



FIRST

Do No Harm

In this Issue

- Notice of new PCA Advisories
- New SQR Reporting Form
- Suicide Risk Assessment
- Peer Review Conference
- Contrast Agents for MRIs
- PCA Profile: Dinesh Patel

Patient Care Assessment Division, Board of Registration in Medicine

June, 2007

DISPARITIES IN HEALTH CARE

In March 2003, the prestigious Institute of Medicine issued a landmark report titled *Unequal Treatment, Confronting Racial and Ethnic Disparities in Healthcare*, which created a stir across the country and touched a nerve in the medical community. It revealed that racial and ethnic minorities receive poorer quality medical care compared to white patients, even when such factors as insurance coverage, ability to pay, and access to care were equivalent among the groups.

Research has confirmed that disparities in treatment affect racial and ethnic minorities even when controlling for socio-economic status and education; minorities are often treated differently—and have adverse outcomes. One example is for pain control, even for the severe pain associated with cancer. One study showed that white patients who present to emergency departments for chest pain are more likely to receive an electrocardiogram and cardiac catheterization than minorities, who are more likely to be treated symptomatically for indigestion or gastroesophageal reflux, than for angina.

The causes of these types of events are multi-factorial and are currently being elucidated. Some possible causes are the nature of the culture from which the patient comes, healthcare provider awareness of treatment difference, workforce diversity, the severity of illness at the patient's, presentation, environmental challenges, and health care literacy—of note patients' understanding of the role of nutrition and prevention among minorities and

lower socio-economic classes. Physician/patient racial and ethnic concordance can only be improved by efforts to increase workforce diversity. However, race/ethnicity is a mere proxy for other biological, economic, social, and cultural traits that may influence access.

There are also severe problems with recruitment and retention of physicians who want to serve underrepresented patients. This causes a longer wait for patients seeking routine or preventive health care. Even in Boston, which has one of the best doctor/patient ratios in the country, physicians are not necessarily located in the minority communities where they are most needed. In a recent study presented in *Health Affairs*, "a substantial percentage in all the racial/ethnic groups reported experiencing barriers to care. In particular, 10-30% of respondents reported going without needed care, having difficulties obtaining it, not having a usual source of care, and encountering organizational barriers such as long waiting times or difficulties obtaining medical appointments."

Provider-patient relationships can also be affected by attitudes and behavior. Some evidence exists that minority patients may not trust health care professionals, thus leading to delays in seeking treatment or avoiding screening tests that could provide early warning signs of disease. Other major concerns are the lack of translation services for those who don't speak English and a lack of communication between physician and patient – many doctors use medical

terms that patients find hard to understand.

The good news is that progress is being made. Health care providers, insurers, hospitals, legislators, and policymakers are all recognizing that disparities do exist and that they must be eliminated. The City of Boston, Boston Public Health Commission, the Commonwealth of Massachusetts, Health Care For All and groups like the Massachusetts Medical Society and American Medical Association are devoting substantial resources to identifying specific causes of these disparities and developing solutions to eliminate them. The medical community is becoming aware that cross-cultural education – learning how racial, ethnic, cultural and social factors influence health care – is important for health care providers.

We are fortunate to live in an area that provides some of the best health care in the world. The fact that disparities in health care exist among racial and ethnic groups is unacceptable and something all of us – hospitals, insurers, policymakers, physicians and patients alike – should be working toward eliminating.

Contributed by Alice A. Coombs, M.D., Vice Chair of the PCA Committee. Dr. Coombs is a critical care specialist and anesthesiologist at South Shore Hospital; Assistant Secretary Treasurer of the Massachusetts Medical Society; and Immediate Past Chair of the Massachusetts Medical Society's Committee on Diversity in Medicine. She is a member of the Committee to End Health Care Disparities of the American Medical Association; and Chair of the Workforce Diversity Committee and the Commonwealth of Massachusetts' Commission to Eliminate Racial and Ethnic Disparities in Health Care.



GADOLINIUM-BASED CONTRAST AGENT FOR MRIs

Since June 2006, the FDA has been reviewing reports about patients who developed Nephrogenic Systemic Fibrosis, a.k.a., Nephrogenic Fibrosing Dermopathy (NSF/NFD) after they received a gadolinium-based contrast agent during a magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA). As of December 2006, 90 individuals with NSF/NSD had been reported to the FDA; all had moderate (GFR < 60 mL/min/1.73m²) to end-stage renal disease (GFR <15 mL/min/1.73²) prior to their MRI or MRA with a gadolinium-based contrast agent.¹

Physicians should carefully assess the need for gadolinium-based contrast agents in patients with moderate to end-stage renal disease when performing an MRI or MRA, and when administering these agents to patients in the same category when undergoing other diagnostic procedures such as conventional angiography and/or CT exams. ("The rationale behind this practice was to avoid the administration of iodinated contrast agents to these patients and to decrease the incidence or likelihood of the development of contrast-induced nephropathy.")²

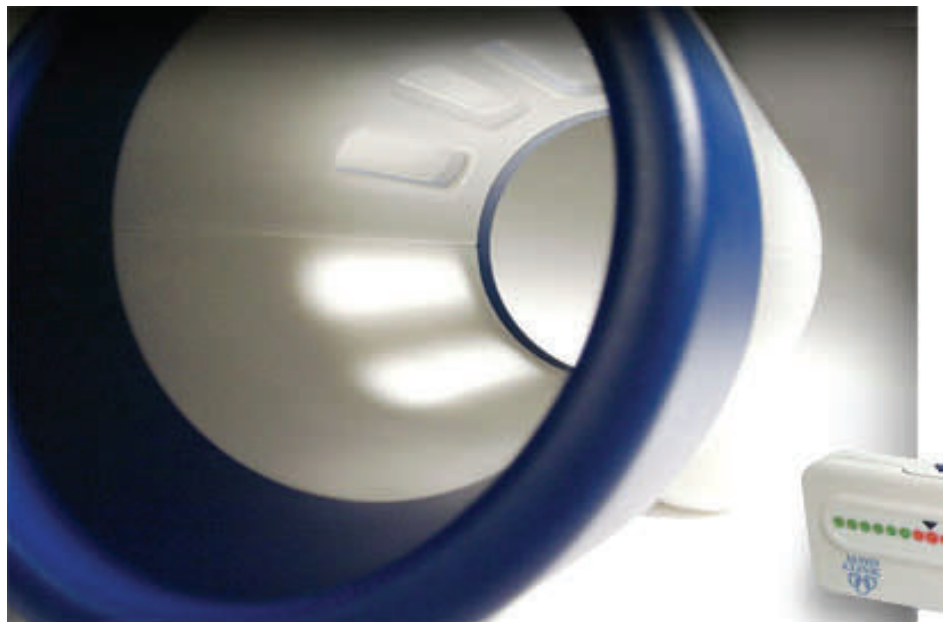
Information for Care Professionals:

- For patients with moderate to end-stage renal disease: When recommending or performing an MRI or MRA, carefully weigh the benefits and risk associated with using a gadolinium-based agent in light of recent reports of NSF/NFD observed following administration of these agents. Choose an alternative imaging method and/or contrast agent whenever possible.
- Although there are no published data to determine the utility of dialysis to prevent or treat NSF/

NFD, consider prompt dialysis of patients with moderate to end-stage renal disease who undergo an MRI or MRA with a gadolinium-based contrast agent. Prompt dialysis of these patients eliminates circulating gadolinium-based contrast agent.³

In addition to the recommendations published by the FDA Alert, Emanuel Kanal, M.D., FACR, MR expert and chairman of

*failure patients, this must be made in the form of a written order. All such requests must be prospectively reviewed and approved by either a radiologist or a pharmacist knowledgeable in the issues raised above, a risk-benefit assessment should be performed, and where practical, informed consent should be provided the patients."*⁴



Above: An MRI machine from the Mayo Clinic.

the American College of Radiology's Blue Ribbon Panel on MR Safety offers some prudent advice:

"In an attempt to prevent inadvertent gadolinium based MR contrast agent (GBMCA) administration to renal disease patients by nonradiologists (who may at this point still not be fully aware of the issues and risks associated with these agents), for now it is thought prudent to ensure that all GBMCAs are to be administered only by radiologists. If there is a request for a GBMCA to be administered by nonradiologist to a patient for an off-label use, such as intra-arterial administration for vascular assessment in renal

Information for the patient:

Physicians who are requesting an MRI or MRA with a GBMCA for a patient with moderate to end-stage kidney disease should discuss the following issues with their patient.

Because the patient has moderate to end-stage kidney disease, they may develop NSF/NFD after receiving an exam with a gadolinium-based contrast agent. NSF/NFD is a debilitating and potentially fatal disease.

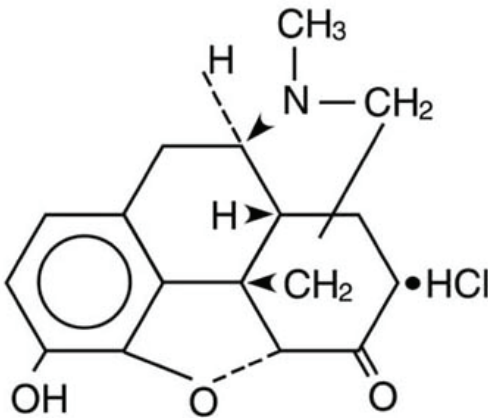
The signs and symptoms of NSF/NFD include:

- For the skin-burning or itching, reddened or darkened patches;

(Continued on page 3)



— HYDROMORPHONE ADVISORY —



In May, an alert about hydromorphone was approved by the PCA Committee for release to health care facilities. It also was mailed and added to the Board's website. Over the last several months, as unexpected events involving hydromorphone were reviewed by the Committee, a number of serious incidents were noted. This Alert outlines recommendations for

Left: The chemical structure of Dilaudid®, a brand name hydromorphone.

hydromorphone dosage, storage, dispensing, and review of concomitant sedative use. The difference in dosage between hydromorphone and morphine is of particular importance, since their potency, onset and duration of action differ significantly. Despite a dosing ratio of 1:8, hydromorphone to morphine, both drugs are available in similar strengths. Please take time to carefully review this Alert. The Committee believes adoption of their recommendations will be life saving.

— HIPAA ADVISORY —

In April, PCA mailed and added to the website an advisory about sharing patient information for quality improvement purposes under HIPAA. If you did not receive a copy or have not yet accessed it at our website, please visit http://www.massmedboard.org/pca/pca_updates.shtm to view it.

In essence, the HIPAA Pri-

vacy Rule permits covered entities to disclose certain protected health information to other covered entities, without an individual's authorization, for the purpose of quality assessment and improvement activities. Included in these activities are outcomes evaluation; reviews of competence or qualifications of health care professionals; health

care professional and non-professional training; and credentialing, accreditation, or licensing activities.

If you haven't reviewed your facility's policies and procedures to assure that they allow for the release of this information when authorized by the HIPAA Privacy Rule, now would be a good opportunity to do so.

— GADOLINIUM, CONT'D —

(Continued from page 2)

and/or skin swelling, hardening and/or tightening.

- For the eyes:yellow raised spots on the whites of the eyes.

- For the bones, joints and muscles:joint stiffness; limited range of motion in the arms, hands, legs, or feet; pain in the hip bone or ribs; and/or muscle weakness.

Patients at risk for NSF/NFD require close monitoring and clinical follow-up after having an MRI or MRA with a gadolinium-based contrast agent.

Currently there are five FDA

approved gadolinium-based contrast agents, Magnevist®, MultiHance®, Omniscan®, OptiMARK®, and ProHance®. These contrast agents are FDA approved for use during an MRI scan, but not for use during an MRA scan. Although NSF/NFD has been reported for only 3 of the 5 gadolinium-based contrast agents, the FDA believes that there is a potential for this to occur with the use of any of the approved agents.⁵

¹FDA ALERT [6/2006, updated 12/2006]: Development of Serious, Sometimes Fatal Nephrogenic Systemic Fibrosis/Nephrogenic Fibrosing Dermopathy following exposure to Gadolinium-based Contrast Agents

²ACR Guidance Document for Safe MR Practice: 2007; page 15

³FDA ALERT [6/2006, updated 12/2006]: Development of Serious, Sometimes Fatal Nephrogenic Systemic Fibrosis/Nephrogenic Fibrosing Dermopathy following exposure to Gadolinium-based Contrast Agents

⁴ACR Guidance Document for Safe MR Practice: 2007; 15,16

⁵Id; FDA ALERT

**This article was contributed by:
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Project & Risk Manager Radiology Imaging Services

Southcoast Hospitals Group



NEW SQR REPORTING FORM

It is time for change! The regulatory term “Major Incident,” used to describe your reports of certain unexpected patient outcomes (243 CMR 3.08) does not accurately reflect the intent and purpose of these reports. As you know, these are reports describing your review, findings and recommendations for quality improvement. We are working

to change the regulatory language. In the interim, we are changing the name of the Major Incident Report. There is a new “Safety and Quality Review” form which will soon be available as an interactive PDF version on the Board’s website. The PCA Division will have a three month trial period for the new version. Your input, criticism, suggestions for

improvement, or any comments you have will be appreciated. There are drop down menus and an improved data entry format. Visually, it is very different from the old form. Most of the data collected is the same, though there is a new list of codes that will allow PCA to collect more meaningful information from your reports.

NURSING PEER REVIEW

The PCA Division is very interested in facilities that have an established process for Nursing Peer Review. If your hospital has a Nursing Peer Review Committee or a similar structure already in place, we would like to hear from you. We

would appreciate a brief summary of your processes that guide Nursing Peer Review. Included in this summary should be: whether case identification is from retrospective review, concurrent review, or by referral from a medical staff

committee; any impacts that the quality review analysis by nursing has had on patient safety at your facility; and any other information that is pertinent. Please submit your responses via e-mail only to: Barbara.Watts@state.ma.us

PCA/REHABILITATION AND LTAC CONFERENCE

Thursday, June 21, 2007 from 10:00 am to 12:30 pm

Whittier Rehabilitation Hospital—Westborough, 150 Flanders Road, Westborough, MA.

Rehabilitation and Long Term Acute Care Hospitals—mark your calendars! This program is a two way discussion between PCA and rehabilitation/LTAC hospitals using common trends noted in MIR reviews. We will discuss clinical issues, process issues, such as

screening and admission from acute care, transfers within 48 hours of admission, unexpected patient outcomes, and other relevant topics. Most important will be hearing hospitals’ experiences, particularly in reference to reporting requirements. PCA can then tailor its oversight

functions in such a way that in addition to being timely, they will also be pertinent to rehabilitation hospitals and LTACs in improving patient safety. If you haven’t received an invitation to the conference and would like to attend, RSVP via e-mail to: kendra.davitt@state.ma.us.

PEER REVIEW

Mark your calendars: *Thursday, September 20, 2007 from 9:00 a.m. to 1:00 p.m.* at the Massachusetts State House. Dr. Leslie Selbovitz, Senior Vice President and CMO at Newton Wellesley Hospital, will lecture on peer review and credentialing processes. This conference, sponsored by the PCA Division, will be invaluable to those in Medical Staff and Quality leadership positions at your facility. More information about the conference and details on how to register will be forthcoming.

PCA PROFILE: DINESH PATEL, M.D.

Dr. Dinesh Patel is a physician member of the Board’s PCA Committee and is Chief of Arthroscopic Surgery at Massachusetts General Hospital and on faculty at Harvard Medical School. He was a member of the Board of Registration in Medicine from 1987-1992, serving as Chairman of the Board from 1990-1992, and also on Committees for Licensure, Complaints, Acupuncture, and Joint Education. He served as a Board member and a member of the Executive Committee of the Federation of State Medical Boards between 1993-1997. He has taught Arthroscopic Surgery all over the world and has been recognized and honored by professional organizations here and abroad. He has been in US News and World report as one the best doctors and in February 2002, Boston Magazine voted him as one of the Top Doctors in the field of Orthopedic Surgery.





McLEAN HOSPITAL – SUICIDE RISK ASSESSMENT

According to the Joint Commission, suicide ranks as the 11th most frequent cause of death in the United States. In an effort to promote focused patient safety improvements, the Joint Commission instituted National Patient Safety Goals. The 15th goal focuses on suicide risk and mandates that “the organization identifies safety risks inherent in its population,” requiring that patients

construct an instrument that facilitates a compilation of risk factors and their severity, which when combined, provides an understanding of overall suicide risk in the context of the comprehensive clinical formulation, including past trauma history. This information is then used to create an individualized safety plan for each McLean patient. The following items are evaluated in the McLean

- History of suicide attempt(s) (consider intent, plans, means, lethality)
- History of threats or harm toward others (consider intent, plans, means, lethality)
- Severe mood symptoms (consider depression, mania, hopelessness, anhedonia)
- Agitation/panic attacks/impulsivity
- Drug/alcohol use or withdrawal
- Delusion that increases risk, e.g., believing one is evil, paranoia about being harmed
- Command auditory hallucinations concerning self-harm or aggression
- Recent losses or relationship problems (consider importance, extent)
- Employment or living situation problems
- Chronic pain or disabling medical illness
- Lack of family/social support
- Lack of treatment alliance

Each of these 19 items are individually rated on a severity scale of none, low, moderate or severe.

The tool asks the evaluator to list “Positive Factors,” (i.e if the patient is at risk what makes them want to live?) An assessment of risk is then documented by a narrative that provides an overall formulation and assessment of risk and allows the evaluator to elaborate on each of the 19 risk assessment indicators. Finally, the evaluator is asked to document a Safety Plan if the patient is at risk.

The risk assessment tool is then signed, dated and used in the patient’s treatment plan. Accordingly, the goal is to minimize the risk of suicide in the patients we serve.

Contributed by: Gail Tsimprea, Ph.D., APRN, BC

Director, Clinical Quality Assurance and Risk Management

McLean Hospital



Above: McLean’s patient residences and pavilions have been consolidated over the last decade to a 50 acre campus of award winning new and recently renovated historic buildings.

at risk for suicide be identified.

To comply with the goal stipulated in this initiative, McLean Hospital, under the leadership of the Chief of Hospital Clinical Services, convened a multidisciplinary committee to review the risk assessment tools being used in our treatment evaluations. In addition, the committee researched and reviewed the latest literature for established risk factors beyond intent, plan, and means considerations typically employed to evaluate suicidality. The committee worked to create a credible tool that would not be perceived or utilized simply as a “tally” of factors to assess risk. Instead, we tried to

Hospital Risk Assessment Tool:

- Current suicidal ideation (consider intent, plans, means [including access to firearms], and lethality)
- Recent suicide attempt (consider intent, lethality, possibility of rescue)
- Recent threats or harm towards others (consider intent, plans, means, lethality)
- Recent threats or destruction of property (consider extent)
- History of suicidal ideation (consider intent, plans, means, lethality)
- History of threats or destruction of property (consider extent)
- Family history of completed suicide (s) (consider relationship to patient)