It can be a part of reducing that burden. She's worked for 38 years in healthcare in Wyoming and has seen trends emerge. Technology is wonderful but in developing better and better technology, practitioners are losing the ability to do patient assessments. Part of that is a training issue. To recruit and retain good people, a system has to be developed that is enticing to good people. Is it tort reform, only? Ms. Pope said she sees some communities doing a good job. She said she did legal reviews for 20 years, for the Doctor's Co., attorneys, and others, and gained a lot of insight from that. One of the primary issues is whether incidents are documented and were those things actually done according to the highest standard of care? Ms. Pope said she thinks Wyoming's healthcare facilities have a lot of room to improve but also has one of the best opportunities in the country to improve because the state is small enough to allow people to work together.

Jill Holt, Director of Nursing, Shepherd of the Valley, for CEO Keith Skatrud

Keith served on the Healthcare Reform Commission and he recognizes the value of this process. Is our current medical injuries compensation system working to promote safety? We don't believe that system addresses medical errors and promotes patient safety. We've had the pleasure of having our general liability insurance rates increase 100% this year. We have had the same company for three years and zero claims. If the current system is working to promote safety and we've had no claims, the assumption could be made that our facility is safe -- why then do our liability rates increase 100%? We didn't do anything wrong, darn it, and look at what happened. What incentives or disincentives do providers help us to safeguard patient safety? Jan Pope and Mountain Pacific is a fabulous resource. We utilize their services; they are resources to us on how to safeguard patient safety. There are not a lot of positive incentives to improve quality. We have many disincentives. We're heavily regulated and closely monitored in long-term care. I suppose you can say we have big guns keeping an eye on us. Mountain Pacific Quality Healthcare Foundation provides us with data, people, and implementation of tools. Our organization has in-house programs, quality assurance types of meetings, and adopts concepts that help prevent errors. Dr. Deborah Fleming: *Is it true that your organization is no longer offering health insurance to your employees?* Ms. Hill: That's true; we ceased to offer healthcare coverage to all employees. Our employees are mostly women who tend be lower income, less educated and not as likely to practice preventive healthcare for better health. Ours is a more expensive industry and healthcare is more

expensive. We were not able to afford to offer insurance to our employees. We did offer a stipend and invited health insurance companies to come in and make their pitches, but most employees take stipend and do not secure health insurance. Our organization is a nonprofit with limited resources. We have done what we can do with the money available to us. We could utilize more software than we have, if we had more money. That helps address some of the nursing shortage. But even with a lot of technology and tools, you have to have good, qualified people who are competent to operate and manage it. We need resources for technology, training, and to retain employees to prevent errors.

Wyoming Senator Charlie Scott

(Handout, Scott.pdf) Think back to your first meeting and the presentations on exploding healthcare costs. The malpractice part of this is a relatively small part. There's an additional component and that's in the defensive medicine area. It's extraordinarily difficult to find good studies that pin that cost down. I've seen figures as high as 20 percent. Experts have trouble identifying what is defensive medicine and what is being reasonably prudent in ensuring you've covering all your bases. But if you compare the U.S. system with those in Canada, Japan, and Europe, we're spending 14% of our GNP on healthcare. The next highest one of them is Switzerland, which is spending 10.6% of its GNP on healthcare. The rest are under 10%. Look at the results. If you just use crude measures of life expectancy, their system is better than ours. We are right down at the very bottom of the developed countries in terms of performance. It does suggest that there is a lot of expenditure in the American system that is not incurred elsewhere. Some of the expenditure in the American system is unnecessary or even counter productive. The administrative costs in our system are running 20% plus of total costs. The complexity of our payment system is to blame, in part, and defensive medicine. We are doing a lot more in this country to be on the safe side to protect the practitioners and it's showing up in that difference between what we spend and what is spent elsewhere. Is our current medical injuries compensation system working to improve medical errors? No. If you look at the chart I've given you, that is part of the basis for my answer. This was the basis for the National Institute of Medicine's report on medical errors. Of all the hospitalizations reviewed, 3% to 4% of those involved injuries due to medical care and 1% of those injuries were due to substandard care. Only 2% of those potentially valid claims resulted in an actual claim being made. The reasons many possible claims weren't filed range from physicians' good bedside manner to simply size of claim. A number of the injuries didn't reach the economic threshold to result in a claim in the tort system. Two percent of claims that were valid constituted 20% of costs. There is a very poor relationship between there actually being substandard care and error made and any recovery in the existing tort system. The recovery appears to be independent of the occurrence of an error in good part. That's a description of a system that is not functional and is not working to promote patient safety. The current tort system inhibits patient safety on quite a scale. You have to remove the fear of retribution in order for your system for finding errors and fixing them to be effective. The federal government does it by having a system where individuals are protected from liability. Some of the hospitals can do it internally with nursing staff and other staff by saying the hospital will have a policy of not having retribution for reporting errors. That's about the limit to it. You can't do that under our legal system for physicians. If it's found the physician has made a

mistake, he's open to public humiliation, a public trial claim, and a damage award exceeding his insurance amount. Physicians and hospitals cannot afford to be open or forthcoming or admit to making mistakes. Ideas for addressing this problem include a cap on non-economic damages and all other pieces of the California micro-system. I think it's important when you're evaluating that proposal to look at the problem you're trying to solve. If the problem you're trying to solve is that malpractice insurance rates are going up so much that in some cases you're losing services as we have in this state with obstetrics in Newcastle, sure, micro-reforms work. What virtually all of them do is cut down the payout that insurance companies have to make. If your cap is low enough, sure enough you'll affect the rates. It takes awhile because Insurance Companies don't believe it until it's held up in court. The statistics are undeniable. But that does not deal with the fear of liability and being honest about patient errors. In fact in the current system somewhere in the vicinity of three quarters of money we spend on medical malpractice goes not to the people who are injured but to the people who run the system – insurance attorneys, plaintiffs' attorneys, and experts. That's a scam. The traditional remedy doesn't work. A constitutional amendment that has been proposed sets us up with a system that is similar in ways to the worker's comp system. It is not worker's comp, which is a no fault system. You can't do that in general with healthcare. You have to have some finding of fault. It creates a commission whose primary focus is reducing medical error and improving patient safety. You then say, 'okay that person is entitled to compensation,' and pay them like in worker's comp with a schedule. It creates a state fund to take care of legitimate medical needs. You then do away with need for a trial and individual fault finding and you create opportunity for the kind of system the VA has, reviewing particular incidents and doing quarterly aggregate reviews. That's how I would envision the system working under this constitutional amendment. The commission would be a group of healthcare professionals not involved in the incident, and a few professionals outside the healthcare realm working with engineering systems and analysis and in the accounting profession who have seen what can go wrong with reporting systems. By and large I would say the VA is functioning the way I would envision functioning under the proposal I have. In this system, you have the right to have legal representation on appeal and the state would pay for it. At an initial hearing, my guess is they would not find that necessary. The proposal gives the Legislature discretion to structure the committee to meet on an informal basis. In fact, in injured patient might appear represented by somebody from the healthcare community -- perhaps their own physician who would be saying, 'look my patient got hurt, we need to compensate and fix what happened.' In a lot of the cases, on the initial look the commission may well have had information from somebody within the healthcare system before the patient comes in. If the committee thinks that a mistake has been made, the bill ought to be remitted or the patient ought not to be charged for extra healthcare. They may choose to take it further and say, 'I ought to have more than that.' You're getting too much of adversarial relationship between doctor and patient. It ought to be a partnership. Where you've got significant damages, the commission can decide how much. Look at the way the worker's comp system work and adapt it. There's a schedule that indicates that if you're out of work for so long, this is what you're entitled to. Occasionally those amounts do get disputed. But that system has been much more effective. Recent figures from worker's comp show that of all the money in for worker's comp, 17% is on administrative costs

and 83% is spent on benefits for injured workers. That's the reverse of what you see in the tort system for medical malpractice. You do need to set up a reserve pot to do payouts. But this is intended to supplant the tort liability system. You cannot turn around and sue. In worker's comp it's the employer who's protected, in medical liability it's the healthcare provider. This works. This means that you do away with any need the physician has to have malpractice insurance. You're dealing with a state fund. How much will it cost initially? That's a question we're going to have to explore. There probably would need to be an appropriation of some magnitude to get this thing implemented. But this does not lead to big settlements and payments up front. If your payments are stretched out as the need for them arises, you might have a need for some state pool there just to be assured that there's something to draw on initially. This is not necessarily going to be a cheaper system. If only 10% of potentially valid claims are compensated under existing system you've got a lot of potentially uncompensated claims out there. It is possible this new system will be more expensive and it will have some administrative costs clearly giving it a major quality control role and that's not free. Not as much as you'd require, though, if the state suddenly had to be a malpractice insurer of last resort. This would help physicians who would like to cut back rather than fully retire. Claim histories shift costs to those doctors with the most. The opportunity is set forth to do an experience rating in determining the premium. One administrative question we face is to what extent is that a productive thing to do. You want to go far enough so that there is some pressure on physicians to show quality improvement. The big question there is the professional question – the physician is dealing with the lives of his friends, neighbors, and others and he's going to do the best job that he possibly can. The same is true of other healthcare professionals. The rating may come more where you're dealing with larger healthcare organizations such as hospitals. We did find worker's comp is not particularly experience rated. When we initiated reforms in 1993, worker's comp went to an experience rated system and found it did improve safety. But frankly, my experience as a small employer under worker's comp is that when I get an employee injured, I am much more concerned about getting him the treatment needed to make him whole and getting him back to productive work. At the end of the year we say our rate went up or down, we need to be more careful, and maybe send a horse to the glue factory since that tends to be the source of injuries in our business. It's a very different degree of pressure – there's not a problem with public knowledge of my having an injury on my ranch. This concept was first presented in November 2002. The committee elected to go with the pure caps proposal, instead. Tex Boggs refined this proposal and introduced it as Senate Joint Resolution No. 2. It slept in Senate Committee No. 10 while the House was considering the proposal for putting a cap on non-economic damages. When the House Judiciary Committee killed that proposal, ours was brought out in the Senate but it died in committee of the whole on a 15 -15 vote. For a new proposal that has not been tried in any other state, that is a good first try and one that has encouraged me to try the proposal again. It has to be a constitutional amendment. The provision in our state Constitution that forbids the putting of caps on is crystal clear. Because you're proposing an exclusive remedy, there are other constitutional provisions you're overriding. This enables you to get the medical review panel back. And again by putting it in the Constitution, you put it where they will hopefully find they have to hold it up. Frankly, a lot of the other parts of the California micro-reforms I'm skeptical will work here. Wyoming's legal precedents

are different. When in the aviation industry there is a crash, they make swift changes. We would be experimenting, feeling our way. We've got the authority through this amendment to give a medical review commission very sweeping powers. I think the VA model and how that works is going to be very instructive. With new technology, medical professionals can in the first two or three days of a newborn's life screen for hearing difficulties that can be remedied. If those hearing problems are not remedied, within about 24 months that part of the child's does not develop and he or she will never hear. The Legislature has gotten 80 percent to 90 percent compliance with rules testing newborns' hearing in hospitals where there are deliveries. A few physicians weren't routinely ordering those tests so the legislators made it mandatory. Regarding information technology, the Labor, Health and Social Services is looking toward putting in a statewide patient records system and basing it on the VA system. We think there's some real promise there. That will be explored at the going to explore at the Committee's Oct. 14 meeting in Casper at the University of Wyoming Outreach Center. We think that has real implications for reducing errors. Concerning the nurse burnout spoken about by the Wyoming Hospital Association presenter: We've been dealing with the nursing shortage. Senators Tex Boggs and Mike Massie are following up on this number of possible initiatives, including Magnet Hospitals. We need to see a little more response from the community regarding both incentives and compulsion as a means of trying to start moving the hospital forward in the work environment arena. Wyoming is 50th in nursing salaries we're probably going to have to do something about that. In terms of insurance rate regulation, I'm going to urge the Insurance Commission to start limiting medical underwriting because we're going to run medical malpractice above the regulated rate unless you do that and there is no effective rate regulation. He said the Legislature is also examining being unable to compensate physicians enough to pay physican insurance on obstetrics. In a state where Medicaid pays for 47% of births should, they may see fit to put in a special surpayment for the first 15 or 30 deliveries as a way to get obstetrics back into our small communities.

Dr. Wayne Couch, Rawlins physician

Dr. Couch said that in 2000, the Institute of Medicine reported that medical errors account for between 44,000 and 98,000 patient deaths per year -- more than breast cancer or auto accidents. Critics suggest that doesn't pertain to patients around here. The review of records leading to the Institute of Medicine report occurred in New York, yes, but also Utah and Colorado. So the report represents patients from our region. More than 90 percent of these errors did not result in litigation. If they had, what would malpractice rates be? Ten times what they are now? As the public becomes more litigious, more claims will be paid. To prevent patient injury, we must first understand why mistakes occur. Five percent of physicians account for 54 percent of all amounts paid out by insurance companies in settlements and jury trial verdicts. Some physicians, for some reason, the public looks for reasons to go after. Good communication skills and bedside manner go a long way toward alleviating that problem. Patient safety systems can go far, as well, as we begin to transition to electronic prescribing. Electronic prescriptions are crosschecked for allergies and drug interactions. With 3 billion prescriptions written every year, that will reduce errors in inpatient and outpatient settings. There are no numbers for errors in outpatient settings. Improvement in individual performance is

required to prevent many injuries. How much time do doctors and nurses spend training for rare emergencies? Many errors occur in intensive care. Requiring these courses only makes sense. I have never ever for even a moment that a physician colleague got up on any particular morning and intended to harm a patient; that's a criminal act. These are unintentional injuries. Risk management components of medical conferences that are specialty specific might go a long ways toward reduction of errors. Procedures can be performed wrong. In medically underserved areas, fatigue of the provider can contribute to mistakes. Imagine working 8 a.m. to 6 p.m. and then getting called in at 2 a.m. to deal with an emergency. After that, you wake up at 6 and again have to deal with making life-or-death decisions. Some errors are due to impairment from alcohol and substance abuse. I recommend the implementation of random alcohol and drug testing. This is not being done in any uniform fashion. This comes as a complete surprise to the public. Doctors abuse drugs and alcohol at the same rate as the regular population. The difference is that the roughnecks working drilling rigs are subject to pre-employment and random drug testing, as are truck drivers and railroad workers. In the aviation industry, you can't be a pilot or astronaut without pre-employment drug testing. I believe the answer to this question is obvious. Currently physicians with substance abuse problems come to the attention of the Board of Medicine when their behavior, not performance, becomes suspect. Some physicians are referred to or seek help themselves from a Wyoming organization working with impaired providers. Wyoming is number one in the nation for cocaine use in under-age-18 group. But that age group is not the dealers' primary market for cocaine. What about those who don't have a problem? Denial is a symptom. The current method of identifying providers with problems is provider focused. Random testing is patient focused. It allows helping these professionals that we need so badly to maintain their own career. Individuals who abuse substances prefer to help themselves. A positive drug test would lead to substance abuse evaluation, treatment, and then a requirement that the practitioner remain unimpaired for two or three trials. The big stick method is not a reality unless they absolutely refuse to respond to treatment. Protection of public safety cannot be achieved in any other fashion. The U.S. Supreme Court has upheld the legality of drug testing. Airline pilots, railroad workers, and truck drivers are randomly tested. Some hospitals require testing for doctors but exclude the majority: physicians who have privileges there who are in private practice. Health care is the last bastion of safety sensitive occupations that is not subject to random drug testing. Some argue that it's cost prohibitive. Let's do the math. If we have 800 doctors and each test costs $50, you can get it cheaper than $40,000 a year in lab fees, hire a full-time employee to test physicians and with program travel expenses the budget would still be under $100,000. You could test each physician once. What about the patients' rights? Don't the patients have a right to a sober doctor? Change state laws next session. Let's not look back and ask why didn't somebody already do this. Let's lead the way in patient safety nationwide by eliminating physician impairment as a cause of medical errors. My recommendation at this point is to start with physicians (not all healthcare workers – but the program could be expanded). Discussion followed regarding whether it is within the power of the state Board of Medicine to require random drug testing.

Marcia Shanor, Wyoming Trial Lawyers

Ms. Shanor acknowledged that tort reform is at the top of the Wyoming Healthcare Commission list. In Wyoming, there is no problem with juries. The total number of medical malpractice cases is about 1 percent of all cases filed. There have been only five verdicts greater than zero since 1998. Claims have also remained stable over the course of last 10 to12 years, so numbers of claims is not the issue. Ms. Shanor said that Wyoming Insurance Department figures show that in 1998, the increase in medical malpractice premiums was 1 percent; in 2001, there was a 10 percent increase; in 2002, there was a 28.8 percent increase; and in 2003, the increase has been 43.3% thus far. Many states with caps have had large premium rates increases. Montana has effective cap of $250,000 and they have had large increases. The Weiss study shows that states without caps have slower or lower increases than states with caps, so there is no firm indication that caps would effectively reduce rates. We should find a way to help places like Newcastle pay their malpractice premiums so services can still be offered. Wyoming policymakers will have to look at medical malpractice suit settlement information to see if caps are warranted. We need to be able to talk about settlements in an informed way before we start talking about limiting options to sue.

Tom Jubin, Cheyenne lawyer

Mr. Jubin said that the tort system in this country has the effect of making the United States a safer place. If people who do something wrong are held accountable, that promotes safety. It's not just in the medical field. Now, we have cars with seatbelts and with gas tanks that don't explode. If a physician makes an error and is held accountable, an error is not likely to occur again. This concept is something that's been around since the founding of this nation. Thomas Jefferson said there should be equal and impartial justice to all its citizens. I want to show you a few photographs of some people who have had to access that justice system (displays photographs of people whom he alleged were victims of medical negligence). Jubin said there already is a cap on damages: it's called the insurance policy limit. That's the risk the insurance company is exposed to. There has been a 33% increase in licensed physicians in Wyoming so the assertion that there is a drain on the number of doctors as a result of our tort environment is not the case. It's always going to be difficult to attract physicians to rural communities. Recruitment problems have no relation to tort systems. Another interesting fact is, the insurance companies told us they don't raise malpractice premiums unless they have a claim showing conduct that fell below the standard of care. Mr. Jubin suggested recommendation of legislation enabling access to closed claim information to find out why a particular physician's rates are skyrocketing (based on claims filed against him). The insurance companies tell us they don't raise rates unless there has been medical negligence. The notion that you hear caps on damages the mantra and the drumming about it in the same breath with the notion that there are frivolous lawsuits. I'm not here to tell you that every single lawsuit filed is absolutely correct. Caps on damages are a backhand fix to a perception of a front-end problem. Take people most seriously injured gravest of injuries punish you because there's a perception of frivolous lawsuit problem. The tort system's intent is to compensate the person as a result of medical negligence. Why is doctor still practicing that concern is properly addressed through board of medicine. To the extent a lawsuit in a physician having to report his or her misconduct coming for review sure it helps. Other aspect is physician will hopefully for their

patients' sake want to practice good medicine and do no harm, additional incentive if you are held accountable. The risk of lowering insurance policy coverage award against you than you would be responsible for the overage. The insurance company is setting its premium based on a known exposure. It's my personal view that people make mistakes. Those mistakes are not necessarily intentional; some are highly egregious and some just happen -- that's what you buy insurance for. I must concede that not being a practicing physician, I'm not in a position to tell you what sort of systemic changes can be made to improve medical safety. If you look at statistics from the jury system, it works more favorably to physicians than to people injured in a statistical way. In terms of awards given, it's working. Caps on damages are not going to make premiums go down and this notion that it's going to stabilize them is incorrect. The law requires that where there is a duty to act reasonably. In the medical context, you have to practice to the standard of care. If the conduct in rendering medical services falls below that standard of care -- whether intentionally or by accident -- it is still considered negligence. If that causes harm or injury, that's when liability attaches. It simply means if the conduct fell below the relevant standard of care, then liability attaches and the physician's insurance company generally is held accountable for the harm caused by that.

Rob Shively, Casper lawyer

My experience in defending and prosecuting for 20 years is that insurance company representatives are sophisticated and generally spare no expense to make sure physicians' cases are adequately defended. Most insurance companies are required to get physician's consent before settling. While we don't have benefit of settlement specifics because no one but the lawyers involved can see those results, I can tell you the physician conceded that maybe he was negligent in order for the settlement to be paid. That is the underlying truth in every settlement that you hear about. Just Friday there was another defense verdict in Jackson in favor of the anesthesiologist. I can always as a defense lawyer bank on Wyoming juries doing their utmost to protect their local physicians. Until last month, the highest verdict in the state was $750,000 for a little boy whose osteomyeolitis had gone undiagnosed. The highest was $307,000 before that in a case where a mother and child died. Not exactly what one would call a runaway verdict. Think about the amount of the cap on noneconomic damages being proposed and ask, what would any of you pay to lose a child, spouse, brother, or sister? That's essentially the kind of computation that we have to think about when we think about caps. What we're really talking about is are we going to attack the jury system. I submit you have no data to do that with. The insurance companies won't let you lower policy limits to $250,000 – the choices are $1 million and $3 million (OHIC and The Doctor's Company) in minimum coverage. I have yet in 20 years never seen a physician's personal assets attacked. Physicians carry malpractice insurance because they want to protect the people they serve. That's why I carry a malpractice policy. If we want to reduce the risk and reduce the cost, get around the constitutional limitations on a medical review panel. Make it so that all the way across the board, in order to sue anyone licensed by the state you must first go through a review panel of some sort. Get around protection of due process objections of the 1980s that arose when the Supreme Court last heard this issue. I don't know that I can accept the premise that errors aren't known. It is known -- it's known in the peer review committee, in incident reports, even by hospital administrators. Montana has a review

panel. A lot of states do have them. They are set up differently in different states. Some are binding some are not. Sen. Charlie Scott said that 25 states had a similar process that has been upheld virtually everywhere else -- we are unusual in having it struck down. The real issue is, should it be admissible in a court of law? Mr. Shively said. I'll leave that up to the Legislature. I don't care. It just helps me analyze the case. I think it gives you great insight into whether or not you've got a case. Trial lawyers have no announced policy one way or the other. Will a medical review panel improve patient safety? It will make it more quick -- from the minute the panel reaches its decision, member physicians will go back to their facilities and say, 'we just had a case that involved this and that is something we have to look out for.' If a large settlement is paid or if a large verdict occurs in the state, the Board of Medicine's practice is to call that physician down and ask why – I know they've been doing that for at least four years.

Toni Decklever, Wyoming Commission on Nursing and Nursing Education
A medication error is an act of commission or omission that prevents the achievement of therapeutic benefit to the patient. Nurses are at the greatest risk for medication errors so we take the issue very personally. Even if the error is acknowledged as a system failure, we live with it forever. We fear increased risk of harm to patients and facing blame and reprisals if harm occurs. There are lots of errors never reported. According to the FDA, 770,000 people were injured by medication errors alone costing hospitals $17 billion to $29 billion. If you want to talk about healthcare costs, this is a big factor. Long term care one residents will receive up to nine medicines and that could be nine medicines three or four times a day. It is estimated that 350,000 medication errors occur in long-term care facilities annually. They are the eighth leading cause of death. A 1996 JCAHO study found that low nursing staff levels were a contributing factor in 24% of medication error cases. RNs on staff have a direct relation to patient outcomes. The more RNs, the better the patient outcome. They have to carry out physician orders. A Harvard study identified that understaffing of nursing in hospitals showed nurses are overworked, stressed, fatigued healthcare workers whose work patterns are frequently interrupted, who are required to carry out illegible orders while being abused on the job. Some are agency nurses without knowledge of hospitals policies. Research that I did found a punitive approach to healthcare errors discourages reporting and eliminates opportunities for identifying the causes of errors. Reports to professional licensing boards are often backlogged. Regulatory and legal sanctions are imposed after the fact do little to address the factors that led to the mistake. We need to be working on preventing anyone from needing to seek malpractice. Medication errors must be viewed and studied as a part of the system. Errors rarely result from one practitioner or a single factor. Some people just aren't paying attention to what they're doing. Future solutions: we can create an environment of safety -- not blame -- where staff is encouraged to report their errors. The aviation industry is doing this. Look at what and why something happened, not at who caused it. We're afraid to make mistakes and when we do, we're afraid to report them. We need whistleblower protection. I have reported practitioners who were unsafe and I never knew what happened after I made the report. We want to protect our physicians. They're the ones who bring money to our hospital. Nurses have substantial contributions to make to reduce healthcare errors. We can give suggestions on how to prevent them and we have important clinical expertise to contribute to new system designs. Facilities must

improve staffing. Especially in acute care and long term care facilities, there is a correlation between nursing levels and patient outcomes. The majority of nurses are in hospitals. With higher nurse/patient ratios, there will be fewer complications, fewer adverse events, shorter lengths of stay, and lower mortality so there will be no reason to sue when there are more nurses. We need top-level management that provides nurses with support in a collaborative culture that has built in resistance to cyclical nursing shortages -- Magnet hospitals. Their culture, their environment, makes it such that employees don't leave and their patent outcome is good. Fatigue is commonly cited as a source of error in human fields. The VA has gone to a bar code system. It is a new system piloting in 2000 that was set up so meds are given to the right person at the right time. Electronic medication systems are being piloted in long-term care facilities in Missouri. Limit use of floor stock. The only people in health care facilities 24 hours a day, seven days a week are for the most part of nurses. Pharmacists get to go home. Require that medical orders are computer generated so physicians don't have to write. Develop and test new technologies to reduce medical errors. Test safety interventions. Use multi-disciplined teams to find causes for medical errors. Understand the environment in which care is provided. Fund research and organizations to develop demonstrate and evaluate new approaches. Look at the physicians as being quarterbacks; they can't do it all by themselves. The Board of Nursing issues licenses. They can put restrictions on licenses, take away licenses, they can refer us to different types of agencies for assistance. In the case of medical errors, to make a medication error is not enough to be reported to the Board of Nursing unless something really bad happened to the patient. If a nurse is deemed unsafe, they can be reported to the Board by anybody and the Board can do an investigation. The Board looks at CNAs, nursing assistants, LPNs, RNs, and nurse practitioners. Carol Jenkins: *Have you read anything that by increasing the length of an RNs career by one year, the nursing shortage could be eliminated?* Ms. Decklever: No. In the research I have done, I have seen reports that new nurses are leaving the profession within three to five years. Increasing nurses' work time by one year is not going to cure the nursing shortage. It's predicted we're going to be short 1 million nurses by 2010. What do we need to do to entice nurses to come and stay in Wyoming? Increase the pay. That's what's pulling them away. I surveyed the graduating 2001 class and of those, most were leaving the state because of pay. Riverton is paying $14.19 an hour and that breaks my heart because that just doesn't seem like very much to me, for an RN. Oregon is paying $20. Why aren't we paying the nurses? Wyoming pays the worst in the nation. Why? I don't know. Part of it is because we have no competition. The reason people like to stay is they have family roots here. If there's only one hospital in a geographical area and I'm an OR nurse, that's the place I go to work. We didn't go into nursing to make a million dollars. We're a service profession. We do it because it's a calling. We want to help people. What keeps nurses where they are is the environment. That is the number one reason people leave nursing is because of their workplace environment. Mr. Vandel said that a lot of nurses have gone into pharmacy, where they can double their salary in three years. Ms. Decklever was asked how many healthcare facilities have gone to computerized charting. She said she is not sure how many in Wyoming. The research indicated bar coding didn't come without flaws. She doesn't know what kind of expense is attached to automated systems. Most new nursing school graduates expect automation.

Mr. Muirhead asked Ms. Decklever if she would share the findings of her 2001 survey and she said she would.

III. Comments from the audience

Jim Carder, State Board of Pharmacy
The Board of Pharmacy is available to provide information on issues impacting the pharmacists in the state, including the international sale of drugs in the United States.

Keith Goodenough, Natrona County Senator
If you just do the simple things well, 90 percent of the problems will take care of themselves. Healthcare errors due to physicians' illegible handwriting -- what could be more ridiculous. It's hard to say how many errors are made because a health professional can't read handwriting. If you can't read your handwriting, find a different system. If you can't write legibly, lose your license. Nurses are working long shifts in our healthcare facilities, often 12 hours or more. If people are fatigued they are going to make a lot of mistakes. I can see where some of that would be due to a lack of nurses. Poor results come from fatigued workers -- that's not rocket science.

IV. Subcommittee reports

Carol Jenkins, Healthcare Access Subcommittee
(Handout, Jenkins.pdf) The Healthcare Access Committee has met four times in the last two months. The Subcommittee is working with a broad subject matter: access to an affordable, effective, quality healthcare system. One of its firsts tasks is to look at the healthcare delivery system. The subcommittee spent two full days looking at what we have in the state Health Department and who is doing what in the state. We have notes from all of the speakers that we're going to provide to the full commission, along with web sites and bullet points. We have had a tremendous response in attendance from the public and healthcare organizations. The Subcommittee's plan of action is to confer next month and to brainstorm some of the solutions. We have a short-term objective to look at things that require potential funding in order to make recommendations by November that will be presented to full commission. Each Subcommittee member has been asked to prioritize a list of research in order to provide the most relevant, best information we have on a topic. The Subcommittee will prioritize a list of the areas that we will be addressing in course of the next year. We have not finalized this list at all. We will be calling upon people in our audience as we go forward and focus on long term recommendations. I think in my mind we have short-term objectives and long-term solutions built on collaborations from the delivery system and the public. One thing I want to promote is development of this electronic medical record system and information technology as a potential long-term solution to what's going on here. Other industries have demonstrated the value and importance of having information available real time, and that is sorely lacking in our industry.

John Vandel, Subcommittee on Reform

Our agenda is quite different from access committee's agenda. The issues assigned to us are highly emotional and there is not a lot of agreement on or much direct communication between various interests. Tort reform, the medical malpractice insurance crisis, and medical errors and patient safety are what we're looking at. We invited representatives from these groups to come together to identify common ground and supply us with the data. In August we found something to agree about: many groups said that was the first time they had talked together on these subjects. Replacements for retiring health professionals are needed in Wyoming. We have to compete nationally and deal directly with states in our region; we are completely surrounded by states with caps on noneconomic damages for medical liability cases. Stats hard to come by or nonexistent on how many physicians are practicing in Wyoming and what their specialties are (the Commission staff will research this). We really need the numbers. There's a need to know more specific numbers regarding medical malpractice settlements vs. jury verdicts and economic and noneconomic damage payouts (Insurance Commissioner Vines is researching this). The Wyoming Legislature has placed time limits on our work. We have some recommendations coming out this fall. Yesterday, the Governor's Office reminded us that the Wyoming constitution has to be amended in order to limit damages in personal injuries or death cases. Sen. Charlie Scott presented his ideas and while we did not approve all of it, it was substantive enough that we thought it should be ongoing and we asked Charlie to continue in the direction in he was headed. Chris Muirhead suggested we were looking at two amendments and that we ought to consider a noneconomic damages cap and an amendment to allow for a medical review panel. We've asked Ken Vines of the Insurance Commissioners Office to draft a report on a Joint Underwriting Association we've been required to examine. He will make a report to the legislative committees by end of October or the first of November.

Ken Vines, Wyoming Insurance Commissioner

We've employed some actuaries who are working on the numbers with regard to a proposed Joint Underwriting Association. We have provided them with certain information they requested and they are in the process of crunching the numbers. They will be able to tell us what kind of rates a JUA would have to charge in order to sustain itself. It's my understanding that I have been directed with the help of my office to take a shot at the draft of a report to the Legislature required statutorily that will include JUA numbers once they come from the actuary. You have a copy of my take on what we got out of the last meeting regarding specific information we needed to ask the medical malpractice insurance companies to get for us. I gave you this list to ask you if you see any further items should be added. I think it's a pretty good list. It's actually quite a bit of information. It will take the insurance companies a little bit of effort to get this together. After I talk to the companies I'll have a better feel of when they can provide it. Chairman Muirhead said the next Commission meeting Oct. 27 will be devoted entirely to the JUA issue.

V. Director's Report

Diane Harrop Executive Director

We're shifting gears. We're into our fourth month of operation and just holding our third full commission meeting. A lot has been happening behind the scenes that the chairman would like you to know about. He and I meet weekly review everything to strategic questions about how best to use the public's time to processes that will facilitate all of our work – and by facilitate I mean facilitate in the highest sense of the word -- not to push a group toward a predetermined conclusion. There really should be no public fear that someone has made an agenda that is pushing in the group in any direction. They will go their own way no matter who tries to decide ahead of time what the results will be. We want to build a good foundation from which innovative conclusions and compromises can result. It became obvious to me that my organizational model for this group was the sheep wagon. We're trying to create a small mobile organization that sets up processes where everything designed sets up three purposes. We try to base all processes on some kind of philosophy. We're up to 200 names on our contacts list. We did that because we wanted to send a clear message that we wanted everyone that had an interest involved in and informed about the work of the Commission. The contacts list receives minutes and agendas and they also forward these messages on to their full organization mailing lists. We tried to design our agendas to send the message that we want to draw on expertise of people working on the frontlines who can provide us with reliable data. Want to hear a wide range of opinions. Our third meeting was structured to begin focusing more surgically, looking at a single broad topic in finer detail from multiple perspectives. That is the other message I continually want to send: we are inclusive and welcoming of anyone who feels they have an interest in what we are doing. I am completely open to comments, ideas, suggestions, and constructive criticism. During my first two weeks on the job, I contacted literally hundreds of organizations to gather information and enlist their support. Good communication will be the foundation for facilitating the work of the Commission. Every two months, we submit reports to the Legislature. Our next one is due Oct. 1. The JUA study is due at the end of October. Our interim study is due in June 2004 and our final study in December 2004. We are sent to sunset in June 2005. We're still a little confused about our funding since it runs out in December 2004. That's something we'll figure out as we go along. These kinds of things are evolutionary processes. Our office is up and running smoothly. In six weeks started a whole new state agency. We are completely independent. We've had great help from the Governor's Office in getting set up, and the Department of Employment in Casper where our offices are. We have a goal of being frugal – although we had to break down and buy new computers. We now have a scanner, a fax machine and we will soon have a web site. All of that feeds into our ultimate goal of having better communication with vested groups, each other and the public. My basic job involves continually repeating the fact that I welcome your input I welcome your involvement I stand willing to do what ever needs doing to facilitate the work of this commission.

VI. Debriefing

The Commissioners reviewed the information they have gathered and what next steps should be taken, in what timeframe.

Timeline

The Legislature's Labor, Health and Social Services Committee meets in mid-November and potentially again in late December or early January. The Committee will begin drafting and reviewing potential legislation at those meetings. The Committee expects to make a determination on whether to take action related to tort reform, including consideration of two possible constitutional amendments and recommendation of a medical review commission.

Topics the Healthcare Commission staff will research and report on at the October meeting were determined to be as follows:

Hospitals

- Magnet/Planetree Hospitals (find out what Sen. Massie has determined in his work to be possible within the policy realm);
- Barriers to using electronic medical records and letting go of paper charting as the VA has done, and to transferring and sharing information electronically;
- The correlation between medical errors, switching to electronic medication systems and reduction of the nursing shortage.

Information management

Discussion highlighted what the Commissioners had learned about technology, including the fact that 90 percent of medication errors are eliminated by bar coding. But the state needs to know how to finance the newer information management systems, for inpatient facilities. They wanted to know if there are Centers for Medicaid and Medicare grants or if private foundations like Robert Wood Johnson might have funding available.

Insurance

- SB2D – Closed Claim legislation in Florida
- Insurance Commissioners' information

Tort Reform

The Commissioners talked about what they have learned thus far, including the importance of monitoring health professionals proactively versus reactively, that the fear of retribution inhibits medical error reporting and whistle blowing and that there are no positive incentives to report errors. They determined that tort reform has to address medical errors, allow patients access to the courts and be attractive to providers. Colorado and Nebraska have state medical error compensation funds partially funded by doctors.

Random drug testing

Comments need to be solicited from the Wyoming Medical Society and the boards licensing physicians, nurses, dentists, chiropractors, optometrists and other allied health professionals regarding random drug testing for health professionals. It also needs to be determined whether the state's substance abuse legislation (HB 59) passed last year enables the Board of Medicine to order random drug testing for physicians. And if it does, why aren't they doing it if they can.

Telemedicine

The state has a telemedicine committee that is examining the potential for implementation of telemedicine in Wyoming using Idaho's model, and U.S. Sen. Craig Thomas has been asked to earmark $3 million for Wyoming's telemedicine system. Wyoming Department of Health Telemedicine Manager Fran Cadez will provide information to the Commission on a survey conducted in the state recently funded by WDH to determine the interest in and utilization of, or potential for, telemedicine in Wyoming.

VII. Meeting adjourned at 5:30 p.m.