ORIGINAL ARTICLES

Health Care Disparities

551 Time for Nursing Homes to Recognize and Address Disparities in Care
A.R. Green
The author discusses how nursing homes should be ready for public reporting of disparities in quality metrics.

554 Examining Racial and Ethnic Differences in Nursing Home Quality
Analyses of eight publicly reported nursing home quality measures suggested that care for approximately 3 million residents in 15,000 nursing homes was similar across racial/ethnic groups.

Coordination of Care

565 Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers
M.C. Britton, G.M. Ouellet, K.E. Minges, M.Gawel, B. Hodshon, S.I. Chaudhry
The care transition from hospital to skilled nursing facility (SNF) is often marked by disruptions in care and poor communication among hospital and SNF providers. Participants in this study praised novel solutions, such as sharing the costs of expensive medications between facilities or using SNFs for hospice care that broke down institutional barriers.

Performance Improvement

573 Use of Unit-Based Interventions to Improve the Quality of Care for Hospitalized Medical Patients: A National Survey
K.J. O’Leary, J.K. Johnson, M. Manojlovich, G.J. Astik, M.V. Williams
A cross-sectional survey of internal medicine residency program directors and hospital medicine group leaders suggested relatively low use of unit-based interventions, such as nurse-physician co-leadership and interdisciplinary rounds, intended to improve quality of care for patients hospitalized for medical conditions.

Risk and Event Assessment

580 Root Cause Analysis of ICU Adverse Events in the Veterans Health Administration
G.S. Corwin, P.D. Mills, H. Shanawani, R.R. Hemphill
Its provision of complex care for critically ill patients renders the ICU an environment with a high potential for adverse events. For 70 root cause analyses identified in 47 of the Veterans Health Administration 120 facilities with an ICU, delays in care (30.0%) and medication errors (28.6%) were the most common types of events. Standardization of care process, implementation of team-training programs, and simulation-based training may improve ICU patient safety.

IMPROVEMENT BRIEF

591 Implementing the Comprehensive Unit-Based Safety Program (CUSP) to Improve Patient Safety in an Academic Primary Care Practice
The Comprehensive Unit-based Safety Program (CUSP), which has been extensively studied in inpatient settings, was implemented in an academic primary care practice. Prioritization of communication and infection control led to standardization of work flows. CUSP is a promising tool to improve safety climate and to identify and address safety concerns in ambulatory health care.

INNOVATION REPORTS

598 Using Fault Trees to Advance Understanding of Diagnostic Errors
D. Rogith, M.S. Iyengar, H. Singh
Fault tree analysis was used to model diagnostic errors to inform understanding and prevention of errors. Fault trees constructed for each of 10 published cases of diagnostic error were synthesized into a single fault tree to identify common contributing factors and pathways leading to diagnostic error. Fault tree analysis holds promise as a way to combine data from disparate cases and across organizations to understand how best to prevent diagnostic errors in the future.
A Scalable Program for Customized Patient Education Videos

A patient education video program was developed to facilitate the delivery of targeted information to patients. In an operational survey, 1,034 (86.0%) of 1,203 patients stated that a video helped them understand their health, medical condition, or treatment plan.

TOOL TUTORIAL

A Novel Process Audit for Standardized Perioperative Handoff Protocols

A novel process audit requiring minimal resources was developed to help ensure that a perioperative handoff protocol is used accurately and appropriately over time.

INFORMATION FOR AUTHORS