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Medicine

Fall 2013

The Wyoming Medical Society (WMS) is the premier membership organization dedicated to promoting the interests of Wyoming physicians and physician assistants through advocacy, education and member services. WYOMING MEDICINE (ISSN-2154-1681) is published bi-annually by WMS at 122 East 17th Street, Cheyenne, Wyoming 82001. Contact WMS at 307-635-2424 or info@wyomed.org.

Subscriptions
To subscribe to WYOMING MEDICINE, write to WMS Department of Communications, P.O. Box 4009, Cheyenne, WY 82003. Subscriptions are $10 per year.

WYOMING MEDICINE is printed by Print By Request, Cheyenne, Wyoming.

Postmaster:
Send address changes to Wyoming Medical Society, P.O. Box 4009, Cheyenne, WY 82003.

Contents

Positive News in Healthcare—Really

BY ROBERT MONGER, MD

Although it seems like all we ever hear about our healthcare system is that everything is getting worse, there are actually a lot of very positive things going on in Wyoming. Here are a few items of interest from our great state that you may have not heard about.

1. "The Biggest Loser" Coming to Wyoming

The Biggest Loser RunWalk Race Series is coming to Casper in the summer of 2014! The Casper race will include 5k and 15K runs for adults as well as a 1-mile fun run for kids, and there will be a Health Expo the day before the race with national and local vendors. Past participants of the Biggest Loser T.V. show will be in Wyoming throughout the next year to promote the event and will be at the race in Casper.

During the year leading up to the race, there will be a statewide initiative for Wyoming residents to "Get Fit, Get Healthy, and Get Ready" for the race, and organizers anticipate that teams of participants from all around Wyoming will travel to Casper for the Health Expo and race. Details are still be finalized, including the date of the event, but watch for much more information about the Biggest Loser in Wyoming in the next few months.

2. A 24/7 Nurse Line for Medicaid Patients

Did you know that there is a free, 24-hour nurse line that is available to all Wyoming Medicaid patients? The service is provided through the Wyoming Medicaid Care Management Program and is a free service for all Wyoming Medicaid clients. The service has been around for some time, but it seems like most providers and Medicaid patients I mention it to aren't aware of it, and statistically the line seems to be underused. Medicaid clients can call any time of the day or night and talk to a registered nurse about anything from questions about their medications to whether or not they should go to the E.R. in the middle of the night. The toll free number for patients to call is 888-545-1710, and much more information about the service is available at the WyHealth website at www.wyhealth.net.

3. A Pre-Authorization Program that Works

I often think that the pre-authorization forms I spend so much time filling out are designed by evil insurance companies simply to hassle me. I am happy to report, however, about a prior-authorization program that has proven to be effective.

Synagis (Palivizumab) is a monoclonal antibody that is indicated for the prevention of RSV infection in children under the age of 24 months who have serious medical problems such as congenital heart disease. The American Academy of Pediatrics (AAP) guidelines recommend a maximum of five doses to be given during the typical RSV season.

Wyoming Medicaid had previously covered the expensive medication without restriction, but a 2010 analysis of its use in Wyoming showed that the average number of doses given per child per year was six and a half and that many of the children receiving the medication were older than 24 months. Based on that information, the Wyoming Medicaid DUR Committee established a prior-authorization program for the drug for Medicaid patients and limited the drug's use to the AAP guidelines of no more than five doses per year and only for children under the age of 24 months.

The program has now been in place for several RSV seasons, and the result is that the total number of doses of Synagis administered to Wyoming Medicaid patients in Wyoming fell from over 1,400 in 2009 to under 600 in 2012, which has resulted in about a $1.5 million yearly savings for the state. Recent analysis shows that the RSV-associated hospitalization rate in Wyoming has not changed during that time.

The program is a success: it has limited use of the drug to the AAP guidelines and by doing so has saved the state quite a bit of money without hurting patients.

WM Makeover

You'll notice that WM has a new look, and we hope that you like it. We've partnered with **Linden**, a Cheyenne-based marketing and communications agency, to help us produce our magazine, and they bring a much-needed level of publishing expertise to our team. Thank you to everyone at Linden for your great work.

I'd also like to thank **Dr. Karl Musgrave,** DVM, MPH, for his article about zoonotic diseases. The State Public Health Veterinarian for Wyoming, he gave a really interesting Grand Rounds lecture at CRMC a few months ago and was more than gracious when I approached him later about writing an article for WM.

Thank you for reading **Wyoming Medicine**. As always, please email us with any comments you may have about the magazine at **info@wyomed.org**.

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Let Me Introduce Myself

BY SHEILA BUSH

This eighth installment of Wyoming Medicine is an issue of introductions. You have already met the magazine's new look, and throughout this issue we will be introducing several leaders in Wyoming's healthcare community, including the past president of the Wyoming Medical Society and the recipient of this year's Physician of the Year award.

It seems an opportune moment, then, for me to make a little introduction of my own. I have had the chance to meet and dialogue with many of you, but here's a bit of background for those whom I haven't crossed paths with yet.

The Path to WMS Director

Born and raised in Casper, I graduated from Natrona County High School before heading to the University of Wyoming to gather what turned out to be a medley of majors. I came away in 2005 with degrees in Classical Piano Performance, English, and Philosophy, with a minor in Criminal Justice.

An expansive foundation in the liberal arts and a general enthusiasm for culture have given me the opportunity to serve in a variety of capacities since leaving UW, including as a member of the Cheyenne Symphony Orchestra's board of directors and as the past chairwoman for Wyoming Art for the Cure.

I also had the privilege of being the Communications Director for WMS shortly after graduating, a position I enjoyed for a little over three years. That was before being named the interim director of the society in the fall of 2009, then the executive director a few months later at the start of the new decade.

I should also mention that I got married along the way and am the happy (and hectic) mother of two small boys: five-year-old Benjamin and two-year-old Ryan.

A New Identity

My seven years with WMS have been formative, and not only in a professional sense. What began as a career in communications became for me an identity: a passion for representing and advocating for Wyoming physicians and physician assistants has grown to be part of who I am and how I identify myself. I am frankly humbled and honored to be the voice for Wyoming's healthcare community and to represent the perspective of Wyoming doctors among our state's decision makers.

I believe that patients win and the quality of Wyoming healthcare is improved when physicians are respected as the leaders of the healthcare team and have the freedom to care for their patients as they deem most appropriate. I also believe that unity and collaboration among Wyoming physicians is the most effective way to make that happen. That's why Dr. Robert Monger and I launched Wyoming Medicine back in 2010, and that's why I am devoted to executing my responsibilities as WMS director with a combination of attentive consideration and thoroughgoing resolve.

Our Legislative Goal: Physician Freedom

Most of the time, our advocacy looks like working to maintain the significant latitude that Wyoming physicians already enjoy. We accomplish that predominantly through educating lawmakers and pushing physicians' interests to the fore in discussions surrounding healthcare legislation. Only infrequently have we fought for new legislation.

In the coming years, however, you can expect WMS to exert a stronger influence during legislative sessions—both by writing new legislation to improve the practice environment and by proposing amendments to existing statutes to make them more physician friendly. Current topics on our radar include: access to immunizations for children; payment reform; new strategies to achieve liability reform; ensuring physician-led teams; and Medicaid expansion, reimbursement, and reform.

This will require us to take tough positions at times—positions that we believe will improve physician practice but that may not receive unanimous support from our membership. Even in the absence of unanimity, however, our goal will still be to foster the unity that comes from collaborative discussion among physicians in every part of the state.

Nothing that we do can be accomplished effectively apart from this. In every aspect of our communication and advocacy, our voice will be clearer and stronger if you let us know what it is you need and want. No matter what issue you are facing, even if you think it is only local, we want to hear from you.

As the only organization in the state dedicated to representing physicians, we invite you to invest in us by passing along the issues and events affecting healthcare in your community. As you do so, we will keep investing in you.

Thanks for reading Wyoming Medicine. It's nice to meet you.

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Wyoming Professional Assistance Program

BY CANDICE COCHRAN

Since 1997, the Wyoming Professional Assistance Program (WPAP) has been offering confidential assistance to health care professionals struggling with chemical dependency and substance abuse. We do this through interventions, evaluations, treatment plans, and a long-term monitoring program. Currently, 25 individuals are participating in the program.

WPAP has undergone numerous staff changes in 2013. Candice Cochran joined WPAP in March as executive director, and John Ordiway, MS, LPC, LAT, began as a clinical coordinator in May. WPAP is also currently working to secure the services of a Wyoming-based medical director.

The new WPAP team is committed to expanding its referral/self-referral program and educational programming. Look for us this fall at your hospitals and association events.

If you or someone you know is struggling with chemical dependency or substance abuse, WPAP can help. Your inquiry will be kept strictly confidential. Call us at 307-472-1222, email us at wpapro@wyonet.net, or visit our website at www.wpapro.org.

Medication Donation Program Helps Meet Several Needs

BY KIM DETI

Wyoming residents are asked to consider donating unused medications to help others who may have trouble affording the prescription drugs and supplies they should have.

> *"Our program brings together people who find they have unused medications on their hands with others who may need those very same medications."*

The Wyoming Department of Health's Medication Donation Program supports qualified residents who have low incomes and who are without insurance or are underinsured. Since 2007, the program has helped residents fill more than 66,000 prescriptions worth about $4.3 million.

"Simply put, our program brings together people who find they have unused medications on their hands with others who may need those very same medications," said Natasha Gallizzi, Medication Donation Program manager and pharmacist with the Wyoming Department of Health.

Residents may call **855-257-5041** toll free to see if they qualify and if the medication they need is available. "We can mail medications throughout Wyoming," Gallizzi said.

The program accepts almost any medication, as well as certain medical items such as diabetes testing supplies or wound care materials. Controlled substances, which are generally prescriptions regulated by the government and used for pain, sleep, anxiety, or ADHD treatment, cannot be accepted.

Donations that can be passed on to help others include:

- Medications in sealed packages
- Unexpired medications
- Medications that do not require refrigeration

Donations not appropriate for sharing are destroyed. "Safe disposal helps avoid both potential prescription drug abuse and the water pollution that can result from flushing medications," Gallizzi said.

For information on how to donate, visit www.wyomedicationdonation.org.

[Business Briefs continues on page 10]

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Employed Physicians: Look to the AMA for Advice

BY THE AMERICAN MEDICAL ASSOCIATION

AMA
AMERICAN MEDICAL ASSOCIATION

American Medical Association (AMA) member physicians in contractual relationships with hospitals, health systems, and other similar entities can receive personal assistance from the AMA. While the AMA cannot provide legal opinions or representation, it is dedicated to answering questions and providing advice on such topics as contracting, credentialing, peer review, due process, and medical staff governance.

AMA members may take advantage of this valuable resource in two ways:

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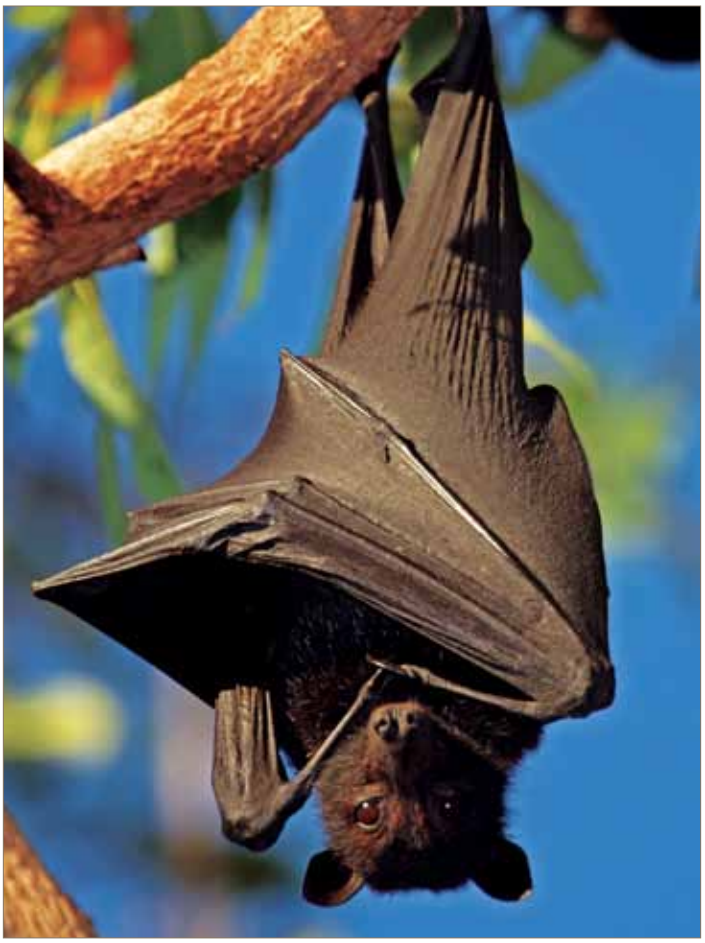
Ten Animal-to-Human Diseases in Wyoming You Should Know About

BY KARL MUSGRAVE, DVM, MPH; EMILY THORP, MS; AND KATIE BRYAN

The Wyoming Department of Health (WDH) often receives calls from the public and from healthcare providers seeking information about diseases in Wyoming. A large percentage of these calls involve questions about animal-to-human (i.e. zoonotic) diseases. Here are 10 zoonotic diseases we are often asked about.



1. Rabies

In Wyoming, rabies is endemic in skunks and bats (from 2000 to 2012, the disease was confirmed in 215 skunks and 104 bats). Other animals develop rabies after being bitten by a skunk or bat carrying the disease. On average, more than 45 individuals each year go through the series of immunoglobulin and vaccine shots after exposure to a rabid or possibly rabid animal, but since record keeping began in 1929, Wyoming has not had a documented case of rabies in a human.

2. Colorado Tick Fever

Colorado tick fever (CTF) is caused by a virus carried by the Rocky Mountain wood tick. In a tick prevalence study conducted in Sublette County in 2010, 21 percent (37/174) of collected ticks contained the CTF virus. Symptoms of CTF are generally mild and include fever, headache, muscle aches, and occasionally a rash. From 1991 to 2012, there were 48 reported cases of CTF in Wyoming.

3. Hantavirus

In Wyoming, hantavirus is most often acquired by individuals inhaling the virus on dust particles created from fecal material and urine left by deer mice. Initial symptoms include fever, myalgia, and gastrointestinal symptoms, followed by respiratory distress. The incubation period for hantavirus can be as long as six weeks. Since 1993, there have been 11 cases of the virus in Wyoming, including seven deaths.

4. West Nile Virus

Studies of West Nile virus (WNV) indicate that around 20 percent of infected individuals develop symptoms. The elderly and people with compromised immune systems often experience more severe symptoms as a result of viral damage to their nervous system. There is a WNV vaccine for horses, but not one for humans. Wyoming has recorded 703 human cases of WNV since 2002.

5. Rocky Mountain Spotted Fever

Symptoms of Rocky Mountain spotted fever (RMSF) include fever, severe headache, malaise, and muscle aches. A characteristic spotted rash initially develops on the extremities and rapidly spreads to the trunk. The Rocky Mountain wood tick only needs to be attached for four to six hours for transmission to occur, and the disease can be fatal if not treated. From 1991 to 2012, there were 89 reported cases of RMSF in Wyoming.

6. Plague

Plague is caused by the bacterium Yersinia pestis. Humans usually get plague after a flea bite or after handling an infected animal. Testing of wild animals has indicated that plague is likely present in every Wyoming county. Symptoms of plague can include fever, headache, chills, weakness, swollen lymph nodes, breathing problems, and red or necrotic patches of skin due to bacteria in the blood. The incubation period is usually two to six days. There have been six documented human cases of plague in Wyoming since 1978.

7. Tularemia

Tularemia is caused by the bacterium Francisella tularensis. Some of the ways humans can acquire the bacteria include through contact with infected animals and through tick or deer fly bites. The symptoms of tularemia vary depending on the route of infection and can include skin, lymph node, eye, lung, oral/gastrointestinal, and blood forms. The incubation period is typically three to five days. From 2007 to 2012, there were 12 reported cases of tularemia in Wyoming.

8. Escherichia Coli

Most Escherichia coli (E. coli) bacteria do not cause disease in humans or animals. The strains that do cause human disease may result in diarrhea, urinary tract infections, lung infections, or kidney failure. In 2010, 19 cases of shiga-toxin producing E. coli, a variant of E. coli that causes gastrointestinal illness, were reported to the WDH. Follow-up investigation of the 19 cases indicated that two cases likely acquired their infection from an animal source.

9. Salmonella

Salmonella bacteria can cause diarrhea, fever, and abdominal cramps. Most individuals recover without treatment but the illness may last up to seven days. In some individuals, the diarrhea may be severe enough that hospitalization is necessary. In 2010, 64 cases of salmonellosis were reported to the WDH. Eighteen of the cases likely acquired their infections from animals.

10. Campylobacteriosis

Campylobacteriosis is caused by Campylobacter bacteria. Symptoms can include diarrhea, abdominal pain, fever, nausea, and vomiting. The diarrhea may be bloody. Some individuals can be infected but not develop any symptoms. In 2010, 74 cases of campylobacteriosis were reported to the WDH. Nineteen of the cases likely acquired their infections from animals.

For additional Information, contact Karl Musgrave, DVM, MPH, at karl.musgrave@wyo.gov.

Karl Musgrave, DVM, MPH, is the State Public Health Veterinarian for Wyoming. Emily Thorp, MS, and Katie Bryan are epidemiologists for the Wyoming Department of Health.

Mike Tracy, MD: Partnering Wyoming Physicians

BY SCOTT HUBBARD

Dr. Mike Tracy knows the value of medical partnerships, and the threats to patient care that result when doctors and hospitals operate outside of a tightly knit healthcare network.

A former member of the National Health Service Corps (NHSC) and now an internal medicine and pediatrics physician in Powell, Tracy has extensive experience collaborating with physicians in environments where patients have less access to comprehensive care. "Almost by definition, most rural areas are underserved; you're always walking a tight line," he said.

As the past president of Wyoming Medical Society—and as a WMS board member since 2008—strengthening the ties that bind Wyoming physicians is one of his top ambitions.

> *"I love practicing in Wyoming. There's a sense of collaboration among the physicians here, especially the rural physicians."*

Rural Physician and Society President

Except for his schooling at the University of Colorado and the University of Rochester, rural living has been the standard for Tracy and his family. A childhood in rural Colorado preceded his undergrad days, and his NHSC appointment in Houston, Missouri directly followed his residency. Then came Powell, where he has been practicing now for 11 years.

The move to Wyoming was a difficult one; the community in Missouri and the experience of serving the residents there had been wonderful for Tracy. His interview with Powell Valley Healthcare, however, was decisive. "Once I interviewed in Powell, I knew this was it," he remembers.

Wyoming's medical partnerships were part of what made the move easier. A decade later, Tracy can say, "I love practicing in Wyoming. There's a sense of collaboration among the physicians here, especially the rural physicians."

During the first few years of living in Powell, Tracy wove his own medical practice into the already present cooperative atmosphere by communicating with neighboring physicians, readily responding to requests from outside the hospital, and working to develop a sense of teamwork among his closest colleagues.

Tracy began fostering the state's collaborative ethos more intentionally when he joined the WMS Board of Trustees in 2008. And even though he never set forth to be the WMS president, he moved into the position three years later, making him the head physician representative on the society's executive committee.

Advocacy Through Unity

Operating as president of the only state society offering representation, advocacy, and service to Wyoming physicians has offered Tracy some unique opportunities and vantage points. "As I look to the future of our medical community, I think we have the chance to do some great things together as a state," he remarked.

First on his list is how Wyoming might respond to the Affordable Care Act. "My hope is that we can figure out a way to work together. If we can keep our efforts internal to the state, it would be ideal." With in-depth payment discussions on the horizon and already occurring, Tracy hopes to help the state's physicians remain one of the integral conversation partners—and to speak with a unified voice.

He also sees the opportunity for a more coordinated, statewide patient safety organization. "Wyoming is in a unique position to do patient safety on a statewide basis. I was just on a panel discussion with a physician from another state, and he talked about the intense competition among hospitals there. I don't think we have that same concern here."

An organization that would connect the safety efforts throughout the state goes beyond partnerships between physicians and gets Tracy considering how to team some of the largest Wyoming organizations that influence healthcare: the Department of Health, the University of Wyoming College of Health Sciences, family practice residencies, and the state's Quality Improvement Organization, among others.

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Collaborative Practice as a Means

In all of these endeavors, however, Tracy is staunch about not letting the means of physician unity overshadow the end of improved patient care. Delivering higher levels of treatment on the ground level is, after all, one of the ultimate objectives behind the medical partnerships he strives to achieve.

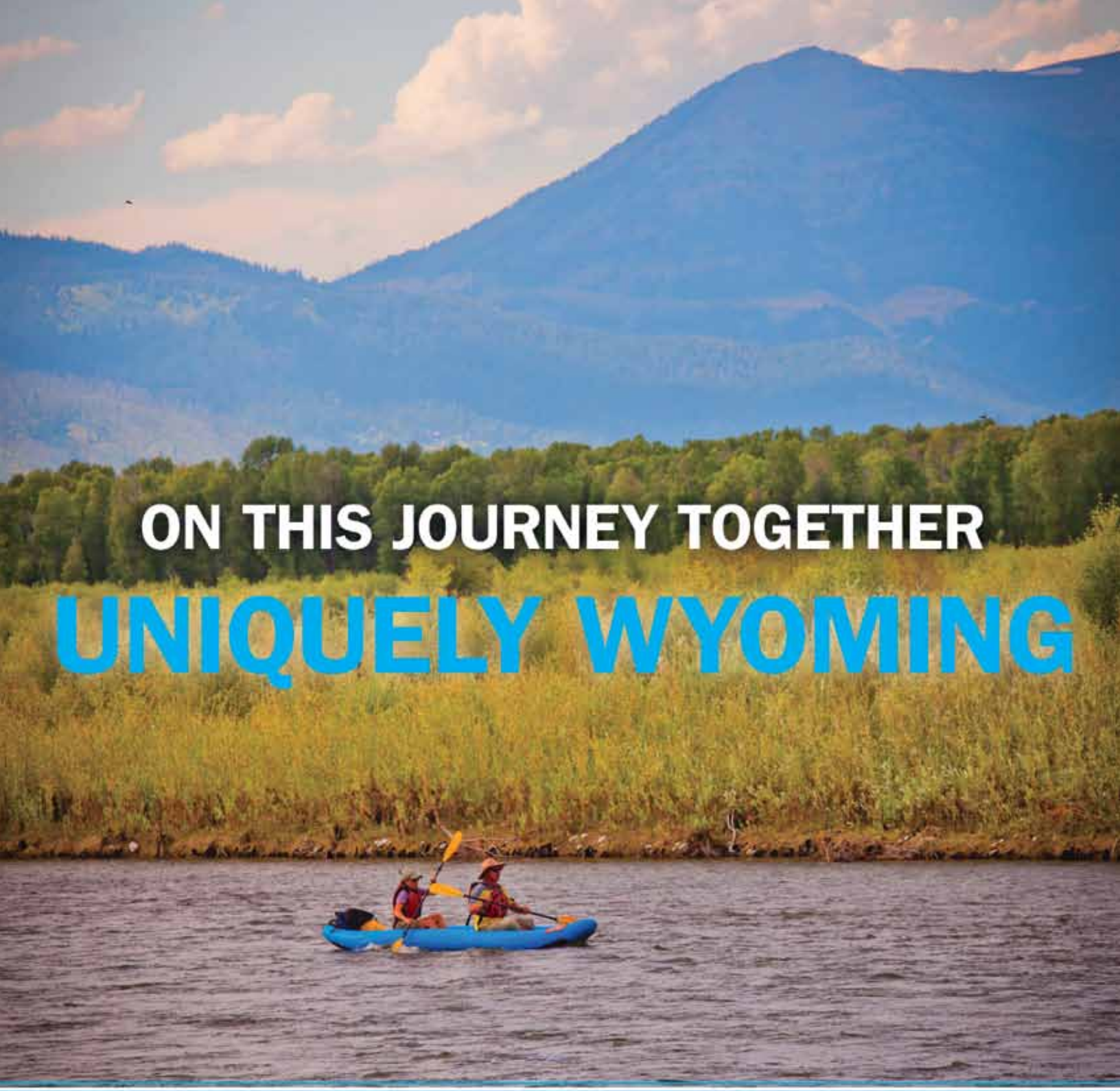
"Relationships with the patients—that's the best part about being a doctor. Trying to understand people and how I might help them is where this job gets interesting and fulfilling."

And in Tracy's experience, the way physicians are able to help their patients most effectively is by operating within cultures of collaborative practice. Patients are best served "when folks work together as a team and everybody on the team has input. When receptionists know people and can help get the process started, and when everyone can practice to the full extent of their license.

"That's the medical culture I want to help create: one where everyone is living up to their potential because they are allowed to exercise their strengths and abilities to the fullest extent."

"That's the medical culture I want to help create: one where everyone is living up to their potential because they are allowed to exercise their strengths and abilities to the fullest extent."

Scott Hubbard is a writer and editor for Wyoming Medicine.



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Physician Supervision of CRNAs Under Medicare Regulations and Wyoming Law: Uncharted Territory for a Frontier State

BY NICK HEALEY, JD

I. Introduction: The governor's choice, whether to opt Wyoming out of Medicare's physician supervision requirement for CRNAs, is a difficult one.

Nurses and physicians are both indispensable parts of the modern healthcare setting; each has a crucial role caring for patients. In recent times, however, the lines between those roles have blurred. Wyoming's Governor Mead has recently considered opting Wyoming out of Medicare's requirements for physician supervision of CRNAs, and asked the Wyoming Board of Medicine and Wyoming Board of Nursing to advise him on the implications of an opt-out. Wyoming and federal law do not clearly state the limits of that "supervision," making the Governor's decision much harder.

II. Medicare requires CRNAs to be supervised by the operating physician or an anesthesiologist unless the state has formally opted out, but Wyoming's licensing regulations are less clear.

Medicare's Condition of Participation for anesthesia in acute care hospitals, 42 C.F.R. §482.52(a)(4), permits anesthesia to be provided by "[a] certified registered nurse anesthetist (CRNA)... who, unless [the state has opted-out], is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed." Medicare's Condition of Participation for anesthesia in critical access hospitals (42 C.F.R. §485.639(c)(2)) and Condition of Coverage for ambulatory surgery centers (42 C.F.R. §416(b)(2)) are similar.

Unlike the federal regulations, Wyoming's licensing regulations on physician supervision for CRNAs varies depending on the surgical setting. Wyoming's acute-care hospital licensing regulations require that "[w]hen anesthetics are not administered by an anesthesiologist, they shall be administered by a registered nurse anesthetist under the supervision of the operating physician."

Wyoming's critical access hospital (CAH) regulations, however, are silent with respect to physician supervision of CRNA's. Under the CAH regulations, every patient is required to be under the care of a physician, or a mid-level practitioner supervised by a physician, and "furnished services [must]… comply with all applicable licensure standards." There is no requirement that a CRNA providing anesthesia specifically be supervised by a physician when doing so, unlike the acute-care hospital regulations. Instead, the care provided by mid-level providers must generally be supervised by a physician.

Wyoming's ambulatory surgery center (ASC) licensing regulations do not appear to require physician supervision of CRNAs, requiring only that the ASC's governing body "ensure that all services provided are consistent with accepted standards of practice." Similar to CAH's, the ASC regulations require that "[f]urnished services, including the contracted services, shall comply with all applicable licensure standards…[m]edical and nursing staff shall be licensed, certified, or registered according to Wyoming laws and rules; and…[s]taff members shall provide health services only within the scope of his or her license, certification, or registration." Wyoming's CAH licensure regulations and ASC regulations therefore seem to defer to the prevailing standard of care and licensing requirements to determine whether a physician must supervise a CRNA.

Wyoming's Nursing Practice Act clearly does not require a physician to supervise a CRNA's work. CRNAs are considered "advanced practice registered nurses" (APRNs) under Wyoming's nursing practice regulations, along with clinical nurse midwives, clinical nurse practitioners, and clinical

nurse specialists. Until 2005, Wyoming's Nursing Practice Act required an APRN (then called an "advanced practitioner of nursing") to practice "in collaboration with a licensed or otherwise legally authorized physician or dentist, in such manner to assure quality and appropriateness of services rendered." The collaboration requirement was removed in 2005, and APRNs' scope of practice was broadened to include, "responsibility for the direct care and management of patients and clients in relation to their human needs, disease states, and therapeutic and technological interventions."

Wyoming APRNs (including CRNAs) may therefore practice in Wyoming without any type of physician supervision, unless the state licensing statutes or regulations require physician supervision.

III. Wyoming does not follow the "captain of the ship" doctrine, which would make the operating physician liable for a CRNA's malpractice.

One common rationale for the opting out of Medicare's supervision requirement is that the operating surgeon does not have the expertise to supervise the CRNA's work, but remains liable for the CRNA's work because he or she is required to supervise the CRNA. Remove the CRNA supervision requirement, the argument goes, and the operating physician's potential liability will be consequently reduced. The kernel of this argument is the "captain of the ship" theory of liability: the operating physician is responsible for every action of every person in the operating room during an operation. Wyoming has, however, never formally adopted the "captain of the ship" theory of liability, and many states' courts have abandoned it. Those that still apply the theory do so, for the most part, in a much reduced form.

Traditionally, surgeons have been described as the "captain of the ship" in the operating room: everyone in the operating room, and everything that happens in it, is the surgeon's responsibility, and the surgeon is liable for all mistakes that happen irrespective of his or her personal responsibility. In a 2010 case applying Wyoming law, the federal Tenth Circuit Court of Appeals in Willis v. Bender noted that Wyoming has never adopted the "captain of the ship" theory, and likely would not, since "more recent courts have rejected the 'captain of the ship' doctrine in favor of general agency principles." The Tenth Circuit specifically quoted from another court's rejection of the "captain of the ship" theory, stating, "[i]n modern medicine, the surgeon is a member of a team of professionals, and we see no reason why the surgeon should be deemed responsible for the actions of other professionals neither employed nor controlled by him."

It is much more likely that a Wyoming court would only find a surgeon liable for a CRNA's malpractice if the surgeon had attempted to exercise some control over the CRNA's practice, as both the states that have explicitly rejected the "captain of the ship" doctrine, and those that apply a modified form, have done. States that reject the "captain of the ship" doctrine have applied the "borrowed servant" doctrine to determine whether a surgeon should be held liable for CRNAs (or other persons in the operating room), which requires that the surgeon actually controls, or has the right to control, the CRNA's actions.

Under Wyoming's version of the "borrowed servant" doctrine, the surgeon becomes liable for the CRNA's work only when the surgeon actually directs the CRNA's work. The Wyoming Supreme Court has stated that a property owner retaining the "broad general power of supervision and control" is not liable for an independent contractor's work. Medicare's "supervision" requirement is unlikely to be construed by a Wyoming court as sufficient to give the physician the ability to "control" the CRNA's work to the extent necessary to make the surgeon liable for the CRNA's work.

IV. Conclusion

As described above, Wyoming does not have to opt out of Medicare's physician-CRNA supervision requirements to reduce the risk of surgeon liability for a CRNA's malpractice. Wyoming's law on the issue is not settled, but it is unlikely that a Wyoming court would find a surgeon liable for a CRNA's negligence unless the surgeon actually attempts to control or specifically direct the CRNA's work.

Moreover, Medicare's physician-CRNA supervision requirement establishes an effective "floor" for all Wyoming hospitals and ASCs with respect to CRNA supervision. Opting out of Medicare's CRNA supervision requirement would leave hospitals and ASCs in a situation where, at best, patients were potentially subjected to two different standards of safety: in acute-care hospitals, CRNAs would operate only with physician supervision, while in CAHs and ASCs, CRNAs may be able to operate without physician supervision.

If Wyoming opts out, the hospital and ASC licensing regulations should be updated to provide one standard of care for Wyoming patients.

Nick Healey, JD, is a partner at Dray, Dyekman, Reed & Healey, P.C., and is legal counsel for the Wyoming Medical Society.

The Gem City's Jewel: Lawrence A. Jenkins, Physician of the Year

BY SCOTT HUBBARD

"We didn't move out here just so I could get a new job. We did it to get a new life."

When Dr. Lawrence A. Jenkins and his family moved from Southern California to Laramie, Wyoming 20 years ago, there were 380 practicing orthopedists in San Diego County alone. "About three times as many as you should have," said Dr. Jenkins, who felt the competitive strain both as a doctor at the beginning of his career and as a father with two young kids.

Although California-born, raised, and educated, five years in an overcrowded, overregulated medical scene was incentive enough for Dr. Jenkins and his wife, Amy, to start checking out the job postings for spinal surgeons. They were looking for a new job, but more than that, a new life—a cultural relocation that could be both a professional and personal boon.

Two decades later, they are more like Laramie natives than newcomers, and the Wyoming Medical Society has awarded this SoCal transplant their Physician of the Year award.

From Sunny SoCal to the Snowy Range

The Jenkinses met the fresh start they were looking for at a San Diego State football game. The Cowboys were the visiting team, and Laramie physician David A. Kieffer was among the traveling fans. Having been in dialogue with Dr. Jenkins about an opening for a spinal surgeon at Gem City Bone & Joint, Dr.

Dr. Jenkins celebrating the award with his staff. From left to right: Lauren, Ronda, Marilyn, Sue, Beth

Kieffer thought a football game was as good a place as any to evaluate his prospective hire.

"My interview was basically at that stadium in San Diego," remembers Dr. Jenkins. The Jenkinses left the meeting intrigued by the opportunity and decided to take a visit to Laramie in the fall of 1993.

The snow was blowing sideways as they crawled up 287 northbound, but their subsequent visit with the team at Dr. Kieffer's practice and their tour of the town won them over. A new life spotted, the Jenkinses picked up their California roots and set them down again in the Gem City, arriving in July 1994.

Despite the radical change, Dr. Jenkins recalls that the transition was smooth. "Raising kids here was immediately better, my wife got involved with the law school, and the practice was busy from day one."

A Medical Island

In several ways, the move was a shift from one side of the medical spectrum to the other. In California, the supply was overwhelming the demand and doctors had to jockey for their positions; but when Dr. Jenkins arrived in Wyoming, there was only one other specialty-trained spine surgeon in the state.

In terms of regulation, too, Dr. Jenkins found that Wyoming gave its doctors a lot more space to practice. "We've been like a small island here for a long time and it's been satisfying as a physician. It's a lot of work and there's a lot of responsibility, but being able to practice without much interference has been wonderful."

Hiking in Steamboat with his wife Amy and their two kids: Lauren, 24, and Nick, 22

> *"It's a lot of work and there's a lot of responsibility, but being able to practice without much interference has been wonderful."*

Dr. Jenkins outside Premier Bone & Joint Centers, where he practices spinal surgery and rehabilitation

"The vast majority of people who come in are working. They are the working poor and they don't have health benefits or any way to get them. It's important to keep these people going—they have families to support."

His position with Gem City Bone & Joint—now Premier Bone & Joint Centers—has contributed generously to that sense of freedom as well. It proved to be a good fit, and even in those early days of Dr. Jenkins's new career, the practice's orthopedists traveled throughout the state to various satellite offices. First to Rawlins, Douglas, and Wheatland, and now to seven more clinics scattered across Wyoming's plains and ranges.

One of the best parts for Dr. Jenkins, however, has been the consistent response from patients. "The people who live in this state are just different," he explained. "They're much more self-sufficient and hard working; and frankly, they don't expect others to take care of them—including the government.

"Coming from an area where people are ingrained in government benefits, that was nice."

Keeping Wyoming Working

Continually encountering that sort of attitude among patients is part of what keeps Dr. Jenkins passionate about the work he does at Laramie's Downtown Clinic.

The clinic is a volunteer-based primary care facility that serves low-income, uninsured individuals and families. Started in 2008 by a group of area physicians—including Daniel Klein, the last Laramie doctor to be named Physician of the Year—the Downtown Clinic provides surgery, therapy, equipment, and medicines to eligible patients.

Dr. Jenkins explained that, though the services are free, it would be misguided to associate the clinic with an enabling government handout. "The vast majority of people who come in are working. They are the working poor and they don't have health benefits or any way to get them. It's important to keep these people going—they have families to support."

Keeping people going is what the Downtown Clinic is all about, and it's also been one of the most galvanizing motivations for Dr. Jenkins in the other positions he has held—whether as spine surgeon at Premier, as Chief of Staff at Ivinson Memorial Hospital, or as a county representative on the Wyoming Medical Society Board. "That's one of the fun things about being a physician" he said. "We strive to fix people."

> *"That's one of the fun things about being a physician... We strive to fix people."*

Physician of the Year

Previously known as the Community Service Award, the Medical Society's Physician of the Year Award recognizes physicians who have poured their time and expertise toward improving Wyoming communities—such as by working at the Laramie Downtown Clinic. Still, Dr. Jenkins's initial response to the award was disbelief and embarrassment.

"Being recognized in the same breath as Daniel Klein and other Wyoming physicians who have received the award was pretty incredible. It felt very nice."

With the award, he joins the ranks of three other Laramie physicians whose legacies are still resounding in the city. As for his own legacy, Dr. Jenkins was clear: "I want to help create a medical atmosphere where patients know we're there for them—that we're their advocates. I want everyone who comes through my practice to feel that they were listened to and treated well."

To many of his patients, that's already his legacy. After he received the award at the Medical Society's annual meeting, a teary-eyed P.A. approached Dr. Jenkins to tell him that she has been a changed person ever since he performed back surgery on her five years ago. The nomination forms for the award teem with corresponding approbation.

Life After Orthopedics

Having practiced orthopedics for 25 years now, retirement is on the horizon of Dr. Jenkins's plans. What life after orthopedics is going to look like, however, he hasn't quite figure out. "We may stick around Laramie, or maybe move to Steamboat. We'll travel and spend time with family. I'll probably volunteer locally or oversees with a medical organization."

Retiring from a three-decades-long career of medical work may not be an easy transition, but it won't be the first one he and his wife have made. The Jenkinses are well into the new life that started on that snowy visit to Laramie back in 1993, and they have plenty of accomplishments to look back upon with satisfaction. Being named Physician of the Year is, of course, not least of these.

But it's also not the greatest of them in Dr. Jenkins's mind. "Being able to integrate with the community and raise a family—to feel that you're needed and have the opportunity to give back—that's personally what I'm most proud of." WM

Scott Hubbard is a writer and editor for Wyoming Medicine.

> *"Being able to integrate with the community and raise a family—to feel that you're needed and have the opportunity to give back—that's personally what I'm most proud of."*

To Opt Out or Not to Opt Out—That is the Question

BY KEVIN BOHNENBLUST, JD

Wyoming, because of its unique circumstances, makes extensive use of mid-level providers. This includes certified registered nurse anesthetists, or CRNAs, to provide anesthesia services in hospitals and ambulatory surgical centers (ASCs).

Regulations from the Centers for Medicare and Medicaid Services (CMS) state that when Medicare and Medicaid patients receive anesthesia in hospitals or ASCs, the anesthetics must be administered by "a qualified anesthesiologist," a "physician qualified to administer anesthesia," a CRNA, or an "anesthesiologist's assistant." If a CRNA administers anesthesia, he or she must be "under the supervision of the operating physician."

The CMS regulations also permit a state's governor to opt out of the supervision requirement for CRNAs. To do so, the Governor must attest that he has consulted with his state's boards of medicine and nursing regarding the following:

1. Issues related to access to, and quality of, anesthesia services in the state;
2. Whether opting out of the requirement for physician supervision of CRNAs is in the best interests of the citizens of the state; and
3. Whether the opt-out is consistent with the state's laws.

While a number of states have opted out of the CRNA supervision requirement, Wyoming has not done so. In addition, Wyoming Department of Health regulations governing hospitals and ASCs require that "when anesthetics are not administered by an anesthesiologist, they shall be administered by a physician anesthetist or a registered nurse anesthetist under the supervision of the operating physician."

Some believe this regulation contradicts the Wyoming Nurse Practice Act, which permits advanced practice registered nurses—including CRNAs—to practice independently and without supervision by, or collaboration with, a physician. These concerns prompted the Department of Health to contact both the Board of Medicine and the Wyoming State Board of Nursing earlier this year, posing the three questions a governor must ask prior to opting out of the federal requirement.

The Board of Medicine heard from numerous groups and individuals on behalf of nurse anesthetists, anesthesiologists, and hospitals regarding how the Board should respond to the Department's inquiry. In addition to comments provided at the Board's meetings in January, April, and August, the Board also received letters, position papers, and studies supporting and opposing the opt-out from the physician supervision requirement.

Ultimately, the Board took a position opposing both opting out of the federal requirement for physician supervision, and the repeal of the Department of Health's corresponding regulation. The reasons cited by the Board for reaching this position included, among others:

- Studies on unsupervised practice by CRNAs are contradictory and, as a body, are inconclusive on what effect the opt-out would have on access to, and quality of, anesthesia services.
- Opting out of the physician supervision requirement would have a negative effect on efforts to recruit anesthesiologists to Wyoming, thereby adversely affecting the quality of, and access to, anesthesia services in the state.
- Opting out could lead to a two-tier system of delivery of anesthesia services in Wyoming, whereby patients in larger communities would have access to both CRNAs and anesthesiologists, while anesthesiologists would not be available in smaller communities.

Instead of opting out, the Board of Medicine recommended that the key players—CRNAs and physicians (through their representative organizations) and Wyoming hospitals—explore a modified supervision model more akin to a collaborative process to remain consistent with existing state regulations. This dovetails with the Wyoming Medical Society's position, which calls for cooperation between the Wyoming Society of Anesthesiologists and non-anesthetist physicians to increase education for supervising physicians and improve access to anesthesiologists through telemedicine.

Kevin Bohnenblust, JD, is the executive director of the Wyoming Board of Medicine.

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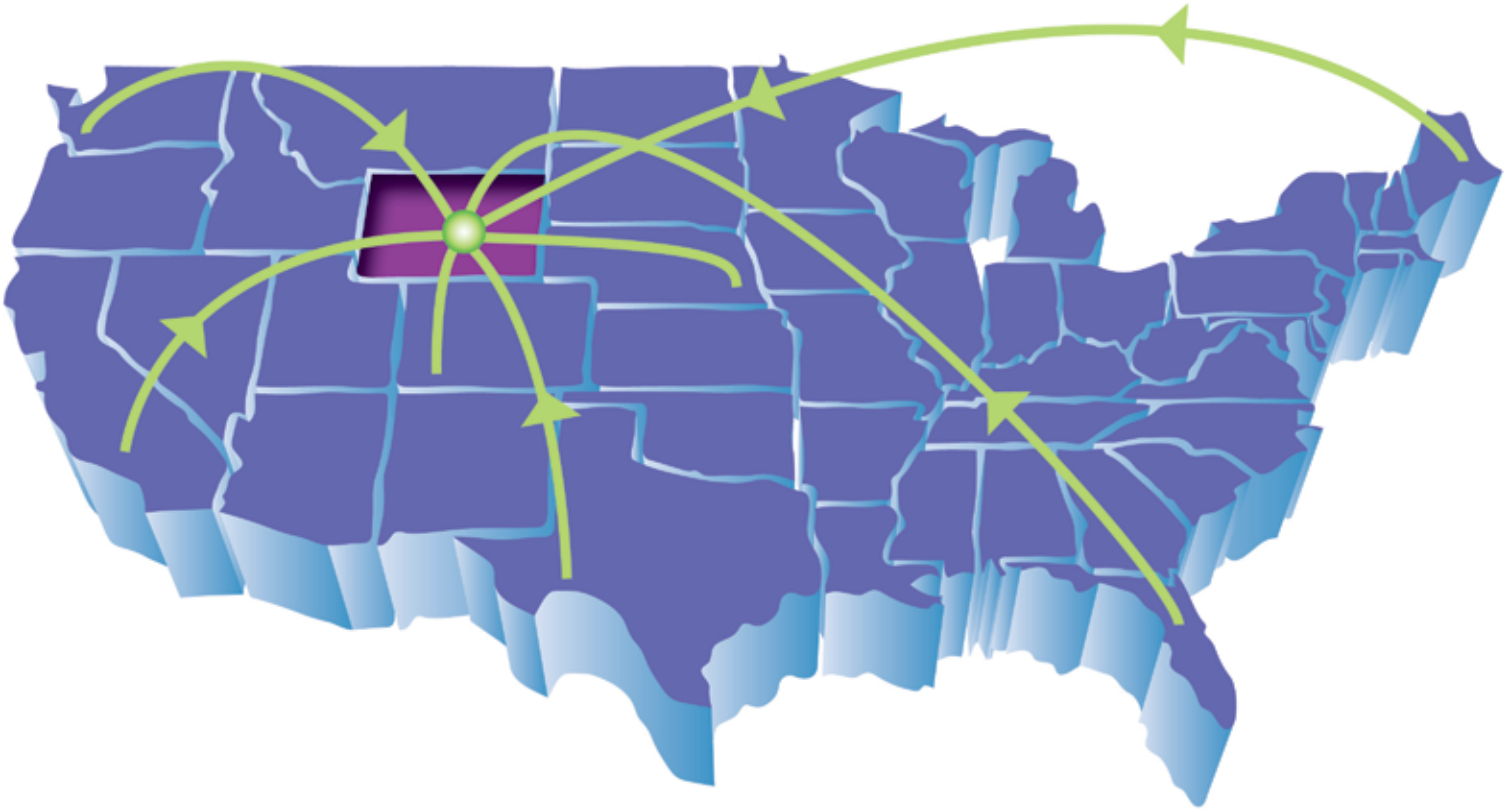

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Obstetric Providers to Face Lower Medicaid Reimbursement: An Interview with Teri Green

BY TOM LACOCK

Medicaid reimbursements for doctors in Wyoming performing obstetric services in 22 specific procedure codes were reduced on August 1. The reduction was announced in a letter from State Medicaid Agent, Teri Green, to Wyoming providers on June 17.

Medicaid provides healthcare coverage to some low-income adults, children, pregnant women, elderly individuals, and disabled citizens. According to the state Medicaid office, the state of Wyoming and the federal government split the program's $500,931,031 cost in Wyoming last year.

Teri Green in her office at the Department of Health

Medicaid is funded by a partnership between the state's general fund and the federal government, making it a $240,738,021 cost for Wyoming.

According to Green's letter, the change is based on research conducted by the Department of Health regarding premium cost and availability of Medical Malpractice Insurance. According to claims data, the projected expenditure reduction from this adjustment is a total of $1,989,228 to Medicaid, with the state seeing a savings of $994,614.

"Our goal was not to make a huge impact to providers," Green said in an interview with the Wyoming Medical Society. "We can't do that. We have to be careful not to do that. We need them—not just from a Medicaid perspective, but from a public health perspective in Wyoming. We need to keep them enrolled and keep them in business.

"Having said that, we have a budget to live within and you have to make choices," Green continued. "You try to make an educated choice that takes into account what providers are getting paid and how much it costs them to provide their service."

Despite the new rates, the Department of Health stated that Wyoming will continue to have the highest reimbursement rates for the 10 specific delivery procedure codes, with rates 12 to 25 percent higher than any other state in the region. The same reimbursement will average between 43 to 83 percent higher than the calculated regional average.

Green said the Department of Health will not know until next year what the specific average of the customary billing Medicaid Wyoming providers received for their services.

Number of Insurers Rise, While Premiums Drop Slightly

During a special session in 2004, the Wyoming Legislature created an enhanced obstetric reimbursement method to reduce economic pressure on providers of obstetric services trying to find malpractice insurance. The Legislature instructed the Department of Health to pay 90 percent of normal and customary billing of obstetrics service providers. That mandate was renewed in 2006, 2008, and 2010.

The hope was that the higher rate of reimbursement would help a healthcare specialty that was struggling to find malpractice insurers willing to write a policy in the Cowboy State. In 2003, there was just one insurer willing to cover Wyoming's OB/GYNs. That

number has since risen to four in 2012. That is the same as Colorado and Idaho and more than every other state in the region.

The annual price of malpractice insurance for obstetrics remains eye-popping, but it has dropped slightly from its high of $89,200 in 2007 to its current cost of $78,144 per year, according to Department of Health numbers. Costs for malpractice insurance in the region vary from states that have caps on pain and suffering damages (Nebraska charges $18,797) to those that do not (Montana charges $81,186).

Green said the combination of a slight drop in insurance rates, as well as a higher number of companies willing to offer insurance to providers offering obstetric services in Wyoming, shows the profession is getting a little healthier.

"What we look at is if there are carriers available. And we found that, yes, there are," Green said. "We haven't had any reduction [in number of insurers offering malpractice coverage] and we are just as high as anyone else in the region. We also looked at premiums. At this point, the average medmal is down to $78,000. "Here's what we asked: how can we save money in this area and meet our required budget cuts, yet still be appropriate in what we pay our providers and fair with what is happening in the area?"

Wyoming Providers Pay More, Receive More for Obstetrics

While the prices paid by Wyoming providers offering obstetric services are higher than the national average, Green said that the payments to Cowboy State providers are higher, too.

Green backs up her statement by pointing to 22 obstetric procedure codes for the labor and delivery of babies, where Wyoming pays more than double (235 percent) the regional average. Department of Health data shows the average global payment for a routine obstetric care (child delivery) is $3,867 in Wyoming, compared to Montana ($2,543), Nebraska ($2,216) and Colorado ($1,316). That number represents 90 percent of the average dollar figure Wyoming obstetric providers bill Medicaid.

Between the fiscal years 2004 and 2012, total delivery costs have more than doubled, from $1,299 in 2004 to $2,829 in 2012.

"Before the budget reduction, we were paying 132 percent of the next highest rate in our region in obstetrics," Green said. "For some of these codes we are paying 235 percent of the next highest rate in the region."

As the numbers for reimbursements have remained high, so have the number of providers in Wyoming. In 2004 there were 137 obstetric providers, a number that dipped to 129 in 2009. According to the Department of Health, that number has rebounded to 145 in 2012.

The New Conversion System for Reimbursement

In the fall of 2012, the Department of Heath proposed and the legislature and governor accepted that a portion of the 2014 budget reduction from the Medicaid agency would come from ending the enhanced rates paid to providers offering obstetric services.

With the 90 percent of customary billing mandate having passed, the Wyoming Department of Health will use the same process to set reimbursement rates as it does for other provider specialties. The Department of Health will now put those services into its Resource-Based Relative Value Scale (RBRVS).

According to Lindsey Schilling, Provider Operations Administrator for Wyoming Department of Health's Division of Healthcare Financing, the RBRVS method offers a relative value for each procedure code.

In an email to the WMS, she wrote, "The relative value is determined by three components: 1. Physician work (52 percent); 2. Practice expense (55 percent); and 3. Malpractice expense (4 percent)."

Schilling went on to say that the state utilizes the same determined relative values as Medicare for calculating reimbursement rates. That relative value is then multiplied by a state-determined conversion factor to result in a code reimbursement fee.

"The current RBRVS State conversion factor is $37.61," Schilling wrote. "To account for the heightened malpractice insurance premiums for OB and family practice physicians performing OB services throughout the state, we established a separate conversation factor for these 22 codes. The new OB specific conversion factor is $45.00."

"We all know that there are issues with the healthcare industry," Green said. "I think we have a very good relationship with our providers in Wyoming—we have nearly 100 percent participation in Medicaid. They have all been part of the conversations. Do they like it? Of course not—but they know they are all willing to be a part of the solution."

Department of Health Examines Managed Medicaid Issue

BY TOM LACOCK

The Wyoming Department of Health has contracted with Health Management Associates (HMA) to produce a feasibility study of managed Medicaid care in Wyoming.

Teri Green of the Wyoming Department of Health (WDH) said the agency has been directed by the Wyoming Legislature to conduct a study to determine if managed care of Medicaid would be beneficial for Wyoming and its providers. Health Management Associates is a nationwide firm based out of Naples, Florida with a presence in 15 states, mostly in the southeast part of the country.

"HMA was selected in large part because they had the most expertise in analysis of Managed Care in Medicaid programs across the country," Green said. "Their resources are experienced in Medicaid Managed Care."

Green said managed healthcare is just what it sounds like—a firm attempt to help manage costs for its clients by negotiating care for better costs and outcomes for patients. She said the study hopes to answer the question of whether managed Medicaid is right for Wyoming and how a managed Medicaid system could be done while maintaining or improving the standard of care.

"We have a balance here," Green said. "We want to keep providers in business in Wyoming. It is a very sensitive balance. We don't want to break a system that is already sensitive. We would want to have provider buy-in and we would want to know on an actuarial basis that it makes sense for everyone."

According to the WDH, the cost of the HMA study is not to exceed $240,000 and will come in three parts. Part I requires that HMA conduct a study into the benefits of various models, of managed care for Wyoming Medicaid. That includes coordinated care models, full and partial at-risk managed care, managed fee-for-service, and carve-out models among others. The research is to focus on Medicaid and CHIP programs with an eye on the Affordable Care Act and its ramifications.

Part II will depend on the outcomes of the first portion of the report. At this juncture, HMA will be asked to use three years of historical Wyoming Medicaid data to estimate caseload, utilization, and per capital trends for the relevant and affected populations through the implementation of the recommended managed care.

Part III is dependent on the report's findings. HMA is required to support the Department of Health's preparation of a final report to the Legislature, offer technical assistance in formalizing the final recommendations, prepare a document including the required budget documents and resources needed to design a managed care system, and develop both detailed and higher-level timelines and project plans.

The Wyoming Department of Health will report findings and recommendations to the Wyoming Medicaid Executive Leadership team. Those findings will be presented to the legislature, which will then decide whether to proceed with such a managed care system.

According to Green, it is likely that the project will wrap up between October and February.

Tom Lacock is a staff writer at gowyogo.com and a contributing columnist for Wyoming Medicine.

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New App Allows for HIPAA-compliant Texting

BY DOCBOOKMD

Few people need to be convinced of the advantages of texting. It may be the fastest and most efficient way of sending information today. Reports show that texting among physicians is widespread and that they are texting clinical information—whether it is legal to do so or not. Physicians who text each other clinical information risk exposing themselves to privacy and security violations of the Health Insurance Portability and Accountability Act (HIPAA).

But a new smartphone app is changing all that.

Physicians in Wyoming now have the option to text each other patient information in a secure, HIPAA-compliant manner, thanks to an app called DocBookMD.

DocBookMD is a physicians-only smartphone app that allows physicians to:

- End HIPAA-compliant text messages and photos;
- Assign an urgency setting to outgoing text messages;
- Search a local pharmacy directory; and
- Search a local medical society directory (including email addresses and photos).

"DocBookMD allows you to look up another doctor at the point of care. You can then either call the physician or send a text message with room numbers, medical record numbers, even pictures of wounds and x-rays. And all of this is sent securely and in a way that meets HIPAA requirements," says Dr. Tim Gueramy.

Dr. Gueramy, an orthopedic surgeon from Austin, Texas, created DocBookMD with his wife, family physician Tracey Haas.

To register or for more information on DocBookMD, please visit www.docbookmd.com. Physicians who would like to use DocBookMD, but live in areas that do not participate, are urged to contact DocBookMD by email at info@docbookmd.com.

Health Information Exchange and You: Why it Matters

BY HEATHER ROE DAY

Securing *your data.* Protecting *your health.*

Are you frustrated because you can't see test results or reports of what happened with your patients when they receive treatment outside your scope of care? Wyoming now has a health information exchange (HIE) to help you see information for your patients across the healthcare continuum. Called "MyWY Health," the HIE provides healthcare professionals access to patient data never before available in Wyoming:

Direct secure messaging: Allows HIPAA-compliant secure email messaging to transport patient data between providers. For example:

- Receive lab results from another organization for attachment to your electronic health record (EHR).
- Send referrals to specialists with summaries from your office and have results reported back to you as soon as treatment is completed.
- Send cancer-screening data to Wyoming Department of Health (coming soon).
- Communicate electronically with nursing homes and home health agencies to improve transitions of care.

Query based "look up" ability: Allows you to view patient treatment occurring outside of your organization. For example:

- See admission and discharge information for patients treated in local hospitals or across the state, all in one view.
- View patient demographics, medications, allergies, lab results, radiology and transcription reports, and problem lists reported across participating HIE members in one portal, whether the care happened locally or across the state.

MyWY Health can electronically send health information straight into your electronic health record (EHR). Information sharing through MyWY Health also supports health initiatives in Wyoming, such as patient-centered medical homes and patient transitions.

Visit www.mywyhealth.com to see members and learn about how health information exchange can help you coordinate the care of your patients through improved access to information.

Total Health Record a Tool for Wyoming Providers

BY JAMES BUSH, MD

In 2008, the Wyoming Department of Health recognized the need for the integration of hundreds of its separate databases into a single, clinically useful database, and they saw a chance to help Wyoming providers.

"At that time, only 20 percent of Wyoming providers had electronic health records (EHRs), and we knew cost was a major barrier, especially for our rural providers", said Dr. James Bush, Wyoming's Medicaid Medical Director. "We saw an opportunity as we were connecting the Department's various databases. With a web-based system, we could allow access for Wyoming providers at no extra cost."

The Total Health Record (THR) is a web-based EHR that provides a patient record by compiling information from multiple healthcare encounters. It is connected to the Immunization Registry and MMIS, the state's Medicaid billing system that enables claims to be added to the chart for all Medicaid patients.

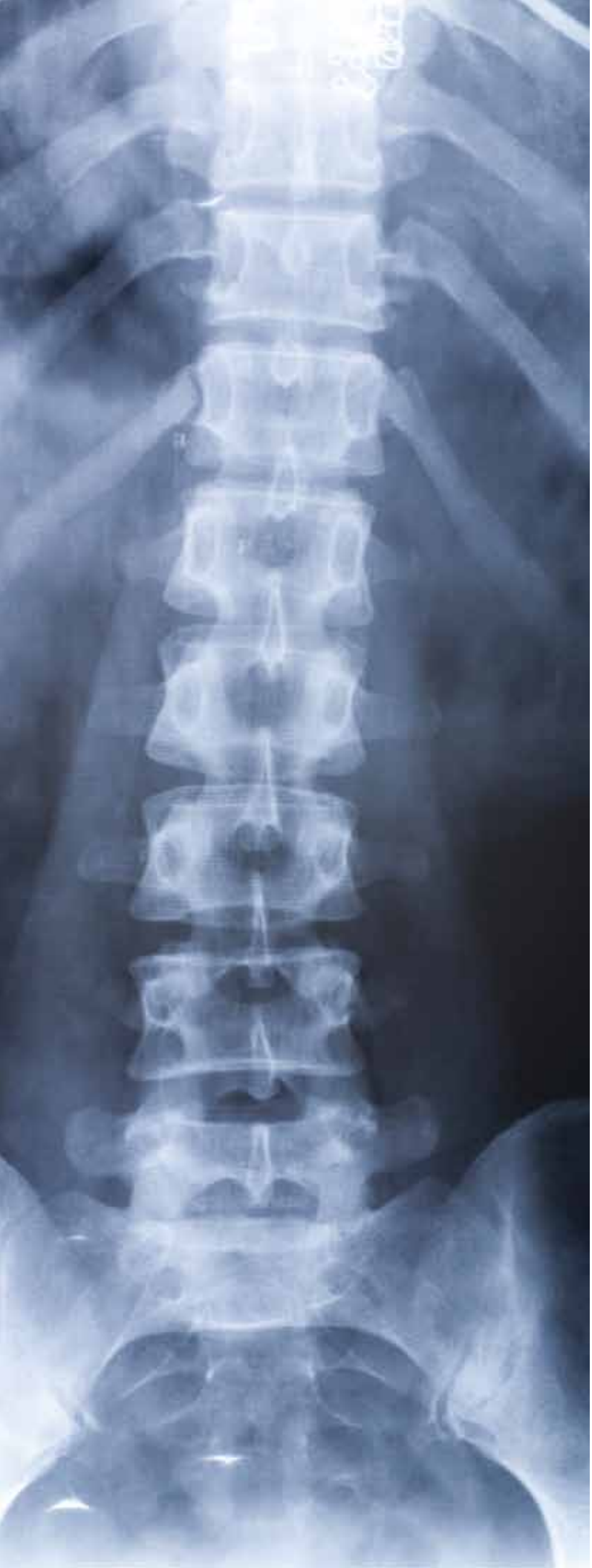
The THR offers an online EHR at no cost to Medicaid providers and is accessible through a secure Web portal. It is ONC certified and has the capability to enable providers to meet Meaningful Use (MU) and qualify for EHR incentives, if eligible.

All providers enrolled in Wyoming Medicaid also have the ability to pull a Continuity of Care Document (CCD), no matter what form of medical records they have in their office.

The CCD is a document that confirms patient eligibility in Medicaid and provides information on all encounters, immunizations, medications, diagnoses, and procedures the patient has had over the last two years.

The THR also offers an online Personal Health Record (PHR) at no cost to patients. The PHR allows patients and their providers to view a broad range of the patient's health information. Educational materials and access to healthcare professionals are also available to patients through the PHR.

Currently, there are over 66 providers in 33 clinics and over 70,000 patient records in the THR. To learn more about the THR or how to access the CCD viewer, visit www.wyomingthr.com.



Improving Patient Safety in Wyoming

BY MIKE TRACY, MD

A great paradox exists in patient safety efforts in this country and in Wyoming: the majority of care is delivered in the office setting, yet the majority of patient safety efforts focus on the inpatient environment. In 2012, for example, 75 percent of the Joint Commission's National Patient Safety goals were considered "not applicable to ambulatory care." The 2013 JCAHO website includes some ambulatory safety goals, but there is much room for growth and recognition of some of the unique aspects of patient safety in the office setting.

Office Hazards

Do bad things not happen related to care rendered in the office? Of course they do. Reasons for the historical focus of patient safety literature on inpatient efforts are multifactorial, and at least partly due to the fact that the hospital is a more contained system than the office. It's easier to observe adverse events when they occur in a setting where patients are being observed continuously. The issue of cause-and-effect is often more apparent in the hospital. It's also more convenient to measure a larger number of issues in one hospital than it is to measure the separate issues in each of the offices that feed that hospital.

The types of errors that jeopardize patient safety in the office setting include delayed diagnosis (such as missed x-ray or lab reports), communication lapses (such as poor communication among providers), prescribing errors (including illegible prescriptions), and adverse drug events. Most offices do not have a fail-proof system to ensure that patients follow through with diagnostic orders and are notified of the results.

Studies show that communication between primary care physicians and specialists (including hospitalists) has considerable room for improvement. Adverse drug events often go unrecorded other than to note the allergy or event in the individual patient's chart. Many offices, including those using electronic health records (EHR), do not have adequate registry functions to manage chronic care and preventive issues proactively and effectively. Are EHRs supposed to fix these problems? EHRs with robust registry and data-mining features are part of the solution, but they are not in themselves able to solve the complex issues of patient safety.

Enlist, Educate, and Inform

One vastly underutilized source of improvement in patient safety efforts is the patient. Buzzwords like "Patient-centered" and "Patient engagement" are often used in discussions of improving care; yet

most hospitals and offices do not have a patient representative on committees or councils dedicated to patient safety. Enlist the patient in safety improvement efforts! Encourage questions. Alert them to potential areas where they could get hurt. A great example is in the area of notification of patients regarding test results. Tell them "no news is not good news, it's just no news." The patient can close the loop if a result was inadvertently not reported.

Another example of an effort that needs to be focused in the office setting is medication reconciliation. If the patient walks out of the office with a prescription, make sure they can read it and tell you how they'll take the medication. Educate patients regarding diagnostic and treatment choices and don't let the conversation stop at, "I don't know, you're the doctor." Engaging patients in their care in these ways will generally enhance the provider-patient relationship and offer another level of safety assurance.

How are adverse events best handled in the office setting? If a safety issue is identified, handle it with honesty, transparency, and full disclosure. Some of the tools used in the hospital setting, such as Root Cause Analysis, are historically not used in the office but there is no reason to not apply the same principles. Patients will generally appreciate candid discussions of the system and how to improve it. There is evidence that full disclosure of adverse events actually decreases medical liability claims.

Partnering the Office and the Hospital

Wyoming has a great opportunity to combine hospital and office patient safety efforts. Providers need a safe venue to share patient care experiences without fear of legal retribution. This could be done through the formation of a statewide patient safety organization. Stakeholders invested in improving patient safety include physicians, physician assistants, nurse practitioners, nurses, pharmacists, social workers, and, of course, our patients. Other stakeholders include the Wyoming Department of Health, the University of Wyoming College of Health Sciences (including WWAMI, the School of Nursing, and the School of Pharmacy), and Family Practice Residencies devoted to training the next generations of providers at the entry level. Another key stakeholder is Wyoming's Quality Improvement Organization (Mountain Pacific Quality Health Foundation).

A patient safety organization would provide the opportunity to discuss adverse outcomes and near misses in a protected setting. It would also allow for collaborative efforts to share and learn from each other on issues such as medication reconciliation and office access and efficiency.

Mike Tracy, MD, is the past president of the Wyoming Medical Society and an internal medicine and pediatrics physician who practices in Powell.

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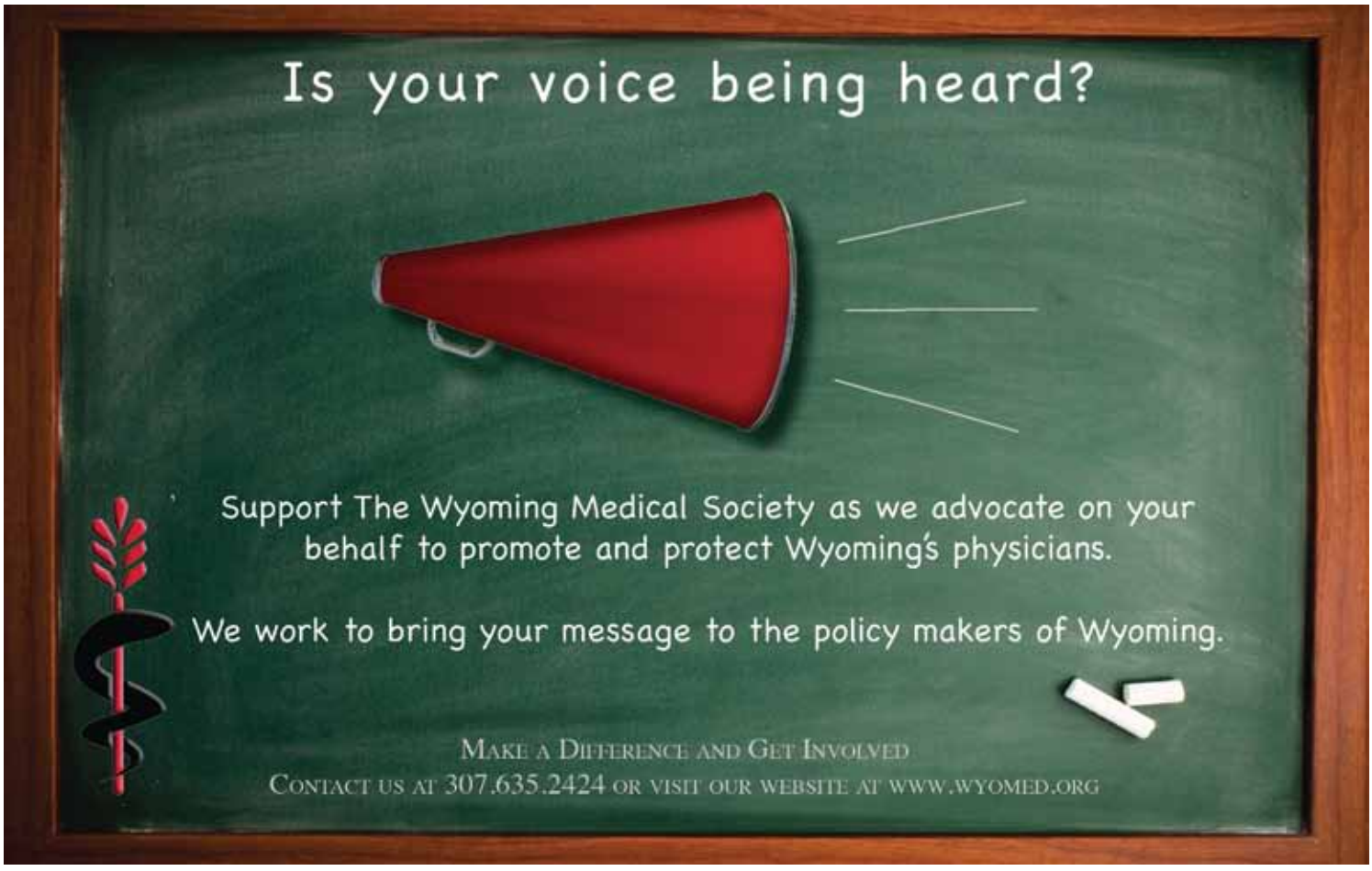

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Megan Woodward, MD
Carol Wright, MD

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Candice Dolbier, DO
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Clinton Lauridsen, DO
Katie Lee, MD
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Daniel Murphy, MD
April Rosalez, DO
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Cameron Werner, MD
Scott Walker, DO
Weston Young, DO

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Nima Azarbehi, DO
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Kristina Behringer, MD
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Bilal Khan, MD
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Steward North, DO
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