

Nevada Chapter GOVERNOR'S NEWSLETTER

ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

Spring 2004

Jim Christensen, MD, FACP
Governor, Nevada Chapter

GOVERNOR'S CORNER



Spring brings us a sense of renewal and hope after the winter months. I just returned from the spring Board of Governors' Meeting of the American College of Physicians (ACP) in "the Big Easy." The topics included: recertification, revitalization, the role of the state medical boards in maintaining competency, performance measures and public health. At the end of the meeting I felt like spring had indeed arrived. I have a sense of hope and renewal. I think they GOT IT! Perhaps it is not too late. If the issues they outlined for the Revitalization of Internal Medicine are prioritized correctly, we will survive as a profession.

Jim Christensen

The Federation of State Medical Boards (FSMB) was represented by **Regina Benjamin MD, MBA**, who spoke on "Maintenance of Competence: A Commitment to Public Trust". She maintains that we physicians should regulate ourselves and not let government or our boards perform this function. Having said this, the three strategic goals of the Federation of State Medical Boards are: clinical skills exam two, portability of licensure, and maintenance of competence. Currently, states require Continuing Medical Education (CME) and renewal fees for re-licensure. The Federation of State Medical Boards is reviewing mechanisms of maintaining competence as a way of keeping public trust in the medical profession intact. The Nevada State Board of Medical Examiners has proposed that a physician can demonstrate competence through peer review as evidenced by membership on a hospital medical staff or equivalent. This action appears to meet the intent of the Federation of State Medical Boards. According to Dr Benjamin, the absence of a plan will force the Federation of State Medical Boards' hand and they will mandate a process for us.

Steven Weinberger, MD, FACP has taken over the reigns of Medical Knowledge and Education Services (MKSAP-Medical Knowledge Self-Assessment Program) for the ACP. He is a well known Pulmonologist and was a principle author of "Up to Date". Medical Knowledge Self-Assessment Program 14 is under development and will likely contain email updates and a summary module as for preparation for the Boards. Maintenance of certification as it relates to the American Board of Internal Medicine will be the major focus of his time. He acknowledges the amount of work to be done and is aware of the delicate politics of this matter. Dr. Weinberger's questions include: What are the needs of practicing physicians? What are the external requirements that practicing physicians need to keep current (to maintain certification)? How do we get more subspecialists involved in maintenance of certification?

Sheldon Greenfield, MD, FACP director of health quality research at University of California, Irvine discussed performance measures and public health. Guidelines vs. performance measures were detailed. Dr. Greenfield introduced the concept of aggregate scores as a fair method of evaluating physicians. Aggregate scores include four or five measures that are: under the doctor's control, should be performed routinely, should improve quality, and should have fairness to all practicing physicians. His work with insurers and other stakeholders is a work in progress that we will be seeing in the future, perhaps as score cards or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

Dennis O'Leary, MD, MACP President and CEO of Joint Commission on Accreditation of Healthcare Organizations spoke on tort reform and patient safety. Four and a half years after the Institute of Medicine (IOM) report, he urged alignment of incentives for patient safety. "We seem to lack the collective will to bring us to the tipping point." For

example as new drugs and devices are brought to market, they also bring new safety concerns that haven't been addressed. Constantly expanding the array of improvements in medicine undermines our efforts to standardize care. This is all happening in the face of a tort crisis. "No hard evidence exists that the tort system has improved the medical system. Specialist and generalist exodus from care is dramatic." Because of this we are spending an extra estimated one billion dollars per year on health care. The current tort system severely retards sentinel event reporting because of the risk of discovery. Less than 1% of sentinel events are reported to Joint Commission on Accreditation of Healthcare Organizations, using the Institute of Medicine numbers total on errors. Dr. O'Leary's point was that we are all to blame in this endeavor. Leaders of health care- physicians, nurses, and administrators- have no training in systems analysis. "We have made no business case to drive a change in behavior. Medicare pays the same if care is good or bad." His prescription thru Joint Commission on Accreditation of Healthcare Organizations: to facilitate communications amongst health care team members, to achieve leadership by example, to investment in RCA technologies, to perform Federal Emergency Management Agency's(FEMA) on new technologies, to give serious effort to retention of staff, to provide just in time education and training of staff (including physicians). To this end Joint Commission on Accreditation of Healthcare Organizations will provide tools, standards, and leverage. National Patient Safety Goals are dick and jane proscriptions. All of this doesn't change culture and we must create a new business case of "payment for performance." The educational system needs to build systems thinking, team work, and human factors training in to its curriculum. Patient safety legislation is desperately needed protecting reporting of adverse events on a national level. Tort reform is a separate need but necessary to patient safety.

Revitalization: In eight months the leadership of the college finished the summit on revitalization. The four main topics identified are: to repair the dysfunctional payment system, increase practice efficiencies and decrease the practice hassles, understand the value of internal medicine using stakeholder groups, and training for the new world. The consensus that Internal Medicine training is out of phase with the clinical realities of day to day practice has been identified and acknowledged. The college pledges to work with the other organizations to rectify this situation.

The **Political Action Committee** (PAC) for the ACP is being set up and should be operational within one year. This will allow the ACP more leverage in its lobbying efforts. The Nevada chapter's resolution on development of CME availability on Chapter Websites was passed and sent forward the Board of Regents. Another resolution forwarded to the Board of Regents concerned recertification. A deadline for resolution of differences between the American Board of Internal Medicine and the ACP will be set and if not met the ACP will develop its own recertification process. So it appears that a line in the sand will be drawn.

For us, the most the important issue in the coming months will be ensuring the passage of **Issue #3** on the **November 2nd ballot**. If passed, this will adopt Medical Injury Compensation Reform Act (MICRA) legislation here in Nevada. I strongly urge all members to actively support this legislation as this will give long term relief to the current malpractice crisis. Remember, we all can lobby each patient with whom we have contact while their mind is focused on the importance of health care. Financial support will be needed as well as time and effort. This should be our finest hour.

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Governor, Nevada Chapter



Nevada Governors' Meeting of the Minds-
(from left) Dr. Jim Christensen (Present)
Dr. Arnold Wax (1999-2003)
Dr. John A. Ellerton (1995-1999)
Dr. Alan W. Feld (1985-1989)
Dr. Robert W. Clark (1991-1995)

2004 NATIONAL PATIENT SAFETY GOALS

The Joint Commission on Accreditation of Health Care Organization has developed seven national patient safety goals. They are:

1. Improve Accuracy of Patient Identification

2. Improve Effectiveness Of Communication Among Caregivers

3. Improve The Safety Of Using High-Alert Medications

- What it means: Pharmacy rounds on units ensuring concentrated electrolytes are not present.
Pharmacy limits and standardizes availability of drug concentrations on units.

4. Eliminate Wrong-Site, Wrong-Patient, Wrong-Procedure Surgery

• What it means: Verify that all appropriate, preoperative patient documents are available and used when confirming correct patient, procedure and side:

- History and Physical
- Consent Form(s)
- Physician Orders
- Physician Progress Notes

Surgeon/Physician will mark on or adjacent to the actual surgical site/side with his or her initials using a permanent marker **WITH THE PATIENT'S PARTICIPATION**. The surgeon's initials must be visible after the surgical site/side has been draped. This process may be completed in the Pre-op Holding Area or the OR suite prior to administration of anesthesia. *If a patient refuses to be marked with a permanent marker, the area may be marked with tape.*

Sites that require marking are:

1. Cases involving right/left distinction.
2. Cases involving multiple structures (such as fingers or toes)
3. Cases involving levels (such as spine)

5. Improve The Safety Of Using Infusion Pumps

6. Improve The Effectiveness Of Clinical Alarm Systems

7. Reduce The Risk of Health Care Acquired Infections

- Know and comply with the current CDC hand hygiene guidelines
- What it means: WASH YOUR HANDS after coming in contact with a patient and before performing a procedure on a patient. Use soap and water or alcohol-based solutions.

**–VISIT OUR
CHAPTER WEB SITE–**

<http://www.acponline.org/chapters/nv>

SAVE THE DATE!!!!



**Nevada Scientific
Chapter Meeting
January 15, 2005
Four Seasons Hotel
Las Vegas, Nevada**



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Receive vital chapter updates.

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