



PathologyToday®

ASCP's Physician Newsmagazine

Board Member Lee Hilborne Strives to Improve Healthcare Worldwide

As deputy director of the Global Health program at the RAND Corporation and director of UCLA Healthcare's Center for Patient Safety and Quality, Lee H. Hilborne, MD, MPH, FASCP has traveled around the world, helping countries such as Qatar and Taiwan improve patient safety and quality of care. These experiences have taught him a valuable lesson.

"It makes you realize that people half way around the world have the same problems we do," he observes. "I'm in a laboratory in Qatar and they face the same challenges we do at home: providing timely service, making sure people are qualified, assuring adequate space requirements, and so on. It gives you an appreciation of the similarities among all the peoples of the world, rather than the differences we hear about everyday in the news."

With other RAND experts, Hilborne is helping Qatar, a small Middle Eastern country of 750,000 residents, develop a world class health system. Hilborne and his associates have met with many of the country's leaders and managers, including labora-

tory managers, to develop a strategy and vision to make this a reality.

The initiative has the support of Qatar's top leadership. The RAND team delivered their most recent briefing to His Highness Sheikh Hamad bin Khalifa Al-Thani and Her Highness Sheikha Mozah Bint Nasser Al-Missned.



Dr. Hilborne outside the Longshan Temple with the family of Chun-Pin Lin, DDS, PhD (the director of the Quality and Patient Safety Department at National Taiwan University Hospital): Adam, Lisa and Ava Lin.

"They're interested in doing it, and they want to do it right," explains Hilborne. "Cost is a minor obstacle – they have the financial resources to build a world class healthcare system that promotes the health of the people. Their biggest challenge is having a trained workforce. They're working really hard to bring people up to speed. Although we have

done this over many years in the United States, Qatar is working to achieve this goal over a much shorter period. Learning from what others have done right – and wrong – is an important way to expedite the process.

"A key issue is making sure people are qualified and we're helping them to do that. For example, they have a sufficient number

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ASCP President's Message



National Medical Laboratory Week. It's Important. Get Started Early!

Yes, I know, Lab Week isn't celebrated until the end of April (24-30). But there's no time like the present to get ready. Let me tell you why it's important to do that now, not later. *Competition.*

Every year the American Hospital Association's Society for Healthcare Strategy and Market Development publishes a useful calendar of health observances and recognition days (available for purchase from www.ahaonlinestore.com). National Medical Laboratory Week is prominently listed...along with 41 other health-related observances taking place in April 2005.

Among them are 14 month-long observances for good causes such as preventing child abuse, signing organ donor cards, and promoting women's eye health and safety. But Lab Week competes for time, attention, media exposure, and publication space with two other simultaneous observances: Administrative Professionals Week and Infant Immunization Week. Competition for exposure inside our organizations is fierce, too. Patient Advocates, Volunteers, Electroneurodiagnostic Services, and Oncology Nurses all celebrate their achievements in April.

ASCP began Lab Week 30 years ago as a way to recognize the vital contributions made to health care by medical laboratory science professionals. And with every passing year, the profession has done an increasingly better job of finding unique and creative ways of calling attention to our good works.

While the important work we do is rarely seen by patients, it is critical to their care, and laboratory professionals should be recognized as valuable members of the health care team. Not only do we want our colleagues to know more about what we do and the issues we deal with daily, we want members of the media and the public to know that as well.

In addition to sound planning, one of the things that goes into producing a successful Lab Week promotion is creativity. And you never know what kinds of great ideas your colleagues can dream up when they set their minds to it.

When I practiced in Minnesota, my pager awakened me one morning. It was one of the lab techs telling me,

"Turn on the radio; we're singing." And sure enough they were. The staff (techs and pathologists alike) had formed a chorus just so they could take part in a local radio station's revered early morning tradition: the daily rendering (by all sorts of individuals and organizations) of "the morning song" (*Good morning, good morning, it's grand to be on hand. Good morning, good morning to you.*). That appearance wasn't just confined to the station's local and regional audience. The "singing laboratorians" videotaped their performance, sent it to "Good Morning America," and it aired on ABC-TV's popular nationwide morning show.

Now's the time to start planning your organization's celebration, if you haven't started already. To help you, ASCP members have received a planning guide in the mail (if you didn't get one, write to labweek@ascp.org). The planning guide features t-shirts, posters, tent cards, buttons, balloons, pens, and more that you can put to good use in your lab's promotion. But no matter how good the promotional items are, *nothing* can take the place of advanced planning by a group of creative individuals. For even more examples of creativity and suggestions for local and state promotions, be sure to visit www.labweek.org.

If we're ever to get our story out to the people who affect legislation, career choices, and funding, it's up to us to start the process by blowing our own horns. Lab Week is the time to start. I think Lab Week is more than just another one of 41 health-related celebrations in April. It's *our* observance—and it's more than just important. It's critical to our future.

Be sure to visit the Lab Week web site and report your successes. I can hardly wait to see if you can top the "singing laboratorians" of my early career.



LoAnn Peterson, MD, FASCP
President@ascp.org

The Need for Rapid HIV Testing in the Perinatal Period

By Leonard I. Boral, MD, MBA, Director of Clinical Pathology and Mardge H. Cohen, MD, Director of Women's HIV Research Stroger Hospital of Cook County

During natural birth, a child is exposed to his/her mother's blood. It should therefore be no surprise that the perinatal transmission of human immunodeficiency virus (HIV) has occurred at a rate of 25 percent from mother to newborn. In 1994, The Pediatric AIDS Clinical Trial Group showed that the transmission rates of the HIV virus from mother to child could be significantly decreased to 8% by giving zidovudine (AZT) to the mother during the prenatal period, including labor, and to the child shortly after birth.¹ In 1999, The International Perinatal HIV Group,

showed that C-section deliveries were associated with decreasing the rate of HIV transmission from mother to child by half.² With the use of currently recommended prenatal antiviral therapy started early in the pregnancy of an HIV positive woman, the estimated risk for HIV transmission to her infant has been reduced to less than 2%.³

However, as emphasized in the 1999 Institute of Medicine report, there are many missed opportunities to prevent perinatal transmission of HIV, particularly when women have never received any prenatal care or when those under a physician's care

are not offered the HIV test.⁴ In fact, of the approximately 280 to 370 infants born with HIV yearly in the United States, 40% are born to women who did not know their HIV status.⁵ The Mother-Infant Rapid Intervention at Delivery (MIRIAD) study published in JAMA in July 2004 showed that rapid HIV testing performed on women in labor was an accurate and effective means of determining HIV infection in mothers.⁶ If the rapid test was positive, antiretroviral treatment was given to the neonate and

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ASCP Volunteers Carry AIDS Mission to Ethiopia

According to the Ethiopian Ministry of Health, more than four million of that nation's citizens are now infected with the HIV virus and fully one-third of its hospital beds are occupied by HIV carriers. That makes Ethiopia the third largest infected population in the world, behind only India and South Africa.

In a public health battle this serious, high quality laboratory science is a top priority, since only accurate testing, reliable diagnosis and effective treatment monitoring can ensure that precious resources are used to greatest effect. That's why ASCP was tapped by the Centers for Disease Control and Prevention and the Association of Public Health Laboratories to implement comprehensive laboratory quality assurance programs and laboratory training in developing nations afflicted by AIDS. The program is in support of PEPFAR, the President's Emergency Plan For AIDS Relief, a \$15 billion international relief effort.

The Society made the commitment to help, but it is members like Vicki S. Freeman, PhD, MT(ASCP)SC, who are fulfilling the promise.

"Teri Somrak [director of ASCP Distance Education Programs] contacted me, probably because of some of the workshops I've given," says Freeman, department chair at the University of Texas Medical Branch in Galveston's Clinical Laboratory Sciences Program. "They were looking for someone with expertise in clinical chemistry and that's one of my favorite teaching topics."

As Somrak explained the purpose and plans for the upcoming Ethiopia trip, Freeman was intrigued for a number of reasons. "My husband is retired military, so we've



ASCP staff and volunteers work with lab professionals in Ethiopia.

lived overseas and I felt like I had some experience in working with other backgrounds and cultures in the laboratory. Though I've never done international teaching, naturally I have a professional interest in helping improve laboratory care wherever help is needed...and it's certainly needed in Ethiopia. And I had never been to Africa. So I signed on."

Within weeks, Freeman found herself on the way to northeastern Africa, joined by, among others, fellow ASCP member John R. Snyder,

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Chair's Message, ASCP Resident Council



Greetings once again from the Resident Council

By now, I trust that all is well and you are settling into the groove of the new year. For many of you that means you've been entertaining and encouraging numerous residency applicants about the highlights of your training program (By now, you're probably saying, "Oh, it's a very strong program!" over and over again in your sleep).

You may be also planning your academic calendar for 2005-06. The Resident Council's subspecialty elective grant program was launched last fall to allow residents enough time to make the best planning decisions for the upcoming academic year. The grant program's initial objective was to encourage residents to consider the concept of studying at an institution away from their primary university – and then to help make that experience a financial reality.

ASCP received a tremendous response to this program as measured both by the number of applications received, other correspondence, and verbal feedback. The application deadline for this year has passed, but for details about how the program worked, please visit www.ascp.org/member/resident/ (and then select the first item, *ASCP Resident Subspecialty Grants being offered by the Resident Council*).

Whenever such opportunities arise, I encourage each of you to apply. It's a great way to gain experience

in your chosen pathology sub-specialty and to do it in an environment different from your primary university – and, best of all, under the mentoring influence of some truly outstanding educators.

In my first Chair's Message, I alluded to the many first-class educational courses and events offered by ASCP and last December, I (along with all resident members) was granted free stand-by registration to a gynecologic pathology course held at the Boca Raton Resort and Tennis Center in south Florida.

The course was a five-day *tour de force* tackling each and every facet of the pathology of the female genital tract. No stone, metaplasia, adnexa, pruritic dermatosis, or raging controversial borderline tumor was left unturned. The course director even dedicated almost an entire day to the placenta! Like the many other courses, this one was absolutely superb – so good nobody even regretted not having time to enjoy the resort.

A fundamental driving force of the ASCP is educating its members, whether they be practicing pathologists, laboratory professionals, or resident physicians. Please take advantage of your resident membership and apply for and attend these educational events.

Francois Cady, MD

RENEW TODAY: SPECIAL OFFERS FOR ASCP MEMBERS

ASCP has prepared a portfolio of additional benefits for ASCP Members. Discount offers through our affinity partners, such as DELL, Hertz, Visa, UPS and Geico Direct give you special deals from these companies.

Visit www.ascp.org/member/specialoffers/.

While you are there, don't forget to renew your ASCP membership!

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2005 Annual Meeting Keynote Addresses

ASCP's 2005 Annual Meeting [Oct. 8-11 in Seattle] line-up will include world-renowned faculty, cutting-edge topics and concepts, a wide variety of educational formats, interactive and dynamic courses, tons of networking opportunities, social events, and more! In addition, two fascinating keynote addresses will kick off the conference.

Don't miss the Opening Keynote Address, "Space Exploration: The Human Equation." **Bernard A. Harris, Jr., MD, FACP**, former NASA astronaut, will give his compelling presentation on



Astronaut Bernard A. Harris, Jr., MD, FACP

the medical and scientific issues of long-duration space flight. Dr. Harris is a two-time Space Shuttle astronaut

and the first African-American to ever perform a space walk. He retired from NASA in 1996, after 13 years of service. At the time of his retirement, he had logged more than 438 hours in space and traveled over 7.2 million miles.

Dr. Harris is a self-described dreamer who believes "Nothing is impossible, if you believe in your dreams." A trained aerospace flight surgeon, accomplished astronaut, and businessman, he credits his many achievements to self-empowerment and self-determination. He was selected as a NASA astronaut in 1990; was payload commander of STS-63, the first flight of the joint Russian-American space program; and conducted the first telemedicine conference from space with Mayo Clinic.

Today, Dr. Harris is President and CEO of Vesalius Ventures, Inc, a

business accelerator for Medical Informatics and Technology. He is also President of the Harris Foundation, a nonprofit organization that invests in the youth of America. Dr. Harris has numerous other business consultancies and board positions. His awards and honors are extensive and include NASA honors of Award of Merit, Space Flight Medal, Equal Opportunity Medal, and Outstanding Leadership Medal, as well as election of Fellowship in the American College of Physicians. Dr. Harris holds several faculty appointments including Associate Professor in internal medicine at the University of Texas Medical Branch, and Assistant Professor at Baylor College of Medicine. He has 15 years of research experience, 12 years of management, and 10 years of hardware/product development. In addition, he is the author and co-author of numerous scientific publications.

Eric D. Green, MD, PhD will present the second Keynote Address, "The Genomic Revolution: Bringing Genes to Life."

The Human Genome Project's



Eric D. Green, MD, PhD

recent completion of the human genome sequence represents a spectacular scientific achievement of historic

proportions. It also signifies a critical transition, as this new, powerful foundation of genetic information is used by researchers and clinicians to tackle complex problems in human biology and disease. The next phase of genomics research will focus on connecting genomic data and technologies to biology, to health, and to society. In the coming decades, it will likely also change biomedical research and the practice of medicine in profound ways.

Dr. Green is Director, Division of Intramural Research; Chief, Genome Technology Branch; Director, NIH Intramural Sequencing Center, National Human Genome Research Institute at the National Institutes of Health

For more information, visit www.pathologytoday.org. ■

AJCP Resident Research Symposium

Present your research at the premier educational event for pathologists and pathology residents: The 2005 ASCP Annual Meeting in Seattle, WA, October 8-11. All abstracts accepted for presentation will be posted on AJCP.com and will be published in the October 2005 issue of *AJCP*.

Residents submitting abstracts may have their submissions considered for the Pathology Resident Award. Awards will be announced at a later date. In past years, Nikon and Leica microscopes have been awarded. Be sure to indicate on the submission form if you wish for your abstract to be included in this competition. Visit ajcp.com for details.

Submission Deadline: April 15, 2005

Notification Date: June 15, 2005

Pathology Today Meeting: October 8-11, 2005 in Seattle

Abstract Publication Date: October 2005 issue of *AJCP*



Washington Report

Federal Agencies

ASCP Urges CMS to Review Flow Cytometry Reimbursement Levels

In December, ASCP urged the Centers for Medicare and Medicaid Services (CMS) to review the 2005 Physician Fee Schedule (PFS) reimbursement levels for flow cytometry. Unfortunately, the 2005 PFS drastically reduces flow cytometry reimbursement.

In a letter to CMS, ASCP President LoAnn Peterson, MD, FASCP raised the issue of physicians forced to compare flow cytometry procedures with inappropriate reference codes when they were surveyed. Between the time that the Proposed 2005 Physician Fee Schedule was published on August 5, 2004 and publication of the Final Rule in November 2004, new changes to the CPT codes for flow cytometry were issued by the American Medical Association in the CPT Manual. The new codes changed the manner by which flow cytometry is reported and billed.

ASCP asked CMS to reexamine the final assigned values for compensation to ensure that all facets of flow cytometry procedure are taken into consideration. ASCP also expressed concern that the reductions to reimbursement for flow cytometry may reduce access to these essential diagnostic services.

OIG Advisory Opinion Makes Case Against Pathology Contractual Joint Ventures

A recent advisory opinion on pathology joint ventures by the Office of the Inspector General at the U.S. Department of Health and Human Services may have a significant impact on laboratory medicine. In its advisory opinion, OIG opined that contractual joint ventures involving fee splitting between a clinical practice or clinician and a clinical laboratory furnishing pathology services appear to violate federal anti-kickback laws. OIG's opinion casts doubt on the legality of certain laboratory contractual arrangements, sometimes referred to as "turnkey", "condo", "pod", or "cubicle" laboratories.

Inappropriate fee splitting and billing arrangements, such as those outlined in the OIG opinion, are at the top of the Society's advocacy priorities. ASCP recently raised concern about this issue with the Centers for Medicare and Medicaid Services as part of the Society's advocacy efforts on changes to the physician fee schedule. The

Society's Board of Directors also recently approved a policy statement on the issue of inappropriate fee splitting.

As stated in the OIG opinion, the federal anti-kickback statute makes it a criminal offense to, knowingly and willfully, "offer, pay, solicit, or receive remuneration to induce or reward referrals of items or services reimbursed by a federal health care program." HHS has promulgated safe harbor regulations to outline those practices not subject to the anti-kickback statute. OIG opined that even though the arrangement in question was supposedly structured to comply with the "in-office ancillary services" exception to the physician self-referral law (Stark), the Stark and anti-kickback statutes are separate entities and thus the "Stark law is immaterial to the anti-kickback statute."

State News

South Carolina Legislature Overturns Veto of Direct Billing Measure

A major legislative victory was scored in South Carolina on January 13th when the state legislature overturned Governor Mark Sanford's (R) veto of a pro-laboratory bill. On that day, the South Carolina state legislature easily surpassed the 2/3 vote required to override the Governor's veto of direct billing legislation. The State Senate's 32 members unanimously approved the override. The House of Representatives approved the override by a vote of 103-11.

To support the veto override, ASCP sent an action alert to its entire South Carolina membership, asking them, via the ASCP e-Advocacy Center, to urge their state legislators to support the veto override on HB 3891. On this initiative, ASCP worked closely with the South Carolina Society of Pathologists and the College of American Pathologists.

ASCP President LoAnn Peterson, MD, FASCP, thanked ASCP's South Carolina members, saying "congratulations to all of the members of the laboratory team who worked to override Governor Sanford's veto of H 3891. This is truly a significant team victory. ASCP South Carolina members, the South Carolina Society of Pathologists, and the College of American Pathologists worked collaboratively and all parties deserve the credit."

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HB 3891 requires patients, insurers or other third party payers to be billed directly by the laboratory or pathologist for the performance of anatomic pathology services. The measure is intended to prevent client billing, which often results in inappropriate markups being added to the bill.

Client billing and fee splitting cause a host of problems, such as inflating the cost of laboratory services for patients, federal and state governments, and other payers as well as undermining patient trust in the medical profession. These practices can also adversely affect clinical laboratories and patient welfare. Patients most likely to be affected by this inappropriate practice are uninsured individuals and those covered by a private third party payer.

Because laboratory medicine is highly dependent on patient referrals, clinicians are in a unique position to control the flow of business to clinical laboratories. As such, laboratories and pathologists have little power to prevent fee splitting, markups and similar practices by the clinician. Direct billing, however, helps address these practices.

ASCP Opposes Florida's Revised Competitive Bidding Plan

Florida's Agency for Health Care Administration (AHCA) has released a revised competitive bidding plan. The plan, identified as the Medicaid Independent Laboratory Services Invitation to Negotiate (ITN), was released on December 13, 2004. AHCA developed the proposal in response to legislation enacted in 2003. AHCA's plan follows a previous competitive bidding request for proposal (RFP) it released on March 2, 2004.

Per state law, AHCA is required to enhance the current Medicaid program by contracting with a

vendor having an interface capacity for real-time electronic transmission of laboratory test results to a real-time prescription tracking and dispensing system. The agency is also required to secure cost savings to the state by entering into a risk-based contract on a per member per month basis. This proposal seeks one vendor to provide all Medicaid outpatient laboratory services. Currently, more than 160 laboratories serve Florida's 1.1 million Medicaid beneficiaries.

On December 23, 2004, the American Clinical Laboratory Association (ACLA), arguing the "one-size-fits-all" plan reduces health care quality for the poor, filed two petitions with the state challenging the ITN proposal. In response to the ACLA petitions, ACHA has temporarily suspended the solicitation for bids. The Society is working with the ACLA and other laboratory organizations in opposition to the Florida competitive bidding plan.

ASCP Nominee Appointed to Arizona DAT Panel

An Arizona state advisory body will soon consider the issue of direct access testing, and it will do so with the help of ASCP past president Anna Graham, MD, FASCP, the Society's nominee to that panel, and two other ASCP members: Kent G. Zimmerman, MD, FASCP and Daniel Lavine, MD, FASCP.

Earlier this year, legislation was enacted establishing the Arizona Advisory Committee on Clinical Laboratories. The panel will provide policy recommendations to the state on direct access testing. Once the legislation was signed into law, ASCP nominated Dr. Graham to serve on the panel.

In addition to serving as a pathologist and faculty member at

University of Arizona College of Medicine, Dr. Graham also served as ASCP Interim Executive Vice President while the Society was conducting a search for its current executive vice president, Dr. John R. Ball. Dr. Graham is a current member of the Society's Commission on Public Policy, which oversees ASCP's advocacy operations, and is also a former president of the Arizona Society of Pathologists.

Kent G. Zimmerman, MD, FASCP, president of Clin-Path Associations in Mesa, Arizona and lecturer with the University of Arizona Health Sciences Center, and Daniel Lavine, MD, FASCP, a pathologist with the Arizona Department of Health Services and the principal representative between the Department and the panel, will also assist the panel in its work.

ASCP Opposes DC Mayor's Plan on Medical Examiner

ASCP recently opposed a proposal by Washington, DC Mayor Anthony Williams to establish an exemption to a city law requiring the chief medical examiner to be a board certified (or eligible) pathologist.

The Mayor's plan would allow his nominee, a pathologist who is neither board certified nor board eligible, to serve as the city's chief medical examiner. ASCP President LoAnn Peterson, MD, FASCP wrote members of the City Council opposing the legislation to implement the Mayor's proposal. Dr. Peterson argued that the post of the chief medical examiner is "simply too important to be filled by an individual who lacks the appropriate qualifications." Despite opposition from ASCP and other laboratory organizations, the legislation passed the Council and was signed into law by Mayor Williams. ■

Introducing Laboratory Interdisciplinary Teams to Reduce Medical Errors

Major causes of medical errors include the lack of review and appropriate interpretation of diagnostic test results, disease detection and monitoring information by medical care providers.

But Eleanor M. Travers, MD, MHA, suggested that laboratories possess an untapped resource that can significantly improve disease management outcomes and reduce medical errors.

That resource, or “hidden treasure in the lab” as Dr. Travers termed it, is a team of laboratory experts that utilizes “their expert knowledge of diagnostic tests, use of tests, complications of tests, a team can help prevent adverse medical events before they occur.”

In her audio conference, “Introducing Laboratory Interdisciplinary Teams to Reduce Medical Errors: Justifying the Need for Clinical Privileges for Lab Professionals,” presented by G-2reports.com, Dr. Travers called for a cultural change in the “clinical laboratory’s role in clinical care” that must involve support from top management.

“We must get together as a laboratory team to raise the level of awareness of top management so that the laboratory can be exposed as an expert team,” said Dr. Travers. “A lab expert SWAT team, so to speak, that may participate in the daily management of patient care with other health care professionals such as physicians, pharmacists, nurses, and clinical providers.”

During her prolific medical career, Dr. Travers, who is board-certified in transfusion medicine, laboratory medicine and anatomic pathology, has served as a chief executive officer and medical director for the nation’s largest clinical laboratory system and chief of service and professor at numerous medical school-affiliated hospitals. A former National Clinical Advisor with the

Department of Veterans Affairs Headquarters in Washington, D.C., she is currently bureau chief of Connecticut’s Department of Health, where she directs the Divisions of Infectious Disease, Environmental Epidemiology/Occupational Health, Health Care Quality, Statistics and Analysis, and the State Public Health Laboratory.

Dr. Travers is familiar with developing regulations and standard operating procedures that help ensure patient quality of care and safety. But the concept of patient management ultimately extends past the pen and paper, said Dr. Travers. It jumps right into the hands of laboratory professionals themselves, she said.

“Disease management is something in the laboratory world we’ve always been doing,” she added, “but very silently.”

According to Dr. Travers, research indicates that most errors in the laboratory diagnostic cycle occur not in the analytical testing phase, but in the pre-analytical specimen collection, pre-analytic transfer and test interpretation of results.

Most likely then, Dr. Travers observed, “The only one who’s going to find (errors) is the laboratory. You’re the first one and first line of defense for the patient.”

Dr. Travers suggested creating a cross-organizational laboratory expert team composed of laboratory personnel specifically trained to fulfill the duties required of a physician team coordinator, team leader, a point-of-care coordinator, nurse clinical liaison, a clinical informatics manager, and experts in chemistry, microbiology, transfusion/coagulation, and immunology.

This laboratory expert team, Dr. Travers stressed, should work with clinicians in actual clinical sites instead of solely working from within the laboratory.

Essentially, she said, “We’re

building an interface to the clinical side of the house. We need to get out of the lab and into the clinical environment. (That’s because) we have expert knowledge that can prevent (errors).”

To put this “paradigm shift” into effect means that “you’ve got to ask top management for money for training to increase interactive communications between clinical and lab experts,” said Dr. Travers, adding that such a task is not for the faint-hearted. “You’ve got to be visible and you’ve got to blow your own horn. Be proactive and not reactive. It takes guts.”

In order for laboratory professionals to become part of a cross-organizational interdisciplinary team, top management must approve the granting of clinical privileges to the laboratory physician and other certified and appropriate laboratory personnel, said Dr. Travers.

“If pharmacists can round, why can’t we?” she asked rhetorically.

She suggested that the system in which an expert laboratory team collaborates with clinical operations mirror the nursing model system, which emphasizes interaction with the clinicians in “a one-to-one interface on the floor and near the bedside.”

But to ensure the timely delivery of data between the laboratory and clinical sides, information technology must be maximized, she stressed.

“Information technology in medicine is remarkable. The trick is to make the interfaces between us and them so slick that they make economic sense for busy clinicians. Informatics support is needed for the laboratory to design faster linkages between clinical care sites and lab team members out on the floor.”

It’s all part of a cross-organizational collaborative approach that all

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Resident Review Course Slated for May in Chicago

By Terri Yablonsky Stat, M.A.

Residents: mark your calendars. You have a chance to sharpen your skills and refresh your knowledge at the ASCP's six-day comprehensive pathology review course to be held May 12 to 17, 2005, in Hoffman Estates, Ill.

The Resident Review Course helps residents hone their study skills said Barbara J. McKenna, MD, clinical associate professor in the Department of Pathology, University of Michigan Hospital in Ann Arbor and co-director of the Resident Review Course. One half of the six-day course is devoted to clinical pathology (CP) and the other half to anatomic pathology (AP). Residents can register for the entire course or for AP or CP sections only.

"The directors and faculty want to make the course not just a review course, but useful information for those about to enter practice," Dr. McKenna said. "This is a general review course with information important for the boards and beyond. We have non-residents who take the course as a refresher as well."

Participants who attended the 2004 ASCP Resident Review Course rated the course 4.5 on a 5.0 scale, according to Stacy Barsztaitis, MT(ASCP), ASCP's manager of educational courses. Ninety-seven percent of attendees indicated they would recommend the course to their colleagues.

"We've been responsive to comments we've received in the past," said Michael Laposata, MD,

PhD, FASCP, director of the clinical laboratory at Massachusetts General Hospital in Boston and co-director of the course. For example, residents asked for a longer coagulation lecture, so it's been lengthened from its original hour-long format, enabling lecturers to cover more material.

Most residents, even if reasonably confident of the material, will benefit from the course by "confirmation of suspicion," Dr. Laposata said. "The course confirms that what you've been thinking is correct," he said.

The course includes:

- A faculty of nationally acclaimed experts
- 1500+ pages of printed reference material
- study questions for each topic area
- free CD ROM of representative images
- lectures presented at a state-of-the-art professional learning center
- breakfasts, lunches, and all-you-can-eat snacks
- affordable, convenient lodging with free transportation to and from the learning center.

CP topics include coagulation, chemistry, hematology, microbiology, molecular diagnostics, blood transfusion service, lab administration, informatics and immunopathology. AP topics include central nervous system, liver, soft tissue, gastrointestinal, kidney, gynecology, pulmonary, breast, cytopathology, pediatrics,

bone, genito-urinary, lymph node and otolaryngology.

Jeffrey Schrager, MD, a staff pathologist in hematopathology at the National Cancer Institute, took the Resident Review Course last spring before passing the ABP exam. "The lecturers ranged from very good to outstanding," he said. "The review questions in the notes were also very useful.

I would definitely recommend this course to other pathology residents."

To register or for more information, contact the ASCP Customer Services Department Monday through Friday, 8 AM to 6 PM CST. United States and Canada: (800) 621-4142, press 2, then x1260. International: Dial your international access number, then (312) 738-4890. Illinois residents: (312) 738-4890.

All courses will be held at the Hoffman Estates Educational Center at Northern Illinois University. A block of rooms has been reserved at the AmeriSuites Hotel in Hoffman Estates at a special rate of \$67/night plus tax. To receive this special group rate, make your reservations (847) 839-1800 no later than Saturday, April 30, 2005, and identify yourself as a participant of the ASCP Resident Review Course.

ASCP gratefully acknowledges Olympus as the exclusive sponsor of the 2005 ASCP Resident Review Course. ■

Medical Errors

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laboratory professionals and clinicians should embrace more often and more fervently, said Dr. Travers. She called it the Four Ps: prevention, prediction, problem solving,

and patient care management support.

"When you put your head on the pillow at night, you will feel great," Dr. Travers concluded.

"Because maybe you didn't get thanked, and maybe nobody patted you on the back, but you know you did something and you kept the patient at the center." ■

Hilborne

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of medical technologists. However, we are now considering the benefit that they could realize by having a certification program similar to our Board of Registry.”

Hilborne and other RAND Health staff members are also collaborating with the Center for Health Improvement in Taiwan to improve the country’s healthcare quality. Taiwan has built a healthcare system that provides almost everyone access to healthcare, something we are far from in the United States, but therein lies the problem, according to Hilborne.

“People go see a doctor three or four times as often as they do in the U.S. for things we wouldn’t think twice about,” explains Hilborne. “They solved the access problem, but as a result, they have created a quality issue – doctor visits are only a couple of minutes because of limited resources. We’re interested in helping them find opportunities for improvements to deliver the highest quality care.”

Hilborne also visited Taiwan to give a talk on patient safety in June 2003, during the height of the SARS epidemic. “Everyone else had

dropped out, but my colleague at National Taiwan University Hospital called and encouraged me to come,” recalls Hilborne. “The good news was that by the time I arrived, all the cases of SARS were confined to hospitals. The bad news was that I was speaking at the hospital with 40 percent of the cases.”

The day he gave the talk, Hilborne visited a Buddhist temple with a close friend. To his surprise, the visit was covered by local reporters; his appearance was taken as a sign that tourists were returning to Taiwan.

One of the things that impressed Hilborne about his visit to National Taiwan University Hospital was how staff had managed to construct a facility in the parking lot to triage patients who might have SARS. “In a matter of days they were able to put up a full facility with a lab, radiology service, and isolation units,” he recalls. “It was a great example of human ingenuity coming through when the situation demanded it.”

Through RAND, Hilborne is also working with the Bill and

Melinda Gates Foundation to improve world health, particularly in underserved areas. His group is helping to explore ways where better diagnostic tests would allow earlier diagnosis or could allow tests that currently require large, complex laboratories to be performed in rural areas. “Improved diagnostic technology allows physicians to better intervene and reduce morbidity and mortality in underdeveloped countries suffering from diseases such as HIV, malaria, tuberculosis, diarrhea, and sexually transmitted diseases,” he says.

In addition to working with UCLA Healthcare’s Center for Patient Safety and Quality and RAND, Hilborne also serves as professor of pathology and laboratory medicine at UCLA and is a member of the Board of Directors of ASCP. He completed his medical degree from the University of California, San Diego, California, and did his pathology internship and residency at UCLA School of Medicine. He serves on many editorial boards and has published many articles related to quality of care, medical appropriateness, and patient safety. ■

AIDS Mission

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PhD, MT(ASCP)SH, already a veteran of PEPFAR expeditions to Zambia and Ethiopia. Over a single short week, the volunteers spent long days visiting rural, regional and private laboratories, assessing the teaching needs and planning a train-the-trainer curriculum. Says Freeman, “We saw some labs using techniques we hadn’t seen since the ‘60s, and some private laboratories that had some of the very latest equipment. Very dichotomous, such a mixture. The laboratory people were extremely knowledgeable, very interested in doing quality work, but so in need of resources to carry it off.”

That shortage of resources was the biggest surprise to Freeman. “Even though I expected conditions to be poor in some of these laboratories, I was shocked at how poor they were, how little they had. We go into our laboratories and find them packed with ‘stuff’—old glassware, lots of equipment, bottles of things. There, the laboratories are so sparse. You might see Bunsen burners and gas cylinders, incinerators that are nothing more than open fires, sheets hanging on a line to dry. But the people are professionals and they’re doing their best to carry out the work that’s asked of them.”

Was the experience worthwhile? “Absolutely. I’m looking forward to visiting some of the other PEPFAR nations and seeing how their needs differ. The biggest concern is time, of course. As a volunteer, you have to balance your work, your life. But when you meet these people, there’s such a personal interaction, such a sense of connection and contribution. The people in Ethiopia really wanted John and me to be the ones to come back and teach these sessions the following month. I couldn’t do that—somebody else had to take my place. But there will be another opportunity. I’ll go back.” ■

Rapid HIV Testing

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in most instances prenatally to the mother in order to reduce HIV transmission. In addition the MIRIAD study found that performing the rapid test at the labor and delivery site was significantly quicker than sending it to the hospital laboratory. The median turnaround time between drawing the participant's blood and her receipt of the rapid HIV test result was 45 minutes at hospitals using point-of-care testing, but more than twice as long if the rapid HIV test was performed in the laboratory. It is important to note that, in the MIRIAD study, antiretroviral medications were given, with the participant's knowledge and consent, to the mother and/or the neonate before a confirmatory test such as the Western Blot could be performed. This process was used in order to enable a previously untested mother, found to be reactive with the rapid HIV test performed during labor, to receive antiretroviral treatment prior to delivery in an attempt to maximally decrease HIV transmission (by half of the expected rate) to the baby. In those rare instances where a rapid HIV test was falsely positive, the antiretroviral medication was stopped when the confirmatory test result was received.

The State of Illinois has recently implemented a law requiring that pregnant women be counseled and tested for HIV. For those mothers not tested by the time of labor, an HIV test must be offered to the mother soon after hospital admission. If the mother declines the test, her newborn will be tested for HIV unless the mother refuses in writing to have the newborn tested. Currently, there is a statewide program to train labor and delivery nursing and medical staff in the use of the rapid HIV test and on giving HIV counseling to mothers prior to

testing. Illinois law now allows a physician to provide perinatal antiretroviral prophylaxis (AZT and/or nevirapine) prior to the availability of a confirmatory HIV test in labor and delivery settings in order to maximize the prevention of perinatal transmission in the most timely manner. In addition to these legislative changes, hospital pharmacies, obstetric nurses, physicians, laboratories and hospital information systems are now working together to ensure that rapid HIV testing and appropriate antiretroviral medication are quickly available. For example, hospital laboratories are helping to perform rapid HIV testing and many smaller hospitals that did not carry AZT or nevirapine in their formulary, now order this medication to have it available when needed.

The rapid HIV test is relatively new and takes only 20 minutes of testing time. It can be performed by non-lab personnel, with minimal training, at the point of care, and is best suited for the single test, stat environment. The traditional HIV EIA (enzyme-linked immunoassay) test, on the other hand, takes several hours to perform because of reagent preparation and the need for a 2 to 3 hour incubation step. It requires days of training of a laboratory scientist because most HIV EIA tests are performed on complex equipment best suited for batch testing in a high volume laboratory. The confirmatory tests for HIV, such as Western Blot, are often not performed in hospital labs and because they are sent to another lab for analysis, will take over 24 hours to obtain results.

After reviewing the available literature and experiences with rapid HIV testing in our state, we [Dr. Boral and his research staff] strongly support the roll out of point of care

rapid testing in order to ensure that the fewest number of infants are born with HIV in Illinois and strongly recommend that health care professionals throughout the US support these initiatives in their state.

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Four ASCP Members Chosen for CMS Competitive Bidding Technical Expert Panel

CMS Announces Competitive Bidding Technical Expert Panel

The Centers for Medicare and Medicaid Services (CMS) have announced the members of the Technical Expert Panel (TEP) for the Demonstration Project for Competitive Bidding of Clinical Laboratory Services.

The demonstration project is mandated by Section 302 (e) of the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173)" and is to apply to laboratory tests performed by entities without a face-to-face encounter with patients. It excludes Pap tests and colorectal screening tests.

In October 2004, CMS announced that the agency had awarded a task order contract to RTI International and their subcontractor Palmetto, GBA, LLC. RTI will assist CMS in the demonstration design including development of the solicitation and bid process and the claims processing plan. RTI will also operate the actual bid sites of the demonstration.

The task order contract requires a TEP that will review design options and provide a forum for raising and resolving technical, operational, and laboratory performance issues associated with implementing the demonstration. The TEP will operate during design and startup of the operational phase of the project.

TEP members were selected from the stakeholder community based on personal expertise in the

areas of laboratory medicine, advocacy for Medicare beneficiaries, quality of care, independent regional clinical laboratory operations, hospital laboratory services, purchasing of laboratory services, and laboratory management and administration.

Four ASCP members will serve on the TEP:

James Robb, M.D.—Medical Director at Integrated Regional Laboratories of Florida.

Lee Hilborne, M.D., MPH—Director of the Center for Patient Safety and Quality, University of California Los Angeles Healthcare.

Donna MacMillan, MT (ASCP), MBA, is the Director of Operations for the Department of Pathology at Massachusetts General Hospital. She is a consultant to RTI for the development and implementation of the demonstration project and will serve as Chair of the TEP. For the past year Donna has served as the Chair of CLMA's Health Care Policy Committee (HCPC).

Ronald Weiss, M.D., MBA is Professor of Pathology at the University Of Utah School Of Medicine and is the President and Chief Operation Officer of the University's Associated Regional and University Pathology Laboratories (ARUP), a national independent reference laboratory. Dr. Weiss is a longstanding member of CLMA's Utah Chapter.

Other members of the TEP in alphabetical order are:

Alfred Chiplin, J.D.—Managing Attorney for the Center for Medicare Advocacy, Inc. in Washington, D.C.

Carlyn Collins, M.D., MPH—Senior Laboratory Advisor for the Public Health Practice Office of the Centers for Disease Control and Prevention (CDC).

Marc Goodman, M.D.—Chairman of the Board, President, Chief Executive Officer and founder of Bio-Reference Laboratories, Inc.

Paula Patterson—Chief of the Clinical Laboratory and Durable Medical Equipment Contracting Unit for California Medi-Cal.

Bonita Warner—National Vice President, Network Services for AmeriChoice Corporation.

CMS invites public comment through a dedicated email box (LAB_BID_DEMO@cms.hhs.gov) and Open Door Forum public meetings.

CMS recently announced that once the TEP is selected, the agency will schedule a Special Open Door to gather public input and information regarding Phase I of the demonstration project. Look for that announcement in the near future at <http://www.cms.hhs.gov/open-door/>.

For detailed information regarding the Demonstration Project for Competitive Bidding of Clinical Laboratory Services and members of the Technical Expert Panel, please visit <http://www.cms.hhs.gov/researchers/demos/clinicallydemo.asp>. ■