LEADERS: DR. SANJAY SAINT

Creating a Laboratory for Better Patient Care

Dr. Sanjay Saint and his colleagues at the Veterans Affairs Medical Center in Ann Arbor, Mich., are turning the inpatient service there into a laboratory, trying to create the ideal hospital experience for patients.

The "Gold Service" project began over the summer and is a small part of Dr. Saint's decade-long quest to curb hospital-acquired complications and infections.

Dr. Saint, a professor of internal medicine at the University of Michigan, said he strives to bring the same type of prevention focus that general internists bring to the outpatient setting to the most vulnerable patients in the hospital. "I wanted to apply that framework to those patients who are so sick that if they actually get a complication under our watch, that could tip them over and it could mean that either they die or they never go home," he said.

For the last 9 years, Dr. Saint has served as director of the Patient Safety Enhancement Program at the Ann Arbor VA Medical Center and the University of Michigan Health System. In this latest project, he is working to create an inpatient service that is highly efficient and effective, achieves a high level of safety, and keeps patients satisfied, while also fulfilling the research and education missions of the VA and University of Michigan.

'We have to look at all these things not in a vacuum, but at how they interrelate.'

DR. SAINT

The overall goal, Dr. Saint said, is to provide the type of care that physicians would want for their own family members.

In practice, that means translating research into practice more quickly, providing appropriate oversight of residents and medical students, and improving communications across disciplines. On his service, they provide reading lists to learners, encourage better communication between nurses and physicians, and conduct multidisciplinary rounds.

Dr. Saint also urges the hospitalists and attending physicians to practice what they preach. For example, physicians can talk about the importance of preventing nosocomial infections, but if they don't wash their hands before and after touching the patient, it doesn't matter what they say. "Learners see that," he said.

Although there are no data from the project so far, Dr. Saint said they plan to measure their progress on several metrics and compare them to those of other services. Specifically, they hope to examine mortality, readmission rates, nosocomial infection rates, hand hygiene adherence rates, length of stay, patient and nurse satisfaction, and teaching evaluations.

The project is just getting off the ground, but Dr. Saint said they have already encountered challenges. One issue is overcoming the "outdated" mindset that physicians, nurses, and social workers should operate in separate silos, he said, rather than functioning as a true health care team. Ultimately, he hopes physicians and nurses will spend less time worrying about what's in their job descriptions and more time figuring out how to make the patient "the central focus," Dr. Saint said.

Another challenge is balancing some of the trade-offs between quality and resource utilization. For example, keeping patients in the hospital slightly longer could increase their satisfaction and potentially decrease readmission rates, but increasing the length of stay has other drawbacks. "We have to look at all these things not in a vacuum, but at how they interrelate," he said.

If he and his team are successful in improving patient care through the Gold Service, Dr. Saint hopes to see the lessons picked up by all kinds of hospitals, not just in the United States, but in countries all around the world. Since the research is being done at a VA facility, which is part of a large, centralized system, other countries with centralized health care systems like Canada, England, Italy, and France may be able to make similar changes, he said. ■

By Mary Ellen Schneider

Hospital 'Report Cards' Don't Improve Cardiac Care

BY MARY ANN MOON

Public release of hospital "report cards" did not measurably improve indicators of care for acute MI or chronic heart failure, according to a Canadian study.

Even though most of the hospitals involved in the study undertook at least one quality improvement initiative in response to the report cards, only 1 of 12 indicators of care for acute MI and only 1 of 6 indicators of care for chronic heart failure improved, said Dr. Jack V. Tu, a professor in the department of health policy, management, and evaluation at the University of Toronto, and his associates.

The investigators studied 81 Ontario hospitals, focusing on cardiac care because of the well-known gap between ideal and actual practice in patients hospitalized with acute MI or chronic heart failure.

At each hospital, a sample of 125 charts for 1999-2001 was reviewed. Participating hospitals were randomly assigned to receive early feedback (in October 2003, before the results were released to the public and received extensive media coverage in January 2004) or delayed feedback (in September 2005, at the same time as their results were released to the public but without any media coverage) on a report card of their performance in the reviewed cases.

Follow-up performance data were obtained on 15,997 patients treated for the same conditions at the same hospitals in 2004-2005.

Although 73% of hospitals that received early feedback changed order sets and/or clinical pathways or care maps for these patient groups during that interval, there was no significant change in performance for either the early-feedback or the late-feedback groups.

Only 1 of 12 factors measured in patients with acute MI—percentage receiving fibrinolytic therapy before transfer to a coronary care or ICU—improved significantly more with early feedback. Only 1 of 6 factors measured in patients with chronic heart failure—rate of ACE inhibitor or angiotensin II receptor blocker use in those with left ventricular dysfunction—improved significantly more with early feedback.

These findings "suggest that public release of hospital-specific performance data may not be a particularly effective system-wide intervention for measurably improving processes of care," Dr. Tu and his associates said (JAMA 2009 Nov. 18; doi:10.1001/jama.2009.1731). The study was released online simultaneously with Dr. Tu's presentation of the data at the annual scientific sessions of the American Heart Association.

A limitation of this study was that it involved one-time-only report cards. "More frequent and timely feedback of publicly released report cards on a regular basis might have been more effective," they added. Dr. Tu reported no financial conflicts of interest. ■

Federal Rule Waivers Allowed During H1N1 Flu Pandemic

BY ALICIA AULT

As a result of the public health emergency declared Oct. 23 by President Obama, hospitals and health providers may ask the Health and Human Services department to waive certain provisions required under federal health programs, including Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Portability and Accountability Act (HIPAA), and the Emergency Medical Treatment and Labor Act (EMTALA).

The declaration—issued in response to the novel influenza A(H1N1) pandemic—allowed HHS Secretary Kathleen Sebelius to authorize what are called section 1135 waivers. Normally, the waivers allow a limited-time suspension of certain federal health program requirements. These waivers usually are granted in a specific geographic area, often during a time of natural disaster such as a hurricane. Under the 2009 H1N1 emergency, the waivers are being granted nationwide and will be in effect for the duration of the pandemic.

To better care for patients during the pandemic, hospitals and health providers may ask HHS to waive requirements in five areas:

- ► Conditions and requirements of participation, certification requirements, and preapproval requirements.
- ► Sanctions against relocations and transfers under EMTALA.
- ► Sanctions related to self-referrals.
- ► Deadlines for performance of required activities, including billing and administrative activities.
- ► Sanctions arising from noncompliance with certain HIPAA rules.

Demand for waivers has been relatively low, according to Jean Sheil, pandemic coordinator at the Centers for Medicare and Medicaid Services. As of early November, 73 waivers had been submitted. Of those, 5 were approved and 64 withdrawn, said David Wright, an HHS official coordinating the waiver process.

Most of the withdrawals came after discussions with the CMS confirmed that the facilities or physicians did not need the waiver, he said.

Providers may be wary of applying out of concern that it may take too long to get an answer. Waiver requests are expedited, however; the five approved waivers were all completed in about 24 hours, according to Mr. Wright.

More information can be found at www.cms.hhs.gov/H1N1. ■

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