# 'Gently Used' Saves Money

**Derm Office** *from page 1*

Dr. Zalla insisted that the examination doors swing open in such a way that the patient cannot be seen while sitting or lying, gowned, on a table.

The building also is soundproof, with double layers of drywall and insulation in the ceiling as well as the walls.

Sometimes construction and design decisions were made that may have been more costly up front but should pay off in the long run. Fabric wall covering was chosen over paint because it "holds up better," said Dr. Zalla.

The same goes for the leather chairs in the main waiting room and the separate waiting area in the Mohs surgery suite. Curved baseboards allow for more efficient cleanup following surgery. The countertop in the reception area has recessed keyboard trays and chart files to reduce clutter.

When children stay occupied in the kid's cave, with its thermal handprint wall, distortion mirror, and fabric bookcase, the waiting room remains calm and quiet.

The water sculpture in the lobby provides a soothing sound as well as an artistic touch. "We get a lot of comments from patients about how relaxing it is, and occasionally someone will say, 'It made me have to go to the bathroom!' " Dr. Zalla joked.

He provided several tips, both large and small, for an efficient, pleasant office redesign:

► Invest in a power-assisted door (his is activated by a push button) and store a wheelchair near the front door for patients who need assistance.

► Install a magnetic card key system rather than traditional locks. This way, if a staff member leaves, there's no need to change the locks; just inactivate the card.

► Design a floor plan so that staff members with similar functions can share equipment. For example, Dr. Zalla's four claim-processing employees occupy cubicles around a common space with a fax machine, shredder, and postage machine.

► Provide a confidential space to phone patients with biopsy results or other protected information.

► Get estimates on a customized, high-tech call system. At Dr. Zalla's office, different lights signal that a patient has arrived, that a room is occupied, and where each physician is. When Dr. Zalla comes out of one room, he just follows the lights to the next patient, and it keeps him on track.

► Look for "gently used" equipment. Dr. Zalla said he bought high-quality, reconditioned surgical lights for half the price of new ones.

► Measure and measure again. Despite all the planning, the autoclave at the tissue prep station for Mohs surgery procedures proved too wide for the counter space—a minor glitch that everyone at the practice has learned to live with, he said. ■

Photos courtesy Dr. James Zalla

**From the cosmetic consultation room (left) to the dermatopathology reading room (right), design decisions were made that may be more costly up front but should pay off in the long run, said Dr. James Zalla.**

# Interdisciplinary Approach Reduces Medication Errors

BY MIRIAM E. TUCKER
*Senior Writer*

PITTSBURGH — An interdisciplinary medication-reconciliation intervention conducted over 2 months at two Boston-area hospitals was associated with a substantial decrease in the number of unintentional medication discrepancies with potential for causing patient harm.

Unintentional medication discrepancies that occur between preadmission and admission or at patient discharge are a major cause of potential adverse drug events (PADEs). To reduce the risk of PADEs at times of patient transition into and out of hospitals and other care settings, the Joint Commission called for all institutions to implement medication-reconciliation programs beginning in January 2006 as one of its National Patient Safety Goals (www.jcipatientsafety.org/14711).

Yet little information is available regarding what programs are most likely to be successful, how best to implement these systems, and which patients are most likely to benefit from them, Dr. Jeffrey L. Schnipper said at the annual meeting of the Society of General Internal Medicine.

Dr. Schnipper of Brigham and Women's Hospital, Boston, and his associates conducted a randomized, controlled trial of one such program on general medical units at two academic medical centers. The intervention consisted of a Web application called a preadmission medication list (PAML) builder, along with a "process redesign," which involved restructuring the way that physicians, nurses, and pharmacists enter patient medication notes into charts.

On admission, the ordering physician took a comprehensive medication history, input the initial PAML, and laid out a plan for the patient's medication during hospitalization. The nurse confirmed the accuracy of the instructions and let the physician know if there were any errors. The pharmacist reconciled the PAML with the physicians' admission orders and also checked for errors.

During the patient's hospital stay, the physician, nurse, and pharmacist worked together as a team to update the orders as needed. At discharge, the physician reviewed the PAML and current medications and created a set of discharge orders, while the nurse and pharmacist again contributed to the process.

Study pharmacists took "gold standard" medication histories using all available resources and those results were compared with the PAML and the admission and discharge orders. If any discrepancies were found, the study pharmacist would seek out the reason for it. Two blinded physician adjudicators then evaluated each error and its potential for harm.

A total of 162 patients were randomized to the intervention floor/team, while 160 patients received the usual care on other floors with other teams. About two-thirds of the patients were judged subjectively by the pharmacist at the time of admission to have low to medium understanding of their own medications, Dr. Schnipper said.

The number of PADEs per patient differed significantly between the two groups, with 1.44 per control patient versus 1.05 per intervention patient. The number of patients needed to treat to prevent one PADE was just 2.6, "not a lot of patients," Dr. Schnipper noted. The intervention was associated with a greater reduction in PADEs at discharge than in PADEs at admission. Despite the intervention's success, there was still an average of one PADE per patient, he said. ■

# *Analysis: Quality Incentives May Backfire on Safety-Net Hospitals*

BY MIRIAM E. TUCKER
*Senior Writer*

PITTSBURGH — The initiation of public reporting and pay-for-performance measures, designed as incentives to improve the quality of care at hospitals, may actually have the opposite effect on those institutions that serve lower-income populations.

That conclusion was based on an analysis of performance data on acute myocardial infarction, heart failure, and pneumonia from approximately 3,600 hospitals in the Web site www.hospitalcompare.com, the near-universal performance measure and public reporting system instituted in 2004 by the Centers for Medicare and Medicaid Services (CMS). Between 2004 and 2006, the hospitals with the highest proportion of Medicaid patients—which had the worst performance on the three measures to begin with—also saw the least improvements in quality, whereas those with the smallest proportion of Medicaid patients achieved the greatest improvements following initiation of the incentives, Dr. Rachel Werner reported at the annual meeting of the Society of General Internal Medicine.

These so-called safety net hospitals were generally in worse financial condition at baseline, and therefore would have fewer resources to invest in quality improvement. As a result, they could receive lower bonus payments and possibly even incur penalties for not meeting quality improvement standards. "There is concern that reporting and pay for performance could set up a system where rich hospitals become richer and poor hospitals become poorer," said Dr. Werner of the Center for Health Equity Research and Promotion at the Philadelphia Veterans Affairs Medical Center.

After controlling for baseline hospital performance and other variables, investigators found that the percentage point improvements from 2004 through 2006 for the hospitals with the highest quartile of Medicaid population (mean, 40%) were 2.3 for composite measures of acute MI, 6.6 for heart failure, and 8.0 for pneumonia, compared with 3.8, 8.0, and 9.3, respectively, for the hospitals in the lowest quartile (mean, 5%).

As a result of these differences, the safety-net hospitals end up with a far lower probability of ranking among the top two deciles for clinical quality scores, designations that earn hospitals bonus incentive payments in the CMS pay-for-performance demonstration: The top decile of participating hospitals receives 2% of the Diagnosis-Related Group (DRG)–based prospective payment for patients with the measured condition for all Medicare fee-for-service beneficiaries. Hospitals in the second decile receive 1% of the payment amount (www.cms.hhs.gov/HospitalQualityInits).

A nationwide simulation of the CMS demonstration showed that not only would the safety-net hospitals suffer because of lower bonus payments, but they would also be financially penalized to a greater extent. If the CMS demonstration were instituted at all hospitals, the result could be substantially smaller payments for the safety-net hospitals, concluded Dr. Werner, who is also with the division of general internal medicine at the University of Pennsylvania, Philadelphia.

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