The Advisory Board Company

The Daily Briefing
News for Health Care Executives

15 BEST PRACTICES TO INSTILL FRONTLINE ACCOUNTABILITY

September 29, 2011

Jennifer Stewart, Nursing Executive Center

The Nursing Executive Center is pleased to announce the release of our latest publication, *Instilling Frontline Accountability*, which features 15 best practices for enhancing individual investment in organizational goals.

What is 'frontline accountability' and why does it matter?

We believe frontline caregivers become accountable when they buy-into key organizational goals. Therefore, we define "frontline accountability" as an individual's responsibility for, and investment in, not only the care delivered to their patients but also their organization's strategic objectives. This buy-in is important because it is the "special sauce" that enables a nursing organization to consistently perform at a high level.

For example, frontline accountability is the difference between a staff member discovering process efficiencies and merely integrating them into their own work versus taking the next step to proactively share the information with others and improving overall hospital performance.

Frontline accountability has never been more foundational to success

Changing reimbursement models and movement toward greater industry transparency have placed substantial pressure on hospitals to deliver stronger performance and better value than ever before. Hospital leaders must not only improve current cost and quality performance but do so quickly to meet increasingly higher standards.

As nurse leaders know, frontline nurses are vital to the success of any organizational goal. Recognizing the importance of frontline investment to the achievement of critical priorities, hospital leaders often seek to secure staff buy-in for individual initiatives through one-off campaigns. However, with the growing number of mission-critical priorities, organizations lack the time and resources to continue this approach. Instead, institutions must seek to instill frontline accountability, so that frontline staff are consistently committed to providing excellent care to their patients and also feel individually accountable for larger institutional performance.

Strategies to instill frontline accountability

The Center recommends a three-part framework to instill frontline accountability:

- Enhance frontline staff members' line-of-sight between their discrete, day-to-day actions and the institution's overall performance against key goals
- Create a culture of shared responsibility in which nurses feel individual responsibility for not only their own patients but all outcomes and goals
- Provide frontline staff with a personal stake in organizational performance

Read the study to learn more

Instilling Frontline Accountability provides 15 best practices for successfully executing the Center's three-part accountability strategy. These practices will help nursing leaders enhance individual frontline staff investment in organizational goals and elevate institutional performance.

Additional resources

SHOULD PHYSICIANS HAVE COACHES?

ATUL GAWANDE ASKS—AND TRIES TO ANSWER—THE QUESTION

September 30, 2011

Dan Diamond, Managing Editor

Atul Gawande—surgeon at **Brigham and Women's Hospital**, best-selling author, and apparently a one-time tennis prodigy—doesn't seem like the type who needs a coach. But writing in the Oct. 3 issue of *The New Yorker*, Gawande relays how the quest to achieve his "personal best" as a surgeon ultimately raised the question: Why don't we have coaches for physicians?

Coaches in many professions

In his piece, Gawande connects a pair of unrelated developments: the inability to cut his surgical complications rate and the decline of his tennis game.

Focusing first on his surgical career, Gawande discusses how he has performed more than 2,000 operations since becoming a surgeon eight years ago. Mastering the craft has involved a simultaneous mix of building knowledge of risks and confidence in his abilities, he writes.

But Gawande's growing skill eventually produced a surprising result. Based solely on complications rate, his operating room performance seemingly "reached a plateau."

"As I went along, I compared my results against national data, and I began beating the averages," Gawande writes. He adds that "my rates of complications moved steadily lower and lower. And then, a couple of years ago, they didn't."

At about the same time, Gawande found himself with a spare afternoon at a tennis club and signed up for a lesson simply to get in a workout. Although Gawande was years past his peak as a high school tennis star, the club pro's basic tips soon had him "serving harder than I ever had in my life."

Curious about the power of coaches, Gawande investigated the presence—and effectiveness—of personal instruction across a diverse set of performers, like elite musicians and top-performing teachers. Intrigued by the results, Gawande made an unusual professional decision: "I decided to try a coach."

Finding his Yoda

For Gawande's surgical coach, he sought out Robert Osteen, a retired general surgeon who had been a favorite of Brigham and Women's residents. Osteen's teaching style, according to Gawande, was less didactic and more observational; his reticence allowed residents to make choices and learn as they went.

In his new role as coach, Osteen first observes a surgery that Gawande believed "went beautifully"—an efficient, 86-minute thyroidectomy. Yet Osteen had a long list of post-surgery critiques for Gawande: Pay more attention to how you drape the patient, because Gawande's choices trapped the surgical assistant in place; avoid reliance on magnifying loupes, which restrict peripheral vision; and so on.

"That one twenty-minute discussion gave me more to consider and work on than I'd had in the past five years," Gawande writes.

That initial experience also raised broader questions about how coaches might be perceived in medicine.

First, it had been awkward for Gawande to explain to others why, as a tenured surgeon, he had invited a coach along for the morning.

Yet "the stranger thing" that occurred to Gawande, "was that no senior colleague had come to observe me" since he'd established his professional practice. Physicians, he concludes, are left with little day-to-day scrutiny—and a set of outside eyes and ears can only help the push toward quality improvement.

Is this a model for others?

Gawande's thought-provoking piece has generated considerable comment, both inside and out of health care this week. Having stuck with Osteen for months, Gawande reports that his complications rate is falling once more and "I know that I'm learning again."

But not all think that Gawande's article heralds a viable model.

The blogger known as Skeptical Scalpel—a longtime surgeon and former surgical department chair who writes under a pseudonym—told the *Briefing* that he's, well, skeptical about the ideas that Gawande raises.

"I would accept a coach but doubt I could find one," according to Skeptical Scalpel, particularly a coach as talented, experienced, and available as Osteen. He adds that surgeons often are challenged by issues outside of the operating room, such as in areas like diagnosis, communication, and bedside manner. Skeptical Scalpel also wonders whether the coach would be liable if the patient experienced complications and elected to sue.

Medicine's cultural barriers may present the most significant barrier. As Gawande acknowledges, many surgeons are happy to prescribe a coach for others—but few would acknowledge the benefits of finding a coach of their own. Skeptical Scalpel told the *Briefing* that a successful surgeon needs a healthy ego; "most of us feel we are the best surgeon we know. If you didn't feel that way, you probably can't do some of the things we do."

ANALYSTS: HOSPITAL MASS LAYOFFS ON THE RISE

SEVERAL HOSPITALS HAVE ANNOUNCED DRASTIC STAFFING REDUCTIONS

September 30, 2011

The sluggish economy and looming provider payment cuts have driven more hospitals to consider reducing staff as a way to stabilize their bottom lines.

According to recent **Bureau of Labor Statistics** (BLS) data, there were 13 hospital mass layoffs—defined as involving 50 or more employees—in August, resulting in 1,085 initial unemployment benefit claims. If the layoff pace continues, BLS analysts say hospitals in 2011 will post 127 mass layoffs involving 8,257 people, which would give 2011 the third-highest number of mass layoff incidents in the last decade.

Systems nationwide announce staff reductions

This week, several major hospitals and health systems announced mass layoffs, highlighting the continuing trend.

For example, Virginia-based **Inova Health System** on Thursday announced plans to cut 606 employees as it moves to outsource environmental services, laundry, and referral management and scheduling. Meanwhile, **MetroHealth System** in Cleveland this week announced plans to reduce its workforce by 450 employees over the next two months in an effort to handle $30 million in budget cuts and stem 2011 losses.

Meanwhile, **Western Connecticut Health Network** (WCHN) on Thursday announced plans to lay off 60 workers, which accounts for about 1% of the network's workforce. According to Phyllis Zappala, WCHN's senior vice president of human resources, the system "was forced to make this difficult decision due to the sluggish economy and as a result of state and federal cuts to hospital reimbursements."

Analysts offer 'gloomy' predictions for industry

As major state and federal budget cuts loom, financial analysts and industry advocates continue to predict financial difficulties for the industry.

A recent **Moody's Investor Service** report outlined dismal fiscal prospects for not-for-profit hospitals, noting that median operating revenue dropped to a decade low of 4% in fiscal year 2010.

Meanwhile, the **American Hospital Association** (AHA) earlier this month said hospitals would lose $41 billion from 2013 to 2021 if Medicare payments are cut by 2%. According to AHA, the 2% cut would cost 92,866 jobs in 2013 and 194,522 jobs by 2021 (Stagg Elliott, *American Medical News*, 9/29; Fischer, *Washington Business Journal*, 9/29; Tribble, Cleveland *Plain Dealer*, 9/27; Miller, *Danbury News Times*, 9/29).

ARE TOO MANY NURSING HOME PATIENTS HOSPITALIZED?

STUDY IDS 'DUBIOUS' TRANSITIONS FOR SOME PATIENTS

September 30, 2011

About one in five Medicare beneficiaries who are in nursing homes for dementia are hospitalized for questionable reasons during their final months, according to a study in *NEJM*.

For the study, **Brown University**, **Harvard University**, and **Dartmouth Medical School** researchers analyzed Medicare records for nearly 475,000 nursing home patients from 2000 to 2007 to identify "burdensome" transfer rates. A transfer was considered burdensome if a patient was moved in the last three days of life, moved multiple times in the last three months of life, or moved to a new nursing home after hospital admission.

The findings showed that overall 19% of nursing home patients with advanced cognitive impairment were moved for "dubious" reasons. Patient moved for questionable reasons were more likely to need a feeding tube, spend time in the ICU in the last month of life, develop severe bedsores, or be enrolled in hospice for three days or less before death.

Meanwhile, the study found that many participants were hospitalized for conditions, including dehydration, pneumonia, or urinary infections. However, the researchers note that such transitions "are often avoidable because common complications ... can be treated with equal efficacy in the nursing home."

The results also showed a large variation in burdensome transfer rates between states. For example, transfer rates in were 2% in Alaska and more than 37% in Louisiana. Although the study uncovered no definitive evidence that money played a role, the researchers said the variation in rates suggested that financial incentives may be a contributor.

According to *AP/Google News*, Medicaid pays $175 daily on average for long-term care, but up to three times that amount for skilled nursing care after a patient returns from a more than three-day hospital stay (Barr, *Modern Healthcare*, 9/28 [subscription required]; Phend, *MedPage Today*, 9/28; Marchione, *AP/Google News*, 9/29).

CHILDHOOD'S END? CHILDREN'S HOSPITALS FACE STARK CHANGES

MEDICAID CUTS, SHIFTING CARE LANDSCAPE PRESENT NEW INDUSTRY CHALLENGES

September 30, 2011

No longer insulated from the health industry's rising cost pressures, children's hospitals are revamping operations and seeking new revenue in the face of major financial and political shifts, *Kaiser Health News* reports.

State budget cuts loom over Medicaid

Many cash-strapped states are scaling back their contributions to Medicaid—which accounts for at least half of children's hospital revenues—and shifting some beneficiaries into more restrictive managed care plans.

According to advocacy groups, even small reductions in Medicaid funding have a significant impact on children's

hospitals' bottom line. For example, three straight years of Medicaid cuts in Arizona have left **Phoenix Children's Hospital** executives struggling to manage a $52 million budget shortfall.

Meanwhile, cuts to physician training programs have left some advocates concerned that there will be too few pediatricians and specialists to provide pediatric care, pointing to children's hospitals in Texas that have had trouble filling openings. *KHN* also notes that demographic shifts have led to fewer children in states like California and Ohio, even as hospitals ramp up their infrastructure to serve them.

Slower demand curve, reform implemention leads to shifting approach

Industry leaders note that overall demand is expected to grow, but at lower rates than in previous years and with tightening margin pressure. The sector also is facing changes with the implementation of the federal health reform law, which is expected to reshape care delivery and greater emphasize primary care.

Many children's hospitals are already shifting care to less expensive outpatient care settings and Larry McAndrews, former head of the **National Association of Children's Hospitals and Related Institutions**, says that children's hospitals are focusing on finding "innovative ways of delivering care by working with their physicians."

Seeking patients from across borders

Surveying the broader market, **Children's Hospital Colorado** CEO James Shmerling says that the pediatric service closures at small community hospitals will continue to drive new volumes to children's hospitals, and the largest children's hospitals will increasingly become "super providers" regionally and nationally.

At the same time, hospitals are seeking new ways to expand their reach and find new patients. For example, **Cincinnati Children's Hospital Medical Center** is marketing its services in other states, including Kentucky and Indiana. According to CFO Scott Hamlin, admissions of children who live outside the primary referral area account for almost 50% of inpatient revenue.

Meanwhile, **Children's Hospital of Philadelphia** has expanded efforts to reach patients in the Middle and Asia, where citizens often benefit from robust health insurance. Over an 18-month period, the hospital grew its international program revenue from $6 million to $30 million—and CEO Steven Altschuler forecasts that the program may produce as much as $150 million within several years. "These days you can't do too much," says Altschuler, adding, "Even if you are as big and sophisticated as Children's Hospital of Philadelphia, you need to be looking for an edge" (Gaul, *KHN*, 9/27).

GOP PLAN SEEKS TO BLOCK HEALTH REFORM FUNDING

PROPOSAL WOULD DELAY OVERHAUL SPENDING UNTIL LEGAL CHALLENGES ARE RESOLVED

September 30, 2011

The House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies on Thursday released a $153.4 billion draft budget for fiscal year 2012 that prohibits funding for the federal health reform law until all legal challenges are settled.

The budget would prohibit **HHS** from continuing implementation of the law until 90 days after the date when all legal challenges have concluded. The draft bill would make various cuts to health care spending, including:

- Blocking funding from reaching the **Center for Consumer Information and Insurance Oversight**, an HHS division that oversees much of the overhaul's implementation;
- Rescinding $15 million for the **Independent Payment Advisory Board**, which is charged with reducing Medicare spending;
- Reducing **CDC** spending by $52 million;
- Cutting $1 billion from the reform law's Prevention and Public Health Fund;
- Preventing funding from going to **Planned Parenthood** unless the organization attests that it will not perform abortions or provide funding to other abortion providers;

- Cutting all funding for Title X, which pays for medical services such as contraception and cancer screenings for low-income women;
- Barring the use of any funding available through the reform law or the spending bill for health plans that cover abortions; and
- Banning funding for needle-exchange programs.

The draft bill ultimately would rescind $8.6 billion in appropriations authorized under the reform law.

Reaction to draft bill

Republicans on the subcommittee said they are attempting to rein in some of the "regulatory overreach" by the Obama administration, including the health reform law. House Appropriations Committee Chair Harold Rogers (R-Ky.) said, "Excessive and wasteful spending over the years has put many of the programs and agencies funded in this bill on an irresponsible and unsustainable fiscal path."

Rep. Rosa DeLauro (D-Conn.), ranking Democrat on the subcommittee, criticized the measure, saying its "main effect would probably be to prohibit Medicaid patients from choosing to receive services such as contraception and cancer screenings from Planned Parenthood clinics."

She noted that the draft bill "contains at least 40 brand new legislative provisions and riders, many of them highly controversial and most dealing with complicated subjects well outside the expertise of the Appropriations Committees."

Markup unlikely

According to *The Hill*'s "Healthwatch," the bill likely will not go markup in its current form because its spending levels are higher than those endorsed by two Republicans on the committee. Reps. Jeff Flake (R-Ariz.) and Cynthia Lummis (R-Wyo.) have opposed appropriations bills higher than $139 billion, the amount of the House-approved GOP fiscal year 2012 budget resolution (H Con Res 34) (Wolfgang, *Washington Times*, 9/29; Ethridge, *CQ Today*, 9/29 [subscription required]; Rogers, *Politico*, 9/29; Baker, "Healthwatch," *The Hill*, 9/29).

EDITOR'S PICKS
OUR READS FOR THE WEEKEND

September 30, 2011

The *Daily Briefing* editorial team highlights several studies and articles that got us talking this week.

Where do terrible singers go wrong? Study explains why many people can't sing. More.

What the United States could learn from Britain's health IT debacle, according to the *New York Times*. More.

Will specialists lose their jobs to highly precise robots? *Slate* explores the possibility. More.

Finding the humor in cancer? How Seth Rogan turned his friend's cancer into a film. More.

Therapy on the go: Video chatting allows patients to "see" their therapists online. More.

California Healthline explains why data took "center stage" at this week's Health 2.0 conference in San Francisco. More.

More hospitals are dedicating staff to palliative care in the ED. The *Philadelphia Inquirer* explains why. More.

How states and health systems are attracting primary care physicians to rural areas. More.

THE ART OF MAKING AN EFFECTIVE APOLOGY

WASHINGTON POST EXAMINES THE SCIENCE BEHIND SAYING SORRY

September 30, 2011

Getting someone to accept your apology may rely more on perception rather than your sincerity when saying sorry, the *Washington Post* reported this week.

Examing the art of crafting a well-received "sorry," the *Post* spoke with Peter Kim—an associate professor at the **Marshall School of Business at the University of Southern California** (USC)—who terms apologies a "double-edged sword": they show an effort to repair a problem, but also confirm that blame is deserved.

Although many individuals believe that direct, explicit, and sincere apologies generally are well received, USC research indicates that people weigh various factors when considering forgiveness.

For example, an apology's effectiveness may depend on whether the offense is believed to be intentional, Kim writes. People are more likely to forgive an unintentional action because they tend to believe that the person will correct the cause of the problem.

According to Kim, the distinction between an act being intentional or a mistake "is important because many offenses can be construed either way, and would-be apologizers often fail to account for people's perception before they respond" (Kim, "On Leadership," *Post*, 9/28).

DAILY ROUNDUP: SEPT. 30, 2011

BITE-SIZED HOSPITAL AND HEALTH INDUSTRY NEWS

September 30, 2011

- **Arizona and Minnesota**: Rochester-based **Mayo Clinic** this week announced plans to partner with **Arizona State University** to build a $266 million medical school facility in Scottsdale, *The Arizona Republic* reports. The school – which could open its doors as early as 2014 – will award students joint degrees in medicine and the science of health care delivery. Mayo CEO John Noseworthy notes that the program aims "to build physicians who understand how to design a higher value healthcare system" by teaching students to administer care more efficiently (Alltucker, *Republic*, 9/28).

- **Connecticut**: On Wednesday, 966-bed **Yale-New Haven Hospital** announced a "definitive agreement" to purchase 511-bed New Haven-based **Hospital of St. Raphael**, which analysts say could boost financial stability and streamline specialty services, the *Hartford Courant* reports. Under the agreement—which is subject to regulatory approval—St. Raphael will continue to operate according to Catholic ethical and religious directives. In addition, the deal will address St. Raphael's liabilities. According to state filings, the hospital has been operating on a deficit since fiscal year 2009 (*Courant*, 9/28).

- **New Hampshire**: The state attorney general last week filed a memorandum of law stating that federal law prohibits 10 not-for-profit hospitals from suing the **New Hampshire Department of Health and Human Services** over Medicaid cuts, the *New Hampshire Union Leader* reports. The memorandum notes that the hospital industry generated more than $1.2 billion from operations over the last five years and paid large salaries to executives. As a result, state lawyers say hospitals do not have a right under federal law to demand a certain payment level (Rayno, *Union Leader*, 9/28).

- **Pennsylvania**: Ambulatory surgery centers (ASCs) across the state continue to profit while acute care hospitals post smaller margins, the *Pittsburgh Business Times* reports. According to a report from the **Pennsylvania**

Health Care Cost Containment Council, the average ASC reported a roughly 26.3% average operating margin in fiscal year (FY) 2010, while hospitals reported a nearly 4.4% average margin. Overall, eight new ASCs opened in FY 2010 and four shut down. "With ASCs treating healthier patients and usually better insured patients, the financial and clinical demands on acute care hospitals, which are a safety net for all Pennsylvanians, continue to grow," said Carolyn Scanlan, president and CEO of the **Hospital & Healthsystem Association of Pennsylvania** (Mamula, *Pittsburgh Business Times*, 9/27).

76% OF PATIENTS LEAVING A DOCTOR'S OFFICE DON'T KNOW WHAT TO DO NEXT

September 30, 2011

Join our webconference on Oct. 25 to learn how to educate and support patients in self care management. More.

ALMOST 1,400 TROOPS SUSTAINED MILD BRAIN INJURIES THIS YEAR

Nearly 1,400 U.S. military personnel in Afghanistan and Iraq this year sustained mild brain injuries or concussions after they were exposed to a blast or traumatic event during combat, *USA Today* reports.

The data were obtained under a new military program, which requires service members to take a break from combat for 24 hours and be monitored for signs of brain injury if they are within 165 feet of a blast or serious incident. The data span from August 2010, when the monitoring and treatment program was launched, through June this year. During the 11-month period, the military pulled about 9,000 servicemembers from combat to check for signs of mild brain injury after they had been involved in events that caused no obvious wounds.

According to Army Col. Jamie Grimes, a neurologist deployed in Afghanistan and director of the **Defense and Veterans Brain Injury Center**, about 90% of the mild trauma cases went away a few days after the incidents. Grimes noted that while troops with more persistent issues were sent home, those with less-severe injuries were moved to special centers for treatment and monitored for at least a week to ensure that their injuries had healed (Zoroya, *USA Today*, 9/28).

The Advisory Board Company

The Daily Briefing
News for Health Care Executives

LEVERAGE DATA TO GUIDE STAFFING DECISIONS

September 29, 2011

In light of the increasing pressure on hospital margins, leaders are seeking to reduce costs wherever possible. Not surprisingly, the managerial ranks often receive particular scrutiny. However, lacking relevant data or industry standards, leaders may be forced to gauge the appropriate manager-to-employee ratio by instinct or institutional precedent. Such an approach can overlook areas of possible administrative excess or, conversely, cut too deeply and leave managers with an unrealistic span of control.

Approximately 90 organizations of varying hospital type and size provided full-time equivalent (FTE) and headcount span data for four managerial ranks: executive, director, manager, and supervisor. Analysis of the survey data reveals several key insights for leaders assessing spans of control in their workforce:

- **Lack of traditional pyramid structures results in span of control variability**: Pyramid structures with a wide span of control at the bottom that tapers consistently toward the top are common in many industries, including insurance, retail banking, and the military. However, hospitals and health systems rarely have such a pyramid structure. Instead, spans vary considerably among managerial levels and departments.

- **Particular scrutiny should be applied to benchmarks at the director level**: Executives generally have wider spans of control than directors. According to the survey data, executives have a median of 3.7 direct reports, while directors have a median of just 1.9 direct reports. Given their relatively narrow spans, many directors may be able to assume greater managerial responsibility.

- **Consider the effects of non-structural factors when examining span of control**: Two high-performing institutions with very similar characteristics may have quite different, but defensible, spans of control. When applying span benchmarks, leaders must consider institution- and situation-specific factors such as managerial competency, leadership style, budget, and talent availability. Certain circumstances may render an unusual span necessary (or at least temporarily necessary).

Learn more
To assist leaders in examining their workforce size and structure, the HR Investment Center members may access Benchmarking Hospital Span of Control: Data, Insights, and Application Framework.

Not a member of the HR Investment Center? *Daily Briefing* readers are invited to learn more on our website.

WHY STAFF ARE FORCED TO SHOUT IN THE ED

STUDY FINDS HOSPITAL STAFF FEEL 'HELPLESS' IN BATTLE TO CURB CLAMOR

September 29, 2011

Constant noise in the ED can create stress for staff members and compromise patient care, according to a study in *Pediatric Emergency Care*.

For the study, researchers monitored noise levels for one week at a pediatric ED nursing workstation at **SickKids Hospital** in Toronto. Throughout the week, researchers surveyed ED physicians and residents on their perception of the noise levels.

The study found that the average noise level throughout the day was about 70 decibels, which is equivalent to the sound made by running a vacuum cleaner all day with "a lawn mower and power drill making random high-intensity noise." Nearly 80% of surveyed staff members said they had to shout at least once per shift to communicate. Some even reported having to shout as much as 10 times per day.

Overall, the noise levels created a stressful atmosphere for physicians and residents, the study found. Physicians said the noise made then feel "more tired and stressed out," while residents reported feeling "irritable and helpless." Some physicians noted that the noise levels affected teaching and interactions with residents. However, staff members said they felt they could not significantly alter the noise levels—even attending physicians rarely felt empowered to ask people to be quiet.

The researchers note that "awareness and active interventions have demonstrated a reduction in hospital noise levels in the past." With this study, they hope to increase awareness "so that it will lead to identification and prevention of excessive noise levels in other health care facilities." In addition, they suggest that future research into the culture of emergency medicine may help explain why physicians do not feel empowered to modify noise levels (Ratnapalan et al., *Pediatric Emergency Care*, September 2011 [subscription required]; Blackwell, *National Post*, 9/27).

PATIENT DEATH SPARKS NURSE STRIKE CONTROVERSY

CALIF. INCIDENT FURTHER STRAINS HOSPITAL-UNION RELATIONS, RENEWS SAFETY DEBATE

September 29, 2011

A patient death during last week's California nurses strike has further strained hospital-labor union relations and renewed the discussion about patient safety during nurse walkouts.

The strike—which affected operations at 34 **Sutter Health** and **Kaiser Permanente** hospitals–involved nearly 4,000 members of the **National Union of Healthcare Workers** (NUHW) and 5,000 members of the **California Nurses Association/National Nurses United** (CNA). About 17,000 nurses and 2,000 stationary engineers at Kaiser also participated in a sympathy strike to support NUHW.

Law enforcement and state health officials currently are investigating the death of a 66-year-old female cancer patient at Oakland-based **Alta Bates Summit Medical Center**. According to news reports, the patient died after being administered "a nutrition supplement that a replacement nurse mistakenly put into a catheter meant for delivering medicine to her bloodstream."

To maintain operations during the strike, Alta Bates had hired 500 nurses who were contracted for five days. The replacement nurse is 23 years old and licensed in four states, including California, where she is listed as an active RN on the California Board of Registered Nursing website.

Incident further strains hospital-labor union relations

Following the incident, CNA alleged that the hospital failed to replace permanent nurses with experienced temporary RNs, which compromised patient care. Some nurses said the replacement staff did not receive adequate training and were overextended, working five 12-hour shifts in a row, the *Oakland Tribune/San Jose Mercury News* reports.

However, hospital spokesperson Carolyn Kemp said the facility uses "rigorous criteria" when hiring temporary nurses. She noted that the replacement nurses were experienced in the area they were assigned and received two to three rounds of orientation before being deployed.

Meanwhile, the **California Hospital Association** (CHA) contends that CNA is leveraging the patient death as bargaining rhetoric, *Modern Healthcare* reports. "It is inappropriate and irresponsible for the California Nurses Association labor union to exploit this tragedy to further their union agenda," CHA President and CEO C. Duane Dauner said. He added, "If the union believes the use of licensed replacement nurses is a threat to public safety, then why have they chosen to pursue a pattern of waging strikes on a routine basis?"

Error renews debate about patient care during strikes

In response to the incident, KQED's "News Fix" this week highlighted research that found that patient safety lags during nurse strikes.

According to a 2010 study from the **National Bureau of Economic Research**, which examined New York hospital strikes from 1984 to 2004, walkouts increased inhospital mortality by 19% and 30-day readmissions by 6.5%.

However, Joanne Spetz, a **University of California-San Francisco** health care economist, said the findings do not mean that temporary nurses do not provide high-quality care. According to her, replacement nurses are forced to work in an unfamiliar setting and may "not necessarily know where every supply is kept" or "understand how the computerized medical record system" functions.

In addition, she noted that patients in the hospital during nurse strikes tend to be the most high-risk patients. "Usually, all of the elective surgeries and all the things that can be postponed are typically delayed until after the strike," she said, which can result in "a patient population at higher risk simply because they're sicker" (Woodall, *Oakland Tribune/San Jose Mercury News*, 9/27; Woodall, *Oakland Tribune/San Jose Mercury News*, 9/28; Bouchard, *Healthcare Finance News*, 9/28; Brooks, "News Fix," KQED, 9/28; Selvam, *Modern Healthcare*, 9/26 [subscription required]).

OBAMA ASKS SUPREME COURT: DECIDE THIS CASE

BOTH SIDES HOPE FOR A QUICK RULING ON HEALTH REFORM LAW

September 29, 2011

The Obama administration on Wednesday filed a formal request to the U.S. Supreme Court to review a decision by a three-judge panel of the 11th Circuit Court of Appeals that declared the federal health reform law's individual mandate unconstitutional.

In August, the three-judge panel reviewed the multistate lawsuit against the overhaul and became the first appellate court to rule against any part of the law. However, the court upheld the remainder of the law.

The plaintiffs in the case—26 states and the **National Federation of Independent Business** (NFIB)—on Wednesday also requested that the high court review the case and said the entire law should be struck down. NFIB said the panel's ruling creates uncertainty for businesses regarding the overhaul's costs and requirements.

Both sides agreed that a quick decision is desirable. "Until this court decides the extent to which the [law] survives, the entire nation will remain mired in doubt, which imposes an enormous drag on the economy," NFIB officials said. Meanwhile, the **Department of Justice**—which filed its appeal more than month before it was due—said an early ruling would allow the federal government to "get on with the business of implementing the law."

The Supreme Court is not required to hear the case. However, disparate rulings in three separate appellate courts and the petitions from both sides of the lawsuit make it "all but certain" the court will accept the case, according to the *New York Times*. If it accepts the case, the high court could issue a ruling as early as June 2012.

Administration takes risk, confident of outcome

The administration is taking a risk by requesting the high court quickly review the case, *Politico* reports. According to *Politico*, the court could rule against the constitutionality of the law in the middle of the 2012 presidential campaign. Further, arguments in the case also could generate media coverage of the least popular provisions in the overhaul.

However, administration officials expressed confidence that the high court would rule in favor of the reform law. "We know the [health reform law] is constitutional. We are confident the Supreme Court will agree," Stephanie Cutter, a White House adviser, said.

Still, the administration also is preparing for the event that the high court strikes down only certain aspects of the overhaul. According to the *Journal*, that would allow the White House to control how the remaining provisions are

implemented (Liptak, *Times*, 9/28; Kendall/Meckler, *Journal*, 9/29; Nather, *Politico*, 9/28).

ARE GROUPONS ILLEGAL IN HEALTH CARE?

HEALTH LAW EXPERTS QUESTION WHETHER DEALS VIOLATE ANTI-KICKBACK LAWS

September 29, 2011

More providers are using websites like Groupon and Living Social to offer discounted care, but these new deals may run afoul of anti-kickback rules, medical law experts warn.

In an effort to grow their customer base, some physicians, dentists, and other health providers are offering deals through popular discount websites, where millions of shoppers take advantage of discounts of up to 90% on a variety of products, the *South Florida Sun-Sentinel* reports. Health providers typically offer discounts on elective services that are not covered by insurance.

For example, the **Florida Center for Cosmetic Surgery** in Fort Lauderdale has featured a $999 deal for laser liposuction surgery, which ordinarily costs $3,500, while **East Boca Dental** has featured deals like a $129 dental package that ordinarily costs $595 and includes an exam, X-rays, a cleaning, and whitening.

However, because the discount websites often keep as much as 50% of the payment, health lawyers say the practice may violate federal and state laws that prohibit kickbacks and splitting fees. Michael Segal, a health care attorney in South Florida, urges physicians to use caution when considering deals, noting that "[y]ou don't want to find out there's a concern after you have done it."

To date, no state has disciplined a provider for offering an online discount. Most medical boards and associations, including the **American Medical Association**, have yet to take a position on the legality of the medical service discounts.

However, Amy Wandel, who has investigated online discounts for the **American Society of Plastic Surgeons**, predicts that some state boards eventually will make a decision on the issue. In Oregon, two medical boards already have banned dentist and chiropractors from offering Groupon-style discounts where the site receives part of the fees. In response, Oregon regulators claim that discount website Living Social changed its billing practice for medical business so that providers pay only an upfront fee, as they would with regular advertising.

Online discounts also may create concerns for patients. Specifically, Wandel notes that some patients have had trouble obtaining refunds for services they were unable to receive because of health issues or complications. In addition, one medical spa owner in Cooper City, Fla., says the discounts may encourage patients to choose price over quality (LaMendola, *Sun Sentinel*, 9/25).

CMS ISSUES MEANINGFUL USE DEADLINE REMINDERS

SOONEST HOSPITAL DEADLINE IS SEPT. 30

September 29, 2011

CMS is reminding health care providers about upcoming deadlines for attesting to meaningful use of electronic health records (EHRs), *AHA News* reports.

The upcoming deadlines are:

- Sept. 30, the last day that hospitals can include in their 90-day reporting period for attesting to meaningful use;
- Oct. 3, the last day that eligible health care professionals can begin their 90-day reporting period to demonstrate meaningful use in calendar year 2011; and

- Nov. 30, the last day for hospitals to register and attest to receive meaningful use incentive payments for fiscal year 2011.

CMS also noted that eligible health care professionals must register and attest by Feb. 29, 2012, to receive meaningful use incentive payments for calendar year 2011.

CMS plans appeals process for meaningful use program

CMS has granted a $2.25 million contract to **Provider Resources** to develop an administrative appeals process for the Medicare EHR incentive program, *Government Health IT* reports.

In August, CMS announced plans to establish policies and procedures for the appeals process. Under the contract, Provider Resources will evaluate and promote the IT infrastructure for the appeals process and work with CMS to conduct outreach on the system (*AHA News*, 9/26; *CMIO*, 9/28; Mosquera, *Government Health IT*, 9/27).

PATIENTS SKIPPING CARE TO MAKE ENDS MEET

CONSUMER REPORTS: U.S. RESIDENTS TAKING RISKS TO SAVE ON MEDICATIONS

September 29, 2011

Despite a greater availability of low-cost generic drugs, nearly half of U.S. residents say they resort to potentially dangerous measures to reduce spending on prescriptions, according to *Consumer Reports*' third annual drug survey.

The survey questioned 2,038 U.S. residents about their prescription drug habits. According to the survey, the number of respondents who reported taking potentially dangerous cost-saving measures increased by 9% from 2010 to 2011.

In addition, the survey found that one-third of respondents failed to take their prescriptions as directed, including:

- 16% who skipped filling prescriptions, including 30% of respondents with monthly drug bills exceeding $50;
- 13% who took an expired medication;
- 12% who skipped a dose without checking with a physician or pharmacist;
- 8% who cut pills in half; and
- 4% who shared a prescription.

The survey also found that consumers are paying less for prescription drugs, likely because of increased use of generics. The average monthly out-of-pocket spending for individuals who regularly take prescription drugs is $59, down from $68 in 2009.

Meanwhile, 39% of respondents had mistaken beliefs about generic drugs. Of that group, 21% doubted their efficacy, 22% believed they have different side effects, and 14% questioned their safety. According to the survey, physicians are doing little to allay these fears, with 41% of respondents saying their physician sometimes or never suggested a generic prescription (Carrns, "Bucks," *AP/New York Times*, 9/27; Stein, "Booster Shots," *Los Angeles Times*, 9/27).

ACCOUNTABLE CARE ROUNDUP

HHS LAUNCHES NEW PCP DEMONSTRATION PROJECT

September 29, 2011

HHS has recruited insurers to help primary care physicians coordinate care under a newly announced demonstration project.

- **HHS** on Wednesday announced a new initiative that will reward primary care physicians who coordinate care and rein in spending. Through the Comprehensive Primary Care initiative—which is funded by the federal health reform law—Medicare will team up with public and private insurers to help physicians manage patients' chronic conditions, improve access to care, and engage patients and family members in treatment. CMS will pay the practices a monthly fee for such services, in addition to typical reimbursement, according to a news release. "We know that when doctors have time to spend time with their patients and can better coordinate care with specialists, people are healthier and we have lower costs in the health care system," CMS Administrator Donald Berwick said (HHS release, 9/28).

- **Maryland**: The state's patient-centered medical home program in its first six months has distributed about $3 million to participating physician groups. According to the *Baltimore Business Journal*, the program aims to provide high-quality primary care and re-enforce treatment by leveraging patient monitoring tactics and electronic health records. The **Maryland Health Care Commission** expects all participating practices to apply for **National Committee for Quality Assurance** medical home certification by Oct. 21 (Graham, *Baltimore Business Journal*, 9/27).

- **Minnesota**: The Minneapolis *Star Tribune*'s Lori Sturdevant last week explained why Hennepin County's Medicaid ACO project is "worth watching," despite continued criticism of the federal health reform law. The program aims to improve outcomes for roughly 12,000 patients ages 18 to 64, while increasing provider experience and reducing costs. Sturdevant says several local politicians have become invested in the project, noting that they are "best positioned to see what's driving local health care costs and how to change course." According to Sturdevant, "if Hennepin County can do it right," the project could become a model for other ACO projects nationwide (Sturdevant, *Star Tribune*, 9/24).

DAILY ROUNDUP: SEPT. 29, 2011

BITE-SIZED HOSPITAL AND HEALTH INDUSTRY NEWS

September 29, 2011

- **District of Columbia**: Although 8,490 physicians are licensed to work in the District of Columbia, only about 4,000 currently are practicing, and only 2,821 spend more than 20 hours per week seeing patients, according to a **D.C. Board of Medicine** report. The report noted that there are only 382 active primary care physicians in internal medicine, 307 in pediatrics, 119 in obstetrics and gynecology, and 110 in family practice. Moreover, the report found that physicians are concentrated in neighborhoods near hospitals, creating perceived shortages in some parts of the city (Sun, *Washington Post*, 9/27).

- **Missouri**: Temporary operations at tornado-ravaged **St. John's Regional Medical Center** in Joplin depend on funding from the **Federal Emergency Management Agency** (FEMA) and would suffer if the agency's funding runs out, KRMG reports. U.S. lawmakers are debating disaster-relief funding as they discuss how to reduce the nation's deficit. FEMA officials said the organization runs the risk of becoming insolvent, but that it has enough money to operate through the end of the fiscal year on Saturday (Davis, KRMG, 9/26; Korte, *USA Today*, 9/27).

- **New York**: **University of Rochester Medical Center** (URMC) and Canandaigua-based **Thompson Health** are considering an affiliation, which hospital officials say could enhance quality and rein in spending, the *Fairport-East Rochester Post* reports. URMC CEO Bradford Berk notes that a partnership could expand outpatient programs, boost regional presence, and eliminate duplicative services. A formal arrangement—which ultimately requires final approval from the **New York State Department of Health**—likely will not be reached for several months (Sherwood, *Post*, 9/27).

- **Pennsylvania**: Many of the nearly 41,000 former members of adultBasic—a state-funded health plan for low-income adults who do not qualify for Medicaid—are uninsured after the program was shut down, *Kaiser Health News* reports. According to state Insurance Department data, about 40% of those who lost adultBasic coverage when it closed in February were able to enroll in either Medicaid or a limited benefit **Blue Cross Blue Shield** Plan. Although some might have sought care at reduced costs through community health centers, "many of them have fallen through the cracks," Sharon Ward, director of the **Pennsylvania Budget and Policy Center**, said (Gold, *KHN*, 9/26).

- **Wisconsin**: State officials on Monday launched a website to outline how they plan to slice $444.6 million from Wisconsin's Medicaid program, the *Milwaukee Journal Sentinel* reports. As of Monday, the site detailed plans for approximately $15 million in new savings. According to Stephanie Smiley, spokesperson for the **Wisconsin Department of Health Services**, administrators will use the website to solicit input from the public before presenting proposals to state lawmakers and federal officials (Stein, *Journal Sentinel*, 9/26).

IN UTERO CHEMOTHERAPY MAY BE SAFER THAN EARLY DELIVERY

Children of women who had chemotherapy during pregnancy suffer more from being delivered prematurely than from the cancer treatment, according to research presented this week at the European Multidisciplinary Cancer Congress.

For the study, researchers from the **University Hospitals Leuven** in Belgium monitored the health and mental development of children born to mothers who were treated for cancer during their pregnancy. Among the 70 children born from the 68 women in the study, about 66% were delivered before 37 weeks of gestation.

Researchers determined that cognitive development was normal for most of the children. However, the children who had below normal IQs mostly were born prematurely, either naturally or by induction (Kelland, *Reuters*, 9/26).

Advisory Board Daily Briefing

The Advisory Board Company

The Daily Briefing
News for Health Care Executives

HITTING THE METRIC BUT MISSING THE POINT

September 07, 2011

Mike Wagner, the Advisory Board's chief teaching officer, discusses why organizations that manage improvement efforts solely according to key performance indicators (KPIs) are likely to constantly struggle to maintain high performance.

Avoid the three common pitfalls that plague executives and learn why hitting standard KPIs shouldn't be your primary goal. Watch now.

MEDICAL MONITORING GOES MOBILE
TEMPORARY TATTOOS FREE PATIENTS FROM WIRES AND MONITORS

September 07, 2011

The *New York Times* this week examined the growing "mHealth" field, noting that minuscule devices similar to press-on tattoos could help rein in health spending.

The mHealth trend uses mobile technologies, such as smartphone applications and wireless sensors, to educate, monitor, and treat patients. According to the *Times*, tattoos and other "epidermal electronics" may allow physicians to monitor patients from any location.

For example, **University of Illinois at Urbana-Champaign** researchers have developed an ultrathin tattoo device that weighs only three-thousandths of an ounce. Meanwhile, **FDA** last year approved a telemetry system that uses a 2-inch by 6-inch monitoring patch that transmits electrocardiogram readings to a central data center.

"Sensors on everyone, including a 60-year-old watching a football game who doesn't know he's at risk for a heart attack, would greatly reduce the changes of a fatal attack," Leslie Saxon, a **University of Southern California** cardiologist says.

Cost-savings potential
Monitoring patients at home could significantly curb health care costs, the *Times* reports. For example a 2008 **Department of Veterans Affairs** study found that patients who used at-home biometric monitoring devices experienced a 19% drop in hospitalizations compared to when they were not participating in the program. According to the findings, the average patient cost $1,600 annually, which was much lower than the $13,121 the department spent to provide home-based primary care without the devices.

Despite mHealth's potential benefits, Chuck Parker, the executive director of **Continua Health Alliance** says only 50,000 to 70,000 U.S. patients currently are being monitored by such devices. He notes that additional financial incentives might encourage more hospitals to adopt the technology (Stross, *Times*, 9/3).

GAP IN THE RANKINGS?

CHILDREN'S HOSPITAL RANKINGS BASED ON UNRELIABLE STATISTIC, STUDY FINDS

September 07, 2011

Mortality rates at children's hospitals, a key component in many popular commercial rankings, may be statistically unreliable, according to a study in *Pediatrics*.

As the U.S. health care system sharpens its focus on care quality, hospital mortality rates have become an increasingly common measure of performance and an important metric in major commercial rankings, such as *U.S. News & World Report*'s 'Best Hospitals' list. However, critics warn that focusing on mortality rates may cause facilities to prioritize numbers over patient care.

To assess the accuracy of rates used in hospital rankings, **Children's Hospital of Philadelphia** researchers and colleagues analyzed more than 475,000 patients discharged in 2008 from 42 children's hospitals. The researchers ranked the hospitals using each facility's adjusted death rate, a measure that accounts for variations in local patient populations.

They found that 22 of the 42 possible ranking slots had overlapping confidence intervals for mortality rates, suggesting that there was no way to statistically determine if the rates actually were different. As a result a children's hospital ranked number 15 might also be ranked number 37, *Reuters* notes.

Although the study's lead author says it is unlikely that patients are harmed by selecting highly ranked hospitals, he says that patients "have to be aware that if the rankings are not that different they should be allowed to think about other things," such as "how close it is to home, will my family be able to visit me?"

According to *U.S. News*' Health Rankings editor, mortality rates are only "one of many key factors" considered in the rankings. He calls the study overly broad and suggests that researchers should focus only on the sickest patients, who can be more indicative of care quality (Joelving, *Reuters*, 9/6).

CAPPING PAYMENTS

MASSACHUSETTS MAY CUT PAYMENTS TO MOST EXPENSIVE HOSPITALS

September 07, 2011

Massachusetts House Majority Leader Ronald Mariano (D) on Tuesday proposed legislation that would require insurers to reduce payments to the state's most expensive hospitals and physicians, the *AP/Boston Herald* reports.

Since the state enacted health reforms in 2006, Massachusetts has been a model for the national health care overhaul. However, a report issued this summer by state Attorney General Martha Coakley (D) found that providers with market leverage because of location or reputation continue to charge up to twice as much as other providers despite the introduction of global payment models intended to control costs.

Mariano's proposal prohibits expensive providers from signing or renewing insurer contracts until their rates are lowered to below the 80th percentile of insurance plan rates. The bill also would require insurance plans to increase reimbursement rates for the state's lowest-paid hospitals to above the 20th percentile. The bill takes geographic factors into account by dividing Massachusetts into four separate rate quadrants. According to Mariano, the plan would save at least $267 million and address "a wide discrepancy between the 'have' hospitals and the 'have-not' hospitals."

Responding to the proposal, **Massachusetts Hospital Association** President Lynn Nicholas acknowledged that a price disparity exists between Massachusetts hospitals but that it was not wide enough to merit government intervention. She warned that "[l]owering existing payments to some hospitals could have very serious unintended consequences," adding that hospitals "could be forced to raise the price of their existing services or eliminate valuable but undercompensated services."

If passed, the law would go into effect on Jan. 1, 2012, and remain in effect until Dec. 31, 2015, when state reform

provisions intended to change the health care payment system are fully implemented (Kowalczyk, *Boston Globe*, 9/6; *AP/Herald*, 9/6; Donnelly, *Boston Business Journal*, 9/6).

PROTECTING LGBT PATIENTS

CMS TELLS INSPECTORS TO ENFORCE SAME-SEX RIGHTS

September 07, 2011

CMS on Wednesday offered guidance to state agencies that conduct on-site inspections of hospitals, reminding the agencies to enforce protections for lesbian, gay, bisexual and transgender patients.

The agency in November issued a final rule that updated hospitals' Conditions of Participation in Medicare and Medicaid. Under the rule, hospitals that participate in the government programs must explain to all patients:

- That patients have a right to choose who can visit them during their stay;
- That these visitors can include family members, spouses, domestic partners, or another type of visitor; and
- That patients can designate a person of his or her choosing to make decisions on the patient's behalf.

According to **HHS** Secretary **Kathleen Sebelius**,"Couples take a vow to be with each other in sickness and in health and it is unacceptable that, in the past, some same-sex partners were denied the right to visit their loved ones in times of need." Sebelius and CMS Administrator Don Berwick stressed that the new guidance will help protect the rights of LGBT patients.

Separately, HHS' **Health Resources and Services Administration** on Wednesday announced a $248,000 grant to Boston's **Fenway Institute** for a national training center to help community health centers serve LGBT patients (CMS release, 9/7).

PRIMARY HEALTH CARE

HOW GOP PRESIDENTIAL CANDIDATES ARE APPROACHING REFORM

September 07, 2011

Although three leading GOP presidential candidates have promised to repeal the federal health reform law, the pledge obscures their divergent health policy records while serving as state governors, the *New York Times* reports.

According to the *Times*, Texas Gov. Rick Perry, former Massachusetts Gov. Mitt Romney, and former Utah Gov. Jon Huntsman all have attempted to distance themselves from their own health care records by ramping up their opposition to the overhaul.

Romney avoids federal overhaul comparisons
Romney—who frequently criticizes the reform law for being a "one-size-fits-all" solution for states—has denied comparisons between the 2006 Massachusetts health law and the federal law. He notes that the Massachusetts law would be "one of my biggest assets" in a campaign debate against President Obama. However, according to a **Massachusetts Institute of Technology** economist, the Massachusetts law "has succeeded spectacularly," but "Romney never explains why it wouldn't work elsewhere. There is no reason it wouldn't work elsewhere."

Perry touts market solutions
Perry leads a state where 26% of residents were uninsured between 2008 and 2009, more than any other state. However, he "believes that expanding government-sponsored insurance is not the answer ... nor is requiring people to purchase it," a spokesperson for Perry said. Instead, she notes that "[h]e looks to free market solutions."

Perry has called for creating multistate compacts to let states opt out of federal health programs but receive federal

funding to run substitute programs and implement malpractice restrictions, *CQ Weekly* reports. However, the *Times* notes that Texas has accepted almost $20 million in grants authorized by the overhaul, including $1 million to plan the state's health insurance exchange.

Huntsman remains quiet about former individual mandate support
In 2007, Huntsman sought to halve the number of uninsured Utah residents by 2010 and hired John Nielsen, a former hospital system lawyer, to facilitate that goal, the *Times* reports. According to Nielsen, Huntsman wanted to investigate whether the state "could replicate what Massachusetts had done." In 2008, Utah enacted a plan that relied on an exchange and an individual mandate, which Huntsman called necessary "if you're going to get it done and get it done right."

In his presidential campaign, Huntsman has remained quiet about his former support of an insurance mandate, the *Times* reports. Meanwhile, he said last month that he would support "a free-market approach to health care reform instead of a heavy handed Obama-like mandate" (Sack, *Times*, 9/3; Page, *USA Today*, 9/5; Kenen, *CQ Weekly*, 9/5 [subscription required]).

STRONGER STROKE STANDARDS
MEDICAL GROUP TIGHTENS STROKE CENTER GUIDELINES

September 07, 2011

The **Brain Attack Coalition** (BAC) has released new guidelines that address standards of care for acute stroke patients in primary stroke centers (PSCs).

A special report detailing the recommendations was published online Aug. 25 and will appear in the September issue of *Stroke*. There currently are more than 800 PSCs certified by the **Joint Commission** and several hundred more that have been certified by the **Healthcare Facilities Accreditation Program** and various state agencies.

The updated recommendations take into account a decade's worth of changes in the diagnosis and treatment of stroke patients. Studies since the last set of BAC recommendations in March 2000 have confirmed that stroke units reduce mortality and length of stay and increase functional independence compared to general wards.

In addition, the authors "beefed up" imaging recommendations, *Medscape Medical News* reports. For example, BAC recommends that PSCs perform a CT scan within 25 minutes, or an MRI if the facility can administer it within the same time frame.

BAC also recommends that:

- Acute stroke teams have at least one physician and one other staff member available at all times;
- Neurosurgical services be available within two hours of when they are deemed clinically necessary;
- Stroke units have a telemetry system for monitoring blood pressure, pulse, and oxygenation, and an established monitoring protocol;
- PSCs have cardiac imaging equipment, such as a cardiac MRI, or a transthoracic or transesophageal echo; and
- PSCs evaluate and initiate early rehabilitation services such as speech, physical, and occupational therapy.

According to the lead author of the report, "Many hospitals have benefited and will continue to benefit from certification as primary stroke centers." He notes that "[e]ven more importantly, the patients cared for at PSCs have clearly benefited by getting better treatment, experiencing fewer complications, and going home from the hospital sooner" (Jeffrey, *Medscape Medical News*, 8/30; National Institutes of Health release, 8/25).

BP HIGHER IN ED THAN WITH PCP
HYPERTENSION MORE COMMON IN EDS THAN PHYSICIAN'S OFFICES

September 07, 2011

Elevated blood pressure readings are more common in EDs than in physician's offices, according to a recent **National Center for Health Statistics** (NCHS) data brief.

For the study, an NCHS researcher analyzed data from the National Hospital Ambulatory Medical Care Survey for ED visits from 2007 to 2008. According to the report, a patient's blood pressure was severely elevated when systolic blood pressure was 160 mm Hg or higher and diastolic pressure was 100 mm Hg or higher. Meanwhile, moderately elevated blood pressure was defined as having systolic readings of 140 to 159 mm Hg or a diastolic reading of 90 to 99 mm Hg.

The findings showed that blood pressure was severely elevated at 16.3% of ED visits and moderately elevated at 27.2% of ED visits. Meanwhile, blood pressure was severely elevated at 6.8% of primary care office visits and moderately elevated at 20.2% of office visits.

Noting that elevated blood pressure readings may suggest underlying hypertension, the report's author said ED visits "could provide opportunities to address elevated blood pressure through patient education, initial treatment, and referral to primary care as deemed clinically appropriate" (Fiore, *MedPage Today*, 9/3).

HIT BY A UFO?
THERE'S AN ICD CODE FOR THAT

September 07, 2011

NPR's "Shots" this week examined some of the "wilder codes" included in the ICD-9 CM diagnostic code book for medical research and billing.

According to "Shots," the database includes specific codes for:

- Accident caused by firearm and air gun missile—air gun, such as BB guns and pellet guns;
- Accident caused by firearm and air gun missile—paintball gun;
- Injury caused by scorpion bite;
- Injury caused by centipede bite; and
- Injury caused by spacecraft.

The precise classification system has helped **Agency for Healthcare Research and Quality** researchers identify national case patterns, "Shots" reports. For example, researchers were able to determine that 97% of the 20,000 gun injuries in 2008 were caused by BB and pellet guns, and that injury rates for air guns that are not paintball guns are higher in the South and in rural areas (Hensley, "Shots," NPR, 9/6).

ANNOUNCING THE ADVISORY BOARD-MERCY CLINICS MEDICAL HOME HEALTH COACH TRAINING PROGRAM

September 07, 2011

The Advisory Board and Mercy Clinics are pleased to announce our inaugural Health Coach Training course, launching this October at Mercy Clinics in Des Moines, Iowa, on October 4-5 and November 2-3.

DAILY ROUNDUP: SEPTEMBER 7, 2011

BITE-SIZED HOSPITAL AND HEALTH INDUSTRY NEWS

September 07, 2011

- **District of Columbia and Maryland**: NPR last week examined the creation of **Walter Reed National Military Medical Center** in Bethesda, a merger of the Army's Walter Reed hospital and the Navy's Bethesda medical center. According to NPR, the new medical center will have to bridge the two military branches' separate traditions and cultures. "It's a bit like merging the Yankees and the Red Sox and then making them play in 'Derek Jeter Fenway Park,'" NPR reports, adding, "Yankees fans and Red Sox Nation would never go for it—but it might make a great baseball team" (Shapiro, NPR, 9/2).

- **Kansas and Missouri**: Findings from a *Kansas City Star* investigation released last week reveal that Kansas and Missouri licensing boards seldom discipline physicians with significant histories of alleged malpractice. Using data from the National Practitioner Data Bank, the newspaper determined that about 200 physicians in the two states have made payments in five or more malpractice suits since 1990 without being disciplined by a licensing board. Moreover, the states' boards do not make malpractice information publicly available, the *Star* found (Bavley, *Star*, 9/3).

- **New Hampshire**: A new state law allows trained pharmacists to give bacterial pneumonia and shingles vaccinations, the *AP/Miami Herald* reports. According to one of the law's sponsors, the change will increase public access to vaccines. However, physicians groups have opposed the new law, noting that it allows pharmacists to administer a vaccination without a prescription and without notifying the patient's physician (Love, *AP/Herald*, 9/4).

- **New York**: The **Niagara Health Quality Coalition** (NHQC) last week released its ninth annual New York State Hospital Report Card, the *Albany Times-Union* reports. The organization named 24 of the state's 209 facilities to its Safest Hospitals List and 20 to its Watch List. According to NHQC's president, mortality and avoidable complication rates are improving statewide (Crowley, *Times-Union*, 9/4).

FDA TO GIVE NUTRITION LABELS A NEW LOOK

FDA recently announced plans to revise the nutrition facts label on packaged foods to provide consumers with more information about nutritional content and help offset the country's increasing rate of obesity, the *AP/Washington Post* reports.

One proposal to alter the label would focus on making serving sizes more accurate and emphasizing calories. Further, the labels might no longer include certain aspects, including calories from fat and statistics that indicate the amount of nutrients an average diet should include. According to the *AP/Post*, the discussion over the changes has been going on since 2003. Some of the changes could be proposed as soon as this year.

FDA Deputy Commissioner Michael Taylor said the effort to revamp food labels marks a shift to create a more useful nutritional tool for U.S. residents. However, he warned against expecting a grand overhaul.

Meanwhile, food industry representatives, including the **Grocery Manufacturers Association**, have opposed the change, saying that the current label is simple, easily recognizable and adaptable to many different food packages (*AP/Post*, 9/3).

www.advisory.com/daily-briefing

Advisory Board Daily Briefing