

Public Health Law Communication Linkages

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APHA Annual Meeting
November 5, 2007
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Why

- Interest in the field has increased, communication within the field has been more limited
- Improved means of identifying, gathering and disseminating relevant public health law materials are needed



Types of materials used in the field

- Federal and state Constitutions, statutes, regulations, as well as local ordinances;
- Case law (federal, state and administrative decisions, both published and unpublished);
- Legal forms and other model documents and contracts;
- Bench books;
- Studies, reports, articles, Model Acts;
- Educational sessions – e.g., presentations, workshops, conference proceedings, etc.
- News and news analysis;
- Informal “curbside” consults with professional colleagues.



Goal

- Analyze approaches which might be undertaken to coordinate communication efforts & generate new content
- Focus on electronic means



Online Lectures: The Supercourse



[Supercourse](#) is a global repository of lectures on public health and prevention targeting educators across the world. Supercourse has a network of over 45300 scientists in 174 countries who are sharing for free a library of over 3335 lectures in 26 languages. The concept of the Supercourse and its lecture style has been described as the [Global Health Network University](#) and the [Hypertext Comic Books](#).

[LatinAmerican Supercourse in Spanish Language](#)



[Chinese Language Front Page](#)

Epidemiology - Internet - Global Health

Global Health Lecture

What is the Supercourse?

- [Overview](#)
- [Developers](#)
- [Internet Resources](#)
- [Publications](#)
- [Supercourse Mirror Sites](#)

Special Lectures

- [Other Supercourse Lectures and Supercourse Courses](#)
- [Supercourse Legacy Lectures](#)
- [NIH Supercourse](#)
- [Supercourse Lectures Available in Power Point](#)

Supercourse Lectures

- [Lecture by Topic](#)
- [Lecture by Author](#)
- [Lecture by Alphabetic Order](#)
- [New Lectures](#)
- [All Lectures](#)

Want to join us?

- [How to join the faculty member?](#)
- [Instructions for authors](#)
- [CD/DVD download](#)
- [Public Health Training in Pittsburgh?](#)

The Lecture of the Week - [Malaria](#)



If you have any comments or questions on this page or the Supercourse, please contact Professor [Ronald E LaPorte](#).

- Updated (September/23/2007) -

Source: <http://www.pitt.edu/~super1/>

Public Health Law Supercourse?

- Early, enthusiastic & active commitment by leaders
- Appropriate resource commitment
- Expert oversight
- Contributions by large # and range of content experts
- Sustained growth, not just added on “special” occasions
- Continuous quality monitoring
- User-friendly interface
- Education, not legal advice
- CLE credit for participants & presenters
- Two tracks – beginner & advanced



Case Conferences: AHRQ Web M&M and PSNet

The screenshot displays the AHRQ web M&M website interface. At the top, the AHRQ logo and 'Agency for Healthcare Research and Quality' are visible. Below this is the 'web M&M' logo and the tagline 'Morbidity & Mortality Rounds on the Web'. A navigation bar includes links for Home, Register/Log In, Submit Case, Case Archive, Perspectives on Safety, CME/CEU, Glossary, Topic Index, Forums, AHRQ PSNet, and About. A search bar is located in the top right corner.

The main content area is divided into three columns of case commentaries:

- Column 1 (Surgery-Anesthesia):**

Medication Reconciliation: Whose Job Is It?
SPOTLIGHT CASE
 Hospitalized for surgery, a woman with a history of seizures was given an overdose of the wrong medicine due to multiple errors, including an inaccurate preadmission medication list, failure to verify medication history, and uncoordinated information systems.
 Commentary by **Eric G. Poon, MD, MPH**
 CME/CEU available
- Column 2 (Medicine):**

Discharging Our Responsibility
 An elderly man with a history of hypertension, coronary artery disease, congestive heart failure (CHF), and countless hospital admissions for CHF came to the emergency department complaining of shortness of breath and fatigue. The admitting physician discovered that the patient had never received clear education about caring for himself outside the hospital.
 Commentary by **Gregg C. Fonarow, MD**
- Column 3 (Medicine):**

Coming Undone: Failure of Closure Device
 A man underwent coronary angiography; one stent was placed and bypass surgery was scheduled for 4 days later. He developed bleeding at the catheter site and returned to the hospital. A CT scan revealed a large retroperitoneal hematoma, which was repaired surgically. While in the hospital awaiting the delayed bypass surgery, the patient had a cardiac arrest and died.
 Commentary by **Jose L. Baez-Escudero, MD; Glenn N. Levine, MD**

On the right side of the page, there are sections for 'Perspectives on Safety' and 'AHRQ PSNet Patient Safety Network'. The 'Perspectives on Safety' section highlights 'This month: Surgical Errors' and lists articles such as 'In Conversation with... Atul Gawande, MD, MA, MPH' and 'Rediscovering the Power of the Surgical M&M Conference: The M+M Matrix' by Leo A. Gordon, MD. A 'Submit your Perspective' link is provided.

The 'AHRQ PSNet Patient Safety Network' section features a 'What's New' article: 'Study identifies nature of trainee-associated errors' and a link to 'Visit AHRQ PSNet for more patient safety news and information'.

Below this is a 'Did You Know?' section titled 'Surgical specimen identification errors'. It includes a bar chart showing the rate of errors per 1000 specimens across six categories:

Category	Rate (per 1000 specimens)
1	0.84
2	0.75
3	0.75
4	0.66
5	0.52
6	0.42
7	0.33

Source: <http://webmm.ahrq.gov>

Web M&M

- Monthly case commentaries (3/mo)
 - Cases submitted anonymously, content expert provides commentary
 - Editorial team oversight
- Honoraria for case contributors & writers
- Continuing Education credit for users



PSNet: Information Portal

The screenshot shows the AHRQ PSNet website. At the top, there is a header for the United States Department of Health & Human Services and the Agency for Healthcare Research and Quality (AHRQ). The AHRQ logo is prominently displayed with the tagline "Advancing Excellence in Health Care" and the website URL "www.ahrq.gov". A navigation menu on the right includes links for "Skip Navigation", "HHS Home", "Questions?", "Contact AHRQ", and "Site Map". Below the header, a blue banner features the text "A national patient safety resource" and "AHRQ PSNet Patient Safety Network". A search bar with a "GO" button and a link to "Advanced Search" is present. On the left, a vertical menu lists various site sections: Home, What's New, My PSNet, Subscribe to Newsletter, CLASSICS, Most Popular, Advanced Search, Advanced Browse, Glossary, AHRQ WebM&M, About, and Contact Us. The main content area is divided into two columns. The left column, titled "What's New This Week" (dated 10/24/07), lists several journal articles with links to view more, XML, and RSS feeds. The right column, titled "Browse the Collection", offers navigation by resource type, origin/sponsor, and subject.

United States Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality

Advancing Excellence in Health Care www.ahrq.gov

Skip Navigation

- HHS Home
- Questions?
- Contact AHRQ
- Site Map

Home ▶ A national patient safety resource

What's New

My PSNet

Subscribe to Newsletter

CLASSICS

Most Popular

Advanced Search

Advanced Browse

Glossary

AHRQ WebM&M

About

Contact Us

AHRQ PSNet Patient Safety Network

Search **GO** Advanced Search

What's New This Week 10/24/07

[View more of What's New](#) **XML** [RSS Feed](#)

Journal Articles

[Medical errors involving trainees: a study of closed malpractice claims from 5 insurers.](#)
Singh H, Thomas EJ, Petersen LA, Studdert DM. Arch Intern Med. 2007;167:2030-2036.

[Drug selection errors in relation to medication labels: a simulation study.](#)
Garnerin P, Perneger T, Chopard P, et al. Anaesthesia. 2007;62:1090-1094.

[Crime in the workplace, part 1.](#)
Pastorius D. Nurs Manage. 2007;38:18, 20, 22, 24, 26-27.

[Medication safety: just a label away.](#)
Jennings J, Foster J. AORN J. 2007;86:618, 620-625.

[Medication tracers: a systems approach to medication safety.](#)
Hendrick EC, Montanya KR, Griffith N. Hosp

Browse the Collection

Browse by Resource Type
[Journal articles](#), [Books and reports](#), [Tools and toolkits](#), [Upcoming meetings](#), [More...](#)

Browse by Origin/Sponsor
[Federal Government](#), [Department of Health and Human Services](#), [Agency for Healthcare Research and Quality](#), [United Kingdom](#), [More...](#)

Browse by Subject

Safety Target
[Medication errors](#), [Diagnostic errors](#), [Nosocomial infections](#), [Post-operative surgical complications](#), [More...](#)

Approach to Improving Safety
[Human factors engineering](#), [Error reporting](#), [Teamwork training](#), [Culture of safety](#), [Nurse staffing ratios](#), [Regulation](#), [More...](#)

Error Types
[Cognitive errors \("mistakes"\)](#), [Non-cognitive errors \("slips & lapses"\)](#), [Latent errors](#), [More...](#)

Source: <http://psnet.ahrq.gov/>

Online, Case-based PH Law Journal?

- Primary & attainable goal
- Case-based education already occurring at live conferences & in classroom
- Need to work out jurisdictional differences



Other Options

- Listservs
- Online Collaboration:
Web 2.0 & Wikis



Recommendations

- Help in-person conferences “go digital”
- Digital champions needed
 - APHA, PHLA, CDC, NACCHO, ASTHO, NGOs
- Consistent support and growth
- Creating a Public Health Law Portal
 - Collaborate with others in the field
- Development of Online Case Study Journal, Webinars, Listservs & Database of information
- Continuing Education Credit Incentives

