

DATE: February 28, 2004

TO: Minnesota State Representatives

FROM: Twila Brase, RN,
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Please consider the following SIX concerns (including cost) regarding HF 1681 (Art. 2 & 3) - MN Health Care Cost Containment Act. The bill has 24 co-authors (LANGUAGE BELOW).

1) STATE-ISSUED PRACTICE DIRECTIVES: Health officials, who are not licensed in medicine, will decide what medical practices physicians and other practitioners should follow. Practice directives will be issued by the Government. This will infuse treatment decisions with bureaucracy, limit individualized patient care, politicize medicine, threaten lives, and lead to government-run health care. There are no one-size-fits-all treatment regimens (*British Medical Journal*, 2/1999), and value systems and personal bias will influence choice of directives. (Art. 2, sec. 1)

2) USE OF GOVERNMENT POWER: The Minnesota Department of Health will be authorized to "track and monitor" physician use of government-issued practice directives. This suggests use of coercion to modify physician practice behavior. It will limit individualized care, it will encourage doctors to manipulate and skew the data (*Institute of Medicine*, 2004) and it is inconsistent with the principles of a free society. (Art 2, sec. 1)

3) PATIENT PRIVACY INFRINGED: The Government will be authorized to access private medical record information to monitor physician compliance with government-issued practice directives. This violates the right of patients to keep their medical records free from government inspection. Such access will also prohibit the frank discussions between patients and doctors that are necessary for good medical care. In 1999, the *California Healthcare Foundation* found 15% of Americans already protecting their privacy by lying on clinic questionnaires, using pseudonyms, asking doctors to omit data, and paying cash though insured. (Art 2, sec. 1)

4) CONFLICTS OF INTEREST: Government agencies will be required to offer "financial and other incentives" to encourage physician cooperation with government-issued practice directives. This threatens the patient-doctor relationship, violates the private contract between patient and doctor, creates conflicts of interest, and encourages breach of medical ethics. (Art 2, sec. 5)

5) LESS INNOVATION & LITTLE MALPRACTICE PROTECTION: Practitioners who follow state-approved practice guidelines will be given an "absolute defense" against certain medical malpractice lawsuits. This will discourage doctors from thinking and acting "outside the box" in medical decision-making, ultimately leading to less individualized and innovative patient care. (*U.S. Office of Technology Assessment*, 1994) However, compliance with such guidelines is unlikely to provide the promised litigation protection. According to a former director of the Agency for Healthcare Research and Quality (AHRQ), treatment guidelines ignore individual situations, while courts focus on rights of individuals in any given instance (*Journal of Health Politics, Policy, and Law*, 4/2001). (Art. 3, sec. 1)

6) COST TO TAXPAYERS: What is the cost of building a medical decision-making bureaucracy in state government? In our upcoming CCHC report on practice guidelines--a draft of which was shared with the HHS Policy Committee on 2/4/04 and the Commerce Committee on 2/24/04--we report that AHRQ's cost to review and update each guideline in 2001 was \$250,000 (*Journal of the American Medical Association, 9/2001*). One federal committee was reported to take 2 years to prepare a guideline, which is out-dated only a few years later (*Preventive Medicine, 2003*). In 1999, the federal cost of the National Guideline Clearinghouse was reported to be \$6.5 million over 4 years.

Yet, HF 1681 seeks to duplicate federal efforts—and the ongoing private distribution of guidelines by professional societies and non-profit groups (ex. Am. Lung Assn, Am. Diabetes Assn). (Art. 2, sec. 1 & 3)

Thank you for your attention to these concerns.

BILL LANGUAGE:

HOUSE FILE 1681

ARTICLE 2

7.36 BEST PRACTICES

8.1 Section 1. [144.7035] [IDENTIFICATION AND TRACKING OF USE

8.2 OF PRACTICE GUIDELINES.]

8.3 The commissioner of health, in consultation with medical

8.4 researchers, consumers, and representatives of health care

8.5 providers and health plan companies, shall review health care

8.6 best practice guidelines and identify five best practice

8.7 guidelines for which, in the determination of the commissioner,

8.8 greater adherence to by Minnesota health care providers would

8.9 lead to a significant improvement in patient health outcomes.

8.10 The commissioner shall encourage Minnesota health care providers

8.11 to follow the guidelines identified and shall monitor and track

8.12 the extent to which Minnesota health care providers follow the

8.13 guidelines.

[...]

8.19 Sec. 3. [147.38] [BEST PRACTICES GUIDELINE.]

8.20 Subdivision 1. [HEALTH-RELATED BOARD.] For purposes of

8.21 this section, "health-related board" means the Board of Medical

8.22 Practice established under section 147.01, the Board of Nursing

8.23 established under section 148.181, the Board of Chiropractic

8.24 Examiners established under section 148.02, the Board of

8.25 Optometry established under section 148.52, the Board of

8.26 Physical Therapy established under section 148.67, the Board of

8.27 Dentistry established under section 150A.02, the Board of

8.28 Pharmacy established under section 151.02, and the Board of

8.29 Podiatry established under section 153.02.

8.30 Subd. 2. [BOARD APPROVAL.] A health-related board, in

8.31 consultation with a relevant professional association or

8.32 specialty organization and the commissioner of health, may

8.33 evaluate and approve best practice guidelines and shall make any
8.34 approved guidelines available to interested practitioners
8.35 through the board's Web site.

[...]

9.14 Sec. 5. [BEST PRACTICES PILOT PROJECT.]
9.15 The commissioners of human services and employee relations
9.16 shall develop and implement a one-year best practices pilot
9.17 project to encourage greater use of at least three of the best
9.18 practice guidelines identified by the commissioner of health
9.19 under Minnesota Statutes, section 144.7035. The pilot project
9.20 must provide health care providers and health plan companies
9.21 serving state employees and enrollees of state health care
9.22 programs administered by the commissioner of human services with
9.23 financial and other incentives to increase the use of the best
9.24 practice guidelines selected. The commissioners shall implement
9.25 the pilot project beginning January 1, 2005, and shall report
9.26 the results of the pilot project to the legislature by June 1,
9.27 2006.

9.28 ARTICLE 3
9.29 MEDICAL MALPRACTICE REFORM
9.30 Section 1. [147.37] [BEST PRACTICE GUIDELINES; USE IN
9.31 MEDICAL MALPRACTICE CASES.]
9.32 (a) In an action against a provider for malpractice, error,
9.33 mistake, or failure to cure, whether based in contract or tort,
9.34 adherence to a best practice guideline approved by either a
9.35 recognized specialty organization or an organization established
9.36 for the purpose of developing community-based clinical practice
10.1 guidelines is an absolute defense against an allegation that the
10.2 provider did not comply with accepted standards of practice in
10.3 the community. This paragraph does not apply if the best
10.4 practice guideline authorizes or recommends denial of treatment,
10.5 food, or fluids necessary to sustain life on the basis of the
10.6 patient's age or expected length of life or the patient's
10.7 present or predicted disability, degree of medical dependency,
10.8 or quality of life.
10.9 (b) Evidence of a departure from a best practice guideline
10.10 is admissible only on the issue of whether the provider is
10.11 entitled to an absolute defense under paragraph (a).
10.12 (c) Paragraphs (a) and (b) apply to claims arising on or
10.13 after August 1, 2004.
10.14 (d) Nothing in this section changes the standard or burden
10.15 of proof in an action alleging a delay in diagnosis, a
10.16 misdiagnosis, inappropriate application of a best practice
10.17 guideline, failure to obtain informed consent, battery or other
10.18 intentional tort, or product liability.