The responsibility of creating a safe health care system, he said, lies primarily with the health care community.

Some fundamental questions that health care is struggling with, he said, is how to (1) promote a no-fault culture for innocent mistakes while holding persistent rule violators or incompetent providers accountable, (2) compensate patients for harm without necessarily invoking the heavy hand of tort law, and (3) hold institutions accountable for allowing unsafe conditions.

“I believe we’ve made essentially no progress grappling with these issues in the five years since the [IOM] report,” Wachter said, adding that he gave accountability and the malpractice system about a D grade.

Having a no-fault system to compensate victims of medical mistakes would help change the dynamics of the malpractice system, he said.

But, he added, the concept has little political support.

Sharing a personal experience, Wachter told the audience about the worries his wife experienced recently while preparing for a surgical procedure in which she was donating a kidney to a friend.

He said his wife was less anxious about living without a kidney, postoperative pain, who would care for her children while she was in the hospital and recovering, and the surgery itself than she was that someone would kill her by making a medical mistake.

When people can check into a hospital and worry about their kids’ carpool, postoperative pain, and healing, but not worry about whether they will be harmed or killed by a medical mistake, Wachter said, that’s when health care can say it has improved patient safety.


—Donna Young

### Billing codes for pharmacy clinical services advance

The pharmacy profession recently had a milestone in the quest to have codes specifically designed for use in billing government health programs, insurance companies, and managed care organizations for the provision of clinical services.

Pharmacy’s proposal for Current Procedural Terminology (CPT) codes covering medication therapy management services “was accepted and sent to a . . . formal work group for refinement,” said Daniel Buffington, one of three ASHP members representing the Society in the Pharmacy Services Technical Advisory Coalition.

Buffington, medical director of Clinical Pharmacology Services Inc. in Tampa, Florida, spoke on behalf of the coalition in its November 6 presentation to the CPT editorial panel.

A date for the work group to meet has not yet been set, he said. But the expectation is that a modified proposal will be presented to the CPT editorial panel in time for its next meeting, scheduled for February 10–13.

C. Edwin Webb, who has served as the American College of Clinical Pharmacy’s staff liaison to the advisory coalition since its formation nearly three years ago, said “we all knew going into this [project] this was something that was going to take some time.”

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But “pharmacy has some good allies in the CPT work group,” he said.

CPT, a product of the American Medical Association (AMA), is a decades-old systematic listing and coding of medical, surgical, and diagnostic procedures and services.

Pharmacists who charge for collaborative therapy management, for example, may be familiar with the CPT code series 99211–99215 for the evaluation and management of established patients.

The CPT editorial panel consists almost exclusively of physicians but receives input on the interests of allied health professionals via the Health Care Professional Advisory Committee. Buffington serves as the AMA-approved pharmacy representative to the advisory committee.

And while the pharmacy coalition “spent a tremendous amount of time learning the intricacies of the CPT [code-approval] process” in order to make the presentation, the effort to refine the proposal will be assisted by members of the editorial panel, he said.

Webb said that the pharmacy coalition initially proposed seven CPT codes to cover what has variously been called clinical pharmacy services, medication therapy management services, and pharmacist professional services related to direct patient-care activities.

Andrew Wilson, pharmacy director of the Medical College of Virginia Hospitals in Richmond, and Mark J. Kliethermes, supervisor of information systems for the University of Illinois at Chicago College of Pharmacy, serve with Buffington as ASHP’s practitioner members of the coalition.

The practitioner members, Webb explained, function as the technical experts, with support provided by the sponsoring organizations’ staff liaisons.

ASHP’s staff liaison is David Chen, director of the Section of Home, Ambulatory, and Chronic Care Practitioners.

Also participating in the coalition are the American Pharmacists Association, the International Academy of Compounding Pharmacists, the National Association of Chain Drug Stores, and the National Community Pharmacists Association.

Buffington received an AMA award for his participation in the CPT Drug Infusion Workgroup, whose assignment was to improve the codes for drug administration and related services.

—Cheryl A. Thompson

Longer life span not in foreseeable future

Williard Scott on NBC’s Today is not the only person interested in centenarians. The Institute of Medicine (IOM) devoted part of its October annual meeting in Washington, D.C., to the issue of longevity and health.

Researchers have not yet determined whether “exceptional longevity” is more a matter of heredity or the environment, according to speaker Richard J. Hodes, director of the National Institute on Aging (NIA), part of the National Institutes of Health.

NIA-supported research, for example, found that the siblings of centenarians were at least eight times more likely than the general population to reach age 100.

The Web site for the Gerontology Research Group listed 17 centenarians residing in the United States on December 1. At that time, there were 54 women and 5 men at least 100 years of age somewhere on the planet. None had reached age 115.

With normal longevity, Hodes indicated, environmental factors account for about 70% of the variance in life spans among humans.

Speaker S. Jay Olshansky, a professor of epidemiology at the University of Illinois School of Public Health in Chicago, noted that humans’ life expectancy at birth has increased steadily for the past 150 years to the current 75–85 years, primarily through decreased mortality in the early decades of life.

He suggested that the “next quantum leap in human life expectancy” can occur only by adding decades to the lives of people who have already lived at least 70 years. For that change to happen, in his opinion, scientists must find ways to modify the aging process itself.

But as researchers seek to unravel the secrets to exceptional longevity, pandemic obesity and infectious diseases loom as the biggest deterrents to increasing the life span of Americans, according to Olshansky. More of the U.S. population is obese than ever before, putting them at increased risk for physical ailments, and more Americans are dying of infectious diseases, he reported.

IOM member Henri R. Manasse Jr., executive vice president of ASHP, said in an interview that the various speakers convinced him “there is nothing on the horizon” that will enable people to live longer. The only exception, he said, is if “inequalities in health” can be corrected.

Simply put, persons with a low social standing do not age as well as those in the higher strata, explained speaker Michael Marmot, director of the International Centre for Health and Society at University College London in the United Kingdom. He is also author of the 2004 book The Status Syndrome: How Social Standing Affects Our Health and Longevity.

Workers in the professional and managerial classes who are in their 70s incur less illness than do “routine and manual” laborers 15 years younger, Marmot reported. People who receive a low level of social support at the workplace have a higher likelihood of poor mental health than do other employees. The better-educated persons in a society live longer.

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