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1. **3D: A Tool for Medication Discharge Education.**
Manning D.M., O'Meara J.G., Williams A.R., et al.
Qual Saf Health Care. 2007 (Feb); 16(1):71-76.
The purpose of this study was to compare a newly designed medication discharge education (MDE) tool, Durable Display at Discharge (3D), with a Medication Discharge Worksheet (MDW) currently in use. An exploratory, randomized trial was conducted to determine efficacy of 3D versus MDW with respect to patient satisfaction, understanding of medications, and self-reported medication errors. The study setting was a 917-bed hospital located in the Midwest U.S., while participants were comprised of 176 hospital patients over age 20 being discharged with more than three medications. The participants were separated into two groups each receiving either a MDW or 3D upon hospital discharge and were surveyed by telephone to determine satisfaction with the respective MDE tool given. Results showed a high level of patient satisfaction and low rates of self-reported error for both 3D and MDW, with no significant differences between the two tools in these areas; however, patients given 3D were found to have a better understanding of their medications. The authors conclude that 3D appears to be more effective than MDW in this area and recommend further study to explore the significance of this result.

2. **A National Framework and Preferred Practices for Palliative and Hospice Care Quality.**
National Quality Forum.
Foreword by Janet M. Corrigan, President & CEO.
Washington, DC: National Quality Forum: 2006.
Available at: http://216.122.138.39/projects/completed/palliative/index.asp
This report from the National Quality Forum (NQF) was created to address the need for standardized performance measures for palliative and hospice care. With support from the Robert Wood Johnson Foundation and the Department of Veterans Affairs, the NQF has developed and endorsed a quality measurement and reporting system focused on these care areas. The three chapters of the report respectively address: selection of an expansive measure set and framework, preferred practices, and key areas where further research is needed. The National Consensus Project for Quality Palliative Care's (NCP's) Clinical Practice Guidelines for Quality Palliative Care was used to begin the consensus framework development. The result of the framework and measure set discussed in chapter one are thirty-eight preferred practices for palliative and hospice care discussed in chapter two. Finally, chapter three discusses further research needed in this area of care. A table displaying the preferred practices and NQF's approach is included in the report along with several appendixes.

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3. **A Pooled Analysis of Data Comparing Sirolimus-Eluting Stents with Bare-Metal Stents.**
Spaulding C., Daemen J., Boersma E., Cutlip D.E., Serruys P.W.
N Engl J Med. 2007 (Mar 8); 356(10):989-997.
This study sought to evaluate the safety of sirolimus-eluting stents versus bare-metal stents with respect to risks of death, myocardial infarction and stent thrombosis. The analysis aggregated results for 1748 patients in four previously conducted randomized trials each of which compared a different sirolimus-eluting stent to an identically-designed bare-metal stent. Analysis showed the 4-year survival rate was slightly higher in bare-metal stent patients, while overall myocardial infarction rates showed no significant differences, and stent thrombosis was found to be more frequent in bare-metal study participant within the first year and late-stent thrombosis was found more frequently within drug-eluting study recipients after the first year. Overall, no significant differences were found in rates of death, myocardial infarction or stent thrombosis between sirolimus-eluting and bare-metal stent patients.

4. **Barriers and Motivators for Making Error Reports from Family Medicine Offices: A Report from the American Academy of Family Physicians National Research Network (AAFP NRN).**
Elder N.C., Graham D., Brandt E., Hickner J.
J Am Board Fam Med. 2007 (Mar/Apr); 20(2):115-123.
Available at: http://www.jabfm.org/cgi/reprint/20/2/115.pdf
The purpose of this study was to assess the barriers and motivators in reporting process errors in ambulatory care. Methodology for this study consisted of focus groups held in eight selected volunteer family physician offices—four family medicine residency clinics and four private practices. This focus group study was conducted within a larger study on testing process errors. At the eight practices studied, physicians, nurse practitioners (NPs), physician assistants (PA), office staff, and nurses submitted anonymous error reports via web site or traditional mail in the areas of: laboratory, radiology, and diagnostic testing processes. Reports were collected over an eight-month period. Study results showed the most often reported barrier to error reporting was burden of effort, more succinctly lack of time and forgetfulness. Confusion over concise reporting rules was also found to be a barrier to error reporting, as was severity of error. Motivators for error reporting were found to be few. The most common reason reported for making an error report was perceived benefits, such as emotional benefit. The authors conclude that although healthcare practitioners are willing to participate in the error reporting process, careful consideration must be given to the barriers and motivators for error reporting in the design of a reporting system.

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5. **Care Patterns in Medicare and Their Implications for Pay for Performance.**
Pham H.H., Schrag D., O'Malley A.S., Wu B., Bach P.B.
N Engl J Med. 2007 (Mar 15); 356(11):1130-1139.
This study sought to analyze patterns of care in the Medicare fee-for-service system, in particular to determine: the number of physicians visited annually by Medicare patients, the extent to which Medicare patients are seen by their assigned physicians and stability of physician assignments, and what proportion of physicians' Medicare patients are their assigned patients. Data from claims was evaluated by performing cross-sectional analyses and longitudinal analyses for 1.79 million Medicare beneficiaries 65 years of age and older, who received treatment between the years 2000-2002 from physicians who completed a Community Tracking Study Physician Survey. Results revealed that Medicare beneficiaries visit many physicians, half of whom are not assigned physicians according to the pay-for-performance model. These findings held true for both specialty and primary care physicians. Results further revealed that due to the number of physicians beneficiaries visit, the ability to direct care by an assigned physician is impeded, thus reducing the ability to improve quality of care, and in turn limiting the potential of incentives to improve care quality. Finally, the authors conclude that care under the current fee-for-performance schedule may be compromised due to the uneven distribution of beneficiaries to physicians.

6. **General Internists' Views on Pay-for-Performance and Public Reporting of Quality Scores: A National Survey.**
Casalino L.P., Alexander G.C., Jin L., Konetzka R.T.
Health Affairs. 2007 (Mar/Apr); 26(2):492-499.
The purpose of this study was to learn about physician views and ideas concerning pay-for-performance (P4P) and public reporting programs. A national survey was given to 1,168 randomly selected general internists working in one of the nationally representative metropolitan areas in the Community Tracking Study (CTS) for the Center for Studying Health System Change (HSC). Of the 48% of physicians who completed the survey, three-fourths responded favorably to incentives for improving quality providing the measures were accurate; however, many physicians did not feel current measures were accurate, though most did believe efforts would be made to improve accuracy. Results further showed that only 45% supported overall public reporting, while only 32% of respondents supported reporting of individual physicians' performance. Many physicians expressed concern that current measures could lead to avoidance of high-risk patients, and might divert attention from non-measurable qualities of care. Finally, the authors note this is the first study to ascertain physicians' views on these programs, and the results identify important opinions that can help shape these programs.

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7. **How Physicians can Change the Future of Health Care.**
Porter M.E., Teisberg E.O.
JAMA. 2007 (Mar 14); 297(10):1103-1111.
This article outlines a proposed model for healthcare reform centered on a physician led, value-based system. Rather than making changes from the outside, the authors assert the benefits of physician led health changes that they believe can only be generated from within the health care system. Discussed is the idea of positive sum competition, where the competition created improves patient care and the value of healthcare dollars. Also discussed are the three principles of the value-based model: value for patients, care delivery organized around medical conditions and care cycles, and measurable results. Attributes of the proposed new model, as described by the authors, include more effective physician collaboration, stronger patient involvement, and a more supportive health plan. The authors conclude by stating all stakeholders involved in a value-based health plan will benefit from a shift in focus to physician led reform which emphasizes value and care improvement.

8. **Improving America's Hospitals: A Report on Quality and Safety.**
The Joint Commission.
The Joint Commission. 2007:1-80.
Available at: http://www.jointcommissionreport.org/
This inaugural report by the Joint Commission evaluates the performance of accredited hospitals in the United States against evidence-based quality measures on myocardial infarction, heart failure, pneumonia, and surgical infection prevention for the year 2005. Measures were derived from the Joint Commission's and the Hospital Core Measure Initiative. The creation of the Hospital Core Measure Initiative was the result of collaboration between the Joint Commission, the Centers for Medicare and Medicaid Services (CMS), and the National Quality Forum (NQF). Also included in the report is data on hospitals' compliance with the Joint Commission 2005 National Patient Safety Goals requirements. Topics covered in the report are: why this report is important, room for improvement, and how the Joint Commission measures performance, along with discussion and data on the above mentioned health issues. Quality and compliance data is presented by year and by state and national rates. This is the first in what is to be an annual report.

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9. **Insufficient Communication About Medication Use at the Interface Between Hospital and Primary Care.**
Glintborg B., Andersen S.E., Dalhoff K.
Qual Saf Health Care. 2007 (Feb); 16(1):34-39.
This study examined hospitals' ability to establish patient medication lists that accurately reflect patients' actual medication use and to identify where errors are most likely to occur in the process of creating medication lists. Medication lists from inpatient hospital files and discharge letters were compared against patients' actual medication use as determined by in-home interviews shortly after discharge. 7 Methodology included a cross-section survey occurring from late 2002 through early 2003 conducted in a hospital in Copenhagen, Denmark. Study participants consisted of patients consenting to in-home interviews regarding their prescription only medication (POM) within the first week of hospital discharge. Results showed, out of 200 homes visited, one of five drugs prescribed by general practitioners was unknown to the hospital, only half of used POM was listed in the discharge letters, and 66% of surgical patients had no medication list at time of discharge. The authors conclude that inconsistent or incomplete medication lists are a frequent occurrence that may significantly impede medication reconciliation, and suggest that further attention is needed to this issue.

10. **Limited English and Health Proficiency: A Call for Action to Promote Patient Safety.**
Liang B.A.
J Patient Saf. 2007 (Mar); 3(1):3-5.
This editorial discusses the implications of limited English literacy for patient safety and health proficiency among U.S. citizens. Liang cites findings showing that patients with limited English proficiency are subject to higher rates of medical error, longer hospital stays, and higher healthcare costs, and have lower rates of compliance with medication instruction and poor understanding of their treatment. The author argues that there is not only an ethical imperative, but also a potential business case for demanding medical rights for persons with limited literacy. Finally, the author suggests changes to improve the current system, such as allowing telephone translation as a primary means of interpretation, simplifying medication instructions for people with limited English skills, and establishing a national forum on health literacy.

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11. **Manic for Medication Safety.**
Rogoski R.R.
Health Mgmt Tech. 2007 (Feb):1-7.
Available at: http://www.healthmgttech.com/archives/0207/0207manic_medication.htm
This article focuses on the role of two technologies—bar-code systems and health information databases—in improving medication safety. Rogoski provides several examples of hospitals that have adopted bar-code tools to reduce medication errors and improve patient safety. For instance, since implementing the technology in 1998, Northern Michigan Hospital has been able to avoid over 21,000 medication errors and five fatalities. The author points out that another area of safety bar-coding tools provides is in patient hand-offs during shift changes. Challenges of adopting the new technology are discussed. Finally, as stated in the article, the most important benefits of implementing a bar-code technology are the reduction of medication errors, adverse events and potential death, and overall improved patient safety.

12. **No Hidden Patient: A Safety Design Model.**
Hardy J.
Trustee. 2007 (Feb):1-3.
Available at:
http://www.trusteemag.com/trusteemag_app/jsp/articledisplay.jsp?dcrpath=TRUSTEEMAG/PubsNewsArticleGen/data/02FEB2007/0702TRU_DEPT_AboveBoard_Design&domain=TRUSTEEMAG
In this article Hardy, a healthcare facility planning and design consultant, offers instructions on how to design what he terms a "No Hidden Patient" hospital. This model aims to rectify elements of traditional hospital design that, the author argues, may hinder patient safety and place unnecessary stress on clinical staff. First, the author explains, all patients should be visible at all times by clinicians. Then, he continues, long corridors should be eliminated to alleviate unnecessary excessive walking for nurses. The author explains that the No Hidden Patient model has had an effect with physicians, one of whom has submitted a proposal to build a care facility according to the design. The author also provides steps for developing the No Hidden Patient design, which are predevelopment, preplanning, and planning. Finally, the author states that though his model may seem to address small flaws, the focal point of the design is an improved working facility which leads to improved patient safety and care.

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13. Patient Safety in the Intensive Care Unit: Challenges and Opportunities.
Clancy C.M.
J Patient Saf. 2007 (Mar); 3(1):6-8.
In this commentary Clancy discusses patient safety issues and challenges in intensive care units (ICUs) as presented in various reports and articles by the Agency for Healthcare Research and Quality (AHRQ) and others. The author comments on a recent report funded by AHRQ describing ICUs as unsafe and facilitating medical errors. Clancy also discusses literature that points out the positive effects of ICUs, including the opportunities ICUs present for preventing medical errors. For instance, the ICU Incident Reporting System, which is a voluntary, anonymous error reporting system derived from the aviation industry, offers an opportunity to learn from the ICU environment. Another report Clancy discusses relates to intern scheduling hours in relation to medical errors in the ICU. The author suggests that although the characterization of the ICU as a facilitator of medical errors is well justified, by the same token, ICUs offer valuable opportunities for studying safety and quality and implementing change that should not be overlooked.

14. Paying for Care Episodes and Care Coordination.
Davis K.
N Engl J Med. 2007(Mar 15); 356(11):1166-1168.
In this article Davis discusses the state of fee-for-performance systems and the various pay-for-performance (P4P) health care models. The author discusses the inequality of some of the P4P models, and points out that few are designed to reward efficiency of care, such as measures that avoid hospitalizations. The author discusses the need for payment systems structured to allocate accountability for care spanning various health settings, among other issues. Davis suggests allowing integrated health systems, physician group practices and physician networks to participate in designing payment systems. Finally, the author states that the P4P system needs further attention and adjustments to meet its intended purpose.

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15. **Prescription for Improving Patient Safety: Addressing Medication Errors: A Report from the Medication Errors Panel.**
Cotterell C., et al.
The Medication Errors Panel. 2007 (Mar).
Available at: http://66.35.213.106/pdf/SCR42_Final_report.pdf
The Medication Errors Panel, established by Senate Concurrent Resolution 49 (2005) and sponsored by the California Pharmacists Association, was created to study the causes of outpatient medication errors and to recommend changes to reduce these errors. This report presents the analysis of the issue and recommendations for change developed by the Panel over its twelve meetings in 2006. Key processes the panel identified as needing better design are: transcription and transmission of prescriptions, consumer education, healthcare provider payments and incentives and healthcare provider training and licensure. Three key stakeholder groups the panel felt would be crucial in effecting necessary changes to the selected processes were consumers and consumer oriented organizations, healthcare providers and related organizations, and healthcare purchasers, payers, regulators and related organizations. The report consists of three sections: report of the panel, recommendations, and appendices.

16. **Safety and Efficacy of Sirolimus- and Paclitaxel-Eluting Coronary Stents.**
Stone G.W., Moses J.W., Ellis S.G., et al.
N Engl J Med. 2007 (Mar 8); 356(10):998-1008.
This study compared data collected from several trials investigating the safety of drug-eluting stents. Analysis consisted of pooling data from four double-blind trials of 1748 patients who received either sirolimus-eluting stents or bare-metal stents and five double-blind trials of 3513 patients who received either paclitaxel-eluting stents or bare-metal stents. The purpose of the study was to determine the short-term and long-term safety of drug-eluting stents compared with bare-metal stents. Study results showed no significant difference in death or myocardial infarction rates for drug-eluting stents compared to bare-metal stents. However, stent thrombosis after the one-year mark was found to be more common among both types of drug-eluting stents as compared to the bare-metal stent group.

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17. **The Problem of Engaging Hospital Doctors in Promoting Safety and Quality in Clinical Care.**
Neale G., Vincent C., Darzi A.
JRSH. 2007 (Mar); 127(2):87-94.
This article focuses on the background and evolution of initiatives to improve the quality and safety of healthcare in relation to the disengagement of physicians from quality and safety issues in the UK's National Health Service (NHS). The authors discuss the historical background of medicine, the national issue of healthcare quality, and the medical culture, among other issues. Recent alterations in medical practice are discussed as is the role of education. Finally, the authors offer three key initiatives for the future which are, exploration of a quality and safety unit, extending IHI initiatives developed by the Health Foundation to the NHS, and development and implementation of programs aimed at educating medical students on quality and safety issues. A table is included listing tasks of clinical governance as established for the NHS Trusts' Clinical Governance Units.

18. **Unanswered Questions—Drug-Eluting Stents and the Risk of Late Thrombosis.**
Maisel W.H.
N Engl J Med. 2007 (Mar 8); 356(10):981-984.
This article reviews the current state of knowledge concerning the safety of drug-eluting stents and attempts to explain and reconcile the apparently conflicting results that have emerged from recent studies. Although some of the conflicting information may be attributable to factors such as differing clinical protocol definitions, variability in patient characteristics, and differences in on-label versus off-label use, the author feels that many questions remain. Maisel touches on the implications for the U.S. medical device regulatory process, arguing that this example illustrates the need for more extensive post-marketing studies and fuller communication with the public regarding new medical devices.

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19. **Weekend Versus Weekday Admission and Mortality from Myocardial Infarction.**
Kostis W.J., Demissie K., Marcella S.W., Shao Y-H., Wilson A.C., Moreyra A.E.
N Engl J Med. 2007 (Mar 15); 356(11):1099-1109.
This study examines the differences in myocardial infarction treatment received on weekends compared to treatment received on weekdays. Methodology consisted of analysis of mortality rates based on information gathered from the Myocardial Infarction Data Acquisition System (MIDAS) database. Study participants were comprised of 231,164 patients admitted for a first acute myocardial infarction at New Jersey hospitals over a fifteen-year period from 1987-2002. Results after adjustment showed that patients admitted on weekends had significantly higher mortality rates, and were less likely to receive invasive cardiac procedures and catheterization, than those admitted on weekdays. The authors suggest that the increased mortality rate may be partially linked to the lower rate of invasive procedures performed on weekends, and hypothesize that increased access to care on weekends could improve outcomes for myocardial infarction patients. Several tables and one figure are included.

20. **Weekend Worriers.**
Redelmeier D.A., Bell C.M.
N Engl J Med. 2007 (Mar 15); 356(11):1164-1165.
This editorial discusses the issue of differences between weekend and weekday hospital care, particularly with regard to the recent study by Kostis, et al., appearing in the same issue of New England Journal of Medicine and included in this issue of Current Awareness. Although results vary, a number of studies have shown higher rates of mortality and adverse events for patients admitted on weekends that for hose admitted on weekdays. The likelihood that reduced staffing on weekends may be responsible for this trend, and possible policy changed to address this issue, such as reimbursement premiums for weekend treatment, are discussed; however, the authors feel that financial incentives alone may not be a complete solution. The authors recommend that in light of this information, patients should contact their doctor during the week if they think they may require medical attention over the weekend to increase their chances of receiving the best care.

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