



Quality Matters

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A BIMONTHLY REPORT ON INNOVATIONS IN HEALTH CARE QUALITY IMPROVEMENT

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Welcome to *Quality Matters*, a bimonthly roundup of news and opinion on quality and efficiency, information technology, performance improvement initiatives, and policy innovations.

Using Patient-Reported Outcomes to Improve Health Care Quality

By Martha Hostetter and Sarah Klein

Patient-reported outcomes measures (PROMs) are a critical component of assessing whether clinicians are improving the health of patients. Unlike process measures, which capture provider productivity and adherence to the standards of recommended care, or patient experience measures, which focus on aspects of care delivery such as communication, PROMs attempt to capture whether the services provided actually improved patients' health and sense of well-being. For example, patients might be asked to assess their general health, ability to complete various activities, mood, level of fatigue, and pain.

Until now, state and federal governments as well as private payers attempting to assess outcomes have mostly relied on measures of avoidable readmissions, hospital-acquired infections, and mortality. They have also turned to objective measures of improvement such as changes in blood pressure among those with hypertension or hemoglobin A1c levels in diabetics. Patients' views of their health status have rarely been sought outside of clinical trials for new drugs or medical devices and medical specialties that focus on conditions for which there are few objective measures of improvement. Yet the ultimate measure of health system performance is whether it helps people recover from an acute illness, live well with a chronic condition, and face the end of life with dignity—and people's reports are the only way to gauge success.

In coming years, patient-reported measures are expected to play a more prominent role in assessing performance and determining the comparative effectiveness of different treatments, in part because of a growing emphasis on patient-centered care and value-based payment approaches. For example, by 2015, health care providers participating in accountable care organizations will have to provide evidence that the care they've delivered produced value for the patient—as reported by the patient. The Department of Health and Human Services' Office of the National Coordinator for

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Health Information Technology also plans to incorporate PROMs into meaningful use standards, which is likely to prompt more widespread use.

They are also expected to be used to benchmark the performance of health care providers, potentially allowing payers to link reimbursement to evidence of the effectiveness of their treatment. “I see patient-reported outcomes as creating a brand new feedback loop and really for the first time creating measures of quality out of the eyes of the patient—not the eyes of the doctor,” says Kristine Martin Anderson, senior vice president at the consulting firm Booz Allen Hamilton.

Use of PROMs in Clinical Practice

In the U.S., PROMs are in the early stages of development for use in clinical practice, as opposed to research. They have been most widely used to monitor conditions that rely on patients’ reports (rather than diagnostic tests), such as depression or certain gastrointestinal disorders.

Dartmouth-Hitchcock Medical Center’s Spine Center has been collecting outcomes data from its patients since 1997, using the [SF-36](#), a “short form” survey with 36 general questions used to assess functional health and well-being, and the [Oswestry Disability Index](#), which is used to measure functional disability from low back pain.

At the center, patients complete the surveys online so that the results are available for their initial clinic visits. The data are collected over time and stratified by illness burden, enabling the center to compare whether a medical or surgical intervention is best for a specific condition. The results are posted on the center’s Web site and patients are encouraged to review them as they consider different treatment options.

PROMs are also used at the University of Pittsburgh Medical Center (UPMC). Patients visiting the center’s outpatient primary care clinic fill out the SF-36 on tablet computers before seeing a physician. The tool has helped clinicians identify patients with depression and older adults with mobility limitations. In a health system such as UPMC, PROMs data could also help improve care coordination, says Rachel Hess, M.D., assistant professor of medicine, epidemiology, and clinical and translational science at the University of Pittsburgh. “One of the things we talked about across the medical center is that as

patients transition from primary care practice to different specialty practices for particular conditions, it would be helpful to have that same sort of standardized data across time so that we know how the condition has evolved and responded to different treatments,” Hess says.

Obstacles to PROM Use

These examples notwithstanding, the use of PROMs is not widespread in the U.S., in part because of the challenges of collecting and using this information in a way that does not disrupt the workflow of clinicians. Another major reason is that, generally, clinicians are not able to bill for time spent fielding outcomes surveys or interpreting such data. It’s also difficult to link patient-reported outcomes to particular treatments since many factors—including patients’ compliance and social factors—influence outcomes. Providers may not see the value in outcome reports, or lack the training or resources to know how to make effective use of them.

To overcome some of these challenges, “we need to demonstrate that it’s feasible to collect these data on a widespread basis—not a small-scale research study,” says Janet Corrigan, Ph.D., M.B.A., president and CEO of the National Quality Forum. “Then we need to begin feeding this information forward to clinicians and patients, and demonstrate how it can best be used to inform care decisions. Third, we need to roll the outcomes data up to help assess the performance of integrated delivery systems, such as ACOs.”

To promote more widespread use, many say, the surveys should also be easy for patients to complete, for example through smartphone apps, Web-based tools, or even in kiosks in drug stores. PROMs data also need to be easy to bring forward at the point of care, says Chris Weiss, co-founder and president of Dynamic Clinical Systems, a vendor of PROMs software and management services. “Electronic health record vendors need to treat PROMs like lab results or anything else that are stored in the record—rather than one-off side issues.”

Finally, clinicians should reconcile themselves to the necessarily imprecise nature of patients’ reports. “There is error in every blood test we order, every scan we perform—we deal with this every day in the clinical world,” says Darren Dewalt, M.D., M.P.H., associate professor of medicine at the University of North Carolina at Chapel

Hill and a PROMs researcher. “PROMs can still provide a structured understanding of patients’ conditions, more than just narrative histories.”

PROMIS: A National Model

Future PROM development is expected to build on the National Institutes of Health’s [Patient Reported Outcomes Measurement Information System](#) (PROMIS), a program begun in 2004 that has brought clinicians, researchers, and patients together to define and validate PROMs for care of patients with HIV, cancer, and disabilities, among many others diseases and conditions. The goal of PROMIS is to create more precise measures and to reduce the number of questions needed to make them more feasible for use in clinical practice.

The measures, which are in the public domain for use by researchers and health care organizations, were developed across several different domains of well-being, such as pain, fatigue, depression, and social or physical functioning. Each domain includes several items from which users can select the most appropriate type and number, and then roll up to create an overall score—allowing for flexibility in use for different conditions and enabling computerized-adaptive testing, in which patients are given the most appropriate questions, based on their answers to previous questions.

Dewalt is testing the PROMIS measures among four groups of pediatric patients: kids with sickle cell disease (SCD), which causes acute episodes of pain; those with nephrotic syndrome, a disease of the kidneys that causes bad swelling; those with asthma; and those with cancer who are undergoing chemotherapy. “We are trying to see how the PROMs change with variations in these conditions and their symptoms,” Dewalt says. “Are they detecting important differences, such as lessening of side effects after chemotherapy, or a change in fatigue in anxiety after a child with SCD recovers from a pain crisis? And how big a change is important, from the kids’ point of view.”

Patients have been involved in developing and validating the PROMIS measures. For example, Dinesh Khanna, M.D., M.S., associate professor of medicine at the University of Michigan, another PROMIS researcher, helped conduct focus groups and cognitive interviews with patients with gastrointestinal conditions such as

irritable bowel syndrome to see if the conceptual approach to measurement achieved face and content validity (i.e., made sense and is comprehensive). Among other things, patients’ responses helped to fine-tune a question about diarrhea (patients noted distinctions between loose stools and frequency) and the difference between how bloating looks and how it feels.

Comparative Effectiveness Research

Patient-reported outcome measures will be essential to the work of the [Patient-Centered Outcomes Research Institute](#) (PCORI), according to Sherine Gabriel, M.D., M.Sc., professor of medicine and epidemiology at the Mayo Clinic and chair of PCORI’s methodology committee. “The motivation behind creation of PCORI was to change how we do medical research by focusing much more on patient needs and what’s important to patients,” she said. PCORI will issue a report in May 2012 identifying methods of improving the measures needed for comparative effectiveness research. The report will include an assessment of current patient-reported outcome measures and supply guidance on their potential use.

The U.K.’s [National Joint Registry](#) offers one model for the use of PROMs in comparative effectiveness research. Since 2002, the joint registry has collected data on all hip, knee, and ankle replacements that take place in England and Wales. Outcomes data—including revision rates, or rates of follow-up surgeries needed to remove and replace a failed implant, as well as mortality data—are tracked for eight years after the initial surgery and published in annual public reports. The goals of the endeavor are to improve patient safety and clinical outcomes by providing information on the comparative effectiveness of different joint replacement techniques and procedures, and to inform patient decision-making. For example, the outcomes data enabled the voluntary recall of a hip replacement system by its manufacturer, and supported an investigation into revisions due to apparent soft tissue reactions in patients receiving “metal-on-metal” hip replacements.

Next Steps

Some experts suggest that rolling up patient-reported outcomes data—at the organizational, regional, or even national levels and among different patient populations—is the most promising way to make use of PROMs to improve health care quality. Within practices, PROMs data

may enable clinicians to identify strengths and weaknesses in the care provided, and to benchmark their outcomes against those of peer organizations (e.g., how successful have they been at getting asthma under control, or encouraging diabetes patients to change their lifestyle).

Accountable care organizations may be well positioned to use PROMs in this way, says Sarah Scholle, Dr.P.H., assistant vice president at the National Committee for Quality Assurance. “ACOs are close enough to the patient to have an effect on their care, but big enough to have good sample sizes,” she says. “And with ACOs you can look at responsibility for the overall care—for

example for joint replacement not just the surgery but the follow-up care, therapy, the whole spectrum of services—that affects patient outcomes.”

Interest in patient-reported outcomes goes hand in hand with the Triple Aim’s focus on improving not just the quality of care, but the health of patients and communities (while reducing costs). And PROMs’ focus on functional outcomes resonates with patients, says Mary Barton, M.D., M.P.P., NCQA’s vice president for performance measurement: “These are things that matter to patients; do I feel better? Can my mom go up the stairs after hip surgery?”

Q&A: Developing Patient-Reported Outcomes Measures

In the U.S., efforts to measure and increase the value of health care services are focusing attention on patient-reported outcomes measures, which are used to assess the effectiveness of care from the patients’ perspective. Eugene Nelson, D.Sc., M.P.H., director of the Population Health Measurement Program at the Dartmouth Institute for Health Policy and Clinical Practice, has been involved in ways to try to measurably improve and innovate in health care since the 1970s. Quality Matters asked Nelson about the benefits of patient-reported outcomes measures and what it will take to promote their widespread use in the U.S.

QM: Who are leaders in using patient-reported outcomes measures and what can we learn from them?

Nelson: Sweden has been the beachhead for the use of patient-reported measures. One of the more advanced examples is their rheumatoid arthritis registry, which has been collecting among other things patient-reported data on joint pain, current health status, and quality of life. This information is fed back to patients and forwarded to providers, as well as population health researchers. The version for clinicians includes information on treatments, medications, and adverse events—all of which can be used for benchmarking. It also allows clinicians to stratify outcomes by age and gender. The data are aggregated at the national level, which allows researchers to identify interactions of drugs and treatment effectiveness.

It’s a model that has captivated some Swedish health policy makers and business thinkers there as a way of getting to the heart of the matter: how quickly can a person get back to full function or how much can they have their functioning improve based on their treatment. They view it as a means of determining the value of health care and as a strategic asset for economy.

QM: How are these measures used in the U.S.?

Nelson: You tend to see them tested in places that are more progressive and see the clinical need. They often have a business model that is less dependent on fee-for-service care and more dependent on capitated payments. That creates an environment in which these innovations can take hold. They have been used at the Dartmouth Spine Center, using a model developed by Dr. Jim Weinstein, that demonstrated the value of patient reported measures more than a decade ago. The spine center’s measures were a model for the Swedish work and have been used to determine whether surgical or medical interventions are best for certain spine conditions (link to In Focus article). There’s also a lot of support for them from the federal government. The National Institutes of Health (NIH) has been a leader in this because of its investment in the patient-reported outcomes measurement information system (PROMIS), which funds about 15 different academic centers and leading psychometricians developing open source and open access, public domain measures of health status for adults and children. NIH got into this because they had the sense, and they were right, that there is a science

of patient-reported measurements that can be used and improved just as there is science of imaging that can be used and improved.

QM: What do you see as their greatest benefit?

Nelson: First and foremost, they can be used to make a plan of care that matches the patient's health needs and then can track the impact of the care plan on the patient's outcomes. They can be used for public reporting and performance improvement based on comparative benchmarking and they can be used for comparative effectiveness research, and they can also be used by drug companies and health care innovation technologists for post-marketing surveillance to determine how a drug or treatment that has been tested has been doing in the real world.

QM: Do you think they will ever become mainstream measures here?

Nelson: Yes. There is an underlying belief at the Office of the National Coordinator of Health Information Technology, and increasingly at the National Quality Forum and the Centers for Medicare and Medicaid Services, that this data can be used for practice-based or clinical program improvement, comparative benchmarking, and public reporting. I hope to see them incorporated into meaningful use measures. Patient-reported measures are also an important part of performance measurement for accountable care organizations (ACOs). One of the hallmarks of an ACO is being accountable for the value of care that you produce. And value can be described or defined as health outcomes plus patient experience in relationship to costs over time. One major

part of value is the changes in health status or health outcomes requiring, in part, patient-reported measures of health status. There is also interest from employers and those in the community health movement. Both are interested in improving population health.

QM: What might spur their adoption?

Nelson: Getting measures that are relevant and meaningful to patients and clinicians. This is going to be really important to gain traction. There's also a need to have supporting technology that makes it easy to integrate the collection, analysis and display [of data] into the clinicians' workflow and the supporting technology that brings this all forward in real time at the point-of-care or in virtual forms of care.

QM: How long do you think it will be before their collection becomes common practice?

Nelson: In a sense the first battle in advancing patient-reported measures has been won and it is called CAHPS (Consumer Assessment of Healthcare Providers and Systems). CAHPS has become an imperfect but well-established way of measuring the quality of care with respect to the patient's experience of care and those are patient-reported data/measures so, in a sense, there has been a lot of headway in accepting the value and importance in that regard. In terms of patient-reported measures of health status, my sense is that in three to five years that these will be much better established. For me it's difficult to imagine a patient-centered health system without having the voice of the patient prominently engaged and often times measured. It starts there.

News Briefs

HRET to Help Hospitals Reach Safety Goals

The Health Research and Educational Trust (HRET), an affiliate of the American Hospital Association, [announced](#) this month that it won a contract from the Centers for Medicare and Medicaid Services (CMS) to support the national [Partnership for Patients campaign](#), which aims to reduce patient harm and readmissions. HRET will use webinars and other training resources to help hospitals implement best practices. Thus far, nearly 2,000 hospitals have been recruited for the campaign.

Don Berwick Ends Tenure at CMS

Don Berwick, M.D., stepped down as CMS administrator this month. In an interview with [Kaiser Health News](#), Berwick called U.S. health care broken. “We have set up a delivery system that is fragmented, unsafe, not patient-centered, full of waste and unreliable,” he said.

“Despite the best efforts of the workforce, we built it wrong. It isn’t built for modern times.” Efforts to reform payment and delivery models under the Affordable Care Act should help, he said, but perhaps not quickly enough to stave off those calling for more wholesale changes to the Medicare and Medicaid programs.

Medicare to Free Up Claims Database for Physician Ratings

Early this month, the federal government [announced](#) that it will—for the first time—give employers, insurance companies, and consumer groups access to Medicare’s extensive claims database to produce ratings on individual physicians. The billing records will enable analysis of information such as how often physicians perform particular procedures and how often their patients experience preventable complications. There are some limits on the use of the data, most notably that individual providers have the right to review their information before it is publicly released, and 60 days to challenge it.

Publications of Note

Mortality Rates Linked to Inability to Effectively Rescue Patients from Complications

A study that sought to determine whether increased mortality rates at low-volume hospitals were due to higher complication rates or less success in rescuing patients from complications found that differences in mortality between high- and low-volume hospitals are not associated with large differences in complication rates. Instead, these differences seem to be associated with the ability of a hospital to effectively rescue patients from complications. The authors of the study—which focused on patients undergoing three high-risk cancer operations: gastrectomy, pancreatectomy, and esophagectomy—concluded that strategies focusing on the timely recognition and management of complications once they occur may be essential to improving outcomes at low-volume hospitals. A. A. Ghaferi, J. D. Birkmeyer, and J. B. Dimick, “[Hospital Volume and Failure to Rescue with High-Risk Surgery](#),” *Medical Care*, Dec. 2011 49(12):1076–81.

Leapfrog Safe Practices Survey Not Linked to Major Surgery Mortality Rates

A study that sought to determine whether hospital compliance with the National Quality Forum Patient Safety Practices was associated with improved outcomes did not find evidence that patients undergoing major surgery at hospitals with higher scores had lower mortality rates. It also found the use of computerized physician order entry and intensive care units’ physician staffing levels were not associated with hospital mortality. The study concluded that the scores, which are reported in the Leapfrog Safe Practices Survey, may have limited power to distinguish between high-quality and low-quality hospitals. F. Qian, S. J. Lustik, C. A. Diachun et al., “[Association Between Leapfrog Safe Practice Score and Hospital Mortality in Major Surgery](#),” *Medical Care*, Dec. 2011 49(12):1082–88.

Capitation Arrangements Lower Costs, Intensity of Care

A study that examined the relationship between primary care physicians’ (PCPs) payment arrangements and the total costs and intensity of care for specific episodes of care for Medicare beneficiaries found that physicians in

highly capitated practices had the lowest total costs and intensity of care, suggesting that these physicians develop an overall approach to care that also applies to their fee-for-service patients. B. E. Landon, J. D. Reschovsky, A. J. O'Malley et al., "The Relationship Between Physician Compensation Strategies and Intensity of Care Delivered to Medicare Beneficiaries," *Health Services Research* Dec. 2011 46(6):1863–82.

Fewer Coordination Failures, Medical Errors in Countries That Rely on Medical Homes for Adults with Complex Care Needs

In 10 countries surveyed, patients who have a medical home reported better coordination of care, fewer medical errors, and greater satisfaction with care than those without one. Sicker adults in the U.S. stood out for having cost and access problems. More than one of four (27%) were unable to pay or encountered serious problems paying medical bills in the past year, compared with between 1 percent and 14 percent of adults in the other countries. In the U.S., 42 percent reported not visiting a doctor, not filling a prescription, or not getting recommended care. This is twice the rate for every other country but Australia, New Zealand, and Germany. C. Schoen, R. Osborn, D. Squires et al., "New 2011 Survey of Patients with Complex Care Needs in Eleven Countries Finds That Care Is Often Poorly Coordinated," *Health Affairs*, published online Nov. 9, 2011.

Safety Attitudes Questionnaire Action Plan Lowers Hospital-Acquired Infection Rates

A study designed to evaluate whether an action plan based on the results of a safety attitudes questionnaire (SAQ) would influence rates of central line-associated bloodstream infection (CLABSIs) and ventilator-associated pneumonia (VAP) in intensive care units (ICUs) found that the ICUs that used such plans reduced CLABSI rates by 10.2 percent in 2008 compared with 2007, while those without action plans had a 2.2 percent decrease in rates. Similarly, VAP rates decreased by 15.2 percent in units with plans, while VAP rates increased by 4.8 percent in units without them. The study also examined whether the action plans influenced results on the 2008 Safety Attitudes Questionnaire (SAQ) found that units that developed these plans demonstrated higher improvement rates in all domains of the SAQ except working conditions. M. C. Vigorito, L. McNicoll, L. Adams et al., "Improving Safety Culture Results in Rhode

Island ICUs: Lessons Learned from the Development of Action-Oriented Plans," *Joint Commission Journal on Quality and Patient Safety*, Nov. 2011 37(11):5091AP.

Low-Quality, High-Cost Hospitals Have Higher Shares of Minority and Poor Patients

A study that sought to assess the potential impact on minority and poor patients of programs designed to improve quality and costs of health care found that the nation's worst hospitals (those where quality is low and costs high) are typically small, public or for-profit institutions in the South that care for double the proportion (15% versus 7%) of elderly black patients as the best hospitals, which provide high-quality, low-cost care. Elderly Hispanic and Medicaid patients accounted for 1 percent and 15 percent, respectively, of the patient population at the best hospitals, while at the worst hospitals, these groups represented 4 percent and 23 percent of the patients. Patients with acute myocardial infarction at the worst hospitals had 7 percent to 10 percent higher odds of death compared with patients with those conditions admitted to the best hospitals. The study notes that under Medicare's forthcoming value-based purchasing program, the worst institutions will have to improve on both costs and quality to avoid incurring financial penalties and exacerbating disparities in care. A. K. Jha, E. J. Orav, and A. M. Epstein, "Low-Quality, High-Cost Hospitals, Mainly in South, Care for Sharply Higher Shares of Elderly Black, Hispanic, and Medicaid Patients," *Health Affairs*, October 2011 30(10):1904–11.

Health Reform's Risks of Exacerbating Racial and Ethnic Disparities Outlined

The authors of this commentary highlighted the challenges of ensuring that quality improvement efforts tied to the Affordable Care Act reduce racial and ethnic disparities. These include making certain that quality improvement efforts measure disparities and improvements in them; that such efforts not create perverse incentives for providers to avoid serving minority patients; that they be applied to institutions where minority patients are most likely to receive care; and that they fully engage minority patients despite language or other barriers. To assist in these efforts, the authors recommend the development of disparities impact assessments to measure the effect that the Affordable Care Act's quality provisions will have on reducing disparities. R. M. Weinick and R. Hasnain-Wynia, "Quality Improvement Efforts

Under Health Reform: How to Ensure That They Help Reduce Disparities—Not Increase Them,” *Health Affairs*, October 2011 30(10):1837–43.

Higher Levels of Nurse Staffing Decrease Readmission Odds

A study designed to determine the impact of unit-level nurse staffing on quality of discharge teaching, patient perception of discharge readiness, postdischarge readmission and emergency department (ED) visits, and cost-benefit of adjustments to unit nurse staffing found that higher registered nurse (RN) non-overtime staffing decreased odds of readmission. It also found higher RN overtime staffing increased the odds of ED visits and RN non-overtime staffing reduced ED visits indirectly, via a sequential path through discharge teaching quality and discharge readiness. The study suggests that postdischarge utilization costs could potentially be reduced by investment in nursing care hours to better prepare patients before hospital discharge. M. E. Weiss, O. Yakusheva, and K. L. Bobay, “Quality and Cost Analysis of Nurse Staffing, Discharge Preparation, and Postdischarge Utilization,” *Health Services Research*, Oct. 2011 46(5):1473–94.

Broader Search for Causes of Readmission Urged

In this commentary, the authors note that while efforts to reduce hospital readmissions have focused on improving the discharge process for medically high-risk patients, this strategy may yield disappointing results because it misses important factors that contribute to readmission, including access to health services and socioeconomic resources such as income and social support. They add that patient-level determinants of readmission also include health status and access to stable housing and food. As a result, the authors recommend using a broader framework to identify alternative strategies to reducing admissions. S. Kangovi and D. Grande, “Hospital Readmissions—Not Just a Measure of Quality” *Journal of the American Medical Association*, October 2011 306(16):1796–97.

Readmission Risk Prediction Models Lacking

A study that sought to summarize readmission risk prediction models, describe their performance, and assess

suitability for clinical or administrative use found current readmission risk prediction models that were designed for either comparative or clinical purposes perform poorly. The authors note that while in certain settings such models may prove useful, efforts to improve their performance are needed as use becomes more widespread. D. Kansagara, H. Englander, A. Salanitro et al., “Risk Prediction Models for Hospital Readmission: A Systematic Review,” *Journal of the American Medical Association*, October 2011 306(15):1688–98.

Consumers Seeking Quality Information Online Often Find Patient Narratives Rather Than Objective Data

A study that investigated how easy or difficult it is for consumers to locate objective, validated health care information online found that Web sites most likely to be found by consumers are owned by private companies and provide information based on anecdotal patient experiences. Web sites less likely to be found have government or community-based ownership, are based on administrative data, and contain a mixture of quality, cost, and patient experience information. Searches for information on hospitals reveal more cost and quality information based on administrative data, whereas searches that focus on clinics or physicians are more likely to produce information based on patient narratives. B. Sick and J. M. Abraham, “Seek and Ye Shall Find: Consumer Search for Objective Health Care Cost and Quality Information,” *American Journal of Medical Quality*, Sept. 2011 (e-pub).

Recommendations to Reduce Unnecessary Hospitalizations from Nursing Homes

The authors of this commentary suggest that multifaceted strategies are needed to reduce unnecessary hospitalizations of nursing home patients. These should include programs to address current incentives for hospitalization. The authors note that interventions designed to reduce preventable hospitalizations should be directed at facilities that have the infrastructure, leadership commitment, and culture of quality and safety necessary to undertake more acute care. J. G. Ouslander and R. A. Berenson, “Reducing Unnecessary Hospitalizations of Nursing Home Residents,” *New England Journal of Medicine*, September 2011 365(13):1165–67.

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Special thanks to Editorial Advisory Board member Christopher Queram for his help with this issue.

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